European Monitoring Centre for Drugs and Drug Addiction

Krajowe Biuro ds. Przeciwdziałania Narkomanii

CENTRUM INFORMACJI O NARKOTYKACH I NARKOMANII

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Ustawa narkotykowa

Podstawowym aktem prawnym z zakresu prawa narkotykowego nadal pozostaje Ustawa z dnia 29 lipca 2005 roku o przeciwdziałaniu narkomanii. Reguluje ona: 1) kompetencje w przeciwdziałaniu narkomanii poszczególnych służb oraz instytucji na stopniu centralnym i samorządowym, 2) działalność w zakresie edukacji, wychowania oraz informacji, 3) sposób postępowania z osobami uzależnionymi, 4) reguły oraz tryb postępowania z prekursorami, środkami odurzającymi i substancjami psychotropowymi, 5) reguły oraz tryb postępowania w związku z uprawami maku i konopi oraz 6) przepisy karne i 7) wykaz substancji kontrolowanych.

Aktem wykonawczym wskazującym kierunki priorytetowe w polityce narkotykowej i spełniającym rolę zarówno Krajowej Strategii, jak i Planu Działania, jest Krajowy Program Przeciwdziałania Narkomanii na lata 2011–2016. Od 2006 roku Krajowy Program jest aktem prawnym w randze rozporządzenia. Promuje on zrównoważone podejście do problemu narkotyków i narkomanii, zachowując proporcje pomiędzy zadaniami z zakresu redukcji popytu i ograniczania podaży. Celem głównym programu jest ograniczanie używania narkotyków i związanych z tym problemów zdrowotnych i społecznych.

Rada ds. Narkomanii jest organem koordynująco-doradczym, który został powołany w 2001 roku. Do zadań Rady należy: 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 krajowych strategii i planów działania, 4) monitorowanie realizacji Krajowego Programu, 5) zalecanie rozwiązań organizacyjnych w zakresie dotyczącym przeciwdziałania narkomanii, 6) współdziałanie z podmiotami realizującymi zadania w obszarze przeciwdziałania narkomanii w zakresie problematyki dotyczącej działalności Rady. W ramach Rady działają cztery zespoły robocze: zespół ds. prekursorów, zespół ds. współpracy międzynarodowej, zespół ds. implementacji Krajowego Programu i zespół ds. nowych substancji psychoaktywnych. Zespoły robocze pełnią rolę doradczą i są wsparciem merytorycznym dla Rady.

W 2013 roku nie wprowadzono znaczących zmian prawnych w obszarze narkotyków i narkomanii. Trwały jednak prace nad nowelizacją ustawy o przeciwdziałaniu narkomanii. W 2013 roku zespół ekspertów opracował projekt nowelizacji, który zakłada wprowadzenie kilku zmian ułatwiających kontrolę nad nowymi substancjami psychoaktywnymi przez Inspekcję Sanitarną, w tym stworzenie mechanizmu oceny ryzyka nowej substancji przed podjęciem działań kontrolnych. Projekt zawiera również przepisy mające na celu redukcję pozamedycznego używania leków dostępnych bez recepty i wykorzystywania ich do produkcji narkotyków. Projekt został poddany konsultacjom międzyresortowym i został przyjęty przez Radę Ministrów.

Poza pracami nad nowymi aktami prawnymi, w 2013 roku Ministerstwo Sprawiedliwości monitorowało i dokonało wstępnej oceny stosowania w praktyce, uchwalonej w 2011 roku, nowelizacji ustawy o przeciwdziałaniu narkomanii, w szczególności art. w zakresie 62a, który daje prokuratorowi lub sędziemu możliwość umorzenia postępowania karnego wobec osoby, która została przyłapana na posiadaniu niewielkiej ilości narkotyku na własny użytek.

Z danych Ministerstwa Sprawiedliwości wynika, że spośród wszystkich spraw dotyczących posiadania narkotyków w 2012 roku 30% zostało umorzonych, warunkowo umorzonych lub osoby zostały uniewinnione przez organy prokuratury i sądu (Wilamowska 2014). W 2013 roku odsetek ten wzrósł do 34%. Ponadto analizując umorzenia przez prokuraturę na mocy samego artykułu 62a także można zaobserwować wyraźny wzrost w liczbach bezwzględnych. W 2011 roku nie odnotowano w statystykach żadnego takiego przypadku. W roku 2012 takich spraw było 2154, a w 2013 roku liczba ta wzrosła do 3132 spraw. Zmiany w strukturze orzecznictwa pokazuje także analiza danych za pierwsze półrocze 2013 roku w zestawieniu z latami wcześniejszymi. Powoli, ale systematycznie spada liczba skazań za posiadanie narkotyków z przepisów ustawy o przeciwdziałaniu narkomanii przy jednoczesnym wzroście umorzeń postępowania i warunkowych umorzeń zarówno na etapie postępowania sądowego jak i prokuratorskiego.

Dane ministerstwa Sprawiedliwości wskazują także na pozytywne tendencje w zakresie wykorzystywania środków probacyjnych po zmodyfikowaniu zasad zgodnie z art. 70 a, 72a i 73a ustawy. Dane wskazują, że wzrosła liczba orzeczeń przez sądy rejonowe środków probacyjnych, co było celem nowelizacji ustawy.

Krajowy Program Przeciwdziałania Narkomanii na lata 2011-2016 (KPPN)[1]

Podstawowym dokumentem będącym zarówno krajową strategię jak i planem działania w zakresie przeciwdziałania narkomanii w Polsce jest Krajowy Program Przeciwdziałania Narkomanii 2011-2016. Podobnie jak poprzedni stanowi podstawę do działań w zakresie przeciwdziałania narkomanii w Polsce. Określa on m.in. harmonogram przyjętych działań, cele, sposoby ich osiągania oraz resorty odpowiedzialne za ich realizację, a także podmioty właściwe do podejmowania określonych działań.

Program określa kierunki działań przewidzianych do realizacji przez jednostki samorządu terytorialnego w zakresie przeciwdziałania narkomanii, które następnie powinny znaleźć swoją konkretyzację w wojewódzkich programach przeciwdziałania narkomanii (zgodnie z Artykułem 9 ust. 1. Ustawy o przeciwdziałaniu narkomanii[2]) oraz w gminnych programach przeciwdziałania narkomanii (zgodnie z Artykułem 10 ust. 2. ww. Ustawy).

Ograniczenie używania narkotyków i związanych z tym problemów społecznych i zdrowotnych jest celem głównym Programu. Zadania Programu realizowane są w pięciu obszarach:

I. Profilaktyki,
II. Leczenia, rehabilitacji, ograniczania szkód zdrowotnych i reintegracji społecznej,
III. Ograniczenia podaży,
IV. Współpracy międzynarodowej,
V. Badań i monitoringu.

Dla każdego z pięciu powyższych obszarów sformułowano cel główny, którego osiągnięcie przyczyni się do zrealizowania założonego celu ogólnego.

W obszarze profilaktyki celem głównym jest zmniejszenie popytu na narkotyki w społeczeństwie polskim. Osiągnięcie pożądanego efektu możliwe będzie m.in. poprzez zsynchronizowane działania instytucjonalnie, realizowane w odniesieniu do ogółu społeczeństwa i wybranych grup docelowych, takich jak: dzieci i młodzież szkolna, grupy szczególnie zagrożone używaniem narkotyków. Ważnym elementem, różnicującym poprzedni i obowiązujący Program jest zwiększenie nacisku na podnoszenie jakości programów profilaktycznych i kwalifikacji realizatorów tych programów.

W obszarze leczenia, rehabilitacji, ograniczania szkód zdrowotnych i reintegracji społecznej, obowiązujący Program kładzie główny nacisk na poprawę jakości życia osób używających narkotyków szkodliwie i osób uzależnionych. Osiągnięcie tego celu planowane jest poprzez profesjonalizację pro-

1 Rozporządzenie Rady Ministrów z 22 marca 2011 roku o Krajowym Programie Przeciwdziałania Narkomanii na lata 2011-2016 (Dziennik Ustaw Nr 78, poz. 428).
2 Ustawa z 29 lipca 2005 o przeciwdziałaniu narkomanii (Dziennik Ustaw Nr 179, poz. 1485).

gramów leczenia, zwiększenie dostępności leczenia substytucyjnego, rozwój programów redukcji szkód, zmniejszenie przypadków bezdomności i bezrobocia wśród osób używających narkotyków szkodliwie oraz osób uzależnionych. Znaczącą zmianą w KPPN 2011-2016, jest zapewnienie dostępu do leczenia substytucyjnego we wszystkich województwach dla co najmniej 25% osób uzależnionych od opiatów poprzez zwiększenie liczby programów i zapewnienie odpowiednich nakładów finansowych przez Narodowy Fundusz Zdrowia. Mimo iż działanie to zaplanowane było w poprzednim Programie nie zostało ono zrealizowane. Leczeniem tym objęto zaledwie 7% osób uzależnionych (zakładano objęcie leczeniem substytucyjnym 20% osób uzależnionych od opiatów).

W obszarze ograniczania podaży na narkotyki obowiązujący Program w dużej części stanowi kontynuację wcześniejszego Programu. Nowe działania są odpowiedzią na niebezpieczne tendencje, które pojawiły się na nielegalnym rynku narkotyków. Według ostatnich danych dotyczących przestępczości narkotykowej w Polsce odnotowano wzrost liczby przestępstw w zakresie nielegalnej uprawy konopi. W związku z powyższym zaplanowane zostały aktywności mając na celu ograniczenie krajowej uprawy konopi innych niż włókniste. Ponadto skoncentrowano się również na walce z krajową produkcją amfetaminy, która jest najbardziej popularnym stymulującym narkotykiem. W ramach prowadzonych działań przewidziano aktywności przeciwko wykorzystaniu prekursorów do produkcji narkotyków. Nowym elementem KPPN 2011-2016 jest ujęcie kwestii dotyczących Internetu, w tym dokonywania transakcji i nielegalnego obrotu zarówno narkotykami, jak też prekursorami.

Jeśli chodzi o obszar współpracy międzynarodowej to celem głównym jest wzmocnienie pozycji Polski na forum międzynarodowym w zakresie ograniczania problemu narkotyków i narkomanii. Działania zaproponowane w programie w znacznej mierze stanowią kontynuację działań realizowanych w ramach poprzedniego KPPN. Wprowadzone zmiany polegają na jednoznacznym rozgraniczeniu kierunków działań (co w poprzednim KPPN nie było wyraźnie zaznaczone) na następujące obszary: współpraca na forum Unii Europejskiej, współpraca z instytucjami i organizacjami międzynarodowymi innymi niż Unia Europejska i współpraca z państwami trzecimi (nie należącymi do Unii Europejskiej). Ponadto KPPN 2011-2016 określa rodzaje działań dotyczące: realizacji inicjatyw krajowych w ramach polskiej Prezydencji w UE z uwzględnieniem aktywności Trio Prezydencji (Polska, Dania, Cypr) oraz realizacji inicjatyw krajowych w ramach tzw. Partnerstwa Wschodniego UE.

Obszar Badania i monitoring stanowi natomiast wsparcie dla realizacji planowanych działań z zakresu profilaktyki, rehabilitacji oraz ograniczenia podaży. Horyzontalny charakter prowadzonych działań w tym obszarze nie uległ zasadniczym zmianom. Wprowadzono jednak kilka zmian stanowiących rozwinięcie wybranych zagadnień. KPPN wprowadza do realizacji następujące działania:

- badania długości czasu utrzymania abstynencji wśród pacjentów opuszczających placówki leczenia uzależnień od narkotyków,
- badania problemowych użytkowników narkotyków,
- upowszechnienie informacji o epidemiologii problemu narkotyków i narkomanii oraz o reakcjach na problem narkotyków i narkomanii,
- ewaluacja Krajowego Programu Przeciwdziałania Narkomanii.

Podkreślono także znaczenie monitorowania rynku nowych środków odurzających, substancji psychoaktywnych i środków zastępczych.

Wnioski z realizacji KPPN

Krajowe Biuro ds. Przeciwdziałania Narkomanii corocznie przygotowuje raport z realizacji KPPN, na podstawie analiz danych oraz analiz sprawozdań nadesłanych ze wszystkich instytucji wskazanych w Programie. Na podstawie analizy ww. danych i sprawozdań w 2014 r. sformułowano następujące wnioski:

1. Niewystarczające wykorzystanie programów profilaktyki uzależnień, które uzyskały rekomendację, to ważny problem występujący w trakcie realizacji KPPN w 2013 roku. Na kwestię tę zwrócono także uwagę podczas kontroli przeprowadzonej w 2012 roku w placówkach sys-

temu oświaty przez Najwyższą Izbę Kontroli. Niezbędne jest zatem podjęcie dalszych działań adresowanych do jednostek samorządu terytorialnego i kuratoriów oświaty mających na celu szersze upowszechnianie w szkołach, na wszystkich poziomach edukacji, programów profilaktycznych o potwierdzonej skuteczności. Podobnie jak w roku poprzednim, MEN nie zbierało danych na temat części istotnych wskaźników realizacji działań prowadzonych w szkołach, co uniemożliwia ocenę efektów realizacji KPPN w takich obszarach jak m.in. upowszechnienie programów profilaktycznych o potwierdzonej skuteczności. Rekomenduje się podjęcie przez MEN działań mających na celu opracowanie systemu zbierania danych umożliwiających monitorowanie postępu realizacji KPPN w placówkach oświaty.

2. W związku z niewielkim zaangażowaniem Urzędów Marszałkowskich w zadania mające na celu wspieranie superwizji osób zaangażowanych w działania profilaktyczne, rekomenduje się szersze wsparcie dla tego rodzaju aktywności w kolejnych latach. Superwizja i inne formy doskonalenia zawodowego mają istotne znaczenie w kontekście jakości pracy profilaktycznej, jak i zapobiegania zjawisku wypalenia zawodowego.
3. Jedynie część Urzędów Marszałkowskich wsparła w 2013 roku działania ukierunkowane na upowszechnianie i realizację programów opartych na naukowych podstawach. Rekomenduje się szersze zaangażowanie samorządów w realizację tego typu działań, zwłaszcza w województwach posiadających przeszkolonych i doświadczonych realizatorów takich programów. Samorządy mogą w tym celu korzystać z bazy programów zamieszczonej na stronie KBPN.
4. Samorządy gmin najwięcej środków finansowych przeznaczają na realizację działań z zakresu profilaktyki uniwersalnej. Nadal jednak w niewielkiej liczbie gmin realizowane są rekomendowane programy profilaktyczne. Ich upowszechnienie wymaga lepszej współpracy pomiędzy samorządami gmin a placówkami oświaty, w tym w szczególności szkołami.
5. Jedynie nieco ponad 28% wszystkich gmin, które przesłały sprawozdanie z realizacji KPPN (2 233 gminy) organizowało lub dofinansowywało szkolenia z zakresu podnoszenia kwalifikacji zawodowych osób zaangażowanych w działalność profilaktyczną. Rekomenduje się szersze wsparcie dla tego rodzaju aktywności z uwagi na fakt, że wszelkie formy doskonalenia zawodowego mają istotne znaczenie w kontekście jakości pracy profilaktycznej, jak i zapobiegania zjawisku tzw. wypalenia zawodowego.
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, szkolenie nowych realizatorów oraz zwiększenie nakładów finansowych na jego realizację.
7. Z roku na rok obserwujemy coraz lepszą dostępność do programów leczenia substytucyjnego, choć nadal programy te nie są w stanie zaspokoić potrzeb wszystkich osób uzależnionych od opiatów. Mimo, że w 2013 roku wydano zgody na uruchomienie kolejnych 4 programów, szacuje się, że tą formą leczenia objętych jest pomiędzy 12% a 23% osób uzależnionych od opiatów. W województwie podlaskim i podkarpackim nadal nie funkcjonują programy leczenia substytucyjnego, wyraźnie ograniczony dostęp do substytucji występuje w województwach: pomorskim, zachodniopomorskim oraz wielkopolskim.
8. Niepokojące jest, iż w roku sprawozdawczym urzędy marszałkowskie w bardzo niewielkim stopniu zaangażowane były w rozwijanie programów ograniczania szkód zdrowotnych. Ani jeden urząd marszałkowski nie wspierał programów wymiany igieł i strzykawek. Także placówki niskoprogowe dla osób uzależnionych, nie zmotywowanych do leczenia (typu noclegownie, świetlice „drop-in") nie były wspierane przez urzędy. Dlatego rekomenduje się jednostkom samorządu terytorialnego, tam gdzie jest to uzasadnione, uwzględnienie działań z obszaru ograniczania szkód zdrowotnych.
9. Odsetek gmin wspierających działania z zakresu leczenia, rehabilitacji, ograniczania szkód zdrowotnych oraz reintegracji społecznej w 2013 roku osiągnął jedynie 37% (tj. 837 gmin z 2233

gmin, które sprawozdały się w roku sprawozdawczym). Mając na uwadze powyższe rekomenduje się szersze wsparcie dla tego rodzaju aktywności w kolejnych latach.

10. Corocznie zwiększa się liczba nielegalnych upraw marihuany wykrywanych przez Policję. Wzrastająca popularność marihuany wśród młodzieży powoduje zwiększenie się liczby krajowych upraw konopi, którymi zajmują się coraz częściej zorganizowane grupy przestępcze. Zwalczanie upraw marihuany prowadzonych przez zorganizowane grupy przestępcze, wymaga intensyfikacji działań oraz współpracy wielu służb.
12. Produkcja narkotyków syntetycznych nie ogranicza się tylko do laboratoriów amfetaminy jak to było kilka lat temu. W Polsce wykrywane są miejsca produkcji metamfetaminy, mefedronu czy BMK. Rozwijający się rynek narkotyków syntetycznych w Polsce, które są produkowane przez zorganizowane grupy przestępcze, stanowić będzie wyzwanie dla służb zajmujących się przestępczością narkotykową.

Działalność Rady ds. Przeciwdziałania Narkomanii

W 2013 roku prace Krajowej Rady ds. Przeciwdziałania Narkomanii i jej zespołów roboczych skupiały się na kwestiach, takich jak: pozamedyczne używanie leków OTC zawierających pseudoefedrynę, DXM, kodeinę i benzydaminę, wstępna ocena efektów funkcjonowania art. 62a ustawy o przeciwdziałaniu narkomanii, wdrażanie Krajowego Programu Przeciwdziałania Narkomanii oraz wyniki kontroli Najwyższej Izby Kontroli w zakresie profilaktyki w szkołach.

Ponadto działania prowadziła Rada ds. Badań Naukowych, powołana w 2011 roku zarządzeniem dyrektora Krajowego Biura ds. Przeciwdziałania Narkomanii. Jest to organ wspierający i pełni funkcje doradcze oraz opiniodawcze. W skład Rady wchodzi siedmiu członków, którzy zostali powołani ze względu na swoją wiedzę i doświadczenie w obszarze badań naukowych nad uzależnieniami. Do zadań Rady należy przede wszystkim inicjowanie badań, określanie potrzeb i priorytetów w obszarze uzależnień. W 2013 roku Rada określiła następujące priorytety badawcze: iniekcyjne przyjmowanie narkotyków w kontekście HIV/AIDS, rynek nielegalnych narkotyków, przestępczość narkotykowa, redukcja podaży narkotyków, poprawa jakości systemu oddziaływań profilaktycznych uzależnień od narkotyków.

Konkurs Badawczy

W celu wspierania działań badawczych Krajowe Biuro od 2008 roku organizuje konkursy dotyczące badań w obszarze uzależnień od narkotyków. Projekty wybierane są przez komisję powołaną przez dyrektora Krajowego Biura z uwzględnieniem dodatkowych recenzji. W 2013 roku sfinansowano dwa nowe projekty badawcze: „Konstruowanie poczucia kontroli użytkowników nad marihuaną i kontekst nie-legalności" Stowarzyszenia Pracowni Rozwoju Osobistego oraz „Program pilotażowy skierowany do osób przyjmujących narkotyki drogą iniekcji (IDU)" Społecznego Komitetu ds. AIDS, a także kontynuowano realizację trzech projektów z lat poprzednich: „Analiza dyskursu nielegalnego rynku narkotykowego w sieci, na podstawie badań największego forum dotyczącego substancji psychoaktywnych" Stowarzyszenia Pracowni Rozwoju Osobistego, „Badanie skuteczności autorskiego programu wspomagania rozwoju psychospołecznego młodzieży w wieku gimnazjalnym" oraz „Badanie skuteczności autorskiego programu wspomagania rozwoju psychospołecznego dzieci w wieku szkolnym z trudnościami w realizacji wymagań programowych" Uniwersytetu Kazimierza Wielkiego w Bydgoszczy .

Badania w populacji ogólnej

Badanie pt. „Diagnoza społeczna 2013", przeprowadzone pod kierownictwem Janusza Czapińskiego, profesora na Wydziale Psychologii Uniwersytetu Warszawskiego oraz prorektora Wyższej Szkoły Finansów i Zarządzania, oraz Tomasza Panka, profesora w Instytucie Statystyki i Demografii Szkoły

Głównej Handlowej w Warszawie, miało na celu dostarczenie kompleksowych informacji na temat warunków i jakości życia Polaków.

Wyniki badania „Diagnoza społeczna 2013" pokazują, że grupą najbardziej zagrożoną narkomanią są mężczyźni poniżej 24. roku życia, w tym uczniowie i studenci, zamieszkujący duże miasta. Odsetek osób przyznających się do zażywania narkotyków w minionym roku wyniósł 1,3%. Biorąc pod uwagę kwestię wieku polskich użytkowników narkotyków, to nadal dominują wśród nich osoby młode – najliczniejszą grupę stanowią osoby do 30. roku życia.

Jedyną zmienną, która nie różnicuje istotnie statystycznie odsetka osób używających nielegalnych substancji psychoaktywnych jest poziom wykształcenia badanych.

W czerwcu 2013 roku zostało przeprowadzone badanie ilościowe na reprezentatywnej próbie Polaków powyżej 15. roku życia (N=1000). Respondenci pytani byli o doświadczenia związane z używaniem poszczególnych, wymienionych z nazwy, substancji w trzech przedziałach czasowych – w ciągu ostatnich 30 dni, 12 miesięcy oraz kiedykolwiek w życiu. Badanie zrealizowano techniką CAPI, w ramach projektu OMNIBUS, za pomocą wywiadów osobistych w domach respondentów. Wyniki badania zostały opracowane przez CINN KBPN[3].

Do najbardziej popularnych nielegalnych substancji psychoaktywnych w Polsce należą przetwory konopi indyjskich i w mniejszym stopniu amfetamina. Do zażywania nielegalnych substancji psychoaktywnych w ciągu ostatniego roku przyznało się 2,5% badanej populacji, kiedykolwiek w życiu – 7,1%; dla marihuany wskaźniki te wynosiły odpowiednio 2,4% oraz 6,6%. Porównując wyniki dotyczące marihuany do używania jakiekolwiek narkotyku, można stwierdzić, że sięganie po nielegalne substancje w Polsce wiąże się przede wszystkim z używaniem przetworów konopi. Używanie określonych substancji łączy się z określonymi zmiennymi demograficznymi. Po narkotyki częściej sięgają mężczyźni, z młodszych kohort wiekowych (15-34 lata), osoby z wyższym bądź średnim wykształceniem. Wyższy odsetek używania narkotyków zaobserwowano również w przypadku mieszkańców większych miast. Należy jednak zaznaczyć, iż cechy te są charakterystyczne dla użytkowników substancji nielegalnych. Działania profilaktyczne powinny zatem dotyczyć nie tylko młodzieży, ale także młodych dorosłych; należy je jednak realizować przede wszystkim w miastach. Marihuana będzie stanowić największe wyzwanie dla systemu pomocy. Mimo sprzeciwu wobec używania tego narkotyku (78% za zakazem używania), wzrasta jego popularność, co może wiązać się ze wzrostem zapotrzebowania na leczenie. Według danych CINN z 2013 roku co druga osoba, która po raz pierwszy w życiu zgłosiła się do leczenia, zrobiła to z powodu problemów związanych z używaniem marihuany. Wiąże się to z faktem, że marihuana ma o wiele większe stężenie THC niż kilka lat temu (średnia zawartość THC według CLKP w 2013 roku wynosiła 10%), co oznacza, iż obecnie palący przyjmują jednorazowo większe dawki substancji narkotycznej niż kiedyś. Amfetamina w dorosłej populacji jest najczęściej używanym stymulantem, jednakże poziom rozpowszechnienia jest mały. Po leki nasenne i uspokajające przyjmowane bez przepisu lekarza częściej sięgają kobiety, ze starszych grup wiekowych (powyżej 45 lat), mieszkanki wsi oraz mniejszych miejscowości, z wykształceniem wyższym bądź zawodowym. Wyniki badań pokazują również, że ruchy na rzecz legalizacji marihuany nie mają szerokiego wsparcia społecznego. Prawie połowa społeczeństwa jest za karaniem więzieniem posiadania jakiejkolwiek ilości marihuany, trzy czwarte uważa natomiast, że używanie marihuany nie powinno być dozwolone.

Pod koniec 2013 roku Fundacja CBOS i Krajowe Biuro ds. Przeciwdziałania Narkomanii zrealizowały badanie wśród młodzieży szkolnej pod nazwą „Młodzież 2013"[4]. Jednym z elementów pomiaru było określenie skali używania substancji psychoaktywnych. Badanie zostało zrealizowane na ogólnopolskiej próbie losowej 65 szkół (jedna klasa w szkole) – liceów, techników i zasadniczych szkół zawodowych. W badaniu uczestniczyła młodzież ostatnich klas szkół ponadgimnazjalnych dziennych, bez szkół specjalnych. W większości byli to uczniowie w wieku 18-19 lat. W każdej klasie badaniem

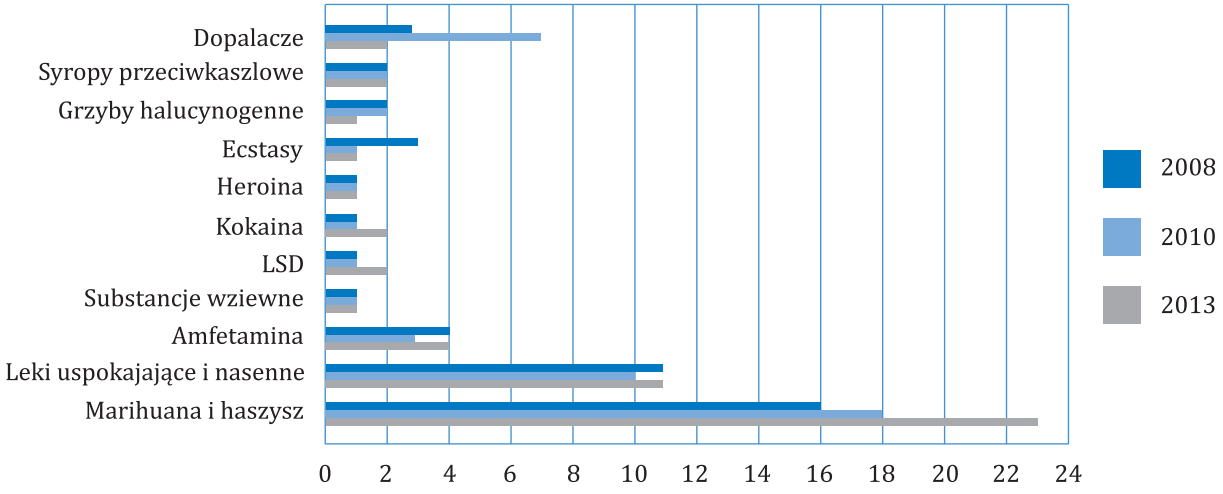
3 Wyniki badania znajdują się na stronie: http://www.cinn.gov.pl/portal?id=15&res_id=789384
4 Raport z badań jest dostępny na stronie: http://www.cinn.gov.pl/portal?id=15&res_id=673746

objęto wszystkich uczniów obecnych w dniu realizacji ankiet: łącznie 1360 osób. Badania zostały zrealizowane metodą audytoryjną – uczniowie samodzielnie i anonimowo wypełniali ankiety w czasie jednej godziny lekcyjnej.

Od początku realizacji badania uczniowie pytani są o używanie narkotyków w ciągu ostatniego roku. W latach 1992–2003 liczba uczniów, którzy używali narkotyków w ciągu ostatniego roku systematycznie wzrastała (z 5% do 24%). W następnych latach odsetki zmniejszyły się do poziomu poniżej 20%. W ostatnim badaniu z 2013 roku osiągnęły 18%. Uczniów, którzy używali narkotyków, zapytano, jakie to były środki. Ponadto mogli wymienić trzy najczęściej używane przez nich substancje. W 2013 roku 88% uczniów, którzy mieli kontakt z narkotykami w ciągu ostatniego roku, wymieniło marihuanę (wzrost o 6 punktów procentowych w porównaniu z rokiem 2010), a 10% – amfetaminę (spadek o 1 punkt procentowy). Oprócz tego uczniowie zadeklarowali używanie kokainy (4%), haszyszu (3%), LSD (2%), grzybów halucynogennych (1%), DXM (1%) oraz mefedronu (1%). Podstawą oprocentowania są uczniowi, którzy zadeklarowali używanie narkotyków w ciągu ostatniego roku. Największy spadek używania środków odurzających odnotowano w przypadku „dopalaczy", których używanie zadeklarowało w 2010 roku 13% badanych, a w 2013 roku 4%. Z badań prowadzonych od 1992 roku wynika, że chłopcy częściej niż dziewczęta mają kontakt z narkotykami. W 2013 roku 24% uczniów i 10% uczennic odpowiadało twierdząco na pytanie o używanie nielegalnych substancji. W 2010 roku sięganie po narkotyki zadeklarowało 20% chłopców i 10% dziewcząt. Wzrost używania narkotyków wśród młodzieży został zatem spowodowany zwiększeniem się odsetka chłopców sięgających po narkotyki.

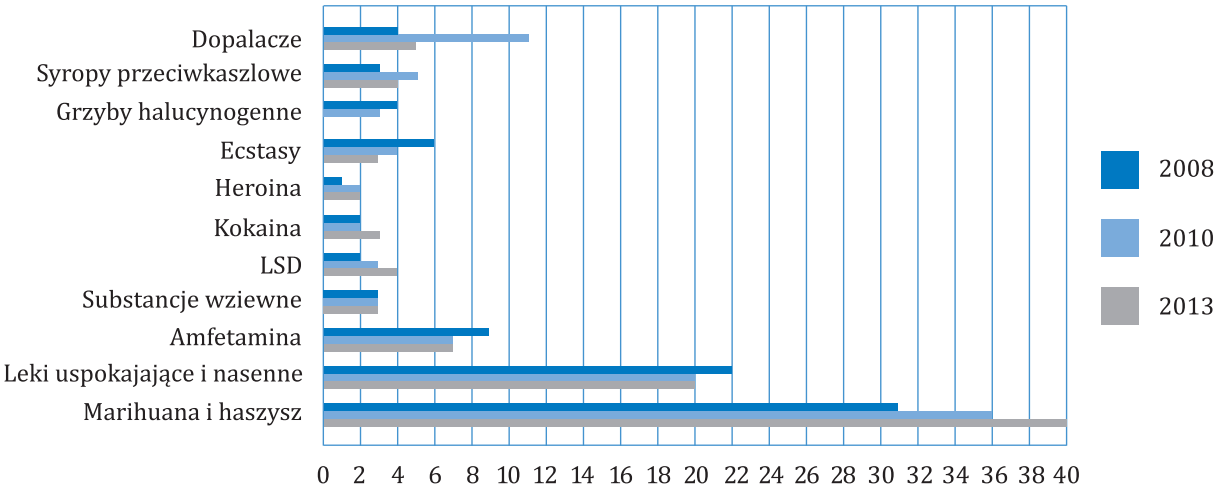
Najczęściej zażywaną substancją przez uczniów była marihuana i haszysz. Do przyjmowania jej kiedykolwiek w życiu przyznało się w 2013 roku 40% badanych, co oznacza wzrost o 4 punkty procentowe w stosunku do roku 2010. Wyniki ostatniego pomiaru pokazały kontynuację trendu wzrostowego również w przypadku używania w ciągu ostatniego roku i w ostatnich 30 dni. W ciągu 12 miesięcy poprzedzających pomiar w roku 2013 marihuanę i haszysz używał co czwarty uczeń (23% w 2012, 18% w 2010 roku), a w ciągu ostatnich 30 dni prawie co dziesiąty (9% w 2012, 8% w 2010 roku). Zażywanie leków uspokajających i nasennych bez przepisu lekarza deklaruje obecnie co piąty uczeń (20% w 2012, 20% w 2010 roku), w ciągu ostatnich 12 miesięcy co dziesiąty uczeń (10% w 2012, 10% w 2010 roku), a w ciągu ostatnich 30 dni, co dwudziesty (5% w 2012, 4% w 2010 roku). Po marihuanie i haszyszu najbardziej rozpowszechnioną nielegalną substancją jest amfetamina. W 2008 roku do eksperymentów z tą substancją przyznało się 9% uczniów, a w 2010 i 2013 – 7%.

Wykres 1. Używanie narkotyków w ciągu ostatniego roku (18-19 lat) (%)



Malczewski 2014c, Młodzież 2013 - Fundacja CBOS i KBPN.

Wykres 2. Używanie narkotyków kiedykolwiek w życiu (18-19 lat) (%)



Malczewski 2014c, Młodzież 2013 - Fundacja CBOS i KBPN.

W 2008 roku rozpoczęto monitorowanie problemu „dopalaczy" w Polsce. Omawiane badanie było pierwszym, które podjęło powyższą tematykę i jednym z pierwszych w Europie. Pod nazwą „dopalacze" kryje się cała gama różnego rodzaju środków. Są wśród nich substancje naturalne, jak roślina Kava kava, czy wytworzone w laboratoriach – BZP, MDPV, AM-2201 i mefedron. Wiele „dopalaczy" zostało objętych kontrolą na mocy nowelizacji ustawy o przeciwdziałaniu narkomanii z 2005 roku. Od 2008 roku ponad 50 substancji psychoaktywnych oraz roślin zostało zdelegalizowanych, co oznacza umieszczenie w załączniku do ustawy. Na miejsce objętych kontrolą „dopalaczy" pojawiają się następne. Po „dopalacze" sięgnęło 4% uczniów w 2008 roku, a w 2010 roku odsetek wzrósł do 11%. Do kontaktu z „dopalaczami" w ciągu roku poprzedzającego badanie z 2010 roku przyznało się 7% uczniów (wobec 3% w 2008 roku), a w ciągu ostatniego miesiąca – 1% (2% w 2008 roku). Wyniki z 2013 roku wskazują na spadek używania „dopalaczy". Do kontaktu kiedykolwiek w życiu z tymi substancjami przyznało się o ponad połowę mniej respondentów niż w 2010 roku, tj. 5,2% (spadek z 11%), ponad trzy razy mniejszy odsetek badanych używał w ciągu ostatniego roku (spadek z 7% w 2010 roku do 2% w 2013 roku), a odsetek osób sięgających po nie w ciągu ostatnich 30 dni powrócił do wartości z 2008 roku, tj. 1%.

Profilaktyka

W 2013 roku Ministerstwo Edukacji Narodowej i Ośrodek Rozwoju Edukacji wdrażały działania ukierunkowane na wzmacnianie systemu wartości młodzieży i rodzin, w szczególności wartości zdrowia, a także kształtowanie przekonań normatywnych i umiejętności psychospołecznych chroniących przed używaniem narkotyków.

Rok szkolny 2013/2014 został ogłoszony przez minister edukacji narodowej Rokiem Szkoły w Ruchu. We współpracy z instytucjami rządowymi, środowiskami naukowymi oraz organizacjami pozarządowymi przygotowano stronę internetową (www.szkolawruchu.men.gov.pl), na której znalazły się materiały informacyjne dotyczące działań podejmowanych przez szkoły, przedszkola oraz organizacje pozarządowe. Dodatkowo w 2013 roku minister edukacji narodowej przyjęła „Program promocji zdrowia i profilaktyki dzieci i młodzieży na lata 2013–2016", który kompleksowo odnosi się do zagadnień ochrony zdrowia psychicznego i fizycznego dzieci i młodzieży.

W celu promowania szkolnych programów profilaktycznych, opartych na dowodach naukowych, Krajowe Biuro ds. Przeciwdziałania Narkomanii kontynuowało w 2013 roku upowszechnianie programu profilaktyki uniwersalnej „Unplugged".

Na stronie www.narkomania.org.pl funkcjonowała internetowa poradnia antynarkotykowa, w ramach której udzielano pomocy i 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 kierowanych do okazjonalnych użytkowników narkotyków, np. bywalców dyskotek.

Podobnie jak w poprzednim roku, Krajowe Biuro ds. Przeciwdziałania Narkomanii wspierało realizację programu wczesnej interwencji „FreD goes Net", opartego na dowodach naukowych. Krajowe Biuro wspierało również realizację programów dla rodzin i bliskich osób z problemem narkotykowym. Realizowane działania ukierunkowane były głównie na doskonalenie umiejętności wychowawczych rodziców/opiekunów.

W 2013 roku Krajowe Biuro zaingurowało ogólnopolską kampanię społeczną pt. „Przyjmuje leki czy bierze? Leki bez recepty do leczenia, nie do brania". Celem głównym kampanii było podniesienie świadomości dotyczącej zagrożeń związanych z pozamedycznym używaniem przez młodzież leków nasennych i uspokajających z grupy benzodiazepin oraz leków dostępnych bez recepty zawierających dekstrometorfan, pseudoefedrynę/efedrynę i kodeinę.

W 2013 roku Główny Inspektorat Sanitarny rozpoczął realizację projektu pn. „Profilaktyczny program w zakresie przeciwdziałania uzależnieniu od alkoholu, tytoniu i innych środków psychoaktywnych", który był współfinansowany w ramach Szwajcarsko-Polskiego Programu Współpracy. Jego celem głównym jest ograniczenie używania przez kobiety w wieku prokreacyjnym (tj. między 15. a 49. rokiem życia) tytoniu, alkoholu i innych substancji psychoaktywnych. W ramach projektu realizowane są następujące działania: szkolenia dla kadry medycznej, programy edukacyjne w zakładach pracy i w szkołach ponadgimnazjalnych, kampania społeczna, badania ankietowe kobiet w ciąży, platforma internetowa – System Elektronicznego Monitorowania i Promocji Zdrowia. Krajowe Biuro współpracowało przy realizacji projektu – brało udział w opracowaniu materiałów edukacyjnych dla pracodawców i pracowników oraz platformy edukacyjnej dla młodzieży.

Problemowe używanie narkotyków

Oszacowanie liczby użytkowników opiatów przeprowadzono w 2012 roku. Obliczono, że liczba wszystkich problemowych użytkowników opiatów w 2009 roku mieściła się w przedziale 10 444 –19 794 osób. Środkowy punkt przedziału przypada na wartość 15 119 osób, którą uznać można za najbardziej prawdopodobną liczbę problemowych użytkowników opiatów w Polsce.

Według ostatniego badania liczba problemowych użytkowników narkotyków (w tym przetworów konopi) w 2009 roku wahała się od 56 tys. do 103 tys. osób, przy średniej wynoszącej ok. 80 tys. Oszacowanie populacji iniekcyjnych użytkowników narkotyków zostało przeprowadzone za pomocą metody multiplikatywnej. Wyniki pokazały, że w 2012 roku liczba iniekcyjnych użytkowników narkotyków wynosiła od 4270 do 10 299 osób, przy średniej na poziomie 7284. Było to badanie wstępne, które zostanie zweryfikowane przez badanie z 2014 roku. Zatem do jego wyników należy podchodzić z ostrożnością.

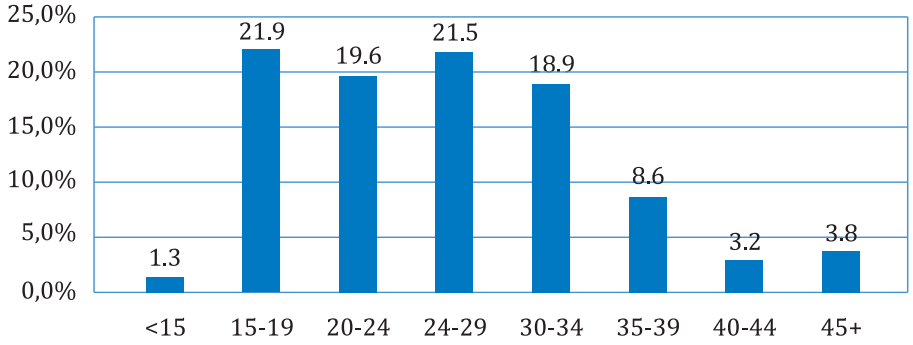
Lecznictwo uzależnień od narkotyków w Polsce

W 2013 roku w ramach pilotażowego systemu zbierania danych z leczenia (TDI), Centrum Informacji o Narkotykach i Narkomanii KBPN otrzymało informacje z 49 placówek leczenia uzależnień na temat osób, które zgłosiły się do leczenia z powodu problemów związanych z używaniem środków odurzających lub substancji psychotropowych.

W latach 2010–2012 liczba placówek przesyłających do KBPN informacje na temat osób zgłaszających się na leczenie z powodu używania narkotyków w ramach projektu pilotażowego systematycznie

rosła, osiągając największą wartość w 2012 roku (59 placówek). W 2013 roku było to 49 podmiotów leczniczych. Największą grupę pacjentów stanowiły osoby w wieku 15-34 lata, przy czym na leczenie z powodu problemów związanych z używaniem narkotyków najczęściej zgłaszały się osoby w wieku 15-19 lat oraz 25-29 lat. Podobnie jak we wcześniejszych latach, również w 2013 roku odsetek osób w wieku poniżej 15. roku życia i powyżej 45 lat zgłaszających się na leczenie, był minimalny.

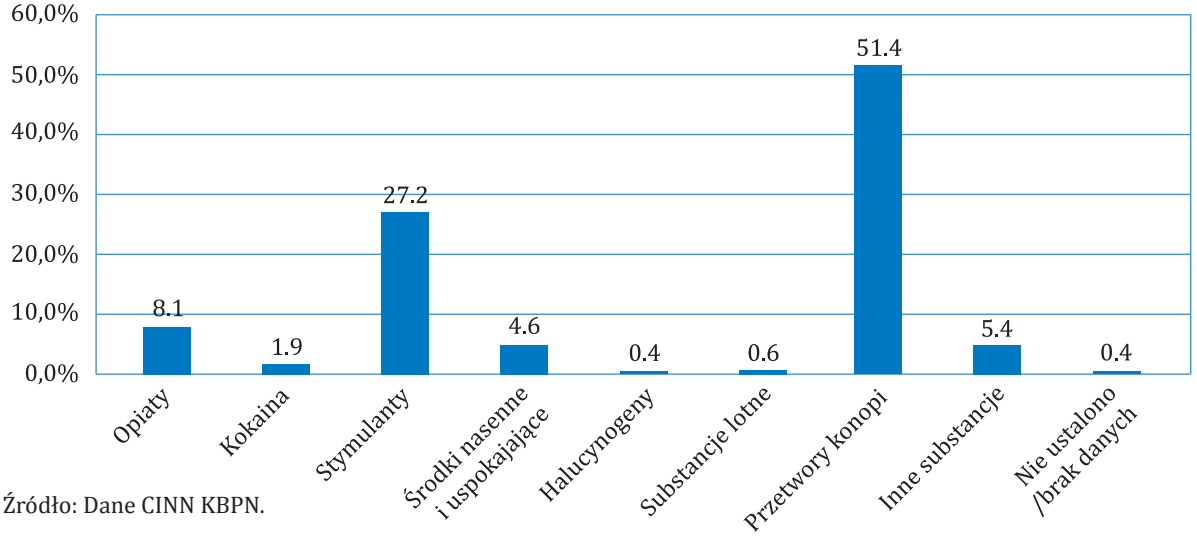
Wykres 3. Osoby zgłaszające się do leczenia lub rehabilitacji z powodu używania środków odurzających lub substancji psychoaktywnych w 2013 roku – odsetek wszystkich pacjentów według grupy wiekowej.



Źródło: Dane CINN KBPN.

W przypadku osób, które w 2013 roku po raz pierwszy w życiu zgłosiły się na leczenie, substancjami, z powodu których podejmowano leczenie, były przetwory konopi (51,4%), stymulanty (27,2%) oraz opiaty, jednak w dużo mniejszym stopniu – 8,1%.

Wykres 4. Osoby zgłaszające się do leczenia lub rehabilitacji z powodu używania środków odurzających lub substancji psychoaktywnych w 2013 roku – odsetek pacjentów zgłaszających się do leczenia po raz pierwszy w podziale na narkotyk podstawowy.



Źródło: Dane CINN KBPN.

Najnowsze dane Instytutu Psychiatrii i Neurologii (IPiN) stanowią drugie źródło informacji o narkotykach i odnoszą się do 2012 roku. W tym czasie ośrodki stacjonarne zarejestrowały 14 526 pacjen-

tów w związku z używaniem narkotyków. W poradniach zdrowia psychicznego, poradniach leczenia uzależnień od substancji psychoaktywnych oraz nadużywania alkoholu leczyło się 29 649 pacjentów.

System specjalistycznej opieki dla osób uzależnionych od substancji psychoaktywnych stanowi w Polsce część systemu opieki zdrowotnej dla osób z zaburzeniami psychicznymi. Leczenie uzależnienia od narkotyków jest regulowane przez szereg aktów prawnych. Działania na rzecz lecznictwa uzależnienia od narkotyków prowadzi m.in. Krajowe Biuro ds. Przeciwdziałania Narkomanii (KBPN) i Narodowy Fundusz Zdrowia, jednakże szereg aktywności w obszarze leczenia prowadzonych jest też przez inne instytucje centralne, jednostki samorządu terytorialnego i organizacje pozarządowe. Leczenie uzależnień od narkotyków może być prowadzone przez publicznie lub niepubliczne podmioty lecznicze oraz przez lekarzy wykonujących praktykę lekarską. Udzielanie świadczeń zdrowotnych osobom uzależnionym od narkotyków opiera się na sieci placówek ambulatoryjnych i stacjonarnych. W Polsce, pomoc ambulatoryjna dla użytkowników narkotyków odbywa się w ramach poradni leczenia uzależnień oraz, w wyjątkowych przypadkach, poradni leczenia uzależnienia od alkoholu. Ponadto osoby dotknięte problemem narkotykowym mogą się leczyć w poradniach zdrowia psychicznego oraz w oddziałach/ośrodkach dziennych.

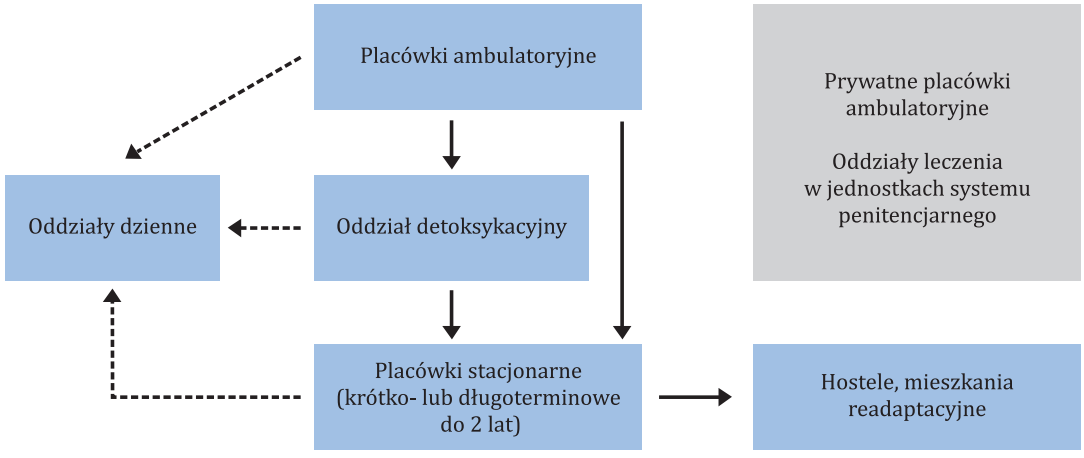
Placówki stacjonarne to głównie szpitalne ośrodki leczenia uzależnień i oddziały detoksykacyjne. W Polsce, funkcjonują głównie długo- i średnioterminowe programy leczenia (do 12 miesięcy). Ale z przyczyn ekonomicznych, jak również z uwagi na zmieniające się wzory używania, okres trwania programów uległ zmniejszeniu. Według danych KBPN (dane dostępne na stronie internetowej na czerwiec 2014 roku) w Polsce działało 87 stacjonarnych i 226 ambulatoryjnych ośrodków leczenia uzależnień od narkotyków.

W 2013 roku w kraju funkcjonowało 25 pozawięziennych programów leczenia substytucyjnego, z pomocy których korzystało 1725 użytkowników narkotyków.

Leczenie uzależnień od narkotyków odbywa się dwutorowo: za pomocą metod psychospołecznych i farmakoterapii.

W Polsce dokonują się zmiany w ofercie leczniczej, a w placówkach leczniczych wdrażane są programy o naukowo udokumentowanej skuteczności. Wyzwaniami stojącymi przed profilaktyką i lecznictwem, są m.in. problemy związane z używaniem konopi indyjskich, zjawisko nowych substancji psychoaktywnych oraz uzależnienia behawioralne. Nowe wyzwania stojące przed współczesnymi społecznościami terapeutycznymi, to m.in. specjalizacja ośrodków, kierowanie oferty do specyficznych grup odbiorców, włączenie farmakoterapii do oddziaływań terapeutycznych. Istnieje też potrzeba zmian w zakresie programów redukcji szkód, rewizji celów postrehabilitacji oraz readaptacji społecznej osób z problemem narkotykowym.

Ryc. 1. Organizacja systemu leczenia uzależnień od substancji psychoaktywnych w Polsce.



Źródło: Na podstawie: Jabłoński P. (2013), *Opieka zdrowotna i rehabilitacja osób uzależnionych od substancji psychoaktywnych. Programy leczenia substytucyjnego*, wykład, Krajowe Biuro ds. Przeciwdziałania Narkomanii.

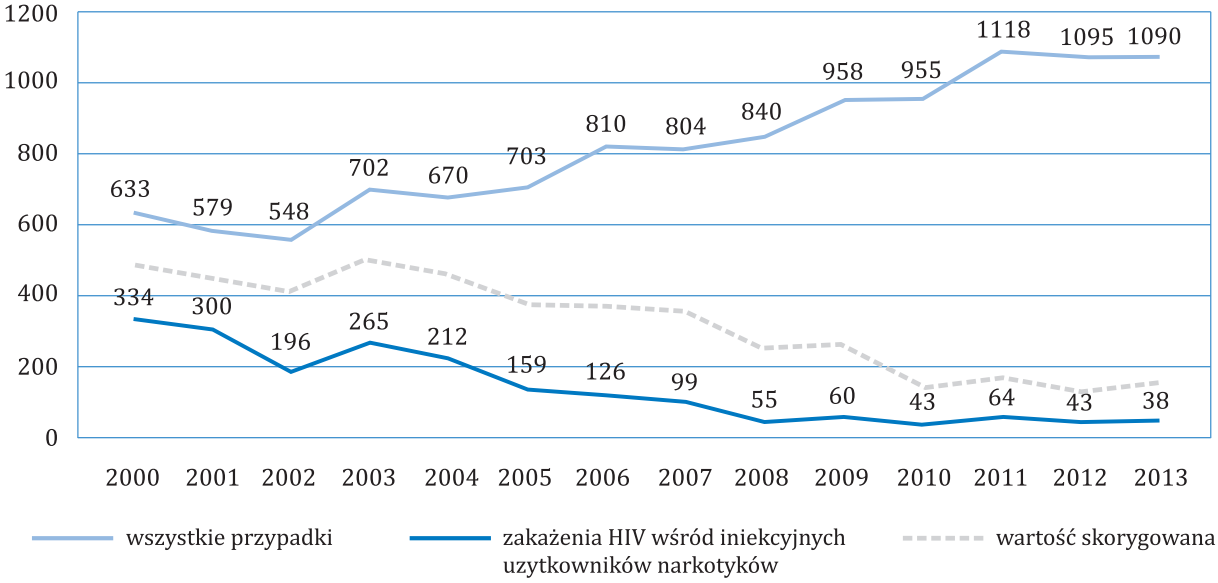
Korelaty i konsekwencje zdrowotne

Informacje o zgonach z powodu narkotyków w Polsce zbierane są przez Główny Urząd Statystyczny (GUS). Krajową definicję zgonu z powodu narkotyków tworzą następujące kody ICD-10: F11-12, F14-16, F19, X42, X62, Y12, X44, X64, Y14. Brak drugiego kodu w określaniu przyczyny zgonu powoduje, że w przypadku większości śmiertelnych przedawkowań nie znamy rodzaju substancji, która była przyczyną zgonu.

Analizując najnowsze dostępne dane za rok 2012, należy odnotować spadek liczby zgonów z 285 w 2011 roku do 227. W 2012 roku średni wiek osoby, która zmarła z powodu narkotyków wynosił 42 lata. Wśród ofiar śmiertelnych przeważali mężczyźni (67%).

Dane na temat infekcji HIV i przypadków zachorowań na AIDS wskutek iniekcyjnego używania narkotyków są pozyskiwane w ramach systemu rutynowej sprawozdawczości o chorobach zakaźnych. Klinicyści oraz laboratoria sprawozdają przypadki infekcji do wojewódzkich stacji sanitarno-epidemiologicznych (SANEPID). Sprawozdania są następnie przekazywane do Narodowego Instytutu Zdrowia Publicznego – Państwowego Zakładu Higieny. Analiza infekcji HIV spowodowanych iniekcyjnym używaniem narkotyków za lata 2000–2013 wskazuje na trend spadkowy i jego stabilizację w ostatnich latach. Zapadalność na AIDS ogółem wykazuje w ostatnich latach dość dużą zmienność, ale pozostaje na porównywalnym poziomie.

Wykres 5. Liczba nowych zakażeń HIV, w tym wśród iniekcyjnych użytkowników narkotyków w latach 2000–2013 (przypadki zgłoszone i wartość skorygowana uwzględniająca braki danych na temat drogi transmisji wirusa; wg daty rozpoznania).



Źródło: Narodowy Instytut Zdrowia Publicznego – Państwowy Zakład Higieny (Zakład Epidemiologii), dane wg roku rozpoznania zgłoszone do 31.05.2014 roku.

Dane na temat infekcji HIV wśród iniekcyjnych użytkowników narkotyków są dostępne również za pośrednictwem sieci punktów konsultacyjno-diagnostycznych (PKD), które wykonują anonimowo i bezpłatnie testy na obecność HIV w połączeniu z poradnictwem okołotestowym. PKD są koordynowane i współfinansowane przez Krajowe Centrum ds. AIDS, a prowadzone przez organizacje po-

zarządowe, które ściśle współpracują z podmiotami leczniczymi. Dominującą drogą zakażenia HIV wśród klientów PKD są kontakty seksualne. W 2013 roku nie odnotowano ani jednego zakażenia HIV w powiązaniu wyłącznie z iniekcyjnym używaniem narkotyków. Jednak jeśli chodzi o podwójne ryzyko, czyli ryzykowne kontakty seksualne i używanie narkotyków w iniekcji, to odsetek zakażeń w tej grupie wynosił 9,2%. Dla porównania w 2012 roku ten sam odsetek wynosił 10,9%.

Wyniki najnowszego badania pilotażowego pn. „Oszacowanie rozpowszechnienia zakażeń HIV i HCV wśród osób przyjmujących substancje psychoaktywne drogą iniekcji na terenie Warszawy i okolic" przeprowadzonego na przełomie 2013 i 2014 roku przez Społeczny Komitet ds. AIDS pokazują, że rozpowszechnienie HIV w badanej populacji wynosiło 14,7%, natomiast w przypadku HCV było to 71,6%.

Do 2005 roku odsetek pacjentów z podwójną diagnozą wśród wszystkich przyjętych do lecznictwa stacjonarnego z powodu problemu narkotyków wzrastał, osiągając w samym 2005 roku wartość 7,6%. Od 2006 roku odnotowuje się zahamowanie tendencji wzrostowej, a udział pacjentów z podwójną diagnozą wśród wszystkich przyjętych do leczenia utrzymuje się na zbliżonym poziomie, oscylując w przedziale 7,4-8,2%. W stacjonarnych ośrodkach psychiatrycznych w Polsce w 2012 roku (najnowsze dane) największą grupę stanowili pacjenci z rozpoznaniem mieszczącym się w kategorii „inne zaburzenia psychiczne" (63%), która obejmuje m.in. zaburzenia psychotyczne, schizofrenię i zaburzenia zachowania. Znaczna liczba pacjentów ujawniała symptomy zaburzeń osobowości (22%). Ponadto pacjenci wykazywali zaburzenia lękowe (8%), objawy depresji (6%) i innych zaburzeń afektywnych (1%).

