

**THE PRACTICES AND CONTEXT OF
PHARMACOTHERAPY
OF OPIOID DEPENDENCE IN
CENTRAL AND EASTERN EUROPE**



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Abstract

This publication presents an overview of the practices and the context of pharmacotherapy of opioid dependence in selected countries in Central and Eastern Europe and the Newly Independent States. Based on reports provided by professionals involved in the treatment of opioid dependence in these regions, this document describes the current situation with opioid use in Central and Eastern Europe and the Newly Independent States, the role of pharmacological treatment of opioid dependence in public health responses to opioid dependence and associated health consequences in the region, as well as priorities and recommendations for development of treatment services and responses. The publication contains key informant reports from Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Estonia, Kyrgyzstan, Hungary, Latvia, Lithuania, Poland, Russian Federation, Slovakia and Ukraine. This publication has been prepared in conjunction with another WHO document that is focused on pharmacotherapy of opioid dependence in selected countries of South-East Asia and Western Pacific regions and both documents are a part of the global activity on treatment of opioid dependence which is currently being implemented by the WHO Department of Mental Health and Substance Abuse.

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PART ONE

Pharmacotherapy of Opioid Dependence in Central and Eastern Europe

INTRODUCTION

The explosive epidemic of HIV/AIDS among injection drug users (IDUs) in Eastern Europe coupled with the epidemic of opioid use necessitate the implementation of effective interventions. There is substantial evidence for the effectiveness of drug dependence treatment in HIV/AIDS prevention and care. Agonist pharmacotherapy of opioid dependence has proven to be effective in HIV/AIDS prevention by attracting IDUs into various drug treatment programmes, and thus reducing participation in risk behaviours and the subsequent health and social consequences of drug dependence. In spite of the rapidly evolving HIV epidemic among injection opioid users, access to effective pharmacological treatment for opioid dependence in this region is very limited. Lack of research activity on the effectiveness of pharmacological treatment of opioid dependence in certain cultural contexts, and in the framework of particular treatment systems, hamper further development of such programmes. In response to the need for a review of current treatment practices in the region and to establish a scientific basis for their development, the WHO Department of Mental Health and Substance Abuse, in consultation with the WHO Regional Office for Europe, convened a meeting of experts from selected countries of Central and Eastern Europe (CEE). This meeting took place in Ljubljana, Slovenia in September 2001.

The key objectives of the meeting were as follows:

- ❑ To review the role and place of pharmacotherapy in the management of opioid dependence in the region.
- ❑ To review currently available programmes of pharmacological treatment of opioid dependence and their legal, professional and institutional context in CEE countries.
- ❑ To identify needs and priorities for further development of pharmacological treatment of opioid dependence in this region, with a particular focus on opioid agonist pharmacotherapy in the countries with rapidly evolving epidemics of HIV/AIDS among drug users.
- ❑ To explore the possibility of establishing a research network incorporating a WHO multi-site evaluation study of pharmacological treatment of opioid dependence in this region.

The aim of this publication, based largely on the results of the WHO meeting in Ljubljana, is to compare the practices and context of pharmacological treatment of opioid dependence across Central and Eastern Europe, in the general framework of pharmacotherapy of opioid dependence. The overview on the implementation of substitution therapy in the region in Part One of this publication represents the situation in the year 2003 for the countries represented at the meeting in Ljubljana.

RANGE OF PHARMACOLOGICAL APPROACHES TO OPIOID DEPENDENCE*

The two primary pharmacological treatment approaches used in managing opioid dependence are detoxification methods (with or without subsequent relapse prevention using naltrexone) and substitution maintenance therapy using synthetic opioids such as methadone and buprenorphine. Substitution maintenance therapy, when administered appropriately, can reduce the spread of infectious diseases, such as HIV/AIDS and hepatitis, lower consumption of illegal drugs, reduce rates of criminality and prostitution, increase chances of psychosocial rehabilitation and employment, and retain patients in treatment for longer periods of time.

A number of different opioid agonists are used in substitution pharmacotherapy, including methadone, levo- α acetyl methadol (LAAM), slow-release morphine, and buprenorphine (Table 1). Findings have consistently demonstrated significant benefits associated with both methadone maintenance and, more recently, buprenorphine maintenance treatment. Several recent studies also report that slow-release morphine is as efficacious as methadone, and the use of a sublingual buprenorphine/naloxone combination tablet (dosing ratio of buprenorphine:naloxone – 2 mg:0.5 mg) in opioid maintenance therapy was well-accepted and tolerated by patients.

Table 1. Types of synthetic opioids used in substitution therapy of opioid dependence

<i>Name / Type</i>	<i>Opioid-Effect</i>	<i>Peak</i>	<i>Duration of effect</i>	<i>Half-Life</i>
Methadone <ul style="list-style-type: none"> • μ opioid receptor agonist • Oral administration 	> 40 minutes	4 hours	36 hours	15–22 hours
Slow-release (sustained) morphine <ul style="list-style-type: none"> • μ opioid receptor agonist • Oral administration • Good bioavailability • Controlled slow-release system 	> 60 minutes	8–9 hours	24 hours	3–4 hours
Levo-α-acetyl-methadol (LAAM) <ul style="list-style-type: none"> • μ opioid receptor agonist • Oral administration • Sufficient oral bioavailability 	> 90 minutes	4 hours	72 hours	48–72 hours
Buprenorphine <ul style="list-style-type: none"> • Partial μ-agonist/κ-antagonist • Sublingual administration • Sufficient sublingual bioavailability 	20 minutes	2 hours	72 hours	6–7 hours

The goals of opioid agonist maintenance treatment, as mentioned earlier, are to lower levels of illicit drug use, to reduce risk behaviours concerning the transmission of blood borne viruses such as HIV and hepatitis B and C, to improve treatment retention, to reduce criminality and to improve overall well-being for the individual, their family and society as a whole. Currently there is moderately robust

* Based on presentation of Professor Gabriele Fischer (Austria)

evidence that this type of treatment can make a substantial contribution to these goals, but that such interventions required the development of training, monitoring, support and supervision to ensure good quality treatment.

TREATMENT DOCUMENTATION AND EVALUATION RESEARCH*

Comprehensive documentation and evaluation are considered an essential component of treatment programme management. Documentation should involve the maintenance of records for each patient, including baseline data (prior to commencing treatment), projected treatment plan and rationale, and appropriate recording of adverse or other events throughout the treatment programme. Documentation of treatment may be classified according to three broad areas, which are outlined in Table 2. These records may serve as tools for internal controls, supervision, and evaluation purposes, and may be of importance should legal disputes arise.

Table 2. Main areas of documentation

<i>Area of Documentation</i>	<i>Main Items</i>
Client/Patient Description	<ul style="list-style-type: none"> • Entry Data <ul style="list-style-type: none"> – Demographic data – Education, professional activities, income – Family history, personal history, social network – Substance use, patterns of use – Past treatment experiences – Convictions, legal status • Data at discharge <ul style="list-style-type: none"> – Type of discharge, follow-up treatment – Changes from entry data
Service Description	<ul style="list-style-type: none"> • Structural Description <ul style="list-style-type: none"> – Legal basis, funding, responsible organization – Orientation, objectives, target population – Therapeutic programme – Rules, controls, sanctions – Staff, training, supervision – Networking, collaboration • Annual Description <ul style="list-style-type: none"> – Staff turnover – Conceptual changes
Treatment Description	<ul style="list-style-type: none"> • Basic Items <ul style="list-style-type: none"> – Diagnostic assessment – Treatment plan – Intervention records – Consultations, medical/psychiatric care • Special Aspects in Substitution Therapy <ul style="list-style-type: none"> – Goals of substitution treatment – Dosages, urine controls, take home possibility

* Based on presentation by Professor Ambros Uchtenhagen (Switzerland)

The objectives of treatment evaluation are to improve service delivery, to assess the quality of treatment, to test therapeutic approaches and methods, to monitor treatment policy, and to assess the adequacy of the programme to meet treatment needs. According to these various objectives, there are different types of evaluation, focusing on:

- the results of treatment (outcome evaluation)
- aspects of service delivery and programme structure, such as client and staff satisfaction (process evaluation)
- the capacity of the service to reach target groups and meet the needs of these individuals (utilisation evaluation, needs assessment)
- the relation of resources to outcome (economic evaluation, especially cost-effectiveness).

Treatment evaluation has rapidly developed in the last decade, on the basis of an increased interest in evidence-based treatment policy. The main trends include developing national documentation systems, systematic and comparative evaluation, improving economic evaluation and needs assessment, evaluating service quality and implementing quality management systems. Overall it is considered that good monitoring and evaluation may have a significant impact on policy and may support the further development of this approach to treatment.

BACKGROUND AND CURRENT PRACTICES OF SUBSTITUTION THERAPIES IN WESTERN EUROPE

The number of opioid users in substitution treatment throughout Western Europe tripled between 1993 and 1999. This dramatic rise is considered to have largely been in response to the HIV epidemic emerging during this time. It is estimated that there were, by 1999, 300 000 opioid dependent individuals accessing substitution treatment, which was provided by a number of service delivery models, including general practitioners, dedicated treatment centres, “methadone buses”, and pharmacies. While substitution treatment was primarily with methadone, several alternatives became available with the introduction of buprenorphine, dihydrocodeine and slow-release morphine.

It was estimated that the number of inhabitants between the ages of 15 and 64 using heroin ranged from 2 (in Germany and Finland) to over 6 (in Italy and Luxembourg) per 1000. The problem of HIV among IDUs had been significantly contained in most countries through the use of an extensive network of treatment and prevention strategies. There continued to be variation between countries in the balance between maintenance and detoxification approaches. Some countries placed greater emphasis on detoxification, but the overall trend was towards greater use of maintenance as experience was gained in the use of opioid agonist pharmacotherapies. Over the past five years, general consensus has emerged in Western Europe regarding the role of substitution therapy as an essential component of treatment options available to opioid-dependent individuals.

There remained, however, considerable variation between countries in terms of treatment delivery and service structure. Some countries employed a combination of service delivery by general practitioners and dedicated treatment centres, while others either primarily used specialist treatment centres or relied heavily on general practitioners. Services with a broad community base were generally much more accessible, and most countries emphasized not only the expansion of the treatment system, but also improvement in the quality of the programme. Guidelines for treatment and service delivery were developed in a number of countries, including the United Kingdom. The European Commission supported the development of such guidelines, which were made available in several languages, including French, German, Spanish, English and Slovenian.

The overall conclusions regarding opioid substitution therapy in Western Europe were as follows:

There has been a ***marked major expansion in maintenance treatment in the European Union (EU) in the past five to ten years.*** Today, all EU Member States run substitution treatment programmes in some shape or form, although the extent and nature of the treatment vary considerably between countries. Between 1995 and 2000, many Member States have reported an expansion in this treatment and the trend continues to rise.

There has been a *general consensus on the role and efficacy of methadone, and more recently, buprenorphine in substitution maintenance therapy of opioid dependence*. There exists a large scientific body of evidence showing the effectiveness of methadone substitution therapy in reducing drug-related harm without giving rise to negative health consequences. Compared to users of illegal opioids, people undergoing methadone maintenance therapy demonstrate lower rates of overdose and overall mortality, reduced involvement in criminal activity and lower rates of HIV infection. More recently, buprenorphine has been undergoing extensive clinical testing for treatment of opioid dependence, and is gradually gaining wider acceptance as an alternative to methadone. Buprenorphine is a partial agonist-antagonist with a longer duration of action than methadone (see Table 1). France, in particular, has administered buprenorphine as its principal agent for opioid-maintenance treatment since 1996. Other countries in Europe reporting use of this substance in 2001 include Belgium, Denmark, Austria, Finland, Italy, Sweden and the United Kingdom.

There is a *need for further research on other agents used in opioid-maintenance therapy*. Although methadone maintenance therapy has been found to be successful overall, it is associated with a number of problems, including limited patient and community acceptance. Therefore, methadone is not ideal for all subjects and there is clearly a need for more research on alternative agents. Several new synthetic oral opioids are currently being investigated as potential treatment options for opioid dependent individuals, with the aim of diversifying the substitution treatment options available to opioid dependent individuals. These include slow-release morphine, dihydrocodeine, heroin and LAAM (Levo-alpha-acetyl-methadol), however, in the European Union LAAM has been recently removed from the market because of concerns about a possible effect on cardiac function.

There exists a *need for further research on the psychosocial and organizational components of substitution maintenance therapy, as well as international guidelines for the pharmacological treatment of opioid dependence and the provision of psychosocial interventions*. Psychosocial interventions can range from individual and group counselling to broader structured programmes with consequent rewards or withdrawal of privileges. In general, research has supported the use of regular counselling or psychotherapy within maintenance pharmacotherapy but further research is required to explore the psychosocial component of drug treatment. While guidelines for the management of opioid dependence and the use of agonist pharmacotherapy are available (Eurometh, United Kingdom, Germany and Switzerland), there remains a need for the development of guidelines for specific populations, such as pregnant women.

There is a *need for ongoing monitoring and evaluation of treatment services*. Despite mounting evidence that programme organization is a major determinant of substitution treatment outcome, there remains a lack of existing quality control, monitoring and evaluation of individual programmes and services. The mechanisms for monitoring such activities are scarce and, once substitution treatment programmes are established, there is frequently considerable freedom in the daily organization of activities. Limited attention has been given to maintaining high standards or developing methods to ensure that set standards are achieved across the broad range of services. The link between such standards and the organization of services will have an important influence on the development and evaluation of these programmes.

There is a *need for a focus on the quality of treatment and development of integration with other services, such as HIV/AIDS, mental health, criminal justice and youth services*. Specific legislation in a number of countries has attempted to enhance links between the criminal justice and health sectors. The growing size of the drug-dependent population in prisons has also emphasized the need for better links between criminal justice agencies and drug treatment services. In the long-term drug-dependent population, the increasing proportion of clients with both major psychiatric and physical problems is becoming more evident. The need for a mixture of skills to address these problems is a key part of a long-term service planning strategy.

An important area requiring further attention is *improving access and continuity of care*. The demand for treatment has continued to increase at a faster rate than investment in, and expansion of, services. In most countries, access to substitution maintenance therapy is largely dependent on treatment provision and also on the inclusion criteria of treatment programmes. In some countries, strict criteria are imposed (e.g. Sweden: four years' intravenous use, over 20 years of age, opioid as main drug abused and not incarcerated), whereas in other countries such as Denmark, Italy and Spain, being opioid-dependent is the only entry criterion. Furthermore, many countries have limited access to

treatment for specific populations, most notably the young (below 18), mentally ill and homeless. On the other hand, pregnant women and those with HIV infection have priority access in most countries.

There is a *need for proper evaluation, research and benchmarking performance of programmes*. Given the level of availability of current services across Europe, very limited research and evaluation of the treatment process has been carried out to date. Such research would be an invaluable source of data, not only to confirm the benefits of treatment but also to identify factors associated with effective treatment. Such factors may include quality of management and organization of services, quality and skill mix of staff, and the level of multidisciplinary and inter-agency work. The challenge now is to determine the optimal methods for delivering high-quality treatment and ensure that this is provided in all settings.

SUBSTITUTION THERAPY IN CENTRAL AND EASTERN EUROPE

1. An overview

During the 1990s, almost all CEE countries faced a rapid increase in heroin use. Before 1990 heroin was more common in the southern part of the CEE region, which was crossed by the so-called “Balkan route” of heroin trafficking and nearby states like Macedonia, Croatia, Slovenia, Bulgaria, Hungary, Czech and Slovak republics. In the northern part of the region (Poland, Baltic States, Russia) heroin was almost non-existent and homemade opioids prevailed (“kompot” in Poland, “cherny” in Baltic States and former Soviet Union). With the establishment of market economies and loosening of border control, the prevalence of heroin dependence sharply increased throughout the region, including Russia and the Baltic States. In particular, the situation in the former Soviet Union countries changed rapidly in 1996–97, when large quantities of heroin started to appear on the black market from Afghanistan through the borders of newly independent countries.

The price of heroin in the Baltic States, Russia, Belarus and Ukraine has decreased almost threefold in the last three to four years, thus making it widely accessible to the low-income youth of these countries. Prices remain extremely low especially in the Central Asian countries bordering Afghanistan. In many of the post-Soviet countries, opioid users constitute anywhere from 80–90% of the total number of registered drug users applying for treatment. In Russia in 2001 there were 254 385 persons officially registered by medical services as being opioid-dependent, constituting up to 89% of all officially known drug-dependent persons.

In the 15 years prior to 2001, a thirtyfold increase in opioid dependence was recorded in **Belarus**, with a major rise in heroin use. In 2001, there were 3600 HIV-positive individuals reported, of whom 88% were injecting drug users. A pilot programme of methadone prescribing has been planned but the project is on hold.

In **Bosnia and Herzegovina** the war burdened the civilian population with a major trauma. It was postulated that this posttraumatic state had a significant impact on the overall rates of drug use. Treatment facilities including methadone existed before the war, but had completely stopped and all records were lost during the war. For the Federation of Bosnia and Herzegovina, methadone maintenance treatment started again in 2002. There is now one well-structured programme in Sarajevo and some less structured programmes in other cities.

During the 1990s, heroin use expanded throughout **Bulgaria**, spreading into small towns and rural areas. While the mean age of first use dropped, rates of HIV remained low among injecting drug users. A methadone programme is operating in the Bulgarian National Centre. Expanding the capacity of this treatment and development of training to support this has been proposed. Opioid agonist treatment is also provided in the private system.

The use of methadone in managing opioid dependence was introduced in **Croatia** in 1990. There was a substantial programme in existence that involved the use of a range of primary care centres. There is now over 10 years of experience with substitution therapy and primary care services are key participants. There are about 4000 clients in methadone treatment (detoxification and maintenance). There are 26 centres and about 1000 General Practitioners involved in opioid agonist treatment.

In the **Czech Republic** approved programmes using methadone started in 1997. In 1999 a Maintenance Treatment Task Force with the aim of improving standards of substitution therapy was established. There are currently eight facilities. The expansion of these services is intended, though dependence on health insurance presents a significant difficulty. A further issue is the need to ensure health insurance companies are mandated to fund this type of treatment. Another significant challenge to the treatment system has been responding appropriately to the needs of ethnic minorities such as the Roma population. Efforts are currently focused on improving the quality of treatment provided and reducing the illicit use of benzodiazepines.

In recent years, dramatic changes have taken place in **Estonia**. There was a major upsurge in heroin use among young people of particular ethnic extraction, and this resulted in over 1000 new cases of HIV among injecting drug users in 2000. The prevalence of drug use and HIV infection is high among prisoners. There is a need to support the expansion of treatment and to develop training to assist those working in primary care to develop the knowledge and skills required to address this major problem. Currently methadone is widely used for detoxification, but maintenance treatment is only provided for a small proportion of users. A second, small programme commenced in 2002.

Heroin problems in **Hungary** increased rapidly during the early 1990s. As a result of this, methadone treatment was established in three cities with over 200 people in maintenance and 300 in detoxification treatment. Guidelines for treatment have been developed and evaluation studies have been proposed.

In **Kyrgyzstan** there has been a major increase in the prevalence of opioid dependence, and over 80% of opioid dependent people are injecting drug users. Currently there are two pilot programmes of methadone maintenance treatment. These were planned as high threshold programmes with high levels of control and scrutiny. The future development of services will depend on the outcome of these pilot programmes.

Heroin appeared in **Latvia** in the 1990s and there has been a substantial increase in opioid use since this time. There is a high injecting rate, and both HIV seroprevalence and overdose mortality are increasing. There are approximately 80 people in a methadone maintenance state programme. The high proportion of very young heroin addicts presents a significant challenge, and has created substantial debate regarding compulsory treatment for young people.

In **Lithuania**, with the support of the Open Society Institute, a needle exchange and treatment network was developed in the mid-1990s in three centres. National Methadone Treatment Guidelines were produced, and by 1997 these had been revised to facilitate the involvement of Primary Health Care in substitution therapy of opioid dependence. The rates of HIV among injecting drug users have remained low, with an overall rate of 1.9%. Overall this package of treatment and prevention response is perceived in Lithuania to have contained the HIV problem. While there is support for further development, funding remains a significant challenge. Currently methadone maintenance treatment is available in five cities with high retention in treatment.

Opioid use in **Poland** evolved from the use of "kompot" during the late-1960s and 1970s. In the late 1990s, with an expanding economy, pure heroin, or "brown sugar" became increasingly available, particularly to the wealthy, urban youth. While the smoking of "brown sugar" was the primary method of administration, a considerable injecting problem subsequently evolved. The first substitution programmes started in 1992, further programmes were developed in 1994 -1995, and by 1999 medium threshold programmes had been established. Overall it was viewed that these treatment programmes had high efficacy in HIV prevention, but that HIV positive individuals were over-represented in the programmes. There was a significant reduction in drug use and a major reduction of drug overdose among those retained in treatment. There was ongoing growth of services and increased acceptance of this type of treatment by both the public, by policy makers and also by professionals in the health and social care field. Overall there is a need to expand the capacity of these programmes but this requires recognition by the insurance companies of the importance of funding such treatment. There is a need for some form of regulation to ensure that insurance companies adequately support this type of treatment. The majority of patients are eligible to receive free treatment. For insured patients, treatment is supported by the national Health Fund (insurance company), while treatment for those without insurance is supported by the Ministry of Health.

Notwithstanding, access to treatment is difficult, with a waiting time for entry of up to 2.5 years in some centres.

In the **Russian Federation**, there has been a manifold increase of heroin and other opioid dependence, and an equally dramatic rise in the seroprevalence of HIV among IDUs. Currently methadone programmes are prohibited and there is significant concern and opposition to the development of methadone or other substitution programmes. Between 1996 and 2000 there was a tenfold increase in the seroprevalence of HIV among injecting drug users. While many cities or regions of the world have experienced outbreaks driven by drug injection, none have experienced as large and sustained an epidemic among IDUs as in Russia, where up to 90% of HIV/AIDS cases were attributable to injecting drug use.

Slovakia experienced a substantial rise in opioid dependence in the mid-1990s. However, it appears from available statistics that this situation has now stabilized, which is reflected in the decline in new treatment episodes. Methadone treatment is available in some centres. The HIV rates remain very low, at less than 0.5% among injecting drug users. There was a desire to expand methadone treatment from its current modest rate of about 400 users to 2000, but there were difficulties obtaining the funding to support this. Access to methadone maintenance is provided by specialist health centres, and is limited to the capital and its surroundings. Maintenance treatment with buprenorphine is available throughout the country and is provided by psychiatrists. About 100 persons receive this form of treatment.

In **Slovenia**, major development has occurred in the past seven years in terms of pharmacotherapy and other forms of treatment and prevention programmes. Overall the current challenge is to ensure that funding is made available to continue these developments and to ensure that the quality and access to programmes continues to improve.

In **Ukraine** there was a constant increase of registered clients with opioid dependence. Injection buprenorphine in low doses is used for the treatment of withdrawal symptoms of opioid dependence. Buprenorphine for sublingual use is imported from India and much more expensive than the injection-based substance. There was a considerable dispute about methadone; however it is now registered for use. A draft of the guidelines for methadone maintenance treatment has been developed. HIV/AIDS remains a major challenge and there is a need for a broad network of interventions to tackle this major problem.

Table 3. Methadone maintenance treatment across CEE in 2003

<i>Country</i>	<i>Available since</i>	<i>Number of treatment centres/ units</i>	<i>Number of patients</i>
Bosnia & Herzegovina	1990, 1999*	1 for Canton of Sarajevo (further less structured ones in other cantons)	75 (Canton of Sarajevo, 09/03)
Bulgaria	1995	1	300 (in 2002)
Croatia	1990	6	974 (in 2002)**
Czech Republic	1997	8	about 450 (in 2002)
Estonia	1999	3	9 (in 2002)**
Hungary	1995	4	706 (in 2002)**
Kyrgyzstan	2002	2	106 (in 2002)**
Latvia	1996	1	71 (in 2002)**
Lithuania	1995	10	568 (in 2002)**
Poland	1992	11	800
Slovakia	1997	1	about 400
Slovenia	1989, structured since 1995	19	2463 (31/01/03)

* Programme was stopped by the war, renewed in 1999 at the level of Canton Sarajevo and in 2002 at the level of the Federation of Bosnia & Herzegovina.

** Source: Newsletter of the Central and Eastern European Harm Reduction Network, Issue 1(5), 2003.

Table 4. Detoxification and long-term opioid agonist treatment (maintenance) in CEE

<i>Programme</i>	<i>Country</i>
Detoxification and Long Term Treatment	Bosnia & Herzegovina, Bulgaria, Croatia, Czech Republic, Estonia, Hungary, Kyrgyzstan, Latvia, Lithuania, Poland, Slovakia, Slovenia
Only Detoxification	Ukraine
None	Russian Federation, Belarus

To summarize the current situation, there appears to be a **significant rise in the levels of heroin use in most countries**. The challenge of ongoing spread of HIV among IDUs is a critical problem in many but not all countries, with the Russian Federation, Belarus, Estonia, Latvia, and the Ukraine reporting rapid rises in seroprevalence among IDUs.

The **extent and nature of services for drug dependence vary substantially** with some countries prioritizing the containment of HIV and the reduction of drug related harm. It is difficult to compare across countries because of the substantial variations in social and economic infrastructure and the differing methods for funding and supporting health and social care interventions.

There are significant **variations in the legal basis for using methadone**, with the Russian Federation still prohibiting its use. In Ukraine, methadone has recently been registered and preparation is underway for several pilots. In Kyrgyzstan there is a pilot methadone maintenance programme in two cities being conducted. In Belarus substitution therapy is legally possible and there are preparations to initiate this form of treatment.

The discussion group considered that **evaluation and outcome studies may demonstrate the value of such treatments**. Funding of treatment programmes is a major issue for many countries. The need for further evaluation in order to assess current performance and to support the development and expansion of these treatments was strongly emphasised.

2. Treatment approaches

All countries reported that treatment existed within the framework of a national treatment policy and that a national treatment structure aimed to provide a range of treatments. Some countries had greater emphasis on long term inpatient and other detoxification and rehabilitation facilities. There was a trend for these types of facilities to be reduced and for more outpatient and community based facilities to be developed, particularly in countries where major reforms had taken place. There are three sectors – governmental, nongovernmental organizations (NGOs) and private – involved in this field, and each have different treatment modalities and different coverage of people with opioid dependence.

In Belarus, Kyrgyzstan, the Russian Federation and Ukraine, the governmental system of drug treatment institutions with regional narcological dispensaries and narcological departments in psychiatric hospitals, provides inpatient and outpatient treatment free of charge or on a partially paid basis for a proportion of people with opioid dependence. The treatment process starts with detoxification (7–10 days), followed by stabilization of physical and mental health status (in the Russian Federation) or “treatment of drug dependence” (Kyrgyzstan) with a cognitive behavioural therapy approach. The third stage (rehabilitation) is provided on a limited basis by the public health sector, but it is primarily NGOs and the private sector offering this service. Rehabilitation facilities include rehabilitation centres, therapeutic communities and 12-step programmes (including outpatient treatment). Self-help groups for people with opioid dependence and their relatives are also available. In Ukraine a non-governmental sector of drug treatment services is rapidly developing. In the Russian Federation, government and municipalities provide funding for establishing rehabilitation centres. In Belarus one rehabilitation centre was opened by the government and NGOs operate two others. In Ukraine a new provision exists for pharmacological treatment of opioid dependence that provides permission to licensed professionals to prescribe controlled substances for treatment in

private, NGO and public health sectors. A biopsychosocial approach is becoming prevalent in Ukraine and Belarus, whereas a more biomedical approach is prevailing in the Russian Federation. In all these countries abstinence-oriented treatment is dominant.

In the Czech Republic a new drug treatment system commenced in 1990–1991 when the first drop-in centre was organized and numerous outreach and low-threshold programmes were established. These services provided needle exchange, consulting and vitamins, and served as entry points to other drug treatment modalities, including MMP (methadone maintenance programmes) and drug-free programmes. In the Czech Republic only four clinical departments in psychiatric hospitals now provide drug treatment, including one MMP, and 95% of services are in the NGO sector. The government funds the comprehensive system of services on a grant basis. The government coordinates the services by the funding system and the National Drug Commission, while NGOs are coordinated by elected bodies.