Zapobieganie konsekwencjom zdrowotnym używania narkotyków

Pierwsze programy dystrybuujące igły i strzykawki powstały w Polsce pod koniec lat 80. ubiegłego stulecia. Na początku XXI wieku, tj. w 2002 roku działało 21 programów wymiany igieł i strzykawek w 23 miastach. W tym czasie odnotowano największą dostępność działań adresowanych do iniekcyjnych użytkowników narkotyków. W ramach działających w 2013 roku 13 programów wymiany rozdano 181 810 igieł (w 2012 roku 145 466) i 124 406 strzykawek (w 2012 roku 99 289), a zebrano 116 770 igieł (w 2012 roku 87 435) i 93 455 strzykawek (w 2012 roku 63 363). Pomocą objęto ponad 1655 osób (1500 osób w 2012 roku).

Inną formą działań mających na celu zapobieganie konsekwencjom zdrowotnym związanym z używaniem substancji psychoaktywnych są programy ograniczania ryzyka szkód zdrowotnych, które zazwyczaj są prowadzone w formie tzw. party workingu. Jednym z celów tych projektów, realizowanych w pubach, klubach, na dyskotekach czy imprezach masowych, jest zapobieganie przedawkowaniom spowodowanym narkotykami, ryzykownym zachowaniom (przygodny seks bez zabezpieczenia, niebezpieczne łączenie poszczególnych substancji, prowadzenie pojazdów mechanicznych pod wpływem środków zmieniających świadomość), a także zmianie wzoru używania narkotyków z okazjonalnego na szkodliwe i uzależnienie. W ramach realizacji tego typu programów poruszane są też zagadnienia dotyczące tzw. pigułek gwałtu.

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

W 2013 roku NFZ finansował działania mające na celu zwiększenie dostępności 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. Ponadto w 2013 roku działały 32 placówki wykonujące anonimowe i bezpłatne testy w kierunku HIV. Z badań prowadzonych co dwa lata wśród odbiorców programów wymiany igieł i strzykawek wiadomo, że w 2012 roku (najnowsze dostępne dane) 68% klientów tego typu programów wykonało test w kierunku zakażenia HCV. W 79% przypadków wynik był pozytywny.

Krajowe Centrum ds. AIDS sprawozdało, że programem leczenia ARV objęte były wszystkie osoby zakażone HIV i chore na AIDS, spełniające kryteria medyczne, w stosunku do których możliwość ob-

jęcia programem polityki zdrowotnej nie pozostaje w sprzeczności z aktualnie obowiązującym prawodawstwem. Programem objęte były również kobiety ciężarne zakażone HIV i noworodki urodzone z matek zakażonych HIV, zgodnie z obowiązującymi w tym zakresie standardami.

Na dzień 31 grudnia 2013 roku leczeniem ARV objętych było 7110 pacjentów zakażonych HIV i chorych na AIDS, tj. o blisko 13% więcej niż w roku poprzednim. U 1837 pacjentów (czyli niespełna 26%) prawdopodobną/potencjalną drogą zakażenia HIV było używanie narkotyków bądź używanie narkotyków i ryzykowne zachowania seksualne. Program leczenia ARV był realizowany w 21 szpitalach, w których działają ośrodki referencyjne leczące zakażonych HIV i chorych na AIDS w Polsce. 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.

Krajowe Biuro ds. Przeciwdziałania Narkomanii od wielu lat dofinansowuje, w ramach otwartego konkursu ofert na działania z zakresu przeciwdziałania narkomanii, programy redukcji szkód zdrowotnych wśród osób uzależnionych. W 2013 roku dofinansowało 14 tego typu projektów, realizowanych przez 8 organizacji pozarządowych. Wspieranie programów redukcji szkód wśród osób uzależnionych należy także do zadań samorządów. Jednak w roku sprawozdawczym spośród 16 urzędów marszałkowskich jedynie jeden wspierał działalność placówek wymiany igieł i strzykawek, oferujących wymianę stacjonarną i uliczną, a także noclegownię dla uzależnionych.

Do zadań samorządów gminnych należy również wspieranie programów redukcji szkód wśród osób uzależnionych. W 2013 roku programy ograniczenia szkód zdrowotnych związanych z używaniem narkotyków były finansowane przez 34 gminy (tj. 1,5% spośród 2233 gmin, które sprawozdały się z realizacji działań wynikających z KPPN).

W 2011 roku (najnowsze dane) funkcjonowały: trzy oddziały przy szpitalach psychiatrycznych z 46 łóżkami, dwa oddziały w ośrodkach rehabilitacyjnych dla uzależnionych od substancji psychoaktywnych z 35 łóżkami oraz jeden oddział w szpitalu ogólnym z 26 łóżkami. W tych placówkach przeprowadzono łącznie 669 hospitalizacji (Boguszewska, Instytut Psychiatrii i Neurologii, korespondencja własna). Powyższe oddziały przyjmują osoby z podwójna diagnozą.

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. Wiadomo natomiast, że używanie substancji psychoaktywnych, zwłaszcza opiatów, w znaczącym stopniu przyczynia się do wykluczenia społecznego. Osoby te doświadczają, oprócz szkód zdrowotnych, problemów natury socjalnej i społecznej, np. bezrobocia, bezdomności, braku środków do życia oraz często konfliktów z prawem, co potwierdzają liczne statystyki i badania naukowe.

Wyniki badania Instytutu Psychiatrii i Neurologii pn. „Koszty ponoszone przez konsumentów narkotyków. Badanie w sześciu miastach europejskich" jednoznacznie wskazują, że opiaty są najbardziej marginalizującym narkotykiem. 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 usługi socjalne. Powyższa sytuacja przyczynia się w jeszcze większym stopniu do pogłębiania szeroko rozumianego wykluczenia społecznego tych osób.

W roku 2013 na terenie całego kraju ośrodki pomocy społecznej udzieliły pomocy z powodu narkomanii 3808 rodzinom, w tym 490 żyjącym na wsi. Pomocy udzielono łącznie 5952 osobom, w tym współuzależnionym.

W 2013 roku Krajowe Biuro ds. Przeciwdziałania Narkomanii dofinansowało cztery programy redukcji ryzyka/szkód zdrowotnych wśród osób używających narkotyków i jednocześnie świadczących

usługi seksualne, dwa programy noclegowni, programy readaptacyjne w 10 hostelach i 19 mieszkaniach readaptacyjnych oraz programy zapobiegania nawrotom w placówkach ambulatoryjnych i stacjonarnych prowadzonych przez organizacje pozarządowe.

Osoby po ukończonym procesie terapii często uczestniczą w kursach zawodowych w celu aktywizacji zawodowej. W roku sprawozdawczym Krajowe Biuro ds. Przeciwdziałania Narkomanii podjęło działania w zakresie aktywizacji zawodowej wobec 122 odbiorców programów postrehabilitacji i reintegracji społecznej.

Niestety, w przypadku hosteli i mieszkań readaptacyjnych oferta samorządów gminnych w 2013 roku, jak też w latach poprzednich, była wciąż niewystarczająca.

Przestępczość narkotykowa

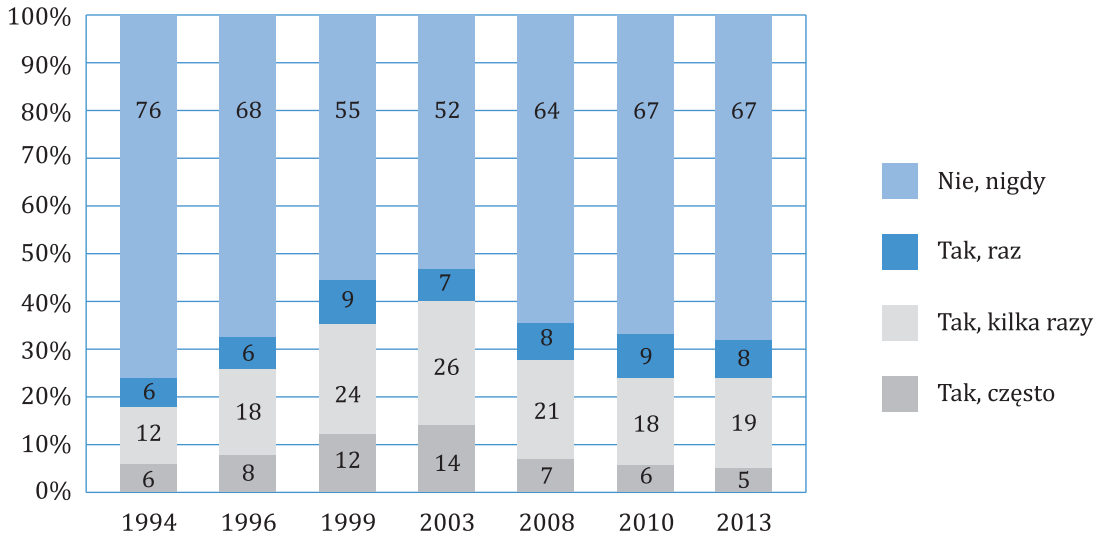
W 2013 roku przestępczością narkotykową w ramach standardowych obowiązków zawodowych zajmowało się w Polsce 1140 funkcjonariuszy Policji. W tymże roku nastąpił wzrost o 8,9% liczby postępowań wszczętych z ustawy o przeciwdziałaniu narkomanii w porównaniu do roku poprzedniego (z 23 001 do 25 033). Największa liczba postępowań wszczętych w 2013 roku dotyczyła nielegalnego posiadania środków odurzających i substancji psychotropowych (art. 62.1 i 62.3 ustawy o przeciwdziałaniu narkomanii), w sumie 19 504 postępowania. W 2013 roku funkcjonariusze Policji zidentyfikowali 27 375 podejrzanych o popełnienie przestępstwa narkotykowego, w tym 3538 nieletnich. Obserwuje się wyraźny trend spadkowy w zakresie liczby podejrzanych (spadek o 7% w odniesieniu do łącznej liczby i 23% w odniesieniu do nieletnich w porównaniu z rokiem 2012). Najliczniejszą grupą (19 504) w roku 2013 były osoby podejrzane o popełnienie czynu zabronionego z art. 62.1 i 62.3 ustawy o przeciwdziałaniu narkomanii (posiadanie). Grupa ta stanowi 71% wszystkich podejrzanych o złamanie ww. Ustawy.

Rynek narkotykowy

Przedmiotem badania młodzieży szkolnej w wieku 18-19 lat z 2013 roku były zagadnienia dotyczące dostępności narkotyków w szkole. W ankiecie młodzież pytana była o znajomość miejsc, gdzie można kupić narkotyki, o oferty kupna, sprzedaż narkotyków w szkołach oraz o to, czy trudno jest, w ich ocenie, zdobyć poszczególne substancje psychoaktywne. W 1994 roku co piąty respondent (22%) wiedział, od kogo lub gdzie można kupić narkotyki, w 2003 roku – już niemal połowa (49%). Jednak od tego czasu odsetek uczniów mających wiedzę o miejscach oferowania narkotyków zmniejsza się. W 2008 roku zwiększyła się natomiast (do 40%) grupa młodych ludzi deklarujących, że nie wiedzą, gdzie można kupić narkotyki. W 2013 roku odsetek takich wskazań utrzymał się na podobnym poziomie (41%). Ponadto odsetek badanych, którzy wiedzieli o kilku takich miejscach lub osobach, był najniższy od 1996 roku. Warto podkreślić, że na odpowiedzi badanych mogą mieć wpływ różne czynniki, np. informacje mediów o działaniach policji przeciwko przestępczości narkotykowej, a zwłaszcza o likwidowaniu miejsc sprzedaży narkotyków. Wskaźnikiem bardziej użytecznym przy opisie rynku narkotykowego pod kątem dostępności nielegalnych substancji psychoaktywnych jest pytanie o propozycje kupna. Od 1994 roku systematycznie rosła liczba uczniów, którym oferowano narkotyki. W 2003 roku blisko połowa badanych (47%) miała takie propozycje. Od tego czasu odsetek respondentów, którym oferowano narkotyki, zaczął się zmniejszać. Prawie trzykrotnie mniejszy odsetek badanych często otrzymywał takie propozycje (spadek z 14% w 2003 roku do 5% w 2013 roku). Ostatni pomiar wykazał, że odsetek uczniów, którzy otrzymali propozycję kupna narkotyków, utrzymuje się na tym samym poziomie co w 2010 roku – 67% badanych twierdziło, że nigdy nie oferowano im

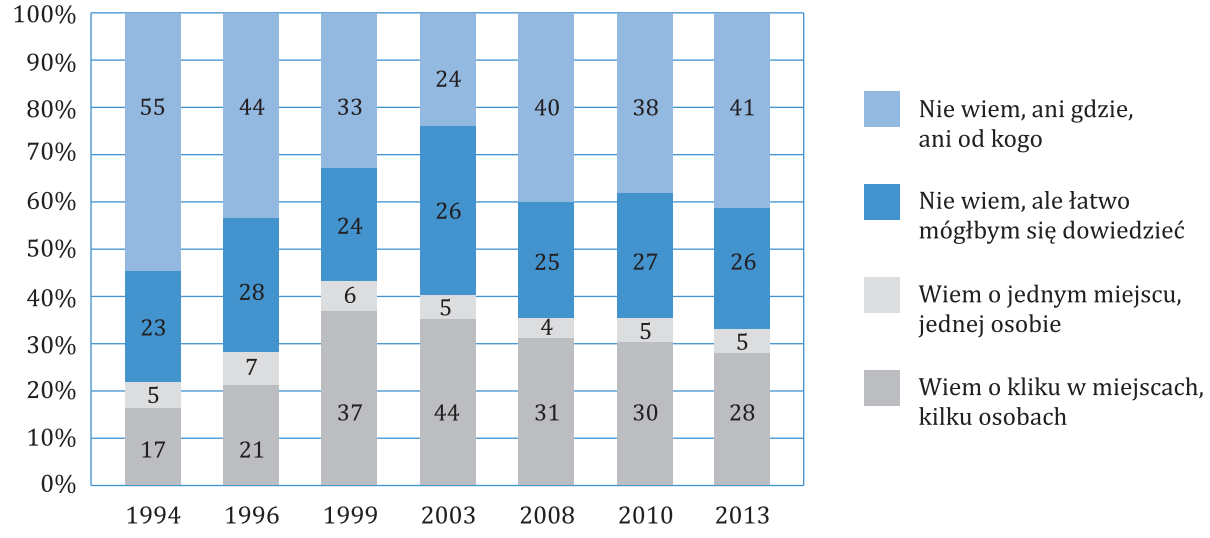
narkotyków. Od połowy lat 90. uczniowie pytani byli również o sprzedaż narkotyków w szkole (wykres 5). Od 1996 roku do 2003 roku na pytanie, czy na terenie ich szkoły można kupić narkotyki, co trzeci badany odpowiadał przecząco, w 2008 roku – co drugi, a w 2010 – ponad połowa (55%). W badaniach przeprowadzonych w 2013 roku odnotowano nieznaczny wzrost, do 58%, odsetka uczniów, którzy uważają, że na terenie ich szkoły narkotyki nie są sprzedawane. Wyniki badania wskazują na spadek dostępności narkotyków w szkole (Malczewski, 2014h).

Wykres 6. Sprzedaż narkotyków na terenie szkół (%).



Źródło: Młodzież 2013 – badanie Fundacji CBOS i KBPN.

Wykres 7. Odsetek badanych, którym proponowano kupno narkotyków (%).



Źródło: Młodzież 2013 – badanie Fundacji CBOS i KBPN.

Przez terytorium Polski przebiegają główne szlaki przemytu narkotyków. Nielegalne substancje przemycane są przez Polskę w tranzycie albo bezpośrednio docierają na rynki zachodnioeuropejskie. Amfetamina jest produkowana w Polsce przede wszystkim metodą Leuckarta. Jej wytwarzaniem i dystrybucją najczęściej zajmują się zorganizowane grupy przestępcze, które organizują, wyposażają i zaopatrują nielegalne laboratoria. W 2013 roku Policja wykryła 19 laboratoriów służących do produkcji amfetaminy. Policja wykrywa duże uprawy konopi w różnych nieczynnych miejscach, np. w magazynach, fabrykach itd. W 2013 roku zabezpieczono 68 555 krzewów konopi (wzrost o 10 399 w porównaniu do 2012 roku). W 2013 roku zarejestrowano wzrost ujawnionej ilości haszyszu (z 38,9 kg do 208,3 kg), heroiny (z 35,6 kg do 48, 6 kg), amfetaminy (z 613, 7 kg do 675,7 kg), metamfetaminy (z 4,2 kg do 9,5 kg) oraz ecstasy (z 31 tys. tabletek do 46 tys. tabletek). Dane z konfiskat wskazują na wzrost występowania na polskim rynku narkotykowym metamfetaminy. Policja zabezpiecza również nowe substancje psychoaktywne (tzw. dopalacze), które nie są objęte ustawową kontrolą. W 2013 roku zabezpieczono następujące substancje: mefedron (2939 g), Szałwię wieszczą (1 g), 4 MEC (9558 g), MDPV (620 g), syntetyczne kannabinoidy (110 g).

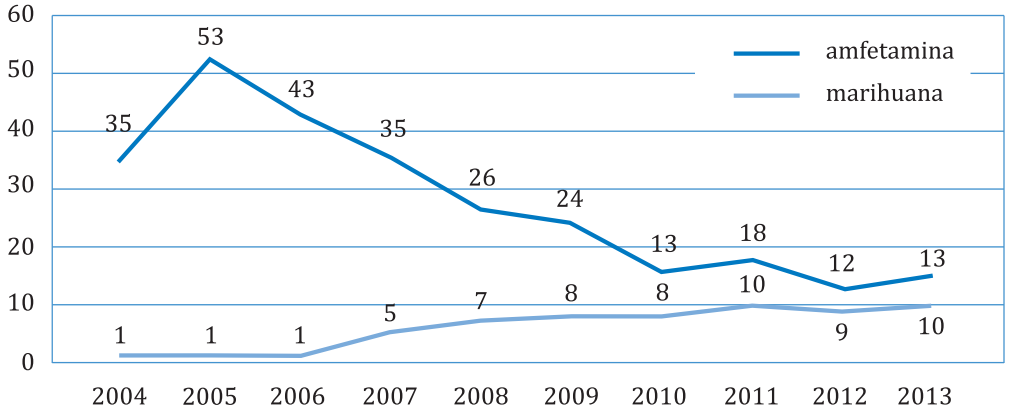
Tabela 1. Ilość ujawnionych narkotyków w Polsce w latach 2005–2013.

Rodzaj narkotyku	2005	2006	2007	2008	2009	2010	2011	2012	2013
Haszysz (kg)	19,292	35,401	33,128	114,681	17,142	85,445	59,139	38,946	208,394
Marihuana (kg)	227,124	401,659	352,934	492,725	883,053	1501,801	1265,403	1489,240	1242,834
Heroina (kg)	41,151	155,401	123,623	78,915	85,873	24,871	51,359	35,620	48,678
Kokaina (kg)	16,871	21,932	160,981	28,710	117,491	111,084	78,121	213,391	20,569
Amfetamina (kg)	344,578	333,038	423,65	356,196	421,65	534,299	394,77	613,733	675,724
Metamfetamina (kg)	-	0,163	5,712	0,124	10,069	1,234	0,517	4,254	9,566
Ecstasy (tabletki)	492531	145344	610383	651 985	218616	269842	75082	31092	45997
LSD (listki)	2226	1453	327	353	642	1353	0	29173	457

Źródło: CINN KBPN.

Dane otrzymane z Centralnego Laboratorium Kryminalistycznego wskazują na wzrost stężenia THC w marihuanie. Im więcej THC, tym „mocniejsza" jest marihuana. W 2013 roku marihuana zawierała 10% THC. W przypadku amfetaminy odnotowujemy trend przeciwny. W 2007 roku średnia czystość amfetaminy oferowanej na nielegalnym rynku wyniosła 35%, podczas gdy w roku 2013 – 13%.

Wykres 8. Czystość amfetaminy i zawartość THC w marihuanie w latach 2004–2013 (%).



Źródło: Centralne Laboratorium Kryminalistyczne.

Informacje dotyczące cen narkotyków pochodzą z dwóch źródeł: od użytkowników oraz od policji. Według informacji od użytkowników narkotyków średnia cena grama marihuany w 2012 roku wyniosła ok. 31 zł i była bardzo zbliżona do najczęściej występującej (30 zł). Amfetamina, podobnie jak marihuana, jest sprzedawana w podobnej cenie (32 zł w 2008 roku i 34 zł w 2012 roku), jednakże średnia jej czystość w tym czasie – zmniejszyła się.

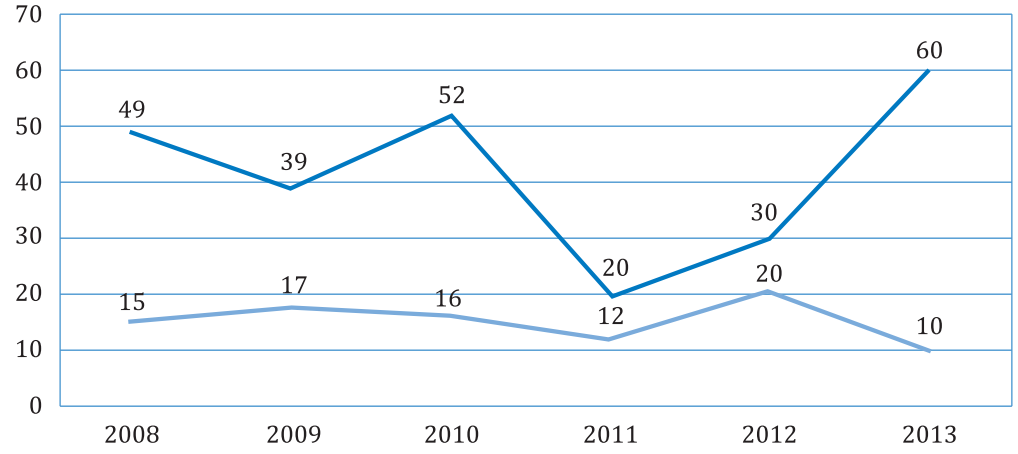
Tabela 2. Ceny narkotyków według informacji od użytkowników narkotyków (badania programów wymiany igieł i strzykawek) (PLN).

	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: CINN KBPN.

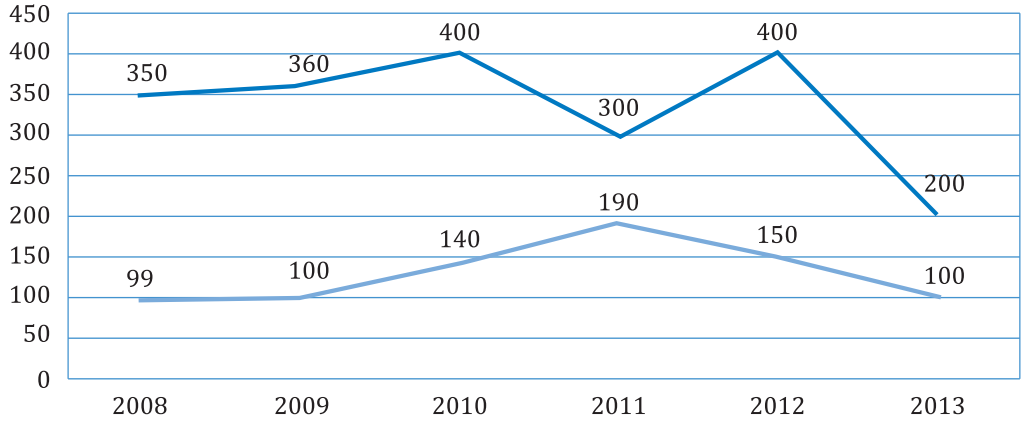
Dane policyjne dotyczą ceny minimalnej i maksymalnej. W 2013 roku cena minimalna marihuany wynosiła 10 zł a maksymalna 60 zł. W przypadku ceny heroiny wyniosły one 100 zł (minimalna) oraz 200 zł (maksymalna).

Wykres 9. Ceny grama marihuany (minimalne i maksymalne) wg statystyk policyjnych (PLN).



Źródło: KGP.

Wykres 10. Ceny grama brązowej heroiny (minimalne i maksymalne) wg statystyk policyjnych (PLN).



Źródło: KGP.

Nowe substancje psychoaktywne

Analizując rynek narkotykowy w Polsce, nie można pominąć sprzedaży „dopalaczy", które nie są substancjami kontrolowanymi. Nowe substancje psychoaktywne są sprzedawane zarówno w sklepach stacjonarnych, jak i internetowych. W wyniku decyzji Głównego Inspektora Sanitarnego i operacji przeprowadzonej przez Policję i Inspekcję Sanitarną zostały zamknięte wszystkie punkty sprzedaży „dopalaczy" w 2010 roku, tj. blisko 1400 sklepów w całym kraju. W efekcie podjętych działań znacznie spadła m.in. liczba zatruć spowodowanych używaniem „dopalaczy" w 2011 i 2012 roku. Instytucją

odpowiedzialną za działania wymierzone przeciwko sklepom z „dopalaczami" w Polsce jest Inspekcja Sanitarna, która podejmuje swoje decyzje w ramach działań administracyjnych. Akcje Inspekcji Sanitarnej przeciwko sklepom wspierane są często przez Policję. Zgodnie ze znowelizowanym w 2010 roku prawem narkotykowym oraz o Inspekcji Sanitarnej, właściwy Państwowy Inspektor Sanitarny ma prawo wycofać z obrotu, w celu ich zbadania, na czas do 18 miesięcy, produkty, co do których zachodzi uzasadnione podejrzenie, że mogą być niebezpieczne dla życia.

Policja zabezpiecza „dopalacze", które są objęte kontrolą prawa narkotykowego, czyli zostały wpisane na listę substancji kontrolowanych stanowiących załącznik do ustawy. W 2013 roku Policja zabezpieczyła: mefedron (2939 g), szałwię wieszczą (1 g), 4 MEC (9558 g), MDPV (620 g), syntetyczne kannabinoidy (110 g). W 2013 roku odnotowano ponowne otwieranie sklepów stacjonarnych z „dopalaczami" oraz wzrost interwencji medycznych z powodu zatrucia tego typu substancjami (1079 przypadków). Do sierpnia 2014 roku liczba ta była już wyższa (1416) niż w 2013 roku. Obecne sklepy starają się nie reklamować swojej działalności jak to było w latach 2008–2010. Punkty dystrybucji ukrywają sprzedaż wśród innych towarów (np. w lombardach czy sex-shopach) i nie umieszczają szyldów informujących o możliwości zakupu „dopalaczy". W 2014 roku w Polsce działało około 120 sklepów z „dopalaczami". Oprócz punktów stacjonarnych w Polsce działa co najmniej kilkanaście sklepów internetowych, w których można zamówić „dopalacze". Przesyłka dostarczana jest z reguły w ciągu 2-3 dni, z możliwością płatności przy odbiorze. Portale mają swoje strony za granicą, jak np. internetowy sklep www.kolekcjoner.nl. Kolejna nowelizacja ustawy narkotykowej w 2015 roku przewiduje objęcie kontrolą 114 „dopalaczy" oraz wprowadzenie nowych rozwiązań, które mają pomóc inspekcji sanitarnej w zamykaniu sklepów z tego typu produktami.

Warto wspomnieć, że obecnie w Polsce jest realizowany międzynarodowy projekt I-TREND. Z ramienia naszego kraju uczestniczy w nim Szkoła Wyższa Psychologii Społecznej (SWPS) i eksperci z polskiego Focal Pointa. W projekcie udział biorą również naukowcy z Francji, Holandii, Wielkiej Brytanii i Czech. Projekt jest realizowany ze środków Komisji Europejskiej w ramach programu Drug Prevention and Information. Jednym z ważniejszych jego celów jest zebranie informacji na temat szkodliwości i działania „dopalaczy", a także sposobów ich używania, co pozwoli na przygotowanie folderów zawierających informację o najbardziej popularnych „dopalaczach" dla osób zajmujących się profilaktyką i leczeniem. W 2013 roku został przygotowany TOP-10 (na podstawie analiz forów internetowych oraz danych z EWS) najbardziej popularnych „dopalaczy" w Polsce. Wśród nich osiem to katynony, a pozostałe substancje to syntetyczne kannabinoidy: 3,4-DMMC, 3-MMC, AM-2201, Brephedrone, Ethcathinone, MDPBP, Pentedrone, alfaPVP, UR-144, pMPPP (Malczewski, 2013e). Warto podkreślić, iż oferta sklepów internetowych nie jest taka sama jak oferta sklepów stacjonarnych. Najbardziej popularny „dopalacz" w 2013 roku – UR-144 (syntetyczny kannabinoid), który nadal, według danych Narodowego Instytut Leków oraz GIS, był na rynku w 2014 roku, bardzo trudno jest kupić w sklepach internetowych, gdzie duża część oferowanych produktów to chemikalia, używane według sprzedawców do celów badawczych. Wyniki analiz „dopalaczy" Narodowego Instytutu Leków w 2013 roku pokazują, że najbardziej rozpowszechnionym dopalaczem był UR-144 (40% próbek). Wśród katynonów najczęściej występował pentedron i izo-pentedron.

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 National Drugs Strategy 2011-2016 is the executive act that lays down the priorities serving both as the National Antidrug Strategy as well as the Action Plan. Since 2006 the National Drugs Strategy 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 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 for 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 Drugs Strategy; 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 is supported by 4 work teams: 1) precursor team, 2) International cooperation team, 3) team on monitoring and implementation of the National Drugs Strategy and 4) team on new psychoactive substances. The teams play an advisory role and provide technical support for the Council.

In 2013, no significant legal changes were introduced in the field of drugs and drug addiction.

However, work was underway on a new amendment to the Act on Counteracting Drug Addiction. The amendment was developed in 2013 by a team of experts and introduces several changes meant to facilitate the implementation of Sanitary Inspection control over new psychoactive substances, introducing the risk assessment mechanism of new psychoactive substances before undertaking control measures, and reducing OTC drug use for non-medical and illicit purposes including manufacturing of drugs. The amendment was drafted, then underwent interministerial consultation and was recently adopted by Council of Ministers.

In the reference period, the Ministry of Justice monitored and produced a preliminary evaluation of the outcome of 2011 amendment to the Act on Counteracting Drug Addiction, which in article 62a empowers a prosecutor or a judge to discontinue penal proceeding toward individuals who have been caught possessing small amount of drugs for personal use. In the two-year period of the provision being in force, the number of cases in which the prosecutors discontinued penal proceedings increased from 2 145 in 2012 to 3 132 in 2013.

Ministries and entities obliged to implement the National Drugs Strategy performed activities in all prevention-related areas planned for 2013. The monitoring and interim evaluation of the National Drug Strategy was continued as in previous years. In the framework of this activity the following were identified as areas to be improved: 1) promotion and support of evidence-based prevention programmes implementation in local communities, 2) further development of treatment programmes for problem cannabis users, 3) increasing the availability of substitution programmes, 4) increasing the

support for harm reduction programmes at local and regional level, 5) the development of synthetic drug production and domestic cannabis production by organized crimes groups as a challenge for Polish drug enforcement agencies.

In the reference period, the work of the Council for Counteracting Drug Addiction and its teams focused on such subjects as non-medical use of pseudoephedrine and DXM, codeine and beznydamine OTC medicines, initial evaluation regarding the impact of article 62a provisions of the act on Counteracting Drug Addiction (see above), implementation of National Drug Strategy and lastly outcome of the Supreme Audit Office into prevention at schools.

Additionally, in 2011 the Director of the National Bureau for Drug Prevention established the Council for Scientific Research, which is an advisory and opinion-making body. The Council is comprised of 7 members, appointed on the basis of their expertise and experience in addiction-related research. The Council is responsible for initiating research as well as defining needs and priorities in the field of addictions. In 2013, the council gave priority to the following research areas: injecting drug use in context of HIV/AIDS, illegal drug market, drug-related crime, drug supply reduction, quality of drug prevention.

In order to support drug-related research, since 2008 the National Bureau has been holding competitions in the field of drug prevention. The projects are selected by the Director-appointed commission on the basis of additional reviews. In 2013, two new projects were financed by way of competition, while the financing of three projects from previous years was continued.

General population studies

The study "Social diagnosis 2013", headed by Janusz Czapiński, professor at the Faculty of Psychology of Warsaw University and vice-president of the Higher School of Finances and management and Tomasz Panek, professor at the Institute of Statistics and Demography of the Warsaw School of Economics, is intended to provide comprehensive information on the conditions and the quality of life among Poles.

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

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

The results of the "Social diagnosis 2013" study show that the group at the highest risk of drug addiction is males under 24, including school and university students. Generally speaking, considering the age of Polish drug users, drug use prevalence is the highest among individuals under 30.

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

In June 2013, there was a quantitative survey conducted on a representative sample of the Polish population aged over 15 (n=1000). The respondents were asked about their experiences with using psychoactive substances listed in the questionnaire in three time frames: in the last 30 days, in the last 12 months and in a lifetime. The survey was implemented by means of the CAPI method under the OMNIBUS project through face-to-face interviews at respondents' homes.

The most prevalent illegal psychoactive substances in Poland include cannabis and, to a lesser extent, amphetamine. Recent use rates (last 12 months) for any illegal substances and lifetime experience rates stood at 2.5% and 7.1% respectively. For cannabis, the rates reached 2.4% and 6.6% respectively. Comparing the results for cannabis with those for any other substance it can be stated that illegal substance use in Poland is mainly related to cannabis use. Using psychoactive substances is linked to demographics. Drugs are more prevalent among younger men (15-34) and individuals with higher or secondary education. Higher prevalence rates are also recorded among residents of big

cities. However, it must be stressed that these features are typical of illegal substance users. Drug prevention should focus not only on adolescents but include young adults and it should be implemented mainly in urban areas. Cannabis will be the biggest challenge for the help system. Despite the opposition to this drug (78% in favour of cannabis ban), its prevalence is on the rise, which might be related to higher demand for treatment. According to the Polish Focal Point data of 2013, one in two first-time patients who entered drug treatment did it due to problems related to cannabis use. It is caused by the fact that cannabis has much higher concentration of THC than several years ago (average THC content according to the Central Forensic Laboratory was 10% in 2013), which means that cannabis smokers take higher doses of this psychoactive agent than ever. Amphetamine in the adult population is the most prevalent stimulant although its prevalence is low. Hypnotics and sedatives without doctor's order are used more frequently by women form older age groups (over 45), residents of villages and small towns with higher education or elementary vocational education. The survey results reveal that cannabis legalization movements fail to win public support. Nearly half of the society are in favour of penalizing possession of any amount of drugs and three quarters believe that cannabis use should be illegal.

Towards the end of 2013, the CBOS Foundation and the National Bureau for Drug Prevention conducted a survey among school youth, called "Youth 2013". One of the aims of the study was to estimate the prevalence of substance use in this population. The survey was conducted on a national random sample of 65 schools (one class per school) – general education secondary schools, secondary vocational schools and elementary vocational schools. The survey included last grades of secondary schools, excluding special education schools. The participants were aged mostly 18 or 19. The survey covered all students present in class on the day of the measurement – a total of 1 360 students.

Since the beginning of the survey students have always been questioned about drug use experiences in the last 12 months. In 1992-2003 the number of students who used drugs in the past year was rising steadily (from 5% to 24%). The latest data indicate an increase in drug consumption (18%). Students who reported having used drugs were asked to mention the specific substances. Moreover, they were allowed to name three substances they had used most often. In 2013, 88% of students who had used drugs in the last 12 months mentioned marijuana (increase of 6 percentage points compared with 2010) and 10% reported amphetamines (decrease of 1 percentage point). Moreover, students reported using cocaine (4%), hashish (3%), LSD (2%), hallucinogenic mushrooms (1%), DXM (1%) and mephedrone (1%). The proportions were calculated on the basis of answers given by students who had used drugs in the last 12 months. The biggest fall was recorded in the case of legal highs. In 2010, 13% of the respondents reported using legal highs while in 2013 it was 4%. The 1992 survey showed that boys used drugs more frequently than girls. In 2013, 24% of male students and 10% of female students responded affirmatively when asked about using illegal psychoactive substances. In 2010, 20% of boys and 10% of girls reported using drugs. The rise in drug use was caused by the increase in the percentage of male users.

The most prevalent substance among students was cannabis. Lifetime prevalence rates for this substance reached 40% in 2013, which constitutes an increase of 4 percentage points compared with the 2010 measurement. The results of the latest survey revealed a continuation of the upward trend also in the case of the last 12 months and last 30 days prevalence. Every fourth student had used cannabis in the last 12 months prior to the 2013 measurement (23%, 18% in 2010) and nearly every tenth student had had done so in the last 30 days (9%, 8% in 2010). Every fifth students reported using sedatives and hypnotics (20%, 20% in 2010). The rates for the last 12 months were 10% (10% in 2010) and for the last 30 days 5% (4% in 2010).

Cannabis was followed by amphetamine. In 2008, 9% of the respondents reported experimenting with these substances while in 2010 and 2013 the rate was 7%.

In 2008, legal highs started to be monitored in Poland. This measurement was the first which discussed these issues and one of the first in Europe. The term 'legal highs' covers a whole range of various substances. They include natural substances such as Kava Kava or those manufactured in labs such as BZP, MDPV, AM-0211 or mephedrone. The controlled legal highs are replaced with new drugs. Legal highs lifetime prevalence rate in 2008 stood at 4% while in 2010 it reached 11%. The last 12 months rate in 2010 was 7% (3% in 2008) and the last 30 days rate reached 1% (2% in 2010). The 2013 results indicate a fall in legal highs prevalence. Lifetime rates more than halved compared with 2010 (5.2%; 11% in 2010). Over three times fewer respondents had used legal highs in the last 12 months (fall from 7% in 2010 to 2% in 2013). The last 30 days prevalence rate returned to the 2008 value i.e. 1%.

Prevention

In 2013, the Ministry of National Education and the Centre for Education Development implemented actions aimed at strengthening the system of values among adolescents and their families, especially values related to health, as well as shaping normative beliefs and psychosocial skills as factors protecting against drug use.

The Ministry of National Education declared school year 2013/2014 as the Year of School in Motion. In collaboration with governmental institutions, scientific communities and NGOs, a special website (www.szkolaruchu.men.gov.pl) was launched. The website featured information on activities performed by schools, nursery schools and NGOs. Additionally, in 2013, Strategy for health promotion and prevention among children and adolescents 2013-2016 was adopted. The strategy comprehensively addresses issues related to mental and physical health care in children and adolescents.

With a view to promoting evidence-based school prevention programmes, the National Bureau for Drug Prevention continued disseminating the Unplugged universal drug prevention programme in 2013.

In 2013, at www.narkomania.org.pl one could access an online drug counselling centre. The centre provided assistance and reliable information on drug addiction, types of drugs and help options for problem drug users and co-dependent individuals.

Similarly to previous years, support was provided for selective drug prevention programmes for at-risk groups as well as prevention programmes for occasional drug users e.g. discotheque goers.

Similarly to the previous year, the National Bureau for Drug Prevention supported the implementation of the "FreD goes net" evidence-based early intervention programme. The National Bureau also supported the implementation of programmes for families of problem drug users. The programmes aimed chiefly at improving parenting skills of parents/legal guardians.

In 2013, the National Bureau inaugurated a national awareness campaign entitled "Taking medication or high on drugs? Prescription drugs serve treatment not getting high". The main goal of the campaign was to raise public awareness of threats related to non-medical use of benzodiazepine-based hypnotics and sedatives as well as OTC drugs containing dextromethorphan, pseudoephedrine/ephedrine and codeine among adolescents.

In 2013, the Main Sanitary Inspectorate started implementing the project entitled "Drug, alcohol, tobacco and other substances prevention programmes", which was co-financed under the Swiss-Polish Cooperation Programme. The general aim of the project is reducing substance use among women at the reproductive age (15-49), especially tobacco, alcohol and other substances. The following activities were performed in the course of the project: training seminars for medical personnel, education programmes at workplaces and secondary schools, awareness campaign, surveys among pregnant women, online platform (Electronic System of Monitoring and Promoting Health). The National Bureau collaborated on the project by participating in developing both educational materials for employers and employees as well as an online educational platform for young people.

High Risk Drug Use

The estimation of problem opioid users was conducted in 2012. It found that the overall number of opioid users ranges from 10 444 to 19 794 in 2009. The middle value of 15 119 can be assumed as the most likely number of problem opioid users in Poland.

According to the last estimation, the number of problem drug users (including cannabis users) ranges from 56 000 to 103 000 with middle point around 80 000 in 2009. The estimate of injecting drug use prevalence was conducted by means of the multiplier method. The estimation shows that the number of injecting drug users ranges from 4 270 to 10299 with the mean of approx. 7 284 in 2012. It was a preliminary estimation to be validated based on 2014 survey, which means that result should be treated with caution.

Drug treatment in Poland

In 2013, within the pilot treatment demand data project (TDI), the National Bureau collected information on drug patients from 49 drug treatment units. Over the years 2010-2012, the number of drug treatment facilities reporting TDI data to the National Bureau under the abovementioned pilot project was steadily rising to reach the highest number of 59 facilities in 2012. In 2013, there were 49 such facilities reporting 2759 drug patients, including 1118 first-timers. Drug patients are predominantly individuals aged 15-34. The most problematic substance is cannabis. The share of opioid-related admissions is gradually falling although opioids are among the top three problematic substances. The second most problematic type of substances are stimulants.

The latest data from the Institute of Psychiatry and Neurology (IPiN) constitute another source and refer to 2012, when residential treatment facilities admitted 14 526 patients due to drug-related problems and 29 649 people were treated in mental health counselling centres, substance abuse counselling centres and alcohol abuse counselling centres.

The system of specialist care for drug-dependent individuals in Poland is part of the health care system for individuals with mental disorders and is governed by a number of legal acts. Drug treatment activities are supported e.g. by the National Bureau for Drug Prevention (KBPN) and the National Health Fund (NFZ). There are also central institutions, local governments as well as non-governmental organizations involved. Drug treatment can be provided by public or non-public health care units and practising doctors. Provision of drug treatment services is performed through a wide network of inpatient and outpatient clinics. In Poland, the outpatient assistance for drug users is provided at substance abuse counselling centres and, in exceptional cases, at outpatient alcohol rehabilitation clinics. Moreover, individuals with drug problem can seek treatment at mental health counselling centres and day-care wards/facilities. Inpatient clinics are mainly hospital-based drug rehabilitation centres and detoxification wards. In Poland, there are mainly long-term and medium-term treatment programmes (up to 12 months); however, these had to be shortened due to economic reasons as well as because of new patient profiles. According to the KBPN data (online data as at June 2014), 87 inpatient and 226 outpatient clinics provided treatment across Poland.

In 2013, there were 25 non-prison substitution treatment programmes across Poland. They provided services for 1725 patients.

Drug treatment is applied via two main intervention channels: psychosocial methods and pharmacological treatment.

In Poland, drug treatment services are constantly being modified. Drug treatment units are introducing evidence-based programmes. The new drug prevention and treatment challenges include cannabis-related problems, new psychoactive substances and behavioural addictions. New challenges for therapeutic communities include the need to create specialist centres, providing services for spe-

cific target populations, including pharmacotherapy in therapeutic interventions. There is also a need to improve harm reduction programmes and review of post-rehabilitation and social reintegration goals.

Health correlates and consequences

Data on drug-related deaths in Poland is collected by the Central Statistical Office (GUS). 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 a separate code to specify the cause of death results in failure to determine the lethal substance in most cases.

Analyzing the latest available data for 2012, we notice a decrease to 227 cases from 285 in 2011. In 2012, the average age of a drug-related death was 42. Out of 227 deaths, most (67%) were male.

Data on HIV infections and AIDS cases related to injecting drug use at the national level are obtained through a 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 2000-2013 indicates a downward trend, which levelled off in more recent years. AIDS incidence rates in recent years have been fluctuating while preserving comparable values.

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 a sexual intercourse. In 2013, no single HIV infection related exclusively to injecting drug use was recorded. However, as regards the double risk of combining both injecting drug use and risky sexual behaviour the rate reached

9.2% in this group. For comparison, in 2012 the rate stood at 10.9%. The results of the latest pilot study entitled "Estimation of HIV and HCV prevalence among injecting drug users in Warsaw and the surrounding area" conducted in the years 2013/2014 by AIDS Social Committee shows the prevalence of HIV in the study population at the level of 14.7% and the rate for HCV - 71.6%.

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 7.4-8.2% ever since. At residential drug treatment clinics in Poland in 2012 (the latest data), the most numerous group was made up by patients falling into the category "other mental disorders" (63%). This group comprises psychotic disorders, including hallucinations and delusions, schizophrenia and behavioural disorders. A considerable number of patients manifested personality disorder symptoms (22%). Moreover, the patients showed symptoms of anxiety disorders (8%), depression (6%) and other affective disorders (1%).

Responses to health correlates and consequences

First needle and syringe programmes (NSP) were established in Poland towards the end of the 1980s. At the beginning of the 21st century, i.e. up to 2002, there were 21 needle and syringe programmes operational in 23 Polish cities. During that time, the widest availability of NSPs for injecting drug users was recorded. Under the 13 programmes operational in 2013, 181 810 needles (145 466 in

2012) and 124 406 syringes (99 289 in 2012) were distributed. 116 770 needles (87 435 in 2012) and 93 455 syringes (63 363 in 2012) were collected. Assistance was provided for 1 655 individuals (1 500 in 2012).

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. 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 2013, the National Health Fund financed activities aimed at improving the availability of drug-related infectious disease prevention programmes. The activities included financing HBV vaccinations and HCV and HIV tests at specialist facilities. Moreover, in 2013 there were 32 testing sites, which provided anonymous and free HIV tests. The survey conducted every two years among clients of syringe and needle exchange programmes showed that in 2012 (latest available data), 68% of the clients were tested for HCV. 79% of the tests proved positive.

The National AIDS Centre reported that all HIV-positive and AIDS patients, who met medical criteria and were eligible for health care programme under the current law, were covered with the ARV treatment. The ARV programmes also covered HIV-positive pregnant women and their newborn children, in accordance with the existing standards.

As at 31 December 2013, the ARV treatment was provided for 7 110 HIV/AIDS patients, which is 13% more compared with the previous year. In 1 827 cases (nearly 26%), the likely route of HIV transmission was injecting drug use or drug use and unprotected sex.

The ARV treatment was provided at 21 hospitals which operate as referral treatment centres for HIV/AIDS patients. The ARV treatment was also provided at correctional facilities. Inmates continued treatment which they had started before being sent to prison or they started forced treatment while incarcerated. For many years, the National Bureau for Drug Prevention (KBPN), under open drug prevention competitions, has been co-financing harm reduction programmes for drug-dependent individuals. In 2013, the National Bureau co- financed 14 such projects, which were run by 8 NGOs. Such programmes are also supported by local governments. However, in the reporting year out of 16 Marshal Offices (= regional governments), only 1 supported needle and syringe exchange programmes: both a stationary and a street syringe and needle exchange programmes as well as a night shelter for drug addicts in Kraków.

Local governments are also responsible for sponsoring drug-related harm reduction programmes. In 2013, 34 communal governments financed harm reduction programmes (1.5% of the overall number of 2 233 communes which submitted National Drugs Strategy implementation reports). In 2011 (latest data), there were 3 wards operational in psychiatric hospitals (46 beds) and 2 wards operational in drug rehabilitation clinics (35 beds). In addition, there was 1 ward in a general hospital (26 beds). 669 hospitalizations were conducted therein. (Boguszewska, Institute of Psychiatry and Neurology, personal communication). The above wards admit patients with dual diagnosis.

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 show 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 is increasingly aggravating their overall social exclusion.

In 2013, social welfare centres across Poland provided drug-related assistance to 3 808 families; including 490 in rural areas. The assistance was provided to 5 952 clients, including co-dependent individuals.

In 2013, 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 10 hostels and 19 re-entry flats, as well as relapse prevention programmes in inpatient and outpatient facilities conducted by 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 122 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

In 2013 years 1 140 police officers dealt with drug-related crime under regular job responsibilities. This year a rise of 8.9% was recorded in the number of proceedings instituted under the drug law compared with the previous year (from 23 001 to 25033) The highest number of legal proceedings instituted in w 2013 concerned illegal possession of narcotic drugs and psychotropic substances (Article 62. 1 & 3 of the Act on counteracting drug addiction), totalling 19 504 cases. In 2013, police officers identified 27 375 suspects of drug-related crimes, including 3538 minors. There is a clear downward trend in the number of suspects (fall of 7% in the overall number and fall of 23% of minors compared to 2012). The most numerous group of drug-related offenders in 2013 were suspects under Article 62. 1 & 3 of the Act on counteracting drug addiction (possession), with the total of 19 504 suspects. This group makes up 71% in the overall number of suspects under the Polish drug law.

Drug market

There are major drug trafficking routes going through the Polish territory. Drugs are transited or they are directly exported from Poland to the Western European market. Amphetamine in Poland is most frequently manufactured using the Leuckart method. The manufacturing process and distribution of the drug is handled by organized crime syndicates, which establish, equip and supply clandestine laboratories. In 2013, the police dismantled 19 clan labs producing amphetamines. The Police are discovering major plantations in unused locations such as warehouses, factories, etc. 68 555 cannabis plants were seized in 2013 (rise of 10 399 plants compared with 2012). In 2013 there was an increase recorded in the seizures of hashish (from 38.9 kg to 208.3 kg), heroin (35.6 kg to 48.6 kg), amphetamine (from 613.7 kg to 675.7 kg), methamphetamine (from 4.2 kg to 9.5 kg) and ecstasy (31 thousands to 46 thousands). Seizure data reveal a rise in methamphetamine on the Polish illegal drug market. The police also seize new psychoactive substances which are not controlled by the drug law. In 2013, the following substances were seized: mephedrone (2939 grams), Salvia Divinorum (1 gram), 4 MEC (9558 grams), MDPV (620 grams), synthetic cannabinoid (110 grams). Data of the Central Forensic

Laboratory demonstrate higher THC levels in marijuana. The more THC marijuana has, the more potent it is. In 2013, marijuana contained 10% of THC. In 2007, the average purity rate of amphetamine available on the illegal market was 35%. The average price of a gram of marijuana in 2012 stood at PLN 31 and approximated to the modal value of PLN 30. Amphetamine, similarly to marijuana, is sold at a similar price (PLN 32 in 2008 and PLN 34 in 2012) however, the average purity level of amphetamine in that period decreased.

Part A: New Developments and Trends

1. Drug policy: legislation, strategies and economic analysis

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1.1. 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 Polish REITOX Focal Point operating within the National Bureau.

The National Drugs Strategy 2010-2016[2,3] is the executive act that lays down the priorities serving both the National Drugs Strategy as well as the action plan. Since 2006 the National Drugs Strategy 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 strategy is "Reducing drug use and drug- related social and health problems". The existing strategy has replaced the National Drugs Strategy 2006-2010. The strategy's structure remains 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 National Drugs Strategy is integrated with the EU Drugs Strategy and Action Plan. Under the National Drugs Strategy there were 110 actions formulated to be implemented by 7 ministries and 22 central level institutions, Provincial Pharmaceutical Inspectorates, as well as provincial and communal governments. The strategy implementation by respective ministers or central agencies often meant the involvement of a number of subordinate institutions, which means that the Strategy had a massive coverage. The strategy was designed to integrate a vast majority of antidrug actions in Poland. The coordinating role in implementing the National Strategy is fulfilled by the Council for Counteracting Drug Addiction[4].

1.2. Legal framework

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

In the reporting period no significant legal changes have been introduced in the field of drugs and drug addiction. However, work was underway on a large amendment to the act on counteracting drug addiction briefly described in National Report 2013. The main focus of this amendment is to improve

1 Act of 29 July 2005 of counteracting drug addiction (Journal of Laws "Dz.U." No. 179, item 1485).
2 Ordinance of Council of Ministries of 22 March 2011 on National Drugs Strategy 2011-2016 (Journal of Laws „Dz. U." No. 78, item 428).
3 More information under 1.3. National action plan, strategy, evaluation and coordination.
4 More information under 1.3. National action plan, strategy, evaluation and coordination.

the current regulation concerning new psychoactive substances. Some provisions proved problematic in terms of implementation and over the course of time problems have been revealed that need to be resolved. In 2013 the expert group developed a framework for the amendment to the Act along with a draft amendment to the Act on counteracting drug addiction (National Report 2013). The draft was also supplemented with provisions aimed at reducing OTC drug use for non-medical and illicit purposes like drug manufacture. In the reporting period, a draft Act was drawn up. It underwent two interministerial consultations due to many reservations concerning its content, mostly in the part devoted to non-medical OTC drug use. The act was recently accepted by Council of Ministers. Below there is a short overview of the amended Act solutions (the act is available at: http://legislacja.rcl.gov.pl/docs//2/201191/201193/201194/dokument135362.pdf).

The Act will feature a new definition of a new psychoactive substance. A substitute drug will also be redefined. The new provisions will define a substitute drug as "a product containing one or more psychoactive agent or another agent of similar effects acting on the central nervous system, which might be used instead of a narcotic drug or psychotropic substance or for the same purpose as a narcotic drug or psychotropic substance, whose manufacture and introduction to trade is not regulated by separate provisions; substitute drugs are not governed by provisions concerning general safety of products". According to the draft Act, a new psychoactive substance is defined as "a substance of natural or synthetic origin in any physical state with effects on the central nervous system defined in schedule announced by way of regulation of Minister of Health". New psychoactive substances will be listed in a separate schedule. The schedule will be announced by way of Regulation of the Minister of Health and might list both individual substances as well as generic groups of substances. Pursuant to the draft Act, new psychoactive substances as well as substitute drugs will be subject to market limitations on similar terms as it has been happening so far i.e. drug manufacture and introduction to trade will be prohibited under Article 44b 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). Penalties for breaching the abovementioned provisions will be imposed by way of administrative decision of a relevant state sanitary inspector. Possession of new psychoactive substances as well as substitute drugs will not be penalized. A list of substitute drugs is intended to cover substances which pose a lesser threat to public health. Consequently, they do not have to be fully controlled by introducing them in the schedules to the Act on counteracting drug addiction.

The draft Act also defines an expert team on risk assessment. The team will be a consultative and advisory body to the Minister of Health. It will comprise specialists in such fields as chemistry, pharmacology, toxicology, psychiatry, social sciences and law. The team members will be appointed by the Minister of Health upon motion of the Minister of Justice, the Minister of National Defence, the Minister of Interior, the Minister of Economy and the Minister of Transport. The team will be responsible for assessing the risk of substances in terms of potential risks to health and life and social harm. Following the assessment, specific substances will be recommended to the Minister of Health to be listed in the schedules to the Act on counteracting drug addiction or regulations on new psychoactive substances of Minister of Health. The control level is intended to correspond to the risk posed by specific substances.

Apart from the abovementioned modifications, there are also plans to extend the list of controlled substances under the drug law. The schedules to the Act are planned to be extended to include over 100 new psychoactive substances. The amendment also introduces a series of technical provisions which will simplify procedures and enable Sanitary Inspection to perform its duties more smoothly.

Moreover, the amended Act introduces changes to the pharmaceutical law. The planned changes are intended to limit access to OTC drugs containing psychoactive substances which are used to extract an active agent and further process and reintroduce the drug onto the black market. Several modifica-

tions have been made to the existing law. Trade in these drugs will be allowed through general access pharmacies and pharmacy outlets. Such drugs will have quantity limitations when it comes to a single purchase depending on the maximum content of a psychoactive substance necessary for an effective therapy. Moreover, a pharmacist will be obliged to refuse to hand over an OTC drug if they have reasons to believe the drug will be used for non-medical purposes. Pharmacists will also be obliged to inform the patient that the drug contains psychoactive agents as well as give instructions concerning dosing, risks and adverse effects. The Minister of Health by way of regulation will list psychoactive substances along with content limits for medical products necessary to be available to the public due to their therapeutic qualities for a single person under a single purchase.

Crossing the sale limit for distribution of medical productscontaining psychoactive substances will be subject to financial penalty imposed by way of a decision of the Provincial Pharmaceutical Inspector. Violating these regulations will be subject to a fine of up to PLN 50 000. While imposing the penalty, the Inspector considers the duration, gravity and circumstances of violating the abovementioned regulations. Moreover, interim regulations till 2016 will limit the number of individually distributed OTC drugs containing pseudoephedrine, dextromethorphan or codeine down to one pack.