3. Current practices of substitution therapy

There are a range of different approaches available in CEE countries, including detoxification (inpatient and outpatient) with methadone, morphine, buprenorphine, dihydrocodeine and also tramadol (in Croatia and Hungary). Substitution treatment, predominantly with methadone, exists in all of these countries, except Russia and Belarus. In Eastern Europe, methadone is usually consumed under the supervision of medical staff in specialized treatment centres. Methadone is not available in pharmacies or by prescription from General Practitioners (GPs). Psychiatrists are responsible for managing methadone maintenance patients, in some cases with the cooperation of GPs (e.g. Lithuania). Regarding Central Europe, in Croatia and in the Czech Republic GPs are involved in the provision of methadone. 'Take home' doses of methadone are available under certain restrictions. Urine controls are not mandatory, but definitely recommended. Entry criteria into methadone maintenance treatment programmes also differ slightly among countries.

Buprenorphine, slow-release morphine and, for short term usage, codeine are used in some of the countries. In the Russian Federation there were episodes of using Norphine (Buprenorphine) for detoxification. Morphine has been also used for detoxification. Kyrgyzstan used Norphine and Tramadol for detoxification. Two methadone pilot programmes for about 100 clients have been running in Kyrgyzstan since 2002.

Table 5. Dosages in methadone maintenance treatment

<i>Country</i>	<i>Average dosage per day</i>	<i>Maximum dosage per day</i>
Bosnia & Herzegovina	76.6 mg.	160 mg.
Bulgaria	90 mg.	no limits
Croatia	65 mg.	150 mg.
Czech Republic	30–87 mg.*	n.i.
Estonia	40–80 mg.*	n.i.
Hungary	60–100 mg.*	n.i.
Kyrgyz Republic	66.3–80 mg.*	n.i.
Latvia	70–80 mg.*	n.i.
Lithuania	30–55 mg.*	n.i.
Poland	ca 80 mg.	no limits (in some cases 140–180 mg.)
Slovak Republic	60 mg.	no limits
Slovenia	78 mg.	150 mg., but can be more

* Source: Database on substitution treatment in Central and Eastern Europe and the Newly Independent States from the Central and Eastern European Harm Reduction Network (CEEHRN).

n.i. = no information

4. Eligible populations for maintenance treatment

Adults aged from 18 or 21 years and above are officially entitled to obtain methadone maintenance treatment in most countries, except for Slovenia where the minimum age is 16 years. HIV positive and pregnant women have priority for treatment entry. Access to treatment for homeless people is also a priority in Hungary. Waiting lists for MMP vary widely across countries. The countries with the highest levels of provision have the shortest waiting times.

5. Perceived barriers

It was reported that, in some countries, methadone programmes had a negative image presented by the media, and this is reflected in the views of both the general population and often the professionals. This is understood to be part of an overall stigma associated with substance abuse services. A lack of financial resources was a critical obstacle to service development and evaluation. Overdoses are often misused by the media as an argument against methadone, despite the fact that methadone treatment reduces the risk of overdose mortality.

Currently, every country has some form of recommendation, protocol or manual on maintenance treatment except the Russian Federation and Belarus where this form of substitution treatment has not yet been developed. In Ukraine a draft of the guidelines for methadone maintenance treatment has been developed. The absence of 'culturally sensitive' national guidelines, manuals and protocols may have contributed greatly towards existing misconceptions about the goals and practices of substitution treatment in the Newly Independent States.

The major needs and priorities in the coming future include intensifying education efforts, training of professionals, involving more GPs and identifying avenues for increasing funding.

6. Training needs and priorities for development

Most countries had one key centre that functioned to deliver substitution treatment and to support the further development of this treatment within the context of a broad and comprehensive range of treatment options. All countries reported that resource constraints limited its range of activities and that many would further develop research, monitoring and evaluation if adequate resources were available.

Several types of training possibilities exist in some countries:

Slovenia has a National Treatment Centre (under the Ministry of Health) which coordinates training of all professionals in maintenance treatment, and provides direct training for the staff of specialized methadone maintenance programmes. There are one-day educational seminars every month for staff from the MMP. Regional centres are responsible for training of GPs in their regions.

The Czech Republic has incorporated education on substitution treatment into curricula for postgraduate training of physicians in psychiatry. Professionals may also participate in specialized training courses on methadone maintenance.

In Croatia, the National Institute for Drug Addictions is responsible for training of all interdisciplinary teams for both specialized treatment centres and for GPs.

In Slovakia, the Institute for Drug Dependencies has provided training in methadone maintenance for medical professionals from the states of former Soviet Republics in Central Asia. There is also a willingness to provide such training for local experts if expansion of methadone maintenance treatment in the Slovak Republic is approved.

In Bulgaria, the National Centre for Addictions is willing to provide training upon approval from the Ministry of Health.

In Hungary, there are supervisory meetings once every three months for professionals from existing methadone maintenance programmes. The course, which consists of one week of theoretical education and one week of practical experience, is required for medical professionals before entering work in MMP.

Lithuania had developed training and also supported aspects of the development of programmes in other countries based on their practical experience to date.

Poland has a number of centres, including the Institute of Psychiatry and Narcology that has provided training for specialists and general practitioners.

The provision of training for specialists and general practitioners differs between countries. A number of countries reported that training was available for both specialists and general practitioners but that the utilization of such training opportunities had been limited.

Table 6. Training for methadone maintenance treatment

<i>Country</i>	<i>Training exists</i>	<i>Certification necessary for prescribing</i>
Bosnia & Herzegovina	yes	yes
Bulgaria	yes	yes
Croatia	yes	yes
Czech Republic	yes	n.i.
Estonia	n.i.	n.i.
Hungary	yes	n.i.
Kyrgyzstan	n.i.	n.i.
Latvia	yes	n.i.
Lithuania	yes	n.i.
Poland	yes	Certification for centres given by "vojevoda" (governor of Psychiatry and Neurology, Warsaw). Foreign training is accepted
Slovakia	no	no
Slovenia	yes	yes

n.i. = no information

Greater political support is considered necessary for substitution programmes in all countries. The development of guidelines and their implementation requires a range of personnel, including pharmacists and other key staff. A multi-disciplinary team would assist in further development of knowledge and understanding of the day-to-day delivery of this treatment. Increased legal and physical protection of substitution treatment by official authorities was also underlined.

The importance of including ex-users and users in the process of designing substitution programmes and training programmes for professionals was stressed.

In all respective countries the training needs and priorities were:

- how to increase participation by trainees and professionals in substitution treatment training, especially psychiatrists and GPs
- improvement of training skills for the work with ethnic minorities, especially Roma and Sinti people
- need to improve counselling skills by staff
- consistency, continuation and sustainability of training

7. Practice of treatment documentation and evaluation research

All countries reported that some form of documentation and evaluation was currently underway but all also expressed considerable interest in collaboration on any future evaluation project.

Poland reported that a number of methadone evaluations had been conducted. Resources were a major issue for future activities and it was pointed out that if international funding were obtained, assistance could be provided in sourcing matched local funding.

Table 7. Status of maintenance pharmacotherapy in CEE in 2003

<i>Country</i>	<i>Methadone maintenance</i>	<i>Buprenorphine maintenance</i>	<i>Guidelines</i>
Belarus	no, but is legally possible	no	no
Bosnia & Herzegovina	established	no	yes
Bulgaria	yes, but not officially registered	no	yes
Croatia	established	no	yes
Czech Republic	established	yes	yes
Estonia	established	no	yes
Hungary	established	no	yes
Kyrgyzstan	pilot programmes	no	yes
Latvia	established	no	yes
Lithuania	established	Buprenorphine got registered in 2002	yes
Poland	established	no*	yes
Russian Federation	no, is prohibited	no	no
Slovakia	established	yes	yes (methadone)
Slovenia	established	Registration of buprenorphine is underway	yes
Ukraine	Methadone is registered, currently preparing for several pilot programmes	no	no

* Buprenorphine in low doses is registered for pain relief purposes but not for maintenance treatment.

The role of needs assessment could be used to highlight the current mismatch between actual levels of provision and demand for substitution treatment.

The groups strongly supported the suggestion for further evaluation in this field. They expressed a need to consider the complexities of treatment outcome across the various national, cultural and treatment groups involved in evaluation research.

CONCLUSIONS AND RECOMMENDATIONS

1. There are major public health and social reasons for investing in the support of a broad and comprehensive range of treatment options for people with drug dependence in CEEC and the Newly Independent States. The rapid rise in the 1990s of heroin use and injection drug use and the rise in HIV and hepatitis seroprevalence in this population necessitate the development of treatment practices.
2. There is now a good evidence base indicating that opioid agonist substitution can have a significant impact on reducing illicit opioid use, reducing drug injection and other drug-related risk taking behaviour, reducing acquisitive criminal behaviour and improving levels of psychological and social well-being and reintegration. This treatment approach should be part of a broad and comprehensive range of treatment options.
3. It was observed that substantial improvements were required in international collaboration and networking with regard to treatment practices. To this end it was recommended that the WHO could assist by providing guidance and support in the following ways:
 - Development of written materials such as treatment manuals and treatment guidelines.
 - Supporting further training initiatives.
 - Providing support for the development of a treatment research network.
 - Providing support for the further development and improvement of approaches to monitoring and evaluation.
4. The range of activities listed above could be promoted in collaboration with WHO, WHO collaborating centres and other relevant organizations.
5. Consideration should be given to developing a multi-site evaluation project which would comprise of two stages:
 - The first stage would involve the preparation and development of a research protocol by a collaborative research network.
 - The second stage would implement a multicentre research trial.
6. WHO publication on the development and current provision of opioid agonist therapies in the CEE Region would be a helpful resource for individual countries.
7. The conclusions of this meeting and the importance of the further development of opioid agonist pharmacotherapy require joint consideration by a range of international organizations including WHO, UNAIDS (Joint United Nations Programme on HIV/AIDS), UNODC (United Nations Office on Drugs and Crime) and the EMCDDA (European Monitoring Centre for Drugs and Drug Addiction). The key issues should be jointly supported by these organizations and well communicated to the individual governments of the region.

PART TWO

Key Informant Country Reports

REPUBLIC OF BELARUS

Dr Vladimir Maksimchouk
Ministry of Health, Belarus

1. Country profile

Size:	207 595 km ²
Inhabitants (2000)	10 006 000
Capital:	Minsk (pop: 1 725 100)

2. Epidemiological data available

The situation concerning opioids in Belarus remains tense. The number of people who become dependent on drugs increases every year. According to the statistics of the Ministry of Health for January 2001, there were 4545 individuals with drug use disorders (of which 2116 were using substances episodically) registered in clinics for drug treatment. The increase in the number of drug cases is observed in all regions of the republic. The largest number, however, is registered in the Gomel region and Minsk City. The number of known cases of drug use disorders has increased 2.1 times relative to the number in 1996. Drug use has become more prevalent in the Vitebsk and Minsk regions. The changes in registered cases of drug use disorders in the republic are shown in Tables 1 and 2.

Table 1. Dynamics of cases of drug use disorders in different regions of the Republic of Belarus

Region	1995	1996	1998	1999	2000
Minsk	337	405	677	972	1513
Brest region	246	321	447	519	567
Vitebsk region	53	95	185	210	284
Gomel region	482	867	989	1098	1176
Grodno region	204	231	291	298	379
Minsk region	127	178	271	285	366
Mogilev region	77	99	186	228	260

Table 2. Registered new cases of drug use disorders in different regions of the Republic of Belarus

Region	1995	1998	2000
Minsk	107	201	477
Brest region	65	58	48
Vitebsk region	23	61	90
Gomel region	216	228	213
Grodno region	44	83	86
Minsk region	47	110	120
Mogilev region	36	89	84

The number of registered individuals with drug use disorders has increased by 52.3% since 1995. The increase in the number of registered individuals with drug use disorders, and the number of new drug cases recorded each year, are displayed in Figures 1 and 2.

Figure 1. Number of registered individuals with drug use disorders in the Republic of Belarus

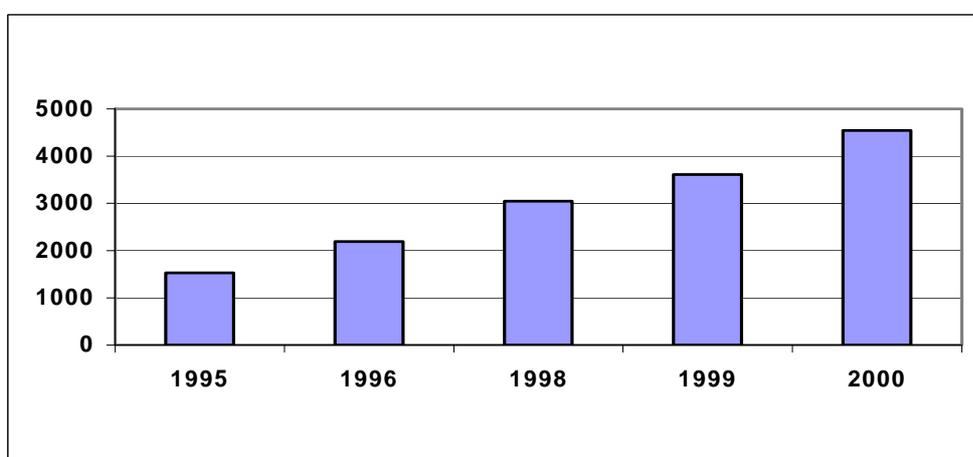
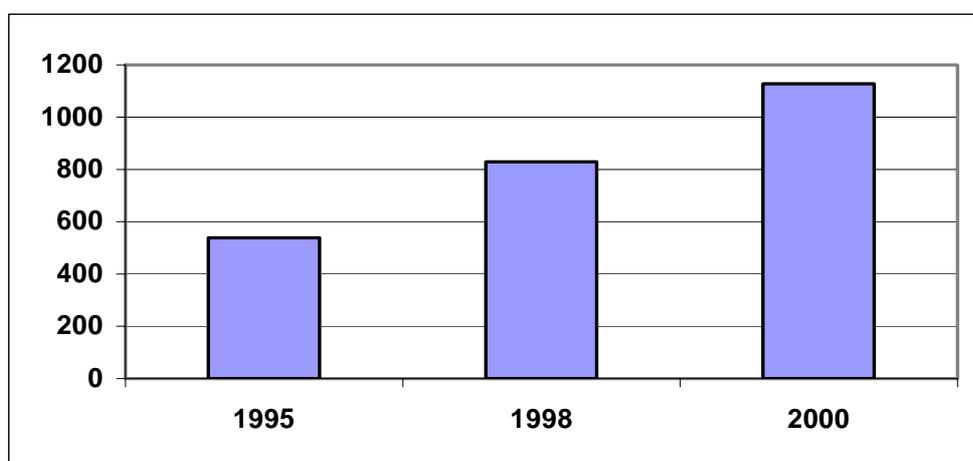


Figure 2. Registered new cases of drug use disorders in the Republic of Belarus



The number of registered drug addicts in 2000 was 45.4 per 100 000 of the population, and the number of those registered within the year was 11.3 per 100 000 of the population. The kinds of illicit

substances (according to the Medical–Biological Laboratory for Narcology by Grodno Medical Institute) are shown in Figure 3.

The growth of opioid use in the population is closely connected with the increase of criminality. The number of drug related crimes has increased by over 11 times in the last ten years. For the last 2–3 years, an increasing number of people with drug use disorders have maintained dens for production and use of illicit substances. The official estimates of the prevalence of drug abuse in Minsk are highly understated. It is considered that there are a minimum of 4 times as many drug users than the estimates assert, and between 8 and 10 times more teenage drug cases than estimated. Figure 4 shows the marital status of drug abusers in the republic for 1999 and 2000.

Figure 3. Type of substance abuse

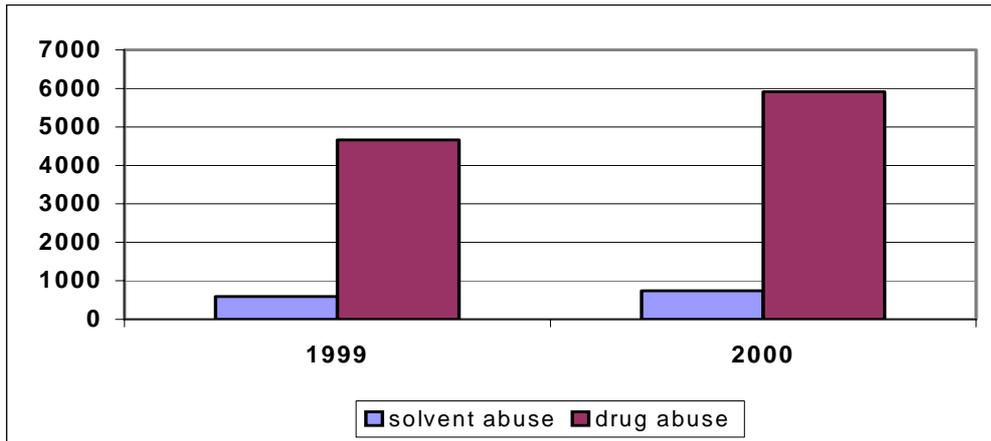
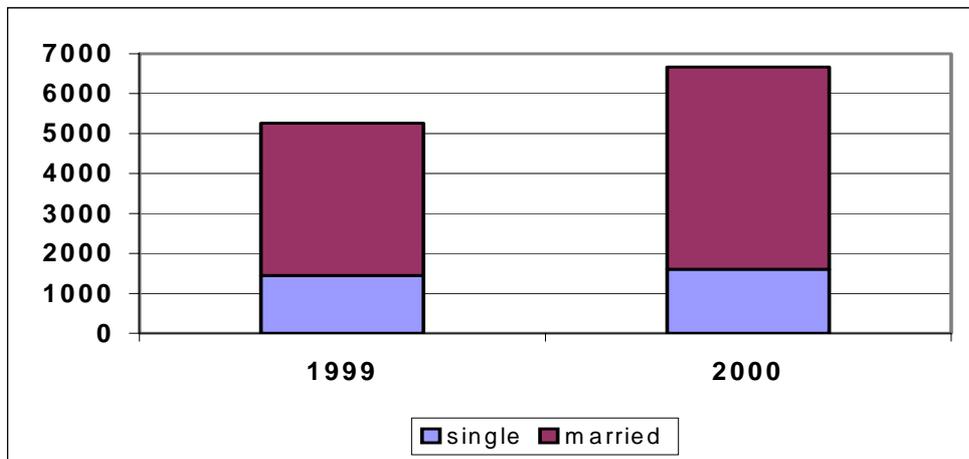


Figure 4. Marital status of drug abusers



3. Health consequences

Seroprevalence of HIV

In Minsk, it has been estimated that up to 91.2% of opioid users inject. High risk injecting practices, such as needle sharing and lack of sterilization of injecting equipment, are also widespread. HIV has spread throughout Minsk and the republic. HIV was first detected in the country in 1996, and by August of that year, 15 drug users were reported to be HIV–positive. According to the data of the Republican AIDS center, over 3000 drug–related cases were registered in the republic in 2001, and given the high rate of injecting among drug users, this situation is likely to worsen.

4. Treatment of drug dependence

People with drug dependence and solvent abusers are treated in specialized establishments. Drug dependent individuals and solvent abusers usually undergo some course of medical treatment in specialized establishments that are part of the narcological service. The narcological service is a system of specialized outpatient and inpatient sub-units in the medical care system that renders medical-prophylactic, medical-social and medical-legal assistance to alcoholics and drug users. It cooperates not only with militia and health bodies, but also with other ministries, departments and social organizations.

Narcological clinics have existed in this country since 1976. Compulsory methods of treatment initially prevailed. Currently the principal treatment is voluntary application, and clinical supervision terms have been reduced to three years. The treatment itself has become more intensive, complex, including also psychological, social and psychotherapeutic assistance. Only 5% of drug addicts (maximum 10%) attend treatment courses by themselves. Others fear that they will be registered as drug users.

Some examples of treatment options for drug dependence include:

1. Rapid and ultra-rapid detoxification
2. Solutions of aminoacids
3. Post-detoxification treatment
4. Naltrexone (Antaxone) treatment

Legislative framework

The normative acts regulating the activity of health bodies for registering and revealing cases of drug dependence include laws and legislative acts and department normative acts that are adopted by the Ministry of Health itself or in conjunction with other ministries (e.g. Ministry of Internal Affairs).

Basic normative acts:

- ❑ Law of the Republic of Belarus (RB) "On health Protection". Department of the Supreme Soviet of Republic of Belarus. 1993 n° 24 Art. 290.
- ❑ Law of RB "On psychiatric care and citizens guarantees", adopted by the Soviet of the Republic on 24 June 1999.
- ❑ Law of RB "On compulsory influence towards chronic alcoholics and drug-abusers who systematically violate rights of other people" – Departments of the Supreme Soviet of Belorussian Republic.

5. Main problems and needs

- ❑ Development of legislative acts
- ❑ HIV prevention
- ❑ Primary prevention which is the prerogative of the Ministry of Education, Ministry of Health
- ❑ Supply reduction
- ❑ One of the most effective approaches to reducing the number of HIV infected drug users is implementation of methadone programmes in treatment process.
- ❑ Lack of rehabilitation centers for people with drug dependence in the republic.

FEDERATION OF BOSNIA AND HERZEGOVINA

Dr Nermana Mehić-Basara

Public Institute for Alcoholism and Substance Abuse, Sarajevo

1. Country profile

Size:	51 129 km ²
Inhabitants (2000)	3 923 000
Capital:	Sarajevo (pop: 552 000)

Bosnia and Herzegovina is a state consisted of two entities:

- A joint Bosniak-Croat Federation (about 51% of the territory)
- Republic Srpska (about 49% of the territory)

2. Epidemiological data available

Problems related to the abuse of various psychoactive substances in Bosnia and Herzegovina were first registered during the early 80s. The first cases of opioid abuse were noticed as early as 1973 but the “experts” and public opinion minimized or completely denied the existence of this problem, even when the first addicts started dying from drug overdose and other health-related consequences of drug abuse. It was claimed that this was “imported fashion” from the West and that only sons of rich and respectful parents, “because of pure rage” were taking the drugs. The general view was that the youth were “immune” to that vice, because they live and are raised according to the socialistic spirit, and therefore do not need drugs to alter their conscience and “run away from reality”, like youth in capitalistic countries. Because that consensus to deny the problem in society existed, the police were hiding real statistical data in relation to drug markets, confiscated quantities of drugs and criminal notifications. Behind this seemingly idyllic social situation lurked a dark and expanding narcotic scene. Since the beginning of drug abuse until today the majority of users have been men. Female addicts have been less typical, and are usually thought to be victims of their partner's dependence, wishing and needing to help their boyfriends recover from their addiction.

Keeping in mind previous remarks, it is perfectly clear that in Sarajevo, and especially in Bosnia and Herzegovina, it was never possible to obtain an objective picture of this problem, due to the lack of real epidemiological data. The majority of opioid addicts before 1992 were taking heroin intravenously. It is worth pointing out that almost all addicts use a number of other drugs and medications besides heroin. The “specialty”, particularly in the Sarajevo region was, and still is, abuse of anticholinergic (antiparkinsonian) medications, mixed with beer and other alcoholic beverages thereby causing characteristic change of conscience. Up to 1992 many problems related to use and abuse of various drugs were under considerable social control, although even then activities in prevention, therapy, and rehabilitation were sporadic and linked to the relatively small number of enthusiasts who were working with addictive medicine at that time.

The beginning of the war brought disorganization to professional psychiatric services and many organizations dealing with prevention and rehabilitation problems for a great number of addicts, primarily alcohol dependents. Catastrophic war events led to social and economic disorganization of society. Huge numbers of people were killed or severely wounded. Many civilians were expelled from their homes and scattered all around the country and the rest of the world. This unseen suffering (1992 – 1996), which had not been seen in Europe since World War II, has led to difficult consequences for individuals, as well as the broader social structure. Society after the war in Bosnia and Herzegovina possessed all the characteristics of a post-traumatic society, namely, a tremendous amount of unemployment, a huge number of physically handicapped people, a large number of stress-related mental disorders, increased number of suicides and homicides, increased levels of criminality and violence, the emergence of family violence and intolerance, and abuse of alcohol and other psychoactive substances.

Problems of psychoactive substance abuse in Bosnia and Herzegovina were primarily linked to the urban settings, such as Sarajevo, Tuzla, Mostar, Travnik and Zenica. Just prior to the beginning of the war in 1992, the Counseling Center for Prevention and Therapy of Drug Addiction of the Psychiatric Clinic in Sarajevo had registered approximately 1000 drug abusers (since 1978). Among these were 45–50 patients who were addicted to heroin and were on maintenance treatment with methadone. A well-organized and highly professional multidisciplinary team led this sophisticated programme. In other cities, the fight against this problem was led by psychiatric services with varying degrees of success.

All organized activities in the field of prevention and treatment of drug abuse stopped in the spring of 1992. During the war only occasional cases were treated due to overdose, withdrawal and toxic psychotic states. By 1996 there was already a noticeable increase in cases of drug abuse, primarily heroin, cannabis products, antiparkinsonian medications, glues, solvents, cocaine, stimulants (Ecstasy) and very rarely LSD-25. Since then, use and abuse of drugs throughout Bosnia and Herzegovina has been continuously increasing, with the simultaneous increase in smuggling of large quantities of drugs (heroin, marijuana, cocaine etc.) through our country towards Western Europe. A certain amount remains in our country, and local drug dealers are selling them for “affordable” prices in many places, especially in elementary and high schools. Regardless of preventive measures of repression from the criminology and police department, the quantity of drugs in the “market” is growing almost every day, and numbers of those who are trying a drug for the first time or who are experimenting with the drugs is increasing. The proportions of these severe socio-pathological problems are unknown, but indirect indicators, such as quantity of confiscated drug, number of judicial charges due to drug handling, utilization of health services for drug abuse related problems, prevalence of fatal overdose, and occasional surveys among school youth, are indicating that the issue is becoming a severe social problem. Despite media reports of the prevalence of drug use within the region, there exists very little reliable epidemiological data to indicate the extent of this problem.

3. Organization of psychiatric services until 1992

1. Psychiatric ambulatory within Dom Zdravlja (Primary Health Care Unit)
2. Psychiatric wards within General hospitals
3. Specialized Psychiatric hospitals for mental patients
4. Institute for alcoholism and other dependencies
5. Special institutions for accommodation of people with disabilities due to mental disorders

1992

- Devastation
- Disintegration
- Disorganization
- A large quantity of documentation related to epidemiological data on alcoholism and drug abuse was destroyed

1992–1995 War period in Bosnia and Herzegovina

- Mass psychological trauma
- Comorbidity of trauma and dependency problems
- Lack of unique monitoring for follow-up of alcoholism and other dependencies

1996–2001 After war period in Bosnia and Herzegovina

- Reform of Health system
- Reform of Mental-Health system with orientation toward community
- Increasing use of alcohol and other psychoactive substances

Reform principles:

- ❑ Organization – With assistance from the World Bank, 38 Centers for Community Mental Health have been opened in the Federation of Bosnia and Herzegovina, and an institution of family doctors was developed
- ❑ Education – Continuously performed even during the war period, still going on. Focus of education is in the area of war trauma; mental health protection and community based psychiatry.
- ❑ Monitoring – We still do not have a comprehensive information system, and we therefore lack epidemiological data describing the prevalence and nature of alcoholism and psychoactive substance use.

Current events

- ❑ 1999 – Programme for prevention of alcoholism and drug addiction in Canton Sarajevo was assimilated
- ❑ 2000 – Federal Commission for development of Federal Programme for prevention of alcoholism and drug addiction was formed.
- ❑ September 2001 – Inpatient wards re-opened.