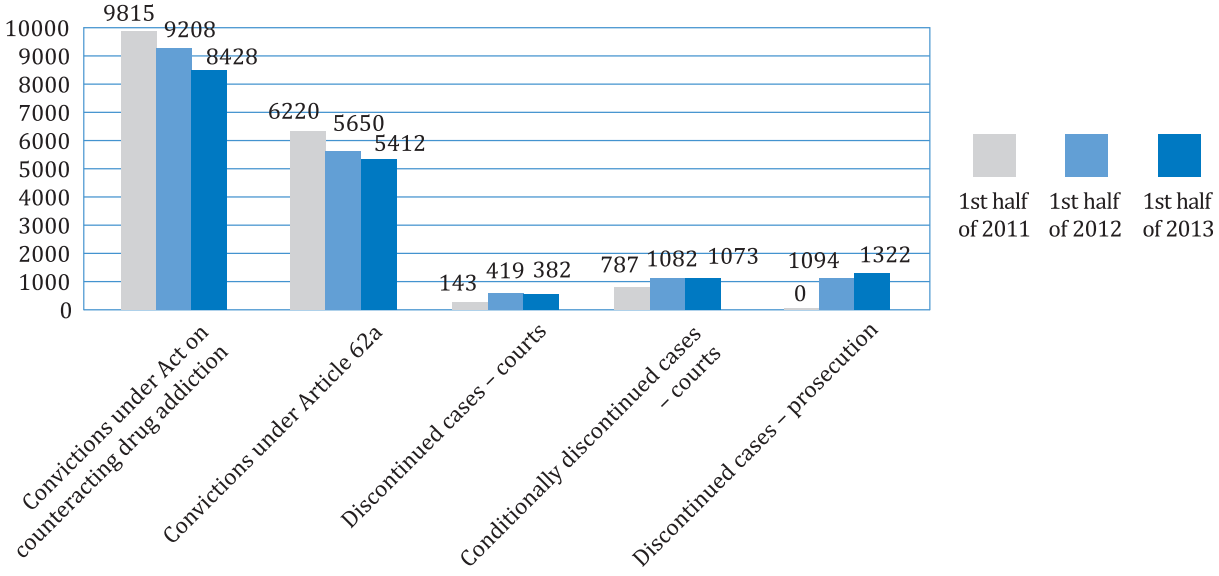
Moreover, in order to streamline law enforcement activities and remove interpretation problems there are plans to change the definition of cannabis. According to the existing definition cannabis is: "the flowering or fruiting tops of the cannabis plant from which the resin has not been extracted, and in the case of plants prior to flowering – leaves and the stem of the plant". The division into different stages of vegetation of the plant causes a number of interpretation difficulties for courts and court experts. An example can be the parts of cannabis such as stems and leaves where the total content of delta–9–tetrahydrocannabinol (Delta-9-Tetrahydrocannabinol-9-Carboxylic Acid) was over 0.20%. Leaves and stems are taken into account only when the inflorescence has formed, which can be ascertained in the case of plantations; however, it cannot be found in the case of cannabis straw. Another problem is when the exhibit is milled and contains over 0.20% THC as then it cannot be clearly determined what part of the plant the milled material comes from and consequently, provisions of the Act on counteracting drug addiction do not apply. Because of this, the legislators propose that the definition of the cannabis be changed so that it covers any part of the plant, excluding seeds, which contains over 0.20% of THC.

Apart from works on the new legal acts in 2013, the Ministry of Justice embarked on an evaluation of the enforcement of the 2011 amendment to the Act on counteracting drug addiction introducing a more liberal approach to drug possession as well as facilitating the use of alternative to punishment (National Report 2011, p.15). As a reminder, Article 62a of the Act gives the prosecutor and the 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. The Article 70a imposes an obligation on the prosecutor in the course of preparatory proceedings and the judge in the course of judicial proceedings to collect information on the use of narcotic drugs or psychotropic substances by the suspect. Previously, the prosecutor or the judge was not responsible for collecting such data, which resulted in failure to apply rules regarding educational or therapeutic measures (i.a. Article 72) towards experimenting or dependent users (Serednicki 2008). Another modification of the rules which facilitates the process of implementing the treat-rather-than-punish principle concerned Article 72a (suspending proceedings while in treatment) and Article 73a (allowing furloughs in serving the sentence while in treatment).

The analyses of the available data show noticeable trends in the structure of convictions in the field of drug possession crimes despite a relatively short time that elapsed since the introduction of the abovementioned solutions.

The data from the Ministry of Justice shows that out of all drug possession cases in 2012, 30% were discontinued, conditionally discontinued or the suspects were acquitted by the prosecution or courts (Wilamowska 2014). In 2013, this percentage rose to 34%. Moreover, the analysis of the cases dropped by the prosecution under the same Article 62a indicates a clear rise in the absolute numbers. In 2011, not a single case of this sort was entered in the statistics. In 2012, there were 2154 such cases and in 2013 the number rose to 3 132. Changes in the structure of judicial decisions are also evidenced by the data for the first half of 2013 when compared with the previous years (Figure 1.2.1.). As it is seen, there is a slow but steady fall in the number of convictions in relation to drug possession under the provisions of the Act on counteracting drug addiction with a simultaneous rise in the number of discontinuances and conditional discontinuances both at the level of courts and prosecutor's offices.

Figure 1.2.1. Comparison of the first halves of 2011, 2012 and 2013 in terms of convictions and discontinuances under the Act on counteracting drug addiction. District Courts. Cases discontinued under Article 62a – prosecution



Source: Wilamowska 2013, Ministry of Justice.

Data from the Ministry of Justice also shows positive trends in the application of probationary measures following the modifications of Article 70a, 72a and 73a. Data shows that the number of probationary measures ordered by district courts has increased, which was one of the aims of the amendment of the Act.

The number of orders under Article 72.1.6[5] of the Criminal Code in 2012 stood at 260, while in the previous year it had been only 11.

By analogy, the number of orders under Article 72.1.5[6] of the Criminal Code rose from 1355 in 2011 to 15101 in 2012. The number of orders under Article 71[7] of the Act on counteracting drug addiction also rose dramatically from 16 in 2011 to 276 in 2012.

5 The article refers to suspension of punishment under condition of discontinuation of drugs and alcohol abuse.
6 The article refers to suspension of punishment under condition of undertaking treatment.
7 The article refers to suspension of punishment for the period of treatment and possibility to discontinue imprisonment depending on the results of treatment. This article refers to drug related crimes.

There is still insufficient data and too little time has passed since the introduction of the abovementioned provisions both in terms of drug possession as well as the application of probation measures in order to clearly conclude how much these changes have met the law makers' expectations. However, it must be noted that the trends observed seem to correspond to the assumptions.

1.3 National action plan, strategy, evaluation and coordination

National action plan and/or strategy

The National Drug Strategy 2011-2016 (KPPN)8, 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 for taking 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[9]) 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 five following areas:

I. Prevention
II. Treatment, rehabilitation, harm reduction and social reintegration
III. Supply reduction
IV. International cooperation
V. 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 as well as 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 placing greater emphasis on raising the quality of both drug prevention programmes and staff responsible for their implementation.

In the area of drug treatment, rehabilitation, harm reduction and social reintegration theexisting Programme focuses mainly on improving the quality of life of harmful drug users and drug dependent individuals. Reaching this aim is planned through a 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 with the 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 shows there has been a rise in the number of illegal cannabis plantations in Poland. Consequently, measures

8 Regulation of Council of Ministries of 22 March 2011 on National Drugs Strategy 2011-2016 (Journal of Laws "Dz. U." No. 78, item 428).
9 Act of 29 July 2005 on counteracting drug addiction (Journal of Laws "Dz.U." No. 179, item1485).

have been taken to limit domestic cultivation of cannabis other than hemp. Moreover, the crackdown on domestic manufacture of amphetamine, which is the most prevalent stimulant, has been intensified. The measures included operations against the use of precursors in the manufacture of drugs. A new element of the National Drugs Strategy 2011-2016 is incorporating 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. To a large extent, the programme continues the activities started in the previous edition. Unlike the previous edition, the new National Drugs Strategy 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 National Drugs Strategy

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 to include 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.

Courses of action for local and regional governments

The KPPN places special emphasis on the role of local governments. Important tasks of the entities involved in the implementation of the National Drug Strategy (KPPN) include developing their own programmes, i.e. strategies which are based on the KPPN and the Act of 2005 on counteracting drug addiction[10]. 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 into 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) Raising 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

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

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 opioid-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.

Implementation and evaluation

National Drugs Strategy implementation in 2013

Ministries and agencies mandated to implement the National Drugs Strategy, except the Ministry of Infrastructure and Development and Central Labour Protection Institute, took action in all prevention-related areas planned for 2013.

Central level institutions performed public education activities related to strengthening attitudes conducive to substance use reduction with the support from the media.

In the reporting year, the National Bureau for Drug Prevention co-financed the implementation of 149 drug prevention programmes across the country aimed at reducing the prevalence of the use of narcotic drugs, psychotropic substances and substitute drugs among adolescents and children. In a competition launched according to the provisions of the Act of 23 April 2003 on public benefit and volunteer work (Journal of Laws "Dz. U.", No. 234, item 1536 as further amended) the following were approved to be implemented: early intervention programmes, selective prevention programmes, indicated prevention programmes and elevated drug-related risk setting prevention programmes. The programmes involved 340 000 participants.

The National Bureau launched a national campaign entitled "Is he/she high on medical or illicit drugs? OTC drugs are intended for treatment and not to get high". The campaign was aimed at raising the awareness of the risks related to using benzodiazepine-based hypnotics and sedatives as well as OTC drugs containing dextromethorphan, pseudoephedrine/ephedrine and codeine for non-medical purposes by adolescents. The campaign was under the honorary patronage of the Minister of Health and Minister of National Education.

Units of State Sanitary Inspection along with the Chief Sanitary Inspectorate performed awareness and educational activities intended to prevent the use of psychoactive substances, especially substitute drugs. The 2012-launched KIK/86 project "Alcohol, tobacco and other substance abuse prevention programme" co-financed under the Swiss-Polish Cooperation Programme was continued. In the reporting year, the Chief Sanitary Inspectorate commissioned the development of an educational programme "ARS – how to nurture love?" addressed to secondary school students. An online platform for the project www.zdrowiewciazy.pl (healthy pregnancy) was created. It contains educational materials for the general population and the key target groups (adolescents, teachers, medical doctors, managerial staff), scientific papers and reports on substance use.

In 2013, work was conducted to develop the framework of in-house universal drug prevention programmes and methods of their implementation. The National Bureau for Drug Prevention collabo-

rated with the Chief Sanitary Inspectorate and the J. Nofer Occupational Medicine Institute in Lodz to develop educational materials for employers under the project "Alcohol, tobacco and other substance abuse prevention programme". In 2013, the prison Service joined the project. The Ministry of National Defence conducted educational actions related to drug prevention among professional servicemen and other military personnel under the strategy of "Strengthening discipline, addiction and social pathology prevention in the Armed Forces of the Republic of Poland 2012-2013".

In primary schools, there were attempts made to support the implementation and promotion of evidence-based universal drug prevention programmes endorsed under the recommendation system. This was in order to counter the initiation of the use of narcotic drugs, psychotropic substances and substitute drugs among Polish children. Similarly to the previous year, the National Bureau for Drug Prevention (KBPN) and the Centre for Education Development (ORE) disseminated the Unplugged, a drug prevention programme designed for middle school students and recommended at the European level. Information on effective drug prevention programmes was also disseminated at conferences and through KBPN and ORE websites. 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 Ministry of National Education awarded grants for the implementation of drug prevention programmes addressed to children and adolescents. 121 entities received the funding.

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

In order to raise the quality of drug prevention the Minister of National Education developed and implemented "Strategy for health promotion and problem prevention among children and adolescents 2013-2016". The strategy addresses comprehensively the issues of physical and mental health of children and adolescents, including drug prevention. Schools and educational facilities implemented the curriculum in the field of substance prevention, including contents on behaviours improving health and security in risky situations as well as contents regarding nicotine, drug and alcohol prevention. At schools and educational facilities, internal educational and prevention programmes were implemented based on the assessment of student needs and problems.

An important course of action of the National Drugs Strategy is raising the quality of drug prevention. This objective is achieved through promoting evidence-based programmes and practices, evaluating the quality of undertaken actions as well as implementing support systems for drug prevention providers. 7 new programmes were entered into the system database under the recommendation system for drug prevention and health promotion programmes developed by the National Bureau for Drug Prevention in collaboration with the Centre for Education Development, State Agency for Preventing Alcohol-Related Problems and the Institute of Psychiatry and Neurology. Preventive actions taken by schools were complemented by trainings and supervisions conducted by the Centre for Education Development. The National Bureau launched a two-year research project aimed at evaluating the implementation of Unplugged school-based universal drug prevention programme in Poland.

In 2013 a variety of drug prevention actions recommended for regional governments were being implemented at regional level. The greatest involvement of regional governments was observed in supporting selective and indicated prevention programmes while the implementation of prevention camps and supervisions of drug prevention providers enjoyed the lowest interest. In total, across the country regional governments co-financed universal prevention in 318 schools and 83 other educational units. In 2012, the figures stood at 253 and 6 respectively. In 2013, the preventive and educational activities at sociotherapeutic centres were financed by seven regional governments and in 8

regions effective evidence- based early intervention programmes were being conducted. These included programmes such as "FreD goes net" and School Preventive Intervention intended for young drug experimenting or occasional users. Similarly to previous years, Marshal Offices continued developing both selective and indicated prevention programmes aimed at individuals with substance abuse problems and their families. Such actions involved 9 641 individuals.

Eleven regional governments got involved in educating the public on substance-related issues and the way of preventing the phenomenon by developing and disseminating information and educational materials as well as conducting awareness campaigns. Mass media were important partners in spreading knowledge on drug-related threats. Nine Marshal Offices collaborated with the media. They issued 399 press releases and published 80 articles. In 2013, 15 regional governments were involved in raising professional competences by holding 12 trainings on prevention programme development and 53 professional improvement courses for prevention programme providers.

Local governments are instrumental in performing drug prevention actions intended for local populations. Out of 2 233 communes (local governments) which submitted National Drugs Strategy implementation reports in 2013, nearly 85% conducted drug prevention activities. The level of local governments' involvement in implementing respective tasks depended on the type of prevention involved. The analysis of reports shows that many 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 2013, universal drug prevention programmes were implemented by 75% of all reporting communes while selective and indicated programme were implemented by merely approx. 20%.

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 modular Candis therapeutic programme for problem cannabis users aged 16 and older was continued and monitored. The National Bureau co-hosted an International Scientific and Training Conference entitled "Motivational interviewing – effective help method". In order to raise competences of primary care doctors in terms of general drug prevention work, the National Bureau launched a series of trainings on the e- learning platform in the reporting year. The series received accreditation of the Polish Chamber of Physicians and Dentists and was widely promoted in the medical community.

In order to improve access to specialist ambulatory health care for problem drug users, the National Health Fund (NFZ) increased in 2013 the spending on ambulatory health care services by approx. 9%.

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 2011-2016.

In 2013, 4 permits to launch 4 more programmes (in Chorzow, Opole and Warsaw) were granted. It is estimated that between 12% and 23% of drug-dependent population are covered by this form of treatment (assuming that the number of opioid-dependent users ranges from 10 400 to 19 800).

In 2013, only four regional NFZ branches (provinces of lubuskie, lubelskie, kujawsko-pomorskie and mazowieckie) managed to or came close to providing access to substitution treatment at the level of 25% of opioid-dependent population.

Substitution treatment is also provided in correctional facilities. In 2013, 7 such programmes were operational. They existed in 23 correctional units. 138 inmates benefited from the programmes. In order to ensure the continuation of treatment which started before entering prison, it is recommended that all correctional facilities offer substitution treatment.

The National AIDS Centre reported that in 2013 the ARV treatment was provided for all HIV and AIDS patients who met medical criteria, who may be covered with a health policy programme and in whose case it is not against the binding regulations. As at 31 December 2013, the ARV treatment was provided for 7 110 HIV and AIDS patients, which is nearly 13% more compared with the previous year. 1 837 of these patients (26%) might have become infected with HIV through injecting drugs or engaging in unsafe sex. The ARV programme was run in 21 hospitals where referral centres for HIV and AIDS patients in Poland are located. Moreover, in 2013 there were 32 sites providing free and anonymous HIV testing.

Apart from the abovementioned substitution treatment, there were also conducted abstinence-oriented programmes, anti-retroviral programmes as well as drug prevention programmes in Prison Service units in 2013. Since 2010, a short-term intervention programme for substance abusers has also been run.

In the reporting year, the National Bureau commissioned post-rehabilitation programmes to be implemented in 10 hostels and 19 re-entry flats as well as addiction counselling centres and day-care facilities across Poland. 2 167 individuals participated in these programmes.

The National Health Fund (NFZ) reported a 4% increase in post-rehabilitation hostel- based spending. 4 regional 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 2013, 12 Marshal Offices financed activities to increase the availability of therapeutic and rehabilitation services. The support involved modernizing the infrastructure of drug treatment and rehabilitation centres as well as financing activities for problem drug users. 20 units were provided with the support. However, it is alarming that in the reporting year, as well as in previous years, Marshal Offices were involved in widening harm reduction services only to a small extent. None of the Marshal Offices supported needle and syringe exchange programmes or any related ones. Only the Marshal Office of Mazowieckie Province reported that in the reporting year it provided support for such facilities as night shelters, hostels or drop-in centres.

Marshal Offices were also not sufficiently involved in supporting programmes aimed at reducing social exclusion among drug users and drug-dependent individuals. Only 3 regional governments provided funding for 7 hostels and re-entry flats. Social Integration Centres were co-financed by 7 Marshal Offices.

Communes (smallest units of local government) constitute an important link especially in performing comprehensive actions towards wider availability of harm reduction and social reintegration but also drug treatment and rehabilitation. In 2013, 837 communes performed activities in this respect (37%).

Local governments performed respective activities to a varied extent 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 (469 communes), including financing drug therapy and rehabilitation programmes (177 communes), disseminating information on drug services (457 communes) as well as rehabilitation camps and stays (76 communes). This type of activity is supported more often by western rather than eastern Polish communes. Another form of communal activity was financing programmes aimed at reducing social exclusion of drug users (201 communes).

Of all reporting communes, 133 supported professional development of drug treatment and rehabilitation staff as well as other professional groups working with drug users. Only 34 communes financed drug-related harm reduction activities. A total of 27 300 beneficiaries took part in commune-sponsored harm reduction programmes. Such activity is still mainly performed by urban communes.

The analysis of the drug treatment system data shows that urban communes are more likely to finance such like activities. Urban communes enjoy higher budgets for tackling social problems, po-

ssess 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 results in the fact that the latter do not have to develop and finance activities in their areas.

In 2013, the cooperation among drug supply reduction agencies was continued. In the field of reducing illicit trade and availability of drugs (including precursors) emphasis was placed on implementing and intensifying operational and intelligence work methods, identifying criminal groups, collecting information on respective substances, organizing specialist trainings and developing intra-institutional and international cooperation.

In 2103, a total of 67 criminal groups were dismantled. The police took action to identify and dismantle criminal groups. Investigative methods to identify the origin of chemicals and precursors were also being developed under the task of controlled deliveries. Backtracking investigations through the analysis of seized chemicals and precursors (packaging, labels, etc.) were also being conducted. Moreover, in 2013 the police dismantled 16 clandestine amphetamine labs, monitored websites related to the cultivation of cannabis and other psychoactive plants. The Central Bureau of Investigation (CBŚ) of the Police Headquarters runs a database named "KOKON". It contains data on police seizures of illicit synthetic drug labs as well as equipment and chemicals used in the manufacturing process. The Internal Security Agency (ABW) conducted reconnaissance of criminal groups in the course of preparatory proceedings. Similarly to the previous year, the Border Guard performed reconnaissance of criminal groups concerned with drug trafficking, distribution and manufacturing.

At the same time, drug enforcement agencies conducted trainings. The Border Guard carried out a training entitled "Identification of narcotic drugs, psychotropic substances and precursors", which focused on supply and demand reduction and the improvement of investigative techniques aimed at determining the origin of seized precursors and key chemicals. In the course of specialist trainings, Border Guard officers gave lectures and workshops to officers of Border Guard operations and investigation department, Police as well as border and criminal services of the Czech Republic. Military Police conducted a training course on combating drug-related crime. Customs Service conducted trainings for customs officers in the course of pan-regional trainings for customs chamber officers. The Main Pharmaceutical Inspectorate (GIF) carried out a training for provincial pharmaceutical inspectors and GIF personnel. A representative of the Central Bureau of Investigation delivered a training on precursors and chemicals as well as medical products containing precursors used for illicit drug manufacture. During the training, there was also a discussion about ways of reducing the sale of pharmaceuticals used for illicit production.

Respective drug enforcement agencies also participated in international operations for combating drugs and precursors. Cooperation with EUROPOL was continued. The Police took part in three international crackdown operations, prepared input data for AWF SOC FP Synergy and Cannabis analytic systems and conducted joint trainings in dismantling clandestine drug labs. The Police also collaborated under the EMPACT Synthetic drugs project. Along with the EMPACT Support Unit, the Police developed Operational Plans on Drugs for 2014. The Border Guard collaborated with EUROPOL regarding the exchange of information on organized crime syndicates and their members involved in drug trafficking. Moreover, the Polish side was awarded membership of the Focal Point Cannabis operating under the AWF SOC (Serious Organized Crime). The Management of the Operations and Investigations Department of the Border Guard Headquarters appointed a national coordinator. The Customs Service reported participation in the control action under WESTERLIES-2 Joint Customs Operation.

International cooperation between national institutions occurred mainly through participation in meetings of working teams on precursors and new psychoactive substances. Moreover, in the course of implementing respective actions, task force groups and working meetings were organized. The tasks force groups included representatives of various institutions. It must be noted that the coope-

ration happened both at a national (appointment of the working teams) and a regional level (Coordinating Team comprising Medyka border crossing officers as well as officers of Rzeszow and Przemysl branches of Central Bureau of Investigation established to dismantle an organized crime syndicate).

In the course of supply reduction actions, respective institutions performed operations aimed at reducing drug-related crime in cyberspace. To this end, the Customs Service, Military Police and Border Guard conducted a number of trainings on such topics as online security. Moreover, the Police analyzed the phenomenon of online drug-related crime and the related legal solutions.

In order to support the implementation of the National Drugs Strategy, the following ministerial drug supply and demand reduction strategies were developed and implemented in 2013: 'Ministry of Internal Affairs Strategy for combating drug addiction and drug-related crime 2011-2016' and 'Military Police Strategy Prevention Strategy for combating drug- related crime 2011-2016'. In 2013, the Military Police also performed tasks aimed at combating drug-related crime under 'Strategy for strengthening discipline, counteracting addictions and prevention social pathologies in Military Force of the Republic of Poland 2010-2015'.

International cooperation tasks constitute support for the implementation of the National Drugs Strategy. The tasks will be reviewed based on 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 policies.

Drug policy actions performed at the EU level in 2013 revolved mainly around the participation in the Horizontal Working Party on Drugs (HDG). It must be stressed that the coordination of the Polish delegation activity within the HDG used to be vested in the Central Bureau of Investigation of the Police Headquarters. At present, this duty is performed by the Ministry of Internal Affairs, which in cooperation with the National Bureau for Drug Prevention participated in establishing the following EU drug-related legal acts at the forum of the HDG:

- regulation of the European Parliament and of the Council on new psychoactive substances;
- development of the EU Action Plan on Drugs 2013-2016;
- proposal ofthe Council to control 4-methylamphetamine and 5-(2-aminopropyl)indole (5-IT) as well as new legal initiatives related to new psychoactive substances.

Moreover, representatives of the Ministry of Internal Affairs and National Bureau for Drug Prevention participated in the following discussions:

- non-medical use of prescription drugs;
- preparations for 56th Session of the Commission on Narcotic Drugs in Vienna in March 2013;
- development of drug supply indicators;
- preparation for the High-Level segment of the Session of the Commission on Narcotic Drugs in 2014 in Vienna.

The main topic of the proceedings of the Horizontal Working Party on Drugs in 2013 was drafting the final version of the Regulation of the European Parliament and of the Council on new psychoactive substances. This document is to replace the Council Decision (2005/387/JHA) on the information exchange, risk assessment and control of new psychoactive substance, which fails to provide proper mechanisms for rapid response to the threats posed by new psychoactive substances. The debate on this document is marked by a lot of controversy and doubt on the part of Member States, which prolongs the legislation process. EU Member States look forward to the arrival of an effective mechanism of NPS prevention; however, they are concerned that the planned solutions might lead to liberalization of previously developed national mechanisms. Work on the document will be continued in 2014.

Apart from the activity at the EU level, a number of actions at the forum of non-EU drug prevention institutions and organizations were being performed.

It must be stressed that the Ministry of Internal Affairs took over from the Police Headquarters some obligations related to the international cooperation including tasks of cooperating with non-EU entities.

In 2013, most institutions mandated to cooperate at international level (the Ministry of Internal Affairs, the National Bureau for Drug Prevention, Main Pharmaceutical Inspectorate) participated in the proceedings of international drug prevention organizations or took part in international anti-drug projects. The institutions concerned included the Commission on Narcotic Drugs (CND) and the International Narcotics Control Board (INCB).

In the field of cooperation with non-EU countries, the National Bureau for Drug Prevention conducted a project with Georgia, an Eastern Partnership country, entitled "Preventing drugs and drug addiction in Georgia". The project consisted of the following components:

- improving professional competencies of staff of Georgian state institutions and non- governmental organizations in the field of drug prevention based on best practice implemented in the EU Member States (responsible institution: National Bureau for Drug Prevention);
- developing models of intra-institutional cooperation based on the Polish experiences in order to combine and increase the potential of public institutions and non- governmental organizations based on conclusions from research and monitoring (responsible institutions: National Bureau for Drug Prevention, Merkury Foundation);
- establishing an anonymous online counselling centre in Georgia for drug-dependent individuals, their loved ones and anybody interested in the problem of drugs and drug addiction (responsible institution: Merkury Foundation).

Moreover, in 2013 the National Bureau designed a framework of a support project for Ukraine entitled "Improving professional competencies of addiction therapists based on best practice used in the EU Member States". The project was launched in 2014 under the Developmental Cooperation Plan of the Ministry of Foreign Affairs. The general aim of the project, implemented in cooperation with the Monar Association, is providing more effective support for substance abusers in Ukraine.

In 2013, the Chief Sanitary Inspectorate implemented the project COHESION concerning the monitoring of international transfer (MCRN) of potassium permanganate and acetic anhydride – Category 2 drug precursors via the PEN-ONLINE system.

Research and monitoring tasks, together with international cooperation, constitute support for the National Drugs Strategy. Respective institutions specified in the KPPN monitored the epidemiological situation by collecting data on drugs and drug addiction according to their competencies. Information collected by central institutions was compiled and processed by the Polish Focal Point in the form of the National 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 2013, the National Bureau continued the initiative aimed at supporting scientific research into drugs and drug addiction by announcing research competitions for projects exploring the following areas: injecting drug use in the context of HIV/AIDS policy, illicit drug market, drug-related crime and drug supply reduction or quality improvement of the drug prevention system. At the same time, in 2013, research projects, chosen under the 2012 competitions were, continued.

In order to improve the quality of monitored indicators, attempts were made to develop a drug information system. The National Bureau for Drug Prevention continued the pilot project of the Polish drug treatment demand system. The results of the pilot project were processed and reported to the

EMCDDA. A deficit area is still the system of collecting data on drug-related deaths. For a number of years, the records on drug-related deaths have not been collected according to the EMCDDA standard protocol. The consequence is lack of credible information on the real number of drug-related deaths and the collected data is underestimated.

In the course of consolidating national systems, emphasis was also placed on improving the quality of local and provincial drug monitoring through national and international conferences and training courses.

The data shown in communal questionnaires shows that 9.6% of communes implemented research and monitoring activities. Similarly to the previous year, monitoring drugs and drug addiction is more frequent in urban communes (22.5%) than in rural communes (5.9%). Monitoring public attitudes towards drugs and drug addiction was performed by 8.3% of local governments in 2013 while the activities related to the development and consolidation of the drug information system were reported by 4.7% of communes.

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

Conclusions and recommendations:

In the framework of monitoring of implementation of National Drug Strategy each year National Bureau for Drug Prevention collects and analyzes information from all involved institution about their activity. Additionally the data on basic indicator on size of drug problem are collected and analyzes. Basing on this sources each year the recommendations and conclusions are prepared. In 2014 the following conclusions were made:

1) An important problem observed in the process of implementing the National Drugs Strategy in 2013 was insufficient use of the recommended drug prevention programmes. This issue was stressed during the 2012 inspection conducted by the Supreme Audit Office in educational units. Consequently, it is necessary to take further action that would encourage local governments and superintendent's offices to promote evidence-based prevention programmes on a wider scale at schools and all levels of education.
2) Similarly to the previous year, the Ministry of National Education failed to collect data on some key indicators of school-based actions, which made it impossible to evaluate the implementation of the National Drugs Strategy (KPPN) in such areas as dissemination of evidence-based drug prevention programmes. It is recommended that the Ministry of National Education take action in order to develop a system of collecting data that would monitor the progress of the KPPN implementation in educational units.
3) Due to low involvement of Marshal Offices in actions aimed at supporting supervision of prevention staff, it is recommended that such activities enjoy wider support in the coming years. Supervision and other forms of professional training are essential for the quality of prevention work and preventing professional burnout.
4) Only some Marshal Offices made efforts to disseminate and implement evidence- based prevention programmes in 2013. It is recommended that provincial governments be involved more widely in the implementation of the abovementioned task, particularly in provinces where trained and experienced providers of such programmes are available. Regional governments may use the database of recommended programmes available on the website of the National Bureau for Drug Prevention.
5) Local governments allocate most financial resources to the implementation of universal drug prevention actions. However, recommended drug prevention programmes are conducted in a limited number of communes. The promotion of such programmes requires cooperation between communal authorities and educational units, especially schools.

6) A little over 28% of all communes which submitted National Drugs Strategy implementation reports (2 233 communes) organized or co-financed professional improvement trainings for drug prevention personnel. It is recommended that this type of activity receives more support as any form of professional training is of key importance in the context of drug prevention work. As well as that, it also prevents professional burnout.
7) Due to an increasing number of problem cannabis users reporting to treatment, 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, train more providers and increase spending on its implementation.
8) Every year, we are observing wider availability of substitution treatment programmes although they fail to meet the needs of the whole opioid-dependent population. Although in 2013 there were permits issued to launch 4 more programmes, it is estimated that between 12 and 23% 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 pomorskie, zachodniopomorskie and wielkopolskie.
9) It is alarming that in the reporting year Marshal Offices were scarcely involved in widening the availability of harm reduction programmes. None of the Marshal Offices supported syringe and needle exchange programmes. Low threshold programmes for drug-dependent individuals unmotivated for treatment (night shelters, drop-in centres) were not financed by the Marshal Offices. Therefore, local and regional governments are recommended that, whenever it is justified, they perform harm reduction activities.
10) The percentage of communes supporting drug treatment, rehabilitation, harm reduction and social reintegration in 2013 reached a mere 37% (i.e. 837 communes out of 2 233 which submitted reports in the reporting year). Considering the above, it is recommended that more emphasis be placed on such activities in the coming years.
11) Every year the number of illicit domestic cannabis plantations dismantled by the Police is increasing. The rising popularity of cannabis among adolescents leads to increases in domestic cannabis plantations, and this activity is increasingly taken up by organized crime syndicates. Seizing cannabis plantations run by organized criminal groups calls for the intensification of operations and cooperation of various services.
12) The manufacture of synthetic drugs is not limited to clandestine amphetamine labs as was the case several years ago. In Poland drug labs producing methamphetamine, mephedrone or BMK are being detected. The development of the market for synthetic drugs produced by organized crime syndicates will pose a challenge for Polish drug enforcement agencies.

Research Competitions

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

In the last several years, 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 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 are concentrated on priorities defined by bodies such as the Council for Scientific Research (Malczewski, Misiurek, 2013).

In 2013, research institutions could seek research project commissions in the following fields: injecting drug use in the context of HIV/AIDS, illegal drug market, drug-related crime, drug supply reduction and improvement of the quality of drug prevention system.

In 2013, the following new projects were financed by way of competition:

- "Pilot project addressed to injecting drug users", AIDS Social Committee;
- "Discourse analysis of illegal drug market on the Internet, based on the exploration of the biggest online psychoactive substance discussion forum", Personal Development Society.

Moreover, in 2013 the National Bureau for Drug Prevention continued to finance research projects selected for implementation under the 2012 Research Competition. These were the following:

- Evaluation of the effectiveness of proprietary programme of psychosocial support for middle-school youth", Kazimierz Wielki University in Bydgoszcz;
- "Evaluation of effectiveness of proprietary programme of psychosocial support for school children to follow the school curriculum", Kazimierz Wielki University in Bydgoszcz;
- "Developing user perceived self-control over cannabis and the context of illegality", Personal Development Society.

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[11], appointed on the basis of their expertise and experience in addiction-related research. The Council is responsible for initiating research, as well as 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 one hand initiates and supports scientific research into drug demand reduction and on the other evaluates the drug information system.

Coordination arrangements

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 Drugs Strategy; 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 coordinate the programme implementation more effectively, there are 4 work teams operating un-

[11] Members of the Council: 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.

der the auspices of the Council: precursors team, international cooperation team, implementing team for the National Programme and new psychoactive substances team, which was created in 2011. The teams play an advisory role and provide technical support for the Council.

In 2013, four session of the Council and several sessions of working teams were held. In the reporting period, the Council dealt mainly with the following issues:

- Assessment of work progress on the implementation of measures preventing non- medical use of pseudoephedrine-based medications and other drugs containing e.g. DXM, benzydamine, codeine used for non-medical purposes. The issues related to the amendment to the pharmaceutical law in reducing this problem were also debated,
- Information from the Minister of Health on monitoring the implementation of new provisions of the Act on counteracting drug addiction introduced by way of amending the Act of 1 April 2011, mainly in the field of Article 62a, which liberalized the provisions related to drug possession for personal use (described in greater detail under section 1.2. Legal framework, Laws, regulations, directives or guidelines in the field of drug issues)
- Results of the audit of the Supreme Audit Office conducted at the National Bureau for Drug Prevention in relation to "Drug prevention at schools" (National report 2013) and implementation of the recommendations formulated in the audit report,
- Progress on the amendment to the National Drugs Strategy 2011–2016,
- Issues related to the draft Act amending the Act on counteracting drug addiction and other selected Acts (described in greater detail in Section 1.2 Legal framework, laws, regulations, directives or guidelines in the field of drug issues).

In the reporting period, work was also underway in the Council Working Teams. The Drug Precursors Team worked towards the assessment of the situation in the field of illegal production of methamphetamine based on precursors obtained from cold OTC medications by organized crime groups. The team also discussed issues related to the European Drug Precursor Database.

The New Psychoactive Substances Team analysed the current data on NPS e.g. analysis of NPS frequency in 2012 and 2013 as well as new NPS emerging on the European drug market. Moreover, work on the amendment to the Act that was being conducted in the reporting period was discussed in terms of the implementation (described in greater detail in Section 1.2 Legal framework, laws, regulations, directives or guidelines in the field of drug issues). Debate revolved mainly around the risk assessment system and the issues related to the operation of the Risk Assessment Team. There was also a discussion on the work at the European level regarding the planned changes of replacing the Council Decision 2005/387/JHA of 10 May 2005 on the information exchange, risk-assessment and control of new psychoactive substances with a new legal instrument at the European level. Moreover, the team discussed issues related to the implementation of NPS prevention.

In 20013, the Working Team on the Implementation of the National Drugs Strategy discussed findings of the post-audit statement of the Supreme Audit Office (NIK) concerning the work of the working team and the "Information on the implementation of the National Drugs Strategy 2006-2011". The team's sessions featured discussions on the changes in the forms of reports on the implementation of the National Drugs Strategy as recommended in the Supreme Audit Office Report on "Drug prevention at schools". Work was also continued on the amendment to the Regulation of the Minister of Health on the National Drugs Strategy 2011-2016 including Supreme Audit Office recommendations. Work on the regulation was discontinued by way of decision of the Minister of Health as it was believed that a new strategy including Supreme Audit Office recommendations should be developed as the duration of the existing strategy would not guarantee the full implementation of the changes by the end of the strategy. Moreover, the team discussed the improvement of action 1.3 of the National Drugs Strategy 2011-2016 on widening access to evidence-based therapeutic programmes as well as the draft amendment to the Pharmaceutical Law concerning limiting access to OTC drugs containing

pseudoephedrine. At the end of 2013, the Council for Counteracting Drug Addiction approved tasks to be implemented in 2014 by the Council and supporting working teams. The following issues were considered crucial: non-medical OTC drug use, precursors and pre-precursors-related issues, drugs in road traffic, monitoring the implementation of the amended Act of 1 April 2011 on counteracting drug addiction, monitoring the situation in relation to substitute drugs, the so-called new psychoactive substances.

Development and consolidation of provincial monitoring systems

Local monitoring

In the course of tasks set out in the National Drugs Strategy 2011–2016 concerning the promotion of cooperation between local governments and the central one, the Polish Focal Point concentrates on developing local monitoring at communal level. It is one of the priorities in the field of developing monitoring systems for drugs and drug addiction in Poland. In 2008, under the twinning programme with Spain, the National Bureau for Drug Prevention began implementing local monitoring in local governments. The local drug monitoring system is supported by the network of Provincial Drug Information Experts. The experts participate in training courses and are responsible for coordinating the local monitoring in their provinces. The Polish Focal Point coordinates the project at the national level by holding trainings and providing technical support. In 2013 and 2014, Provincial Drug Information Experts held trainings and a conference for communal and municipal authorities in the provinces of mazowieckie, wielkopolskie, zachodniopomorskie and małopolskie. Moreover, in 2013 and 2014, the Polish Focal Point held two international conferences for local and regional governments under the network of drug monitoring communes. The conferences were organized in collaboration with the Mazovian Centre for Social Policy. The latest one was devoted to promoting the European Drug Prevention Quality Standards.

According to the National Drugs Strategy implementation data, over 200 communes and municipalities in Poland monitored drugs and drug addiction.

Drug Policy in large cities[12]

Local communities are an important partner for central institutions in solving the drugs problem. Cities and communes have been active in drug prevention for a number of years. Every year a conference for communes and Provincial Drug Information Experts is held by the Reitox Polish Focal Point. The conference shows that local government officials recognize the importance of the problem.

The last meeting for communes and municipalities under the multi-year cooperation between the National Bureau and local governments was organized at the beginning of October in collaboration with the Mazovian Centre for Social Policy (MCPS) in Warsaw.

The conference entitled European Drug Prevention Quality Standards was devoted to the promotion of the prevention standards and was attended by both representatives of local governments and foreign visitors, who presented their experience in raising the quality of prevention in home countries. Both the National Bureau for Drug Prevention and the MCPS are involved in the project of "Promotion of best practice in drug prevention" (European Drug Prevention Quality Standards - EDPQS). The drug

[12] Published in: Malczewski A., Misiurek A., (2014) Działania dużych miast w przeciwdziałaniu narkomanii w 2013 r. cz. I. Serwis Informacyjny NARKOMANIA 4 (68)

problem is most prevalent in cities. That is why the drug prevention activities of the ten biggest Polish cities (Wroclaw, Bydgoszcz, Lublin, Lodz, Krakow, Warszawa, Gdansk, Katowice, Poznan, Szczecin) were analyzed.

New challenges as of 2005

The Act of 2005 on counteracting drug addiction increased the powers of local governments, including large municipalities, to get involved in preventing drugs and drug addiction. Communes and municipalities were able to allocate financial resources obtained from alcohol licence fees to drug prevention as well as other activities such as drug treatment and harm reduction. In order to effectively run activities at local level, local governments were obliged to develop and implement local drugs strategies.

Since 2005, revenues from alcohol licence fees (the so-called "cork tax") are used to implement communal drugs strategies. Communes are also able to use other funds to sponsor drug prevention programmes. According the Ministry of Finance, in 2013, local governments spend approx. PLN 36.7 million on the implementation of drug prevention activities under local drugs strategies. The nature and scope of the activities vary. In some provinces, the municipal spending accounts for the majority of drug prevention financial resources. For example, in łódzkie province, the spending of the city of Lodz constitutes half of the total spending of the province's cities and communes on drug prevention obtained from alcohol licence fees.

Legal grounds

Data on the largest Polish cities compiled in this report comes from the annual reports on the implementation of the National Drugs Strategy, which are submitted to the National Bureau for Drug Prevention on an annual basis via the network of Provincial Drug Information Experts. Information on the activities of all communes in drug prevention was presented in Chapter 3 hereof. Communes and municipalities are obliged to develop their own local drugs strategies based on two documents: the Act of 2005 on counteracting drug addiction and the National Drugs Strategy 2011-2016. According to the Act, drug prevention remains the statutory obligation of communes, which includes:

1) increasing the availability of therapeutic and rehabilitative offer for drug addicts and drug-endangered individuals;
2) providing drug-related families with psychosocial and legal assistance;
3) implementing drug prevention through informing, educating and training, especially children and youth, including sport and recreational classes for pupils and actions aimed at feeding children who participate in extracurricular custodial and upbringing programmes as well as socio-therapeutic ones;
4) supporting institutions, non-governmental organizations and natural persons in solving drug-related problems;
5) providing welfare services to drug addicts and drug-related families stricken by poverty and social exclusion and integrating these individuals with the local community through social work and social contacts.

The National Drugs Strategy (KPPN) sets out courses of action for local governments. Based on the problem assessment as well as on the KPPN courses of action and the provisions of the Act on counteracting drug addiction, local governments develop local drugs strategies, which also serve as munici-

pal strategies. Municipalities may develop separate drugs or alcohol strategies. In the case of the latter, a strategy covers the period of a single year. Drugs strategies might be operational for several years.

The majority of the cities developed separate drugs and alcohol strategies. In the case of Wroclaw and Krakow, these were joint strategies (Table 1.3.1.). Most of the cities designed their drugs strategies based on a prior assessment. All the cities in question took measures to prevent drug addiction; however, Lublin did not implement any universal drug prevention programmes under the municipal strategy while Warsaw did not implement selective or indicated prevention programmes. All the cities provided drug treatment services and, to a large extent, ran harm reduction programmes (except Katowice and Bydgoszcz for harm reduction). Wroclaw, Gdansk and Szczecin sponsored substitution treatment. Drug monitoring and research were implemented to a lesser extent. Three cities (Warsaw, Katowice and Poznan) did not perform any activities related to drug research and monitoring.

Spending on counteracting drug addiction

In 2013, in the course of monitoring the implementation of the National Drugs Strategy, communal governments were asked to report spending on counteracting drug addiction under local drugs strategies. Calculating spending on counteracting drug addiction, especially in the field of prevention, is not an easy task. This is because of the fact that drug prevention activities are also performed under local alcohol strategies. Substance prevention frequently covers licit and illicit substances. Consequently, it is sometimes hard to determine what substances a drug prevention programme covered. To handle this issue, in the reporting questionnaire the source of financing the activities in place was adopted as the indicator for categorising the prevention activities. Communes and municipalities should finance activities of counteracting drug addiction under one section. Counteracting drug addiction is a separate budgetary item – section 85153, under which drug-related measures are financed. In 2013, the activities of the cities in question accounted for 22% of all drug-related spending of communes and municipalities across Poland (over PLN 8 million out of PLN 36.7 million disbursed by local governments under section 85153). Under resources from this budget, the highest spending was recorded in Katowice (over PLN 2 million) and Lodz (over PLN 1.2 million). The lowest spending was recorded in Krakow (nearly PLN 100 thousand). However, Lublin reported no resources available under this section. An important role of large cities in provinces is evidenced by a large share of certain expenses in the total spending of all communes on counteracting drug addiction in a province. The spending of Katowice on counteracting drug addiction constituted a third of the expenditure of all communes and cities in śląskie province in 2013. This was also the case in the province of łódzkie, where the total expenditure on solving drug addiction-related problems of the city accounted for 50% of the expenditure of the whole province. Both cities spent the most resources under the so- called 'cork tax' (alcohol licence fee revenues). Katowice allocated 27% of the alcohol licence fee revenues and Lodz almost 10%. The cities with the high expenditure on counteracting drug addiction also included Gdansk (9%) and Poznan (8%). At the national level, this rate reached 5%. Therefore, every twentieth zloty from alcohol licence revenues was allocated to counteracting drug addiction. The questionnaire also featured questions about the total expenditure on counteracting drug addiction, also under section 85153. The cities with the highest spending included Bydgoszcz (PLN 2.095 million) and Katowice (PLN 2.014 million). In Bydgoszcz, most resources on counteracting drug addiction came from outside section 85153 (75% in total). The lowest spending was recorded in Lublin (PLN 268 thousand). The municipal expenditure on counteracting drug addiction is presented in Table 1.3.1.

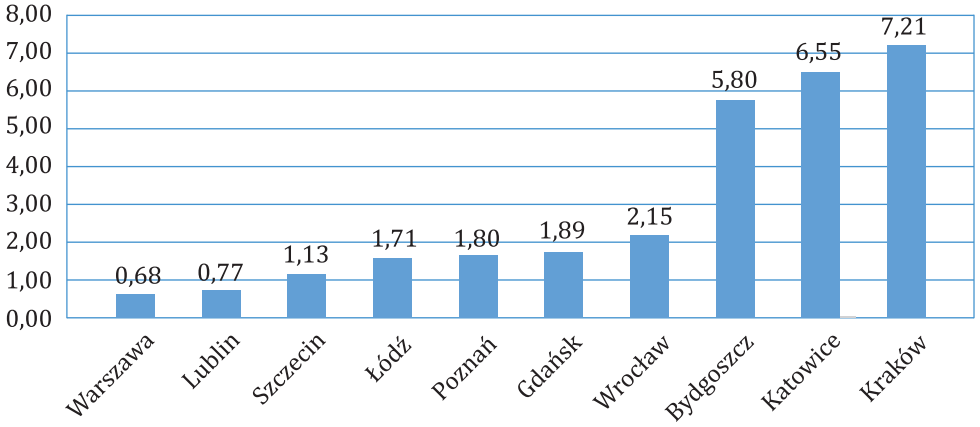
Table 1.3.1. Expenditure on counteracting drug addiction, assessment and programme in 2013

City	Province	Total expenditure on counteracting drug addiction	Expenditure on counteracting drug addiction under section 85153	Assessment / diagnose - based strategy	Separate strategy/ Joint with alcohol strategy
Wrocław	dolnośląskie	1358996	870000	yes	joint
Bydgoszcz	kujawsko-pomorskie	2095000	520039	yes	separate
Lublin	lubelskie	268368	0	yes	separate
Łódź	łódzkie	1232872	1232872	no	separate
Kraków	małopolskie	5467763	99281	yes	joint
Warszawa	mazowieckie	1162310	1162310	no	separate
Gdańsk	pomorskie	869955	869955	yes	separate
Katowice	ślaskie	2013807	2013807	no	separate
Poznań	wielkopolskie	989677	989677	yes	separate
Szczecin	zachodniopomorskie	460735	398320	yes	separate

Source: internal estimation based on KPPN reporting questionnaire in 2013.

Let us take a look at the municipal expenditure per resident. The analysis includes the spending under section 85153 as well as the total expenditure of cities on counteracting drug addiction, also from other sources. Figure 1.3.1. presents the total spending on counteracting drug addiction per resident. The data shows that the spending per capita was the highest in Krakow (PLN 7), Katowice (PLN 6.5) and Bydgoszcz (PLN 5.8). The lowest spending (under PLN 1) was recorded in Warsaw and Lublin.

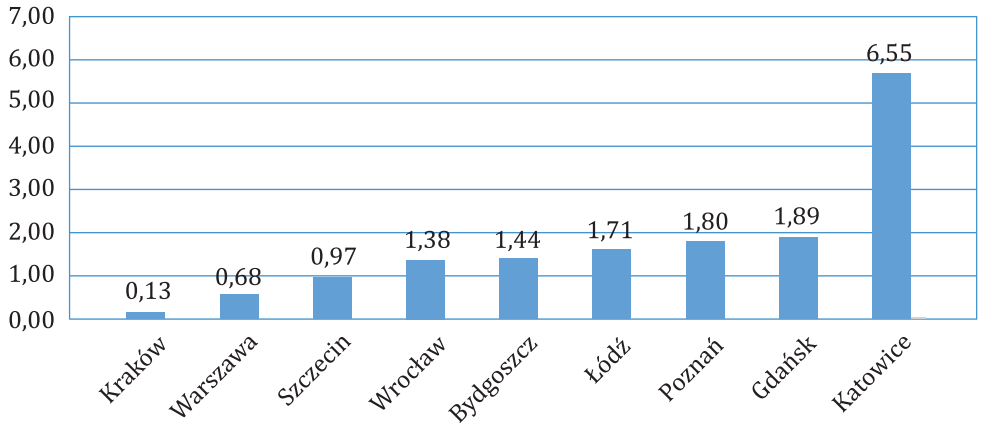
Figure 1.3.1. Total expenditure on counteracting drug addiction per resident (PLN)



Source: Malczewski, Misiurek (2014), internal estimation based on KPPN reporting questionnaire in 2013.

The expenditure under section 81153 per resident has been presented in Figure 1.3.2. Similarly to the total expenditure, the highest spending was recorded in Katowice (PLN 6.5). Krakow and Warsaw spent the least (Lublin reported no resources available under section 85153 and therefore was excluded from this analysis).

Figure 1.3.2. Expenditure under section 85153 on counteracting drug addiction per resident (PLN)



Source: Malczewski, Misiurek (2014), internal estimation based on KPPN reporting questionnaire in 2013.

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

prepared by Artur Malczewski, Anna Strzelecka, Anna Misiurek

2.1. Introduction

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

2.2. Drug use in the general population

"Social diagnosis 2013. Conditions and the quality of life among Poles"

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Implementing institution: Polish Statistical Association

Introduction and project aim

The study "Social diagnosis 2013", headed by Janusz Czapiński, professor at the Faculty of Psychology of Warsaw University and vice-president of the Higher School of Finances and Management and Tomasz Panek, professor at the Institute of Statistics and Demography of the Warsaw School of Economics, is intended to provide comprehensive information on the conditions and the quality of life among Poles.

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

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

The "Social diagnosis" study is financed both under public funds and currently also under Operational Programme Human Capital (European Social Fund) research grant by the National Science Centre as well as by the National Bank of Poland and private donations. However, as a whole, the study is of public character.

Method

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

The study uses two questionnaires. One is related to the conditions and the quality of life in households and it is completed by the interviewer during an interview with a household member. This

questionnaire is a source of information on the household structure and living conditions. It also provides socio-demographic data on the respective members of the household. The other questionnaire provides information on the quality of life of the respective members of the household and is intended for self-completion by all present household members aged 16 and older.

The measurement is always taken in March or in March and April by professional interviewers of the Central Statistical Office. Organizational matters of the study were handled by the Office of Statistical Studies and Analyses of the Polish Statistical Association.

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

In 2013, 12 370 households (36 133 members) were studied. Individual interviews were conducted with 26 307 household members aged 16 and older.

Out of the 2011 sample, 9 114 households were reached (73.58%) with 25 914 the same members (70.51%) and 18 020 the same individual respondents (68.12%). Out of the 2009 sample, 6 599 households were reached (53.28%) with 18 008 the same members (49%) and 12 380 the same individual respondents (46.80%).

The respondents were questioned, among other things, about drug consumption in the last 12 months (Czapiński, Panek 2014).

Outcome

The distribution of answers to the question: "Have you used drugs in the last year?" is presented in Table 2.2.1.

Table 2.2.1. Prevalence of drug use in the last year in 2000, 2003, 2005, 2007, 2009, 2011 and 2013 by sex, age, place of residence, province, education, income per capita and socio-demographic status (%)

Population	2013	2011	2009	2007	2005	2003	2000
Total	1.31	1.27	1.16	1.03	1.31	0.96	0.96
Sex							
Male	2.12	2.11	1.78	1.67	1.91	1.51	1.59
Female	0.58	0.51	0.58	0.51	0.79	0.48	0.42
Age							
under 24	4.13	4.61	3.75	3.67	3.83	3.91	3.75
25-34	2.85	1.91	2.14	1.54	2.45	1.31	1.77
35-44	0.61	0.89	0.47	0.53	0.48	0.05	0.30
45-59	0.24	0.15	0.14	0.05	0.27	0.08	0.30

Place of residence							
Cities of >500k	2.65	2.17	2.60	1.54	2.64	2.03	1.66
Cities 200-500k	2.09	2.29	0.93	1.91	1.80	1.91	1.97
Cities 100-200k	1.78	1.46	1.74	1.28	1.91	0.60	1.03
Cities 20-100k	1.18	1.40	1.09	0.65	1.44	0.68	1.00
Towns <20k.	1.41	1.19	1.18	1.54	0.99	0.80	0.73
Rural areas	0.67	0.64	0.66	1.91	0.72	0.63	0.51
Province							
Dolnośląskie	1.94	1.48	1.21	0.92	1.04	1.57	1.05
Kujawsko-pomorskie	1.22	1.74	1.13	1.63	1.25	1.64	0.68
Lubelskie	0.61	1.27	0.53	1.58	0.47	1.08	1.38
Lubuskie	1.87	1.86	1.26	1.17	1.15	1.24	1.19
Łódzkie	1.51	0.84	1.13	0.85	1.23	0.68	1.35
Małopolskie	0.61	0.48	0.81	0.87	1.33	0.43	1.22
Mazowieckie	2.07	1.03	2.07	0.84	2.20	1.01	0.63
Opolskie	0.58	0.96	1.20	1.11	0.96	0.66	0.72
Podkarpackie	0.69	1.07	0.97	0.98	1.44	0.89	0.44
Podlaskie	1.46	1.02	0.44	1.18	0.97	0.61	0.19
Pomorskie	1.92	0.90	0.81	1.77	2.17	1.49	2.53
Śląskie	1.26	1.31	1.06	0.91	1.23	1.15	0.55
Świętokrzyskie	0.34	0.81	0.44	1.00	1.07	0.80	0.31
Warminsko-mazurskie	0.41	1.50	0.80	0.55	1.04	0.58	1.33
Wielkopolskie	1.13	1.52	1.34	0.83	0.70	0.41	0.00
Zachodniopomorskie	2.06	3.57	1.59	1.08	1.53	0.96	2.19
Education							
Primary and lower	0.95	0.53	0.55	0.34	0.74	1.02	0.69
Vocational /upper-primary	1.19	1.61	1.15	1.47	1.51	0.67	1.16
Secondary	1.71	1.61	1.43	1.16	1.55	1.41	0.98
Tertiary	1.14	0.85	1.26	0.70	1.17	0.55	1.04

Income per capita							
Bottom quartile	1.30	1.02	0.88	1.39	0.96	0.53	0.54
Middle 50%	1.14	1.31	1.16	0.98	1.25	1.15	1.14
Top quartile	1.77	1.38	1.47	0.86	1.95	1.27	1.29
Socio-demographic status							
Public sector	0.70	0.72	0.19	0.32	0.43	0.38	0.66
Private sector	1.76	1.20	1.39	1.58	1.47	1.23	1.29
Private business people	1.26	1.18	2.07	1.44	1.53	0.34	0.65
Farmers	0.30	0.22	0.14	0.14	0.17	0.00	0.22
Long-term disability beneficiaries	0.81	0.17	0.59	0.59	0.87	0.44	0.44
Pensioners	0.13	0.07	0.03	0.00	0.10	0.23	0.00
School and university students	3.50	4.26	3.38	3.37	4.31	4.06	5.76
Unemployed	2.18	1.87	2.65	1.05	2.03	1.42	1.09
Other vocationally passive	1.78	1.95	1.46	1.06	1.28	0.55	1.20

Source: Czapiński & Panek (2014), pp. 274-275.

Similarly to previous years, the results of the "Social diagnosis 2013" study show that drug users are predominantly male. Among females there are almost three times fewer illegal substance users.

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

Residents of the biggest cities (over 500 thousand population) use drugs nearly twice as often as residents of cities with population of between 20-100 thousand and towns with population of below 20 thousand as well as almost four times as often as rural residents. The highest drug prevalence rates were recorded in the following provinces: mazowieckie, zachodniopomorskie, dolnośląskie and pomorskie.

The results of the 2013 survey show that currently the highest risk related to drug addiction concerns males, school and university students, i.e. generally speaking – younger individuals, residents of big cities, unemployed and other vocationally passive individuals as well as secondary school graduates.

However, the results of the logistic regression show that women use drugs over three times less frequently than men, elderly individuals (aged over 59) over 20 times less frequently compared with the youngest users (aged up to 24), residents of small towns and villages from two to five times less frequently than residents of urban areas with population over 500 thousand, other vocationally pas-

sive individuals by 70% more frequently than public sector staff, single individuals almost 4 times as often as married individuals and lastly individuals with higher education almost twice less frequently than primary education holders.

Moreover, the risk of drug addiction varies greatly in terms of life stress, however, similarly to alcohol abuse, it is not known what the trend of the above variable is: both using drugs might aggravate life problems but also high build-up of stress might make people resort to illegal psychoactive substances.

Summary

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

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

The results of the "Social diagnosis 2013" study show that the group at the highest risk of drug addiction is males under 24, including school and university students. Generally speaking, considering the age of Polish drug users, drug use prevalence is the highest among individuals under 30.

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

Drug use prevalence and attitudes towards psychoactive substances in general population in 2013[13]

Introduction

Drug use prevalence surveys play an important role in the process of monitoring drug addiction. They also complement the existing knowledge based on drugs and the related phenomena. This facilitates the process of planning activities and developing drugs strategies. Drug use prevalence measurements tend to include attitudes towards drugs and drug addiction. The results help to determine the support for drug liberalization.

In mid-2013, there was a quantitative survey conducted on a representative sample of the Polish population aged over 15. The field part was carried out by the TNS Polska opinion poll company while the questionnaire was developed by the Polish Focal Point. The survey was implemented by means of the CAPI method under the OMNIBUS project through face-to-face interviews at respondents' homes. A characteristic of the OMNIBUS surveys applied e.g. in marketing is that a single questionnaire features questions concerning a wide range of areas of one's life.

Sample and analyses

The survey was conducted in June 2013 and included a representative sample of the Polish population (n=1000). The respondents were questioned about their experiences with using psychoactive substances listed in the questionnaire in three time frames: in the last 30 days, in the last 12 months and in a lifetime. These time frames are standard practice in the European population surveys. Lifetime prevalence rates determine the level of experimenting with drugs. The respondents might have had contact with a given substance or used it many years before the measurement. This question makes

[13] Published in: Malczewski A., Misiurek A., (2014) Używanie i postawy wobec substancji psychoaktywnych w populacji generalnej w 2013 roku. Serwis Informacyjny NARKOMANIA 4 (68)

it possible to estimate the prevalence of most drugs whose rates are much smaller than in the case of the last 12 months or 30 days time frames. The last 12 months prevalence rates refer to the recent use and the last 30 days the so-called current use. This analysis focuses on four types of substances with the highest prevalence rates: hypnotics/sedatives, new psychoactive substances (legal highs), cannabis and stimulants. Relationships between substance use and the following variables were analyzed: sex, age (seven age groups), size of place of residence (four categories: village, cities: up to 100 thousand population, 100-500 thousand population and over 500 thousand population) and education (primary, elementary vocational, secondary, higher).

Table. 2.2.2. Drug use prevalence: lifetime, last 12 months and last 30 days in 2013 (%)[14]

Substance	Lifetime	Last 12 months	Last 30 days
Any drug	7.1	2.5	1.5
Cannabis	6.6	2.4	1.1
LSD/hallucinogenic mushrooms	1.3	0.4	0.2
Amphetamine	2.1	0.4	0.4
Ecstasy	1.6	0.5	0.3
Cocaine/crack	1	0.4	0.2
Astrolit	0.4	0.3	0.2
Heroin	0.6	0.3	0.1
Methadone	0.4	0.2	0.2
Polish homemade heroin 'kompot'	0.5	0.2	0.1
Anabolic steroids	0.9	0.3	0.2
Inhalants	0.6	-	-
Hypnotics/sedatives	11.6	3.7	1

Source: Malczewski, Misiurek (2014a).

Low prevalence of new psychoactive substances

The prevalence of new psychoactive substance started to be monitored through youth and general population surveys in 2008. A sharp rise in head shops in 2008-2010 translated into a surge in prevalence of new psychoactive substances. The results of the survey in question indicate low prevalence of new psychoactive substances in Poland. Lifetime prevalence rates stood at 2% with slightly higher

[14] The 'Any drug' variable has been developed following the respondents' answers in which they checked 'yes' at least once in response to questions about respective substances in the following time frames: lifetime, last 12 months and last 30 days. The 'Any drug' variable includes the following types of substances: cannabis, LSD, amphetamine, hallucinogenic mushrooms, cocaine, crack, heroin, methadone and Polish homemade heroin (kompot).

figures recorded among men (3%) than women (2%). New psychoactive substances were reported to have been used by almost every twelfth respondent in the age group 20-24 (8%). It was the highest rate among all the age groups. A half lower rate was recorded among respondents aged 15-29 (4%). In the remaining age cohorts, the rates ranged from 3% (25-34) to 0% (55-64). 1% of the respondents had used new psychoactive substances in the last 12 months. The same figure is observed for the last 30 days, which proves a low level of current use. The last 30 days prevalence rates among 15-34-year-olds stood at 1.7%. The analysis of place of residence among lifetime new psychoactive substances users reveals the highest rates among residents of cities with population of up to 100 thousand (3%) and the lowest rates in cities with population of over 500 thousand (1%). If we look at education of the new psychoactive substance users we will see that the highest rate was observed among university graduates (3%) and the lowest among individuals with primary education (1%).

In 2014, the European Commission ordered a European survey among young people aged 15-24. The results concerning new psychoactive substance in this project did not differ from these of the Polish FP-commissioned OMNIBUS survey. In the OMNIBUS survey, 8% of the respondents reported lifetime use of new psychoactive substances while in the European project this rate was a little more than 6%. Due to differences in methodologies, these results are not fully comparable. However, it is clear that new psychoactive substances are used mostly by young people.

Amphetamine

Poland, apart from the Netherlands and Belgium, is one of the leading producers of amphetamine in Europe. This substance is the most prevalent stimulant not only in Poland but also in the Scandinavian countries. In 2012, following the Police operations, 675 kg of this drug was seized i.e. 60 kg more compared with 2012. Under Article 62 of the Act on counteracting drug addiction, the Police conducted 6 149 amphetamine seizures, which accounted for 16% of criminal cases under this Article in 2013. Article 62 refers to drug possession and makes up half of all the crimes recorded in Poland. Every year the Police dismantle 15-16 clandestine synthetic drug labs, producing mainly amphetamine. The OMNIBUS survey revealed that 2% of the respondents had used amphetamine in a lifetime (the same percentage of men and women – 2%). The last 12 months rate was low and stood at 0.4%. However, the current use rate among young adults (15-34) stood at 1.2%.

The highest prevalence rates for amphetamine were recorded among 20-24-year-olds (7%), individuals with higher education (5%) and in cities with population of up to 100 thousand or over 500 thousand (3%). Amphetamine is a much more prevalent drug among injecting users. According to the Polish Focal Point survey of 2012 conducted among harm reduction programme clients, half of the injecting drug users had used amphetamine in the last 30 days.

Sedatives and hypnotics

Drug use prevalence surveys show that Poland belongs to a group of countries with the highest prevalence rates for hypnotics and sedatives taken without doctor's order. This trend is being observed among adult Poles and youth (see ESPAD, Polish NFP surveys 2008-2010). The results of the 2013 OMNIBUS survey also corroborate this trend.

Among all the analyzed substance used for non-medical purposes, the highest rates were recorded for hypnotics and sedatives. Lifetime experience rate for these substances in 2013 stood at 12%, with the rate for women being 5 percentage points higher compared with men. Slightly lower rates for men were also recorded in the case of non-medical use in the last 12 months prior to survey. Non-medical drug use was often reported by middle-aged individuals aged 35-44 and 45-54 (lifetime prevalence

rates for these groups were 13% and 15% respectively). The lowest rates were recorded in the youngest age cohorts (7% in both 15-19 and 20-24). In the case of recent use, no significant differences were noticed among the age groups. Rates for non-medical drug use in the last 30 days stood at 3% in the youngest age group and 2% in group 45-54. Among young adults (15-34) the current use rate was a little more than 3%. A differentiating variable for the prevalence of sedative and hypnotics was the place of residence. Almost 15% the non-medical drug users resided in two categories of cities: up to 100 thousand and 100-499 thousand population. In the case of recent and current use these rates are similar across all places of residence and range between 3 and 5% for the last 12 months and 0-2% for the last 30 days.

However, the wording of the questions must be noted. The abovementioned results referred to the following question: "Have you ever used hypnotics or sedatives without doctor's order?"[15] It is in line with the methodology of the international ESPAD survey and consistently applied in its subsequent editions. The OMNIBUS questionnaire, as commissioned by the Polish Focal Point, included an additional question concerning hypnotics and sedatives taken without doctor's order. First, the respondents were asked to answer the following question: "Have you ever taken prescription sedatives or hypnotics without doctor's order?"[16]; then they could enter the name of the drug. The percentages of the answers to the abovementioned question differ from the lifetime experience results obtained in the course of the ESPAD survey. Over 5% of the respondents reported that they had experimented with prescription sedatives and hypnotics without doctor's order. The rates for recent and current use stood at 3% and 1% respectively.

This additional prompt in the questionnaire was added to review the drugs of choice. It was mainly intended to capture those individuals who use prescription hypnotics and/or sedatives without doctor's order. In previous editions of the OMNIBUS survey, the respondents reported using OTC drugs such as Persen, Nervosol or Kalms (compare survey of 2009). In 2013, the answer also included widely available sedatives and/or hypnotics (approx. 1% of individuals who answered the above question). Approx. 3% of the respondents were unable to give the name of the drug of choice while 2% reported prescription drugs (e.g. Relanium, Xanax or Diphergan).

Discrepancies in the results regarding the last two questions show how much care must be given to analyzing and interpreting the prevalence rates for sedatives and hypnotics. The analysis of the results must be based not only on the numerical indicators but also on the verification of the answers provided by respondents. This way, the answers concerning the dietary supplements or OTC drugs will be controlled.

Cannabis

Cannabis is one of the most prevalent psychoactive substances in Poland. According to the OMNIBUS findings, the lifetime prevalence rate reached 7% and the last 12 months and last 30 days rates stood at 2% and 1% respectively.

Higher figures are observed among men. Lifetime prevalence rate among men was 10% and 4% among women. The difference is also consistent as regards the last 12 months window (4% - men and 1% - women). Cannabis is usually used by young people. The highest lifetime experience rates are recorded in the age groups 20-24 and 25-34, 15% and 10% respectively. The lowest rates were recorded

[15] This question referred to the use of sedatives and hypnotics in the last 12 months and last 30 days prior to survey.

[16] This question also referred to the use of sedatives and hypnotics in the last 12 months and last 30 days prior to survey.

in the age cohorts older than 55 and 65 (1% each). In the age group 15-34, the recent prevalence rate stood at almost 5%.

As far as education of the respondents is concerned, 13% university graduates reported having used cannabis at least once in a lifetime. In the case of the remaining education categories (secondary, elementary vocational, primary) lifetime experience rates did not exceed 8%. However, no discrepancies are observed between the recent and current use also with reference to the place of residence. The lifetime prevalence rates for individuals residing in cities with a population of up to 100 thousand, 100-499 thousand and over 500 thousand were similar and stood at 8-9%. Slight differences emerge at the level of recent and current use – large city dwellers tended to report using cannabis most frequently.

In 2013, the Police performed 29 544 cannabis seizures under Article 62 of the Act on counteracting drug addiction, which accounted for 79% of all crimes registered under this Article. Consequently, the Police and Border Guard seized 208 394 grams of hashish and 1 232 834 grams of marijuana. The Police dismantled 1 246 illegal cannabis plantations and seized 68 555 cannabis plants.

Attitudes to drugs

A discussion on the drug law in Poland has been continuing for several years now. The existing law is considered too repressive and in need of change. It is worth finding out what the public think of the drug-related issues and what their tolerance of substance use and views on punishment for drug possession are.

The OMNIBUS survey respondents were asked whether substance use should be legal. 78% of the respondents stated that cannabis use should be illegal and 90% expressed the same views concerning heroin. It is worth noting that according to the Polish law using drugs is not considered a crime. The survey shows that the public share more radical views compared to the legal status quo. For comparison, significantly fewer respondents approved of the ban on alcohol consumption (11%) and cigarette smoking (16%). Tolerance towards legal psychoactive substances is much higher compared with illegal ones.

Table 2.2.3. Which substances should be banned (2013; %)

	Alcohol	Cannabis	Heroin	Cigarettes
Definitely yes	5	55	70	7
Rather yes	6	23	20	9
Rather not	48	12	4	46
Definitely not	39	8	4	35
I don't know/Hard to say	2	2	1	3

Source: Malczewski, Misiurek (2014a).

The respondents were also asked whether they believed drug possession, regardless of the amount, should be punished with imprisonment. Almost half of the respondents (48%) approved of such a solution.

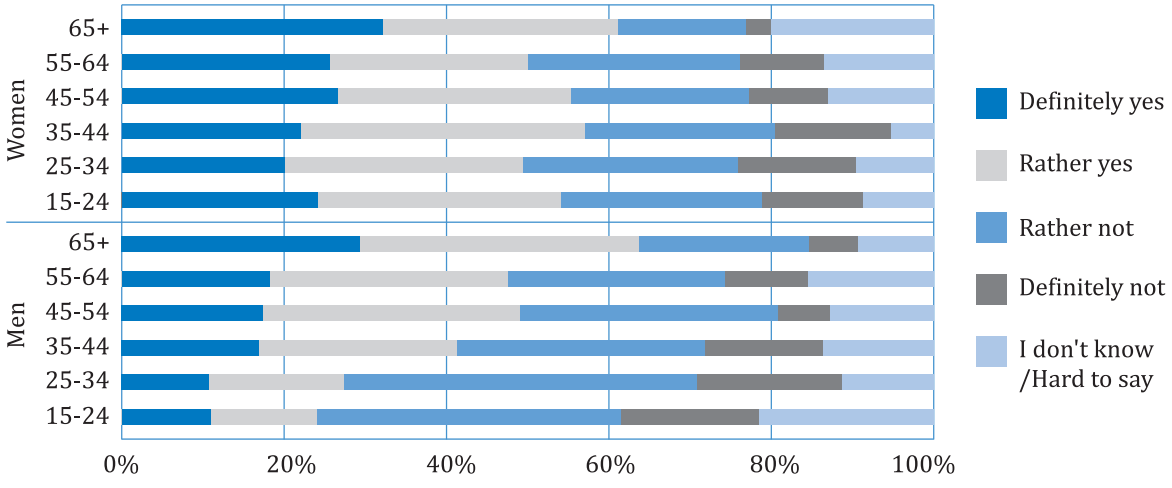
Table 2.2.4. Imprisonment for drug possession (2013; %)

	Should drug possession, regardless of the amount, be punished with imprisonment?
Definitely yes	21
Rather yes	27
Rather not	27
Definitely not	12
I don't know/Hard to say	12

Source: Malczewski, Misiurek (2014a).

Differentiating variables for views on punishment for drug possession include sex, age and education. Based on Figure 2.2.1. several conclusions might be drawn. Firstly, both men and women from the oldest age group believe that drug possession should be punished with prison. Secondly, the percentage of respondents who believed that drug possession should not be punished with prison lowered with age of the respondents i.e. younger respondents were more inclined to state that illegal substance possession should not be penalized. Thirdly, men in younger age groups were less likely, compared with women, to point to imprisonment as a form of punishment for drug possession.

Figure 2.2.1. Do you think that drug possession, regardless of the amount, should be punished with imprisonment?

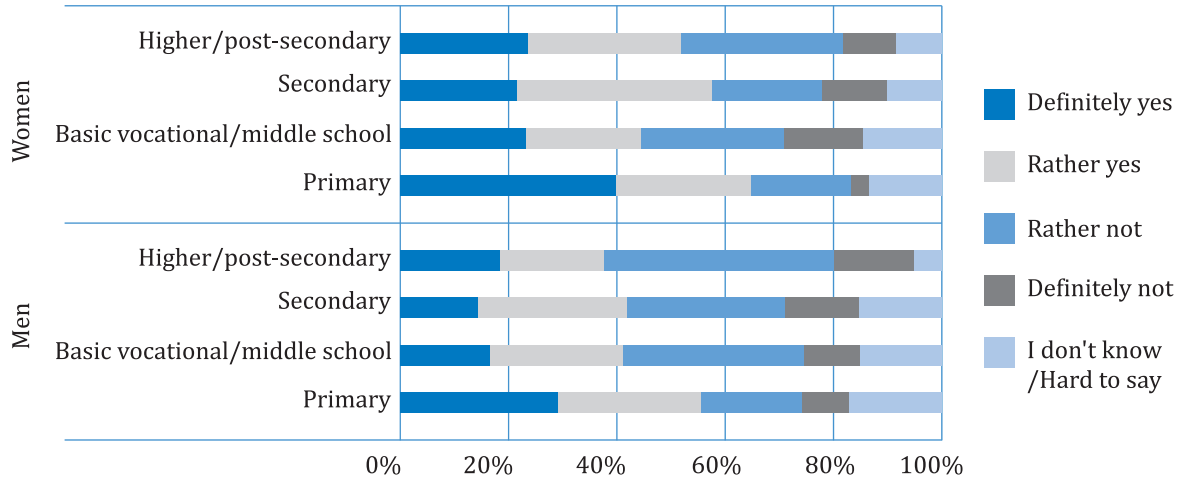


Source: Malczewski, Misiurek (2014a).

Another variable that differentiates the results obtained in the survey is education. Primary education holders were more frequent to state that possession of illegal substances should be punished with imprisonment (compare Figure 2.2.2.). Generally, as the level of education increased, the inclination of respondents to favour imprisonment for drug possession fell. Men with higher education are

decisively against such a solution (15%) along with, surprisingly enough, women with elementary vocational/middle school education.

Figure 2.2.2. Do you think that drug possession, regardless of the amount, should be punished with imprisonment?



Source: Malczewski, Misiurek (2014a).

Summing up, individuals who think that possessing any amount of drugs should be punished with imprisonment are chiefly women with primary education from the oldest age groups (over 55).

Summary

The most prevalent illegal psychoactive substances in Poland include cannabis and, to a lesser extent, amphetamine. Recent use rates (in the last 12 months) for any illegal substances and lifetime experience rates stood at 2.5% and 7.1% respectively. For cannabis, the rates reached 2.4% and 6.6% respectively. Comparing the results for cannabis and any other substance it can be stated that illegal substance use in Poland is mainly related to cannabis use. Using psychoactive substances is linked to demographics. Drugs are more prevalent among younger men (15-34) and individuals with higher or secondary education. Higher prevalence rates are also recorded among residents of big cities. However, it must be stressed that these features are typical of illegal substance users. Drug prevention should focus not only on adolescents but include young adults and it should be implemented mainly in urban areas. Cannabis will be the biggest challenge to the help system. Despite the opposition to this drug (78% in favour of cannabis ban), its prevalence is on the rise, which might be related to higher demand for treatment. According to the Polish Focal Point data for 2013, one in two first-time patients who entered drug treatment did it due to problems related to cannabis use. It is caused by the fact that cannabis has much higher concentration of THC than several years ago (average THC content according to the Central Forensic Laboratory was 10% in 2013), which means that cannabis smokers take higher doses of this psychoactive agent than ever. Amphetamine in the adult population is the most prevalent stimulant although its prevalence is low. Hypnotics and sedatives without doctor's order are used more frequently by women from older age groups (over 45), residents of villages and small towns with higher education or elementary vocational education. The survey results reveal that cannabis legalization movements fail to win public support. Nearly half of the society are in favour of penalizing possession of any amount of drugs and three quarters believe that cannabis use should be illegal.

2.3. Drug use in the school and youth population

Polish youth and psychoactive substances - Youth 2013

Authors: Artur Malczewski – Reitox Focal Point – National Bureau for Drug Prevention and Foundation of the Centre for Public Opinion Research CBOS

Towards the end of 2013, the CBOS Foundation and the National Bureau for Drug Prevention conducted a survey among school youth. One of the aims of the study was to estimate the prevalence of substance use in this population. The substance use survey has been conducted by the CBOS opinion poll company since 1992. Since 2003 the project has been implemented along with the National Bureau for Drug Prevention, which has financed the latest 4 measurements. Moreover, in 2008 the survey questionnaire was extended to include additional questions concerning the use of legal highs. Poland was one of the first, if not the first, country which started monitoring legal highs by means of surveys. The survey "Youth 2013" was conducted on a national random sample of 65 schools (one class per school) – general education secondary schools, secondary vocational schools and elementary vocational schools. The survey included last grades of secondary schools, excluding special needs education schools. The participants were mostly aged 18 and 19. The survey covered all students present in class on the day of the measurement – a total of 1 360 students. The survey was conducted through the auditorium method – each student completed an anonymous questionnaire during a single lesson.

Substance use trends

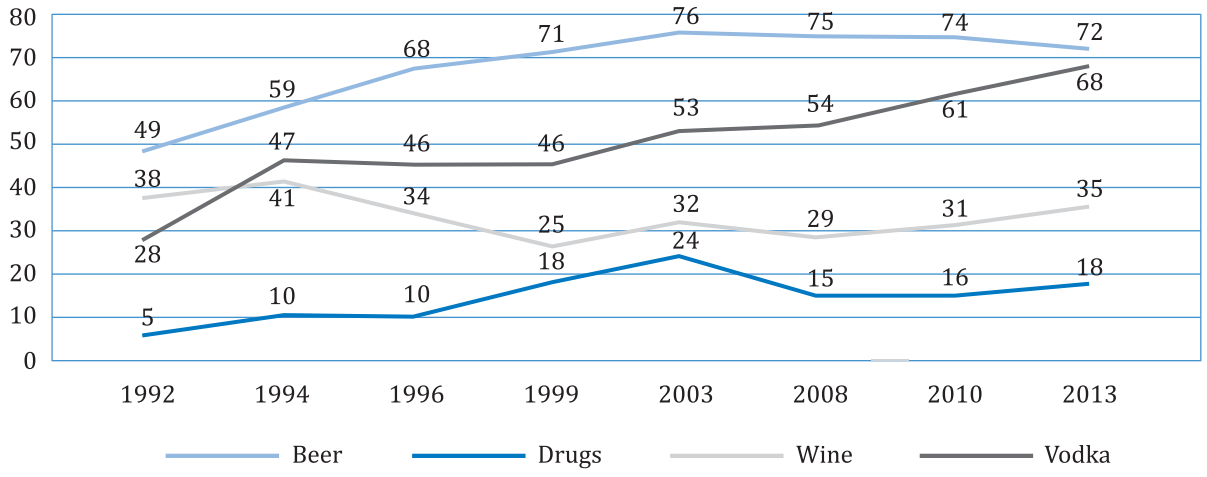
Since the beginning of the survey, students have always been questioned about drug use experiences in the last 12 months. In 1992-2003 the number of students who used drugs in the past year was rising steadily (from 5% to 24%). The latest data indicate an increase in drug consumption (18%). It is worth looking at the prevalence of use of other psychoactive substances during this time. Since 1999 wine drinking figures have been similar to drug use. However, it is hard to speak of some sort of interdependencies in this respect. Beer consumption has fallen slightly since 2003; contrary to vodka, whose consumption showed the highest rates in 2008 (68%).

Students who reported having used drugs were asked to mention the specific substances. Moreover, they were allowed to name three substances they had used most often. In 2013, 88% of students who had used drugs in the last 12 months mentioned marijuana (increase of 6 percentage points compared with 2010) and 10% reported amphetamines (decrease of 1 percentage point). Moreover, students reported using cocaine (4%), hashish (3%), LSD (2%), hallucinogenic mushrooms (1%), DXM (1%) and mephedrone (1%). The proportions were calculated on the basis of answers given by students who had used drugs in the last 12 months. The biggest fall was recorded in the case of legal highs. In 2010, 13% of the respondents reported using legal highs while in 2013 it was 4%. The 1992 survey showed that boys used drugs more frequently than girls. In 2013, 24% of male students and 10% of female students responded affirmatively to the question about using illegal psychoactive substances. In 2010, 20% of boys and 10% of girls reported using drugs. The rise in drug use was caused by the increase in the percentage of male users.

The highest percentage of drug users was recorded in elementary vocational schools (26%, in 2010 – 22%) followed by general education secondary schools (18%, in 2010 – 14%) and finally secondary vocational schools (12%, in 2010 – 16%). Drug use prevalence rates among C and D students stood at 22% (18% in 2010) and among B students it was 14% (the same proportion in 2010).

Among the highest grade students drug use prevalence rates stood at 12% (12 % in 2010). The higher the position of students according to the school grade scale, the lower the drug use rates. Students with college education parents are more likely to use drugs. Among students whose mother or father graduated from college every fifth had used drugs. In the case of primary education the rate was 14%. The highest proportion of students who reported using drugs reside in cities with population of over 500 000 (28%). Nearly half a lower proportion (15%) was recorded among students living in rural areas. A protective factor for drug experimentation is participation in religious practices. This pattern was also recorded in the previous surveys. Every fourth respondent not involved in religious practices reported using drugs (25%). In the case of individuals practising religion several times a week the drug use rate stood at 9%.

Figure 2.3.1. Consumption of beer, wine and vodka in the last 30 days as well as drug use prevalence in the last 12 months (%)



Source: Malczewski 2014c, Youth 2013 – survey by CBOS Foundation and KBPN.

Individuals considering themselves to be strong believers were less likely to use drugs (12%) than non-believers (31%). Drugs had been used more frequently among adolescents whose parents had worked abroad in the last 12 months (22%) compared with students whose parents had not worked abroad during that time (17%).

Prevalence of specific substances

In 2008, the survey questionnaire for the first time included questions concerning drug use patterns among youth with division into specific substances. The respondents were asked to tick off items whether they had used a specific substance in the last 30 days, in the last 12 months or in a lifetime. Respondents who reported using drugs in the last 30 days were also included in the groups of last 12 months and lifetime users. Consequently, percentages of answers to these questions cannot be totalled. The results have been presented in Table 2.3.1. In order to simplify the questionnaire some substances were combined in 2013 e.g. crack and cocaine or LSD and hallucinogenic mushrooms.

Table 2.3.1. Prevalence of substance use among school students in 2008-2013 (%)

	No, never			Yes, in a lifetime			Yes, in the last 12 months			Yes, in the last 30 days		
	2008	2010	2013	2008	2010	2013	2008	2010	2013	2008	2010	2013
Cannabis	69.1	63.0	59.3	30.5	35.7	40.2	16.4	18.0	23.0	7.3	7.7	9.0
Sedatives and hypnotics without doctor's prescription	77.9	78.4	79.6	21.8	19.9	19.7	11.2	9.6	11.0	4.7	3.8	5.1
Amphetamine	90.6	91.0	92.1	9.0	6.8	6.9	3.7	3.0	3.4	1.1	1.5	1.7
Ecstasy	94.3	94.8	96.7	5.5	3.5	2.6	3.0	1.4	1.4	1.1	0.8	1.0
Inhalants	96.8	95.3	96.5	2.9	2.8	2.8	1.0	0.7	0.7	0.6	0.5	0.5
LSD or other hallucinogens /in 2013 together with hallucinogenic mushrooms	97.5	94.9	95.1	2.3	3.3	4.4	1.3	1.4	1.8	0.5	0.7	1.1
Hallucinogenic mushrooms	96.1	94.7	-	3.6	3.4	-	2.0	1.4	-	1.1	0.6	-
Cocaine/ in 2013 together with crack	97.5	94.8	96	2.2	2.3	3.5	1.1	0.7	1.9	0.6	0.6	1.1
Crack	98.6	95.8	-	1.2	2.3	-	0.5	0.6	-	0.4	0.5	-
Relevin	99.1	96.7	98.5	0.8	1.4	1.0	0.4	0.4	0.4	0.3	0.3	0.2
Heroin	98.5	96.3	97.9	1.3	1.9	1.6	0.6	0.8	1.0	0.1	0.5	0.7
Cough or cold medication taken to get high	96.5	93.6	95.3	3.2	4.7	4.2	1.9	2.2	2.1	0.9	1.1	1.0
Legal highs	96.4	86.8	94.3	3.5	11.4	5.2	2.6	7.2	2.0	1.5	1.1	1.0
Dextromethorphanum (DXM)	98.8	97.0	98.1	1.0	1.3	1.4	0.6	0.4	0.8	0.5	0.2	0.1
Anabolic steroids	96.4	95.2	97.1	3.4	2.9	2.2	1.9	0.9	1.2	0.7	0.5	0.7

The table figures have been adjusted to take account of missing data

Source: Malczewski (2014c) Youth 2013 – survey by CBOS Foundation and KBPN.

The most prevalent substance among students was cannabis. Lifetime prevalence rates for this substance reached 40% in 2013, which constitutes an increase of 4 percentage points compared with the 2010 measurement. The results of the latest survey revealed a continuation of the upward trend also in the case of the last 12 months and last 30 days prevalence. Every fourth student had used cannabis in the last 12 months prior to the 2013 measurement (23%, 18% in 2010) and nearly every

tenth student had had done so in the last 30 days (9%, 8% in 2010). Every fifth students reported using sedatives and hypnotics (20%, 20% in 2010). The rates for the last 12 months were 10% (10% in 2010) and for the last 30 days 5% (4% in 2010).

Cannabis was followed by amphetamine. In 2008, 9% of the respondents reported experimenting with this substance while in 2010 and 2013 the rate was 7%. In 2008 4% of the students had used amphetamines in the last 12 months (3% in 2010 and 2013). The rates for the last 30 days were 1% in 2008 and 2% in 2010 and 2013. There were also falls in ecstasy users. In the latest measurement, 3% of the respondents reported lifetime use of this substance (4% in 2010; 6% in 2008), in the last 12 months it was 1% (3% in 2008; 1% in 2010) and in the last 30 days 1% across all measurements. Table 2.3.1. lists a non-existent substance called Relevin. The question about this 'drug' was intended to verify the credibility of the students' answers. 1% of the respondents admitted experimenting with this substance in 2013, 1.5% in 2010 and 1% in 2008. The results of the measurements might therefore be overestimated by approx. 1 percentage point.

The students were also asked how many times they had used the substances listed in the questionnaire. The most prevalent substance was marijuana or hashish: 14% of the respondents had used it once or twice, 13% 3-9 times, 8% 10-39 times with 7% having used it more than 40 times. The 2013 results showed slight rises across all these groups. Every eleventh student reported that they had taken sedatives or hypnotics without doctor's prescription once or twice, 4% had used them 3-9 times. The frequency of amphetamine use was much lower: 2% of the respondents had used it once or twice, 3% 3-9 times and 2% 10-39 times. The analysis of the responses to the question about the frequency of use of the respective substances shows that in most of the substances the students had used them predominantly once or twice.

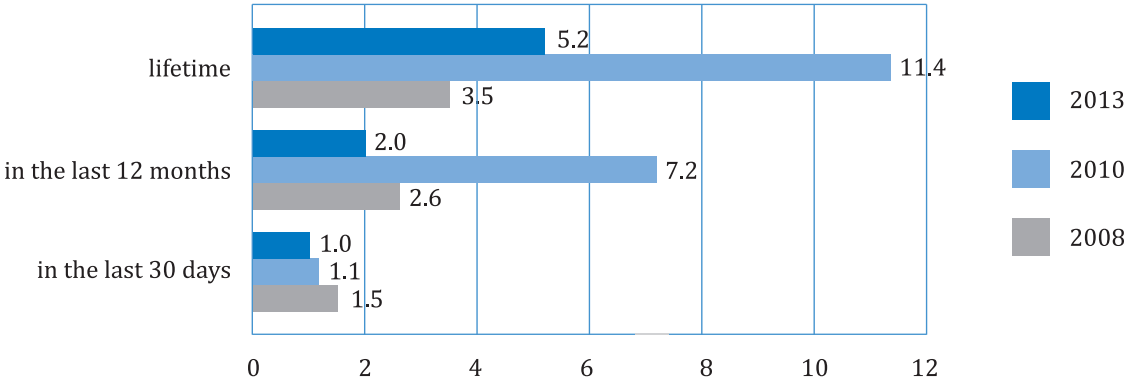
It is worth noting a discrepancy between the percentages of respondents who answered the last 12 months prevalence question concerning any drug (item present in the questionnaire since 1992) and the last 12 months prevalence question concerning respective substances (question added in 2008). 18% of the students responded affirmatively to the question about drug use experiences in the last 12 months whereas 23% reported using marijuana in this period. If we take into account only individuals who had used marijuana in the last 12 months then 37% of them responded negatively to the question about using drugs in the last 12 months. It means that every third respondent does not consider marijuana a drug.

Consumption and availability of legal highs

In 2008, legal highs started to be monitored in Poland. This measurement was the first which discussed these issues and one of the first in Europe. The term 'legal highs' covers a whole range of various substances. They include natural substances such as Kava Kava or those manufactured in labs such as BZP, MDPV, AM-0211 or mephedrone. A number of legal highs were put under control following the 2005 Amendment to the Act on counteracting drug addiction. Since 2008 more than 50 psychoactive substances and plants have been criminalised by being entered in the schedule to the Act. The controlled legal highs are replaced with new drugs. Legal highs lifetime prevalence rate in 2008 stood at 4% while in 2010 it reached 11%. The last 12 months rate in 2010 was 7% (3% in 2008) and the last 30 days rate reached 1% (2% in 2010). The 2013 results indicate a fall in legal highs prevalence. Lifetime rates more than halved compared with 2010 (5.2%; 11% in 2010). Over three times as few respondents had used legal highs in the last 12 months (fall from 7% in 2010 to 2% in 2013). The last 30 days prevalence rate returned to the 2008 value i.e. 1%. Let us see who the most prevalent legal highs users were. More boys (7.7%) than girls (2.7%) had used legal highs. The values vary depending on the type of school. The highest rates were recorded in vocational schools. Every tenth vocational school student (9%) had lifetime use of legal highs. The lowest rate (more than half as low compared

with the previous group) was recorded in general education secondary schools (4.1%). Legal highs were mostly used by students from big cities (over 500 thousand population) (7.8%). The lowest legal highs prevalence rate was observed among students from small towns of up to 20 thousand population (3.6%). A slightly higher rate was recorded among village dwellers (4.5%). There are also clear differences in the case of financial status as assessed by the respondents. The legal highs prevalence rates were far lower among students who considered their living conditions very good (approx. 4.7%), rather good (4.1%), average (4%), poor (11.7%) and vary bad (12.2%). Quite striking responses were obtained in relation to the questions about involvement in religious practices. Students who declared that they frequently participated in religious practices (several times a week) did not differ in terms of legal highs prevalence from those who did not participate at all (6.7% and 8.9% respectively). The lowest rate was recorded among students who attended religious services once or twice a month on average (2.3%). However, respondents who considered themselves non-believers constituted a much broader group of legal highs users (9.3%) than individuals who considered themselves strong believers (5.7%) (Malczewski 2014c).

Figure 2.3.2. Legal highs prevalence (%)



Source: Malczewski 2014c,Youth 2013 – survey by CBOS Foundation and KBPN.

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

Analysis of online discourse on illegal drug market based on the survey of the largest Internet discussion forum on psychoactive substances

Authors: Anna Czerner, Dariusz Parzych, Magdalena Piejko, Michał Wanke, Pracownia Rozwoju Osobistego.

The subject of the research project was a discourse about the illicit drug market that went on at Hyperreal, an Internet forum dedicated to psychoactive substances. The aim of the project was on the one hand to describe the historical background and structure of the forum and on the other to explain the way Internet users generate knowledge on potentially illegal situations related to psychoactive substances. The project was implemented between November 2013 and July 2014.

The project employed qualitative and quantitative methods. Varied empirical input was obtained which allowed for a multidimensional analysis of the alternative knowledge development process concerning the drug market. Data was collected by applying the following: a) virtual ethnography method along with asynchronous observation of the Hyperreal forum community, b) qualitative analysis of the contents of the forum, c) network technique analyses and d) in-depth interviews. Following its

collection, the data underwent detailed qualitative and quantitative analysis by means of Atlas software package i.e. SPSS and Gephi based on selected analysis areas.

The analysis of the knowledge development process concerning psychoactive substances necessitated the assumption of the alternative nature of illicit psychoactive substances discourse within the Hyperreal forum. Consequently, the users community could be viewed as a separate world governed by social mechanisms related to the intersubjective construction of the social order. It is in the mindset of the forum user that the procedures of permanent reconstructing discourse of psychoactive substances in the context of their illegality can be observed.

The Internet has been used as a primary tool to conduct alternative discourse regarding drugs since the very beginning of its existence. Important components of the alternative ecosystem of psychoactive substances include anonymity technologies developed both in the area of anonymous access to problematic websites as well as making transactions beyond state jurisdiction. The forum is used to build cumulative knowledge and not social coexistence. Moreover, in the linear structure of the thread it is hard to generate a network structure and the forum users are far from doing it, which does not prevent the networks from developing in completely different ways. By implementing two simultaneous field studies, we both gathered it from our informers and it became clear to us in the course of report data analysis that social networks between users do exist. However, due to robust discretion norms and reticence they are not demonstrated. The relationship with the contents and the flow of topics are not as networked as we expected. The forum features a rigid structure and, as we noticed, according to the norm of reliable and hierarchical knowledge accumulation, topics are channelled in threads and do not go beyond thematic fields of given sections. However, apart from the abovementioned limitations, we were able to notice the basic pattern: the forum is solidified by a group of users strongly related to one another – experts, who provide and organize knowledge. They appear in the same threads and probably more, which we failed to notice.

The forum's resources and the thematic diversity mean that users visit the site no matter what their experience with psychoactive substances are. Users include both individuals without direct drug-related experience as well as those with extensive drug history. As a result, a clear profile of the forum user is difficult to present. Discovering the forum and exploring its resources constitutes another step in a substance-related experience. The forum is a place where not only knowledge is shared but also contact details, which are frequently made use offline. Information sharing might be used to make contacts and the social capital built this way might be useful to obtain psychoactive substances.

Alternative discourse on illicit substances developed on the forum is based mainly on personal experiences and sustained by the constantly recreated impression of the forum's elite nature. Knowledge that is developed on the forum is subject to professionalization, normalization and privatization. The forum can hence be considered a self-contained database and a tool for reproducing information on the illicit drug market.

3. Prevention

prepared by Anna Radomska, Elżbieta Stawecka, Anna Poleganow, Artur Malczewski

3.1. Introduction

Drug prevention in Poland is performed under the Act of counteracting drug addiction. It covers areas such as promotion of mental health, healthy lifestyle; psychological, social as well as legal education and interventions. Pursuant to the Act, drug prevention should be incorporated into vocational training curricula at organizational units of the education system. It should also target educators and prevention personnel at schools, other education system facilities, including higher education units. Drug prevention should also be implemented among soldiers of basic military training, candidates for professional servicemen and professional soldiers. Drug-related issues should be one of the core elements of prevention among communities at risk of addiction. National and local organizations should also be provided support in this regard. Specific objectives and types of educational, informational and preventive actions are laid down in the National Drugs Strategy 2011-2016.

Data on the number of participants in National Bureau for Drug Prevention-commissioned prevention programmes is collected through an electronic system designed to monitor the implementation thereof.

3.2. Universal prevention

School

In Poland, drug prevention at schools lies within the responsibility of the Ministry of National Education and its agency – the Centre for Education Development. Major acts regulating legal issues related to the education system in Poland include the Act of 7 September 1991 on the education system and Regulation of the Minister of National Education of 27 August 2012 on the core curriculum in nursery schools and general education in all types of schools.

One of the key activities implemented by the Ministry of Education was introducing adequate preventive contents to the core curriculum which defines mandatory objectives of education in nursery schools and all other types of schools.

In order to strengthen the physical and mental well-being and to promote physical activity and healthy lifestyle among children and adolescents, the Minister of National Education announced the school year 2013/2014 to be the Year of School in Motion (RSR). In cooperation with other governmental agencies, scientific community and NGOs a website (www.szkolawruchu.men.gov.pl) was launched. The website featured information on actions at schools, kindergartens and non-governmental organizations. The RSR action goals included the following:

- making pupils aware that physical activity is not only about obligatory PE classes but any kind of work-out during the day;
- necessity to plan time for studying and active recreation during the day in order to lead a healthy and hygienic life;
- showing the relationship between physical activity/healthy diet and health, good physical condition and well-being;
- making pupils aware that active lifestyle is a way to become successful in life and boost self-confidence;
- stressing the role of physical education teachers as important animators of school life and their role in health education and the education of young people in general.

In order to streamline communication with schools and nursery schools the Ministry of National Education set up a Year of School in Motion facebook fanpage. Thanks to active participation in the action, the fanpage became a database of the best and most interesting practices.

Moreover, in 2013, the Minister of National Education approved the Strategy for promoting health and problem prevention among children and adolescents 2013-2016. The Strategy comprehensively addresses the issues of physical and mental health protection among children and adolescents. It also covers issues related to suicide prevention among adolescents as well as counselling and assistance in mental crises.

The Ministry of Education continued to develop the Health Promoting School programme, which is being implemented by the Centre for Education Development under the Schools for Health in Europe network. The Health Promoting Schools provide conditions for local and school communities to lead healthy lifestyles. They educate students and staff about health, attach great importance to healthy diet issues and physical activity as well as cooperate with pupils' parents. The network of health promoting schools in Poland includes 2 659 units.

The National Bureau for Drug Prevention supported the nationwide dissemination of a universal drug prevention programme Unplugged. The programme targets school population aged 12-14. It is based on the comprehensive social influence approach. The aim of the programme is to reduce 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 2-3-hour workshops for parents of the participants. The programme is conducted by teachers/pedagogues previously trained by qualified trainers. In 2013, the National Bureau-trained trainers prepared 400 teachers/pedagogues.

In 2013, the Centre for Education Development along with the National Bureau for Drug Prevention trained 15 new Unplugged trainers, who were authorised to train teachers – direct programme providers in schools.

Moreover, in 2013 the National Bureau commissioned the evaluation of the Unplugged programme. The aim of the evaluation was to measure the effectiveness of the programme implementation in Polish conditions among 12-14-year-old pupils of primary and middle schools. Under the evaluation project data from the programme providers and participants (pupils and parents) is collected. The evaluation project report will be available towards the end of 2014.

Family

In 2013, the National Bureau co-financed two trainings for providers of the "Family Strengthening Programme 10-14". The aim of the programme is to reduce drug and alcohol consumption as well as adolescence-related problems. 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 pre-implementation training was attended by 25 individuals.

The National Bureau runs the National Drugs Helpline which targets substance abusers, addicted individuals and their relatives. The Helpline staff provide information on drug treatment options, contact details for drug rehab centres as well as legal regulations with reference to drug addiction. However, most work of the helpline staff is focused on giving advice and psychological support. In 2013, 1391 consultations were provided. In 70% of cases, the hotline mainly attracted families of drug users or individuals with other problems impacting the quality of family life, 21% callers reported their own problems with using psychoactive substances and 13% were callers interested in drug-related matters for various reasons (users' friends, teachers, neighbours, doctors, etc.).

In 2013, the National Bureau kept financing the operation of an online drug counselling centre (www.narkomania.org.pl). The centre provided free consultations from a psychologist, a doctor and a lawyer. A chat room service was launched by means of which the centre clients received access to fast and professional assistance. There were 1 100 online inquiries and 191 individuals were consulted via the chat room.

Local government activity

The Act of 2005 on counteracting drug addiction widened options available to local governments to prevent drug addiction. Communal and municipal authorities were able to allocate resources from alcohol licence fees to drug prevention as well as other activities such as drug treatment and harm reduction. In order to effectively perform activities at a local level, local governments were obliged to develop local drugs strategies. Since 2005, revenues from alcohol licence fees (the so-called 'cork tax') have been used to implement local drugs strategies. Communal authorities are able to use other funds to conduct drug prevention programmes. According to the Ministry of Finance, in 2013 local government spent PLN 36.7 million on the implementation of drug prevention activities under local drugs strategies. The data on the implementation of the National Drugs Strategy (KPPN) is collected annually.

Universal prevention

In 2013, 1 668 communes (75% of all communes which submitted KPPN implementation reports) co-financed universal drug prevention programmes. In this field, 1 460 communes supported prevention programmes at all levels of education (nursery schools, primary schools, middle schools, secondary schools). 1 086 communal authorities co-financed extramural activities for children and adolescents, 778 communes – prevention programmes for parents while 319 communes – other activities in accordance with tasks defined in Article 2.1.1-3 and Article 10.1 of the Act on counteracting drug addiction.

More information on the abovementioned activities is presented in Table 3.2.1. below.

Table 3.2.1. Universal drug prevention programmes financed by communal governments in 2013

	Total
Schools conducting universal prevention programmes	10 735[17]
Education system facilities, other than schools, conducting universal prevention programmes	3 084
Beneficiaries of universal prevention programmes within education system	1 425 962

Source: KPPN 2013 reports as completed by communes.

The National Bureau for Drug Prevention, the Institute of Psychiatry and Neurology, Centre for Education Development and State Agency for Preventing Alcohol-Related Problems recommend a number of

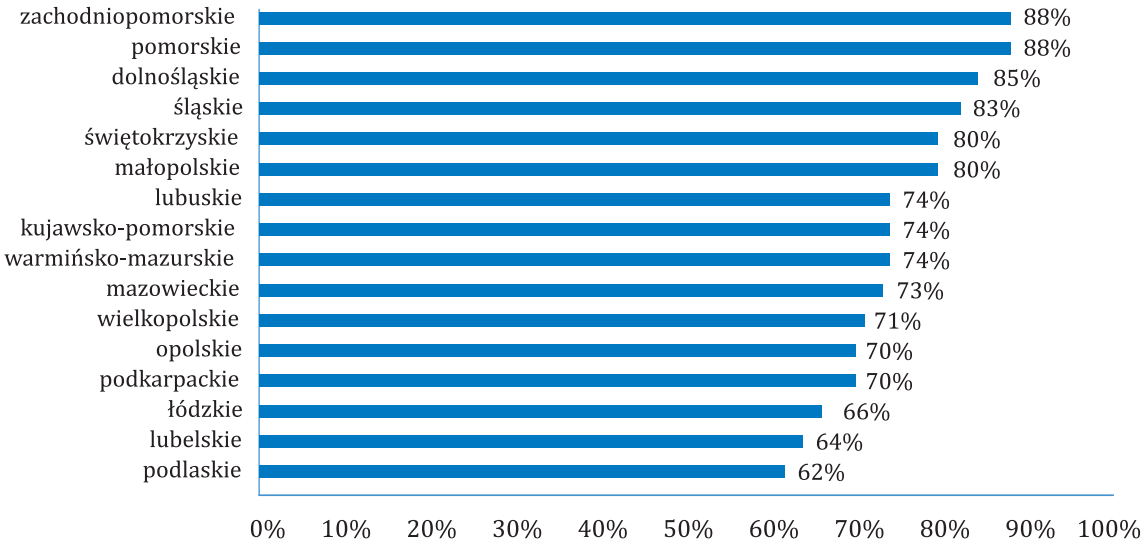
[17] The above figure constitutes 42% of all schools whose supervisory bodies are local governments. Specific information on the types of schools supervised by local governments as well as the numbers of schools and students are contained in Schedule entitled *Schools and students by supervisory body – local governments.*

universal prevention programmes, of which local governments most often implemented the ones entitled "School for Parents and Educators" (89 communes) and "Archipelago of Treasures" (62 communes).

Information on the recommended programmes is available on the www.programyrekomendowane.pl.

Moreover, 37 communes financed the "Unplugged" programme coordinated by the National Bureau for Drug Prevention. The abovementioned programme was conducted in 149 schools and education units and targeted 5 381 children and parents.

Figure 3.2.1. Percentages of communes in respective provinces, which financed universal prevention programmes (based on communes which submitted reports in respective provinces)



Source: KPPN 2013 reports as completed by communes.

The highest percentage of communes supporting universal prevention programmes was recorded in zachodniopomorskie province (88%), pomorskie province (88%) and dolnośląskie province (85%) while the lowest figures were found in the provinces of podlaskie (62%), lubelskie (64%) and łódzkie (66%). The financing of universal prevention programmes was reported by 269 urban communes, which accounts for 93% of all reporting urban communes, 455 urban-rural communes (nearly 82% of all reporting urban-rural communes) and 944 rural communes (nearly 68% of all KPPN reporting rural communes in 2013).

Selective and indicated prevention

In 2013, 439 of all communes which submitted KPPN implementation reports (approx. 20%) financed a total of 2 305 selective and indicated prevention programmes for individuals or groups at risk of problem drug use. Activities in this field were performed by 557 communes, which financed prevention and educational activities at sociotherapeutic centres and educational facilities. 378 communes financed prevention camps, 139 communes financed early intervention programmes, such as "FreD goes net" and "School-based Preventive Intervention", addressed to experimenting and occasional adolescent drug users. 62 communes sponsored selective prevention programmes in recreational

settings with higher drug-related risk (clubs, discotheques, mass events) while 338 communes financed other programmes addressed to at-risk children and adolescents (marginalized, at risk of depravation and social exclusion) as well as children and adolescents with special educational needs. Additionally, 134 communes supported other than the abovementioned activities, pursuant to the tasks defined in Article 2.1.1-3 and Article 10.1 of the Act on counteracting drug addiction. Most frequently they were educational and awareness activities.

The table below shows the numbers of selective and indicated prevention programmes conducted by communes in 2013.

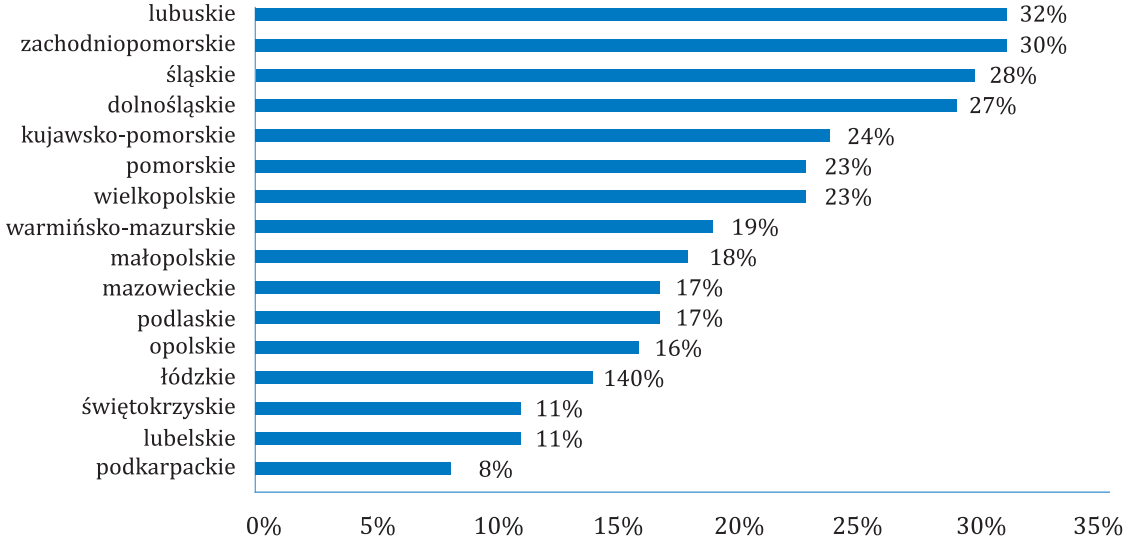
Table 3.2.2. Selective and indicated prevention programmes financed by communal governments in 2013

	Total
Beneficiaries of selective and indicated prevention programmes	135 037
Individuals who benefited from psychological assistance due to drug problem in family	25 162
Individuals who benefited from legal assistance due to drug problem in family	9 239

Source: KPPN 2013 reports as completed by communes.

Commune-sponsored selective and indicated prevention programmes in 2013 included recommended programmes. Most communes (47) financed "FreD goes net" programme. More information on the abovementioned programme is listed in the figure below.

Figure 3.2.2. Percentages of communes in respective provinces, which financed selective and indicated prevention programmes (based on communes which submitted reports in respective provinces)



Source: KPPN 2013 reports as completed by communes.

The highest percentages of communes which financed selective and indicate prevention programmes were recorded in lubuskie province (32%) and zachodniopomorskie province (30%) while the lowest in the provinces of lubelskie and świętokrzyskie (11% each) and podkarpackie (8%). Of 439 communal governments which financed selective and indicated prevention programmes, there were 163 urban communes (56.5% of all reporting urban communes), 153 urban-rural communes (27.5% of all reporting urban-rural communes) and 123 rural communes (9% of all KPPN reporting rural communes in 2013).

3.3. Selective prevention in at-risk groups and settings

At-risk groups

In 2013, the National Bureau for Drug Prevention, as a result of an open competition, financed the implementation of 42 selective prevention programmes aimed at reducing risk factors related to home and peer environment, improving emotional and social functioning of children and adolescents, shaping adequate normative beliefs regarding drugs, promoting pro-health behaviours as well as providing assistance in critical drug-related situations.

The programmes targeted socially excluded children and adolescents. The prevention actions targeted young people spending free time in the street, shopping centres, parks, etc. and therefore putting themselves at risk of using drugs and other threats. These settings mainly featured outreach activities performed by specially trained social workers. They were intended to organize leisure time for young people e.g. by means of life skill workshops, sociotherapeutic classes as well as alternative actions.

Another target group were at-risk adolescents i.e. young people committing punishable acts, using psychoactive substances occasionally, manifesting destructive behaviour. These individuals took part in life skills workshops, anger management trainings, and development groups. They were also provided with alternative leisure time opportunities. An intermediate target group were the beneficiaries' parents and relatives or friends, who were provided with family counselling.

The implementers of the tasks commissioned by the National Bureau stated that programme participants improved their knowledge on the risks related to substance use. They mastered skills of reducing risky behaviours as well as coping skills. Over 300 000 participants were reached.

The National Bureau continues the implementation of the "FreD goes net" early intervention programme. The programme aims at reducing substance use in adolescents. The programme participants learn about the harms of using drugs and existing legal regulations. Participation in the programme helps to set personal goals related to drug use or abstinence. The programme targets young occasional or problem drug users aged 14-21, excluding dependent individuals. It is conducted in small groups organised by means of the motivational interviewing method.

In 2013, the National Bureau financed 26 runs of the programmes which featured early intervention workshops, promotional actions, project partner meetings (schools, police, courts, probation officers). Contact with early intervention graduates was kept by holding regular graduate meetings.

The programme providers reported that thanks to the participation in the programme, the participants were able to confront their knowledge on the harmfulness of drugs, usually based on myths and media reports, with scientific evidence. After completing the programme young people reformulated their attitudes towards substance use and were able to notice development and health threats related to it. 2 186 participants took part in National Bureau- sponsored "FreD goes net" programmes.

The programme providers reported that for 88% of the participants "Fred goes net" was their first drug-related assistance programme. The most prevalent substance following alcohol (78%) was

cannabis (57% lifetime prevalence rate). The main referring institutions included schools (36% of participants), families (20%), followed by the Police (15%), 'other institutions' (13%) and criminal justice system (10%). Approx. 7% of the participants reported to the programme out of their own volition. Most participants stated that thanks to the participation in the programme they improved their knowledge on the risks related to substance use (63%). Half of the participants stated that thanks to the programme they had mastered vital skills of solving drug and alcohol-related problems while 66% stated that they had found out where to seek help in case of problems. 81% of the participants were satisfied or greatly satisfied with the programme and as many as 87% would recommend the programme to their peers.

Moreover, in 2013, there was another round of the programme provider training, which included 22 people. At present, there are 122 trained programme providers at 69 drug prevention and treatment facilities as well as Psychological and Pedagogical Assistance Centres.

In 2013, a seminar for "FreD goes net" providers was held. The meeting served to share experiences and evaluate the programme implementation. At local and regional levels, the providers conducted a number of visibility actions such as partner meetings, trainings, publications in local press and TV. Thanks to experience exchange, mutual support and new ideas, the seminars make it possible to implement the programme in all types of facilities in line with the approved standards.

In 2013, the Centre for Education Development, held another instructor training for the School Preventive Intervention. 19 instructors and 16 providers were trained and the programme attracted 428 participants. The aim of the programme was to prevent substance use (nicotine, alcohol, drugs, legal highs) among adolescents and target pupil experimental users with specialist interventions. The programme can be implemented in schools at all levels of education.

In 2013, the Ministry of National Defence performed educational activities related to drug prevention based on the "Strategy for strengthening discipline, addiction prevention and social pathology prevention in the Armed Forces of the Republic of Poland 2012-2013". The aim of the strategy was to implement an integrated system of preventing and reducing undesired behaviours among the military, including social pathology reduction. At military units, the Strategy served as the basis for developing local needs-oriented discipline-boosting, drug prevention and social pathology prevention programmes. The Strategy targets soldiers and military personnel and its implementation lies within the responsibility of commanders (directors, heads and chiefs) of organizational units of the Ministry of Defence, corresponding their competencies. In the course of the drug prevention training activity, the Ministry of Defence took a number of actions, which involved the majority of soldiers of all corps and military personnel. Some training participants took part in more than one form of training.

At-risk families

In 2013, 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 involved 4 000 participants across Poland.

In 2013, 28 family support programmes were selected for implementation following an open competition organized by the National Bureau. The programmes were aimed at providing assistance to families at risk of drug addiction or those where drug problem was already present. The programmes focused on strengthening parenting skills and coping skills in family as well as the abilities to tackle

crises. The programme featured education and awareness activities for parents and close relatives and was related to the mechanisms of addiction and co-addiction, family counselling, critical interventions, support groups, parenting skills workshops, developmental and psychoeducational classes as well as legal consultations. According to the providers, a noticeable effect of the programmes was improvement in the knowledge of addictions and co-addictions, mastering the skills of constructive problem-solving, provision of constructive methods of emotion management as well as improvement in parenting skills among parents of adolescents and in interpersonal skills. The activities targeted nearly 4 500 participants.

3.4. Indicated prevention

In 2013, the National Bureau commissioned 38 indicated prevention programmes addressed to drug users, particularly in towns and settings where such assistance is insufficient and fails to meet the needs. The programme beneficiaries included non- dependent individuals, drug users with first symptoms of drug-related disorders, as well as individuals reporting to the prevention programme under Article 72.1 of the Act on counteracting drug addiction[18]. The programmes aimed at effecting and maintaining abstinence from drugs, preventing further development of substance dependence, shaping adequate normative beliefs regarding drugs and promoting healthy lifestyle. The programmes featured awareness activities concerning drugs and mechanisms of drug addiction, drug law, critical interventions, psychosocial skills workshops, support groups, family counselling regarding the problem reported as well as evaluation. Actions targeting families and loved ones of problem users were also conducted. Thanks to the work of the programme providers, the programme participants improved their knowledge of harmfulness of substance use, dependence mechanisms and legal issues. They also developed skills of identifying personal problems and found out about alternative, drug-free ways of spending free time. The above results substantially increase the chances of abstaining from drugs. The programmes involved almost 11 000 participants.