Figure 1. Registered number of people with drug dependence admitted at the Psychiatric Clinic of Sarajevo University

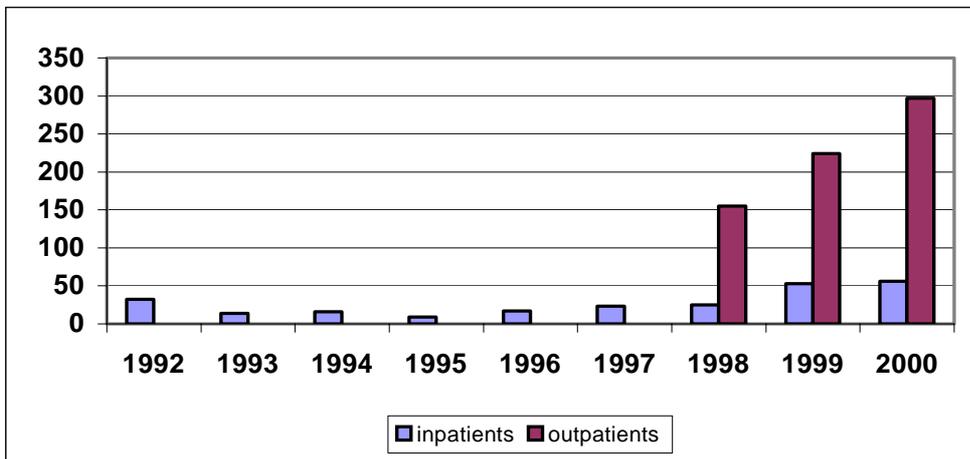
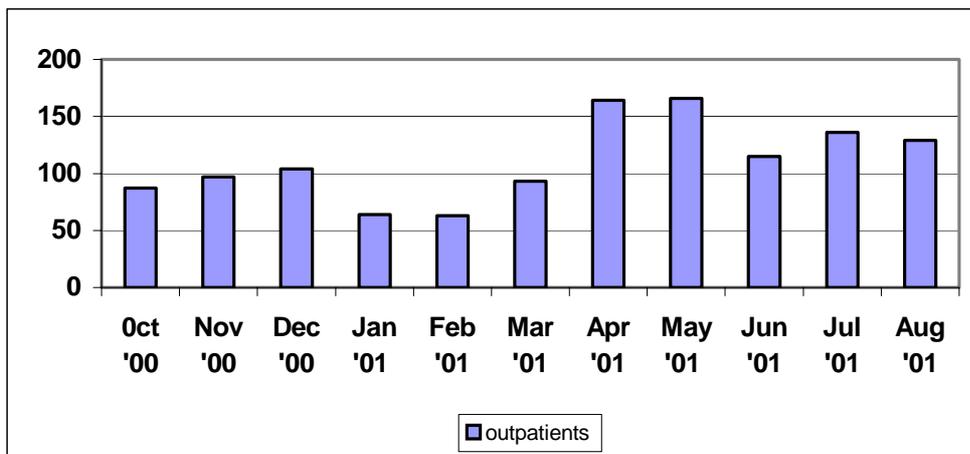


Figure 2. Registered number of people with drug dependence admitted at the Public Institute for Alcoholism and Substance Abuse of Canton Sarajevo



BULGARIA

Dr Georgi Vassilev
National Centre of Drug Addiction, Sofia

1. Country profile

Size:	110 994 km ²
Inhabitants (2000)	8 167 000
Capital:	Sofija/Sofia (pop: 1 114 168)

2. Epidemiological data available

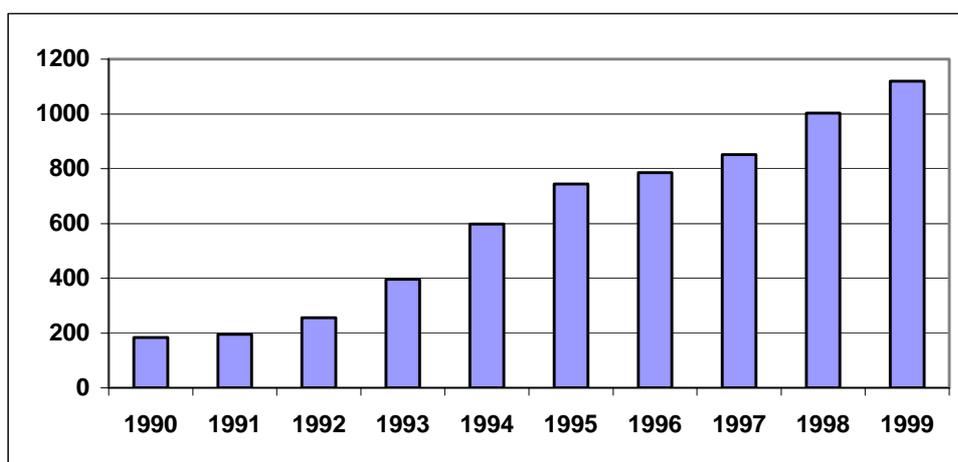
History of opioid use

Opioid use within the region may be traced to the period just after the national liberation and the reinstatement of the independent Bulgarian State in the year 1878. However, the recent generation of opioid abuse emerged in the 1960s and can best be described chronologically as spreading in several different waves. In the mid-1960s, as a reflection of youth processes and movements in the Western world, a small group of about 100–150 young people started to use psychoactive, mainly opioid, substances (morphine, lydol, codeine, etc.). They were medically treated and prosecuted for criminal behavior. Most of them were registered with the psychiatric services and police. The second wave appeared in the mid-1970s, and was motivated by personal, psychological and interaction problems in family and social environments. Drugs of choice were opioids and pharmaceuticals containing codeine, benzodiazepines, hallucinogenic medicines (antiparkinsonics) and volatile solvents (glue). In the mid-1980s, the number of registered drug abusing persons (The Ninth Revision of the International Statistical Classification of Diseases and Related Health Problems or ICD-9: codes 304 and 305) reached approximately 1400 and medical treatment for these individuals was mainly provided through psychiatric services. The formation of drug using groups was an important feature of this period. Drugs were supplied mainly through criminal activities in pharmacies, hospitals and pharmaceutical factories. Both periods of use primarily involved the administration of opioids by injection.

The third wave started in the late 80s, when public control significantly diminished and many rules and norms lost their value. This process gained power rapidly after 1989, when communications with the Western world were liberalized, and the social crisis and inter-generational conflict deepened. The main drug of choice was, and continues to be, heroin. This is mainly administered by injection, though smoking, sniffing, and inhaling are also reported. A network of drug dealers rapidly developed, which initially consisted primarily of Iranians who were staying in the country illegally. With time, Bulgarian criminal structures became heavily involved in the illegal drug market.

The fourth wave of opioid misuse started in early 1990s, and an epidemic spread of drug abuse is currently being observed. At present, the use of heroin is rapidly becoming a significant public health problem. The production of cannabis in the southern parts of the country is growing rapidly in number and in volume of produced cannabis products, which has led to a sudden rise in cannabis use amongst the youth in large urban areas. The use of “new drugs”, especially ecstasy, has permeated to wide groups of youngsters. The estimated number of daily heroin users in Bulgaria in 2000 was between 27 000 and 32 000. The number of occasional or episodic heroin users is likely to have been double. These estimates are based on the results from different studies, the observation of key experts, anecdotal and non-structured information. Between 1990 and 1999, the number of patients with a diagnosis of drug addiction (ICD-code 304) and admissions into psychiatric hospitals in Bulgaria increased more than 6 times (see Figure 1). In 1999 this number was 1120 had been identified at that time. The percentage of Hepatitis C positive among intravenous heroin users was 70%, while the percentage of Hepatitis B positive among the IDUs was between 5 and 10%, representing a decrease compared to the previous years. The estimated number of overdose deaths in 1999 for Sofia, the capital of the country, was approximately 60 cases.

Figure 1. Number of admissions into psychiatric hospitals in Bulgaria with diagnosis of drug addiction (1999–2000)



Substances used

Cannabis is the most widespread substance in terms of non-regular, annual use, particularly among pupils, university students and intellectuals. This is followed by heroin and benzodiazepines. The use of cannabis has also increased most rapidly during the last 2–3 years. In terms of daily drug use, heroin and cannabis are most widespread. The daily abuse of hallucinogens, volatile solvents and even cocaine seem not to be as significant. About 14% of surveyed 15 to 16-year-old pupils in Bulgaria report having ever used a drug. The data indicates that cannabis is abused to the greatest extent, with 25% of those surveyed reporting that they have experimented at least once with marijuana or hashish. Following this are cocaine (4%) and heroin (2%) which in accordance with other investigations and observations are abused at the largest scale among drug dependents.

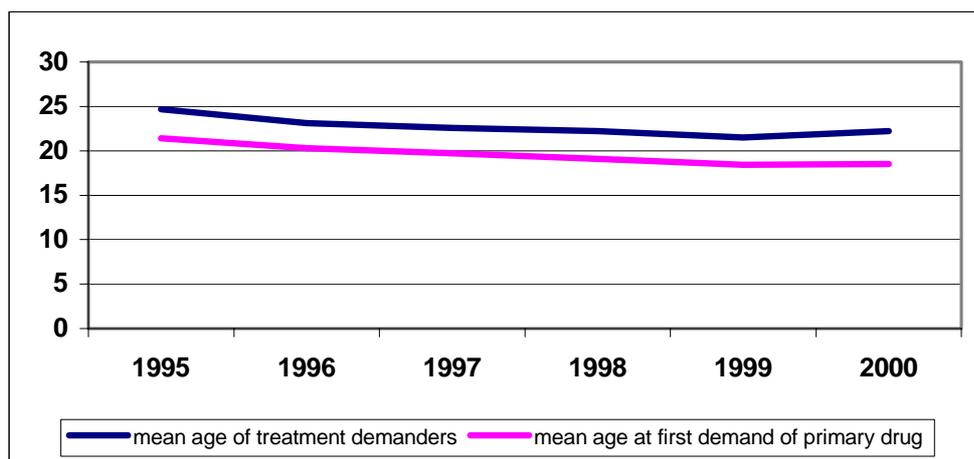
Gender and age

One of the most reliable sources of data about the users' age and gender is the Survey on Treatment Demands and First Treatment Demands in Sofia, conducted by the National Center for Addictions (see Figure 2). With regard to gender, about 3/4 to 4/5 of treatment demanders (79% in 2000) and first treatment demanders (79% in 2000) are male. This has been a relatively stable trend in the last 5–6 years.

The mean age of treatment demanders (TD) decreased constantly until 1999. In this year, the mean age for TDs was 21.5, and 20.7 for first-time TDs. An increase in age was observed in 2000; however there is no indication that this may be considered a stable trend. A slight increase was also observed in the mean age of first use of the primary drug. The majority of reported first use of primary drug continues to occur between the ages of 15 and 24. These trends correspond with expert estimates.

The main characteristics of the treatment demanders are as follows: the proportion of females remained relatively stable (about 20 to 25%); the mean age decreased until 1999; the majority are younger than 25 years when asking for treatment; most are living with their parents or extended family (relatively stable); most are casual workers or unemployed; and there are 15 to 20%, who are still undergoing full-time education (relatively stable).

Figure 2. Survey on treatment demands and first treatment demands



Source: National Centre for Addictions

Data collected through a representative study among young people aged 14–30 years old in Sofia is another source of information about the age specificity of drug use.

From this study, several significant facts may be noted:

- ❑ Concerning any illicit drug, those aged between 20–24 years display the greatest prevalence of use, followed by those 14–19 years old;
- ❑ Cannabis and hypnotics / sedatives are the most commonly used substances;
- ❑ Hypnotics / sedatives and cocaine are used more frequently by people between 25 and 30 years old; while cannabis, heroin, ecstasy, amphetamines are substances preferred by younger people.

In terms of gender specificity, it has been shown that the proportion of males (16.9%) who have ever used an illicit drug is significantly higher than the proportion of females (12.2%). This trend is consistent for all types of drug, except hypnotic and sedatives, where the proportion is inverse (10.0% males against 18.2% females).

Proportion of different users

Cannabis continues to be the primary drug of choice (followed by benzodiazepines) amongst 14 to 18 year old students (source: school surveys 1996, 1999, 2000). Studies in Sofia (source: Snowball sampling studies 1995, 1998) show that cannabis is also often the "gateway drug" for a large proportion of heroin users. At the same time according to available data from treatment demands and snowball sampling studies, heroin remains the main drug of regular misuse and dependence. The approximate number of regular heroin users in Bulgaria is in excess of 25 000–30 000. This number will be more accurate if the assumption is made that there are approximately the same number of people occasionally using (not in a regular base) heroin. Ethnographic studies and observations on the sites of dealing indicate that this approach is closer to the reality.

Between 1997 and 2000 the primary drug used by 95% to 98% of the treated population in Sofia was heroin or another opioid. A slight increase has been observed, which is mainly due to the larger consumption of other opioids, such as codeine combined with glutetamide in particular. Injection has consistently been the main route of administration of primary drug over the last few years, with 74% to 81% of TDs and 65% to 77% of first treatment demanders (FTDs) reporting that they usually inject their primary drug. Among heroin users these percentages are 76–82% and 68–73% for TDs and FTDs, respectively. In general, 81–82% of all TDs and 71–74% of FTDs report currently injecting any drug (source: Treatment demands study in Sofia 1998, 1999, 2000).

The demand for cocaine has increased marginally, but due to its relatively high price it is still used mainly in closed groups of predominantly well paid people. Available estimates indicate there are several thousand (5000–10 000) non-regular users, and approximately 2000–2500 regular users of cocaine. Sniffing is the preferred route of administration for cocaine in Bulgaria. Using information

from different studies 2–4% out of pupils have ever in their life used cocaine, and 0.5–1% report using it in the last 30 days. Approximately the same estimates are reported for amphetamines.

3. Health consequences

Seroprevalence of HIV

Data pertaining to the proportion of seropositivity for HIV or other infectious diseases in the methadone maintenance programme may be found in Table 1. HIV infection prevalence is still relatively low among methadone patients and there are only 7 cases of HIV among the tested intravenous heroin addicts. On the other hand, three out of every four tested persons are positive for Hepatitis C virus.

Table 1. Proportion of seropositivity for HIV and other infectious diseases for patients in methadone maintenance programme

<i>Virus</i>	<i>Number of tested persons</i>	<i>Positive results</i>
HIV	158	1 (0.6 %)
HCV	176	134 (76.1 %)
HBV	175	25 (14.3 %)

Source: National Centre for Addictions, methadone maintenance programme

Opioid overdose deaths

There are no reliable data on fatal opioid overdose. The National Centre for Addictions (NCA) carried out a study based on special prepared methodology for evaluation of drug related deaths. This technique used examples of snowball sampling covering all treatment demands for a period of two months and geographically covered the city of Sofia. In 1996 and 1997 the NCA carried out the latest study on the number of deaths due to overdose. The main objective of this study was to estimate the approximate annual number of deaths due directly to drug overdose in Sofia. Linguistic and logical methods were implemented for double-counting control. Using this approach the estimated number of drug related deaths in Sofia for 1996 and 1997 was approximately 20–25 persons per year. The observations and the expert estimations during the following period show an increase of these cases. A larger study, incorporating a larger geographic area, is intended.

4. Treatment of opioid dependence

In order to best understand the structure of Bulgarian drug abuse treatment facilities and the current situation and problems in the field, we must take into account several major processes in the area of public health and psychiatry as a whole. First of all, Bulgaria is currently undergoing a major change in health system. One aspect of this change involves the move from state budget funded health care to the constitution of a National Insurance Fund, and the transition to general insurance cover and specialist inpatient and outpatient health care services that are appointed annually according to the National Framework Contract. This reform coincides with a change in the ownership, structure and functioning of the treatment facilities according to the Treatment Facilities Law. Another basic process of change is the transition of mental health care and its facilities from a disease model, based in psychiatric hospitals to a community based mental health care system of services. Current drug dependence treatment may therefore be considered to be in a rapid process of transition. In this infrastructure, there are considerable differences between the outpatient and inpatient treatment facilities. The outpatient treatment system is financed by the National Insurance Fund and the general framework for their functioning is The National Framework Contract (NFC) The NFC represents a spectrum of private, governmental, NGO and communal companies. The treatment of alcohol and drug abuse is set as a priority in the NFC, and there is a list of specialized health services that are considered fundamental to treatment by both GPs and specialized outpatient facilities. Currently, the availability of specialized outpatient treatment and the level of integration with other mental health services vary between cities and other regions.

The availability of treatment in rural areas is low, but at the present moment there are no signs of a strong need for such treatment in these areas. Primary health care specialists are not adequately involved in drug abuse treatment, and this is mainly due to insufficient training. However, they play a very important role in the referral of individuals with drug problems to other health services. The existing links between outpatient treatment facilities and harm reduction programmes vary significantly from city to city based on whether such harm reduction programmes exist and the interrelations between them.

The inpatient treatment facilities for treatment of persons with drug problems (mainly psychiatric hospitals) are financed directly from the state budget (Ministry of Health). There are two specialized psychiatric hospitals for treatment of drug addicts: The Inpatient Unit of the National Center for Addictions, and the Psychiatric Hospital of Karvuna, near the town of Dobrich. However, there are several specialized departments in the general psychiatric hospitals for inpatient treatment of patients with substance abuse problems. These departments typically treat patients with alcohol and other drug problems. In all other cases, the inpatient treatment for drug addicts is provided in general psychiatric departments.

Low threshold care

This type of care is becoming available for the people with heroin dependence in the larger cities in Bulgaria (Sofia – two programmes, Plovdiv, Pleven, Bourgas) through programmes for outreach and needle exchange. In 2000 a drop-in centre was opened in the town of Pleven. Such programmes typically provide consultation and treatment referral, leaflets, needle exchange facilities and clean injecting packages. One programme is also offering to take samples for testing of HIV, hepatitis B and C for opioid users not in treatment. The legislative basis for their existence and functioning is found in Decree No. 30/11.2000 of the Ministry of Health that regulates the organization and functioning of the pre-treatment and rehabilitation programmes.

Types of treatment available

- ❑ *Detoxification* (7–14 days depending on the treatment setting) – this type of treatment is the most common, both in outpatient and inpatient settings. A special programme exists for home detoxification at the National Centre for Addictions.
- ❑ *Intensive Inpatient Treatment Programmes* (45–60 days) – intensive treatment programmes applied after detoxification, combining pharmacotherapy with a range of psychosocial interventions intended to stabilize the patient.
- ❑ *Outpatient treatment programmes* (2–12 months) – varying in intensity (from day clinic programmes to outpatient treatment for 2–3 hours per week) treatment programmes applied after the detoxification, combining pharmacotherapy with a large range of psychosocial interventions intended for the stabilization of the heroin dependent patients. Compared to the inpatient programmes these are less intense and much more tailored to the patient.
- ❑ *Long-term residential rehabilitation programmes* (9 months to 3 years) – just emerging in the country. These use the therapeutic community model, aiming to assist the recovering patient reach the best possible level of psychological and social functioning following cessation of drug use.
- ❑ *Methadone maintenance programme* (no maximal restrictions) – one methadone maintenance programme, which is based at the National Centre for Addictions, was commenced in 1995. Three new methadone programmes were opened in 2004.

Access to drug treatment

The fact that the treatment system for people with drug dependence is unevenly distributed throughout the country is reflective of, not only the substantial difference in the development and the severity of the drug-related problems in the various regions, but also of differences with respect to general health care and specific mental health care reforms. There are some programmes that exist only in certain cities (e.g. methadone programme is only available for Sofia citizens, low threshold programmes, etc.) and therefore available only for residents of that particular city or region.

Further compounding the imbalance in access to treatment is the regional basis for the payment of the National Health Insurance Fund, meaning that if an individual requires treatment outside their

residential region, they incur the cost themselves. Some treatment is offered by private practices/treatment facilities, the cost of which is also incurred by the patients.

The treatment system for people with drug dependence is unevenly distributed throughout the country and certain types of treatment programmes are not available to some residents. For example, in 2000 there was only one methadone maintenance programme, which was located in Sofia. This type of treatment was therefore not available outside the capital. Similarly, there are only two specialized departments (in Sofia and Varna) providing inpatient detoxification programmes. Also, the low threshold programmes for drug users currently not in treatment are available only in certain cities. There is only one official long-term residential rehabilitation programme, which has a capacity of 14 residents. There are certain age limits for participation in some programmes, and 18 years is the minimum age for entry into methadone maintenance. Pregnant women have priority for admission into methadone maintenance. While the methadone maintenance programme in Sofia is the only such programme available in the country, there is no such limiting factor for detoxification and short-term substitution with medicines other than methadone. Some of the opioid agonist treatment (especially detoxification and short-term substitution with medicines other than methadone) is done in private practices/treatment facilities.

Legislative framework

The legislative basis for developing programmes for agonist pharmacotherapy of opioid dependence is Decree 24/31.10.2000 of the Ministry of Health, on the conditions and organization for implementation of substitution and maintenance programmes for harm reduction for people dependent on opioid drugs. The Decree reflects the need for the development of substitution and maintenance programmes for injecting opioid users for the reduction of harm and the prevention of HIV/AIDS among this high risk group. The decree presents opportunities for development of such programmes for public and private, large scale psychiatric treatment facilities. The decree recognized the need for the development of training and educational programmes for the substitution and maintenance programmes staff.

A further important consideration is the conditions for admission into the programme. The minimal standard requirements of eligibility for substitution programmes are:

- minimum 18 years of age
- proven dependence on opioid drugs
- minimal duration of regular use – 3 years
- minimal duration of intravenous use of opioid drugs – 1 year
- three officially documented unsuccessful treatment attempts in different treatment modalities.

The following groups of people have priority entry for treatment into substitution programmes: 1) HIV positive individuals; 2) pregnant women; 3) individuals severely ill from hepatitis B and C. There are strict procedures for control and reporting on the overall functioning of the substitution and maintenance programmes.

It should be noted that the above mentioned regulations are only valid for the long-term substitution programmes and not for the use of opioid agonists for detoxification purposes as well as for short-term substitution treatment (programmes are defined as long-term if they are in excess of 6 months).

Another important decree influencing the development of substitution programmes in Bulgaria is Decree 4/, relating to the prescription of opioid and psychotropic drugs. The decree aims to increase control over the prescription and use of opioid and psychotropic substances, in accordance with international conventions.

Drugs used in agonist treatment

The only drug used for long-term substitution is Methadone Hydrochloride in the form of 1% sugar solution. It is presented to the drug addicts free of charge at state methadone maintenance programmes. Methadone Hydrochloride is not registered officially as a medicine in Bulgaria and therefore it is imported as a special non-registered medicine using the regulations set for importing opioids. There is a central quota for importing Methadone Hydrochloride into Bulgaria and it is upheld by the National Centre for Addictions. The price of the 1% syrup of Methadone Hydrochloride is very low (approximately 0.3 – 0.4 levas (\$0.1 – 0.15) for a daily dose of 100 mg).

As a non-registered medicine, methadone is not available for the purpose of detoxification and short-term substitution therapies. For these, other opioid agonists are used – mainly morphine sulfate in tablets (MST) and slow-release dihydrocodeine (DHC) (mainly used for pain control in oncology patients). MST is under the regulation of schedule II and therefore is sold on “yellow” recipe only from specially licensed apothecaries working with opioid drugs. The DHC is under the regulation of Schedule III and is sold on “green” recipe for duration of no more than 2 weeks. The average price for a daily dose of MST or DHC is 9–15 levas (US\$ 4 to US\$ 6).

Patients in agonist treatment (year 2000)

The number of patients in the programme has increased every year since the start of the service in November 1995. During 2000, 236 patients were treated in the methadone maintenance programme at the National Centre for Addictions (219 were enrolled at the start of the year and 17 were admitted throughout the year) (see Table 2). 35 patients were discharged during the year, leaving 201 patients enrolled at the end of 2000. There are currently 247 patients enrolled in the program.

Table 2. Number of patients in the methadone maintenance programme

<i>Treated persons (1 Jan – 12 Dec 2000)</i>	<i>Total</i>	<i>Males</i>	<i>Females</i>
In treatment at 1 January	219	158	61
Admitted during the year	17	14	3
Discharged from the programme	35	29	6
In treatment at 31 December	201	143	58

The mean age of patients enrolled in the programme during 2000 was 30 years. Approximately ¼ (64 persons, 27.1%) of all 236 treated persons during the year were female. The mean age of the females in the program was 29 years, while the mean age of males (172 persons, 72.9%) in the programme was 31 years (see Tables 2 and 3).

Table 3. Age of patients in methadone maintenance treatment

<i>Indicators</i>	<i>Total</i>	<i>Males</i>	<i>Females</i>
Mean age	30	31	29
Age of the youngest patient	19	20	19
Age of the oldest patient	57	57	48

The system of general practitioners (GPs) has been developed in Bulgaria since July 2000, and GPs are currently not involved in providing agonist treatment for opioid users. No Bulgarian pharmaceutical company is involved in agonist treatment.

Documentation and evaluation

- ❑ Documents on admission (list of candidates, results and decision of the admitting commission, protocol, therapeutic agreement)
- ❑ Documents on treatment (case history, monthly register of daily doses of all programme patients)
- ❑ Additional documentation aiding the treatment of the patients (including medical certificates, urine tests, daily report form, incident form, form for hepatitis A and B tests, protocol for changing the dose)
- ❑ Documentation for registering the used quantity of methadone (protocols for acceptance of quantity of methadone, monthly and annual reports about the quantity of methadone used by the programme, annexes with the daily and monthly quantities personally used by the patients)
- ❑ Documentation on the programme activity (programme description, protocols from team meetings, programme meetings, group and individual sessions, annual report of the programme activity, annual assessment of the programme effectiveness)

5. Main problems and needs

Methadone is not registered officially as a legal form of medicine, which is a restricting factor for the development of new methadone maintenance programmes. A training programme for the managers and members of future methadone maintenance programme teams is to be prepared by the National Center for Addictions.

The National Programme for Drug Addiction Prevention, Treatment and Rehabilitation in the Republic of Bulgaria (for 2001 to 2005) has projected that the number of patients in methadone maintenance programmes will increase to reach 1500 by the end of year 2005.

Main problems and needs include:

- ❑ Improving the quality of methadone maintenance programmes through participation in international scientific collaboration and information exchange, and financial support for participation in scientific seminars, conferences and meetings related to opioid treatment
- ❑ Support in the development of an appropriate system and criteria for opioid agonist therapy, including the capacity for evaluation of effectiveness
- ❑ Support for the development of ongoing education and training for the programme team members involved in treatment.

CROATIA

Dr Slavko Sakoman
Department of Addictions, University Hospital, Zagreb

1. Country profile

Size:	56 542 km ²
Inhabitants (2000)	4 460 000
Capital:	Zagreb (pop: 779 145)

2. Epidemiological trends available

History of opioid use

Opioid abuse in its contemporary form started to appear in the Republic of Croatia at the end of the 1960s. As heroin had not yet become available, the opium used was produced in large quantities by the former Republic of Macedonia in the territory of the former Yugoslavia. The poppies had also been cultivated in Croatia (without limitations) for food purposes. Thus, during that time and even today, it is seemingly not difficult to obtain opium illegally. At the beginning of the 1970s, an increasing number of opioids (morphine, codeine) were abused as control in health institutions and pharmacies were weak. At that time (1970), the late Professor Dr V. Hudolin established the first specialized hospital department for the treatment of opioid dependence, at the present Clinical Hospital "Sestre Milosrdnice" in Zagreb. By the mid-seventies, the first open opioid-scene appeared in Zagreb, and soon after that, the first groups of intravenous opioid addicts emerged in four more coastal towns (Pula, Rijeka, Zadar, Split). At the end of the seventies, heroin became increasingly accessible. The development of opioid abuse control programmes (prevention, therapy, repression) stopped the growth of the problem in Zagreb and Rijeka but the problem started to spread out of control in Split, Zadar and Pula. From the mid-1980s until the mid-1990s, in addition to the increasing availability of heroin, opium tea was also used extensively (produced by cooking dried poppy pods). At the beginning of the war (1991), to coincide with the transition period, the supply and demand of opioids increased within a short time. Since 1993, at the wider territory of the State, a new wave of the epidemic expansion of heroin abuse has emerged. It was only in Split that the epidemic started several years earlier and there, already at the end of the 1980s, one could purchase methadone in the streets. In 2000, heroin was easily accessible (at the price of about US\$ 35.00 for a gram and the price of US\$ 7.50 – 12.50 per dose) in the wider territories of the country. Methadone can be bought on the illicit market at a price of US\$ 30.00 for a box containing 20 pills of 5 mg each, and as the substitution programmes are easily accessible to heroin addicts, the interest in opium and opium tea is exceptionally small nowadays.

Substances used

Since the mid-1960s, the use of cannabis, among other non-opioid drugs, has been gradually expanding. Initially, hashish smuggled from abroad was in predominant use. It was mainly brought by consumers who had travelled abroad. Several hundred thousand people from Croatia lived and worked in the western countries, and with the development of tourism, hundreds of thousands of people from Western Europe were visiting the country. As a result of this, Croatia has been under the continuous influence of all the trends that have taken place abroad for many years. During the last 20 years, the illicit cultivation of marijuana has expanded and it is the only illicit drug that does not need to be imported. By the age of 18, about 35% of young people have experienced consuming cannabis at least once. Cocaine had been used from time to time during the last 25 years and from the beginning of the war. As it is becoming increasingly available the number of consumers is also increasing. "Ecstasy" (3–4 methylenedioxymethamphetamine, or MDMA) has been more accessible since 1993, and large "rave-parties" and the popularization of "techno" music has contributed to the increasing use of that drug. About 4% of the youth between the age of 16 and 17 take MDMA recreationally, and by the age of 18, about 7% of the youth will have at least one experience. Amphetamine is becoming more and more accessible since 1995 but it is less popular than MDMA. The above-mentioned psychostimulant drugs are often an inter-step on the way to heroin addiction.