3.5. National and local media campaigns

In 2013, the National Bureau for Drug Prevention launched a national campaign "Taking medication or high on drugs? Prescription drugs serve treatment not getting high". The campaign was conducted under the auspices of the Minister of Health and the Minister of National Education. It was intended to raise public awareness of non-medical use of benzodiazepine-based hypnotics and sedatives as well as OTC drugs containing dextromethorphan, pseudoephedrine/ephedrine and codeine among adolescents.

The campaign targeted adolescents' parents and teachers, counsellors at middle schools and secondary schools. The campaign featured special educational materials: a guidebook for parents "About pharmaceuticals, cannabis and legal highs – without hysteria" and a guidebook for teachers "School and parents in the face of challenges of substance-related threats", which contained educational lesson plans for parents. These materials were posted online and sent directly to schools by post.

The campaign was conducted in cooperation with the Centre for Education Development, Main Pharmaceutical Inspectorate, Chief Sanitary Inspectorate and Office for registration of Medicinal Products, Medical Devices and Biocidal Products, Superintendents' Offices, Marshal Offices (provincial

[18] "In the event that an addicted person or a person using psychoactive substances in a harmful manner charged with committing the offence subject to the penalty of deprivation of liberty for a term up to 5 years enters treatment and rehabilitation or participates in a prevention and treatment programme in a relevant health care centre or another entity in the health care sector, the prosecutor may suspend the proceedings until the treatment is completed"

governments) and non-governmental organizations. The campaign featured a website www.przyjmujelekiczybierze.pl.

At the beginning of 2013, the National Bureau organized an awareness campaign "Treat rather than punish". The action targeted courts, prosecutor's offices and police. Information on the "FreD goes net" and CANDIS drug prevention programmes was sent to the abovementioned institutions in the hope that it would be used as a tool in connection with Article 72.11 and Article 73a[19] of the amended Act on counteracting drug addiction. Calendars were also sent to 1 000 courts and prosecutor's offices as well as provincial Police Headquarters.

In 2013, the Chief Sanitary Inspectorate launched a project "Alcohol, tobacco and other substance abuse prevention programme" co-financed under the Swiss-Polish Cooperation Programme. The main aim of the programme is reducing tobacco, alcohol and substance use among women at the reproductive age (15-49). The project was implemented jointly by four institutions: Institute of Rural Health in Lublin, J. Nofer Labour Medicine Institute in Lodz, State Agency for Prevention of Alcohol-Related Problems and the National Bureau for Drug Prevention. Under the project, the following actions are being implemented: trainings for medical staff, educational programmes at work places and secondary schools, awareness campaign, questionnaire survey among pregnant women, an online platform – Electronic System of Monitoring and Promoting Health. The National Bureau collaborated in the project through participation in developing educational materials for employers and employees as well as educational online platform for young people. The brochure addressed to employers and managers entitled "Managing the problem of tobacco, alcohol, and substance use at work" contained information regarding substance use among employees, health promotion as a health policy, advantages to the company resulting from tackling the problem of substance use, methodology of tobacco and other substance use reduction programme at work. The brochure also contained information on the effects of various psychoactive substances as well as legal regulations regarding alcohol and drug use at work. All the educational materials are available at the project. J. Nofer Labour Medicine Institute developed training materials and held training seminars for representatives of employers in five Polish cities. During the seminars the main goals of the programme were presented. Overview of the prevalence of substance use among employees and methods of prevention was also delivered. The seminars were attended by 319 representatives of 234 companies, including 17 regional leaders. In 2013, the Institute launched preliminary audits in project companies.

Under the project there was also developed an educational programme for young people "ARS – how to care for love?" The programme is going to be implemented in secondary schools. The project online platform (www.zdrowiewciazy.pl) was also established. It is a multifaceted communication forum containing educational materials, scientific publications and drug prevention reports.

3.6. Recommendation system for drug prevention programmes

While implementing the National Drugs Strategy 2006-2010, there were developed drug prevention quality standards and framework for the recommendation system for drug prevention and health promotion programmes. A pilot project to implement the system was also conducted. Four institutions collaborated to perform this task: the National Bureau for Drug Prevention, Centre for Education Development, State Agency for Prevention of Alcohol- Related Problems and the Institute of Psychiatry and Neurology. In the existing National Drugs Strategy 2011-2016, collecting information on and

[19] If it is dictated by therapeutic and educational reasons, the offender addicted to narcotic drugs or psychotropic substances serving a custodial sentence for an offence committed in relation to the use of narcotic drugs or psychotropic substances may be granted a furlough from serving the sentence in order to enter treatment or rehabilitation.

disseminating evidence-based drug prevention programmes is one of the priority actions both for central level institutions as well as local and regional governments.

The candidate projects are assessed by an interdisciplinary team for programme assessment and recommendation, operating at the National Bureau for Drug Prevention. Once a positive opinion is passed, the programme can seek recommendation at one of the three levels of quality:

- level 1 – Promising programme – recommendation at this level might be granted to a programme of proper design, based on scientific evidence and validated prevention strategies and enjoying process evaluation results that allow to conclude that it is likely to generate expected results after implementation.
- level 2 – Good practice – recommendations at this level might be granted to a programme of proper design, based on scientific evidence and validated prevention strategies and enjoying evaluation results that corroborate the effectiveness in terms of impact on intermediate factors for behavioural change.
- level 3 – Model programme - recommendation at this level might be granted to a programme of proper design, based on scientific evidence and validated prevention strategies and enjoying evaluation-proven effectiveness in terms of impact on problem behaviours.

At present, the database of recommended programme lists 13 programmes in the following fields: health promotion (2 programmes), universal prevention (5 programmes) and selective prevention (8 programmes).

Information on the recommended programmes is available through the programme database on www.programyrekomendowane.pl

3.7. Profnet. Support project for NGOs

In 2014, Praesterno Foundation, in collaboration with the National Bureau for Drug Prevention, Psychology Faculty of Warsaw University and Polish Society for Prevention of Drug Abuse, launched a nationwide-scale project entitled "Profnet. Support for drug prevention NGOs". The project was awarded a financial grant under the 2nd edition of the Citizens for Democracy Programme, financed under the Financial Mechanism of the European Economic Area and implemented by Stefan Batory Foundation in partnership with Polish Children and Youth Foundation. The aim of the project is to boost the sector of non- governmental organizations concerned with drug prevention. The programme features the following actions:

- developing a national electronic database of non-governmental organizations dealing with drug prevention,
- developing tools to conduct an audit of an organization, transferring tools and audit consultations for interested organizations; assessing an organization's training needs; developing e-learning trainings adequate to an organization's needs and posting them at a project internet portal, free sharing of trainings,
- developing (based on consultations with non-governmental organizations and other field institutions) curricula for prevention work training and a model training programme; training candidates for drug prevention sent by interested organizations under a pilot programme,
- developing and transferring to interested organizations a manual for evaluating drug prevention programmes, consultation in the field of prevention programme evaluations, support of interested organizations in implementing procedures connected with placing programmes in the database of recommended drug prevention programmes,
- supporting interested organizations in conducting supervisions of technical teams,
- promoting drug prevention non-governmental organizations and lobbying in the circles of decision-makers in order to finance evidence-based drug prevention.

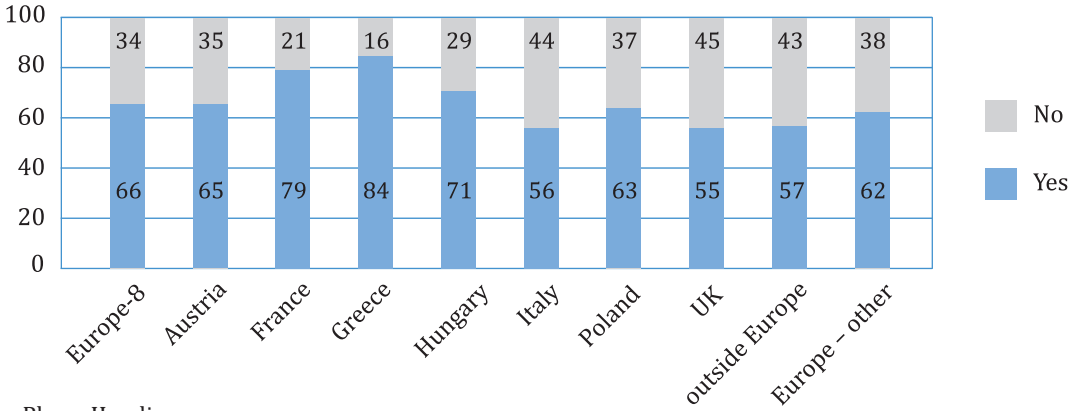
3.8. European Drug Prevention Quality Standards

Promoting excellence in drug prevention

The Mazovian Centre for Social Policy along with the National Bureau for Drug Prevention are partners in an international project entitled "Promoting excellence in drug prevention", also called "the European Drug Prevention Quality Standards (EDPQS) Phase II". The project is sponsored by the European Union under the Drug Prevention and Information Programme. One of the aims is to develop support materials for the European Standards at the beginning of 2013. The project involved conducting both quantitative (online survey) and qualitative studies (focus groups. 505 participants, mainly from seven EU countries, took part in the studies. The survey covered 30 countries in total. The number of respondents ranged from 49 (Hungary) to 90 (Greece). In Poland, 61 individuals were involved. They included drug prevention professionals, municipal officials or staff of central institutions. The respondents were asked whether drug prevention is their main professional activity. Most were professionally related to the field (Figure 3.8.1.) and fewer than a half considered drug prevention to be their main job responsibility. Comparing the results between the countries, it must be noted that the lowest percentages of respondents who responded affirmatively to this questions were recorded in Poland (13%) and Italy (18%). It should be stressed that in Greece 96% of the survey participants were involved in drug prevention. It is the result of 71 Prevention Centres for Addiction and Psychosocial Health Promotion operating in Greece and also handling the drug-related issues. The results also show that in Poland drug prevention professionals are also involved in other related activities e.g. alcohol prevention. Approx. 30% of Polish respondents reported performing prevention duties in 2013 "less often than once a month". The respondents also pointed to the fact that they had only recently started working in prevention (2 years' working experience). Conclusions from the survey should be drawn with care, as the sample was not representative.

Compared with the other countries, Polish respondents most often defined their job responsibilities as social issues. Funders, which means mainly individuals concerned with allocating funding to prevention on behalf of local and public administration, were particularly well represented compared with other partner countries. However, the sample included few service managers. The survey also featured questions whether the respondents had received any drug prevention training (Figure 3.8.1.). In Poland, the percentage of affirmative answers was similar to the European average (63%). The highest percentage of respondents with drug prevention training experience was recorded in Greece (84%) while the lowest in the United Kingdom (55%).

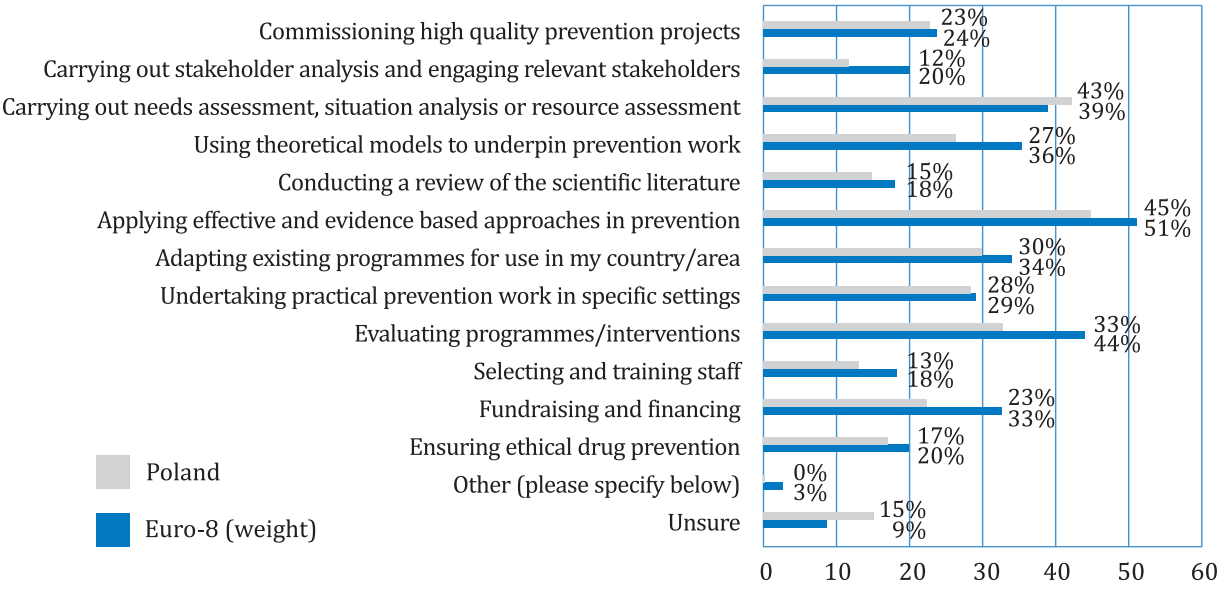
Figure 3.8.1. Have you ever received any specific training on drug prevention? (%)



Source: Phase II online survey.

The European Standards partly draw on the Polish standards used in the recommendation system for drug prevention and health promotion programmes. They are promoted in Poland e.g. as a tool to adapt the programmes to be listed in the recommended programmes database. The online survey was also an attempt both to identify deficits and expected support on the part of drug prevention professionals and to apply the existing tools. The answers regarding the knowledge of the European Standards and their use in Poland (88% knew and/or used the standards) were similar to the European weighted average (84%). Polish respondents were most often familiar with the EDPQS Manual, available in Polish. Answering the question about obstacles to use the European Standards, the respondents most frequently mentioned the lack of assistance in implementing the standards e.g. support materials, training courses (38% in Poland vs. 23% in Europe). The main obstacle to use support materials for the standards was lack of time (25% in Poland vs. 34% in Europe) and lack of knowledge how to use the standards in practice (22% in Poland vs. 17% in Europe). For most of the respondents, the preferred method to learn about the European Drug Prevention Quality Standards is a face-to-face presentation or a lecture e.g. during a conference (68% in Poland vs. 45% in Europe) and assisted learning in face-to-face training programmes e.g. in small group workshops (65% in Poland vs. 55% in Europe). Self-learning with printed support was not as popular in Poland as in Europe (37% in Poland vs. 45% in Europe). The highest percentage of respondents in Europe (51%) and Poland (45%) indicated that they needed support in applying evidence-based prevention work model (Figure 3.8.2.).

Figure 3.8.2. In what areas do you require support to feel more confident and competent in your drug prevention work? (%)



Source: EDPQS Phase II online survey.

In the course of implementing the European drug prevention quality standards, focus group sessions were conducted in partner countries. The focus groups aimed at discussing and enhancing the understanding of the online survey results. Ways of implementing the standards were explored. During two three-hour meetings, which took place in several European countries, contents of support materials for the European Standards were also discussed. Moreover, in Warsaw there were talks conducted on implementing drug prevention in Poland. 18 local drug prevention specialists attended two focus groups.

The results of the focus groups corroborated the results of the online survey. According to the focus group participants, two groups of stakeholders matter. In the online survey they were defined as 'sponsors' and in the Polish reality they are mostly representatives of local authorities. Local decision-makers commission drug prevention programmes and in this case the European Standard might facilitate their task of selecting winners of drug prevention competitions. Moreover, the application of the European Standards might have impact on the quality of drug prevention at local, i.e. communal, level. The other group of stakeholders who might best benefit from the European Standards are practitioners (prevention programme providers and developers). According to the respondents, each stakeholder group is able to draw benefits from the European Standards, however, the two abovementioned seemed to be the most important ones. The participants of the focus groups stressed the need to implement the European Standards in Poland as a useful tool to raise quality of drug prevention. The results of the online survey showed that the most attractive forms of training would include publications, conferences and training seminars. However, the participants of the focus groups pointed out that the online option for training or promoting the European Standards should be considered. The Polish system is decentralized in terms of taking actions and the position of local and regional governments is strong. If we take into account the prevention expenditure of communes (local governments) and Marshal offices (regional governments) it is clear these authorities are the main spender in terms of financing drug prevention in Poland. In 2013, PLN 36 million was allocated from the alcohol licence fee revenues to drug prevention in communes and cities while alcohol prevention cost PLN 600 million. The discussion that took place during the sessions of the focus groups showed that there are expectations of local and regional governments to act as institutions which have impact on the quality of drug prevention in Poland. Annual competitions organized by communes or municipalities might become such a tool providing that local officials take into consideration guidelines for annual competitions for non-governmental organizations defined e.g. in the European Standards. The challenges of promoting the European Standards among drug prevention practitioners were also discussed. Introducing guidelines defined in the European Standards to communal competitions, e.g. as additional points to score, could contribute to the application of the European Standards by funding-seeking organizations. Raising quality of drug prevention is clearly related to additional costs incurred by the providers. That is why the idea of promoting the standards by local and regional governments seems interesting, though challenging in terms of implementing under the decentralized system. The experiences of implementing the recommendation system for drug prevention and health promotion programmes show that both communes and non-governmental organizations do not fully use the available options. The recommended programmes are still financed to a limited extent. In 2013, the most communes co-financed the following programmes "School for Parents and Educators" (89 communes) coordinated by the Centre for Education Development and "Treasure Archipelago" (62 communes) coordinated by Homo Homini Foundation. In total, 202 communes financed recommended programmes in 2013. It is still necessary to develop and promote quality standards, which might translate into the creation of high quality drug prevention programmes and their wider application (Malczewski 2013d,e).

Promoting EDPQS in Poland

At the beginning of October 2014, a conference was held in Warsaw entitled "European Drug Prevention Quality Standards". The conference was organized by the Polish Focal Point and the Mazovian Centre for Social Policy (MCPS). This annual conference is held for local governments monitoring drugs and drug addiction and Provincial Drug Information Experts. However, participants also include representatives of other local authorities, NGOS and drug treatment units. The European Drug Prevention Quality Standards are the first reference framework for high-quality drug prevention work based on

the European consensus. The EDPQS were developed in 2008-2010 by over a dozen experts from the United Kingdom, Italy, Spain, Hungary, Romania and Poland, who make up the Prevention Standards Partnership. The EDPQS project is sponsored by the European Union. The result of Phase I was the EDPSQ Manual published by the European Monitoring Centre for Drugs and Drug Addiction in Lisbon in 2011. A Polish version was also released by the National Bureau for Drug Prevention and is available on the website of the Polish Focal Point: http://www.cinn.gov.pl/portal?id=15&res_id=454227. The conference was aimed at presenting the EDPQS project and its Phase II, which is underway. In the first half of 2014, an online needs assessment and focus groups among drug prevention professionals were conducted. The conference was attended by 120 participants from Poland and 20 experts from abroad (over 10 EU Member States and Georgia). At the first conference session, Ms Angelina Brotherhood of John Moores University in Liverpool presented the EDPQS project and the expected results of Phase II. The other participants from Italy (Rachele Donini), France (Carine Mutatayi) and Poland (Artur Malczewski) reviewed the current work on the project. Ms Brotherhood's presentation was devoted to the concept of the project and the ways of applying the standards in practice. One of the highlights of the presentation was the need to support the EDPQS champions i.e. individuals who wish to raise the quality of drug prevention by means of the European Standards. Raising the quality effectively requires the support of professionals involved in drug prevention at local level. Phase II of the project is also aimed at developing the EDPQS support materials. The project will include: one-page summary, training materials to be used in face-to-face workshops, trainer's guide, multimedia presentations and workshop activities. The European Standards can be used to highlight best practice in prevention and identify areas requiring further development. Ms Rachele Donini of Italy presented a doctor's perspective on implementing the EDPQS while Ms Carine Mutatayi of France presented a concept of the toolkit publication for decision-makers and commissioners. The conference was also attended by Ms Alessandra Bo, who presented the EMCDDA portal devoted to best practice in drug prevention, treatment and harm reduction. In October, an upgraded version of the portal was launched at: http://www.emcdda.europa.eu/best-practice (Malczewski 2014f).

4. High Risk Drug Use

prepared by Artur Malczewski

There has not been done any new estimation in Poland in 2014.

In 2012, the estimation of problem opioid users was conducted for the first time. In this estimation a problem opioid user is defined as a person who regularly uses substances from the opioid group (mainly heroin), experiencing serious problems as a result. The estimation was conducted based on the benchmark method (Taylor 1997). It was estimated that the overall number of opioid users ranges from 10 444 to 19 794 in 2009. The middle value of 15 119 can be assumed as the most likely number of problem opioid users in Poland (Sierosławski 2012).

According to the last estimation, the number of problem drug users (including cannabis) ranges from 56 000 to 103 000 with middle point around 80 000 in 2009 (Sierosławski 2012).

The estimation of injecting drug use prevalence was conducted by means of the multiplier method based on data of residential and ambulatory drug treatment, the 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.

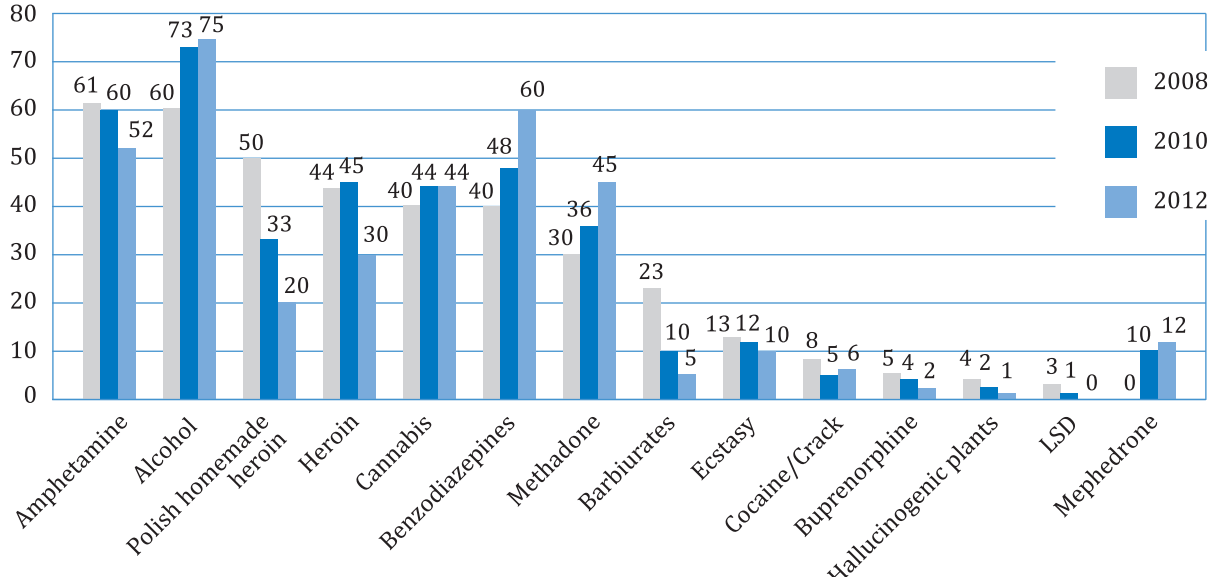
The estimation shows that the number of injecting drug users ranges from 4 270 to 10299 with the mean of approx. 7 284 in 2012 (Malczewski 2013c). It was a preliminary estimation, which will be validated based on 2014 survey, which means that the result should be treated with caution.

Survey among high risk drug use

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) held questionnaire interviews with the programme clients for two weeks at the turn of November and December. Contacts were made through drug users in order to exchange injecting equipment, give advice, and 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 in the same period of a year, which makes it possible to estimate fluctuations in client numbers (Malczewski 2013d). In 2008 a downward trend could be observed. The survey included over 700 clients, in 2010 it was 400 and in 2012 approx. 350. Most interviewees were male 74% (261 individuals in 2012). 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). Clients of low-threshold programmes were questioned about using respective psychoactive substances in the last 30 days prior to survey along with the use pattern. Figure 4.1.1. shows percentages of the survey respondents who reported last 30 days use of the respective psychoactive substances in the measurements of 2008, 2010 and 2012. During the questionnaire interviews the respondents were questioned 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 are 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 (kompot), from 50% to 20% and heroin from 44% to 30%. In the following measurements 10% (2010) and 12% (2012) of users reported using it. Mephedrone is a new psychoactive substance and was criminalised in 2009 following the amendment to the Act on counteracting drug addiction. There was also a drop in the percentage of amphetamine users from 61% to 52% and barbiturates users 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 with 2008. A sharp increase of 50% must also be noted in the case of benzodiazepines. Minor percentages of the respondents reported using hallucinogens. 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 half of the respondents, was considered most problematic by 2%. 5% of the respondents were unable to determine the most problematic substance. 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.

Figure 4.1.1 Prevalence of drugs use in the last 30 days – percentages of respondents



Source: Malczewski, A. (2013d),

5. Treatment – workbook

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Overview

National profile

The system of specialist care for drug-dependent individuals in Poland is part of the health care system for individuals with mental disorders and is governed by a number of legal acts. Drug treatment activities are supported e.g. by the National Bureau for Drug Prevention (KBPN) and the National Health Fund (NFZ). There are also central institutions, local governments as well as non-governmental organizations involved. Drug treatment can be provided by public or non-public health care units and practising doctors. Provision of drug treatment services is performed through a wide network of inpatient and outpatient clinics. In Poland, the outpatient assistance to drug users is provided at substance abuse counselling centres and, in exceptional cases, at outpatient alcohol rehabilitation clinics. Moreover, individuals with drug problem can seek treatment at mental health counselling centres and day-care wards/facilities. Inpatient clinics are mainly hospital-based drug rehabilitation centres and detoxification wards. In Poland, there are mainly long-term and medium-term treatment programmes (up to 12 months); however, these had to be shortened due to economic reasons as well as because of new patient profiles. According to the KBPN data (online data as at June 2014), 87 inpatient and 226 outpatient clinics provided treatment across Poland.

In 2013, there were 25 non-prison substitution treatment programmes across Poland. They provided services for 1725 patients.

Drug treatment is applied via two main intervention channels: psychosocial methods and pharmacological treatment.

Trends

In 2013, within the pilot treatment demand data project (TDI), the National Bureau collected information on drug patients from 49 drug treatment units. Over the years 2010-2012, the number of drug treatment facilities reporting TDI data to the National Bureau under the abovementioned pilot project was steadily rising to reach the highest number of 59 facilities in 2012. In 2013, there were 49 such facilities reporting 2759 drug patients, including 1118 first-timers. Drug patients are predominantly individuals aged 15-34. The most problematic substance is cannabis. The share of opioid-related admissions is gradually falling although opioids are among the top three problematic substances. The second most problematic type of substance are stimulants.

The latest data from the Institute of Psychiatry and Neurology (IPiN) constitutes another source and refers to 2012, when the residential treatment facilities admitted 14 526 patients due to drug-related problems and 29 649 people were treated in mental health counselling centres, substance abuse counselling centres and alcohol abuse counselling centres.

New developments

In Poland, drug treatment services are constantly being modified. Drug treatment units are introducing evidence-based programmes. The new drug prevention and treatment challenges include canna-

bis-related problems, new psychoactive substances and behavioural addictions. New challenges for therapeutic communities include the need to create specialist centres, providing services for specific target populations, including pharmacotherapy in therapeutic interventions. There is also a need to improve harm reduction programmes, as well as to review goals of post-rehabilitation and social re-integration of problem drug users.

5.1. National profile

5.1.1. Policies and coordination

The system of specialist care for drug-dependent individuals in Poland is part of the health care system for individuals with mental disorders. Drug treatment in Poland is regulated by a number of legal acts and therefore is not coordinated by a single central institution. The National Bureau for Drug Prevention (KBPN) performs activities aimed at raising the quality of drug rehabilitation and social reintegration programmes as well as improving the qualifications of drug professionals in Poland, including drug treatment specialists. The National Health Fund in turn handles issues related to financing drug treatment programmes and medical care standards. The NFZ regulates minimum guaranteed service quotas in residential treatment centres. Drug treatment is financed based on contracts with the National Health Fund. The activities not contracted by the National Health Fund can be sponsored by the National Bureau for Drug Prevention, local governments and the EU funds in the course of competitions.

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 "Dz. U." 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);
- Regulation of Minister of Health of 17 October 2013 on the scope and manner of cooperation between drug treatment and rehabilitation centres and the National Bureau for Drug Prevention.

The Act of 29 July 2005 on counteracting drug addiction features two definitions of drug treatment. One refers to the treatment of mental and behavioural disorders caused by using narcotic drugs or psychotropic substances whereas the other refers to rehabilitation in the course of which an individual with mental disorders caused by using narcotic drugs or psychotropic substances reaches the optimal health as well as mental and social functioning.

In the section on drug treatment, the Act of 29 July 2005 on counteracting drug addiction stipulates 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 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. Moreover, under Article 73a, if it is dictated by therapeutic and educational reasons, the offender addicted to narcotic drugs or psychotropic substances serving a custodial sentence for an offence committed in relation to the use of narcotic drugs or psychotropic substances may be granted a furlough from serving the sentence referred to in Article 153.1 of the Executive Penal Code in order to enter treatment or rehabilitation. The furlough may be granted on the condition that the offender proves that they have been guaranteed a place at a health care centre that addresses their therapeutic needs.

In the field of drug treatment, rehabilitation, harm reduction and social reintegration, the National Drugs Strategy for the years 2011-2016 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 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 correctional institutions (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 are patient's rights, which is reflected in the following two sentences: "Developing and incorporating the aspects of patient's rights in the addiction training programmes conducted by entities recommended by the Director of the National Bureau for Drug Prevention" and "Disseminating information on patient's rights e.g. via the Internet and information and education materials for patients and programme providers".

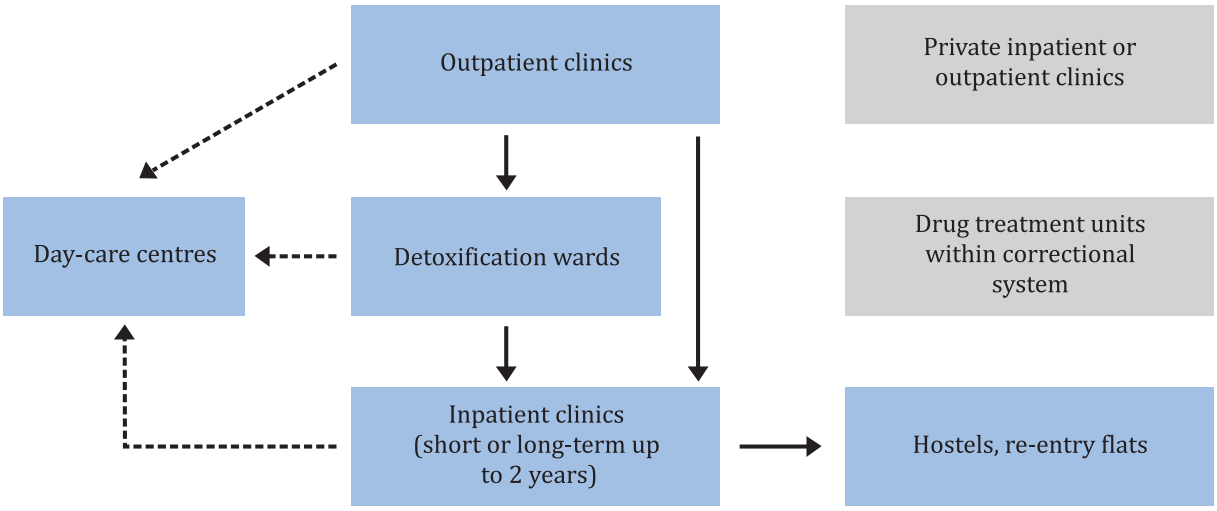
5.1.2. Organisation and provision of drug treatment

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 doctors, including groups of practising doctors. 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, rehabilitation 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. 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.

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 by private clinics or by private therapists (paid). No data on the private drug treatment sector is 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.

Figure 5.1.2.1. Structure of drug treatment system



Source: Based on Jabłoński, P. (2013) Opieka zdrowotna i rehabilitacja osób uzależnionych od substancji psychoaktywnych. Programy leczenia substytucyjnego. (lecture) National Bureau for Drug Prevention.

Referring to residential treatment centres or detoxification wards is done through ambulatory drug services. Ambulatory units also provide post-rehabilitation for residential treatment graduates.

Outpatient network

In Poland, the outpatient assistance for users of illicit psychoactive substances is provided in substance abuse counselling centres 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 include individuals with a drug problem.

According to the on-line drug services database run by the KBPN, the number of drug treatment outpatient clinics across Poland stands at 226 (as at 30 July 2014). According to the data from the Institute of Psychiatry and Neurology (IPiN), in 2012 in Poland, there were 81 drug counselling centres. The discrepancy in data results i.a. from the fact that among 226 drug treatment units listed in the KBPN database there are also consultation sites, which, by default, do not provide drug treatment but counselling, consultation and emergency support. The Institute of Psychiatry and Neurology does not collect data on the consultation sites. Moreover, the KBPN database also lists facilities which are not drug counselling centres but nonetheless provide assistance for drug-dependent individuals in a way similar to alcohol or mental health counselling centres.

The offer of assistance services such as day-care wards/centres still seems to be 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, 2012).

In 2012 (latest data), outpatient drug clinics provided treatment for 15 732 patients. In mental health counselling centres, drug abuse counselling centres, alcohol abuse counselling centres as well as day-care wards/centres there were 31 277 patients in 2011. Unfortunately, today (October 2014) it is not possible to state the exact patient numbers for the following years as there is no data available regarding the drug patients treated at day-care centres. However, it can be assumed that the number for 2012 is similar because in that year at the abovementioned facilities, excluding day-care wards, there were 29 649 patients and the number of day-care patients was very low (Institute of Psychiatry and Neurology, 2013).

In order to improve the availability of outpatient drug treatment from the first year of the operation of the new National Drugs Strategy, the National Health Fund increased spending in this field from PLN 12 665 591 to PLN 14 206 853[20]. The increase in the NFZ financing of outpatient treatment is in line with the drug policy defined in the National Drugs Strategy, where one of the tasks under 'Treatment, rehabilitation, harm reduction and social reintegration" is "raising spending of the National Health Fund on health services provided at ambulatory drug treatment units".

In 2012, the National Bureau started the implementation of a new therapeutic programme called CANDIS. The programme was developed in Germany and adapted to Polish conditions. It is a short-term modular therapy programme for problem cannabis users. The implementation and dissemination of the CANDIS programme in Poland is a major goal considering the rising number of cannabis users and the necessity to ensure access to the treatment offer which is adequate to the needs of this population. Consequently, a CANDIS website (www.candisprogram.pl) was launched. In order to maintain high quality of the CANDIS programme implementation, the National Bureau published (500 copies) a manual entitled "CANDIS – Modular therapy programme for problem cannabis users" for the programme providers (therapists who underwent specialist CANDIS implementation training). This manual was translated from German and adapted to Polish conditions. The CANDIS programme is currently being conducted in about 70 Polish cities by a few dozen facilities and over 100 trained professionals.

In 2013, similar to 2012, there were 25 non-prison substitution treatment programmes across Poland. They provided services for 1725 patients (data from the National Bureau's Registry of Substitution Treatment Patients). Despite the fact that in 2013 the National Health Fund increased spending on substitution treatment by 4.5% compared with 2012, in 3 provinces the availability of this service was below 10% and in 2 provinces no such programmes existed. No competition for substitution treatment services was announced in those 2 provinces as no service provider declared their interest in conducting such programmes. Considering the fact that substitution treatment is listed in the catalogue of guaranteed services, the obligation of announcing a substitution treatment competition is dictated by the Act of 27 August 2004 on health care services financed from public funds, particularly Article 6 which sets out tasks of public authorities to provide equal access to health care services and Article 65 stating that health insurance is based on the principle of providing an insured individual with equal access to health care services. It must also be noted that the provisions of this Act, which set out the procedure for contracting services, do not mention declarations of potential health care service providers as part of the contracting procedure.

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 to undergo 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.

20 Data as at 30 April; subject to minor changes (approx. 2%) upon closure of the financial year.

Table 5.1.2.1. Network of outpatient treatment facilities (total number of units)

	Total number of units	National Definition (Characteristics/Types of centre included within your country)
Specialised drug treatment centres	Difficult to present the total number of units because data comes from different sources (overlaps). Detailed data are the following:	
	a) 81	outpatient drug clinics (data for 2012 from the Institute of Psychiatry and Neurology) (drug counselling centres),
	b) 226	outpatient units (including consultation settings that are not health care centres and do not provide treatment but counselling, consultation and emergency support) – data from the on-line facilities data base – as at 30 July 2104 (National Bureau for Drug Prevention).
Low-threshold agencies	Do not provide treatment, mostly exchange needles and syringes.	
General /Mental health care	a) General health care – no data available.	
	b) Mental health care	Mental health care – 1346 (including 161 for children and youngsters). 1346 mental health care outpatient centres operate in Poland but only small part of them do treat drug dependent patients. Mental health care centres usually provide the first consultation and refer to specialized drug treatment centres.
Other outpatient units: opioid substitution treatment	25	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 (data for 2013).

Source: IPiN and data calculated by NFP.

Table 5.1.2.2. Total outpatient treatment provision (number of clients)

	Total number of units	National Definition (Characteristics/Types of centre included within your country)
Specialised drug treatment centres	29 649	Data from the Institute of Psychiatry and Neurology for 2012 from mental health counselling centres, drug counselling centres, alcohol counselling centres. Individuals admitted to treatment due to drug problem. Outpatient treatment centres are providing aggregated data to IPiN, which means that double-counting is not controlled.
Low-threshold agencies	Do not provide treatment, mostly exchange needles and syringes.	

General / Mental health care	a) General health care	No data available.
	b) Mental health care – 7999	Data for 2012 from IPiN, double-counting not controlled This number (7999) is also included under the category "Specialised drug treatment centres" – 29 649.
Prisons	Not applicable.	
Other outpatient units: opioid substitution treatment	1725	Data from the National Bureau's Registry of Substitution Treatment Patients as of 03.08.2014. Data for 2013. All substitution treatment facilities in Poland are obliged to report data on new patients to the abovementioned database on an ongoing basis. Data is coded in order to avoid double counting.

Source: IPiN and data calculated by NFP.

General comment on the data on the number of patients collected by the Institute of Psychiatry and Neurology from the outpatient treatment centres: there is no guarantee that no double counting exists at treatment centres.

Inpatient network

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, these had to be shortened due to economic reasons as well as because of new patient profiles. In August 2013, the Ombudsman for Drug-Dependent Individuals, a social institution established by the Polish Drug Policy Network and JUMP Society '93, released Report on Polish Drug Policy. The report points to the inadequate structure of the National Health Fund spending on drug treatment and rehabilitation. According to the report, the National Health Fund allocates almost four times more resources to the inpatient treatment compared with the outpatient spending. At the same time, there are significantly fewer patients at inpatient facilities. Consequently, it is recommended that the residential spending be frozen and the treatment duration shortened whereas the ambulatory spending should be doubled. It is also recommended that the drug treatment should be provided in accordance with most up-to-date knowledge:

- outpatient treatment and replacement therapies should be primary forms of care,
- emphasis on the widest possible access to substitution treatment programmes (low threshold),
- emphasis on diversifying medications: buprenorphine, complex preparations,
- short- and medium-term residential therapies (3-6 months),
- emphasis on the development of post-rehabilitation services and access to support in place of residence following completion of treatment.

At the conference of harm reduction programmes organized by the Polish Focal Point at the end of 2013, during which the report was presented, an expert of the Institute of Psychiatry and Neurology commented on the report stating that the authors did not consider the treatment demand in Poland. The report mainly describes the resources and fails to pay attention to the demand for respective forms of treatment in Poland as well as respective provinces.

The National Health Care Strategy 2007-2015 sets out in operational goal 5.17 the following: Reducing substance use and the related health harm. Tasks: Establishing new treatment and rehabilita-

tion centres offering varied therapeutic programmes with particular emphasis on outpatient facilities. Establishing new substitution treatment programmes as well as extending the range of substitution medications.

The abovementioned documents clearly stress the need to support and develop services alternative to residential treatment. Particular importance should be attached to the development of substitution treatment programmes and the funding of counselling centres. The need to develop post-rehabilitation services was also emphasised. Very similar recommendations in the field of drug treatment, rehabilitation, harm reduction and social reintegration are listed in the existing National Drugs Strategy (see Chapter 1. Drug policy: legislation, strategies and economic analysis). The only sector which was not reflected in the priorities of the National Drugs Strategy 2011-2016 is residential treatment.

The above challenges were met by the National Health Fund. According to the Ordinance of the President of the National Health Fund of 13 December 2013 on conditions of concluding and implementing psychiatric care and drug treatment contracts, which came into force on 1 January 2014, the National Health Fund ceased to finance health care services provided at residential centres for patients who have completed 18 months of therapy. At the same time the level of the person-day financing at such facilities between the 12th and 18th month of the therapy was reduced from 100% to 70%.

As for the 3 August 2014 there were 87 inpatient drug rehabilitation clinics (in the on-line facilities data base, run by the National Bureau for Drug Prevention) including clinics admitting patients with dual diagnosis. Of these 87 centres – 34 admitted under age patients.

The above data generally does not include psychiatric hospitals (only 3 of 87 were hospital wards) where drug-dependent and problem users are also treated; however, usually due to co-existing psychotic symptoms, not drug addiction.

According to the Statistical Yearbook of the Institute of Psychiatry and Neurology in the 2012 (latest data) there were 58 drug rehabilitation centres (hospital based) operating with 2431 beds available. 8183 patients were treated in those facilities. However according to other document from the Institute of Psychiatry and Neurology, in 2012 14 526 individuals were admitted to inpatient treatment centres due to drug problem (Sierosławski J., 2014). This document lacks data on the number of inpatient treatment centres providing treatment.

Moreover, 19 detoxification wards were operating in 2011 (latest data) and provided services for individuals dependent on psychoactive substances other than alcohol. They offered 198 beds (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 predominantly methadone. Symptomatic treatment and clonidine therapy are far less common. Detoxification at hospitals usually lasts 8-14 days (Habrat B., 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 (Habrat, B., Institute of Psychiatry and Neurology, personal communication).

Based on the NFZ data, available at the Fund's website (http://kolejki.nfz.gov.pl/), at the turn of May and June 2014, out of the overall number of 58 drug rehab facilities, a patient is admitted immediately to 22 of them (38%), in the case of 27 (47%) the waiting time is up to three weeks while in 9 facilities (15%) the waiting time is over 3 weeks (sometimes even approx. 3 months). A different situation is when it comes to substance abuse counselling centres. Out of 94 facilities as many as 69

(73%) admit patients straight away followed by 13 centres (14%) where the waiting time is up to a week and then 12 centres (13%) where the waiting time exceeds a week (in three cases over 1.5 month). 13 out of 15 day-care wards (86%) will admit a patient immediately while in the remaining two (13%) the waiting time is approx. 4 months. A drug-dependent individual does not have to wait to enter 9 out of 17 detoxification wards (53%), in 6 (35%) – the waiting time is up to 10 days while in the remaining 2 – the waiting time is approx. a month. The NFZ data shows that it is the easiest to seek treatment at day-care wards and ambulatory centres and the longest waiting time is at residential centres (based on National Information Brochure on Health Care Services Waiting Time, as at 31 July 2014).

Table 5.1.2.3. Network of inpatient treatment facilities (total number of units)

	Total number of units	**National Definition (Characteristics/ Types of centre included within your country)**
Hospital-based residential drug treatment	87 (online database of the National Bureau for Drug Prevention)	Rehabilitation centres run by NGO, hospital facilities. According to the online database on facilities operated by the National Bureau for Drug Prevention (as at 30 July 2014).
Residential drug treatment (non-hospital based)	Not applicable.	
Therapeutic communities	All or vast majority of the hospital-based residential drug treatment centres are working with the therapeutic communities.	
Prisons *	1) 15 2) 22 3) 23	1) therapeutic wards for inmates dependent on narcotic drugs or psychotropic substances 2) therapeutic wards for mentally disabled convicts or convicts manifesting non-psychotic mental disorders 3) correctional units running substitution treatment for opioid-dependent inmates.
Other inpatient units: Inpatient substitution treatment programmes	1	Youth Rehabilitation Centre, Warsaw Charity Society, Kazuń Bielany – conducting the first and the only inpatient substitution programme in Poland.
Other inpatient units: detoxification wards	19	Data for 2011 from IPiN. The wards targeted mainly opioid withdrawals. The main form of withdrawal treatment at detoxification wards is the administration of decreasing doses of opioids.

Source: Standard table 24.

Table 5.1.2.4. Total inpatient treatment provision (number of clients)

	Total number of units	National Definition (Characteristics/ Types of centre included within your country)
Hospital-based residential drug treatment	14 526	Every person who was admitted to residential treatment due to drug problem (drug inpatient treatment centres: NGO, psychiatric hospitals, detoxification wards). Data from IPiN for 2012.
Residential drug treatment (non-hospital based)	Not applicable.	
Therapeutic communities	All or vast majority of the hospital-based residential drug treatment centres work using the therapeutic communities approach.	
Prisons *	1) 1489 2) 261 3) 138	1) therapeutic wards for inmates dependent on narcotic drugs or psychotropic substances 2) therapeutic wards for mentally disabled convicts or convicts manifesting non-psychotic mental disorders 3) correctional units running substitution treatment for opioid-dependent inmates Data for 2013.
Other inpatient units: Inpatient substitution treatment programmes	5	Data for 2013.
Other inpatient units: detoxification wards	198 (beds) Data on the number of patients treated in detoxification wards is also included under the category "Hospital-based residential drug treatment"	Data for 2011 from IPiN. The wards targeted mainly opioid withdrawals. The main form of withdrawal treatment at detoxification wards is the administration of decreasing doses of opioids.

Source: Standard table 24.
* For more information on prison service see chapter: 9. Drug related crime.

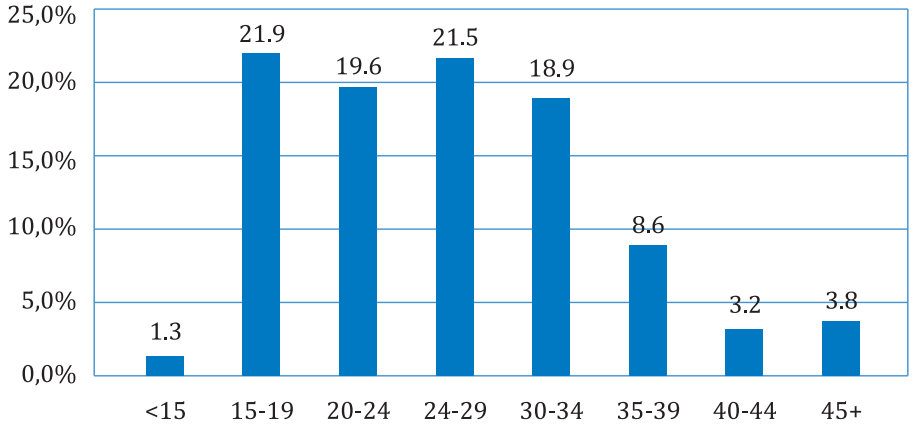
5.1.3. Key data

In 2013, under the pilot TDI project, the Polish Focal Point collected information from drug patients at 49 drug treatment units, including 27 outpatient clinics (25 addiction counselling centres and 2 day-care centres), 22 inpatient clinics and 1 detoxification ward (coverage around 17%). In January 2014, an ordinance was published imposing an obligation on the treatment facilities to report TDI data to the Polish NFP (National Bureau). Consequently, the Polish NFP developed an online TDI reporting database.

In 2013, there were 2759 individuals who reported to drug treatment, including 1118 first-time patients. The patients were predominantly male (2238) compared with 521 females. Among first-timers, there were 877 men and 241 women.

In 2013, the biggest group of drug patients were those aged 15-34, with most frequent patients aged 15-19 as well as 25-29. By analogy to the previous years, also in 2013, the percentages of individuals reporting to treatment under the age of 15 as well as over 45 were minimal. Specific information on TDI patients by ages is presented in the Figure below.

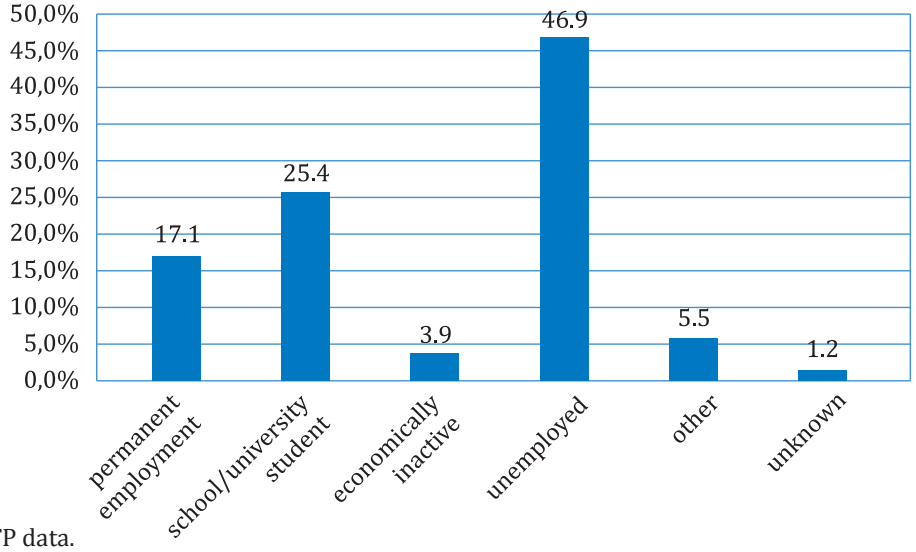
Figure 5.1.3.1. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2013 – proportions of patients by age (%)



Source: TDI NFP data.

In terms of the employment status of drug patients in 2013, the unemployed constituted the largest group, followed by school and university students.

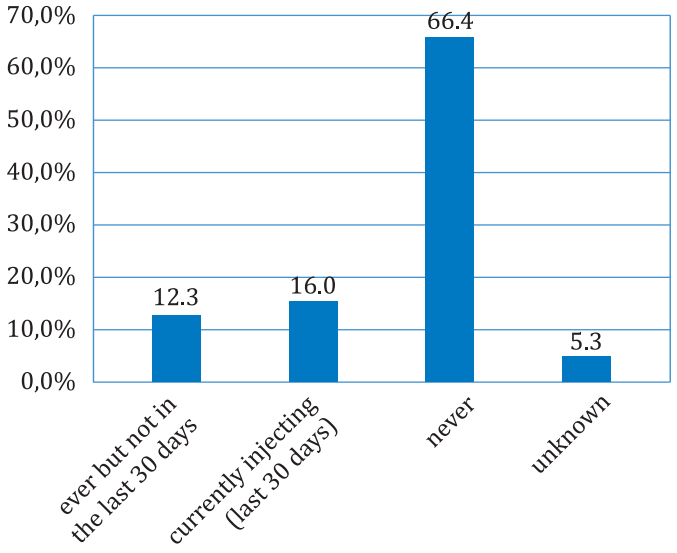
Figure 5.1.3.2. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2013 – proportions of patients by employment status (%)



Source: TDI NFP data.

In 2013, 16% of drug patients were injecting drug users, similarly to 2012 (16.7%). The Figure below shows specific data on drug patients in 2013 in terms of injecting drug use.

Figure 5.1.3.3. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2013 – proportions of patients by injecting drug use (%)

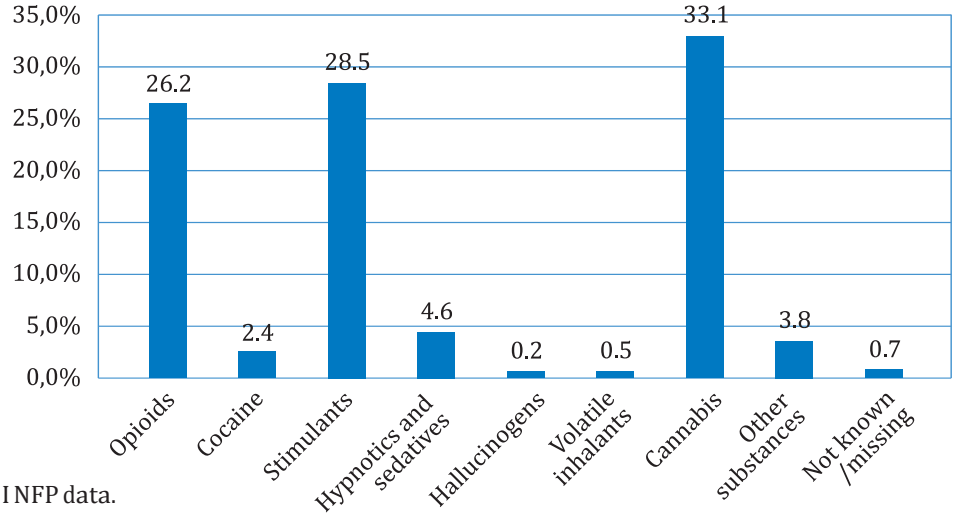


Source: TDI NFP data.

Primary drugs i.e. most problematic substances due to which users reported to treatment in 2013 (all patients) included the following: cannabis (33.1%), stimulants (28.5%) and opioids (26.2%).

Figure 5.1.3.4. shows percentages of all patients who reported to treatment in 2013 with division by primary drug.

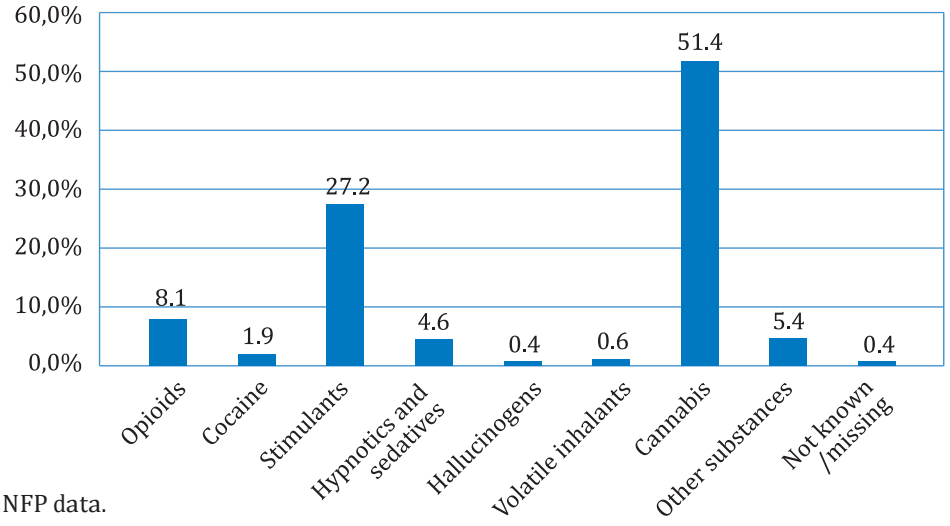
Figure 5.1.3.4. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2013 – proportions of patients by primary drug (%)



Source: TDI NFP data.

As for the primary drugs among first-time drug patients in 2013 the percentages are as follows: cannabis (51.4%) – cannabis was the substance that generated over half of the drug patients, stimulants (27.2%) and, to a much lesser extent, opioids – 8.1%.

Figure 5.1.3.5. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2013 – proportions of first-time patients by primary drug (%)

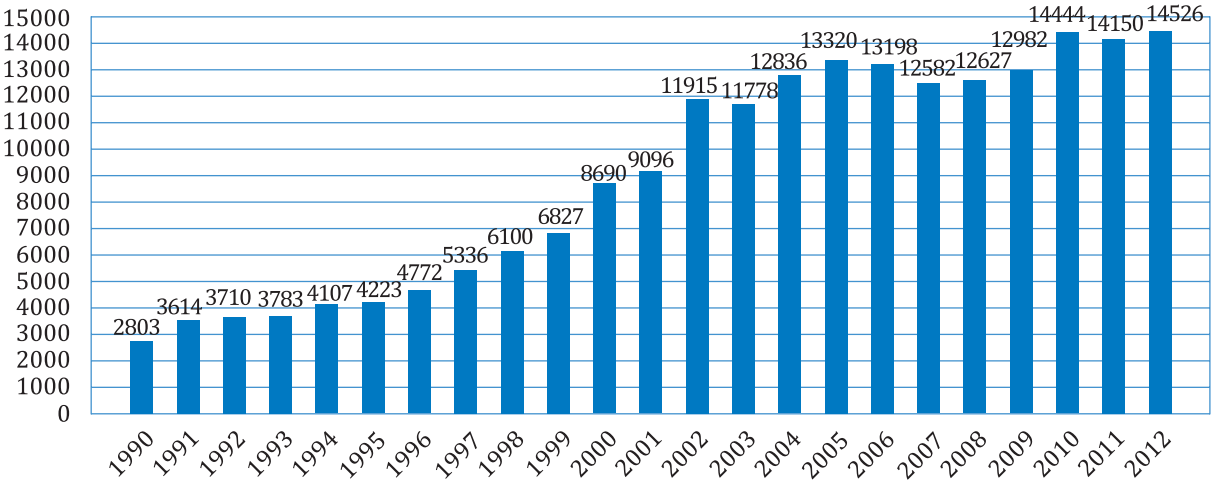


Source: TDI NFP data.

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

Another source of data on drug patients are the statistics of the Institute of Psychiatry and Neurology on residential treatment. Statistical data of residential psychiatric drug treatment is used to analyze trends in drug-related mental and behavioural disorders. The latest data from the Institute of Psychiatry and Neurology (IPiN) refers to 2012, when the residential treatment facilities admitted 14 526 patients due to drug-related problems. Compared with 2011, there was a slight rise. 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 2002, despite fluctuations in respective years, the overall trend seems to be upward.

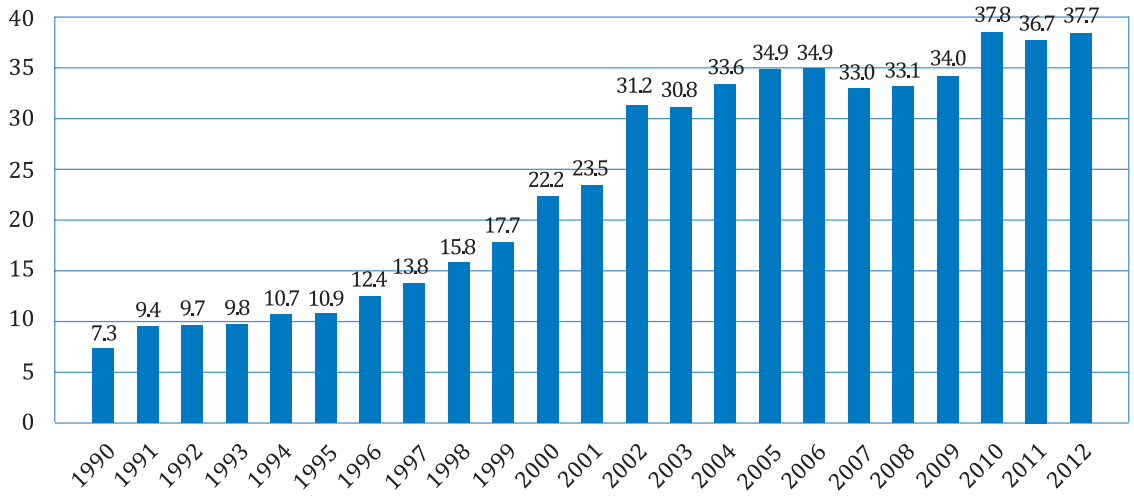
Figure 5.1.3.6. Admissions to residential drug treatment in 1990-2012 (numbers of patients)



Source: IPiN (2014).

Figure 5.1.3.7. shows the number of patients admitted to residential treatment per 100 000 population in 1990-2012. This data demonstrated the same trends as shown in the previous figure. The rate per 100 000 population in 2012 stands at 37.7.

Figure 5.1.3.7. Admissions to residential drug treatment in 1990-2012 (per 100 000 population)



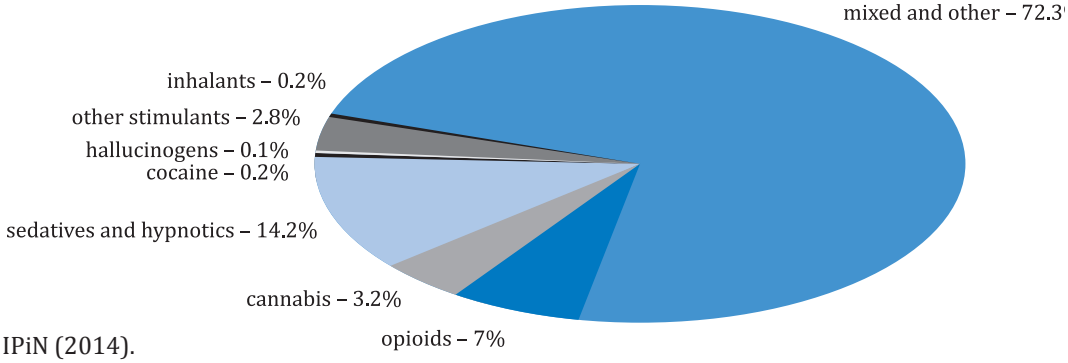
Source: IPiN (2014).

In 2012, similarly to previous years, male patients constituted the vast majority in residential drug treatment facilities (74.9%).

Most patients admitted to residential treatment units in 2012 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 (72.3%) nothing can be said about the types of substances which caused the patients to start treatment.

Opioid users accounted for 7% of all admissions and compared with 2010 (12.5%) this figure is lower. 14.2% of the patients reported to residential treatment due to problems related to the use of sedatives and hypnotics (13% in 2011) and in 2.8% of the patients problems related to using other stimulants were diagnosed (3.5% in 2011). In 2012, similarly to previous years, small numbers of patients were addicted to cannabis (3.2%), inhalants (0.2%), cocaine (0.2%) and hallucinogens (0.1%).

Figure 5.1.3.8. Admissions to residential drug treatment in 2012 due to mental and behavioural disorders by type of substance



Source: IPiN (2014).

5.1.4. Treatment modalities

Drug treatment is applied via two main intervention channels: psychosocial methods and pharmacological treatment. The psychosocial methods, which are more popular, include the following: therapeutic community, cognitive-behavioural psychotherapy, 12 steps, case management and self-help movements. The wide range of drug treatment methods are reflected in practice, as very few drug treatment units use a single method. The units mostly apply an eclectic range of methods.

Pharmacotherapy is mainly based on substitution treatment and detoxification. These forms should be complemented with therapeutic activities adapted to individual needs of a drug user. Another matter, going beyond the scope of these methods, is post-rehabilitation and harm reduction.

The oldest and most common component of Polish substance abuse treatment system is residential treatment. The programmes offered are divided into short, medium and long-term. Residential rehabilitation in Poland, provided by centres which remain within the domain of the government or NGOs, is almost universally based on the therapeutic community approach as the primary intervention. According to the information booklet from 2011: "Drug addiction – where to seek help?", this method was reported by 70 centres, 59 of which 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.

Drug treatment system in Poland requires that the services should fit the patients' needs i.e. there should be an individual treatment plan which:

- is individualized and regularly updated depending on the rapidly changing needs of the patient,
- offers a range of medical, psychological, education, social and legal service,
- is adapted to the needs related to age and sex.

Outpatient and inpatient services

Table 5.1.4.1. Services available in the Outpatient setting

	Not available	<25% of outpatient facilities provide this service	Between 25% and 50%	>50% and 75%	> 75%
Psychosocial treatment/counselling				YES	
Screening of mental health disorders				YES	
Mental health services				YES	
Case management					YES
Outreach to clients in the community in need of treatment		YES			
Established referral processes to relevant medical and social services					YES

Source: Structured questionnaire 27P1.

Table 5.1.4.2. Services available in the Inpatient setting

	Not available	<25% of outpatient facilities provide this service	Between 25% and 50%	>50% and 75%	> 75%
Psychosocial treatment/counselling					YES
Screening of mental health disorders					YES
Mental health services					YES
Case management					YES
Detoxification		YES			
Established referral processes to relevant medical and social services					YES

Source: Structured questionnaire 27P1.

Opioid substitution treatment (OST)

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. The main substitute drug administered in Poland is methadone; however, buprenorphine and suboxone are becoming widely used. A significant change in the current National Drugs Strategy 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. It is worth stressing that substitution treatment is listed in the catalogue of warranted health care services. The obligation to announce competitions for substitution treatment is dictated by the Act of 27 August 2004 on health care services financed from public funds (Journal of Laws "Dz. U." of 2008 No 164, item 1027, as further amended), particularly Article 6 setting out the tasks of public authorities to provide equal access to health care services and Article 65 indicating that health insurance is based on the principle of providing an insured person with equal access to health care. Consequently, the NFZ should allocate financial resources to this goal and announce substitution treatment provision competitions. 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. In 2013, the National Health Fund increased spending on substitution treatment services by 4.5% compared with 2012. The NFZ concluded contracts with 25 providers of such services. These programmes were conducted in 14 provinces. According to the NFZ data for 2013, there were 25 non-prison substitution treatment programmes running in 14 provinces. Despite permits issued in 2013

to launch 4 more programmes, it is estimated that this form of treatment covers 12-23% of opioid-dependent individuals. In the provinces of podlaskie and podkarpackie there are still no substitution treatment programmes and clearly limited access thereto has been recorded in the provinces of pomorskie, zachodniopomorskie and wielkopolskie.

The Opole Provincial Department of the National Health Fund reported in 2013 that substitution treatment covered at least 25% of opioid-dependent individuals. NFZ Provincial Departments which were close to reaching this level included: kujawsko-pomorskie, lubelskie, lubuskie and mazowieckie, which concluded contracts allowing for covering approx. 23% of the opioid-dependent population. Access to this form of treatment in the remaining provinces (where substitution treatment was provided) was far more limited and ranged between 6% (warminsko-mazurskie province) and 18% (slaskie province). Low access figures in the provinces of wielkopolskie (7%), pomorskie (8%) and zachodniopomorskie (10%) should also be noted.

Substitution treatment programmes are also available for prison inmates. According to the data reported by the Central Management Board of the Prison Service in 2013, there were 138 patients receiving substitution treatment at correctional institutions under 7 programmes (23 correctional units). However, the number of programmes was not increased compared with 2012. The number of inmates in substitution treatment in 2013 did not rise either (138 in 2013 vs. 147 in 2012). In 2013, work was underway to introduce new organizational solutions in substitution treatment aimed at providing such services in every correctional unit.

5.1.5. Quality assurance of drug treatment services

In Poland, work is underway to raise the quality of drug services. Considering the quality and the effectiveness of drug treatment, on the one hand accreditation rules and standards for residential drug treatment units are being implemented, while on the other moral duties of a drug therapist are stressed i.e. following the Ethical Code.

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, other trainings for specialists from different groups (not only for drug therapy instructors/specialists) are also being provided.

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, work on the standards for inpatient/outpatient clinics and day-care centres was 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 Centre for Monitoring 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.

In 2013, the Minister of Health approved the accreditation standards in providing health care services and operation of residential drug treatment units by initiating the implementation of the accreditation system for residential drug treatment units (ordinance of Minister of Health of 4 July 2013 on accreditation standards in health care provision and operation of residential drug treatment units Official Journal "Dz. Urz. Min. Zdrow." item 28). The National Bureau for Drug Prevention in collaboration with the State Agency for Preventing Alcohol-related Problems and the Centre for Monitoring

Quality in Health Care performed activities aimed at developing specific guidelines on accreditation audits.

In Poland, pursuant to Article 27.1 of the Act of 29 July 2005 on counteracting drug addiction, there are conducted specialist training courses on addictions to narcotic drugs and psychotropic substances (http://www.kbpn.gov.pl/portal?id=104958). The Act lists university degrees holding which makes an applicant eligible to seek a title of drug therapy specialists. The Regulation of Minister of Health of 2006 on training in addictions specifies training entities in the field of addictions, training curricula, procedure and manner of holding examinations, composition of exam panels and certificate templates. Consequently, two training modules were introduced:

- for individuals with therapy experience of less than two years, Module I was introduced to be followed by Module II. The total number of hours cannot be lower than 690 hours in the case of a drug therapy specialist and 650 hours for a drug therapy instructor. The training participants are obliged to take part in at least 30 hours of psychopathology classes and 100 hours of workshops during which the following are practiced: interpersonal skills necessary in therapeutic work, making therapeutic contact and forming foundations of individual work with a patient. An obligatory element of Module I is a 120-hour clinical internship at one of the recommended residential drug treatment units where the training participant becomes familiar with the nature of work with drug-dependent individuals and learns to apply the work methods in practice;
- individuals with drug therapy experience of more than two years are admitted directly to the Module II course. It involves at least 440 hours of didactic classes in the case of a drug therapy specialist and 400 hours for a drug therapy instructor. Module II covers 50 hours of theoretical classes, 80 hours of psychological training, 160 hours of workshops and an internship (minimum 80 hours) and supervision (minimum 70 hours).

Upon commission of the National Bureau, an e-learning course for primary care doctors was developed. The course received accreditation of the Supreme Medical Chamber. The course covers the following:

- profile of psychoactive substances: routes of administration, withdrawal symptoms, dependence, (somatic and psychiatric) health harm;
- somatic and psychiatric symptoms of drug use;
- risk factors for drug addiction;
- substance dependence assessment criteria;
- basic principles of interventions in problem substance users;
- available methods and drug treatment units.

The e-learning platform also contains links and downloadable support materials. The course also includes three short films which present a model motivational interview intended to make the patient shift the drug use pattern into the less harmful one or give up the substance (the so-called short-term intervention). The factor motivating doctors to join such courses should be Regulation of Minister of Health of 6 October 2004 on professional training obligation among doctors and dentists (Journal of Laws "Dz. U. " No. 231, item 2326, as further amended). According to the Regulation doctors are obliged to keep improving their professional qualifications and over the course of every four years they must score a certain number of educational points (200).

5.2. Trends

Over the years 2010-2012, the number of drug treatment units reporting to the National Bureau information on individuals entering drug treatment under the pilot project was steadily rising to

reach the highest value (59 units) in 2012. It was possible thanks to the cooperation with the network of Provincial TDI Coordinators. The Coordinators were responsible for reaching new drug treatment units, encouraging the treatment personnel to participate in the project and provide trainings. Thanks to the involvement of the Coordinators, the number of the TDI system units more than doubled.

Between 2010 and 2013, the number of patients fluctuated. The 2012 rise is related to extending the cooperation between the National Bureau and the network of Provincial TDI Coordinators, responsible for winning and training new drug treatment units. Thanks to the cooperation network, the number of new TDI system units increased, which also resulted in a higher number of patients compared with previous years.

Due to work related to the Regulation of Minister of Health on collecting drug treatment data as well as the modification of the TDI Protocol in line with the EMCDDA standards and a new software application, the National Bureau was forced to withdraw from cooperation with the network of TDI Coordinators, which was reflected in the lower number of drug treatment units reporting drug patients in 2013.

Table 5.2.1. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2010-2013

Patients in respective years	2010	2011	2012	2013
All patients	1342	2217	2833	2759
First-time patients	364	813	1171	1118
Number of reporting facilities	21	28	59	49

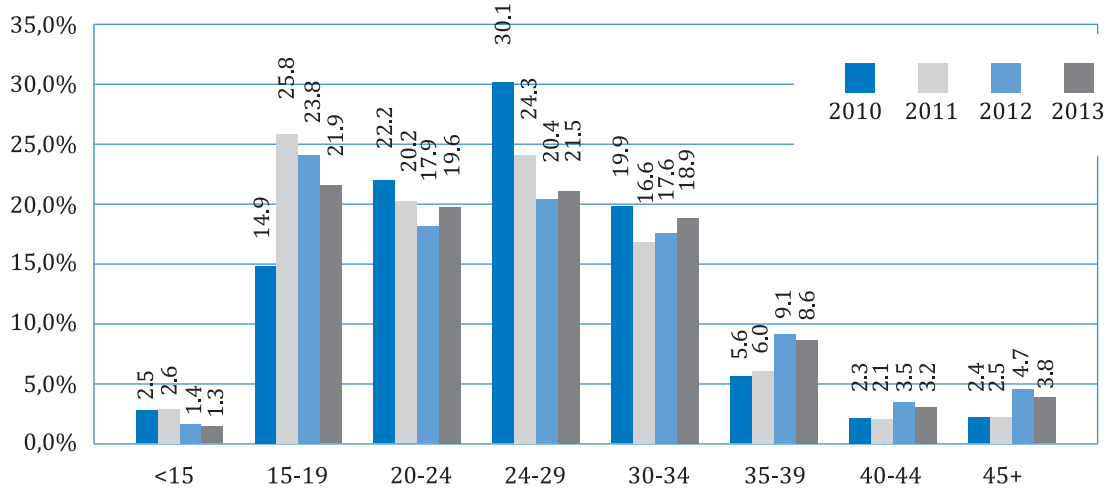
Source: TDI NFP data.

In January 2014, Regulation of the Minister of Health of 17 October 2013 on the scope and manner of cooperation between drug treatment and rehabilitation centres and the National Bureau for Drug Prevention came into force. The Regulation obliges drug treatment units to report relevant data, which results in a constantly rising number of the reporting units. A decision was also taken to resume cooperation with the network of the TDI Coordinators, which will be reflected in the 2014 TDI data.

If we analyse age of drug patients from 2011, we observe stabilization of this trend. Following the rise in the percentage of drug patients in the respective age groups in 2011 caused most likely by the closure of smart shops in the autumn of 2010, the trend has remained stable with minor fluctuations. Drug patients are aged mostly 15-34. In the case of the youngest age group steady, if minimal, falls in drug patients are observed. With reference to patients aged 20-29, up to 2012 there was a steady drop in patient numbers to be followed by a slight rise in 2013. In the case of patients aged 30-34, following a decrease in percentages in 2011, a minimal rise occurred. The percentages of drug patients under 15 did not exceed 3% in 2010-2013 with the value under 2% in 2012 and 2013.

The percentages of drug users over 40 did not cross a 5% threshold. Specific TDI data are presented in the Figure below.

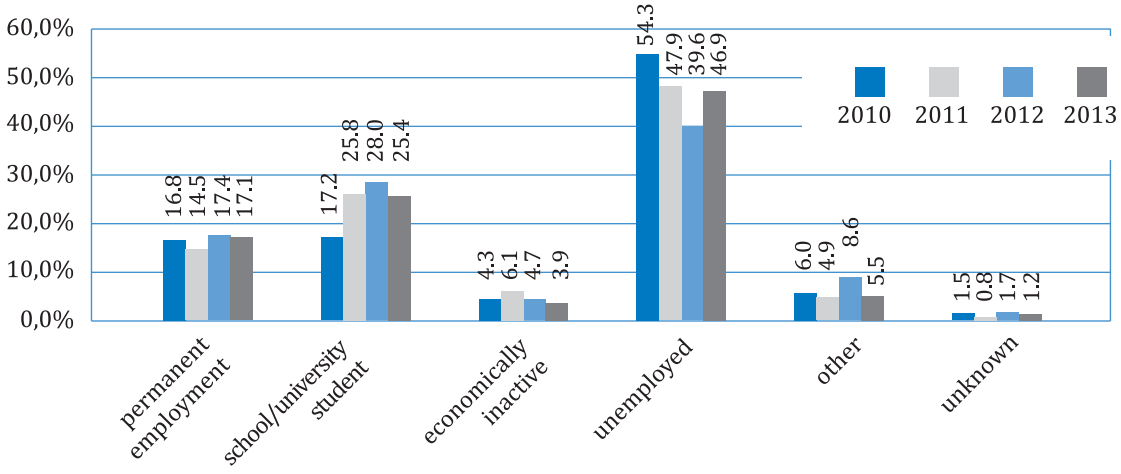
Figure 5.2.1. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2010-2013 – proportions of patients by age (%)



Source: TDI NFP data.

Considering the employment status of drug patients, the most numerous group were the unemployed and school/university students. The percentages of student drug patients increased slightly in 2010-2012 to fall by nearly 3 percentage points in 2013. In the case of unemployed drug patients, a reverse situation was observed. In 2010-2012 there was a steady drop in the percentage of unemployed drug patients while in 2013 a major increase of over 7 percentage points was observed. Detailed information is shown in Figure 5.2.2.

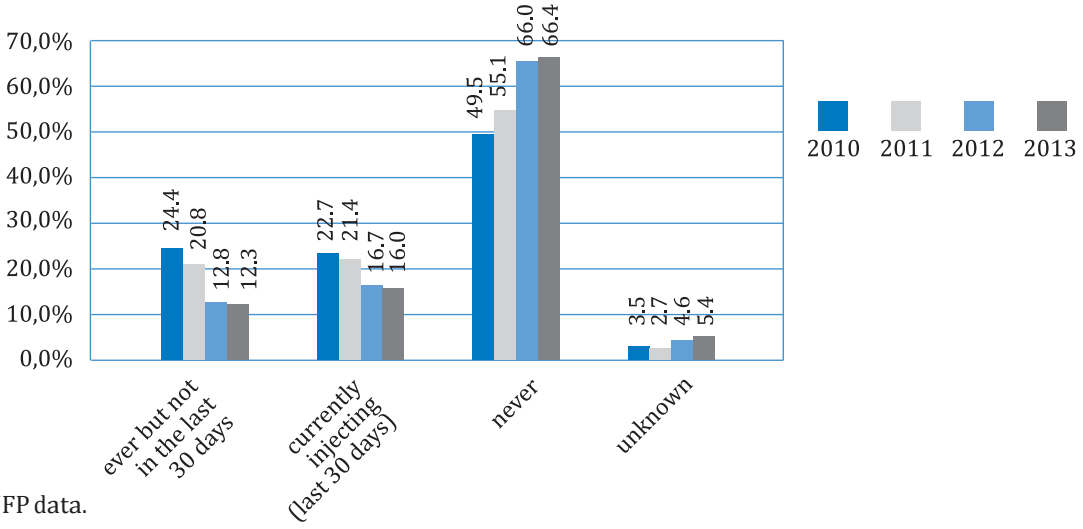
Figure 5.2.2. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2010-2013 – proportions of patients by employment status (%)



Source: TDI NFP data.

The percentages of patients who have injected drugs in the last 30 days prior to admission to drug treatment have been steadily going down for years. In 2010 and 2011 over half of drug patients reported that they had never injected drugs while in 2012 and 2013 this percentage rose to more than 60%. More information on injecting drug use among drug patients is presented in Figure 5.2.3.

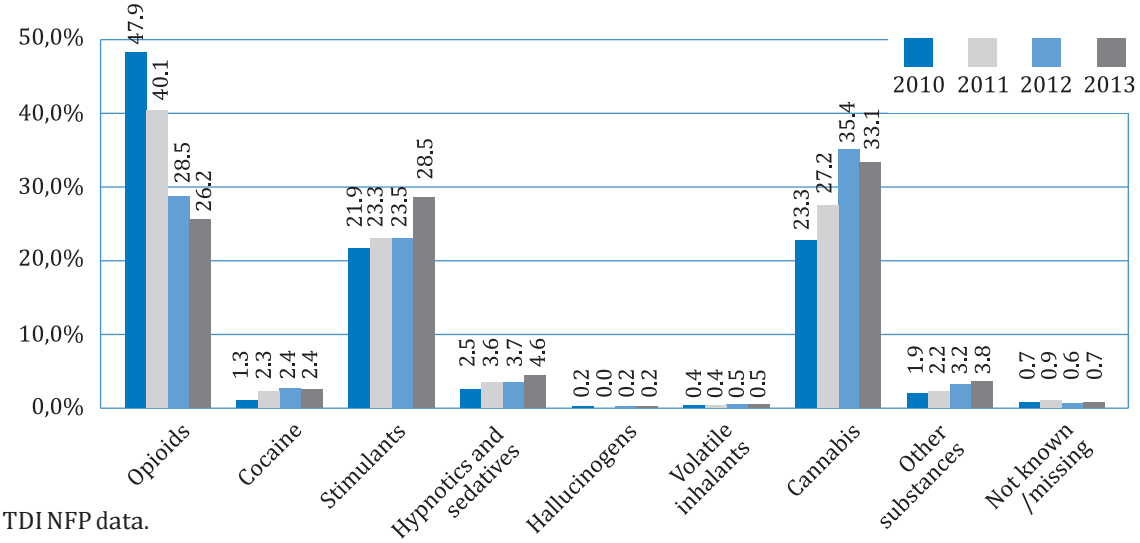
Figure 5.2.3. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2010-2013 – proportions of patients by injecting drug use (%)



Source: TDI NFP data.

Data on the primary drug due to which users seek treatment shows that the most prevalent substance is cannabis. However, following a significant increase in such patients in 2012, a slight decrease was recorded in 2013. The importance of opioids as a primary drug has been constantly falling though opioids are one of the three main problematic substances. In 2010, nearly half of drug patients reported opioid-related problems while in 2012 and 2013 the percentages did not exceed 30%. The share of stimulants among the substances generating problem drug use is growing. Stimulants are the second most problematic substance due to which drugs users enter treatment. In 2010-2013, there was a rise of nearly 7 percentage points in the percentage of stimulant patients. In 2013 alone, compared with 2012, this percentage rose by 5 percentage points. Since 2010, the percentage of drug users seeking treatment due to the use of the so-called other unspecified substances has been rising. Although this percentage did not reach 4% in 2013, compared with 2010, it doubled. Detailed information is presented in Figure 5.2.4.

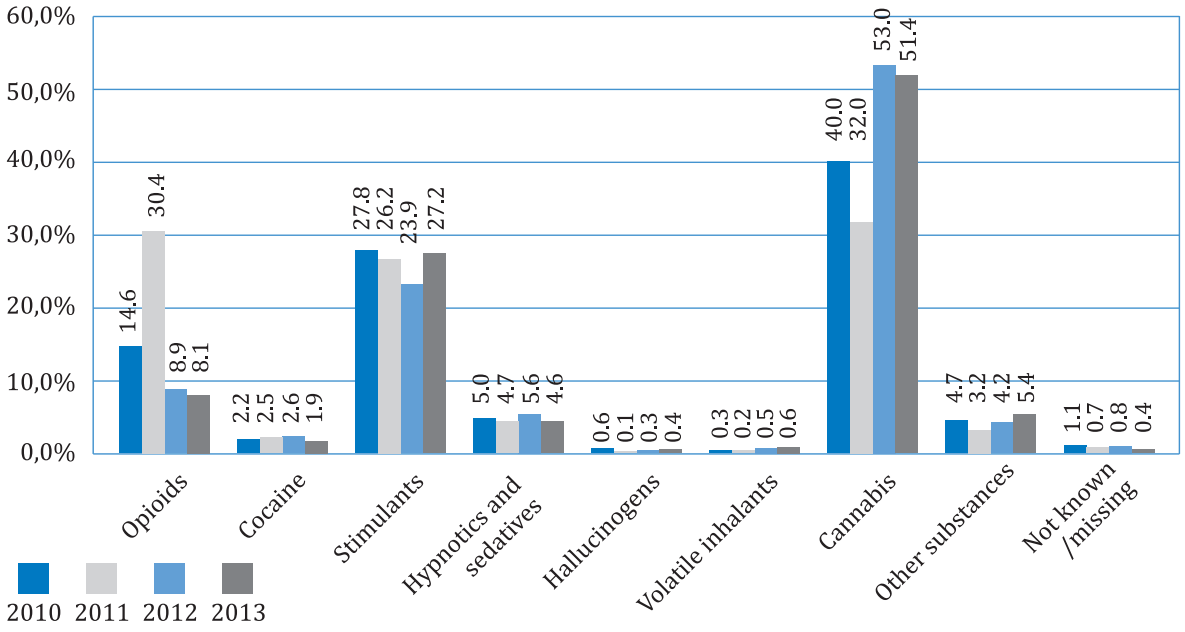
Figure 5.2.4. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2010-2013 – proportions of patients by primary drug (%)



Source: TDI NFP data.

Data on first-time drug patients show that half of them report to treatment due to cannabis use. In 2011, the percentage decreased to the level of 32% while since 2012 it has held relatively steady. Compared with 2012, there was a rise in the percentage of first-time patients due to stimulant use (slightly more than 27%) and the percentage reached the same level as recorded in 2010. The biggest fluctuations for a primary drug due to which drug users report to treatment for the first time were observed in the case of opioids. Following a dramatic (over twofold) increase in the percentage of opioid patients in 2011, there was a considerable decrease. Detailed information is presented in Figure below.

Figure 5.2.5. Admissions to drug treatment or rehabilitation due to using narcotic drugs or psychotropic substances in 2010-2013 – proportions of first-time patients by primary drug (%)



Source: TDI NFP data.

5.3. New developments

The observed evolution of drug addiction is related to changes in the way the problem is perceived, its social definition and the approach to drug prevention and treatment. The perception has shifted from viewing drug addiction through the paradigm of crime (evil, deviance) to the paradigm of disease (medical model).

The current challenges for drug prevention and treatment include cannabis or opioids-related problems. There are also challenges of new psychoactive substances and behavioural addictions. As regards the system of drug therapy training and certification as well as highlighting the new challenges in this respect it is necessary to include changes taking place in drug treatment in the programmes as well as to identify the need for both integrating training models of different fields i.e. drug/alcohol addiction and cooperation with psychotherapy training centres. New challenges for modern therapeutic communities include the specialization of therapeutic facilities, targeting specific groups of clients, incorporating pharmacotherapy in therapeutic interventions. There is also a need to further develop harm reduction programmes and review of post-rehabilitation and social reintegration goals.

In Poland, in recent years, there are constant changes taking place in drug treatment. At drug treatment units, evidence-based programmes are being implemented. However, it is important to chan-

nel the ongoing changes and develop a coherent systemic approach to substance abuse treatment. It is especially important to strengthen cooperation, share information and care for the quality of the drug treatment services. It is also necessary to optimize the available resources and to further the professional development of drug specialists. The above goals should be achieved through investing in the quality of the drug services, promoting the collaboration of the public sector with civic society as well as eliminating unethical and unprofessional activities. It is also recommended that innovative, evidence-based programmes and services be opened. Investment in knowledge and infrastructure should also be stimulated.

On 2 January 2014, the director of the National Bureau for Drug Prevention responded to the discussion taking place in Poland on the necessity to introduce changes to the existing drug care and rehabilitation model by appointing an advisory team on drug treatment, rehabilitation, harm reduction and social reintegration. The team members were asked to participate in the discussion and identify problematic areas in drug services as well as work out preliminary framework for research into the optimal structure and principles of the drug treatment, rehabilitation and harm reduction system.

5.4. Notes and queries

5.4.1. Is there any monitoring in place and data available on the misuse of opioid substitution medications?

Yes. In Poland, substitution medications are administered exclusively under the registered substitution treatment programmes. Other health care entities or e.g. primary care doctors are not competent to prescribe opioid substitution medications to addicted individuals. The most common substitution medications used in Poland include methadone and buprenorphine. The abuse of these drugs is monitored in the course of regular surveys among drug user population. Since 2008, every two years, a national interview survey has been conducted among low-threshold programmes clients. Respondents are asked about using respective substances in the last 30 days prior to measurement along with the use pattern. During questionnaire interviews, information is collected on the use of various types of opioids, including methadone. The methadone abuse data was also collected under the survey conducted at the turn of 2013 and 2014 among injecting drug users in Warsaw and the surrounding area.

5.4.2. Is Internet-based treatment available in your country?

No. In Poland, there are no online structured drug treatment programmes. The Internet is mostly used as an information channel concerning inpatient and outpatient drug treatment programmes. Websites provide drug users with information about available assistance services as well as the opportunity to have a preliminary assessment of his or her drug problem as is the case in CANDIS, a short-term individual therapeutic programme for problem cannabis users. Online drug counselling centre run by the National Bureau for Drug Prevention can be considered a form of Internet-based help programme for problem drug users and their relatives. However, the centre activity focuses on consultations and support in response to emails from enquirers. Within a few days an Internet user receives an answer from a specialist (drug therapy professional, psychologist, doctor, lawyer). Consultations are provided anonymously and free of charge. The centre's services do not constitute a structured therapeutic programme.

5.4.3. Has your country developed any specific treatment programmes for NPS users?

No. Treatment for NPS users is provided under the general and psychiatric health care system. In case of poisonings such individuals are sent to toxicological and detoxification wards and then they may

enter treatment in specialist substance abuse treatment units, which are located both at psychiatric and neurological wards as well as specialist drug rehabilitation facilities. There are no specific treatment programmes for NPS users operational in Poland. Assistance is provided under the existing services; however, they take into account patient's individual needs e.g. necessity to have physical rehabilitation in the event of a locomotor system impairment as a result of using ephedrone or mephedrone. Drug professionals include issues of new psychoactive substances in diagnostic, educational, preventive and therapeutic practices.

6. Health correlates and consequences

prepared by 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 is 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.

Another source of information are the results of the latest pilot study entitled "Estimation of HIV and HCV prevalence among injecting drug users in Warsaw and the surrounding area" conducted by AIDS Social Committee.

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 significantly biased due to the fact that data comes exclusively from residential facilities as diagnosing co-morbidity still remains difficult or is not systematically reported. The latest available data dates back to 2012.

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 2013[21], 17 662 HIV infections were diagnosed. Of these, 6028 (34%) were injecting drug users (IDUs), including 4521 men (75%) and 1451 women (24%) (in 56 cases the information on sex is missing). Analyzing the above monitoring period in terms of AIDS, 3082 cases were diagnosed. Of these, 1465 (47%) were IDUs, including 1 148 men (78%) and 317 (22%) women.

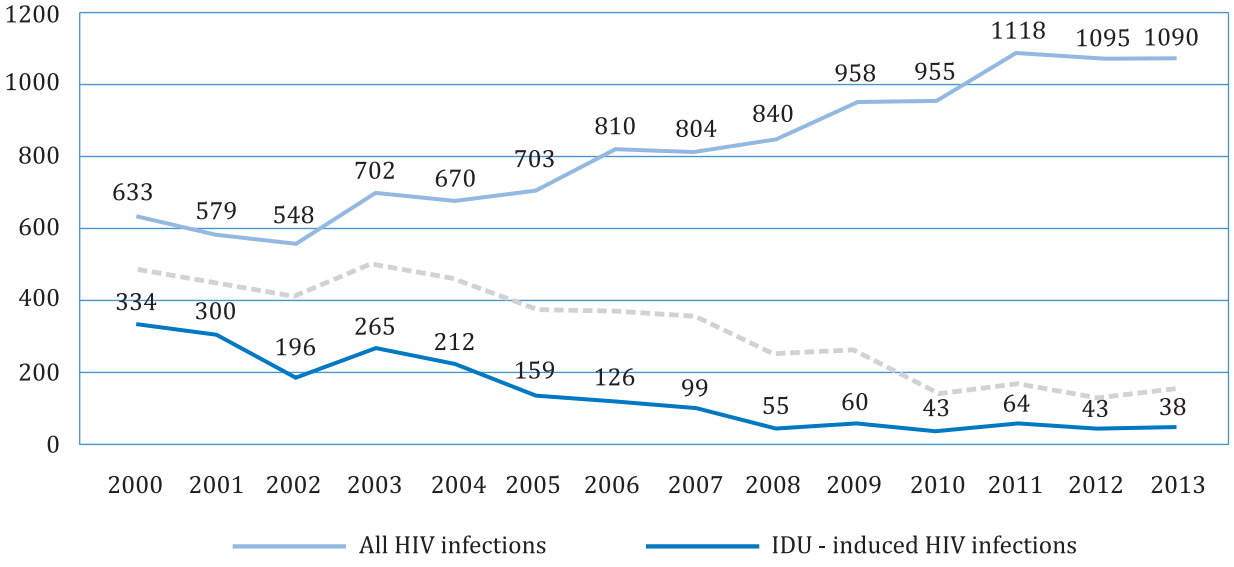
Analysis of HIV/AIDS data by year of detection

The analysis of IDU-related HIV infections for 2000-2013 indicates a downward trend, which levelled off in more recent years. In 2012 there were 43 IDU-related HIV infections detected in Poland and in

[21] Reported until 31 May 2014

2013 - 38. When interpreting this data one should consider a notification delay and the fact that there was reported a considerable number of infections with no likely route of HIV transmission (in 2013 it referred to 65% 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 May 2014 by year of detection with the 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. It means that the 2013 data may be still underestimated. Data for the years 2004-2011 show the overall rise in the new infections with signs of levelling off in 2012 – 2013. These cases include mostly sexually acquired HIV. It should be noted that the surveillance data does not distinguish sexually acquired HIV infections among IDUs from other sexually transmitted HIV infections.

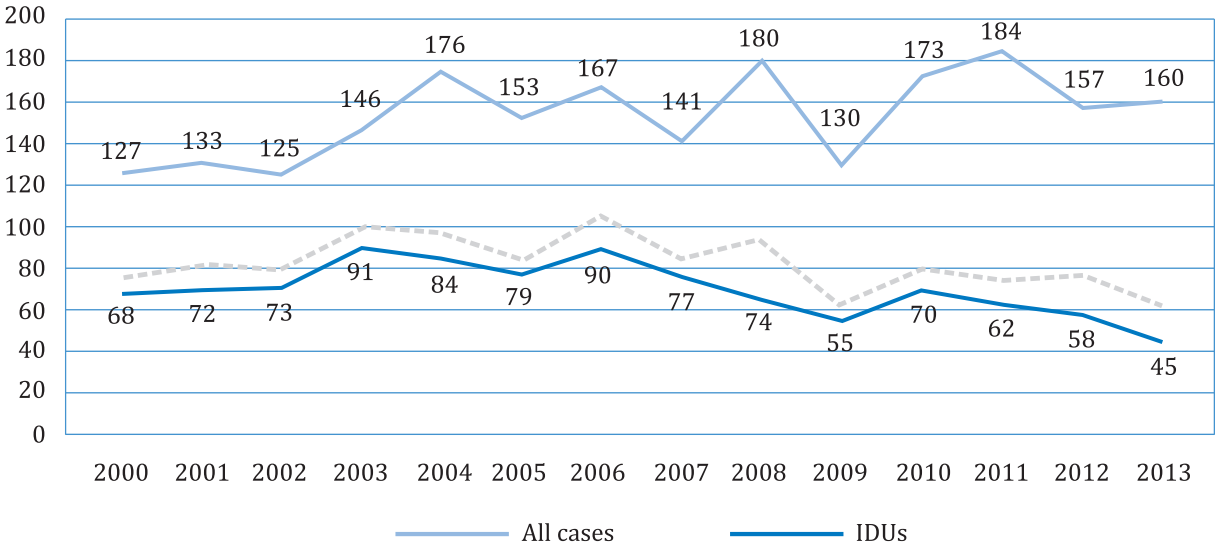
Figure 6.2.1. Number of new HIV infections, including injecting drug use (recorded number and corrected value imputing missing data on route of transmission) detected in 2000-2013



Source: National Institute of Public Health - National Institute of Hygiene (Epidemiology Department) by date of detection, registered by 31 May 2014.

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 in total, including 77 among IDUs. In 2008, 180 AIDS cases were recorded in total, including 74 among IDUs. The data for 2009 included the total of 130 cases, including 55 among IDUs and 173 and 70 respectively in 2010. In 2011 the total number of AIDS cases was 184, including 62 among IDUs, in 2012 this number decreased to 157 of total AIDS cases and 58 among IDUs. The data for 2013 includes the total of 160 cases with 45 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 28% between 2009 and 2013. 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 2013 incidence statistics will probably 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 2000-2013

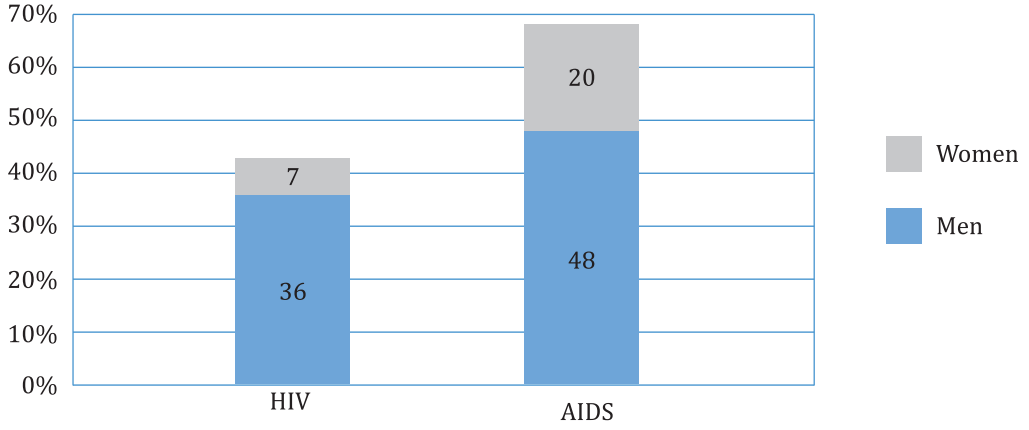


Source: National Institute of Public Health - National Institute of Hygiene (Epidemiology Department) by date of detection, registered by 31 May 2014.

Analysis of HIV/AIDS data by year of registration

The below analysis of HIV/AIDS incidence includes cases registered in 2013 (44 newly registered HIV cases and 68 newly registered AIDS cases among IDUs). Among HIV IDU patients registered in 2013 there were 36 men (82%) and 7 women (16%) (there is no information on sex for one HIV infection). Newly registered AIDS cases among IDUs in 2013 referred to 48 men (71%) and 20 women (29%).

Figure 6.2.3. HIV/AIDS cases among IDUs registered in 2013, by sex (numbers of people)[22]

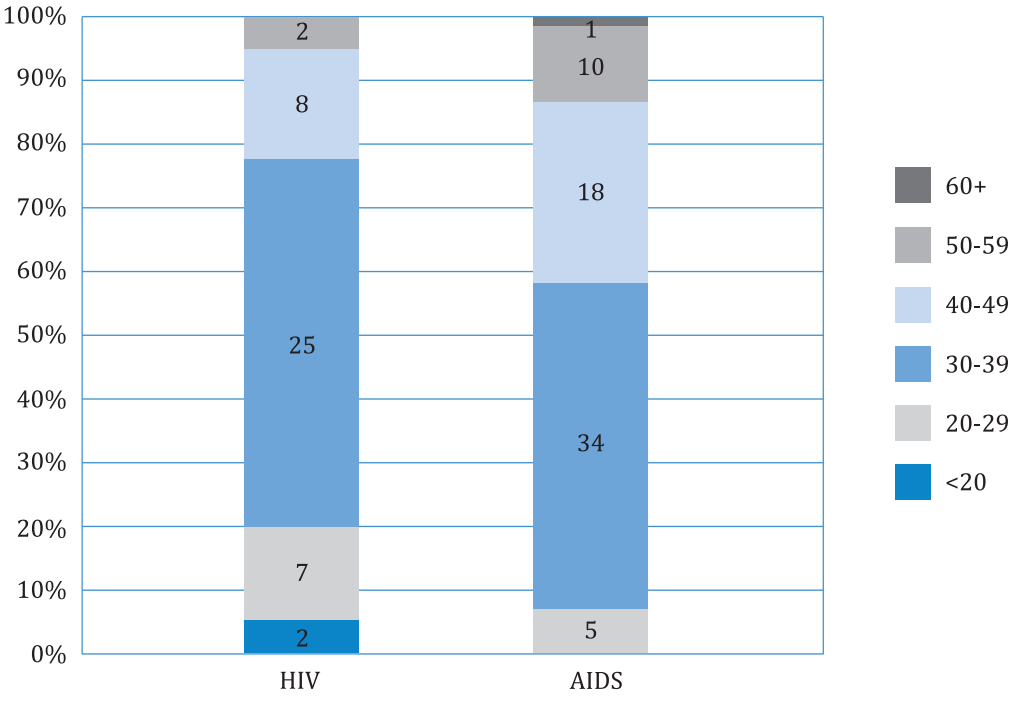


Source: National Institute of Public Health - National Institute of Hygiene (Epidemiology Department).

[22] For HIV infection in 1 case there is no information on sex

In 2013, among newly registered HIV infections related to IDU the largest group were users aged 30-39 (25 individuals, 57%), then 40-49 (8 individuals, 18%) and 20-29 (7 individuals, 16%). In 2013, of the newly reported AIDS cases among IDUs the largest group were users aged 30-39 (34 individuals, 50%) and 40-49 (18 individuals, 26%), then 50-59 (10 individuals, 15%).

Figure 6.2.4. HIV/AIDS cases among IDUs registered in 2013 by age group (numbers of people)



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

HIV detection rates for IDUs in 2008-2013 fluctuated between 0.10 and 0.17 per 100 000 population. The HIV detection varies across provinces. In 2013, the most cases were recorded in mazowieckie province (10) but the highest rate per 100 000 population was recorded in dolnośląskie province (0.31). In the provinces of kujawsko-pomorskie, lubuskie, małopolskie, opolskie and świętokrzyskie no new HIV case among IDUs was recorded in 2013. Over the period 2008-2013 no HIV infections among IDUs per year were registered in świętokrzyskie province (during 4 years), kujawsko-pomorskie (3 years), opolskie province (3 years), lubelskie (3 years), lubuskie (2 years), małopolskie (2 years) and podkarpackie (2 years).

Table 6.2.1. HIV detection rates for IDUs in 2008-2013 (per 100 000 population) (infections registered by place of residence)

Province	2008		2009		2010		2011		2012		2013	
	number	rate	number	rate	number	rate	number	rate	number	rate	number	rate
dolnośląskie	18	0.63	7	0.24	9	0.31	6	0.21	4	0.14	9	0.31
kujawsko-pomorskie	1	0.05	4	0.19	0	0.00	4	0.19	0	0.00	0	0.00
lubelskie	1	0.05	0	0.00	0	0.00	0	0.00	3	0.14	1	0.05
lubuskie	4	0.40	7	0.69	2	0.20	3	0.30	0	0.00	0	0.00
łódzkie	6	0.23	9	0.35	5	0.20	7	0.28	8	0.32	2	0.08
małopolskie	1	0.03	1	0.03	0	0.00	2	0.06	2	0.06	0	0.00
mazowieckie	3	0.06	3	0.06	4	0.08	10	0.19	6	0.11	10	0.19
opolskie	0	0.00	0	0.00	1	0.10	2	0.19	2	0.20	0	0.00
podkarpackie	0	0.00	3	0.14	0	0.00	3	0.14	1	0.05	3	0.14
podlaskie	0	0.00	4	0.34	5	0.42	5	0.42	1	0.08	1	0.08
pomorskie	1	0.05	2	0.09	2	0.09	2	0.09	2	0.09	2	0.09
śląskie	3	0.06	2	0.04	7	0.15	9	0.19	4	0.09	2	0.04
świętokrzyskie	1	0.08	1	0.08	0	0.00	0	0.00	0	0.00	0	0.00
warminsko-mazurskie	6	0.42	3	0.21	1	0.07	5	0.35	3	0.21	4	0.28
wielkopolskie	4	0.12	6	0.18	5	0.15	3	0.09	4	0.12	1	0.03
zachodnio-pomorskie	1	0.06	3	0.18	1	0.06	2	0.12	2	0.12	2	0.12
POLSKA	53	0.14	60	0.16	43	0.11	64	0.17	43	0.11	38	0.10

Source: National Institute of Public Health - National Institute of Hygiene (by date of detection).

AIDS incidence rates for IDUs in 2008-2013 fluctuated between 0.12 and 0.19 per 100 000 population. In 2013, the highest rates were recorded in the provinces of dolnośląskie (0.72), zachodnio-pomorskie (0.17) and łódzkie (0.16). In 2013 no new AIDS cases among IDUs were recorded in the provinces of kujawsko-pomorskie, lubelskie, lubuskie, podlaskie and świętokrzyskie. Over the period 2008-2013 no AIDS cases were registered in świętokrzyskie province (during 5 years), kujawsko-pomorskie province (4 years), lubelskie (2 years), lubuskie (2 years), podlaskie (2 years) and podkarpackie (1 year).

Table 6.2.2. AIDS incidence rates for IDUs in 2008-2013 (per 100 000 population) (infections registered by place of residence)

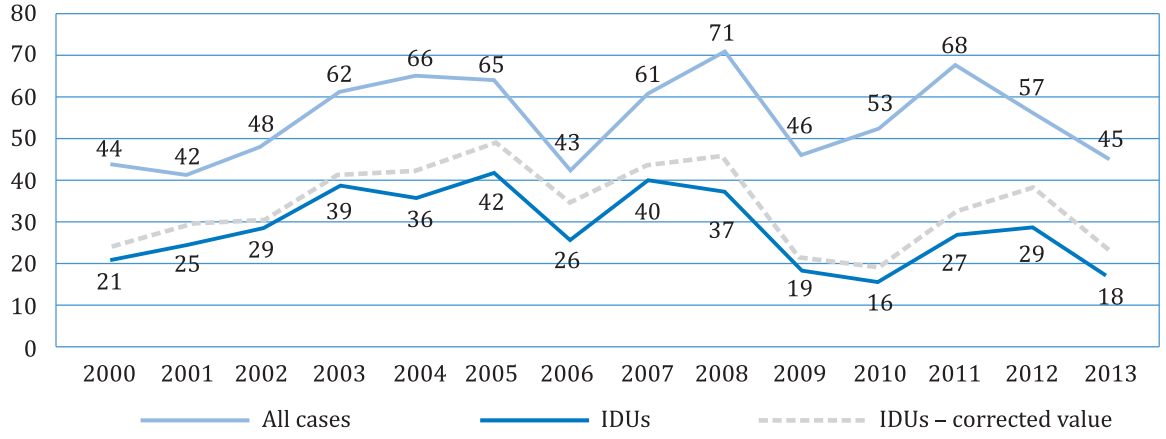
Province	2008		2009		2010		2011		2012		2013	
	number	rate	number	rate	number	rate	number	rate	number	rate	number	rate
dolnośląskie	24	0.83	18	0.63	21	0.73	17	0.59	16	0.55	21	0.72
kujawsko-pomorskie	3	0.15	0	0.00	0	0.00	1	0.05	0	0.00	0	0.00
lubelskie	5	0.23	0	0.00	2	0.09	1	0.05	1	0.05	0	0.00
lubuskie	2	0.20	4	0.40	8	0.79	8	0.79	0	0.00	0	0.00
łódzkie	5	0.20	7	0.27	11	0.43	9	0.36	10	0.39	4	0.16
małopolskie	4	0.12	2	0.06	2	0.06	3	0.09	2	0.06	1	0.03
mazowieckie	4	0.08	1	0.02	3	0.06	3	0.06	2	0.04	2	0.04
opolskie	1	0.10	2	0.19	3	0.29	1	0.10	3	0.30	1	0.10
podkarpackie	2	0.10	4	0.19	0	0.00	2	0.10	1	0.05	1	0.05
podlaskie	3	0.25	2	0.17	1	0.08	2	0.17	0	0.00	0	0.00
pomorskie	1	0.05	4	0.18	6	0.27	2	0.09	5	0.22	2	0.09
śląskie	7	0.15	1	0.02	5	0.11	4	0.09	10	0.22	5	0.11
świętokrzyskie	2	0.16	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
warminsko-mazurskie	7	0.49	5	0.35	2	0.14	3	0.21	3	0.21	4	0.28
wielkopolskie	2	0.06	3	0.09	4	0.12	3	0.09	1	0.03	1	0.03
zachodnio-pomorskie	2	0.12	2	0.12	2	0.12	3	0.18	4	0.23	3	0.17
POLSKA	74	0.19	55	0.14	70	0.18	62	0.16	58	0.15	45	0.12

Source: National Institute of Public Health - National Institute of Hygiene (by date of detection).

Other statistics

According to the statistics collected since 1986, 1 255 deaths of AIDS patients had been recorded by 31 May 2014, including 622 (around 50%) among IDUs.

Figure 6.2.5. Deaths of patients ever diagnosed with AIDS recorded in Poland by 31 May 2014, including IDUs, by date of death



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

In 2013, 61 AIDS-related deaths were recorded (45 occurred in 2013), including 27 deaths of IDUs (18 took place in 2013). The monitoring of AIDS-related mortality among IDUs reveals that deaths registered in 2013 related to18 men (67%) and 9 women (33%). In 2013 the highest mortality concerned the registered cases of IDUs in the age group 40-49 (12 deaths), 30-39 (7 deaths), then in the age group 50+ (5 deaths) but deaths were also noted in the age group 20-29 (3 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 2007-2013 but also a huge decrease in the number of tests reported was noted between 2009-2013 (Table 6.2.3). This may not necessarily reflect the trend testing patterns among drug users, but could result from organizational changes at the laboratories participating in the survey, which are not mandated to store risk group data. The data does have a number of limitations. It is unknown how far an IDU who comes for testing is representative of the whole IDU population. 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 ceasing to collect the risk information from the test seekers.

Table 6.2.3. HIV frequency in diagnostic testing among IDUs in 2007-2013

	2007	2008	2009	2010	2011	2012	2013
Number of HIV-positive IDUs	121	101	65	45	26	11	10
Number of all IDUs tested for HIV (valid tests)	1064	1084	1176	657	884	219	217
HIV frequency rate	0.1137	0.0932	0.0553	0.0685	0.0294	0.0502	0.0461

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

- **Data from the network of consultation and testing sites - PKD (based on the report „Analysis of survey questionnaires at consultation and testing sites in 2012" by TNS Polska by order of the National AIDS Centre and on data for 2013 by the National AIDS Centre)**

Since 1996, a network of consultation and testing sites (PKDs) has been operational in Poland. The sites provide anonymous and free HIV testing combined with preliminary consultation. The PKD network, coordinated and co-financed by the National AIDS Centre, is run by NGOs which closely collaborate with drug treatment units. Basic services offered by a site include:

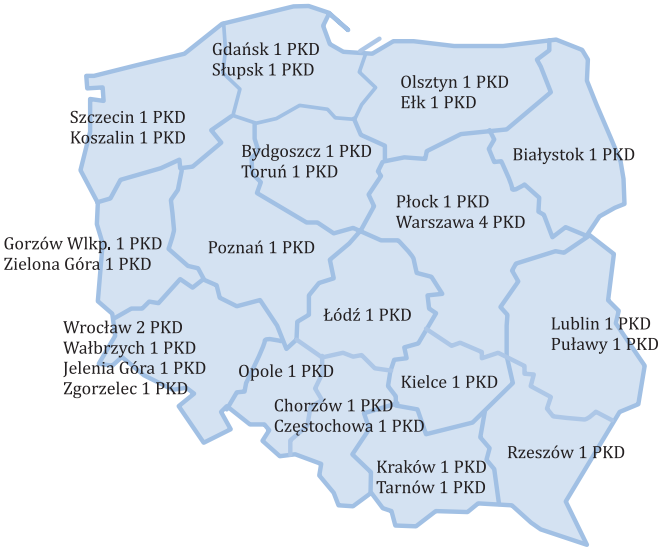
- providing anonymous and free HIV testing for individuals engaging in risky behaviours who wish to keep it private and not reveal personal data. It allows early detection of HIV infections, which prevents further transmission. It also allows for timely medical care and disease-specific therapy, which consequently constitutes preventive anti-epidemic measures,
- providing professional counselling, which is important from the educational and prevention perspective. The counselling is intended to make PKD clients aware of risky behaviours and the possibility of reducing or eliminating the risk of infection by changing one's behaviour. Such action might reduce the incidence of HIV infections in the general population,
- collecting epidemiological data on routes of HIV transmission in Poland based on the information provided by the PKD clients.

From the initiation of the PKD network till 31 December 2013 a total of 241 387 individuals were tested for HIV and in 2 779 cases positive results were recorded, which is 1.15% of the total.

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.

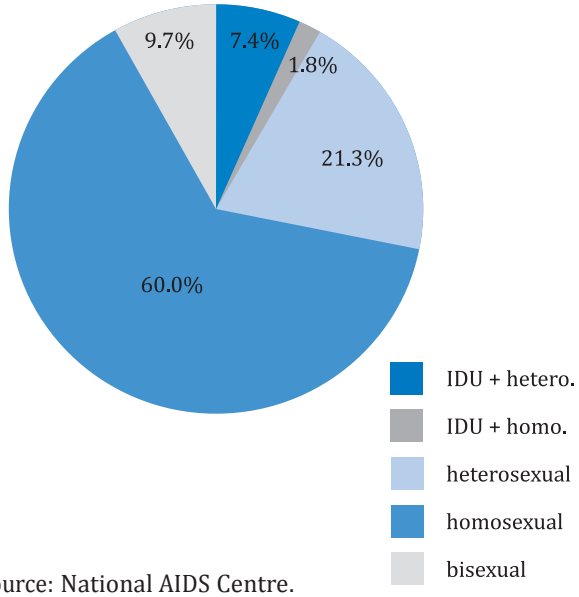
The main route of HIV transmission among PKD clients is sexual intercourse. In 2013, no single HIV infection related exclusively to injecting drug use was recorded. However, as regards the double risk of combining both injecting drug use and risky sexual behaviour the rate reached 9.2% in this group. For comparison, in 2012 the same rate stood at 10.9%.

Map 6.2.1. Consultation and Diagnostic Sites (PKD) in 2013



Source: National AIDS Centre.

Figure 6.2.6. HIV transmission routes among PKD clients – PKD data for 2013



Source: National AIDS Centre.

Injecting drug users (IDUs) as PKD clients

Detailed data for 2013 is being processed and will be made available in due course. However, an in-depth analysis of the 2012 data has been carried out. As a result, the qualities of injecting drug users were obtained that occur significantly more or less frequently compared with the random PKD population. See tables below for details.