Figure 1. Number of opioid users undergoing first time inpatient treatment

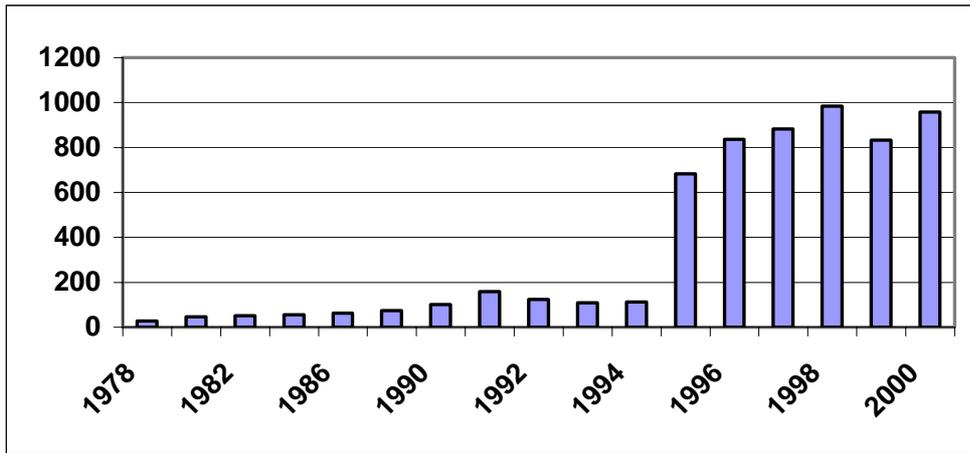
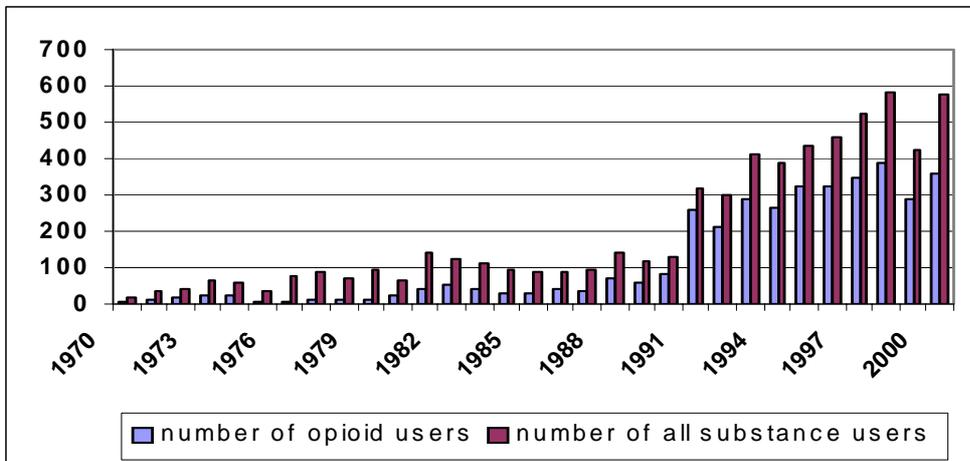


Figure 2. Drug users treated in National Centre for Substance Dependence



Most of the new heroin addicts to have been admitted into treatment during the last 5 years reported having taken ecstasy at the mentioned age. Dealers are often reported to have offered a line of heroin to teenagers as a means of tranquilizing the restlessness caused by MDMA or amphetamine before returning home. Typically, those who accepted it were dependent on heroin three years later. Hallucinogens (predominantly LSD) have been in use during the last 30 years but that kind of substance, although accessible, has never been particularly popular. Within the age of 18, 3.6% of the youth are reported to have used LSD ("Ivo Pilar", Social Science Institute Zagreb).

Figure 3. First Time Demand (FTD) for treatment

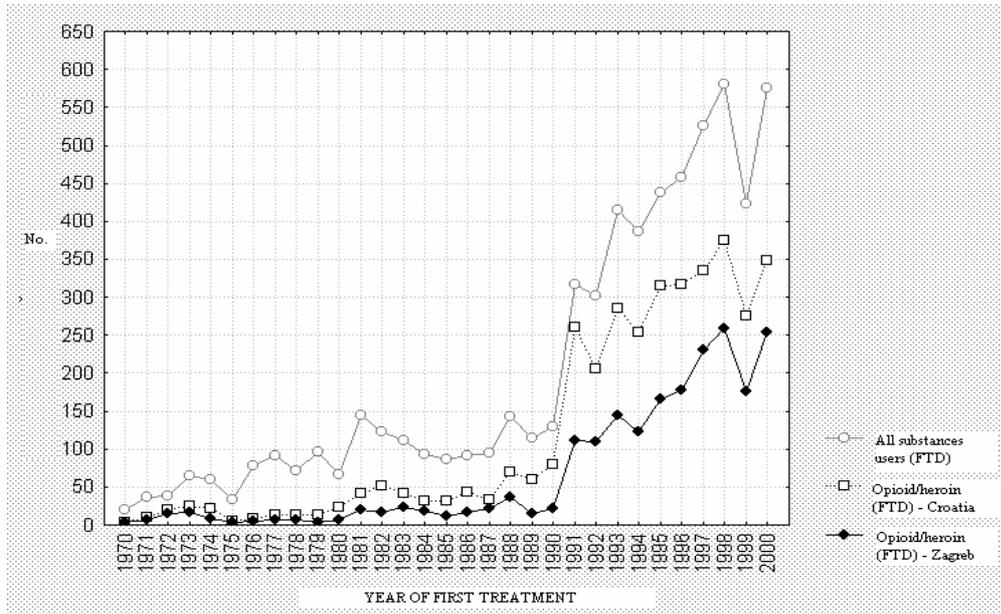


Table 1. Proportion of substances used (%)

Type of substance	YEAR		
	1998	1999	2000
Opioid	79.8	69.8	67.9
Cannabis	9.0	20.2	23.4
Sedatives	5.2	3.4	3.0
Cocaine	0.6	0.4	0.4
Stimulants	0.7	1.7	1.4
Hallucinogens	0.6	0.3	0.4
Volatile solvents	0.6	0.5	0.4
Multiple/additional	3.5	3.7	3.1
SUM	100.0	100.0	100.0

Figure 4. Gender distribution

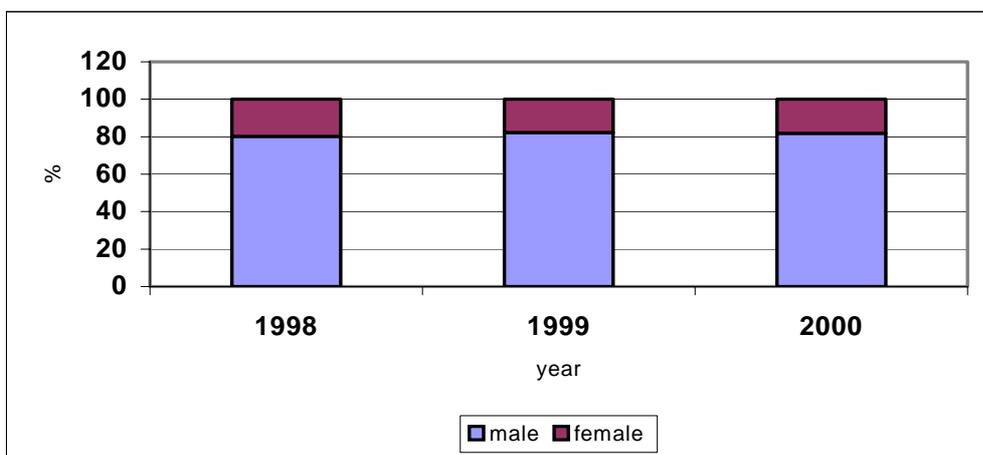


Figure 5. First time treated opioid/heroin users

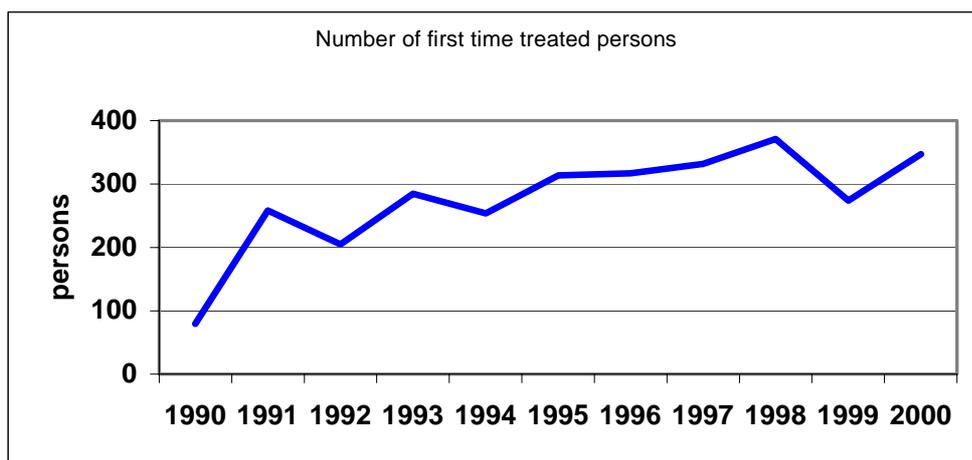


Figure 6. Age of treated users

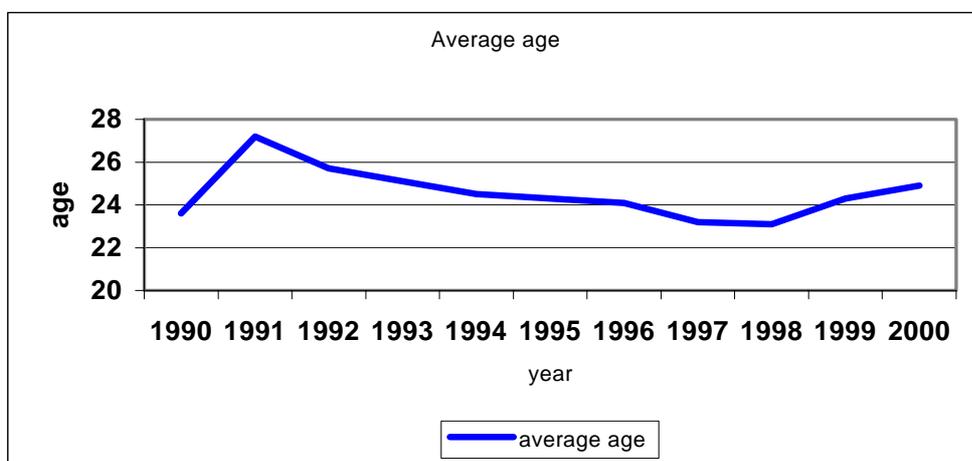


Table 2. Proportion of injectors from opioid/heroin users (first time treated)

Year	%
1998	78.8
1999	80.0
2000	79.7

Proportion of different users

In Croatia alcohol consumption is traditionally common, and the prevalence of alcoholism in the population older than 18 years of age is approximately 9%. Youth who are inclined to illicit drugs, consume less alcohol than others, therefore the combination of alcoholism and illicit drug addiction is rare. During the later stages of dependence, a portion of users are reported to engage in uncontrolled drinking. Alcohol consumption in combination with sedatives among adolescents is somewhat more frequent than the European average (The European School Survey Project on Alcohol and Other Drugs (ESPAD) 1999), and is more prevalent among females. In terms of concomitant use of illicit drugs, cannabis is the most frequently reported substance to be used in addition to heroin. About 85% of the heroin addicts commence illicit drug use with cannabis and it is the most common secondary drug. The MDMA and amphetamine consumers continue with cannabis as their second choice, and with the commencement of opioid use, stimulant use is frequently reduced, while cannabis use continues. A small percentage of addicts combine heroin and cocaine. Opioid addicts often also take sedatives

(BZD) and in the absence of heroin, some of them use easily available analgesics (most often Tramadol).

Number of opioid/heroin users

In the report that was prepared for the Government of the Republic of Croatia and the Croatian Parliament by the Commission for Narcotic Drug Abuse Prevention, the estimated number of opioid dependent persons is distinguished from the non-dependent users who consume opioids occasionally. The estimate includes the total number of treated opioid dependent individuals (Central National Records), and takes into consideration the fact that a large percentage of the users report to treatment due to the easy access to pharmacotherapy using opioid agonists (methadone). The Rapid Assessment Studies confirmed that the ratio of users who have been treated to users who have never been treated is about 1:1. Therefore the estimated number of opioid dependent individuals is between 13 000 and 14 000. Research conducted by the Social Science Institute "Ivo Pilar" in Zagreb (1998), established that 2.4% of the youth have tried heroin at least once by the age of 18. By means of a special calculation based on the duration of opioid consumption before presenting for first treatment, 8000 more users were estimated to consume heroin occasionally. An average of four years elapsed from the start of heroin consumption until the first intervention. The length of time between the onset of dependence and time of first treatment is shorter and, on average, lasts less than two years. As the number of treated users is about 1000 per year, there are always four generations of the younger, occasional consumers outside of treatment, on their way to dependence. At the end of the year 2000 the cumulative number of opioid users registered in treatment was 7142. It is estimated that approximately 600 have died from 1978, so today it is assumed that some 6500 opioid/heroin treated users in national health treatment institution are alive. (Source: Croatian National Institute of Public Health). Police records show that about 14 000 substance users participated in minor criminal activity.

Figure 7. Number of persons committing drug related crime

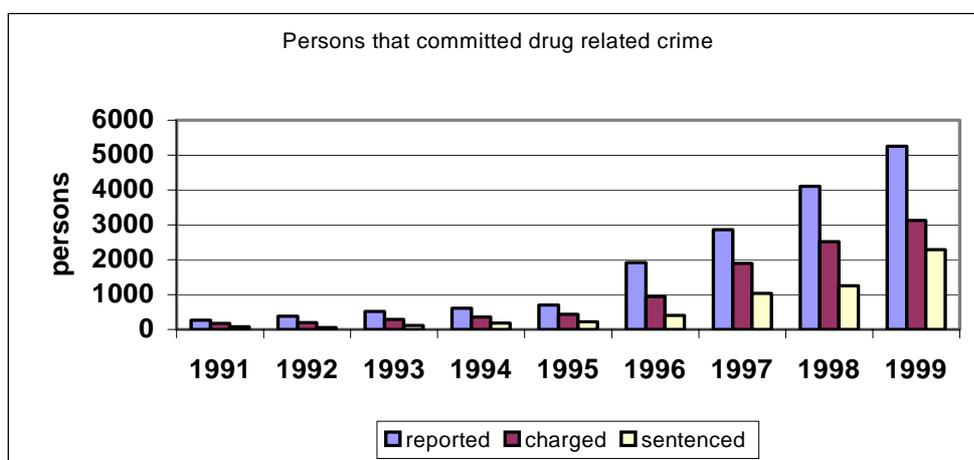


Table 3. Drug users in penal system by type of substance (1999)

<i>Type of substance</i>	<i>Number of persons</i>			<i>Total</i>
	<i>Convicts</i>	<i>Prisoners at the bar</i>	<i>Underage offenders</i>	
Heroin	158	293	9	460
Heroin + cocaine	27	33	2	62
Heroin + cannabis	65	39	8	112
Heroin + Methadone	42	62	8	112
Cannabis	44	57	25	126
Multiple/additional	123	208	18	349
Total	459	692	70	1221

Characteristics of the users

87% of users live with their families, 5.9% live alone, and 3.9% with a partner. 44.5% are unemployed, while 23.3% have a job, and 22.3% are pupils or students.

3. Health consequences

Seroprevalence of HIV

Prevention activities to curb the spreading of the HIV infection started in Croatia before the spread of the virus itself among the population of injecting drug users. The basic elements of prevention (commencing in the first half of the 1980s) consisted of:

- ❑ Enabling the users to easily buy clean injecting accessories in pharmacies all over the country. In that sense, the experts of the Center for the Addict Treatment in Zagreb (KB. "Sestre milosrdnice") performed a continuous education of pharmaceutical professionals and their contribution to the good results is certainly considerable.
- ❑ The face-to-face education of all the dependents who have reported to the treatment programme was performed, with encouragement to pass the information received on to their "friends".
- ❑ Everybody received a special leaflet with instructions on how to protect oneself.
- ❑ The media conducted a mass education campaign.
- ❑ Provision of regular education in the main prison, in which most of the drug dependent individuals sentenced to prison are treated,
- ❑ The addicts were encouraged to go for testing performed by the departments for infectious diseases. Those departments (especially the Infective Disease Clinic in Zagreb) contributed greatly to the prevention of HIV infection.
- ❑ The continuity of the prevention programme among the general population.
- ❑ Since the beginning of the 1990s, special units for the exchange of drug injecting accessories have been established, first in Split and later on in four more towns.

Table 4. Proportion of seropositivity for HIV (all tested users)

<i>Year</i>	<i>% of seropositivity for HIV</i>
1998	0.8
1999	0.7
2000	1.7

Source – Croatian National Institute of Public Health

The results of such an approach have been excellent. Since the first cases of HIV sero-positive injecting drug users until today, in spite of an epidemic of heroin dependence, the prevalence of HIV remains under 1% among the population of IDU addicts. For the sake of comparison, at the same time (at the end of the 1980s) in the capital of the former common state (Belgrade), in spite of the launching of substitution methadone therapy a few years earlier, more than 50% of the dependent heroin users were infected with HIV.

Table 5. Opioid/heroin users treated in National Centre for Addiction (2000)

<i>HBV</i>	<i>Number</i>	<i>%</i>
Negative	628	82.0
Positive	138	18.0
Not tested	104	
Unknown	520	

Table 6. Opioid/heroin users treated in National Centre for Addiction (2000)

<i>HCV</i>	<i>Number</i>	<i>%</i>
Negative	468	54.4
Positive	392	45.6
Not tested	103	
Unknown	427	

Table 7. Opioid/heroin users treated in National Centre for Addiction (2000)

<i>HIV</i>	<i>Number</i>	<i>%</i>
Negative	755	99.1
Positive	7	0.9
Not tested	107	
Unknown	521	

Opioid overdose deaths

Due to the expansion and improvement of treatment possibilities, and the introduction of methadone treatment in 1991 (i.e. immediately before the war, the post-war and “transitional” epidemic), the number of fatal overdoses among injecting drug users has not changed considerably (between 35 and 50 cases annually). Only in the first two years of the methadone programme (when the war was most fierce), there was a slight increase in overdoses in the towns where it was difficult, due to war operations, to administer methadone to the patients regularly (daily). Nowadays, in several towns, there are many cases of non-fatal overdose among drug users but their care is well-organized in the intensive units of internal medicine clinics and departments. The number of deaths resulting from drug overdose was 53 cases in the year 2000.

4. Treatment of opioid dependence

Current treatment infrastructure

The system for treatment of people with drug dependence started to develop within psychiatric hospital institutions. As mentioned before, the first specialized treatment programme for people dependent on opioids (with 20 beds) started its work in Zagreb in 1970. Other psychiatric institutions became involved in inpatient and outpatient treatment, usually in emergency conditions or in cases of double diagnoses. However, despite a need for specialized treatment programmes in several more towns up to ten years ago, no further specialized programmes were developed. It was not until 1997 that another specialized department with some 40 beds was opened within the Psychiatric hospital “Vrapče” in Zagreb.

After achieving independence in 1990, the Croatian Ministry of Health formed a special professional Commission entrusted with the control of opioid abuse. Its president (the author of this report) made the first draft of the National Programme, within which the organization of treatment services was also foreseen. That proposal was accepted by the Ministry of Health and the model it proposed for the development of a specialized network of outpatient programmes was accepted in 1991. In the outpatient programmes, the interdisciplinary teams assumed care of the treatment of dependence, in cooperation with all the local community resources (general practitioners (GPs), psychiatric hospitals and other institutions, welfare care institutions, prisons and therapeutic communities). As an important part of the treatment policy, as well as part of the strategy for the control of drug-related problems, the programme involved the implementation of substitution programmes. By enacting the National Strategy (to have been adopted by the Croatian Parliament in 1996) the development of the network of the Centres for Prevention and outpatient Treatment of Addiction was continued. There are currently centers and trained teams in all the counties in which opioid use is prominent. There exist a total of 15 large centers with several smaller ones at the local town level. In five or more towns, units

for the detoxification of the users are being established within psychiatric institutions. The centers are the places of primary, specific medical and psychosocial care for persons with opioid dependence problems. The patients are able to utilize the service anonymously, and without a referral slip, and all services (medical examination, urine control of drugs, counseling, psychotherapy, education, family therapy) are available free of charge. If the professional team recognizes that there exists a need for the application of methadone (or some other medical drugs), the patient is referred to his/her general practitioner who assumes care of the patient, and directly administers, under supervised control, the suggested substance. Therefore GPs are, beside the centers, the most important part of the system participating in treatment. On the other hand, if the hospital programme requests detoxification to be carried out, the patient is referred to one of the psychiatric institutions. The capacity of the specialized hospital programme is too small. The teams of the center cooperate in the care of the patients with many other institutions. For example, if a patient is found to be hepatitis or HIV positive, a referral is made to the infectious disease department. If a patient is pregnant, cooperation is established with the gynecologic department. If the user is imprisoned, cooperation is established with the health service of the prison for detoxification (most often with the administration of methadone), and with the therapeutic communities in the need for a long rehabilitation. The centers cooperate with schools if a pupil is found to be using illicit substances, as well as with social welfare if such a need exists. An important element is also the cooperation with the law enforcement system. They have regular contacts with local police and public prosecutor's office. If there is a charge for the possession of illicit drugs, the prosecutor's office will represent the proceedings and offer the possibility of treatment at the center. If the patient accepts it, the criminal proceedings are stopped. The centers are entrusted with the epidemiological observation and coordination of all the activities with the objective of reducing illicit drug demand. All the mentioned activities, at the level of each county, are coordinated by special boards to include the representatives of all the departments of the local levels and the representatives of the political authorities.

Since 1991, the establishment of therapeutic communities for the rehabilitation of drug dependent individuals commenced within the NGO system. Nowadays, ten programmes of that type are operational throughout the country, with a capacity of about 200 places. Some of the programmes mediate the departure of local drug users to other countries (Italy, and especially Spain) and it is estimated that at this moment, about 400 heroin dependents are there. Only one of the programmes is financed by the State, and the others are self-financed and affiliated with church institutions.

Within the penal system, the first specialized treatment programme for drug dependent individuals started working in 1980 at the largest penal institution (Lepoglava). In all the penal institutions, a specific health care is provided for the dependents, including detoxification (with or without the application of methadone), group therapy, if necessary, individual sessions and contacts with family members. Maintenance with methadone is not currently available. The professional teams of the Center cooperate directly and supervise treatment within the penal system. The system has about 400 dependents on a daily average and during a year about 1200 pass through it (of which between 700 – 800 cases are heroin dependent).

Low threshold care

Since 1993, within the activities of the NGO "Help", the first needle exchange unit commenced operation. The specially trained team developed the model of operation with the drug dependent individuals not in treatment, and became the first step between the "street" and going to the Center (for those who became motivated to seek treatment). According to a similar model, with inclusion of the Croatian Red Cross, units are open in Zadar, Pula, Zagreb and Dubrovnik. Regretfully, there are still no advances in the development of the outreach programmes.

Types of treatment available

The largest number of patients, from first point of contact to the end of the treatment, uses the services of therapeutic teams from the network of specialized outpatient centers. Occasionally, the patients must wait several days to be admitted. The number of contacts and the time devoted to them and their families are reduced in some centers due to insufficient employed professionals relative to demand. The centers adjust the therapeutic approach individually to fit the clinical picture of the dependence and to the needs and requirements of the user. Therefore, some users accept *drug-free* treatment from the beginning, while for others the treatment is started with a short outpatient

detoxification programme with the application of methadone or some other substance. If there is no reduction in opioid use, the patient becomes eligible to apply for methadone maintenance. Whenever it is necessary to use medical drugs during the treatment, the general practitioner is involved in the treatment. GPs are highly sensitive, educated and motivated to accept the drug dependents. The majority of them have had one or more cases. In addition to daily visits with their GP, methadone maintenance patients are also able to take their prescribed methadone dose at the GP's clinic, so this type of treatment becomes easily accessible in the whole territory of Croatia.

There are waiting lists for the hospital detoxification programme and the present capacity is too small. The capacity for the longer specialized hospital treatment is also too small, and the quality of the services of "non-specialized" psychiatric programmes does not satisfy the needs of the addicts so these are often avoided.

In terms of entering treatment at one of the therapeutic communities operated under the NGOs, different demand and "preparation procedures" exist. The selection criteria are very different. For this type of programme, accessing treatment is not so restricted in terms of capacity, but rather in relation to the approach taken by the programme (for example, too much emphasis on religious orientation, demanding preparation procedures, rigid rules, difficult "gratis" work) that often does not appeal to the user, and can result in many of them giving up. As the State has not provided any rehabilitation programme of a therapeutic type, despite of the above mentioned restrictions, therapeutic communities are typically well utilized,

- ❑ Outpatient programmes within the network of Specialized Centres last as long as is necessary. For those who are heroin dependent, it is planned for at least two years. The frequency and number of admissions are determined individually, in order to be able to perform the supportive, behavioural, cognitive or reality psychotherapy, as well as urine controls to monitor abstinence. Whenever it is possible, the family procedure is also applied. Due to the recidivism, a considerable percentage of the patients will be involved in treatment for life.
- ❑ Hospital specialized detoxification procedures last, on average, for three weeks.
- ❑ Hospital programmes for the purpose of abstinence stabilization, which continues as required after detoxification, last for about two months.
- ❑ The methadone maintenance programme can last for life.
- ❑ Outpatient "short" detoxification programmes with the administration of methadone lasts up to one month.
- ❑ Outpatient "slow" detoxification programmes with the administration of methadone lasts up to six months.
- ❑ Outpatient programmes of abstinence "preserving" with administration of naltrexone lasts for six months.
- ❑ The programmes in therapeutic communities (TC) last between one and four years.

Number of opioid/heroin patients in treatment (year 2000)

The estimated number of opioid users in treatment in the year 2000 is approximately 5000 patients. This number includes around 500 users in therapeutic communities (run by NGOs). Users treated in the prison system are not included in these figures.

Access to drug treatment

The described model of the treatment system as an integral component of the National Strategy is still developing. In relation to the number of engaged professionals and invested resources, it provides good results. In order to achieve optimal functioning, several areas require attention:

- ❑ increase (at least duplicate) the capacity of hospital specialized programmes;
- ❑ considerably increase the number of permanently employed experts in the network of the Centres for Prevention and Outpatient Treatment of the Addiction; open five more county centers and ten smaller ones in towns;
- ❑ provide support for the rehabilitation programmes (according to the types of therapeutic communities) within the State System,
- ❑ strengthen further the participation of GPs in early identification and treatment of drug dependence; provide support for their ongoing education and engagement;
- ❑ improve the quality of therapeutic programmes within the Penal System
- ❑ provision of better political and financial support for the implementation of the National Programme and, at the same time, reduce interference of politicians and insufficiently competent “experts” on the professional issues (e.g. the question of pharmacotherapy of heroin dependence).

The inadequate engagement of the State (particularly of the Ministry of Health) since 1993 to support the development and growth of the *drug-free* programme capacity influenced the wider application of opioid agonist therapy. To the affirmation of those programmes and their success, numerous GPs have given their contribution despite initial skepticism. However, many GPs, psychiatrists and institutions have a negative attitude towards drug dependent individuals and the use of agonist therapy. Many families of individuals with drug dependence speak in favor of methadone administration, as within a short time “their children” start to withdraw from “the street”, demanding less money and behaving in a more acceptable manner. The law enforcement authorities also support agonist therapy as following enrollment in the maintenance programme, within a short time, criminal activities are considerably reduced, including drug dealing, thus contributing to protection of the youth. The professionals are conscious that opioid agonist treatment attracts a large number of users into treatment who would otherwise not seek professional help. This reduces numerous risks, particularly the transmission of the HIV infection and hepatitis. Most of all, our developing understanding of the nature of addiction, research and *cost-benefit* analyses, and the experts themselves, have contributed to the success and acceptability of this form of treatment.