Table 6.2.4. Profile of injecting drug users as PKD clients in 2012 (variables significantly more prevalent compared with random PKD population)

demographics	• men (74% IDU vs. 51% random population) • aged under 17 (2% IDU vs. 1% random population); 30-34 (27% IDU vs. 17% random population); 40-45 (7% IDU vs. 3% random population) • individuals with primary education (30% IDU vs. 5% random population); individuals with vocational education (23% IDU vs. 6% random population) • single individuals (67% IDU vs. 55% random population) • individuals who consider their financial status poor (30% IDU vs. 5% random population) and very poor (7% IDU vs. 0% random population)
sex life	• individuals who consider themselves heterosexual (90% IDU vs. 82% random population) • individuals who engage in sexual contact with the opposite sex (M+W) (91% IDU vs. 85% random population) • individuals with a stable partner of the opposite sex (92% IDU vs. 85% random population) • individuals with another (non-stable) partner of the opposite sex (91% IDU vs. 81% random population) • individuals who have ever had an HIV-positive partner (15% IDU vs. 3% random population) • individuals who have ever had an IDU partner (36% IDU vs. 3% random population) • individuals who have ever had a partner who has had multiple partners (44% IDU vs. 37% random population) • individuals who have ever had a sex-worker partner (19% IDU vs. 6% random population) • individuals who have had 11-20 partners (19% IDU vs. 11% random population); 21-50 partners (13% IDU vs. 6% random population); over 50 partners (3% IDU vs. 0% random population) • individuals who have had other (non-stable) partners in the last 12 months: 6-10 (7% IDU vs. 4% random population); 21-50 (2% IDU vs. 1% random population) • individuals who engage in active anal sex (28% IDU vs. 18% random population) • individuals who have sex under the influence of drugs (53% IDU vs. 4% random population) • individuals who have sex under the influence of alcohol (46% IDU vs. 20% random population)
other variables	• individuals who use other drugs (65% IDU vs. 15% random population) • individuals who share syringes (58% IDU vs. 1% random population) • individuals with a tattoo (49% IDU vs. 14% random population)

Source: "Review of questionnaires completed in consultation and testing sites in 2012" TNS Polska upon commission of National AIDS Centre.

Table 6.2.5. Profile of injecting drug users as PKD clients in 2012 (variables significantly less prevalent compared with random PKD population)

demographics	• women (26% IDU vs. 49% random population) • individuals aged 18-24 (17% IDU vs. 25% random population); 25-29 (21% IDU vs. 31% random population) • individuals with higher education (12% IDU vs. 53% random population) • married individuals (11% IDU vs. 21% random population) • individuals who consider their financial status very good (5% IDU vs. 12% random population) and good (28% IDU vs. 51% random population)
sex life	• individuals who consider themselves homosexual (5% IDU vs. 12% random population) • men who have sex with men (6% IDU vs. 16% random population) • individuals with a stable partner (66% IDU vs. 78% random population) • individuals with a stable partner of the same sex (8% IDU vs. 16% random population) • individuals with another (non-stable) partner of the same sex (11% IDU vs. 21% random population) • individuals with a single partner (2% IDU vs. 7% random population); 2-5 partners (23% IDU vs. 40% random population) • individuals who have had a single stable partner in the last 12 months (51% IDU vs. 60% random population) • individuals who engage in passive anal sex (11% IDU vs. 16% random population)

Source: "Review of questionnaires completed in consultation and testing sites in 2012" TNS Polska upon commission of National AIDS Centre.

Comparing the rates of positive HIV test results in the IDU population it emerges that there was a clear rise in HIV infections in 2011. However, next year this rate fell to 9.1%. For comparison, the percentage of positive results in the population of men who have sex with men, in whose case positive PKD HIV test results are most prevalent, stood at 4.7% in 2010, 5.4% in 2011 and 4.8% in 2012.

Figure 6.2.7. Percentage of positive results among IDUs in 2010 (n=333)

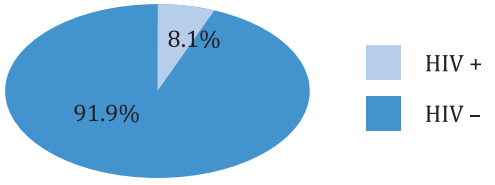


Figure 6.2.8. Percentage of positive results among IDUs in 2011 (n=224)

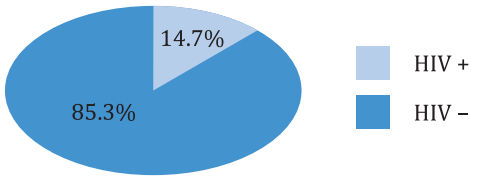
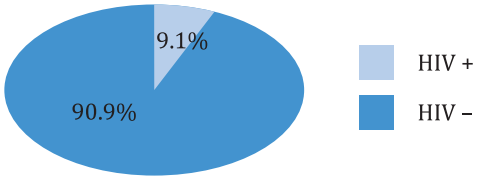


Figure 6.2.9. Percentage of positive results among IDUs in 2012 (n=186)



Source: National AIDS Centre.

Injecting drug users are hardly ever tested for HIV in the PKD network. A higher percentage of those who do is recorded in testing sites which are located by drug rehabilitation centres or methadone treatment units.

- **Results of pilot study entitled "Estimation of HIV and HCV prevalence among injecting drug users in Warsaw and the surrounding area" AIDS Social Committee**

The survey was conducted by the AIDS Social Committee from the funds granted by the National Bureau for Drug Prevention and the Global Drug Policy Programme in Open Society Foundations.

The project aimed at estimating prevalence of HIV and HCV among injecting drug users in Warsaw and the surrounding area, obtaining a profile of the target population, identifying risky behaviours related to the high risk of HIV and HCV transmission as well as defining risk factors for blood borne infections among injecting drug users. Moreover, the survey featured identification of information flow channels in the study population and the effectiveness analysis thereof. The survey was also intended to evaluate the effectiveness of respondent recruitment procedure in the context of wider research projects.

The project was implemented according to cross-sectional design based on anonymous questionnaires containing closed and open-ended questions as well as HIV and HCV lab tests. The survey was conducted between 6 December 2013 and 23 May 2014.

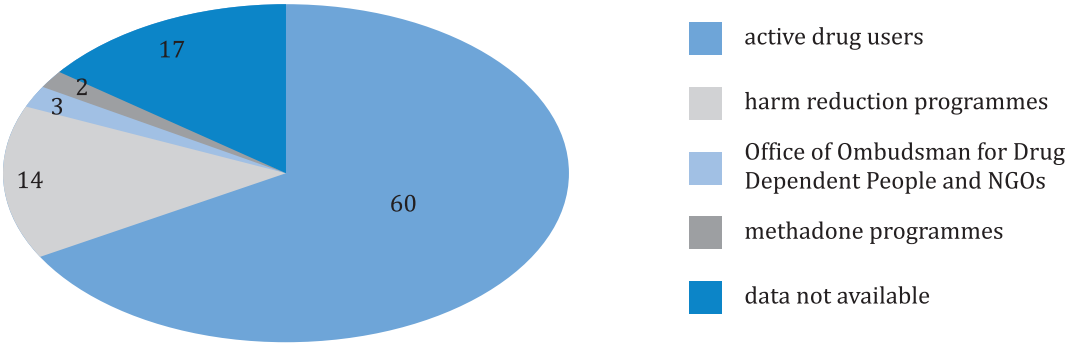
The respondents were recruited by trained volunteer leaders (active drug users and patients of methadone programmes) and through invitations distributed in drug treatment centres and organizations. It was also assumed that the accepted recruitment model does not guarantee sample representativeness. The survey included individuals who met the following criteria:

- at least once in a lifetime had injected drugs,
- resided permanently (in the last 3 months) in Warsaw and/or the surrounding area,
- were aged over 18.

96 participants took part in the survey. All the respondents filled in questionnaires and blood samples were collected from 95 of them. The analysis included only those respondents who participated in both stages of the study.

The majority of the study participants (60 individuals) were recruited by active drug users. The profile of the study population by manner of recruitment is presented in the chart below.

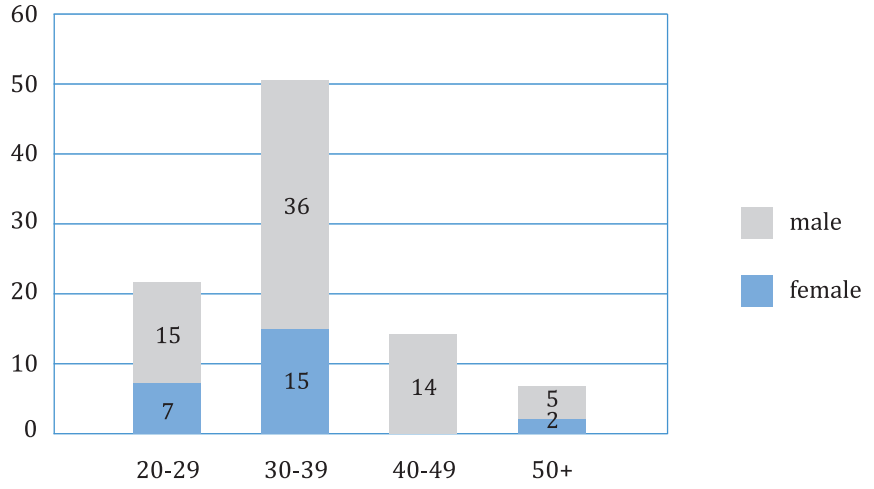
Figure 6.2.10. Numbers of study participants by manner of recruitment



Source: Report of the study "Estimation of HIV and HCV prevalence among injecting drug users in Warsaw and the surrounding area" (2014) AIDS Social Committee.

The majority of the study participants were male aged 30-39. The data regarding sex and age of the respondents are presented below.

Figure 6.2.11. Numbers of study participants by age and sex[23]



Source: Report of the study "Estimation of HIV and HCV prevalence among injecting drug users in Warsaw and the surrounding area" (2014) AIDS Social Committee.

The prevalence of HIV in the study population stood at 14.7% while the rate for HCV reached 71.6%. A total HIV and/or HCV prevalence rate in the study population was 73.7%. 85.7% of HIV-positive respondents were also HCV positive. The study report shows both the characteristics of total study population and additionally the profile of HIV and HCV positive drug users.

57.4% of the study participants had been patients of inpatient drug rehab clinics. 28.3% had stayed at such facilities in the last 12 months prior to study. 34.4% of the respondents had used in this period the services of specialist outpatient clinics. 57.1% of the HIV-positive respondents had used inpatient drug treatment services. However, none of the HIV-positive study participants had resided in an inpatient drug rehab clinic in the last 12 months prior to survey. HIV-positive individuals relatively infrequently had visited specialist outpatient drug facilities (7.1%). They were willing to use NGO services and drop-in centres though (71.4% and 58.3% respectively).

64.2% of the respondents had injected drugs in the last 30 days prior to study. 94.7% of all the respondents reported getting supplies of clean injecting equipment. 87.2% purchased the equipment at pharmacies while 30.9% obtained it at syringe and needle exchange centres. In the HIV-positive group, 35.7% had used the equipment bought at pharmacies and 64.3% received the supplies at drop-in centres. 89.6% of HCV-positive users received sterile injecting equipment from the pharmacies, 38.8% contacted drop-in points.

77.4% of the respondents reported sharing injecting equipment. 78.7% of the respondents indicated that in the last 12 months prior to study they had had unsafe sex. Risky sexual behaviour following alcohol consumption occurred in 36.3% of the respondents and the same type of behaviour but under the influence of drugs was found in 65.6% of the study participants.

Most respondents were informed on the risk of HIV and HCV (68.1% and 69.1% respectively). Among those who received the information on HIV and/or HCV transmission 73.8% were HIV and/or HCV positive.

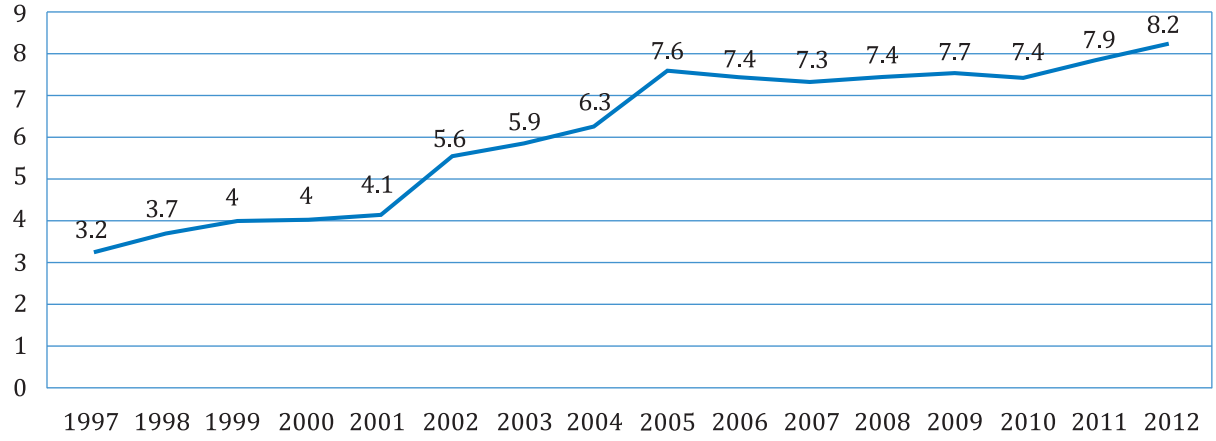
23 N=94 (2 individuals were not included due to lack of information on sex and the test results).

6.3. Other drug-related health correlates and consequences

- **Patients with dual diagnosis in residential drug treatment**

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 7.4-8.2% ever since.

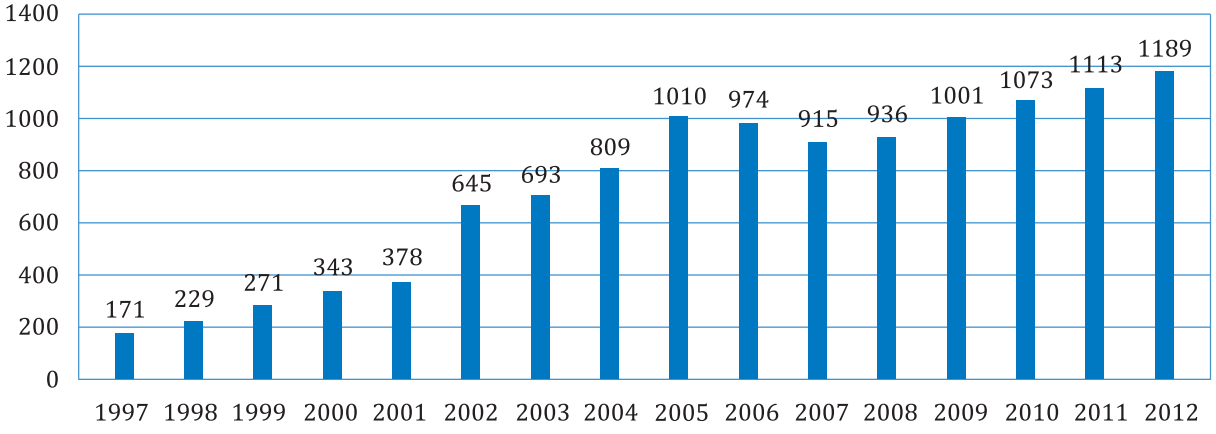
Figure 6.3.1. Patients with dual diagnosis among all admissions to residential psychiatric treatment in 1997-2012 (%)



Source: Institute of Psychiatry and Neurology (2014).

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, an upward trend was observed again, though less dynamic than previously. In 2012, the highest number of dual diagnosis admissions was recorded i.e. 1 189 patients.

Figure 6.3.2. Patients with dual diagnosis admitted to residential treatment in 1997-2012



Source: Institute of Psychiatry and Neurology (2014).

In 2012, the most numerous group at residential psychiatric clinics in Poland was made up by patients falling into the category "other mental disorders" (63%). This group comprises psychotic disorders, including hallucinations and delusions, schizophrenia and behavioural disorders. A considerable number of patients manifested personality disorder symptoms (22%). Moreover, the patients showed symptoms of anxiety disorders (8%), depression (6%) and other affective disorders (1%)

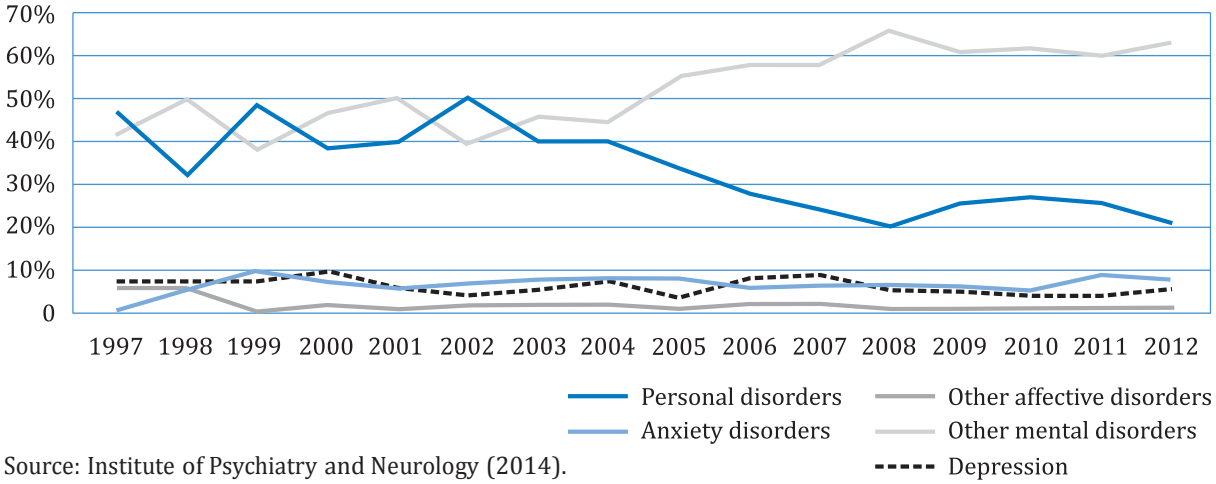
Table 6.3.1. Percentages of patients with drug problem admitted to residential psychiatric treatment in 2000-2012, by ICD-10 diagnosis

ICD-10 diagnosis	2000	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%	22%
Depression	9%	5%	4%	5%	7%	5%	8%	9%	6%	6%	5%	5%	6%
Other affective disorders	2%	1%	2%	2%	2%	1%	2%	2%	1%	1%	1%	1%	1%
Anxiety disorders	6%	5%	6%	7%	7%	7%	6%	7%	7%	7%	6%	9%	8%
Other mental disorders	46%	50%	38%	47%	45%	54%	58%	58%	66%	61%	62%	60%	63%

Source: Institute of Psychiatry and Neurology (2014).

Analyzing data on what mental disorders are manifested by patients admitted to residential drug 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 downward trend halted in 2008, the percentage of patients with personality disorders has been holding relatively steady. The 2012 data indicate slight changes i.e. a decrease in the percentage of personality disorder patients (by 3 percentage points compared with 2011) and an increase in other mental disorders (by 3 percentage points compared with 2011). Between 1999 and 2012 there was a stable trend of admissions related to anxiety disorders, depression and other affective disorders.

Figure 6.3.3. Percentages of drug problem patients admitted to residential psychiatric treatment in 1997-2012, by ICD-10 diagnosis



Source: Institute of Psychiatry and Neurology (2014).

The analysis of the 2012 data indicates that dual diagnosis was most often established among individuals addicted to inhalants (lack of dual diagnosis occurred in 75.8% of cases). The fewest cases of co-morbidity were recorded in opioid patients (98.3% of patients without dual diagnosis). The "other mental disorders" category, i.e. the diagnostic category which most often pertains to drug problem patients, in 2012 was mainly identified in users of inhalants (18.2%), cannabis (6.5%) and multiple psychoactive substances (5.8%). In 2012, personality disorders were most frequently observed among individuals dependent on inhalants (3.0%), cocaine (2.8%) and amphetamines (2.5%). Anxiety disorders were most often diagnosed in patients addicted to sedatives and hypnotics (2.8%).

Table 6.3.2. Percentages of patients with dual diagnosis admitted to residential psychiatric treatment in 2012, by type of drug addiction

Type of drug addiction	Lack of dual diagnosis	Personality disorders	Depression	Other affective disorders	Anxiety disorders	Other mental disorders
Opioids	98.3%	0.5%	0.3%	0.0%	0.1%	0.8%
Cannabis	91.7%	0.7%	0.7%	0.2%	0.2%	6.5%
Sedatives and hypnotics	91.5%	1.0%	0.8%	0.0%	2.8%	3.9%
Cocaine	94.3%	2.8%	0.0%	0.0%	0.0%	2.9%
Amphetamines	93.6%	2.5%	0.0%	0.0%	0.2%	3.7%
Hallucinogens	94.4%	0.0%	0.0%	0.0%	0.0%	5.6%
Inhalants	75.8%	3.0%	3.0%	0.0%	0.0%	18.2%
Polydrug use	91.3%	2.1%	0.5%	0.0%	0.3%	5.8%

Source: Institute of Psychiatry and Neurology (2014).

- **Drug-related deaths and poisonings**

Data on drug-related deaths in Poland is 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 specifies 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 failure to determine the 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 (DRD) 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 fluctuated between 214 (2007) and 290 (2005), approaching the values from the beginning of the 21st century only in 2005.

Analyzing the latest available data for 2012, we notice a decrease to 227 cases. In 2012, the average age of a drug-related death was 42. Of 227 deaths, most cases (67%) were male. Throughout all the years, most fatal drug overdoses were recorded in men.

Table 6.3.3. Number of drug-related deaths in 2001 – 2012

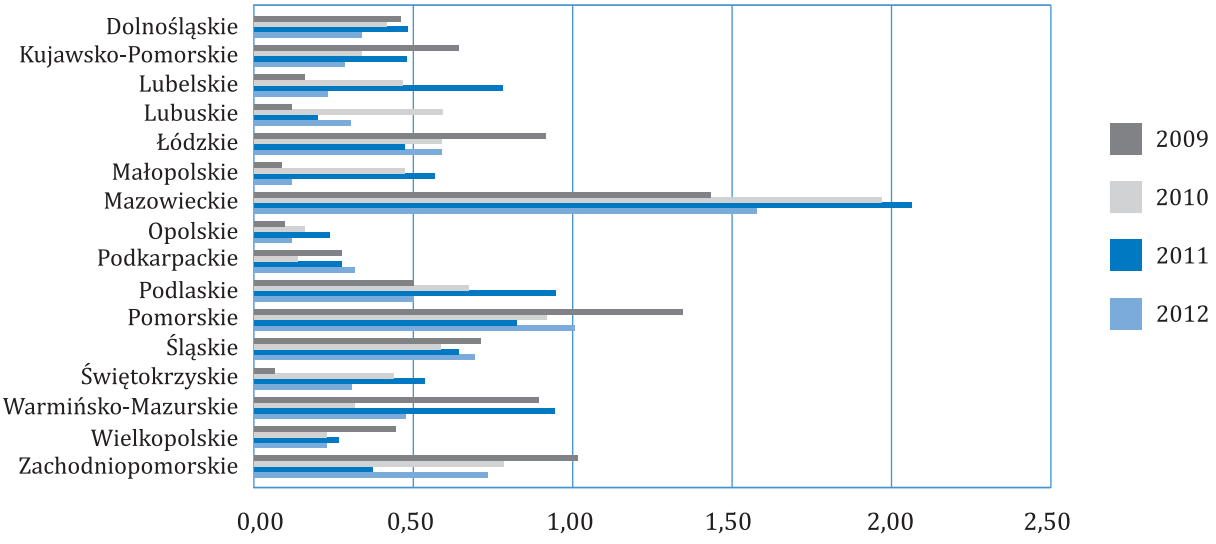
ICD-10 diagnosis	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Men	184	186	187	143	172	145	137	142	174	160	198	152
Women	110	138	90	88	118	96	77	102	73	101	87	75
Total	294	324	277	231	290	241	214	244	247	261	285	227

Source: GUS.

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 1.60 (2.08 per 100 thousand population in 2010) and pomorskie 1.00 (0.79 in 2011) while the lowest one in opolskie province 0.1 (0.2 in 2011) and małopolskie province 0.12 (0.2 in 2011).

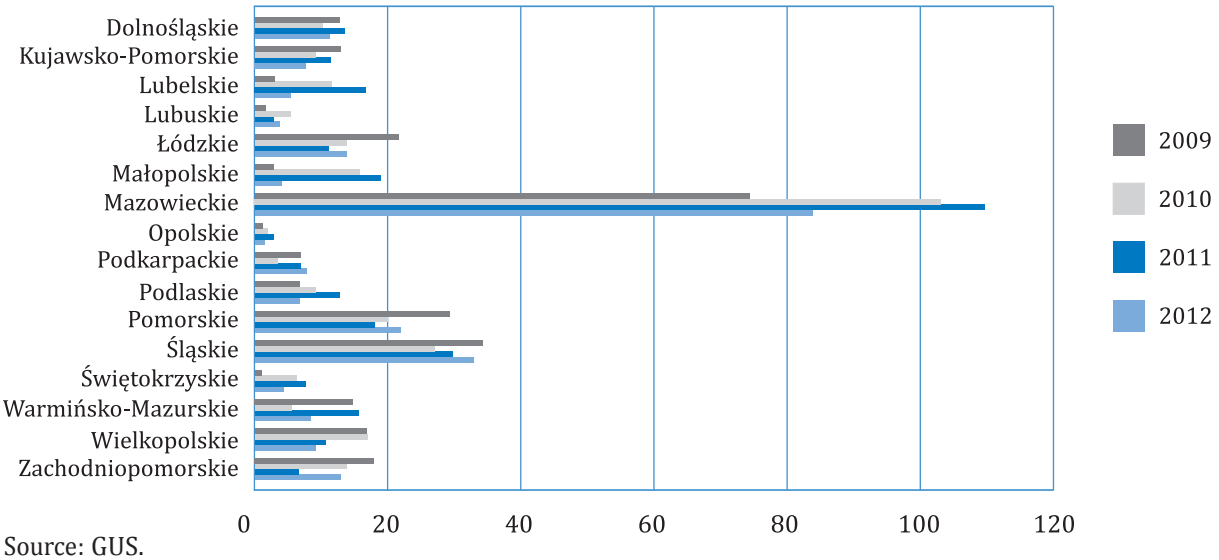
Figure 6.3.5. Drug-related mortality in 2009-2012 by province; national rate at 0.74 (2012)



Source: GUS.

In absolute terms the highest numbers were recorded in the provinces of mazowieckie (85), śląskie (31) and pomorskie (23). Deaths in mazowieckie province account for 37% of all fatal cases in Poland, with Warsaw topping the statistics.

Figure 6.3.6. Drug-related mortality in 2009-2012 by province



Source: GUS.

NPS poisonings and overdoses

In 2010, 562 NPS-related poisonings were recorded. The number of poisonings after the closure of legal highs stores in November fell dramatically to 118 in 2011 and 299 in 2012. We had observed an increase in highs-related poisonings in 2013 to 1079.

Last data from 2014 (till October) shows an increasing trend in poisoning as there were around 1600 cases notified. Moreover, three fatalities were recorded in 2013 and another three in 2014. Data are from National Consultant in Clinical Toxicology.

7. Responses to health correlates and consequences

prepared by Dawid Chojecki, Artur Malczewski

7.1. Introduction

Harm reduction programmes have been conducted in Poland since 1996. However, needle and syringe exchange programmes were launched as early as in 1989 as additional services at selected outpatient clinics and not as independent programmes. Since the beginning, harm reduction programmes have been 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.

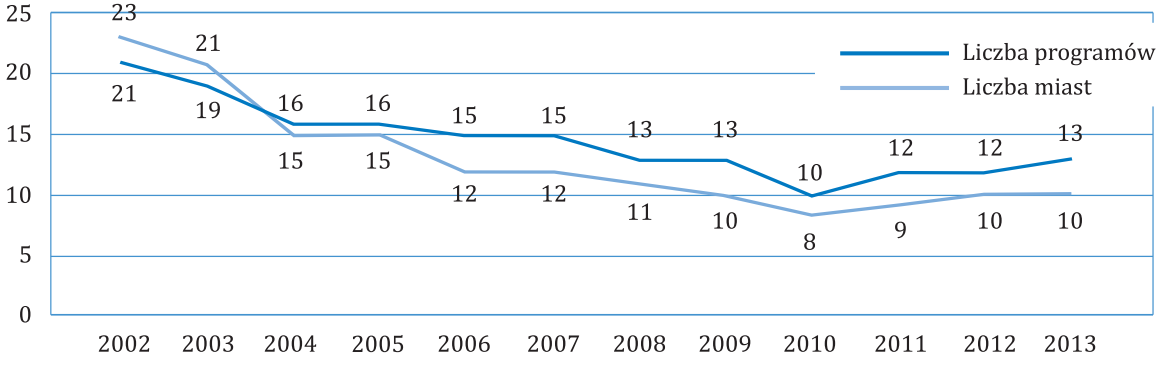
The following section discusses life-saving medications administered in drug overdoses, infectious diseases and dual diagnosis.

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 into the National Drugs Strategy 2011-2016 (KPPN).

7.2. Harm reduction in Poland

First needle and syringe programmes (NSP) were established in Poland towards the end of the 1980s. At the beginning of the 21st century, i.e. up to 2002, there were 21 needle and syringe programmes operational in 23 Polish cities. During that time, the widest availability of NSPs for injecting drug users was recorded. After 10 years, the number of NSPs almost halved to 13 programmes (2013) operating in Wroclaw, Czestochowa, Warsaw, Zielona Gora, Zgorzelec, Olsztyn, Pulawy, Krakow, Katowice and Gdansk. Apart from the injecting equipment, the programmes provide counselling, education and social support. The highest number of NSPs (7) is run by the Monar Society. The programmes are stationary but the equipment is also distributed to injecting drug users by outreach workers. Figure 7.1.1 shows a clear fall in the number of NSPs in Poland. A new programme that has opened in recent years is run by the Drug Therapy and Prevention Centre (PTZN) in Zielona Gora (Malczewski 2014g).

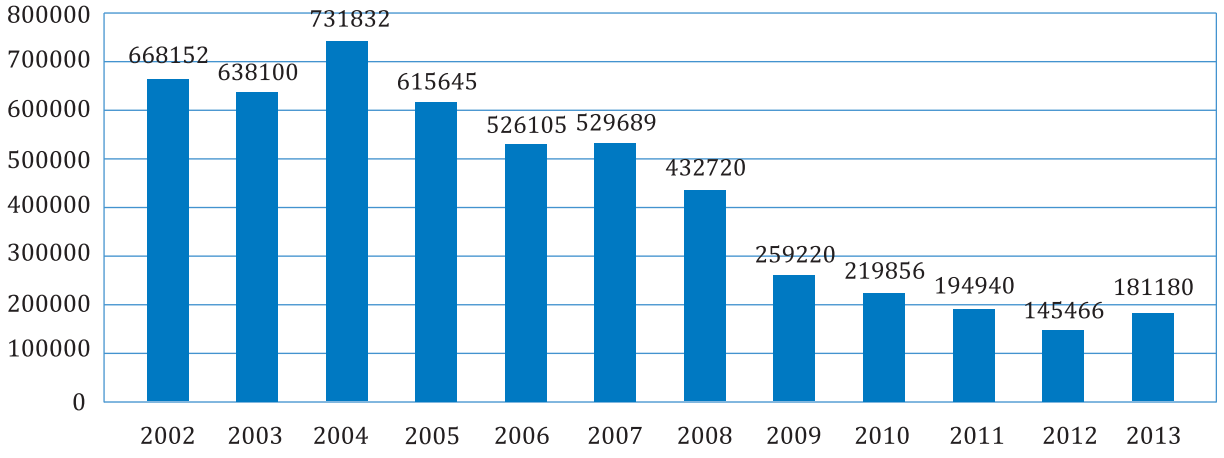
Figure 7.2.1. Needle and syringe programmes in Poland in 2002-2013 – in 2013: 13 programmes and 10 cities.



Source: Polish Focal Point.

Under the 13 programmes operational in 2013, 181 810 needles (145 466 in 2012) and 124 406 syringes (99 289 in 2012) were distributed (Figure 7.1.2.). 116 770 needles (87 435 in 2012) and 93 455 syringes (63 363 in 2012) were collected. Assistance was provided for 1 655 individuals (1 500 in 2012). The number of injecting drugs users is estimated at between 4 270 and 10 299, which means that 16-39% of injecting drug users receive harm reduction services. However, these are preliminary estimations and they should be handled with care. For comparison, in 2005 there were 5000 NSP beneficiaries, who received 615 thousand needles. In 2012, every injecting drug user received on average 95 needles while in 2005 it was 120. In 2013, the number of distributed needles rose to 110 per user. There are wide discrepancies in the number of NSP beneficiaries. Some programmes are used by very few users e.g. in Pulawy or Gdansk, where there are not more than 20 IDUs a year while there were 400 IDUs in one of the programmes in Warsaw. The latest data indicate a halt in the downward trend of NSP beneficiaries. Moreover, data from the biennial survey in injecting drug users shows a steady fall in the number of NSP beneficiaries. In 2008, questionnaire interviews were conducted with over 700 individuals, in 2010 with 400 and 2012 with 350. Analyzing changes in the services for injecting drug users, one must note a lower number and narrower coverage of operational NSPs. In the last 10 years, needle and syringe programmes have ceased to operate in such cities as Szczecin, Poznan, Jelenia Gora, Rzeszow and several cities in the region of Silesia. Cities with high number of NSP beneficiaries include Wroclaw, Warsaw and Krakow. Apart from typical activities (exchange of needles, counselling, etc.) the NSP also house drop-in centres as well as night shelters (two programmes) (Malczewski 2014a)

Figure 7.1.2. Number of needles in distribution in 2002-2013



Source: Polish Focal Point.

The monitoring results show that the number of activities in Poland for injecting drug users is falling. The situation in Poland was presented at an international Reitox Academy conference in Tallinn (21-22 November in 2013). The conference was the result of cooperation among the Baltic countries. The conference, which was organized by the European Centre for Disease Prevention and Control (ECDC) and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), was devoted to the HIV and HCV epidemiological situation among injecting drug users as well as to the activities aimed at preventing HIV, HBV and HCV infections. Poland was represented by the Polish Focal Point and the National AIDS Centre. Staff members of these two agencies presented harm reduction activities and epidemiological situation in Poland. They also suggested action that should be implemented

to improve the situation, such as identifying, describing and understanding reasons for downward trends in harm reduction services (needle and syringe programmes); developing ways of promoting harm reduction programmes; specifying sources of funding prevention (local and regional governments); increasing availability of diagnostic tests, designing best strategies for widening access to diagnostic tests among IDUs; strengthening/delegating more power to harm reduction programmes (communication platform – conferences, coordination implementation, partnerships); increasing supervision and monitoring of HIV and hepatitis as well as other infectious diseases among injecting drugs users; conducting behavioural studies. Conclusions from the Tallinn conference were discussed at the December conference of harm reduction programmes in Warsaw in 2013 (12-13 December). At present, a discussion is underway in Poland on the new formula of harm reduction programmes, which are changing their profiles by adapting their services to be suitable for clients who do not inject drugs as often as they used to and who need not only sterile injecting equipment but also social care, legal advice or support in official paperwork. One of the challenges is adapting to the needs of the new drug market, which is offering new psychoactive substances online. One of the goals of the December conference of harm reduction programmes was the attempt to assess the situation of harm reduction programmes. In mid-December, the 9th annual conference of harm reduction programmes was held in Warsaw by the Polish Focal Point in the course of cooperation of representatives of harm reduction programmes addressed to injecting drug users as well as individuals using drugs in dance clubs or discotheques. The meeting was intended to exchange experiences among harm reduction programmes, analyze the drug scene, present the latest study results and plan further actions. The conference was attended by 30 participants from across the country, including staff members of the National AIDS Centre, the Institute of Psychiatry and Neurology, National Medicines Institute and National Institute of Public Health. During the conference possible actions to support harm reduction programmes in Poland were discussed. One of the major factors for lowering coverage and scale of harm reduction programmes is limited funding on the part of local and regional governments. While implementing the National Drugs Strategy (KPPN), local and regional authorities are involved in countering drug addiction, mainly drug prevention. According to the KPPN monitoring data, little funding is allocated to harm and risk reduction programmes under communal and municipal drugs strategies. The Polish Focal Point took measures to promote harm reduction programmes. For example, during the October conference in 2014 in Warsaw, which was organized for local and regional governments, one of the sessions was devoted to harm reduction programmes. It was attended by a representative of the EMCDDA and the Estonian Focal Point. At the conference in mid-December 2013 for harm reduction programmes, discussions took place on the drug scene developments to which personnel of harm reduction programmes responded by modifying their range of services. The disappearance of open drug scenes (the so-called 'bajzle'), where drug users met as well as selling drugs on the phone caused that outreach workers find it increasingly difficult to reach drug users. At present, drug users meet in the vicinity of substitution treatment centres and this is the area which outreach workers explore by providing support, advice or sterile injecting equipment. Moreover, with the increased availability of substitution treatment programmes, there is higher demand for methadone, which is also injected. Injecting drug users are using new psychoactive substances, mainly mephedrone or other cathinones but also methcathinone extracted from pseudoephedrine-based medications e.g. Acatar. In the case of the latter substance, serious consequences might follow because potassium permanganate is applied in the methcathinone extraction process. As a result, serious poisonings occur, the so-called Parkinsonism. The next conference of harm reduction programmes scheduled in December 2014 will be attended by representatives of substitution treatment programmes in order to jointly discuss challenges for harm reduction programmes (Malczewski 2014a).

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

Due to the increased prevalence 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 not available on prescription and it is not distributed through pharmacies. It is distributed exclusively to inpatient health care units (hospitals) as well as sobriety chambers and emergency services (in ambulance equipment).

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).

7.4. 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 2013, the National Health Fund financed activities aimed at improving the availability of drug-related infectious disease prevention programmes. The activities included financing HBV vaccinations and HCV and HIV tests done at specialist sites. Moreover, in 2013 there were 32 testing sites, which provided anonymous and free HIV tests. The survey conducted every two years among clients of syringe and needle exchange programmes showed that in 2012 (latest available data), 68% of the clients were tested for HCV. 79% of the tests proved positive.

In the reporting year, 8 Marshal Offices co-financed 12 HIV prevention programmes, including diagnostic and consultation centres, where HIV tests could be done anonymously and free of charge.

The programmes provided services for at least 5 516 individuals (not all Marshal Offices provide data on the number of programmes and beneficiaries).

Infectious diseases treatment

The National AIDS Centre reported that all HIV-positive and AIDS patients, who met medical criteria and were eligible for health care programme under the current law, were covered with the ARV treatment. The ARV programmes also covered HIV-positive pregnant women and their newborn children, according to the existing standards.

As at 31 December 2013, the ARV treatment was provided for 7 110 HIV/AIDS patients, which is 13% more compared to the previous year. In 1 827 cases (nearly 26%), the likely route of HIV transmission was injecting drug use or drug use and unprotected sex.

It is worth noting that over the years, the share of such patients in the whole ARV population is falling. It is the consequence of the falling number of HIV-positive drug users, which in turn is the consequence of the change of drug use patterns into non-injecting use and the increasingly less frequent practice of sharing the injecting equipment. The ARV treatment was provided at 21 hospitals which operate as referral treatment centres for HIV/AIDS patients.

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

7.5. Responses to other health correlates among drug users

Harm reduction programmes for drug users

For many years, the National Bureau for Drug Prevention (KBPN), under open drug prevention competitions, has been co-financing harm reduction programmes for drug- dependent individuals. In 2013, the National Bureau co-financed 14 such projects, which were run by 8 NGOs. The programmes were conducted in major Polish cities including Warszawa, Częstochowa, Jelenia Góra, Kraków, Olsztyn, Puławy, Wrocław, Zgorzelec, Zielona Góra and Chorzów. The projects were implemented in a variety of locations: streets, railway stations, drug user meeting spots, 6 drop-in centres, 2 night shelters for problem drug users, 3 correctional facilities/remand centres and 1 infectious diseases hospital.

The projects were aimed at achieving the following goals:

- preventing health and social harm reduction related to drug addiction (e.g. preventing fatal drug overdoses);
- motivating drug users to change their drug use pattern to a less harmful one (HIV, HCV, HBV prevention);
- providing information on the availability of specialist care and promoting such forms of assistance among drug users;
- interventions.

The above programmes provided services for the total of 3 382 clients. Approx. 136 000 needles and 98 203 syringes were distributed

In order to illustrate the Polish needle and syringe exchange programmes, the tables below show profiles of programme clients, most prevalent psychoactive substances and figures concerning the exchanged equipment. The most prevalent drug used by the clients of such programmes is heroin. More than a third of users are dependent on more than one psychoactive substance.

Table 7.5.1. Client profile of KBPN-financed health and social harm reduction programmes for drug dependent users in 2013

Type of clients	Total of clients
School students	110
University students	37
Employed individuals	200
Individuals with social problems	1 825
Individuals with legal problems	1 380
Individuals with health problems	1 573
Parents, families	26

Source: National Bureau for Drug Prevention, 2014.

Table 7.5.2. Substances used by clients of KBPN-financed health and social harm reduction programmes for drug-dependent individuals in 2013

Primary drugs	Total of clients
Alcohol	289
Amphetamine	702
Crack	0
Ecstasy	1
Hallucinogenic mushrooms	0
White heroin	0
Brown heroin	746
Polish homemade heroin	314
Cocaine	7
Hypnotics/ Sedatives	32
LSD	4
Mixed	1538
Cannabis	266
Inhalants	3
Other	689

Source: National Bureau for Drug Prevention, 2014.

In 2013, 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. The magazine publishes a lot of information in the field of safe injecting methods, conduct in emergencies (e.g. first aid towards an individual who has just overdosed drugs), especially dangerous substances and related health complications, substitution treatment as well as legal aspects and drugs policy.

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

According to the National Drugs Strategy, such programmes should involve local and regional governments. However, in 2013 only the Marshal Office of lubuskie province supported operations of low-threshold programmes offering services for drug-dependent individuals (excluding needle and syringe exchange programmes). Under the Marshal Office- sponsored programme, homeless individuals dependent on alcohol, drugs and psychotropic drugs participated in a support group and educational classes; they also received individual legal, social, psychological as well as material assistance.

Local governments are also responsible for sponsoring drug-related harm reduction programmes. In 2013, 34 communal governments financed harm reduction programmes (1.5% of the overall number of 2 233 communes which submitted National Drugs Strategy implementation reports). A more detailed analysis of the programmes sponsored by communal governments shows that 34 communes financed harm reduction programmes related to drugs, 5 communes allocated funds to drop-in centres and street-based needle and syringe exchange programmes (7 programmes with a total of 3 165 beneficiaries), 27 communes supported HIV/HBV/HCV prevention programmes for drug-dependent individuals (34 programmes with a total of 24 135 beneficiaries), 16 communes co-financed low-threshold programmes such as night shelters (23 night shelters with a total of 609 beneficiaries), shelters and day-care centres (7 sites with a total of 505 beneficiaries).

The analysis of harm reduction activities 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.

Activities related to coexistence of mental diseases

In 2011 (latest data), there were 3 wards operational in psychiatric hospitals (46 beds) and 2 wards operational in drug rehabilitation clinics (35 beds). In addition, there was 1 ward in a general hospital (26 beds). 669 hospitalizations were conducted therein. (Boguszewska, Institute of Psychiatry and Neurology, personal communication). The above wards admit patients with dual diagnosis.

In the event of a drug treatment unit not being ready to treat patients with dual diagnosis, they 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 minimum. 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

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.

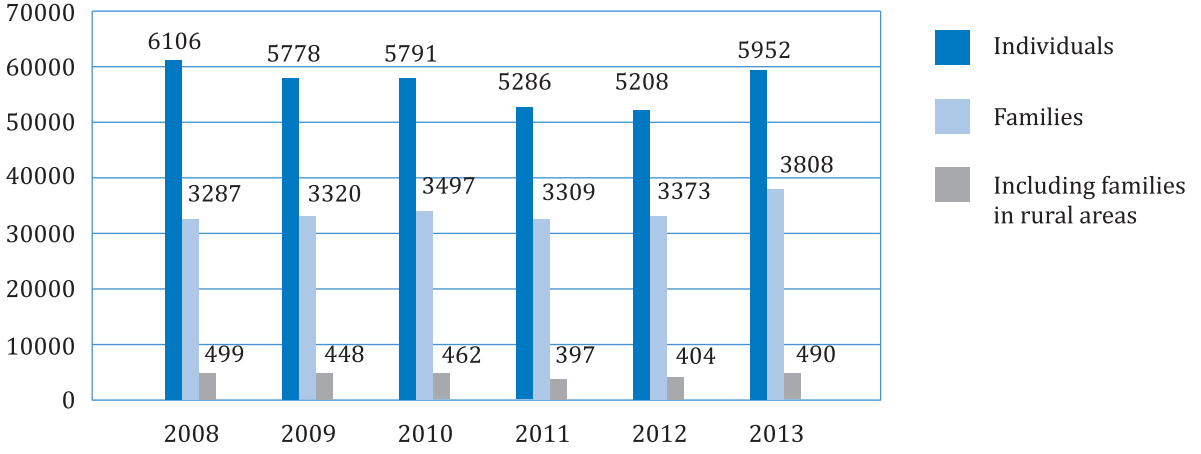
It is confirmed by numerous statistics and studies. The results of the research project by the Institute of Psychiatry and Neurology entitled "Social costs incurred by drug users. Survey of six European cities" clearly shows that opioids are the most powerful in generating social exclusion. Insufficient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

8.2. Social exclusion among drug users

Social exclusion among drug users

In 2013, social care centres across Poland provided drug-related care for 3 808 families (3 373 the year before); including 490 residing in rural areas (404 in the previous year). The assistance was provided for 5 952 clients, including co-dependent individuals (5 208 in 2012). Similarly to previous years, the highest proportion of beneficiaries came from mazowieckie province – 1 060 individuals (657 families) and the lowest from świętokrzyskie province (118, 73 families), podkarpackie province (131, 84 families), podlaskie province (121, 88 families) and opolskie province (129, 82 families) (Ministry of Labour – Department of Social Care and Integration, 2014).

Figure 8.2.1. Individuals and families provided with social care due to drug addiction in 2008-2013

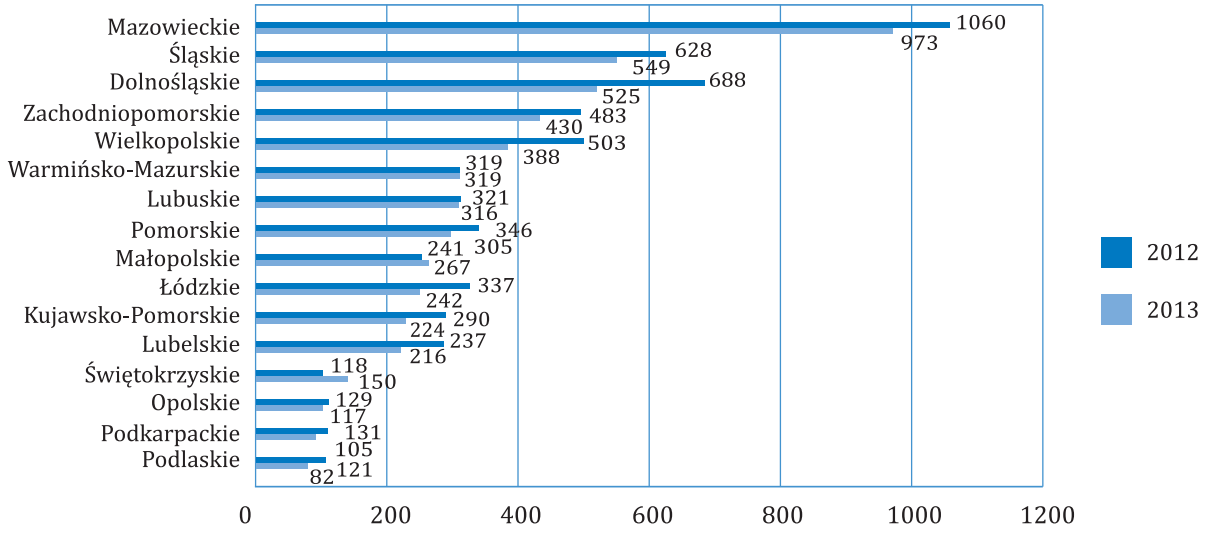


Source: Ministry of Labour and Social Care.

The numbers of drug-related social care beneficiaries vary across provinces. The highest numbers were recorded in the provinces of mazowieckie, śląskie and dolnośląskie (over 500 individuals) and

the lowest ones in the provinces of podlaskie, podkarpackie and opolskie (150 individuals or fewer). Dolnośląskie province saw a considerable fall in the number of drug-related social care beneficiaries.

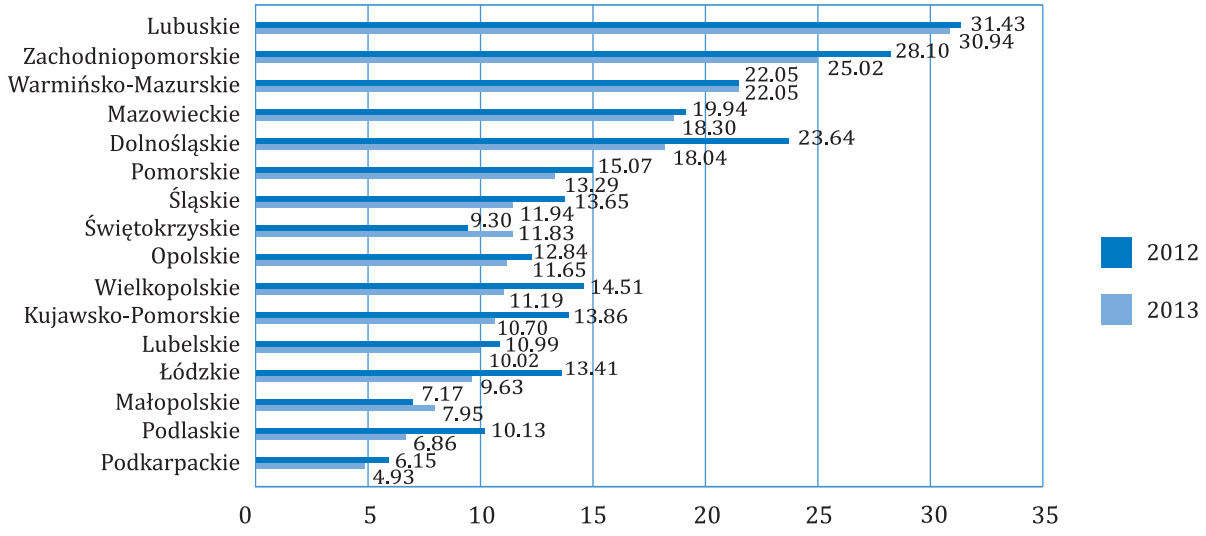
Figure 8.2.2. Drug-related social care beneficiaries in families (absolute number), Poland's total: 5208 (2013)



Source: Ministry of Labour and Social Care.

For comparison reasons, numbers in respective provinces have been converted into rates per 100 000 population. For the whole Poland, the rate stood at 13. In five provinces, the rate was higher. The top provinces included lubuskie, zachodniopomorskie and warmińsko- mazurskie. The lowest rates were recorded in the provinces of podkarpackie, podlaskie and malopolskie.

Figure 8.2.3. Drug-related social care beneficiaries in families (rates per 100 000 population), Poland's average: 13.53 (2013)



Source: Ministry of Labour and Social Care.

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, social care and harm reduction programmes for prostitutes are being developed in Poland.

In 2013, the National Bureau for Drug Prevention co-financed 4 harm/risk reductionprogrammes for prostitute drug users. One of the programmes was conducted by the Kraków-based Centre for Prevention and Social Education "Parasol". A total of 64 sex workers (including 5 aged under 19) received assistance. The programme settings included streets, night clubs and escort agencies, which was possible 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 care centres where material assistance was provided, employment agencies, and drug treatment units (Centre for Prevention and Social Education "Parasol", 2014). In Szczecin, a similar programme was run. In the course of the programme entitled "Harm reduction among female prostitutes and men who have sex with men", conducted by the DA-DU Charity, 169 individuals received assistance. The outreach was primarily provided in the work environment of the programme participants. 47 escort agencies were reached (DA-DU Charity, 2014).

A programme by the Slysze Serce International Association commissioned by the National Bureau for Drug Prevention was a standard programme targeting drug using sexual minorities. The programme was conducted in the community of drug-using sex workers remaining outside health care system. The programme featured distribution of materials on the risk of HIV, STDs and substance use as well as outreach forms and sites. Leaflets and condoms were also handed out. The programme included 55 participants (Słyszę Serce International Association, 2014). Also in the course of another programme entitled "Social work activities in music clubs and during selected music events in Wrocław and Poland" and run by the Dolnośląskie Prevention Society "Return" there were performed some activities aimed at homosexuals (Dolnośląskie Prevention Society "Return", 2014).

Homelessness

The number of registered homeless individuals is closely linked to the number of residents in a given province. The higher the population of a province, the higher the homeless population. Most homeless people are located in the largest urban areas and richest provinces (e.g. mazowieckie, śląskie, wielkopolskie). The total homeless population in Poland in 2013 stood at 32 000 (Ministry of Labour and Social Care, 2013).

However, we do not have data on the number of homeless drug users. It is widely known that a lot of addicts, particularly opioid users, are homeless. Such conclusions might be drawn upon the data analysis 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 2013, the National Bureau sponsored a night shelter programmes operated by the Monar Society in Warsaw. 101 clients benefited from the programme. 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 2013, the National Bureau also co-financed reintegration programmes in hostels and re- entry flats. In 2013, the co-financing included projects run by NGOS in 10 hostels and 19 re- entry flats. 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 2013, provincial governments also financed social exclusion prevention programmes for drug-dependent individuals. 10 hostels and re-entry flats for these individuals were operated in four provinces: kujawsko-pomorskie, mazowieckie, pomorskie and śląskie. In 2013, 24 communes (of 2 233 which submitted National Drugs Strategy reports) co-financed such facilities (total of 39 hostels and re-entry flats).

8.3. Social reintegration

Post-rehabilitation programmes for drug rehabilitation graduates and substitution treatment patients are conducted in hostels, re-entry flats, and inpatient and outpatient clinics. They are intended 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 a 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 search assistance, 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 2013, the National Bureau for Drug Prevention co-financed relapse prevention programmes operated at inpatient and outpatient clinics. These programmes offered counselling to drug rehabilitation graduates who return home or try to become self-reliant in another city as well as their families. The programmes were run in outpatient clinics, hostels and re-entry flats. In 2013, the National Bureau co-financed 39 abstinence-supporting programmes conducted by NGOs. The programmes included 2 167 participants. Among National Bureau-sponsored post-rehabilitation programmes 1 127 clients (52%) were in employment, 317 were at school (that is 15% but including children of hostel and re-entry flat residents). The above programme also involved family members of abstinent drug abusers (428). 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 2013 (age)

Age groups	Total
Under 12	9
12–15	9
16-19	155
20-24	542
25–34	816
over 34	636
Total number of participants	2 167
New participants	9

Source: National Bureau for Drug Prevention, 2014.

Table 8.3.2. Client structure of KBPN – financed abstinence-based post-rehabilitation programmes in 2013 (characteristics)

Target groups	Total
Pupils	227
Students	90
Clients in employment	1 127
Clients with social problems	837
Clients with legal problems	600
Clients with health problems	481
Parents, families	428

Source: National Bureau for Drug Prevention, 2014.

The Act of 13 June 2003 on social employment (Journal of Laws 'Dz. U.' of 2013 No. 122, item 1143) obliges local authorities and social care centres to provide social reintegration programmes for drug users under social policy and integration strategies. Unfortunately, post-rehabilitation services for graduates of full-time drug treatment programmes are insufficient. There are still not enough re-entry flats and hostels. In 2013, 11 provincial governments co-financed social exclusion prevention programmes for drug users and drug addicts. Provincial governments co-finance the so-called

Social Integration Centres. The aim of the centres is to provide assistance in mastering skills needed to assume social roles, obtain 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 substance users upon completion of drug rehabilitation. Such centres were co-financed by 7 provincial governments.

In 2013, 201 communes (9%) co-funded the implementation of social reintegration programmes for harmful users and drug-dependent individuals, which constitutes an increase of 91 communes compared to 2012 (110). Among these communes, there were 88 urban communes, 47 rural communes and 66 urban-rural communes. Social exclusion reduction programmes are infrequently sponsored by communal authorities. The Social Integration Centres were co-financed by 58 communes

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 (operated by city councils) based on approval of a social care 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, treatment graduates take vocational courses. In the reporting year, the National Bureau for Drug Prevention financed 670 hours of vocational training for 122 participants of post- rehabilitation and social reintegration programmes.

Communal authorities are also responsible for supporting vocational trainings. However, out of 2 233 communes which filed annual National Drugs Strategy reports, only 18 communes sponsored vocational trainings for harmful drug users and drug-dependent individuals.

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, 317were pupils or university students. They accounted for 15% 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-introducing 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 them to work at the Centre. A job referral 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 from the Labour Fund.

Another form of employment is establishing (e.g. under the Vocational Stimulation Programme) the so-called social companies. Non-governmental organizations which assist in setting up such companies recruit prospective employees at mental health counselling centres, social care 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 would have any bearing on a recruitment process for a post offered by a social company, however, a mental illness or disorder which co-exists in drug addiction is. Establishing social companies can be performed under priority VII of the Operational Programme Human Capital 2007-2013: Promotion of Social Integration.