Some countries may have problems related to the use of opioid agonists for various reasons, which may include:

- ❑ treatment policy may be overly influenced by politicians (they may utilize this problem for political purposes)
- ❑ treatment policy may be overly influenced by experts from fields other than public health, or by those whose field of experience and knowledge does not extend to this type of care
- ❑ low level of knowledge about possibilities for the care of drug dependent individuals in general, and particularly about the advantages of this method in comparison with others
- ❑ negative attitude of the community toward the drug users and the opinion that dependence (addiction) is not an illness
- ❑ large influence of criminal structures and their criminal connections to the treatment policy
- ❑ small number of experienced and influential professionals who could contribute to the realization of the most suitable solutions
- ❑ fear that through its application, methadone itself and the method will be abused
- ❑ poor economic situation in the country and questionable financial support
- ❑ influence of professionals (and their institutions) who prefer drug-free programmes. There is a fear that “methadone use” in treatment could threaten their monopoly in the field and therefore would impede the possibilities of client selection and accommodation capacities.

Legislative framework

In Croatia, there are no legal limitations for the application of the opioid agonists in pain treatment or treatment of heroin/opioid dependence. In order to prevent the abuse of the method and of the agonists themselves (e.g. leaking methadone to the illicit market), administration of methadone is specially regulated and described as being a part of the National Strategy. For example, every GP (or medical practitioner in a hospital) can, in the situation of an acute withdrawal crisis, prescribe methadone to a patient. However, in order to include a patient into the maintenance programme, an authorized medical practitioner from a specialized centre must assess the patient and provide a diagnosis and the most suitable methadone treatment approach (for example, for slow detoxification or long-term maintenance). In terms of dosing protocol, patients meet with their GPs on a daily basis and receive the methadone under supervised dosing. A stabilized patient can receive advance therapy only for the weekend or, in the case of going on a journey, up to 14 days.

Drugs used in agonist treatment

Methadone is used almost exclusively, and agonist therapy is available in all territories of the country. For about 40% of the dependent users, it is the most acceptable form of treatment. The families in a smaller percentage accept to support that form of treatment though the public in general still has a negative attitude. The programme is financed entirely by the State from the resources of the Health Insurance Fund. Every drug dependent individual can access health insurance and receive methadone maintenance without payment. The price of such a programme is, on average, US\$ 800 per drug-dependent individual yearly.

Number of patients in agonist treatment (year 2000 and trends)

Table 8. Opioid/heroin addicts in methadone treatment (detoxification and maintenance)

<i>Year</i>	<i>Number</i>
1999	2476
2000	2719

Table 9. All treated opioid/heroin addicts in National Centre for Addiction by type of treatment (2000)

<i>Type of treatment</i>	<i>Number</i>	<i>Percentage</i>
Rapid detoxification	151	11.5
Slow detoxification	303	23.0
Maintenance	463	35.2
Methadone free	399	30.3
No data in computer	74	

Eligibility requirements for agonist treatment

The need for such a form of opioid dependence treatment was particularly great before the war when 3000 heroin dependents with a long history of use (of which 50% had previously sought treatment, but had not maintained abstinence as required by the *drug-free* treatment approaches) were not in treatment. Furthermore, due to the war, there was the abrupt growth of supply and demand of illicit drugs on the one hand, and the reduced possibility of the State providing for the expensive *drug-free* programme on the other. As the population was completely engaged with the war and political questions, there was little resistance to introduce agonist treatment.

Patient characteristics

In order to use methadone for short detoxification, a diagnosis of opioid dependence must be made (according to the Tenth Revision of the International Classification of Diseases and Related Health Problems or ICD-10). Patients younger than 18 years of age may be accepted into this treatment. Some other form of pharmacotherapy may be used prior to methadone, which may include clonidine, sedatives, milder analgesics, hypnotics or combinations of these. Sometimes, acute effects can be eased with the help of the analgesic Tramadol. In order to use methadone for longer detoxification, or to include a young patient into the methadone maintenance programme, the patient's capacity to remain abstinent is assessed over one or two years, using occasional detoxification in the case of relapse. With the long-time opioid dependent patients, methadone maintenance may be commenced relatively quickly at the request of the patient.

Primary health / pharmacy care involvement in agonist treatment

As mentioned previously, GPs play an exceptionally important role in carrying out opioid agonist treatment. While specific psychotherapy and urine controls are performed in specialized centers (to which the GP provides a referral), the methadone is taken under supervision by attending the GPs office on a daily basis. There are an increasing number of GPs devoting special time for conversation with methadone patients and their families, which may also play a role in changing the user's behaviour. However, only 10% of users are referred by GPs to the centre.

The pharmacy service and its professionals have been involved in work with patients since HIV prevention was started. The service accepted its position in the process of methadone maintenance therapy. Some patients in maintenance receive their methadone directly from the pharmacies.

Documentation and evaluation

All institutions dealing with the treatment of drug dependent individuals are obliged to keep records. There exists an official form (modified "treatment demand" questionnaire, developed by the Pompidou Group Council of Europe) that is completed at the beginning of a treatment programme and sent to the State Institute of Public Health, which keeps the Central Registry of Treated Addicts. Each centre keeps its own records according to its needs for epidemiological work and evaluation, and all have a common computer programme by which to record and process the data. For the last two years, the input of data relating to the condition of each patient is performed at the center. Some data is recorded that is important for continuous evaluation: testing of hepatitis B and C, HIV, employment data, problems with the law, urine results, and general estimate of progress or aggravation. For all those enrolling into a methadone programme, the daily dose and the kind of programme (detoxification or maintenance) are entered. The evaluation of all those receiving methadone demonstrated that, during 2000, heroin use was interrupted in 60% of cases, heroin use was reduced in a further 20%, and no progress was observed or the condition was aggravated in another 20% of cases. In 2000, approximately 30% of clients with opioid dependence accessing the centres were not prescribed methadone (even for detoxification).

Table 10. Treatment outcomes for opioid addicts treated in National Centre for Addiction (2000).

<i>Treatment outcome</i>	<i>Number</i>	<i>Percent</i>
In abstinence	731	60.8
Improved/reduced abuse	303	25.2
Non improved/aggravated	168	14.0
No data in computer	188	
Sum Total	1390	

5. Main problems and needs

The action required to improve the quality of treatment for heroin dependent individuals has already been described. Heroin addicts make up about 60% of all cases to have been reported for first treatment for illicit drug use. Of all cases to be treated during 2000, more than 80% of all the service capacity has been used for heroin dependence. The application of opioid agonists also introduces certain problems:

- ❑ Due to insufficient control, methadone is appearing on the black market. There is a permanent demand for it and the price is comparatively high. This indicates that a lot of heroin dependent individuals exist outside of the programme. Methadone is purchased on the illicit market almost exclusively by the heroin users who have not yet decided to seek treatment. Methadone is not the primary drug used by heroin dependent individuals. The high unemployment rate makes it difficult for clients in methadone maintenance treatment to find work and earn a legitimate income, and may explain why many heroin dependent people wish “to live off methadone”.
- ❑ About 15% of the dependents have difficult behavioural disorders. The problems that they create in GP offices reduce the motivation of those professionals to deal with them. It is therefore proposed that several centres be established in larger towns to provide methadone dosing “in a centralized way” and not at the GP offices.
- ❑ Undergraduate education and training of medical and other health practitioners is unsatisfactory for the management of heroin dependence. The negative attitudes towards drug users are difficult to change later.
- ❑ There are few incentives for professionals working with users, and the pressure of the public and those who are opposed to the use of agonist substitution treatment further reduces the motivation to work with this population.

In conclusion, in order to promote professional guidelines for the treatment of opioid dependence, there is an important role for WHO and other international bodies in creating an understanding that opioid pharmacotherapy is a professional, and not a political, issue. The involvement of the many systems outside of health services should be limited. Health professions require assistance in curriculum development and education of the future professionals in the management of opioid dependence, with a clearly defined role for agonist pharmacotherapy. The states should be assisted in developing the policy and system for the treatment of users as one of the most important elements of the National Drug Control Strategy.

CZECH REPUBLIC

Dr Tomáš Zábránský
National Drug Commission

1. Country profile

Size:	78 866 km ²
Inhabitants (2000)	10 273 000
Capital:	Prague (pop: 1 178 576)

2. Epidemiological data available

History of opioid use

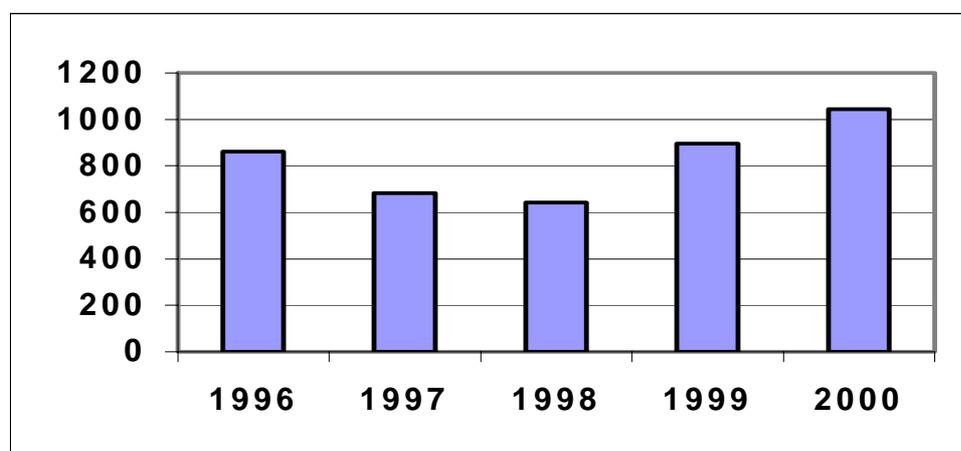
The first references made to opioid abuse (morphine, heroin, opium) in the territory of the Czech Republic can be traced back to the 1880s (especially among medical doctors and pharmacists) and subsequently again in the early 1920s. Following this, there is only anecdotal evidence about such use until the late 1970s, when together with methamphetamine (pervitin) a new opioid-type drug made from freely available composite analgesics containing codeine started to appear. This was known as "braun" ("brown"), and was usually a mixture of hydrocodon, hydrocodeine and codeine. This drug was used intravenously. The intravenous use of simple analgesic (containing opioids) solutions was also widespread in some Czech regions.

After the fall of the communist regime (1989) and the opening of the society, the use of "braun" (and to some extent methamphetamine) was displaced by heroin. This began as a problem in the capital, Prague, and then spread to the region of Northern Bohemia (1992–1997). Other parts of the country were still dominated by methamphetamine (pervitin) use. Marijuana use is widespread throughout the country, and this trend continues to grow. In 1997 the first signs of substantial heroin use spreading to other Czech regions (until then largely unaffected) became apparent, and this growth is still occurring.

Substances used

Heroin and (to a lesser extent) "braun" are the two main opioids used in the Czech Republic. The evidence of methadone leaking onto the blackmarket is isolated and has not been proven by police or therapists/low-threshold services workers. There are only isolated cases of morphine and/or codeine abuse.

Figure 1. Incidence of (first) treatment demand on opioid-type drugs by year



Gender and age

The average age (based on First Treatment Demand – FTD) (Šejda, Studničková, Klaka, Šeblová, & Hančlová, 2001) is around 21–22 years and the opioid–FTD population seems to be slowly increasing. The gender ratio is 1(Female):4(Male) and this ratio is stable.

Proportion of different users

The prevalence of users according to primary drug is 1(opioids):2(stimulants). In general terms, 22% of all FTDs in the year 2000 were opioid users, and this trend is slowly rising. The trend is identical in the sense of all (not only institutional) users. Of first treatment demanders who are injecting drug users, 90% are opioid users.

Poly–drug use is generally common amongst users in the Czech Republic, though typical "speedball–use" is rare. The most recent qualitative research (Miovský, 2001) suggests that users have been becoming more "exclusive" in recent years, primarily using one type of substance. The proportion of FTDs who are stimulant users was recently reported to be 46% (Šejda et al., 2001), and this trend is reportedly stable.

Number of opioid/heroin users

The estimated number of opioid users in the Czech Republic is between 12 000 and 18 000. These figures are based on capture–recapture and in–treatment ratio methods combination (Mravčík & Zábanský, 2001). The police data are extremely difficult to obtain since there is strong reluctance to share this data from Czech Police authorities.

The only one valid source in that sense are the FTD data (Šejda et al., 2001):

<i>Demography</i>		<i>Employment Status</i>					<i>Education</i>							
<i>mean age</i>	<i>share male//female employed</i>	<i>Employed</i>	<i>Unemployed</i>	<i>students or pupils</i>	<i>retired</i>	<i>n.a./ others</i>	<i>not finished yet</i>	<i>grade school</i>	<i>Apprenticeship</i>	<i>high school</i>	<i>bachelor</i>	<i>university</i>	<i>n.a./others</i>	
21.8	2.50	15.7%	58.6%	17.7%	0.8%	7.3%	3.9%	48.3%	25.1%	13.2%	0.1%	0.3%	9.0%	

Though since the matching/availability of the (treatment and other care) services for the most affected (Roma) population is very low, the reliability of this data is unfortunately very limited.

3. Health consequences

Seroprevalence of HIV

There have been 18 HIV–positive IDUs identified of all 500 cases found between 1987 and 2001. Another four positive cases are IDUs+homo/bisexuals (Bručková, 2001). Free testing is very common in the drug–using population. The HIV seroprevalence rate is close to zero (based on Bručková, 2001; Mravčík, Šebáková, & Andel, 2000). There is some evidence of limited epidemics of hepatitis A among the Prague Roma drug (predominantly heroin) users in Prague, which is likely to be related to general living conditions of this ethnic minority. The hepatitis B seroprevalence is around 8% (Mravčík et al., 2000) and the hepatitis C seroprevalence for all IDUs (no evidence for opioids users only) is around 30% (Mravčík et al., 2000).

Opioid overdose deaths

Fatal overdoses in 1998 according to drug:

- 41 benzodiazepine overdoses
- 40 opioid overdoses
- 21 stimulant (pervitin) overdoses
- 20 solvent ODs.

The data for 1999 and 2000 have been gathered, but are not processed yet.

1999: 45 opioid deaths (document in preparation)

2000: 49 opioid deaths (document in preparation)

4. Treatment of opioid dependence

Current treatment infrastructure

The majority of treatment and services for drug users are delivered by NGOs, but the role of psychiatric hospitals in the (abstinence-oriented) treatment is also significant. There are 14 therapeutic communities in the Czech Republic. Commercial services are also delivered, but only to a very restricted extent. These services do not have links to the rest of the sector and also lack the proper structure (guidelines, supervision, etc.), thus the information about this segment is very limited. The availability of treatment in rural areas is lower than in urban centres, but this is due to the comparatively lower demand. The structure of “local drug coordinators” was established in the mid-1990s. These trained and educated people are a part of local governments, and are exclusively focused on drug-related issues. As far as is known, all 82 county seats have some service/treatment facility for drug users and a substantial number of smaller cities also have some form of facility. Since the population density is quite high in the Czech Republic, it is considered that there is no location in the country where treatment or service for drug-related problems is unavailable. The NGOs usually have another linked (somatic) treatment facility, to which clients are referred if necessary. Harm reduction programmes operate mainly in bigger cities, but in many smaller cities some kind of streetwork and needle exchange programme are also established, even if it is sometimes not fully utilized. As mentioned above, the HIV rate is very low in the Czech Republic. The low threshold services as well as hygienic stations offer free HIV (saliva) testing for high-risk groups (IDUs, prostitutes, etc.). Overall, a suitable network of treatment and care facilities was established during the 1990s and now the phase of standardizing and improvement of quality has commenced.

Low threshold care

Low threshold care is available in all areas where it is necessary. The most substantial part of First Treatment Demand comes from this sector of treatment and/or services facilities (Šejda et al., 2001).

Types of treatment available

All types of substance abuse treatment are widely available throughout the Czech Republic (with periodical exception of detoxification beds described above), from high threshold abstinence-oriented treatment to drop-in facilities and street-work. Safe injecting rooms do not exist in the Czech Republic; however there has been some public discussion about this issue in Prague in recent years.

There are eight opioid agonist treatment facilities in the Czech Republic: three faculty hospitals, two co-joint projects of NGOs with faculty hospitals, one NGO facility, one local hospital, and one outpatient care facility in a smaller city.

Number of patients in treatment (year 2000)

The number of patients in treatment can only be estimated due to the lack of a valid database. It is estimated that in the year 2000 there were 8200 to 8500 patients/clients in treatment (based on prevalence/incidence ratio calculated on a representative sample).

Access to drug treatment

Overall, drug treatment is widely available. The only limitation is access to detoxification beds, though this is related to the Czech health system rather than a specific drug treatment problem. The only significant and persistent concern is the provision of services to the biggest ethnic minority – the Romas, and especially the Olah tribe.

Legislative framework

The use of illicit substances for medical purposes is permitted in the Czech Republic. There was a two-year “pilot project” of methadone treatment in a framework of the state hospital in Prague from 1996. In addition to strengthening of drug laws in the Czech Republic (1998/9) the Parliament urged the Government to broaden the maintenance programmes.

The “Methadone Board” was established, with the Deputy Minister of Health as chairman. The Minister of Health issued a decree containing the Opioid Maintenance Treatment Guidelines in 1999 (Ministerstvo zdravotnictví ČR, 2001). This is considered to constitute official standardization of the treatment and thus allows its implementation for any facility fulfilling the “certification” criteria.

Organization of agonist treatment

Methadone is available free of charge, with a budget for the generic substance granted by the Ministry of Health. Buprenorphine (Subutex®) is prescribed by psychiatrists and medical doctors certified for alcohol and drug abuse treatment. This treatment is fully covered by the largest health insurance company (76% market share) but the strategy of the company is to limit the extent of prescriptions.

Eligibility requirements for agonist treatment are:

- opioid dependence
- 18 years and older (in special cases 16)
- signature of three-way contract (medical facility, psychosocial treatment facility/adviser, patient).

No valid epidemiological study of the characteristics of patients in agonist pharmacotherapy in the Czech Republic has been done. The population, though, is quite diverse. Since a vast majority of the corresponding facilities are run within the framework of bigger hospitals or are in close cooperation with them, the involvement of primary health care is sufficient. The pharmacies prepare the solution and deliver it to the facilities/departments on a regular basis. Around ten kilograms of generic methadone was purchased by the Ministry of Health. The substance is stored in the faculty (well equipped and secured) pharmacy in Prague, which is responsible for delivering it to local pharmacies.

The rules to gain access to opioid agonist drug treatment are as follows:

Absolute contraindications:

- if there is abstinence-oriented treatment possible and preferable
- if there is no evidence of physical dependence
- if the primary drug is a non-opioid one

Relative contraindications:

- the abuse of substitution medicines in the anamnesis (sale of substitution substance, sale/delivery of drugs in the treatment facility, repeated serious interactions between the substitution substance and other drugs in the anamnesis)
- combined dependence (such as opioids and benzodiazepines)
- incapability to stop the use of illicit opioids even if the substitution substance dosage is sufficient to prevent the experience of withdrawal
- impending imprisonment (until there will be substitution treatment in prisons available)
- less than 16 years of age
- serious liver damage

Documentation and evaluation

There is a substitution/opioid agonist treatment registry in operation (managed by Bureau for Health Information Systems and Statistics in accordance with personal data protection), containing the following information:

- whole name and surname
- id # (a unique code)
- place of residence
- nationality
- insurance (if insured)
- name of the department
- date of patient's first visit
- HIV testing in last three months (yes/no)
- licit and illicit drugs being used
- injection use (yes/no)
- type of treatment (maintenance/detoxification)
- type of substance.

Every doctor starting opioid agonist treatment is obliged to complete the form and deliver it to the registry. Standard medical documentation is also administrated. There has been no evaluation study in the Czech Republic yet. There is some documentation of the participant's characteristics and basic outcome data of the "pilot project" available.

5. Main problems and needs

- The inoperability of the opioid agonist treatment in the Northern Moravia.
- Matching the facilities for needs of Roma clients.
- Better cooperation between governmental and nongovernmental facilities; better use of appropriate treatment options.
- Linking low-threshold and agonist treatment services in some locations.

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ESTONIA

Dr Mari Järvelaid

Department of Public Health, Ministry of Social Affairs, Estonia

1. Country profile

Size:	45 227 km ²
Inhabitants (2000)	1 435 000
Capital:	Tallinn (Reval) (pop: 396 879)

2. Epidemiological data available

History of opioid use

In the beginning of the 1990s there were five patients known to be addicted to homemade poppy extracts in the Narva area (Ida-Virumaa county). However, since then, treatment needs for homemade poppy extract addicts have increased, particularly over 1995–1996. The homemade poppy extract was the most commonly used drug until 1998 when very cheap heroin for injection started to spread from Russia to the Estonian border town of Narva. The price of heroin was lower than the price of poppy extract. Therefore from 1998, the use of injected heroin has grown rapidly among the Russian-speaking population.

Substances used

Homemade poppy extract was the substance first used, and started to spread in 1995–1996. From 1998, heroin for injection entered the illicit drug market.

Gender and age

Gender – male (82%).

Age – 15 to 24-year-olds.

Social background – Russian-speaking unemployed person

Trends: Towards younger age (the youngest are 10 to 12-year-olds), more female users and native Estonians.

Proportion of different users

Heroin is the primary drug used in 47% of cases; in 83% of cases heroin is used by injecting. Also widely used is heroin + hypnotics (Flunitrazepam).

Trends: Towards younger age, more females and Estonians.

Figure 1. Number of patients treated for polydrug abuse in hospitals and polyclinics by year

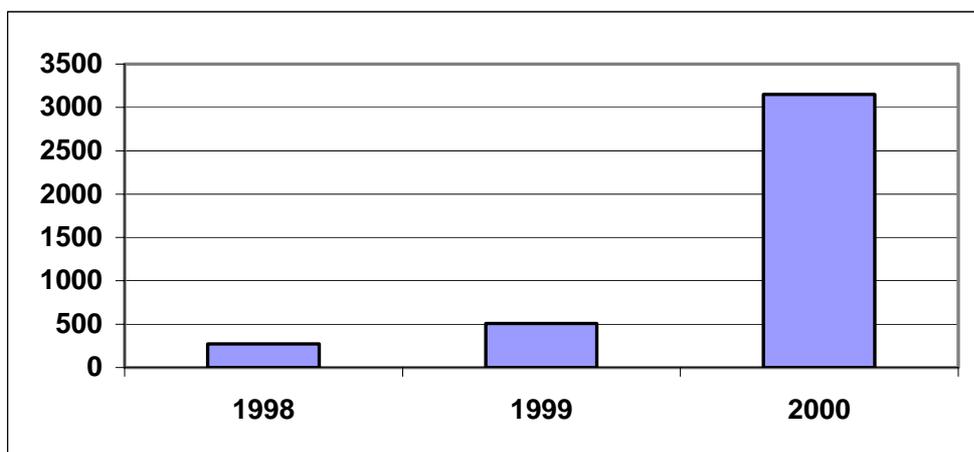


Figure 2. Number of patients treated for heroin/opioid abuse in hospitals and polyclinics by year

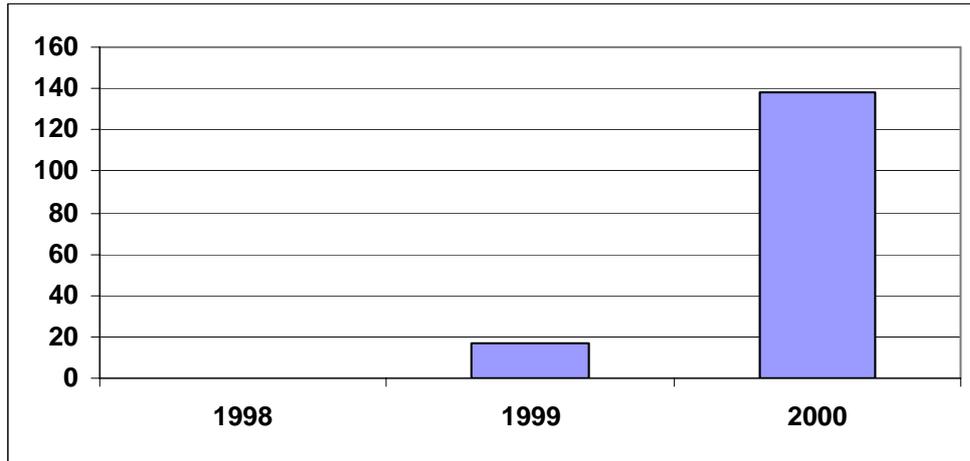
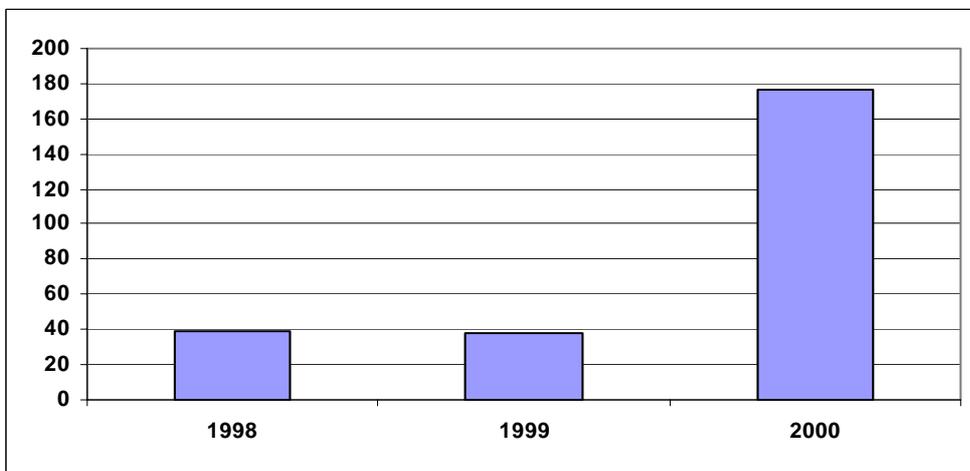


Figure 3. Number of patients treated for stimulants-abuse in hospitals and polyclinics by year

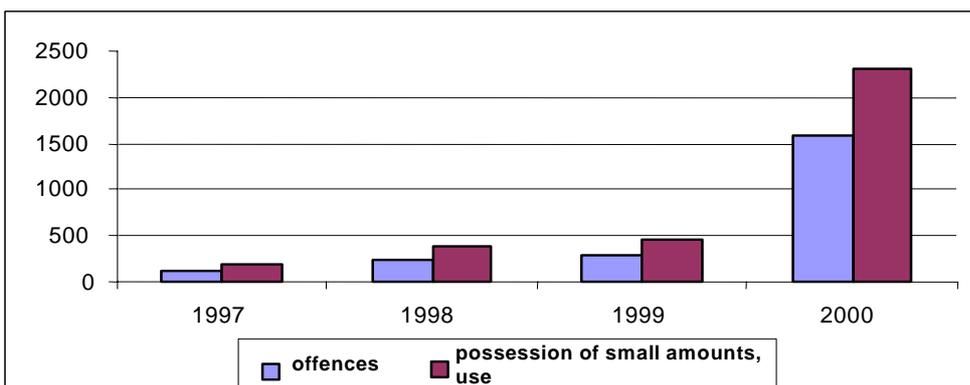


The use of amphetamines is growing quickly in Estonia, with a reported 1.2% of 20 to 24-year-old males in Tallinn using Ecstasy regularly (Survey by A.Talu, 2001). Stimulants are very popular among young people as party-drugs.

Number of opioid/heroin users

It is estimated that there are currently approximately 15 000 to 17 000 regular heroin users in Estonia (Dr. E. Eik, Head of State Programme of Prevention of Alcoholism and Drug Addiction). In 2000, a total of 3 149 known opioid/heroin dependent patients were in treatment (hospital + outpatient) (please see Figure 1).

Figure 4. Illicit drug offences in Estonia



Characteristics of opioid/heroin users

Table 1 displays figures from the Ida–Virumaa Police about drug users in the county for the year 2000 (Narva is excluded) by year of birth. Of 855 recorded drug users, 718 are males and 568 are males between the ages of 12 and 25 years.

Table 1. Number of drug users in Ida–Virumaa County by gender

Year of birth	Total	Males	Females
Before 1960	19	8	11
1960–1964	32	20	12
1965–1969	45	36	9
1970–1974	98	86	12
1975–1979	272	246	26
1980–1984	353	297	56
1985–1988	36	25	11

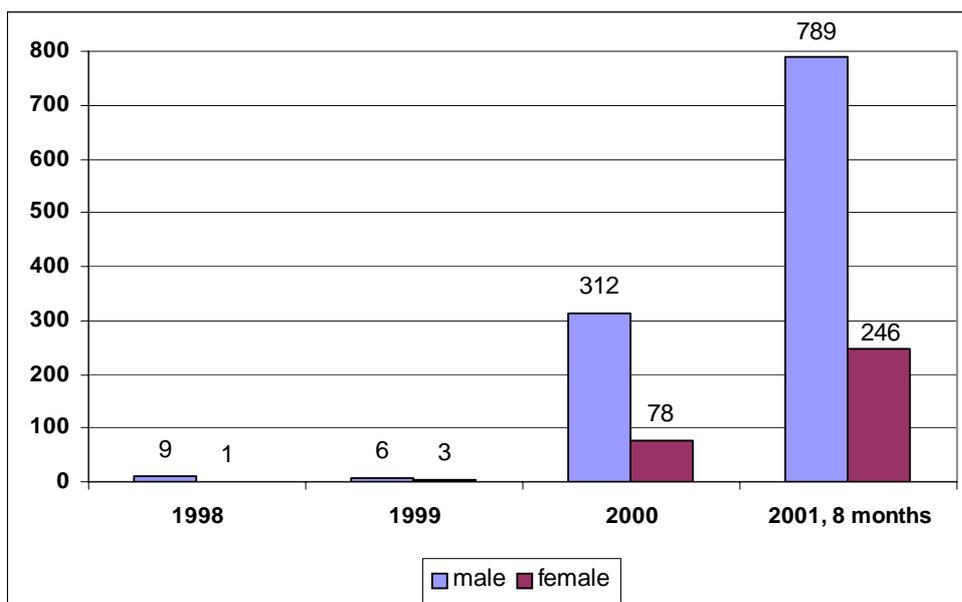
The typical profile of a current heroin addict in Estonia is a 20 to 22-year-old urban male, unable to speak the Estonian language, graduated only from basic school and unemployed.

3. Health consequences

Seroprevalence for HIV

Before the year 2000, there were up to 12 cases of HIV seropositivity each year. In 2000, 390 new cases emerged and in 2001, during only the first eight months, there were 1035 new cases. Most of these cases are in the group of 15 to 24-year-olds (822), and there are 26 cases among children under the age of 14 years.

Figure 5. HIV-positive male and female patients (1998 – August 2001)



In 2001, there was a local epidemic of HIV in the cities of Narva and Tallinn, in the county Ida-Virumaa and the suburb of Tallinn. There have been several cases of inborn HIV and more than 200 new cases among schoolchildren in that year.

Table 2. Seroprevalence of hepatitis cases (1998 – 2000)

<i>ICD-10</i>		<i>1998</i>		<i>1999</i>		<i>2000</i>	
		Males	Females	Males	females	males	females
Hepatitis	B15–B19	1360	626	675	364	765	305
A	B15	604	385	199	179	46	33
B	B16	347	148	191	89	319	118
	Z22.5	37	43	28	26	33	40
C	B17.1	300	67	186	58	265	100

About 95% to 97% of cases of hepatitis C and about 50 % of hepatitis B seropositivity are heroin users (N.Kalikova, AIDS Prevention Centre).

Opioid overdose deaths

Data on fatal opioid overdose are not available for Estonia. There are no officially recorded deaths from opioid overdose (Department of Medical Statistics, Ministry of Social Affairs). In Tallinn, during the last year, there were more than 500 calls for emergency aid due to heroin overdose and about 20 overdoses resulting in death. Post-mortem data indicate that there were about 200 autopsies of people suspected to have died from heroin overdose. In official statistics there were no cases of death from any psychoactive substances from 1997 to 1999. Official data from the year 2000 is still not available.

4. Treatment of opioid dependence

In total, there are 18 treatment institutions. From these institutions, there are two private doctors, eight hospitals with a department for psychiatric disorders, three psychiatric hospitals, one NGO and four institutions for outpatient treatment (Department of Medical Statistics, Ministry of Social Affairs). Low threshold care for dependent persons is available in one NGO – the A-Polyclinic in Tartu.

Types of treatment available:

- Short-term detoxification: methadone during 10–14 days in quickly decreasing doses.
- Abstinence-oriented treatment supported by non-opioid pain-relievers in hospital.
- Outpatient detoxification through private clinic, “Life Hope”, according to individual needs.
- Methadone maintenance – four persons known in Estonia.

In hospital all treatment takes up to 14 days. The duration of outpatient treatment is longer and highly variable, normally from 14 days (very rare) up to three months. The number of all cases by the ICD-10 code F11.X was 3149 patients in 18 treatment institutions during the year 2000. In the private clinic “Life Hope”, between 1997 and 2001, about 850 individuals participated in the outpatient methadone detoxification programme, some of them several times. On average, every day about 25 to 30 persons undergo detoxification.

Factors affecting access to drug treatment are the number of beds and scarcity of financial resources. For methadone maintenance there must be a signed agreement from two psychiatric doctors who take responsibility for treatment. In June 1997, the Narcotic Drugs and Psychotropic Substances Act was adopted by the Estonian Parliament and the law entered into force on 1 November 1997. Approval of Procedure for Handling for Medical and Science Purposes of Narcotic Drugs, Psychotropic Substances Subject to Special Recording, Procedure for Related Recording and Reporting, and Schedules of Precursors, regulation No 39 of the Minister of Social Affairs of 4 November 1997. Methadone is used in specialized psychiatric departments (Wismari Hospital) and in the outpatient private clinic “Life Hope” (more than 850 persons). Eligibility requirements for agonist treatment are the patient’s motivation, the intact structure of personality, and support network from relatives. There

are very few beds in Wismari Hospital, and there is a long waiting period. Outpatient treatment is available only in Tallinn.

5. Main problems and needs

- ❑ Lack of human and financial resources in all institutions at all levels.
- ❑ Lack of training programmes for medical doctors about modern treatment methods, absence of guidelines for treatment.
- ❑ Lack of network at all levels.
- ❑ To motivate medical doctors to improve their knowledge and skills about drug addiction. To establish network of treatment institutions.
- ❑ To exchange experience at local and international levels.
- ❑ Methadone detoxification and maintenance programme needs in Ida-Virumaa county and Narva city is high.

HUNGARY

Dr József Csorba
Metropolitan Hospital, Budapest

1. Country profile

Size:	93 030 km ²
Inhabitants (2000)	10 075 034
Capital:	Budapest (pop: 1 838 753)

2. Epidemiological data available

The use of poppy seeds has been widely accepted as a food ingredient in Hungary since the Roman ages. However, the opium-containing seeds were used as a tranquillizer by the peasants in the countryside for many years. The use of opium developed among youth in the big cities during the 1970s. In the 1980s, opioid drugs (Codeine, Di-Hydrocodein, Morphium, etc.) gradually became involved in the drug-consuming culture. In the early 1990s, the use of heroin spread, growing dramatically in 1991–92. Initially, the definition of opioid consumption implied largely heroin use. According to estimates, 75% of those who use opioids use heroin, whereas 25% of those would drink poppy tea or take pills containing opioids. The consumption of heroin is growing gradually in the illicit opioid market. Among other drugs, the most popular ones are the cannabis-derivatives from Hungary. There are approximately a few hundred thousand people who use cannabis. Since 1995, the use of Ecstasy has grown dramatically. A slight increase can be observed in the use of amphetamine and hallucinogenic drugs. Although the use of cocaine is also growing it is used only by a narrow cross-section.

In terms of gender, the number of female opioid consumers has been growing for the last five years. In the early 1990s, this ratio was 1 female to 5 males; nowadays the ratio is 1 to 3. In terms of age groups, the age range of opioid users is increasing as the number of very young and very old people using opioids is constantly increasing. Among heroin consumers, the rate of intravenous injections is about 75–80%. The morphium consumers only use the drug intravenously. The intravenous use of the repeatedly filtered poppy tea is relatively rare.

It is proven that in Hungary, nobody has been infected with HIV by the intravenous use of drugs. The fact that nobody has been infected with HIV in the Hungarian drug consuming population is regarded as a miracle by many people. The numbers of those who die from drug overdose is increasing. Until the middle of 2001, 28 cases had been registered in that year. This number was 40 in 1999, and 23 people died of opioid overdose in 1998. The estimated number of heroin consumers is about fifty thousand (50 000) in Hungary. Exact evaluations are not available in this area but if we consider the number of patients who are registered at health institutes and the increasing rate of crimes connected to consuming heroin plus the increasing mortality rate, it is presumed that the number of consumers is increasing constantly. The number of opioid consumers officially registered at health institutes was 3857 in 1999, and 3071 in 1998. Forty-two per cent of all the patients treated in health institutes were opioid consumers.

According to the police record of crimes committed in 2001, heroin was the major factor involved in 13.7% of incidents. From the demographic point of view, in the last few years it has been observed that it is primarily the poorer, socially underprivileged youth who are heroin users. Heroin usage is increasingly accompanied by crime too. Family influence is also a significant contributor to heroin consumption. If one family member is a heroin consumer, the chances of becoming a heroin consumer for the other siblings are about 75–80%. It is also noticed that the use of opioid derivatives is frequent among youths with lower educational level.

3. Health consequences

Among the heroin consumers no HIV-infected patient has been identified so far. At the same time in Hungary the hepatitis B and C virus has spread to a vast extent. Among the intravenous heroin users the rate of the hepatitis infection is 28–30%.

4. Treatment of opioid dependence

Several different sectors participate in the treatment of opioid dependent patients. The governmental sector participates through the social insurance and the health care system, and there is also a contribution from civilian organizations and the churches. Private doctors participate minimally in treating opioid dependence. In the health network there are 12 independently functioning drug ambulances in addition to TAMASZ caring network, which mainly deals with alcohol abuse, but accepts other substance abusers in a relatively small number. In rural environments access to treatment of drug dependence is a problem, and in many cases the patient has to travel 100 km to get into a specialized center.

The GP service is not prepared, in terms of professional service provision or infrastructure, to treat heroin consumers. Low level services are in a primitive phase in Hungary. Needle exchange programmes are operating in three towns (in Budapest, Miskolc, Pécs) but these programmes are not sufficient to cope with the need. Social workers on the streets and outreach programmes are almost completely absent. The methadone programme takes place in three cities at present: in Budapest, Veszprém and Pécs. Only a very small rate of the heroin users (0.3–0.5 %) have the chance to take part in the methadone programme due to limited capacity. In rehabilitation centres there are a total of 350 places for patients, but need for these treatments would be higher. The rehabilitation programmes last a minimum of six months and a maximum of two years. The detoxification treatment in hospitals is possible in departments specialized in drug dependence and at psychiatric departments. The treatment lasts 2 – 3 weeks. There are no exact data for the consumption in 2000 but the estimated number of opioid addicts is about 4000. Factors that are major influences on access to drug treatment include place of residence, limited treatment capacity, age (for juvenile drug users there is no therapeutic institution), and social status.

Although agonist treatment has been used for 10 years, methadone treatment has never been thoroughly regulated. The basic principles of methadone treatment were established by the Psychiatric Chamber. These principles have been accepted by the Governing Committee of Health Sciences. However, the provision of financial support is still not satisfactorily handled. Essentially, methadone treatment can be used for two purposes: the first is for the management of short-term detoxification, and the second is for longer-term maintenance treatment. This treatment can be carried out only within an institutional framework (either in an outpatient department or in an inpatient institute); theoretically the patient cannot obtain methadone directly.

In Hungary, methadone is the only substance used for agonist treatment. In 2001, 10 pills (50 milligrams) cost 300 forints which is about US\$ 1. In the year 2000 about two hundred patients were participating in long-term (>3 months) methadone treatment. Approximately 300 patients underwent methadone detoxification treatment at either inpatient institutes or outpatient departments. It is very hard for many patients to get access to long term maintenance programmes as there are only three centres dealing with methadone treatment. Even the centre in Budapest is able to fulfil only 15% of demand. Those opioid addicts who live far from the three centres have very limited chance of receiving methadone treatment. Another important factor is that certain components of dependence professionals still object to methadone treatment. The patients who are involved in methadone maintenance programmes usually come from the lower social strata. Many times other somatic illnesses are also associated with opioid use. There are often problems in family relationships as well as with the non-drug using environment, and they are often involved in criminal activities. The country-wide network of GPs and the pharmacy network are generally not drawn into methadone substitution treatment.

Efficiency examinations for methadone treatment have not been pursued in Hungary so far. In the Budapest centre a very detailed efficiency examination has been going on for six months. An account of its results will be given in April 2002. The ambulatory clinic in Budapest receives the data for

administrational purposes from the two country centres. A brief report is made and is sent to the Hungarian Institute of Alcohol and to the Hungarian Chief Chemist Officer.

5. Main problems and needs

- ❑ to get the necessary funding source (the medicine must be free of charge for patients)
- ❑ establishing methadone centres, at least one in each geographical region
- ❑ implementing other products that are appropriate for substitution (for example buprenorphine)
- ❑ training professionals in suitable quantity and quality
- ❑ constantly monitoring efficiency

These development points mentioned above are also included in the “National Strategy for Repressing Drug Problems” programme. This strategy was accepted on 5 December 2000 by the Parliament.

KYRGYZSTAN

Dr T. Asanov
Chief Narcologist of the Ministry of Health of the Kyrgyz Republic
Director of the Republican Narcological Center

1. Country profile

Size:	198 500 km ²
Inhabitants (2000)	about 4 800 000
Capital:	Bishkek (pop. about 800 000)

2. Epidemiological trends for the last three years

2.1. History of opioid use in the country

Despite the fact that plants containing opioids and their effects have been known on the territory of the Kyrgyz Republic for centuries, there is no evidence of any substantial level of their consumption in the past. Opioids had been used by people for medical purposes, such as pain relief. In the period from 1917 until 1973, almost 85% of poppy crops for the production of opium for medical needs of the former Soviet Union were on the territory of Kyrgyzstan, which accounted for 16% of total world production of opiate raw materials in the world. Until 1965, Kyrgyz Soviet Republic was also the main producer of Indian and other types of hemp plant that were used for production of high quality hemp. In 1974, after “Ukaz” of Presidium of Supreme Soviet of USSR “On strengthening activities against drug addiction”, industrial production of opiate raw materials in Kyrgyzstan was closed (Information Bulletin no. 1 of the governmental State Commission on opioid control in the Kyrgyz Republic, 1996).

Social and economic changes at the end of the 20th century resulted in significant increases in non-medical use of illicit drugs. The structure of clients of illicit drug institutions in the republic has changed and opioid dependence has become the “number one” addiction in the Republic. During the last few years opioid users comprised 50–52% of the total number of people registered in the illicit drug institutions of Kyrgyzstan.

2.2. Gender and age trends

Opioid users are predominantly male (about 90% in 1998–2000); however among heroin users, the proportion of females is increasing, rising from 3.1% in 1998 to 7.9% in 2000. Age distribution is given in the table below.

Table 1. Age distribution among registered clients of illicit drug services in Kyrgyzstan

<i>Age</i>		<i>1998</i>		<i>1999</i>		<i>2000</i>	
<i>(absolute figures)</i>		Opioids (3182)	Heroin (33)	Opioids (4198)	Heroin (154)	Opioids (4242)	Heroin (785)
Less than 15 years	Men	0	0	0	0	0	0
	Women	0	0	0	0	2	2
	Total	0	0	0	0	2	2
						(0.05%)	(0.25%)
15–19	Men	49	0	86	4	28	11
	Women	15	1	22	1	14	3
	Total	64	1	108	5	42	14
		(2.0%)	(3.0%)	(2.6%)	(3.2%)	(1.0%)	(1.8%)
20–34	Men	2009	29	2624	122	2782	514
	Women	213	0	293	10	212	39
	Total	2222	29	2917	132	2994	553
		(69.8%)	(87.9%)	(69.5%)	(85.7%)	(70.6%)	(70.4%)
35 and older	Men	838	3	1103	16	1104	198
	Women	58	0	90	1	100	18
	Total	896	3	1193	17	1204	216
		(28.2%)	(9.1%)	(28.4%)	(11.0%)	(28.3%)	(27.5%)

2.3. Substances used

According to the profiles of registered cases, the main drugs of abuse in Kyrgyzstan between 1998 and 2000 were opioids (51.8–52.8%) and cannabinoids (37.4–38–37.8%).

2.4. Proportion of opioid/heroin users and of injectors

	<i>1998</i>	<i>1999</i>	<i>2000</i>
Total number of registered drug users	6140 (100%)	8083 (100%)	8036 (100%)
Opioids	3182 (51.8%)	4198 (52%)	4242 (52.8%)
Heroin	33 (1%)	154 (3.7%)	785 (18.5%)
Injecting opioid users	3081 (96.8%)	4048 (96.4%)	3995 (94.1%)
Injecting heroin users	11 (33.3%)	106 (68.8%)	650 (82.8%)

Injection drug use is the main mode of administration of opioids in the country (96.8% in 1998; 96.4% in 1999 and 94.1% in 2000).

Among heroin users the proportion of injectors has increased significantly, from 33.3% in 1998 to 82.8% in 2000.

2.5. Polysubstance use

In terms of frequency, polysubstance use occupies the third place among registered drug users after opioid use and cannabis use.

	<i>1998</i>	<i>1999</i>	<i>2000</i>
Total number of registered drug users	6140 (100%)	8083 (100%)	8036 (100%)
Polysubstance use	515 (8.3%)	685 (8.4%)	637 (7.9%)

The most common substances to be combined are alcohol, opioids and cannabis, as well as of opioids and benzodiazepines.

2.6. Amphetamine-type stimulant (ATS) use

Prevalence of ATS use is low and does not exceed 1% of registered cases.

2.7. Latest epidemiological data for the estimated number of opioid/heroin users

It is estimated that the total number of opioid users is about 20 000–25 000.

3. Health consequences

3.1. Proportion of HIV seropositive among drug users

There had been 150 seropositive cases reported until September 2001, and 120 of these cases (80%) were injecting drug users. Injection drug use is the main mode of HIV transmission in Kyrgyzstan.

<i>New cases of HIV</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001-09-10</i>
Total	6	10	16	150
IDU	2 (33.3%)	8 (80%)	14 (87.5%)	120 (80%)

3.2 Opioid overdoses

In 2000, 90 opioid overdoses were reported, of which 22 (24.4%) resulted in death.

4. Treatment of opioid dependence

There are governmental and nongovernmental (predominantly commercial) structures involved in medical aspects of drug abuse.

The state system is represented by narcological services, which include:

- a) Republican centre of narcology;
- b) regional narcological dispensaries and narcological units in the regional multi-field hospitals;
- c) narcological offices in central district hospitals or district centres of family medicine.

Narcological services are separated from mental health care services. Primary health care services are involved in treatment of drug dependence, but their effectiveness is not high and optimization of these activities is needed. Narcological services interact with HIV/AIDS and infectious diseases services. A draft of the National programme on HIV/AIDS prevention is multisectoral and includes coordination of different medical services.

A. Accessible treatment for opioid dependence

Treatment of opioid dependence and opioid detoxification in particular, is easily available for the majority of drug users. Treatment is offered in state treatment institutions, private treatment centers and by private medical doctors. However, treatment of opioid dependence beyond detoxification is hardly accessible due to lack of rehabilitation centres and rehabilitation programmes. Inpatient rehabilitation programmes are available only at the Republican narcological centre and private medical centre of Dr Nazarliev.

B. Duration of treatment for opioid dependence

Duration of opioid detoxification is 10 days. Inpatient treatment of opioid dependence takes 21 days.

C. Number of treated patients in 2000

In 2000, inpatient treatment for drug dependence was rendered to 326 clients, and outpatient treatment to 503 clients.

D. Factors influencing accessibility of treatment

A. Insufficient funding.

B. Lack of good coordination with other sectors of health care in treatment and rehabilitation.

5. Main problems and needs

1. Lack of valid and reliable data on prevalence of substance use disorders and medical consequences of substance use.
2. Ineffective and unsystematic prevention interventions.
3. Restricted effectiveness of treatment. Detoxification is the main treatment approach and treatment of substance dependence is neglected.
4. Lack of rehabilitation system for people suffering from substance use disorders.

LATVIA

Dr Sarmite Skaida
State Centre for Drug Abuse Prevention and Treatment, Riga

1. Country profile

Size:	64 589 km ²
Inhabitants (2000)	2 417 000
Capital:	Riga (pop: 764 328)

2. Epidemiological data available

During the 1960s and 70s, Latvian drug users started to use codeine, eat poppy straws and inject “summer” poppies (poppies milk) in order to achieve intoxication. From 1981 poppy straw extract was used. This substance was called “himhanka” and it was injected. After 1990, heroin started to appear episodically in the drug market, but usually in small doses and of low quality. At the beginning of 1998, poppy straw in the Latvian market disappeared and heroin started appearing in large quantities.

According to the data of the Narcological Service, the number of registered and treated dependent patients as well as the number of drug and psychotropic substance users have been increasing for several consecutive years. The analysis of substance users show that during the last three years, there has been a 1.8-fold increase in the opioid users group. Considerable increases can be observed also for the groups of cannabis, sedatives and hypnotics.

Figure 1. Types of drugs first used by minor drug users

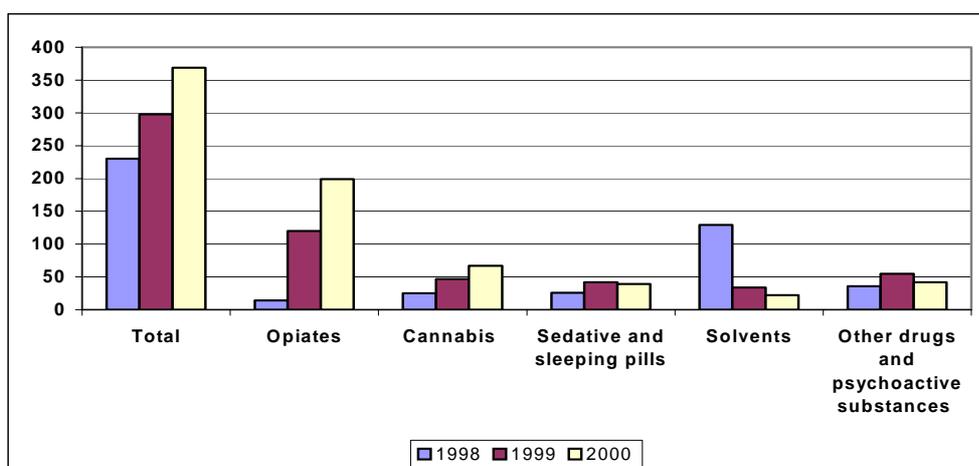
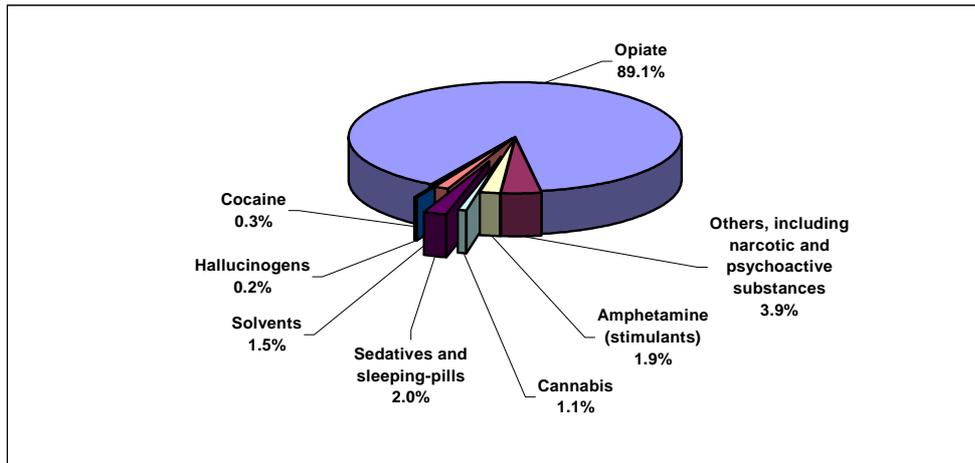


Figure 2. Percentage of drug type used among 645 new cases of drug addiction in 2000

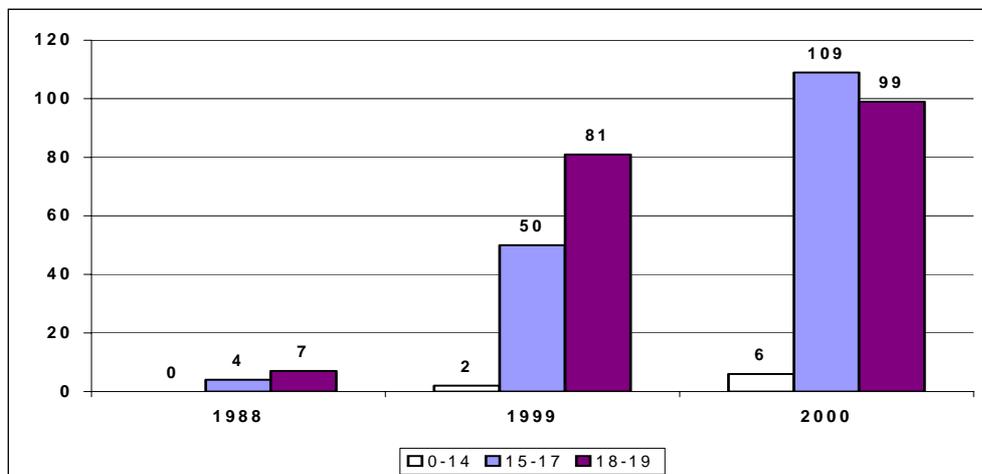


Marijuana and hashish are very popular drugs among teenagers. Another frequently used substance is the synthetic opioid analgesic tramadol, which for a long period could be obtained at the pharmacy without a prescription. The dosage can be up to 50-60 tablets per day. The benzodiazepine clonazepam, which can cause dependency, is also frequently used. At the same time the number of teenagers sniffing glue decreased, which is attributed to the increasing uptake of heroin use.

The ratio of registered individuals by gender is 3.5 males to 1 female with the following age ranges:

- in the age group under 15 years of age the ratio is 1.8 males to 1 female;
- in the age group of 15-19 the ratio is 3 males to 1 female.

Figure 3. Prevalence of new drug cases by age group



Approximately 60.6% of all opioid users and addicts inject, and unfortunately this proportion is increasing. Approximately 2/3 of the listed drug-using teenagers are polydrug users (medicines+cannabis+heroin). Five percent of all registered patients use stimulants. For some years this number has been consistent. In 1993 the first HIV positive drug user was registered. Until the year 1997 a number of new cases were reported. Since this time though, a significant increase in the number of HIV-positive drug users has been observed. This is considered to be a result of the large amount of heroin flowing into the Latvian drug market. Since 1997, opioid overdoses have been observed, with 30 such cases recorded in the last year.

According to the Narcological Centre and Drug Enforcement Bureau, it is estimated that there are approximately 40 000 drug users and drug addicts in Latvia. The greatest number of people to access inpatient treatment in the narcological hospitals has been heroin addicts. There were 2124 substance use patients treated by inpatient facilities in 2000, of whom 1960 were opioid users. This number has increased by almost three times since 1998.