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

prepared by Artur Malczewski, Dawid Chojecki

9.1. Introduction

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 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.

This chapter discusses drug-related crime against the Act on counteracting drug addiction as reported by the Police. Police data on drug-related crime is registered in the TEMIDA (till 2012) police and prosecution database, which contains violations of the Act on counteracting drug addiction. Basic statistical units used by the Police include suspects, instituted proceedings as well as recorded crimes. The analysis includes suspects under the Drugs Act and instituted proceedings. In August 2014, in śląskie province, over a dozen suspects faced 140 charges under the Drugs Act. The analysis of drug-related crimes should account for that fact that the number of drug-related offences does not depend solely on the illicit drug market but also the intensity of the Police activity.

At the beginning it is worth mentioning that 1 140 police officers dealt with drug-related crime under regular job responsibilities (December 2013). The number of officers ranged from 25 in opolskie province Police department to 144 in śląskie province Police department (MSW, 2014). In 2013, the Police instituted a total of 25 055 preliminary proceedings under the Act of counteracting drug addiction while in 2012 there were 23 001 such proceedings. In 2013 a rise of 8.9% was recorded in the number of proceedings instituted under the drug law compared with the previous year. Table 9.1.1. shows proceedings instituted in the last 5 years. The highest number of legal proceedings instituted in w 2013 concerned illegal possession of narcotic drugs and psychotropic substances (Article 62. 1 & 3 of the Act on counteracting drug addiction), totalling 19 504 cases (Malczewski 2013a). In the period analyzed, it was the highest number of instituted proceedings. It accounted for 77.8% of the overall number of preliminary proceedings instituted under the Polish drug law. In 2012, the percentage of such proceedings stood at 75.1% (MS, 2014). Far fewer instituted proceedings were recorded with reference to substantial quantities of drugs (Article 62.2). They accounted for 3.4% of all proceedings instituted in 2013. The number of proceedings in 2013 was similar to that of 2012; however, it was lower than in 2010 and 2011.

The second most prevalent category of drug-related crime was illegal trade in narcotic drugs and psychotropic substances (Article 59 of the Act on counteracting drug addiction). In2013, 1 500 proceedings were instituted, which made up 6% of the total number of „drug- related cases". Supplying drugs to another person was the third most prevalent proceeding instituted in 2013. In the case of such proceedings a slight fall was recorded. In 2013, they accounted for 4% of all proceedings.

Table 9.1.1. Instituted proceedings of the Police

Legal grounds	2009	2010	2011	2012	2013
Art. 53. 1 – manufacture	55	58	56	62	50
Art. 53. 2 – manufacture of substantial quantities	20	25	33	51	58
Art. 54 – possession, purchase of manufacturing equipment	36	28	37	22	20
Art. 55. 1 & 2 – trafficking	399	222	216	264	271
Art. 55. 3 – trafficking of substantial quantities	62	69	98	86	82
Art. 56. 1 & 2 – introducing to trade	139	147	195	97	141
Art. 56. 3 – introducing substantial quantities to trade	173	219	217	185	162
Art. 57 - reparing to commit a crime	-	-	-	-	19
Art. 58 – supplying	1112	1102	1073	1119	1074
Art. 59 – trade	1408	1734	1679	1590	1500
Art. 60 – failure to report trade	9	6	11	6	1
Art. 61 – precursors	50	33	47	39	18
Art. 62a – discontinuing investigation			-	11	-
Art. 62. 1 & 3 – possession	15494	15734	17608	17266	19504
Art. 62. 2 – possession of substantial quantities	686	724	788	864	861
Art. 63. 1 & 3 – cultivation	565	689	848	1289	1256
Art. 63. 2 – cultivation of substantial quantities	24	24	24	27	4
Art. 64 - stealing a drug	42	11	6	18	30
Art. 68 – advertising	14	7	4	5	4
Total	20252	20832	22940	23001	25055

Source: Police.

In 2013, police officers identified 27 375 suspects of drug-related crimes, including 3538 minors. A clear downward trend in the number of suspects is seen (fall of 7% in the overall number and fall of 23% of minors compared to 2012). The most numerous group of drug- related offenders in 2013 were suspects under Article 62. 1 & 3 of the Act on counteracting drug addiction (possession), with the total of 19 504 suspects. This group makes up 71% of the overall number of suspects under the Polish drug law (MSW, 2014). The number of suspects under Article 62.1 and 3 rose in 2013 and reached the highest value. Due to possession of substantial amount of drugs, the number of suspects in 2013 stood at 995 (Article 62.2). It constitutes a fall compared with 2012. The second most numerous category of suspects were dealers in narcotic drugs and psychotropic substances (Article 59 of the Act on counteracting drug addiction). In 2013, 2033 individuals suspected of committing this crime were identified. They accounted for 7% of all

drug-related crime suspects. Compared with 2012, the number of drug-dealing suspects fell by 31% (MSW, 2014). A considerable number of suspects (1804, 6%) was made up by individuals tried under Article 58 (supplying drugs). The number of individuals under this article fell and was the lowest since 2010.

Table 9.1.2. Suspects of the Police

Legal grounds	2009	2010	2011	2012	2013
Art. 53. 1 – manufacture	60	58	61	99	68
Art. 53. 2 – manufacture of substantial quantities	51	60	102	76	104
Art. 54 – possession, purchase of manufacturing equipment	37	40	49	50	55
Art. 55. 1 & 2 – trafficking	232	272	260	318	359
Art. 55. 3 – trafficking of substantial quantities	151	170	177	187	134
Art. 56. 1 & 2 – introducing to trade	323	394	389	267	426
Art. 56. 3 – introducing substantial quantities to trade	917	1102	1143	1099	700
Art. 57 - preparing to commit a crime	-	-	-	-	25
Art. 58 – supplying	2069	2145	2110	2212	1804
Art. 59 – trade	2998	3052	3195	2942	2033
Art. 60 – failure to report trade	7	4	8	5	-
Art. 61 – precursors	44	47	56	58	8
Art. 62. 1 & 3 – possession	17954	17843	19787	18725	19504
Art. 62. 2 – possession of substantial quantities	859	1023	1057	1064	995
Art. 63. 1 & 3 – cultivation	443	610	703	1043	1125
Art. 63. 2 – cultivation of substantial quantities	29	31	37	56	14
Art. 64 - stealing a drug	17	8	6	19	21
Art. 68 – advertising	11	6	6	5	-
Total	26165	26865	29146	28225	27375

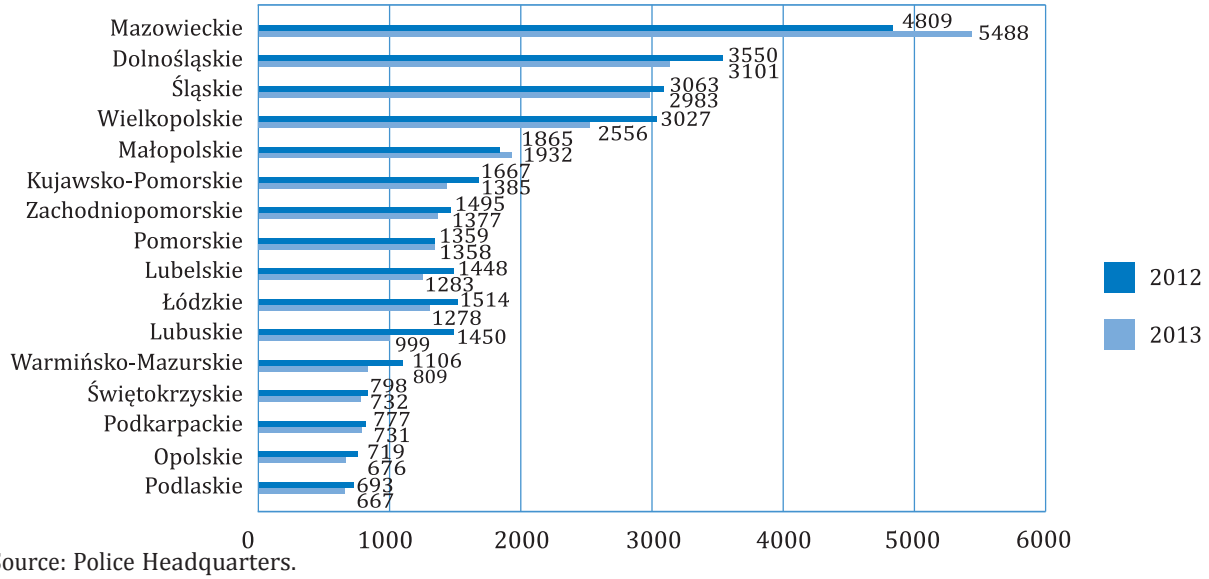
Source: Police.

Situation in provinces

Let us look at drug-related crime in respective provinces. The first Figure contains data on the number of suspects under the Act on counteracting drug addiction. In all provinces (except for małopolskie province), a fall in the number of suspects was recorded (Figure 9.1.1.).The most dramatic decrease in suspects (of 45%) occurred in lubuskie province. The highest numbers of drug-related crime suspects were recorded in the provinces of dolnośląskie, mazowieckie and lubuskie. The lowest numbers of su-

spects were registered in the provinces of podlaskie, opolskie and podkarpackie. Despite the fact that in both groups there are border provinces, it is clear that drug-related crime affects eastern Poland to a smaller extent than the western regions. In order to obtain comparable data between provinces, the numbers of suspects were converted per 100 thousand population.

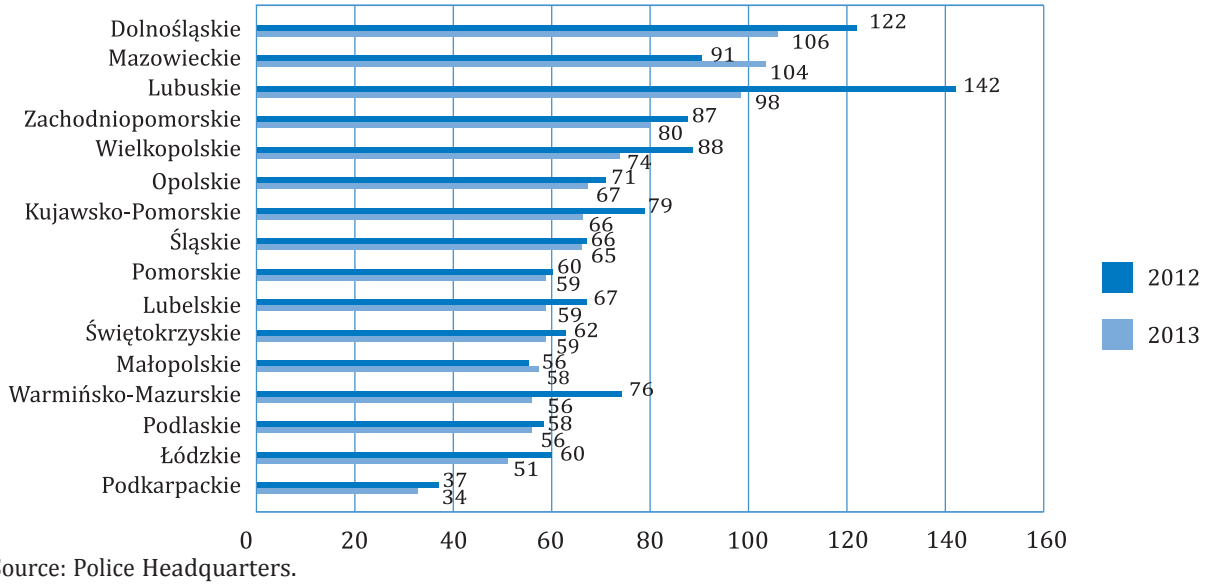
Figure 9.1.1. Suspects under the Act on counteracting drug addiction in respective provinces



Source: Police Headquarters.

The highest drug-related crime rates were recorded in the provinces of dolnośląskie, mazowieckie and lubuskie while the lowest ones in the provinces of podkarpackie, łódzkie and podlaskie (Figure 9.1.2.). Eleven provinces ranked lower than the national average, which stood at 70 individuals per 100 000 population.

Figure 9.1.2. Suspects under the Act on counteracting drug addiction in respective provinces, per 100 000 population



Source: Police Headquarters.

9.2. Drug related crime

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. Table 9.2.1. presents data concerning individuals finally sentenced to deprivation of liberty as well as convicts handed custodial sentences and those handed suspended sentences. The data comes from the period between 1997 and 2010 and was collected by the Ministry of Justice. It is difficult to compare it with 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 2012 there was a drop to 19 226 in the number of convictions under the Act. Of all convicts, the percentage of those convicted under the Act stood at nearly 5%. Of all convictions under the Act on counteracting drug addiction in 2012, 68% were custodial prison sentences (13 131). 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 2012, there were 2 019 individuals whose sentences were suspended, which is the lowest figure in the last five years.

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 suspended and custodial sentences in years 1999-2012

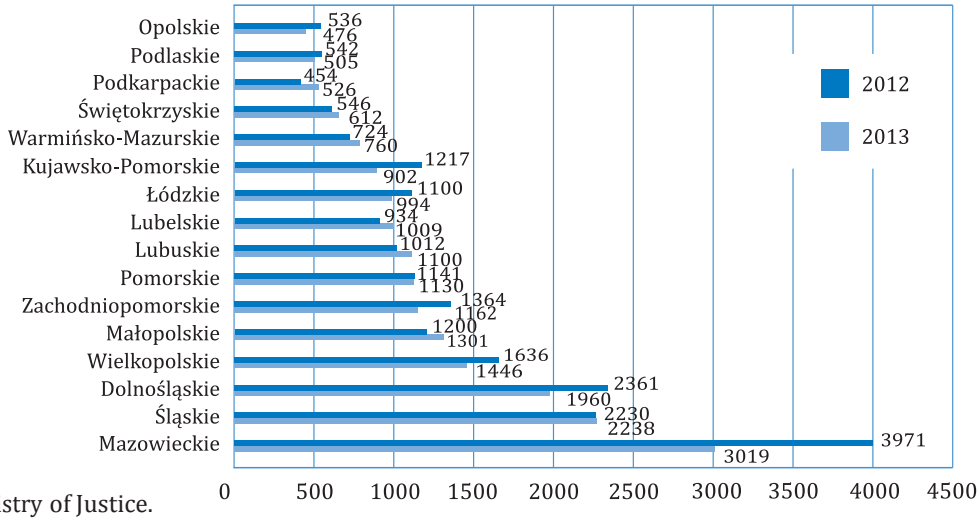
	All convicts with final sentences, including convictions under the Act on counteracting drug addiction and drug prevention			Convicts with prison sentences, including convictions under the Act on counteracting drug addiction and drug prevention		
	Total	Under Act on counteracting drug addiction	Percentage of convicts under the Acts	Convicts in total	Convicts with suspended prison sentences	Convicts with custodial prison sentences
1999	207 607	2 264	1.09	1 865	420	1 445
2000	222 815	2 878	1.29	2 428	572	1 856
2001	315 013	4 300	1.36	3 802	1 024	2 778
2002	365 326	6 407	1.75	5 417	1282	4 133
2003	415 533	9 815	2.36	7 785	1489	6 296
2004	512 969	16 608	3.30	12 417	2308	10 109
2005	503 909	20 164	4.00	14 249	2085	12 164
2006	462 937	20 381	4.40	15 383	2355	13 028
2007	426 377	20 801	4.87	15 475	2118	13 357
2008	421 051	20 631	4.89	15 165	2390	12 775
2009	415 272	20 024	4.82	14 739	2188	12 551
2010	432 891	20 601	4.75	14 837	2278	12 559
2011	423 464	21 049	4.97	14 437	2163	12 274
2012	408 107	19 226	4.71	13 131	2019	11 112

Source: Ministry of Justice.

Situations in provinces

There are considerable differences between the provinces in terms of the numbers of convicts. The highest number of drug-related convictions was recorded in the provinces of mazowieckie, slaskie and dolnoslaskie. It is worth noting a dramatic decrease in mazowieckie province. The lowest numbers of drug-related convictions was observed in the provinces of opolskie, podlaskie and podkarpackie. In none of these provinces was the number of convicts higher than 600.

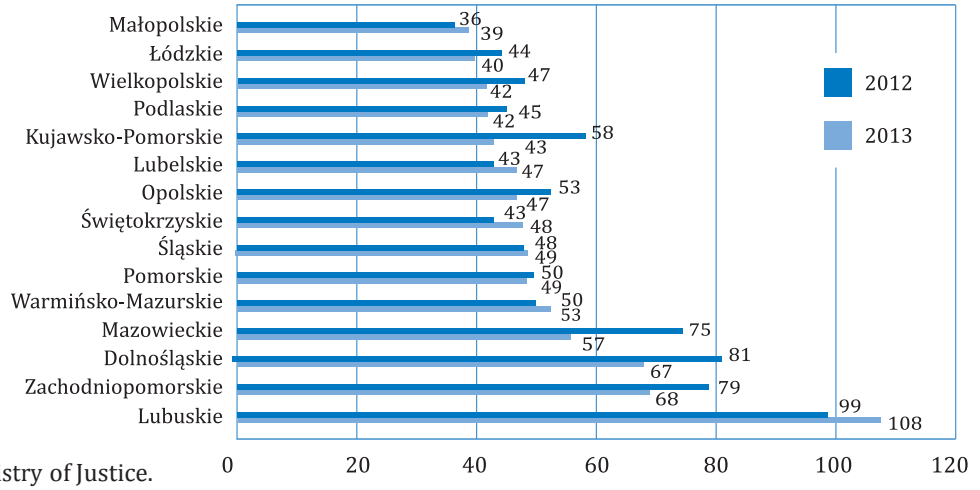
Figure 9.2.1. Convictions under the Act on counteracting drug addiction by place of crime (absolute numbers), Poland's total: 19 140 (2012)



Source: Ministry of Justice.

In order to compare situations in respective provinces, the best way is to apply a rate because the numbers might be higher in provinces with larger populations. Analyzing the rates, we find out that five provinces had the rate of over 50 convicted individuals per 100 000 population. The highest rates were registered in the provinces of lubuskie, zachodniopomorskie and dolnoslaskie while the lowest ones in the provinces of wielkopolskie, lodzkie and malopolskie.

Figure 9.2.2. Convictions under the Act on counteracting drug addiction by place of crime (per 100 000 population), Poland's average: 50 (2012)



Source: Ministry of Justice.

9.3. Interventions in the criminel justice system

Alternatives to prison

The Act of 29 July 2005 on counteracting drug addiction as further amended provides the following:

- article 72. In the event that an addicted person or an individual using psychoactive substances in a harmful manner has been charged with committing the offence subject to the penalty of deprivation of liberty for a term up to 5 years, enters treatment and rehabilitation or participates in a prevention and treatment programme in a relevant health care centre or another entity in the health care sector the prosecutor may suspend the proceedings until the treatment is completed. Upon initiating proceedings the prosecutor shall, considering the results of the treatment, rehabilitation or participation in an education and prevention programme, decide whether to continue the proceedings or file the court with the request for the conditional discontinuance thereof;
- article 73a. If it is dictated by therapeutic and educational reasons, the offender addicted to narcotic drugs or psychotropic substances serving the penalty of deprivation of liberty for the offence committed in relation to the use of narcotic drugs or psychotropic substances may be granted a furlough from serving the sentence referred to in Article 153.1 of the Executive Penal Code in order to enter treatment or rehabilitation.

Other 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 have become major risk factors for criminal behaviour. Consequently, correctional actions aim at diversifying drug services, including drug therapy for risky, harmful and dependent individuals. 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 users 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 use. The overall goal of such intervention is to reduce the potential harm which might result from substance use as well as to generate 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 for self-change).

In 2013, 6 977 inmates participated in short-term interventions, including 764 problem drug users (455 in the previous year). It must be noted that this programme became widespread in no time. In 2013, short-term interventions were conducted in nearly all (148 out of 156) Polish correctional institutions.

Among short-term intervention clients there is a considerable number of alcohol or drug- dependent individuals. They are short-sentence inmates, which prevents them from entering prison thera-

peutic wards. The short-term intervention, which was developed for risky or harmful alcohol or drug users, is applied in such cases as an alternative to long-term therapy.

This new approach has been implemented in correctional settings for 4 years. It complements long-term options provided in therapeutic wards. Thanks to the short-term intervention, it is possible to initiate the substance abuse-related change, even in the case of prisoners with very short sentences.

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 2013, 653 group sessions were conducted for the total number of 8 096 inmates.

Self-help group for addicted inmates, including drug addicts (Narcotics Anonymous), was provided in correctional facilities. In 2013, 26 such groups were active. Approx. 245 inmates benefited from this type of assistance (National Drugs Strategy implementation report 2013, Central Management Board of Prison Service, 2014).

9.4. Drug use and abuse in correctional facilities

In 2013, in 140 cases drug therapy was imposed on the basis of judicial decisions. 63 inmates were referred to drug therapy pursuant to Article 62 of the Penal Code and 77 inmates were obliged 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.

In 2013, similarly to previous years, data was collected on psychoactive substances which inmates treated at prison therapeutic wards were addicted to. Among inmates enrolled for therapy (n=1020), polydrug use was most prevalent (440 cases), followed by addiction to stimulants other than cocaine (mainly amphetamines – 277 cases). Opioid addiction was ranked third (153 cases).

Table 9.4.1. Numbers of inmates addicted to respective substances among inmates admitted to drug therapeutic wards in 2013 (n=1020)

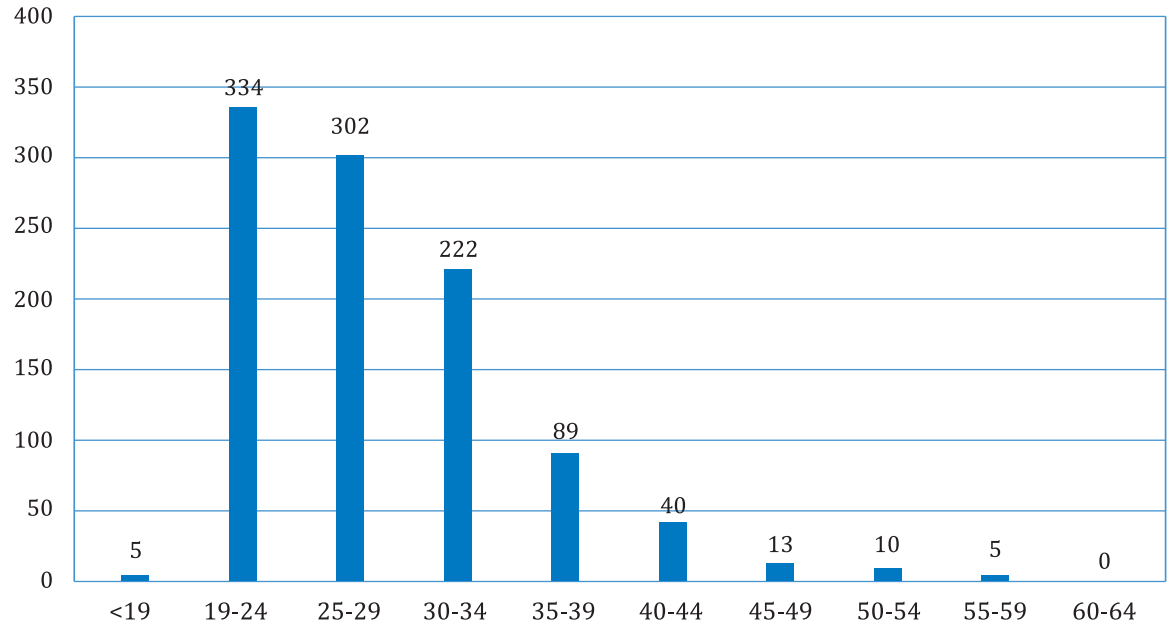
Substance	N
Alcohol	2
Opioids	153
Cannabinols	110
Sedatives	11
Cocaine	8
Other stimulants	277
Hallucinogens	1
Volatile solvents	7
Other	11
Polydrug use	440
Total:	1 020
Total, including only tobacco-dependent inmates	826

Source: Central Management Board of Prison Service, 2014.

Type of substance data is generally similar to the data collected in previous years. It is worth noting that there was a further fall in the number of opioid-dependent individuals, which is indicative of a trend. Opioid-dependent inmates accounted for 14.9% of all drug therapy admissions in 2013 (15.9% in 2012, 16.5% in 2011 and 20.2% in 2010).

The year 2013 was another year of collecting data on the age of inmates admitted to drug 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 2013 by age (n=1020)



Source: Central Management Board of Prison Service, 2014.

As the above data shows, the group is largely made up of inmates aged 19-39. The numbers support the supposition that addiction to narcotic drugs or psychotropic substances is mainly the problem of young people. Individuals aged 40 and over accounted for just 4.5% of all inmates in drug therapy (5.7% in 2012). Patients older than 50 were admitted to therapeutic wards occasionally (1% of all admissions).

Of all admissions in 2013 (n=1020), 244 inmates (23.9%) were injecting drug users (23.5% in the previous year, 28% two year before). At least 37 individuals (3.63%) were HIV positive (3.28% the year before, 3.4% two years before) and 5 were diagnosed with AIDS. Compared with previous years, it can be noticed that the number of injecting drug users in prisons is levelling off and the number of HIV/AIDS inmates in therapy is also slightly lower. The data for the two previous years seemed to indicate a steady shift away from the most destructive drugs and riskiest ways of using thereof as well as health improvement of this population. Unfortunately, the 2013 data shows that these trends were halted.

The drug treatment history data indicate that out of 1 020 inmates admitted to therapy in 2013, 624 were first-timers, 326 had previously been treated for substance abuse outside prison and 129 had been treated in prison. The data also show that first-timers still dominate the whole group (61.1% of all admissions; 61.4% in 2012, 65% in 2011). Data regarding the age, drug use pattern and treatment history is similar to the data from the previous year.

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

Drug treatment (including substitution treatment)

Abstinence-based programmes (6 months) were run in 15 therapeutic wards for 1489 inmates, almost as many as in 2012 (1493).

Moreover, in 2013, similarly to 2012, there were 261 (279 in 2011) patients with dual diagnosis (mental disorders and addiction to psychoactive substances other than alcohol) in 22 therapeutic wards for inmates with non-psychotic mental disorders or mentally disabled.

In 2013, 7 methadone-based substitution treatment programmes were being run in 23 organizational units of Prison Service. 138 patients (143 in 2012) were treated in 23 correctional facilities. In the reporting year, work was being continued to introduce substitution treatment into each correctional unit (National Drugs Strategy implementation report 2013, Central Management Board of Prison Service, 2014).

What is worth noting is a positive phenomenon of a further decrease in the number of drug-dependent inmates discharged from therapeutic wards prior to therapy completion for a number of therapy-interfering reasons. In 2011, there were 153 such inmates, 127 in 2012 and only 92 in 2013. In 2013, similarly to the previous years, the most frequent cause of therapy drop-out was the judicial order to transfer inmates to other correctional facilities due to ongoing preparatory proceedings in relation to other criminal acts committed by these inmates (48 cases). Another cause was the decision of the penitentiary court to grant a furlough or a parole to an inmate while in therapy (19 cases). ("Information on the operation of prison drug therapy system in 2013", Central Management Board of prison Service, 2014).

Drug prevention and harm reduction

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, acting upon approval of the management of correctional institutions, may enter the premises and conduct educational harm reduction programmes for psychoactive substance users.

In 2013, the National Bureau co-financed 2 such programmes conducted by non-governmental organizations. The providers visited prisons (also for women) and remand centres in Warsaw, Czestochowa and around Czestochowa. The programmes featured participation in court trials, support and individual consultations, motivating for behavioural change, information and education classes in harm reduction (including safe injection trainings), support groups and group sessions for inmates who had not been admitted to in- prison therapeutic wards. There was also material help e.g. in the form of parcels (Harm Reduction Foundation & Monar Association – Czestochowa branch, operational reports).

Infectious disease prevention, treatment and care

In Polish correctional institutions, all HIV inmates in need of treatment are provided with antiretroviral therapy, regardless whether they have used drugs or not. In 2013, antiretroviral treatment was provided for 297 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 4 261 HIV lab analyses or tests performed in the whole population of inmates. Tests proved positive in 182 cases, including 46 new cases. Moreover, in the reporting year, laboratory tests were carried out to detect HBV (8 434) and HCV (9 070). TB was detected in 445 inmates (new cases).

Overdose prevention after release from prison

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

9.6. Social reintegration 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 this form of assistance is earmarked each year for raising the effectiveness of social reintegration among 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 of various social problems (e.g. aggression, physical abuse, domestic violence) and all kinds of psychological interventions (e.g. social or cognitive skill trainings).

Moreover, prisons use EU structural funds and implement programmes aimed at raising the effectiveness of institutions dealing with the labour market, social policy and social security, improving vocational activity of disadvantaged or excluded groups on the job market, preventing further social disruption in inmates and teaching them coping skills. Such 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 reform introduced by the Ministry of National Education, all previous school complexes were transformed into Continuing Education Centres. Consequently, the prison education is formed exclusively by continuing education facilities under the name of Continuing Education Centre. Currently, the centres provide education at 5 levels: primary (2 schools), upper-primary (9 schools), vocational (18 schools), secondary (18 schools) and post-secondary (1 school).

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 2014, they will completely replace elementary vocational schools for adults and secondary vocational schools for adults, which have already been 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 1 986 inmates in school year 2013/14.

In school year 2013/14, similarly to previous years, inmates were provided with education opportunities in schools 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 4 391 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 about to complete their sentences in order to increase their chances of finding employment upon release from prison and to reduce crime relapse. In 2013, 11 170 inmates took part in 990 training courses and the number of graduates reached about 11 000.

90 students took Matura exam (i.e. final secondary school exam). 58 students passed the exam (64% pass rate).

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

Each year prison authorities conduct a number of social rehabilitation programmes aimed at reducing crime relapse. Similarly to previous years, in 2013, 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

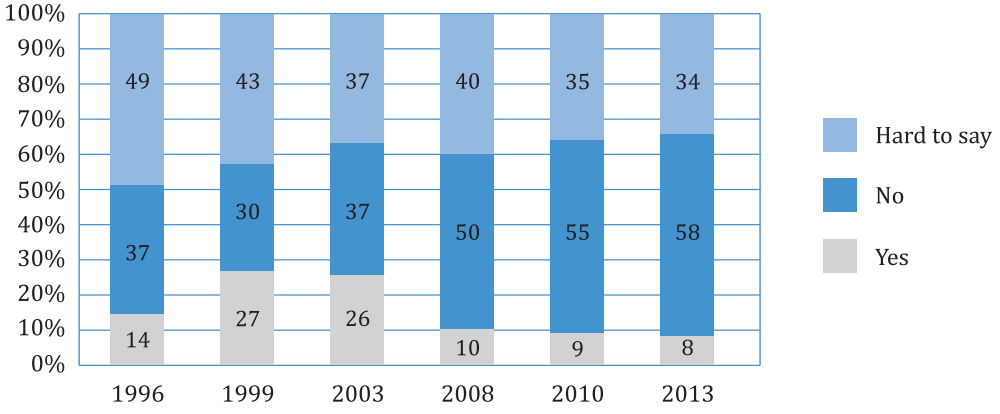
prepared by Artur Malczewski

10.1. Availability and supply

Drug availability at school

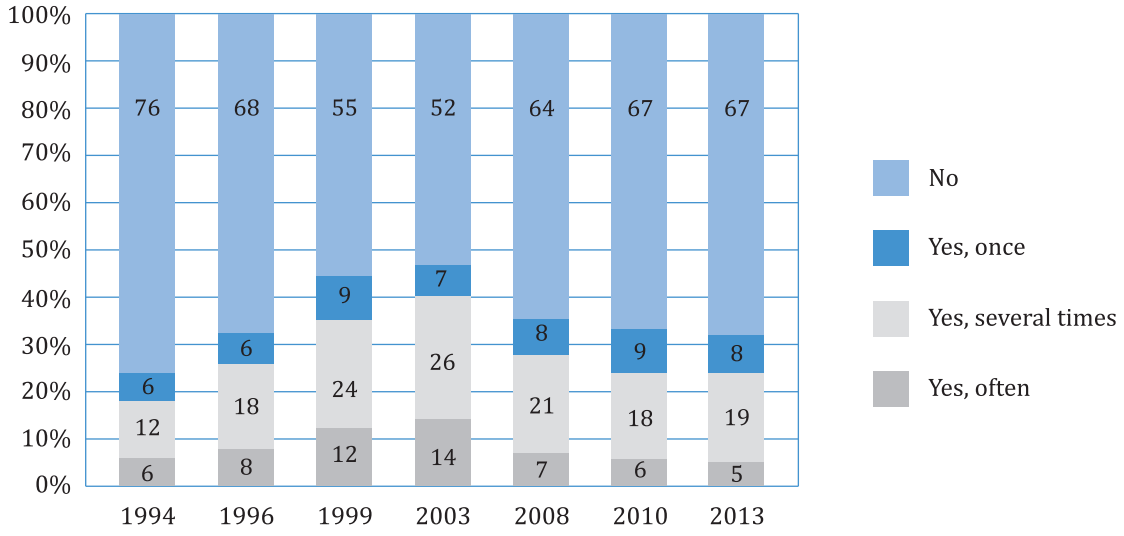
The subject of the 2013 national survey among school students aged 18-19 (for more information about the survey see Chapter 2) was the availability of drugs at school. The survey questionnaire contained questions about the familiarity with places where drugs could be purchased, drug solicitations, sale of drugs on the school premises, and whether they considered it hard to obtain respective psychoactive substances. Every fifth respondent in the 1994 survey (22%) knew from whom or where drugs could be bought while in 2003 it was almost half of the respondents (49%). However, since that time, the percentage of students knowing where to obtain drugs has been falling. On the other hand, in 2008, there was a rise (up to 40%) in the number of young people stating that they did not know where to get drugs. In 2013, the percentage of such responses stood at a similar level (41%). Moreover, the percentage of respondents who knew of several such places or individuals was the lowest since 1996. It is worth stressing that a number of factors might have influenced the students' responses e.g. media reports of police operations against drug-related crime, particularly raids on drug dealing locations. An indicator that is more useful in describing the drug market in terms of the availability of illegal psychoactive substances is the drug solicitation question. From 1994, the number of students solicited to buy drugs was steadily rising. In 2003, almost half of the respondents (47%) were solicited. Since that time, the percentage of solicited respondents has been falling. Almost three times fewer respondents received such offer (a decrease from 14% in 2003 to 5% in 2013). The latest measurement showed that the percentage of students who were solicited to buy drugs still remained at the same level as in 2010, namely 67% of the respondents reported that they had never been solicited to buy drugs. Since the mid-1990s students were also asked about drug solicitation at school (Figure 10.1.1.). Between 1996 and 2003 every third student, when asked whether drugs could be bought on the premises of their schools, gave a negative answer. For comparison, in 2008 every second and in 2010 more than a half of the respondents provided negative answers (55%). The 2013 survey recorded a slight increase (up to 58%) in the number of students who believed that drugs were not sold in their schools. The survey results show a fall in the drug availability at school (Malczewski 2014h).

Figure 10.1.1. Drug solicitation at school (18-19 years old; %)



Source: Malczewski 2014 h, Youth 2013 – CBOS Foundation and KBPN survey.

Figure 10.1.2. Percentages of respondents who were solicited to buy drugs (%)



Source: Malczewski 2014 h, Youth 2013 – CBOS Foundation and KBPN survey.

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.

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. 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 there has been a rise in domestic cannabis plantations grown by organized crime syndicates. 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. In September 2014 the Police in lubuskie (on the border with Germany) province detained several individuals on the charge of heroin trafficking and production. In the cour-

se of the investigation, the Police seized 14 litres of the Polish homemade heroin, metal containers and other paraphernalia intended for illicit manufacture of narcotic drugs, chemical agents, precursors and poppy straw. 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. In June 2014, police officers of Zgorzelec-based Polish-German NYSA group detained an individual suspected of drug-related crimes. On the man's property, they found a production line and precursors used in narcotic drug manufacture as well as ready-made methamphetamine. 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 a psychoactive substance that can be homemade on the market as this would mean a drop in profits for organized crime syndicates. In 2013 Police took active part in international cooperation on drugs (MSW, 2014):

- Operation conducted with Dutch police in cooperation with Europol regarding trafficking of chemical substances from Polish companies to the Netherlands (Golden Tulip operation),
- Operation conducted with Belgian police regarding dismantling of clandestine labs in Belgium (AS-BURCHT operation),
- CHOPIN project regarding the reduction of manufacture and distribution of drugs across the EU. The funding for the project entitled „Reduction of production and distribution of drugs in the EU – Project CHOPIN" was granted by the European Commission (ISEC 2011). The project is a series of comprehensive operational, training and border actions addressed to combating illegal manufacture, extraction, trafficking and distribution of drugs (especially synthetic drugs and cocaine) as well as precursors in the EU. The project was conducted by the Central Bureau of Investigation of the Police Headquarters in 2013-2014 with the support of EU Member States (BE, CZ, DE, NL, LT), Europol, Border Guard and Customs Service,
- Controlled deliveries conducted with Police of other countries.

Moreover in 2013 the Central Bureau of Investigation took part in international operations of combating precursor trafficking (MSW, 2014):

- Operation conducted along with Europol as well as Dutch, Belgian and German Police forces regarding trafficking into Poland of substantial quantities of chemicals for amphetamine and MDMA manufacture,
- Participation in controlled deliveries in cooperation with German and Dutch Police in connection with trafficking of chemicals and precursors from China and India to Europe.

Drug production in Poland

Amphetamine in Poland is most frequently manufactured using 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 amphetami-

ne production lines are established. 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 town 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. In 2013, the Police dismantled 19 clan labs producing amphetamines. One of the last clan labs was detected in 2014 in September, when police officers of the Central Bureau of Investigation dismantled a clandestine amphetamine lab. This professional production site was located in an inconspicuous building on a property in wielkopolskie province. Apart from the equipment, police officers found several dozen litres of various substances, including 10 litres of BMK (benzyl methyl ketone), a major constituent of the 'white powder' as well as several dozen grams of the ready-made drug.

APPAN (alpha-phenylacetoacetonitrile), a chemical used to produce BMK, has become a challenge for the drug enforcement agencies. The reduction of the availability of BMK (amphetamine precursor) in Poland meant that a chemical was found so that the precursor could be obtained independently. 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 were imported to Poland. (Malczewski 2013b) The APPAN started to be controlled in 2014; however, it is still being used for amphetamine production. In September 2014, Police officers of the Krakow department of the Central Bureau of Investigation dismantled an enormous clandestine lab and an organized criminal group concerned with production, trafficking and trade in drugs on a large scale. An estimated quantity of substances imported by the group made it possible to produce over 10 tonnes of pure amphetamine. The dismantled BMK manufacturing site was located in cellars. Two professional production lines were capable of continuous production of illicit substances. Apart from reactors and synthesis equipment, police officers seized over half a tonne of APAAN, 25 litres of ready-made liquid amphetamine and over 6.5kg of marijuana.

The Police data shows that heroin is not the most prevalent drug on the Polish market. It is evidenced by the fact that that 4.8 kg of this substance was seized by officers of 11 Police departments and Central Bureau of Investigation, with the highest figures for the Warsaw metropolitan department (1163.1 g) and dolnośląskie police department (191.02 g). The following Police departments seized no heroin: mazowieckie, opolskie, podkarpackie, świętokrzyskie, wielkopolskie and zachodnio-pomorskie (MSW 2014).

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. 68 555 cannabis plants were seized in 2013 (rise of 10 399 plants compared with 2012). The Police records show that the highest numbers of plants were seized in wielkopolskie province (8821 plants) and dolnośląskie province (8448 plants). In 2013, 1246 cannabis

plantations were dismantled - 720 indoors and 526 outdoors. The cannabis plantations covered the area of 17919, 82 square metres.

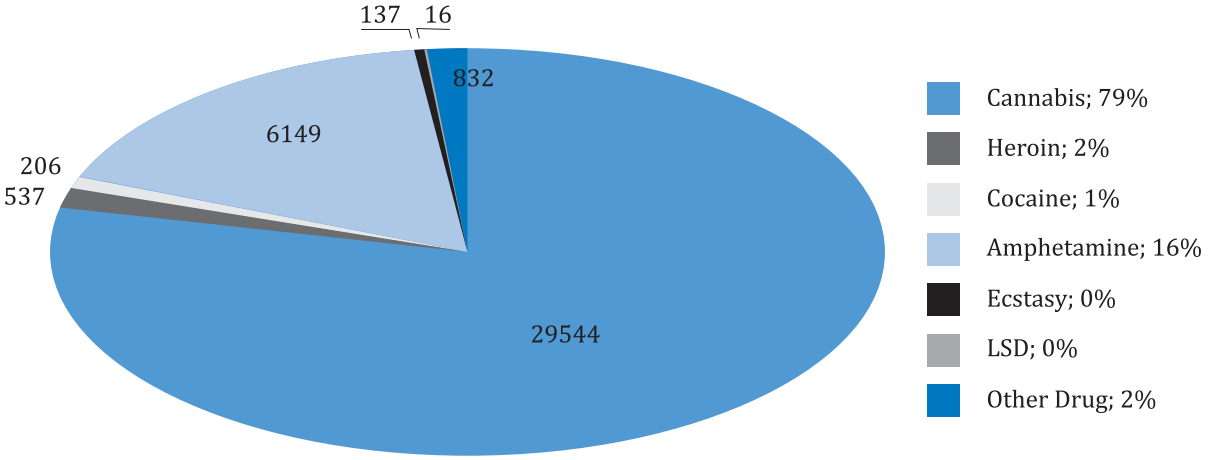
Heroin in Poland originates from domestic production (largely reduced by the introduction of low-morphine poppy) and largely from drug trafficking. Domestic production manifests itself in the seizures of homemade heroin called 'kompot', which is produced exclusively in Poland, and poppy straw. In June 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 town of Inowroclaw. As a result of police operations, 800 kg of poppy straw and 1 500 mg of methadone were 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 2013 we record an increase in the seizures of hashish, heroin, amphetamine, methamphetamine and ecstasy. Seizure data reveal a rise in methamphetamine on the Polish illegal drug market. In 2013, methamphetamine seizures had been the highest in the last four years.

The Police have not recorded the number of seizures. However, crimes against Article 62 refer to the possession of drugs and registering thereof equals a drug seizure. Last available data is from 2012. In this year, crimes against Article 62 accounted for 49% of all crimes against the Act on counteracting drug addiction. Taking into account this article we notice that the biggest number of seizures refers to cannabis (79%, 29544) with amphetamine coming second (16%, 6149).

Figure 10.2.1. Number of seizures in 2012 (art. 62)

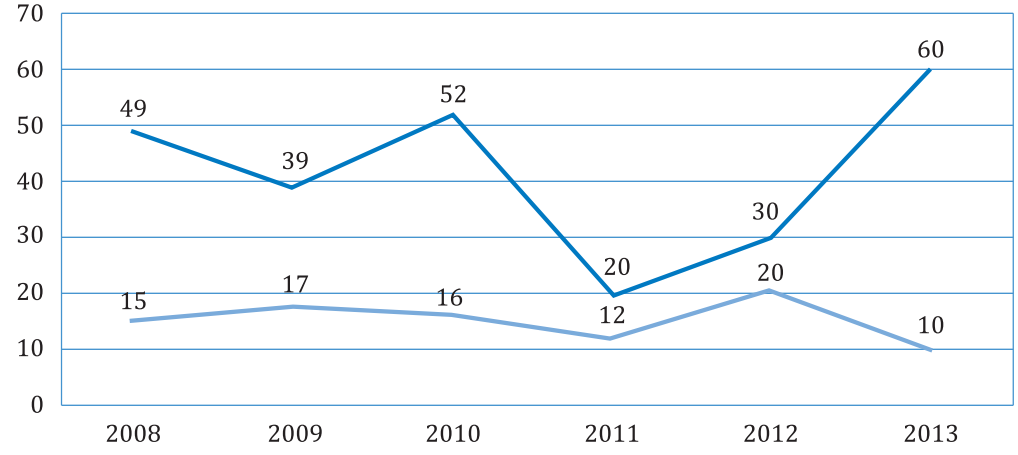


Source: Police.

10.3. Price/purity

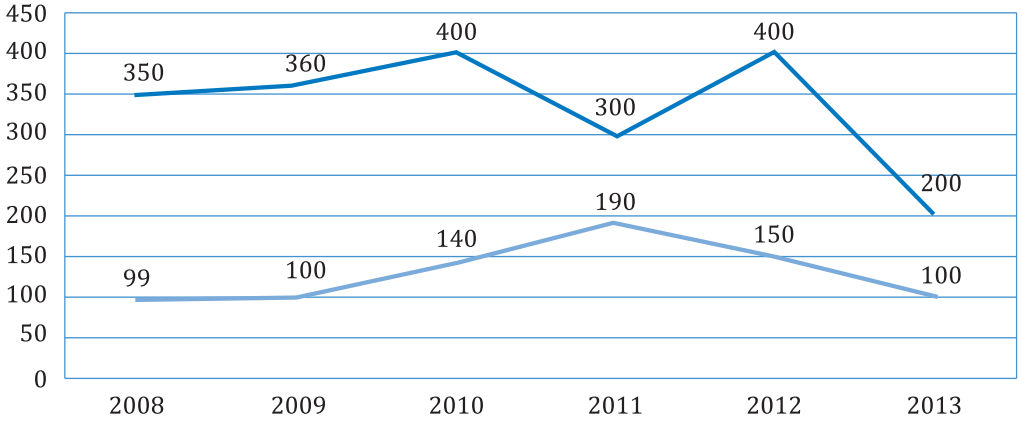
Based on the Police data and qualitative surveys conducted among drug users, we know that the purity of drugs sold on the illegal market varies substantially. Data from the Central Forensic Laboratory demonstrates higher THC levels in marijuana. The more THC marijuana has, the more potent it is. In 2007, marijuana contained 5% of THC while in 2013 this rate stood at 10%. In the case of amphetamine, the trend is reversed. In 2007, average purity rate of amphetamine available on the illegal market was 35% compared with 13% in 2012. 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. The data from the Police on marijuana and heroin is presented in figures 10.3.1 and 10.3.2.

Figure 10.3.1. Prices of cannabis herbs (minimum and maximum) Police data (PLN)



Source: Police.

Figure 10.3.2. Prices of brown heroin (minimum and maximum) Police data (PLN)



Source: Police.

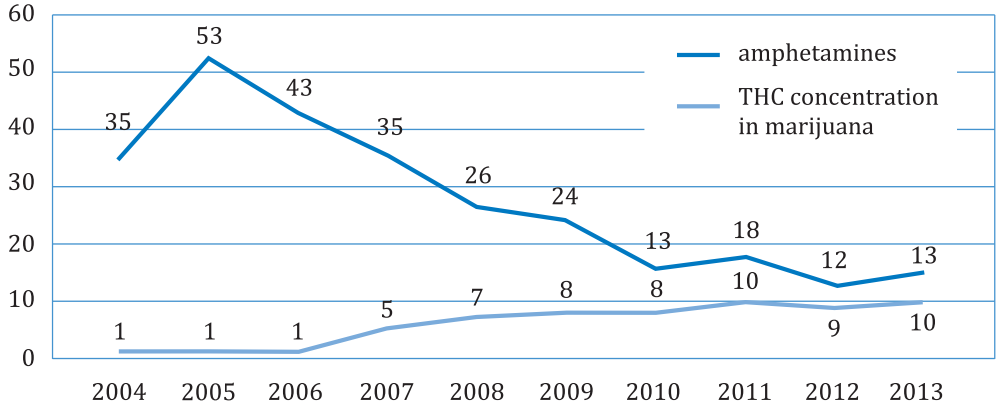
In order to obtain information on an average or most frequent (modal) price of a drug, surveys are conducted. Since 2008, problem drug users have been asked about the value of their most recent drug purchase. Based on this information an average, modal and median price was calculated. Table 10.3.2. shows 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 10.3.1. 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 2005-2013

Drugs	2005	2006	2007	2008	2009	2010	2011	2012	2013
Hashish (kg)	19.292	35.401	33.128	114.681	17.142	85.445	59.139	38.946	208.394
Marijuana (kg)	227.124	401.659	352.934	492.725	883.053	1501.801	1265.403	1489.240	1242.834
Heroin (kg)	41.151	155.401	123.623	78.915	85.873	24.871	51.359	35.620	48.678
Cocaine (kg)	16.871	21.932	160.981	28.710	117.491	111.084	78.121	213.391	20.569
Amphetamine (kg)	344.578	333.038	423.65	356.196	421.65	534.299	394.77	613.733	675.724
Methamphetamine (kg)	-	0.163	5.712	0.124	10.069	1.234	0.517	4.254	9.566
Ecstasy (tablets)	492 531	145 344	610 383	651 985	218 616	269 842	75 082	31 092	45 997
LSD (blotter)	2226	1453	327	353	642	1353	0	29173	457

Source: Polish Focal Point (CINN KBPN).

Figure 10.3.3. Purity of amphetamines and THC concentration in marijuana in 2004-2013 (%)



Source: Central Forensic Laboratory of the Police.

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

	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
Number of sources of information	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)

New Psychoactive Substances

The analysis of the Polish illicit drug market cannot be performed without the sale of new psychoactive substances (NPS), which are not controlled. Some of those are sold in high street head shops and online. As a result of the Decision of the Chief Sanitary Inspectorate and the joint operation of the Police and Sanitary Inspectorate all head shops, i.e. 1400 across the country, were closed down in 2010. Consequently, the number of NPS-related poisonings fell dramatically in 2011 and 2012. The institution responsible for combating head shops in Poland is the Sanitary Inspectorate which issues decisions in the course of administrative actions. Operations of the Sanitary Inspectorate against head shops are supported by the Police. According to the drug law and the Act on Sanitary Inspectorate amended in 2010, a relevant State Sanitary Inspector has the power to withdraw from trade for the period of up to 18 months for lab test purposes products as to which there is a reasonable suspicion that they might pose a risk to life. The police seize new psychoactive substances which are not controlled by the drug law. In 2013, the following substances were seized: mephedrone (2939 grams), Salvia Divinorum (1 gram), 4 MEC (9558 grams), MDPV (620 grams), synthetic cannabinoid (110 grams). The Customs Service seize shipments of NPS mainly at the border. In mid-2013, one of the Customs Offices revealed a 60-kilogram shipment of a new psychoactive substance named pentedron, which had been declared to be an ingredient used in the production of concrete. In 2013, head shops started reopening and a rise in medical interventions due to NPS-related poisonings was recorded (1079 cases). By August 2014, the number reached 1416 cases. At present, head shops keep a low profile on their sales as was the case in 2008-2010. Head shops hide sales behind other products and do not place NPS advertising banners as was the case in 2010. In 2014, there were 120 head shops operational in Poland. Some of them could be sex shops or places for gambling activities. In 2014, sanitary inspectorate imposed PLN 7 million worth of fines on the owners of head shops. However, fines are hard to collect. In Poland, apart from high NPS shops, there are over a dozen online stores where new psychoactive substances can be purchased. The order is usually shipped within 2-3 days with the cash on delivery option. Online stores are registered abroad e.g. www.kolekcjoner.nl. Next year it will be the amendment to the drug law in aim to controlle 114 new psychoactive substances.

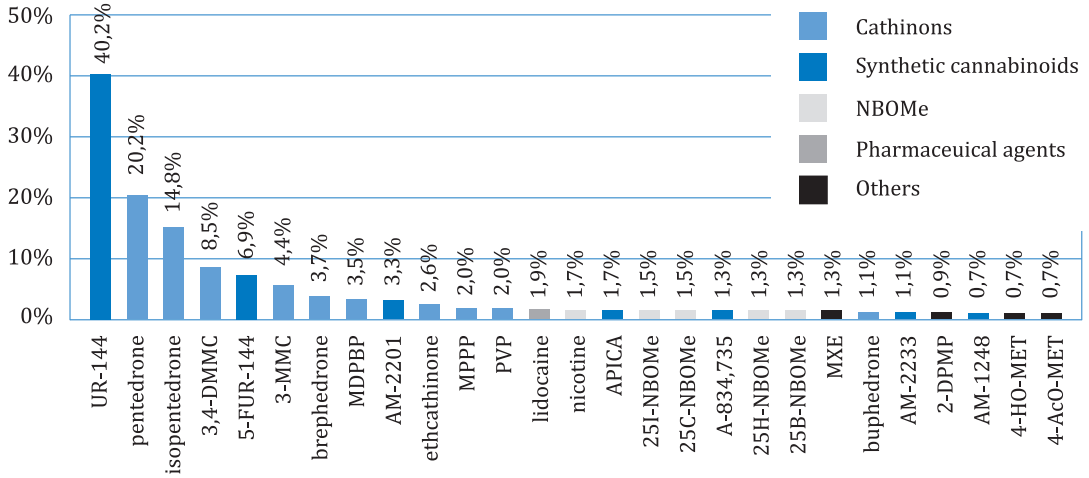
Table 10.3.3. Operations of the State Sanitary Inspectorate in the field of substitute drugs in 2011-2013

Year	Total of inspections	Fines imposed (PLN)	Total of entities found to be introducing substitute drugs to trade	Total of samples taken for lab tests	Total of products seized
2011	335	0	11	35	1 819
2012	548	495 000	103	443	19 997
2013	779	10 669 370	134	1 448	28 402
2014 (6 months)	333	7 790100	128	728	25 389

Source: Białas 2014 - Chief Sanitary Inspectorate.

At present, the EU-sponsored I-TREND project is being implemented in Poland by the University of Social Sciences and Humanities (SWPS) and Polish Focal Point experts. Apart from the SWPS, the project involves researchers from France, Netherlands, United Kingdom and Czech Republic. One of the major goals of the I-Trend project is to collect information on the harm and effects of new psychoactive substances as well as use patterns. Consequently, information brochures on the most prevalent new psychoactive substances will be developed for drug prevention and treatment professionals. In 2013, following a review of the Internet forums and EWS data, the TOP 10 of the most prevalent new psychoactive substances in Poland was compiled. The list included 8 cathinones with the remaining substances such as synthetic cannabinoids: 3,4-DMMC, 3-MMC, AM-2201, Brephedrone, Ethcathinone, MDPBP, Pentedrone, alfaPVP, UR-144, pMPPP (Malczewski 2013e). It is worth stressing that the products offered by online stores are not the same as those available via high street head shops. The most popular new psychoactive substance in 2013was UR-144 (synthetic cannabinoid), which, according to the National Medicines Institute and Chief Sanitary Inspectorate, is still very hard to obtain online in 2014. Most products sold online are research chemicals (RC). They are powder-type products marketed for chemical tests. UR-144 is frequently not offered under its name but added to herbal concoctions. Their contents are not revealed by retailer or the producer. Figure 10.3.4. shows results of NPS lab tests conducted by National Medicines Institute in 2014. The most prevalent NPS was UR 144 (in 40% of samples).

Figure10.3.4. Analysis of National Institute Medicines in 2013 (604 samples of NPS)



Source: Błażewicz 2014, NIL.

Part B

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Annexes

Figures and Tables

Abbreviations

1) ABW – Agencja Bezpieczeństwa Wewnętrznego (Internal Security Agency)

2) AIDS – Acquired Immune Deficiency Syndrome

3) ARV – Antiretroviral

4) BMK – benzyl methon ketone (benzylometyloketon)

5) CBOS – Public Opinion Research Centre (Centrum Badania Opinii Społecznej)

6) CBŚ – Centralne Biuro Śledcze Komendy Głównej Policji
(Central Bureau of Investigation of the Polish Police Headquarters)

7) CINN – Centrum Informacji o Narkotykach i Narkomanii

8) ESPAD – European School Survey Project on Alcohol and other Drugs

9) EMCDDA – European Monitoring Centre for Drugs and Drug Addiction in Lisbon

10) EU – European Union

11) GHB – Gamma – Hudroxybutyric acid

12) GUS – Główny Urząd Statystyczny (Central Statistic Office)

13) HIV – Human immunodeficiency virus

14) ICD – International Classification of Disease

15) IDU – Injection drug users

16) IPiN – Institute of Psychiatry and Neurology (Instytut Psychiatrii i Neurologii)

17) KBPN / NBDP – Krajowe Biuro ds. Przeciwdziałania Narkomanii
(National Bureau for Drug Prevention)

18) MCPS – Mazovian Centre for Social Policy (Mazowieckie Centrum Polityki Społecznej)

19) MSW – Ministry of the Interior (Ministerstwo Spraw Wewnętrznych)

20) NFP – National Focal Point

21) NGO – Nongovernmental organizations

22) NIK – Supreme Audit Office (Najwyższa Izba Kontroli)

23) Narodowy Fundusz Zdrowia – National Health Fund

24) NPCDA – National Programme for Counteraction Drug Addiction (pl: Krajowy Program Przeciwdziałania Narkomanii)

25) NPS – new psychoactive substances

26) NSP – needle and syringe programme

27) PLN – name of the Polish currency

28) PMMA – p-methoxy-methaphetamine