Figure 4. Number of people with drug dependence undergoing treatment at inpatient hospitals

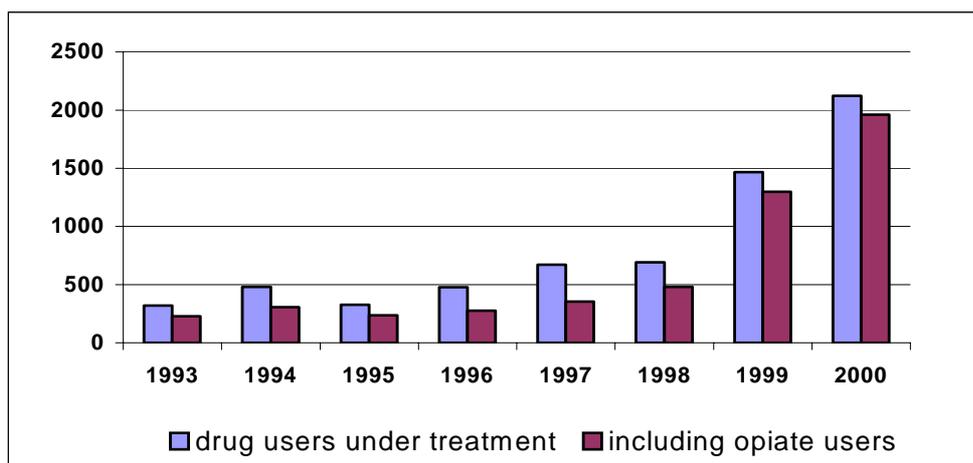
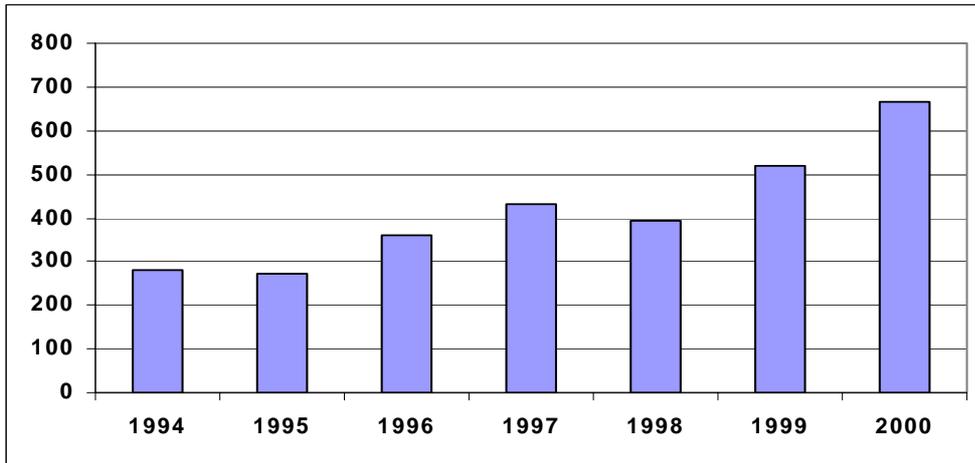


Table 1. Number of clients admitted to drug treatment by type of drugs used

<i>Substances</i>	<i>1994</i>	<i>1995</i>	<i>1996</i>	<i>1997</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>
Opioid	238	237	276	353	480	1299	1960
Amphetamine	34	27	39	36	33	41	25
Solvents	8	6	118	158	101	22	21
Sedative and sleeping pills	7	8	14	22	20	26	24
Cannabis	3	2	2	9	7	4	9
Hallucinogens	2	2	2	8	2	1	3
Cocaine	--	--	--	11	2	7	3
Other drugs, including psychoactive substances	56	43	36	85	47	67	79
In total	348	325	478	672	692	1467	2124

The annual reports of Drug Enforcement Bureau do not reflect the concrete number of drug users. They reflect the number of drug-related crimes in Latvia. In 2000 this number has increased to 668, of which 328 were connected to heroin.

Figure 5. Number of drug-related crimes in Latvia



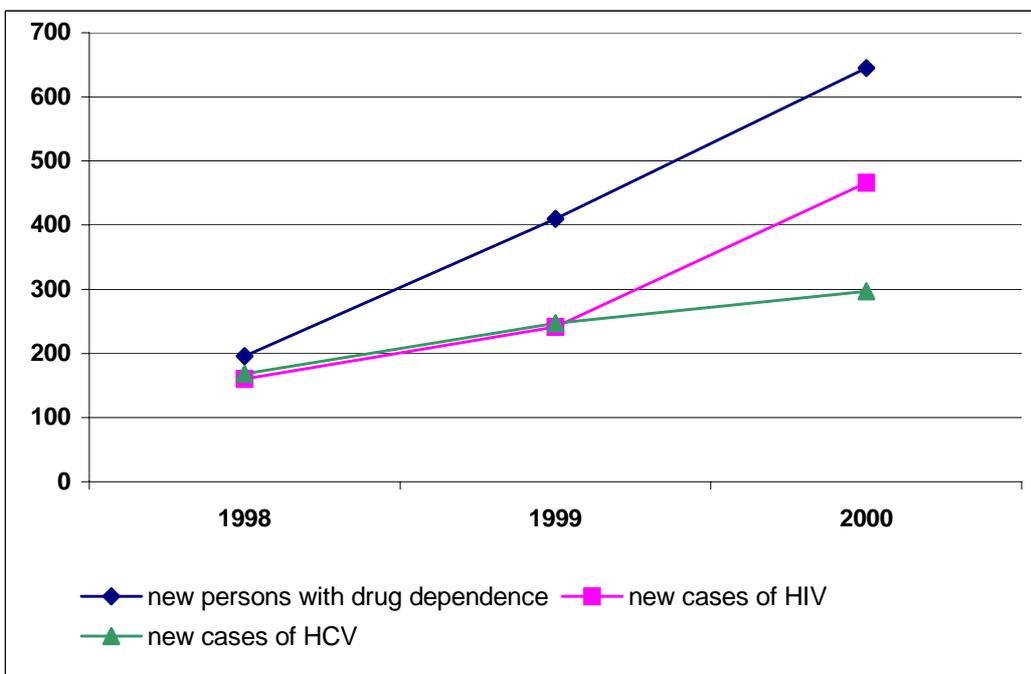
Analyzing the different data, we can derive the following portrait of a typical opioid addict: male (78.8% of cases), under the age of 24 (81.1%), with low level of education (unfinished primary school or primary school, 64%), unemployed or without permanent job (71.5%), living in the largest cities of Latvia.

3. Health consequences

Seroprevalence of hepatitis C / HIV

In the year 2000 the number of registered hepatitis C cases increased to a total of 297, or 12.2 cases per 100 000 inhabitants. The number increase parallel to the increasing number of drug addicts. The spread of HIV/AIDS in Latvia is growing rapidly.

Figure 6. New cases of hepatitis C virus (HCV) infections and HIV

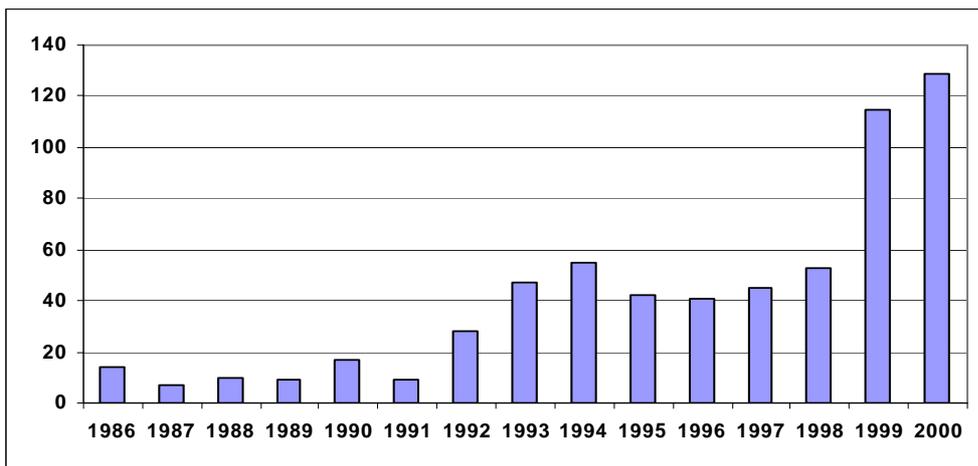


According to the data of the AIDS Prevention Centre, 466 new HIV cases and 24 new AIDS cases were registered in the year 2000. At the beginning of September, 2001, there were 1505 recorded HIV-positive individuals, of whom 1084 were drug users. The number of opioid users with hepatitis and HIV/AIDS cases is not recorded.

Opioid overdose deaths

The number of deaths due to drug and psychotropic substance use was 129 in the year 2000. Approximately 50% of the mortality is from combined poisoning with heroin as a base.

Figure 7. Number of drug-related deaths



4. Treatment of opioid dependence

In Latvia the treatment of drug addicts is included in the state-paid health programme. It is also possible to be treated anonymously. The state health treatment structure is as follows: there are five narcological hospitals in Latvia. In addition to this, there exists outpatient treatment in every region. There are also three rehabilitation centres (two for adults and one for teenagers). Substance abuse treatment is distinct from mental health services. There is a very wide private substance abuse practice in Latvia. Primary health care providers make a diagnosis and then the patient is sent to a specialist. Following outpatient consultation opioid addicts are usually sent to inpatient detoxification. The duration of treatment paid by the state is 10 days. It is possible to get ultra-rapid detoxification, but it is very expensive, and the state does not incur the cost for this. Following detoxification, treatment takes place in the motivation department for 12 days. Following this, patients attend either the Minnesota programme (12 steps) for 28 days, rehabilitation centres for one year, or outpatient treatment. With the initiative of some clergymen, two rehabilitation centres for drug users have been opened by churches.

Methadone in Latvia has been officially permitted for opioid maintenance therapy since May, 1996. The adoption of methadone maintenance therapy is regulated by instruction of the Centre of Drug Abuse Prevention and Treatment. Storage and delivery is prescribed by the Order No 281 issued by the Ministry of Health. Methadone can be prescribed only by psychiatrists/narcologists who have participated in a special training course.

The Soros foundation was a cosponsor of the methadone programme for the first three years of operation. At the moment it is included in the state programme, and is therefore free for patients. One visit costs approximately US\$ 1 per day. The methadone maintenance programme can treat 100 patients. Taking into account that it is the only one in Latvia, treating more than 100 patients in one time is not possible. Patients above the age of 21 are eligible for the programme. Only patients with drug dependence for more than five years are selected for the programme, as well as those who have attempted treatment at hospital and rehabilitation centres several times and not been successful. The methadone programme is also available to opioid dependent individuals who are pregnant or are HIV/AIDS positive.

According to the current situation, many eligible users are currently not participating in a treatment program. These are primarily young opioid addicts, who are not able to stop using heroin, and become involved in criminal activities, such as theft and prostitution. With this programme, we hope to change their lifestyle and social status.

Unfortunately substance treatment professionals from rural areas and other cities have not shown much interest in this treatment. There are patients who live 30–40 km from Riga or even more. Many are patients with a 25–30 year history of opioid use. Before starting the programme, each patient signs a contract and outpatient cards are issued. Daily dosage is recorded in the monthly procedure list and is signed by patients.

Effectiveness is evaluated by questionnaires twice a year. There are questions about changes in clients' health, social and financial situation. The proportion of patients who are able to secure employment is another measure of programme effectiveness. Regular urine tests are conducted to indicate additional drug using.

5. Main problems and needs

The main problem at the moment is the increased number of very young drug users. Unfortunately this group does not seek treatment and, in most cases, refuse treatment. Therefore we consider that a special law about forced treatment should be introduced. Unfortunately our government is too slow in discussing this matter. However, it is necessary, due to the increase in HIV positive cases among young people. The youngest HIV-positive drug user is only ten years old.

It is also necessary to open more rehabilitation centres as there are too few places in the current services.

LITHUANIA

Dr Emilis Subata
Vilnius University Substance Abuse Treatment Centre

1. Country profile

Size:	65 301 km ²
Inhabitants (2000)	3 698 000
Capital:	Vilnius (pop: 543 000)

2. Epidemiological data available

History of opioid use in the country

During the Soviet period the use of illegal drugs, like many other negative social phenomena, was not publicly acknowledged in Lithuania. Opium produced from poppies growing in Lithuania began to be used at the end of the 1970s (both as a drink and intravenously), while opioid medication compounds which UN conventions define as being illegal drugs (e.g. codeine) were being used even earlier for their intoxicating effect. At that time, the use of illegal drugs was not related to youth culture and leisure. As it had somewhat earlier in Western Europe, drug use in Lithuania became an expression of youth “protest” at the end of 1970s and in the beginning of the 1980s. However, only several hundred followers of the belated “hippie” culture in Lithuania used poppy straw derivatives intravenously. Due to their limited numbers, drug users were often considered to be emotionally disturbed, and were therefore treated in psychiatric hospitals. In society, drug dependent people were denounced and looked upon as dangerous criminals. Drug users were severely punished and incarcerated, which in turn contributed to the tendency for the spread of illegal drugs in prisons and among former convicts. The changes, which began in 1990, affected the use of illegal drugs in Lithuania as well as in other Central and Eastern European (CEE) countries. Drug use began to spread among young people as a manifestation of a Western lifestyle. Other factors also played an important role, particularly the opening up of markets, the increase in trafficking, ineffective legislation and law enforcement, and rising standards of living.

Lithuania gained independence from the Soviet Union in 1991. Before independence, alcoholism was the main problem and the general public knew little about other forms of drug abuse. Indeed, in those days the only drug problem worth mentioning was in prisons where some wardens (usually natives of Central Asia), sold opioids to the inmates. A proportion of young Lithuanian soldiers who had fought in Afghanistan came home with an opium or heroin habit. But since relatively few people were affected, it was fairly easy to either rehabilitate them or isolate them in prisons before they “contaminated” the rest of the society. Opening of the borders after independence has facilitated the penetration of organized crime, including drug trafficking. The young state, which has borders with four countries, including the Russian enclave of Kaliningrad, and 100 km of the Baltic Sea coast, was not adequately equipped to resist the development of drug trafficking on its territory.

Substances used

Abuse of illicit substances among young people became a new social phenomenon at entertainment events, clubs, and discotheques. Drugs are distributed in discotheques, near schools, and on streets in major cities. Young people take interest in the new Western youth philosophy and ideology related to use of drugs such as heroin, marijuana, synthetic drugs of the amphetamine group, Ecstasy, LSD. Young people also engage in inhaling or sniffing heroin, which has become popular in recent years. Usually within a short period they start to use heroin intravenously (according to information provided by the Vilnius Substance Abuse Treatment Centre, and Toxicological Department of the First Aid, Vilnius University Hospital).

Gender and age

Males account for ¾ of opioid users entering treatment. In terms of age distribution of users, in 2000, among registered drug users 0.2% were younger than 14 years old, 9.2% between 15 and 19, 26.4% between 20 and 24, 38.1% between 25 and 34, and 26.1% older than 35 years.

In 2000, 804 new opioid users sought medical treatment in Vilnius Substance Abuse Centre after treatment with naltrexone was made available free of charge for a period of a few months. Most new patients were between 18 and 22 years, with 15% being younger than 18 years old. With the appearance of heroin on the black market and the change in pattern of use (smoking) the average age of the patients decreased significantly.

Proportion of different users

According to data by treatment institutions drug profiles have been changing. Most of the older drug users are using homemade heroin or poppy extract from poppy heads and poppy straw (“shirka” in slang), dried poppy straw is prepared in a simple manner with solvents, and the brown colour solution is injected once or twice a day. Treatment data indicated that in 1999, 95.4% of drug addicts used opioids intravenously and 4.6% orally. IDUs use a mixture of poppy extract with tranquilizers or antihistamines. Heroin of high purity (60–90%) for inhaling is a new drug that has been introduced during the last few years in Lithuania, and consumption by young people very quickly led to dependence and typically to intravenous use.

According to the State Mental Health Care department in 1999, opioid-dependent patients accounted for 71.6% (2207 persons) of all registered drug users (3082). Additionally 15.3% (472 persons) used different drugs, which frequently included opioids. In 2000, opioid-dependent patients accounted for 74.4% (2619 persons) of all registered drug users (3521). Additionally 13.8 % (487 persons) used different drugs including opioids.

At the end of 1999, 472 polydrug users were registered in health care institutions and this accounted for 15.3% of all drug users. In 1998 this group accounted for 16.7%. Traditionally psychostimulants were used, including “jeff”, which is produced from medications containing ephedrine, and ephedrine powder – “Kristal”. These were injected up to ten times a day. In 1996 new amphetamines were introduced into the “black market” and consumed by young people, aged 15–19, in tablets or intravenously, as well as through synthetic drugs (Ecstasy, LSD). Among children, aged 9–14, sniffing of volatile substances (mainly glue) is popular. Smoking of marijuana and hashish increased significantly, and growing of plants for drug raw materials has also increased.

Number of opioid/heroin users

In Lithuania the real epidemiological situation is not known. Surveys in terms of drug use have been carried out solely among schoolchildren but not among other community groups. A survey, carried out by the Information on Alcohol and Other Drugs Council of Sweden and the EC Pompidou Group on Alcohol and Drug Abuse among schoolchildren (ESPAD) simultaneously in 26 European countries (including Lithuania) studied the patterns of psychoactive substance use among 3196 students aged 15–16 from high and technical schools, and reflected the existing situation in Lithuania. The questionnaires revealed the following information: 25.3% of the participants smoked daily, 94.8% used alcohol (over two-thirds used to get intoxicated), 3.2% used illegal drugs (smoked marijuana mainly, used amphetamine, crack, Ecstasy, heroin and LSD), 14.6% used tranquilizers, hypnotics, 15% used sniff volatile substances, glue, aerosol. The rates of frequent use of inhalants were higher for boys than for girls (17.6% and 14%, respectively). Inhalants were popular among the age group of 13–14. Until 1995 the prevalence of different drugs in Lithuania among students was low in comparison with other Baltic States or European countries (ESPAD Report, 1995). The survey in 1997 in Vilnius schools showed the tendency for rapid growth of drug abuse among the schoolchildren aged 15–16, and they were familiar with most of the drugs. The use of illicit drugs in the same age group (in Vilnius) became alarming, increasing from 3.2% in 1995 to 26% in 1997, an increase of eight times. Every fifth participant of the survey had “experimented” with drugs such as marijuana or hashish, Ecstasy, LSD, and amphetamines. ESPAD (1999) confirmed that illegal drug usage among schoolchildren has recently considerably increased, especially in large cities like Vilnius and Klaipėda.

The table below shows the cases of usage of different drugs among schoolchildren in the country in 1995 and 1999 and in the cities of Vilnius and Klaipeda.

Table 1. *Illegal drug use among students 1995–1999 (%)*

Survey	Sex	Name of drug							
		Marijuana/ Hashish	Ampheta mine	LSD	Ecstasy	Cocaine	Heroin	Crack	Any kind
Country ESPAD 95	Boys	2.0	0.3	0.1	0.4	0.1	0.1	0.1	3.4
	Girls	1.2	0.3	0.1	0.4	0.6	0.2	0.1	2.7
	All	1.6	0.3	0.1	0.4	0.4	0.2	0.1	3.2
Country ESPAD 99	Boys	17.4	1.9	2.9	6.4	1.3	5.9	0.5	21.0
	Girls	6.1	1.0	0.7	2.3	0.8	3.6	0.1	9.6
	All	11.9	1.5	1.4	4.4	1.1	4.8	0.3	15.5
Vilnius 1998	Boys	28.7	8.2	8.7	13.0	–	1.1	2.3	30.2
	Girls	11.9	2.3	1.8	4.7	–	–	1.5	14.6
	All	19.8	4.5	5.1	8.3	–	0.5	1.8	22.7
Klaipeda 1999 (Grade 9)	Boys	23.1	3.1	4.6	3.1	–	1.5	–	27.7
	Girls	4.7	–	–	0.7	0.7	–	–	6.0
	All	13.3	1.4	2.2	1.8	0.4	0.7	–	16.1
Klaipeda 1999 (Grade 11)	Boys	31.7	3.1	3.7	9.3	2.5	4.3	3.1	37.3
	Girls	14.4	0.9	2.8	7.0	1.9	0.9	1.4	14.0
	All	27.1	1.9	3.2	8.0	2.1	2.4	2.1	23.9

The ESPAD survey in 1999 revealed a new tendency for heroin inhaling (smoking and sniffing) among schoolchildren, including those living in small regions. In comparison with 1995, usage of heroin increased from 0.2% to 4.8%. Usage of marijuana/hashish increased about eight times. Usage of amphetamines, LSD and ecstasy also increased. Intravenous opium extract is produced under home conditions from the heads and "straw" of local poppies. Drug dependent individuals usually manufacture this substance: dried poppy straw is prepared in a simple manner with solvents. However, in less than ten years the consumption of "shirka", a crude form of heroin manufactured from poppy "straw" (in fact, from the fresh stems and bulbs of the poppy plant, which is akin to the "kompot" used by Polish addicts) has reached epidemic level. The drug is manufactured by boiling the "straw" in a large pot and adding acetic anhydride to the concoction. Opium extracts derived from poppy straw remain the most frequently injected substance. However, "brown sugar" heroin has recently become available in Lithuania and usage among youth has been increasing (data from survey and observation of professionals based on applications for medical treatment). According to data by the Vilnius Substance Abuse Treatment Centre, Vilnius police and mass media information, heroin is becoming more popular among youth. According to the municipal police of Vilnius, the most widespread method of consumption is inhaling: it is rolled in common paper like a cigarette, a small heroin dose is put on aluminum film, and heroin is heated from the bottom, while the user inhales the steam. For youth, this method of drug usage is very attractive as it is safe from HIV transmission, and the first use is often free of charge. According to the survey data, heroin usage increased from 0.2% (1995) to 4.8% (1999), especially among boys.

Table 2. ESPAD survey data among 15 to 16-year-old students 1995–1999 (%)

<i>Drug name</i>	<i>Sex</i>	<i>Country ESPAD 1995</i>	<i>Country ESPAD 1999</i>	<i>Vilnius Capital 1998</i>	<i>Klaipeda 1999 Grade 9</i>	<i>Klaipeda 1999 Grade 11</i>
	Boys	0.1	5.9	1.1	1.5	4.3
Heroin	Girls	0.2	3.6	–	–	0.9
	Total	0.2	4.8	0.5	0.7	2.4

Based on data from routine statistical analysis by the State Mental Health Centre, between 1991 and 2000, the prevalence of drug dependent individuals increased six times per 100 000 population (in 1991 – 15.3 cases per 100 000 population, in 2000 – 95.3 cases per 100 000 population). The prevalence between 1998 and 2000 increased from 77.4 cases per 100 000 population in 1998, to 95.3 cases per 100 000 population in 2000. Ninety-four percent of all drug addicts are urban dwelling and 80.9% are male. According to the statistical analysis for the year 1999, the highest prevalence of drug addiction was in the city of Visaginas – 462.9 per 100 000 population (5.5 times in excess of the country level of 83.3 per 100 000 population). The second highest rate of addiction was identified in the regional town Birzai, with 426.1 drug addiction cases per 100 000 population (5.1 times greater than the country level); followed by Klaipeda, with 220.2 drug addiction cases per 100 000 population (2.6 times greater than the country level), and Druskininkai, with 213.1 per 100 000. Since 1997 the ICD–10 drug abuse classification has been applied in Lithuania. According to the data by the State Mental Health Care Centre, 3521 drug addiction cases were registered at the end of 2000. These included 546 newly registered drug dependence cases during the last year, while 159 were deleted from the list due to death (61), recovery or unknown location. The number of recorded drug addicts who, for various reasons, died in 1999 was 37, while in 2000 this increased to 61.

Table 3. Morbidity with dependence disorders per 100 000 population according to ICD–10, 1997–1999 (data by the State Mental Health Care Centre)

<i>ICD–10</i>	<i>F10</i>	<i>F11</i>	<i>F12</i>	<i>F13</i>	<i>F14</i>	<i>F15</i>	<i>F16</i>	<i>F17</i>	<i>F18</i>	<i>F19</i>	<i>All</i>
1997	2026.0	54.3	0.5	3.7	–	2.2	0.3	0.1	2.8	13.5	2103.4
1998	1927.4	53.8	0.7	3.5	0.03	2.2	0.2	0.2	4.0	12.9	2004.9
1999	1840.0	59.6	0.8	3.1	0.1	2.3	0.2	–	4.4	12.8	1923.3

In 1999, 71.5% (2207) of the observed drug addicts used opioids as the primary drug, and 15.3% (472) were polydrug users, 1% (28) used cannabis preparations, 2.7% (84) used amphetamines and other stimulants, 0.3% (9) used hallucinogenic substances, 3.8 (117) used sedative substances, 5.2% (161) used solvents (including volatile substances), and 0.1% (4) used cocaine.

In 2000, 74.4% (2619) of the observed drug addicts used mainly opioids, 13.8% (487) were polydrug users, 0.8% (27) used cannabis preparations, 2.8% (98) used amphetamines and other stimulants, 0.2% (9) used hallucinogenic substances, 3.3 (115) used sedative substances, 4.6% (162) used solvents (including volatile substances), and 0.1% (4) used cocaine.

Compared with data from 1998, the age of drug addicts continues to be young. The age distribution of drug abuse cases registered with health institutions are distributed as follows: under 14 years – 0.6%, 15–19 years – 7.5%, 20–24 years – 24.5%, 25–35 years – 39.5% and 27.9% over 35 years of age. During 1999, 2323 drug users were treated, including 400 who applied for the treatment institutions the first time. According to doctors of the Vilnius University Children Mental Development Clinic and Vilnius Substance Abuse Treatment Centre, heroin users have been approaching these institutions for anonymous help and advice more frequently. Many are not on the register of medical institutions as drug addicts. For example, in 2000 in one of Vilnius’s private treatment centres, 165 heroin users received naltrexone–depot implants but patients were not listed in the current treatment data statistics. In 2000, in Vilnius Substance Abuse Treatment Centre, around 500 heroin users were not

put on the register because they sought medical treatment anonymously. In addition in Vilnius 700 drug users who are not in treatment are reached by outreach service.

According to the Ministry of Interior, within the last years the situation in terms of drug use has worsened dramatically. The number of criminal offences related to drugs in 1999 (701) had increased nine times compared to the number in 1990 (76), and there was a 12% increase from 1998 (629). Illegal trafficking, production, possession, acquisition, transportation, shipment and trade in illicit drugs dominate these cases. A stable drug trade network exists in Vilnius.

In 1999, drug addicts committed 207 offences (compared to 213 in 1998), or every fourth offence. Intoxicated drug addicts committed 53 offences. Every third person who committed an offence had already been delinquent earlier. Persons who had previously been prisoners performed 253 drug offences. Persons who neither worked nor studied committed 343 offences, or every second offence. 19 criminal offence cases were committed by teenagers (18 in 1998). Male offenders accounted for 74% of offences. Two hundred and fifty-five offences related to drugs, and 40% were committed in the capital city of Vilnius. Six hundred and ninety-three persons were applied to penal provisions (Penal Code, 232).

Table 4. Drug-related crimes (data by the Ministry of Interior)

<i>Year</i>	<i>1994</i>	<i>1995</i>	<i>1996</i>	<i>1997</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>
Drug related crimes registered	334	395	511	630	629	701	926
Solved crimes committed by drug addicts	235	215	382	502	881	735	894
% of total solved crimes	1.0	0.9	1.4	1.4	1.6	2.3	1
Crimes committed by individuals under the influence of drugs	82	94	82	91	91	53	78
% of total solved crimes	0.4	0.4	0.4	0.4	0.4	0.2	0.2

In 1999, 12 foreigners from Russia, Latvia, Azerbaijan, and the Republic of Korea were arrested in Lithuania, compared with eight foreign arrests in 1998. In 1999, 173 drug dealers were arrested, including six foreigners, 30 women, and eight teenagers. The Public Police Prevention Service executed complex "Aguona" (*Poppy*) measures in summer 1999 (legal basis: Decree No. 390 by the Minister of Interior) during which more than 300 raids were organized, together with the police divisions from different regions and cities, with the aim of preventing illicit drug trafficking, destroying raw drug crops, discovering dens and uncovering other activities related to illicit drugs.

The following were achieved during a two month period:

- ❑ 33 679 m² of poppy fields and 1842 m² of cannabis crops were destroyed;
- ❑ Established 219 persons (1998 – 148) who committed administrative violations while intoxicated with an illicit substance, including 27 underaged persons (15 in 1998), mainly (15) in the seaside region Kretinga;
- ❑ For the administrative violations related to narcotic drugs administrative penalties were applied to 4503 individuals (3037 in 1998, including 18 teenagers);
- ❑ In compliance with article 44 of the Administrative Code ("illegal drug acquisition and storage of small quantities and usage without prescription") administrative penalties were applied to 353 persons including eight teenagers (200 persons including 18 teenagers in 1998); most such violations were performed in the biggest cities (Vilnius – 93, Kaunas – 23, Klaipeda – 22 and Siauliai – 18);
- ❑ According to the Administrative Code, article 44 (illegal pharmaceutical activity) administrative penalties were applied to 12 persons;
- ❑ According to the Administrative Code, article 107 (illicit growing of drug raw material) administrative penalties were applied to 4224 persons in 1999, 2836 persons were persecuted legally in 1998, representing an increase of 49 % compared to 1998.

During these operations, the following were also established: 129 drug dealers, 740 drug users including 13 underaged, 90 underaged who were intoxicated with drugs (most of them in the large

cities); 94 dens where narcotic drugs were used (mainly in Kaunas and Klaipeda); and 291 persons who kept or carried raw drug materials or narcotic drugs. During the operation were seized: 326 736 g of poppy straw, 15 723 g of cannabis, 109 846 g prepared drugs from plants and 577 g of synthetic drugs.

This action was taken by the police, transport services, criminal police, organized crime investigation police service, Narcotic Drugs Investigation Division (anti-drug unit), border police and municipal police. In 1999, 3.6 times more cannabis was destroyed than in 1998. The cannabis has been becoming more popular among users and growing of cannabis has increased.

Table 5. Drugs withdrawn from illicit trafficking (1997 - 2000) (Data by the Ministry of Interior)

<i>No.</i>	<i>Name of drug</i>	<i>Seized in 1997 Quantities</i>	<i>Seized in 1998 Quantities</i>	<i>Seized in 1999 Quantities</i>	<i>Seized in 2000 Quantities</i>
1.	Opioids				
1.1.	Poppy heads and straw	1 291 kg	1 525 kg	744 kg	623 kg
1.2.	Opium extract	86.04 litres	49.49 litres	190 litres+ 190 g.	77 litres +129 g.
1.3.	Opium	236 g.	101.3 g.	35.9 g.	47 g.
1.4.	Acetylopium	16.461 g.	182.38 g.	-	-
1.5.	Heroin	89.3 g.	422.62 g.	923 g.	943 g.
1.6.	Methadone	252 pills, 10 ml., 0.34 g.	13 pills, 0.04 g.	210 ml+92 tablets	888 ml.
1.7.	Monoacetylmorphi	4.41g.	-	-	-
2.	Cannabis				
2.1.	Marijuana	8.063 kg	30.357 kg	25.667 kg.	14.428 kg.
2.2.	Hashish	78.4 g	3.78 kg	1.054 kg	169 g.
3.	Cocaine	2.049 kg	10.78 kg	275 g.	169 g.
4.	Psychotropic substances				
4.1.	Amphetamine	171 g 5641 pills	12.84 g 142 pills	77.5 g 2276 tablets	19.495 kg 42 tablets
4.2.	Ecstasy	1641 pills	831 pills	1122 tablets	150 724 tablets
4.3.	Ephedronum	1.348 ml	994.9 ml	486 ml	482 ml
4.4.	Phencyclidine (PCP)	2.21 g	-	-	-
4.5.	LSD	2 marks	342 marks	164 marks	26 marks
4.6.	Relanium	123 amp.	671 amp.	580 amp.	106 amp.
4.7.	Rodedorm (nitrazepam)	143 pills.	566 pills	-	-
4.8.	Oksazepam	-	43	-	-
4.9	Ephedrine	-	-	8.860 kg	198 g

Table 6. Quantity and number of seizures per drug (1996–2000)

	1996		1997		1998		1999		2000	
	No.	Quant.	No.	Quant.	No.	Quant.	No.	Quant.	No.	Quant.
Cannabis (kg)	5	0.826	13	8.63	70	30.35 7	45	25.66 7	72	14.42 8
Cocaine (kg)	2	1.056	2	2.049 kg.	16	0.275	11	10.13 3 kg.	7	0.275
Heroin (kg)	–	–	2	0.089 kg.	34	0.923	6	0.423 kg.	103	0.943
Ecstasy (tablets)	6	56	3	1641	22	831	10	1122	11	150 724
Amphetamines (kg, tablets)	2	0.05	8	0.171 5641	29	0.013 142	12	0.077 2276	27	19.5 42
LSD (pieces)	–	–	2	2	9	342	19	164	4	26

Table 7. Average “street” prices of drugs (US\$ 1 equivalent to 4 Litas)

Name of drug	1998 in Litas	1999 in Litas	2000 in Litas
Poppy heads and straw (1 glass)	From 2 to 20 Litas	from 4 to 30 Litas	from 7 to 15 Litas
Opium extract (ml)	4 to 10 Litas/ml.	4 to 15 Litas/ml.	4 to 10 Litas/ml.
Marijuana (g)	20 to 60 Litas/g.	15–60 Litas/g.	40–60 Litas/g.
Hashish (g)	60 Litas/g.	50–60 Litas/g.	30–40 Litas/g.
Amphetamine (tablets)	30–40 Litas/tab.	16–40 Litas/tab.	20–40 Litas/tab.
Amphetamine (g)/wholesale	120 Litas/g.	80–100 Litas/g.	60–120/25–40
Ecstasy (tablets)	40–60 Litas/tab.	25–60 Litas/tab.	25–50/7–15
LSD (unit)	50–60 Litas	30–50 Litas	40–70 Litas
Heroin (g)	600–1000 Litas/g.	200–350 Litas/g.	150–200/80–150
Heroin (1 dose = 0.015 g.)	60 Litas/dose	30–40 Litas/dose	15–40 Litas/dose
Cocaine (g)	360–400 Litas/g.	240–350 Litas/g.	200–350 Litas/g.

The prices vary in relation to the quantity and the seller. Earlier the sellers were more specialized and generally dealt with only one type of drug; however sellers are now frequently dealing in several different drug types. The sellers act in discotheques and other entertainment places, bars, and in the streets. Drug prices decreased in the year 2000. The most expensive drug remains cocaine, and prices remained most stable for LSD. Phencyclidine (PCP) is very expensive, with one gram costing about US\$

220 or 880 Litars. Overall, the prices are decreasing because the market is replete or is aiming at more consumers. Higher prices of drugs are observed in the city of Vilnius.

3. Health consequences

Seroprevalence of HIV, hepatitis B/C

According to a decree by the Health Ministry of Lithuania, all drug addicts must be checked for HIV infection once or twice per year. The first HIV-infected injecting opioid user was identified in Klaipeda in 1994. In September 2001, 319 HIV-positive cases had been registered in Lithuania, of which 200 cases were IDUs.

Table 8. HIV prevalence among IDU population in Lithuania (1994–1999)

<i>Year</i>	<i>1994</i>	<i>1995</i>	<i>1996</i>	<i>1997</i>	<i>1998</i>	<i>1999</i>
All tested drug addicts	130	290	398	1072	1389	1953
HIV positive	1	1	4	22	37	45
HBV Tested/Positive		9/0	46/3	47/15	199/15	382/16
HCV Tested/positive		9/9	46/46	47/32	199/159	382/235

Ninety-five officially registered drug addicts use drugs intravenously. Five syringe exchange programmes were started in different places in the country to reduce risks related to infection of HIV and hepatitis. At the same time information is provided regarding the safe use of syringes. In pharmacies, disposable syringes are available, but the infection risk is increased due to the fact that the users mainly use homemade drugs, drawing from one container and sharing needles. The AIDS risk also arises from neighbouring regions, such as the Kaliningrad region, and Belarus.

Number of overdose deaths

According to data from the State Mental Health Centre, 37 drug addicts died in 1999 (suicide – 1, accident – 4, infectious disease – 4, somatic disease – 1, overdose – 4, cause unknown – 22). This figure increased to 61 deaths in the year 2000 (suicide – 3 (5%), accidents – 4 (6.5%), infectious diseases – 4 (6.5%), somatic diseases – 8 (13.1%), overdose – 8 (13.1%), uncertain reasons – 32 (52.5%), violent deaths – 2 (3.3%).

Table 9. Deaths caused by drug abuse (1998–1999)

<i>Age</i>	<i>1998</i>			<i>1999</i>		
	<i>Male</i>	<i>Female</i>	<i>Total</i>	<i>Male</i>	<i>Female</i>	<i>Total</i>
Under 15	–	–	–	–	–	–
15–19	–	–	–	2	2	4
20–24	2	3	5	7	1	8
25–29	3	1	4	8	2	10
30–34	3	2	5	4	–	4
35–39	7	2	9	4	2	6
40–44	2	1	3	3	–	3
45–49	5	–	5	2	–	2
50–54	–	–	–	–	–	–
55 and older	1	–	1	–	–	–
Unknown	–	–	–	–	–	–
Total	23	9	32	30	7	37
From them:						
F11	9	3	12	4	3	7
F19	3	2	5	8	–	8
X42	5	3	8	14	2	16
X62	2	–	2	4	2	6
Y12	4	1	5	–	–	–

4. Treatment of opioid dependence

Current treatment infrastructure

In 1999, according to reports by health care institutions, 2323 drug addicts were treated, and 400 drug addicts applied for the first time for medical advice. Funds for treatment of drug addicts are provided from two sources: the state (municipal) budget and state health insurance fund. According to the Law on Narcological care and other health system laws treatment of this group must be funded by the state budget.

On the primary health care level, which is funded from the state health insurance, primary, secondary and tertiary prevention of drug dependence is the responsibility of community mental health centres. Community mental health centres are situated either in primary health care centres (polyclinics) or operate separately. By January 2001 there were 60 mental health care centres, employing a team of mental health specialists including adult and child psychiatrists, addiction psychiatrists, nurses, psychologists and social workers. Mental health care centres offer specialist consultations, design of multidisciplinary treatment plan and cooperation with general practitioners. Addiction psychiatrists usually prescribe medications for outpatient detoxification and are also responsible for providing follow-up services. Naltrexone (an opioid antagonist) is relatively widely prescribed for the outpatient treatment of opioid dependence. Some mental health care centres do random urine drug testing on the spot for monitoring of the follow-up treatment. Methadone maintenance and detoxification have been provided in one of the mental health care centres in Druskininkai since 1998. The Ministry of Health has given permission for methadone treatment in another Mental Health Treatment Centre in Visaginas. Until 2001 only two specialized drug addiction treatment centres existed in the country: Vilnius Substance Abuse Treatment Centres and Klaipeda Drug Addiction Treatment Centre. Since 2001, three new national treatment centres were established in the biggest regional cities, Kaunas, Siauliai and Panevezys, which will provide a wide range of outpatient and inpatient treatment. Specialized drug treatment centres in Vilnius and Klaipeda have offered a wide spectrum of treatment interventions for a number of years, including outpatient and inpatient detoxification, rapid opioid detoxification, methadone maintenance or opioid antagonist therapy, telephone hotline, outreach and needle exchange, inpatient and outpatient Minnesota-type programmes, long term rehabilitation and day centre programmes. Despite the wide spectrum of services, the capacity of all five specialized treatment institutions for treatment of drug addicts is limited. The remainder of the drug dependent patients may undergo detoxification in psychiatric hospitals, where they are usually treated together with the mentally ill and these programmes have no aftercare programmes. The overdoses are treated in the Toxicology Department of Vilnius University, toxicology departments in children clinics in Vilnius, and in intensive care units throughout the country. Many drug addicts, due to emergency medical situations, attend the First Aid Hospital in Vilnius. In other towns drug addicts receive treatment in reanimation wards. After detoxification patients should undergo rehabilitation but this component is not developed yet. In the country (Vilnius) there are 22 slots for inpatient drug-free rehabilitation (with elements of therapeutic community), which are funded by the state. Rehabilitation institutions were established in the Vilnius Substance Abuse Treatment Centre and the Lithuanian AIDS Centre. During the last three years a number of new NGO-initiated therapeutic communities emerged in the country. Most of them are based on different religious or 12-step philosophies and are self-sustained. The number of such communities in 2001 reached seven and the number of individuals who are undergoing rehabilitation in them could reach 50. During 2001, private treatment centres started to appear, targeting young heroin addicts from affluent families. "Ausros Vartu ligonine", established in 2000, has developed inpatient and outpatient services for heroin addicts, including rapid opioid detoxification and naltrexone-depot implants, which have been administered to 165 persons. In August 2000 though, the Ministry of Health stated that the use of naltrexone-depot implants was not legal as the medications used are to be fully registered in Lithuania.

Low threshold care

A needle and syringe exchange programme was started by the Vilnius Substance Abuse Treatment Centre in 1996 in the Vilnius Roma community, where there was a serious drug-injecting problem. Needle and syringe exchange was provided together with a low threshold methadone maintenance programme, and was run from the office of the primary health care centre. In May 1997, in response to the emerging HIV epidemic among IDUs, Klaipeda Municipality and Addiction Treatment Centre opened the first low threshold drop-in centre. The drop-in centre gained great popularity among IDUs and sex workers and the spread of the epidemic became better controlled. In 2001, the Klaipeda city

authorities opened the second drop-in centre in the northern part of the city. In Vilnius an outreach and needle exchange programme was developed in combination with a methadone maintenance programme. This exchange program has gradually expanded since 1996 to annually reach 700 clients previously not in treatment. In 2001 Vilnius Substance Abuse Treatment Centre established the country's first mobile outreach and needle exchange programme working from a minivan. "The Blue Bus" programme became very popular among IDUs not in treatment, including sex workers. During the first months of operation the programme reached more than 100 IDU sex workers. Drop-in centres and outreach are available to some extent in other cities of the country (Druskininkai, Panevezys and Alytus).

Types of treatment available

Prior to 1995, the treatment of drug dependent individuals was usually limited to detoxification in psychiatric hospitals. Increased attention was later given to the social needs of these marginalized groups, and a broader application of outpatient health care and rehabilitation, including methadone treatment programmes, was introduced. Outpatient substitution treatment programmes have been operating in Vilnius, Kaunas and Klaipeda since 1995, and a Druskininkai primary health care centre since 1998. Currently following services are available (depending on treatment centre):

- Telephone hotline and information about treatment
- Outreach
- Needle exchange
- Informal and confidential consultation at the treatment facility
- Outpatient detoxification
- Outpatient detoxification with methadone
- Long-term opioid agonist treatment with methadone
- Opioid antagonist treatment with naltrexone
- A range of outpatient psychosocial counselling (including day centre, outpatient Minnesota-type, programme, self-help methadone patient clubs)
- Inpatient detoxification (including rapid or with opioid agonists)
- Minnesota-type (12-step) rehabilitation programmes (short, average, long term)

Outpatient detoxification usually last between one and two weeks. Outpatient detoxification with methadone could last from three weeks to six months depending on the severity of withdrawal symptoms and heroin dose. Outpatient treatment with opioid antagonists (naltrexone) is recommended from six months to 2-3 years. Patient compliance presents a significant problem. Recently naltrexone-depot was available in one of the private treatment centres for payment. Methadone maintenance programmes have no defined duration. In Vilnius, 34 patients have entered the methadone maintenance programme since its inception (5-6 years). Minnesota-type short inpatient rehabilitation traditionally lasts 28 days, while the outpatient programme lasts four months. Inpatient or outpatient long-term rehabilitation with elements of therapeutic community lasts 8-12 months.

In total, during 1999, 2323 drug addicts were treated in an inpatient setting (75% of registered drug users). In 2000, Vilnius Substance Abuse Treatment Centre was approached by 804 previously unknown heroin users, most of whom were aged between 18 and 22. The majority of these individuals were treated on an outpatient basis with opioid antagonists or agonists.

Access to drug treatment

Access to specialized treatment is to some extent limited geographically due to specialized centres existing in five regional cities. Primary treatment from addiction psychiatrists and a team of other professionals is available at community mental health care centres, which nevertheless have a need for more training.

Access to treatment is also limited by the cost of medications, which have to be covered by the patient or their family.

Legislative framework

The methadone maintenance programme was allowed by the order No.252 by the Minister of Health on 15 May 1995. Methadone maintenance treatment started as a high threshold programme and was developed with the assistance of Swedish experts. The national guidelines for methadone maintenance in 1995 formulated treatment as a high threshold programme. The main entrance criteria were a diagnosis of opioid dependence, five years of regular opioid use, age above 20 years and several unsuccessful attempts at drug-free treatment. Inpatient detoxification was required before admittance to a substitution treatment programme. Detoxification with methadone was not allowed. Agonist treatment was allowed only in specialized institutions. Swedish experts from the Karolinska Institute carried out an evaluation in 1996 at the Department of Neuroscience section of Psychiatry, St. Goran Clinic of Dependence Disorders. In 1997 the regulations of the methadone programme and admission criteria to methadone substitution therapy for drug addicts were revised by the Minister of Health (Order No.702; 1997), the latter was amended by Order No.68 by the Minister of Health. The Resolution on Control of the Substitution Programme by the Parliamentary Health Committee was adopted in 1998. The new national guidelines for methadone treatment approved by the order of the Ministry of Health on 23 December 1999 allowed agonist pharmacotherapy in primary health care institutions to be implemented by psychiatrists or GPs. Special permission for a state health care institution was needed to obtain a license to practice. In 1998, the agonist therapy programme started at the Druskininkai Primary Health Care Centre (for a small group) and in three primary health care institutions of Vilnius in collaboration with the Vilnius Substance Abuse Treatment Centre.

Drugs used in agonist treatment

Methadone hydrochloride 0.1% solution is used routinely in agonist treatment. The price is approximately US\$ 2 per 1000 mg. The solution is manufactured in pharmacies from methadone powder. Tablets (5 mg) produced by Nycomed are also available. Since 10 September 2001, Vilnius Substance Abuse Centre has been using Methadone hydrochloride 0.1% solution manufactured by Nycomed. The cost is approximately US\$ 7 per 1000 mg. Methadone cannot be prescribed by institutions that have no special license from the Ministry of Health.

Number of patients in agonist treatment

In 1999, 577 persons participated in methadone substitution therapy (493 in 1998). By region the numbers were as follows: 236 in Vilnius, 200 in Kaunas, 118 in Klaipeda and 23 in Druskininkai. In 2001 the number of treated persons in methadone maintenance programmes was 748 (258 in Vilnius, 258 in Kaunas, 198 in Klaipeda, and 34 in Druskininkai). Treatment effectiveness is somewhat limited due to lack of facilities, overload of work for the personnel, and limited social and psychological measures. The social integration of the drug addicts is also limited due to increasing unemployment. Financing of the substitution therapy has not been adequately resolved. To the extent where it is possible, the Vilnius Substance Abuse Treatment Centre has made considerable effort towards implementation of substitution therapy, having published methodological recommendations, translated and published books, and produced a special video on drug-related health problems. The Ministry of Health plans to revise the regulations and admission criteria for the methadone programme. Decentralization of the programme from the specialized centre to primary health care institutions is planned in relation to reorganization of specialized health care, and establishment of centres for dependence disorders in the counties.

Eligibility requirements for agonist treatment

The target group for substitution therapy in Lithuania is opioid users. Methadone maintenance programmes (MMP), after a very careful preparation period, were authorized by order of the Health Ministry in 1995 and started in major cities in Lithuania (Vilnius, Kaunas and Klaipeda) as pilot programmes in specialized institutions. The criteria for admission into the programme were elaborated in accordance with the Swedish model. The professionals were trained in Stockholm at the Karolinska Institute. The admission criteria for substitution therapy were: regular opioid user for five years, two or more unsuccessful attempts of drug free treatment, minimum age of 20 years, incurable disease and other individual reasons in accordance with the decision of the special commission on methadone programme. Additionally, investigation of mental, physical and social state was recommended before starting and during the programme. Detoxification was recommended before commencing the programme, control of

abuse of other drugs was required, and psychological and social assistance was recommended. The special regulations for methadone and drug control were prepared. Having been given the starting dose that was minimally effective, a patient was not permitted to concurrently use other drugs. Termination of the programme was to occur for medical reasons and in case of serious violation of the regulations, including use of other drugs. Involvement of GPs was not allowed, take-home doses or prescription of drugs were not allowed, and detoxification after termination of treatment was not regulated. In 1997, the new national methadone guidelines allowed for methadone substitution therapy in primary health care institutions and mental health care centres. Admission criteria were lowered: regular opioid injection for two years, unsuccessful attempts of drug free treatment, HIV infection or severe physical illness were additional criteria for eligibility. According to the guidelines, detoxification before admittance to MMP was not required but recommended, dosage of methadone was not regulated, urine screens were recommended, psychological and social assistance was recommended, take-home doses for stable clients or in extraordinary situations were allowed, and involvement of GPs in cooperation with the MMP and short detoxification (2–12 weeks) were allowed. The criteria for termination of treatment were determined by the methadone programme commission, and there were no age limitations. The commission of three physicians is in charge of the decision-making process, starting the discussion of eligibility criteria, allowing take-home doses, terminating the treatment and other aspects of treatment. The interest from users has been very high. One of the reasons that drug-free treatment facilities (detoxification and rehabilitation) were very limited was the active promotion of very positive treatment results with methadone by the Lithuanian press. Some specialists were very interested to start this programme; other specialists supported only the development of drug-free treatment facilities for people with drug dependence. Mothers of drug dependent individuals supported the methadone policy, and this familial factor was deemed to be important.

Patient characteristics in agonist pharmacotherapy

In 1998, according to a report by the Vilnius Substance Abuse Treatment Centre on methadone substitution therapy, 493 persons participated in such programmes. All were opioid intravenous drug users, 77% were male, and the age distribution of the group was as follows: 20–30 years old (33%), 31–40 years old (50%), over 40 years old (17%). Termination of treatment in 1998 was as follows: 7% stopped using methadone for medical reasons, 4% were sentenced to prison, 2% died, and 21% dropped out due to other drug use. Sixty-six percent remained in treatment. In 1999 a total of 577 patients were treated with maintenance substitution therapy and 261 underwent outpatient detoxification with methadone.

Methadone maintenance treatment:

From the total of 577 patients, 236 were treated in the Vilnius Substance Abuse Treatment Centre, 200 in Kaunas Psychiatric Hospital, 118 in Klaipeda Addiction Treatment Centre and 23 in Druskininkai Primary Health Care Centre.

A total of 170 patients were admitted to MMP, of whom 118 (69%) were admitted for the first time and 52 for second or subsequent admission. From the patients admitted to MMP, 93% (158) used home-made poppies and only 7% used heroin. There were 16 HIV-positive patients in MMP.

The age groups:

under 20	13	(2.3%)
21–30	173	(30.0%)
31–40	290	(50.3%)
41–50	86	(14.9%)
over 50	15	(2.5%)
Male	445	(77.1%)
Female	132	(22.9%).

The overall outcomes of four methadone maintenance programmes in Lithuania were as follows:

Successful detoxification	17	(3.0%)
Drop-outs	77	(13.3%)
Excluded	3	(0.5%)
Imprisoned	26	(4.5%)
Remained in treatment	454	(78.7%)

Detoxification with methadone:

A total of 261 (205 males and 56 females) patients underwent detoxification with methadone: 175 in the Vilnius Substance Abuse Treatment Centre, six in Kaunas Psychiatric Hospital, 79 in Klaipeda Addiction Treatment Centre, and one in Druskininkai Primary Health Care Centre.

Of the patients who underwent detoxification, 45.6% (119) were in the 19–25 age group, and 33.0% (86) in the 25–35 age group.

Of the patients who were accepted into detoxification, 210 (80.5%) used homemade poppy extract and 51 used heroin. Most of the heroin users (34 out of 51) were non-injectors (i.e. heroin sniffers or smokers).

The outcomes of detoxification:

Detoxification was successfully completed for 69 patients (26.5%), 64 patients after unsuccessful detoxification were transferred to methadone maintenance treatment (24.5%), 128 patients dropped out (49.0%).

There were 10 HIV-positive patients in methadone detoxification.

According to the database of the Vilnius Substance Abuse Treatment Centre, 203 out of the 258 patients treated in methadone maintenance programme were male.

The age distribution of patients was:

<i>Age</i>	<i>Number</i>
Less than 20	2
20–29	91
30–39	94
40–49	57
50 and more	14

One-hundred and sixty-six patients (64.3%) had previously been in court for criminal offences. Thirty-eight patients (15%) had regular jobs, and 33 (13%) were registered with an unemployment agency. Thirty patients had a tertiary education (12 had graduated), while 130 had a secondary education.

Infectious diseases and physical illness were common among patients. Prevalence rates were as follows: Tuberculosis – 3.9%, hepatitis B – 7.0%, hepatitis C – 65.1%, HIV – 1.9%. Trombophlebitis was observed among 18.2% of patients, skin lesions among 22.1%, and symptomatic mental disorders among 8.5% of MMP patients.

Primary Health Care involvement in agonist treatment

Since 1996 the methadone maintenance programme carried out by the Vilnius Substance Abuse Treatment Centre has been collaborating with Naujininkai primary health care center in order to reach Roma community outside Vilnius. A GP and a nurse were employed to dispense methadone. Since then a number of other primary health care centers have been contracted to provide methadone with the

support of the specialized centre. In 1998, methadone maintenance treatment was established in the Druskininkai primary health care centre (PHCC). The mental health care centre, which is part of PHCC, was in charge of the programme. The unresolved issues of government financing methadone programmes prevent other mental health care centres from establishing methadone treatment.

Pharmacy involvement in agonist treatment

Methadone is not available from pharmacies by prescription. The role of pharmacies is restricted to the manufacture of methadone solution.

Access to agonist drug treatment

- ❑ Geographical factors – methadone maintenance is available only in four cities and is not accessible in other industrial cities. In large industrial cities where methadone treatment programmes exist (for example, Kaunas and Klaipeda) methadone is dispensed in only one treatment facility and clients are required to travel daily to the health care centre.
- ❑ Limited capacity – Vilnius and Kaunas Substance Abuse Treatment Centres have to limit the number of patients in maintenance and outpatient detoxification programmes and there are waiting lists.
- ❑ Financially – the patients themselves are paying for methadone. While it is an inexpensive medication, the cost can create problems, especially for patients who have no legal income sources.

Documentation and evaluation

The Vilnius Substance Abuse Treatment Centre has a centralized database for the country. The annual evaluation of the centre's methadone maintenance programme showed that the retention rate in 2000 was 72.5%. Successful detoxification was completed for 14 patients (5.4%), who left the methadone maintenance programme and became drug-free. Four patients died due to somatic complications and suicide. Twelve patients were excluded from the programme for non-compliance, ten moved to another city, and 14 were incarcerated for criminal offences that typically took place before treatment. A significant number of patients showed a marked improvement in physical and mental health status. Social status (employment and family status) also improved, but due to constraints of the social assistance programme, the improvement rate was slower.

In 2001 the State Mental Health Centre conducted a review of methadone maintenance treatment in four health care institutions in Lithuania, and reported to the Ministry of Health that methadone maintenance is a valuable tool of tertiary prevention of drug dependence and drug related harm and should be expanded further. Better documented evaluation is also clearly required.

5. Main problems and needs

Considerable experience has been gained through six years of operating substitution treatment programmes in Lithuania. More than 2000 patients were treated during this period. Nevertheless agonist treatment is not accessible in many ways for the patients, either geographically or economically.

There are several problems to be addressed in the future:

- ❑ Adequate funding of agonist treatment programmes by the state authorities (budget or health insurance) should be available.
- ❑ Agonist therapy with methadone should be accessible in primary health institutions across the country.
- ❑ Agonist therapy should be integrated in the general context of health and social care services.
- ❑ Other agonist medications (like buprenorphine) should be registered and made widely available in primary and specialized health care with partial (or full) coverage of the treatment costs by health insurance.
- ❑ Standards should be developed in order to ensure the quality of agonist treatment in the country.
- ❑ Better-documented, continuous evaluation is needed.

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POLAND

Dr Boguslav Habrat
Drug Treatment Unit, Institute of Psychiatry and Neurology

1. Country profile

Size:	312 685 km ²
Inhabitants (2000)	38 625 478
Capital:	Warszawa (pop: 1 632 500)

2. Epidemiological data available

History of opioid use in Poland:

Until the 1960s–70s, occasional treatment of patients for opioid dependence was recorded. The most frequently used opioids were analgesics used by medical staff. In the late 1960s and in the 1970s, a wave of global contesting movements (hippies) began production and use of so-called “Polish heroine” or “kompot”. It was produced illegally from poppies and used mainly in a liquid form intravenously and, rarely, orally. The content of “kompot” is not stable but heroin, morphine, and other alkaloids in different proportions have been found by police laboratories. “Kompot” is not only a mixture of alkaloids, but contains many unidentified chemical and biological materials, very often with infectious properties. Until the time of legal restriction in distribution of pharmaceutical forms of opioid analgesics, these agents were also abused. Epidemiological data concerning medical and other problems caused by the use of opioids were not collected because of denial of social pathology by the communist government. Beginning in the early 1980s, and particularly during the 1990s, many medical and prevention activities for addressing opioid problems were undertaken. In the late 1990s especially, there was an observed stable number of opioid-dependent patients using medical services in the public sector. Quite a new phenomenon observed in recent years is using imported pure heroin and smoking “brown sugar”.

Substances used

The main opioid substance used by Polish users and dependent patients is the so-called “Polish heroin” or “kompot”. In the majority of cases this substance is homemade from poppies without basic chemical, aseptic or antiseptic conditions. “Kompot” is used intravenously. In the early “HIV era” very often “kompot” was taken from the same container and/or with the same needle and syringe by many users. Currently, the situation is a little better, but the risk of new infections is still high in some regions (for example in Poznan) and among opioid-dependent individuals (who cannot make injections, thus, cooked poppies – “zupa”, “zielone”, “makiwara” are taken orally). Since the introduction of legal restrictions, medical opioids are rarely abused and present a less significant problem. For many years, pure heroin from abroad was too expensive for Polish addicts and due to these high prices it was only a marginal problem. In the late-1990s, due to expansion of the Polish economy, heroin or “brown sugar” became available to many young, affluent (or with affluent parents) people. “Brown sugar”, especially, was attractive because of its image of being a “safe”, non-injecting drug. In the last 2–3 years a rapidly increasing number of “brown sugar” smokers have been observed, but this is restricted to Warsaw and other large cities only. There are some epidemiological data concerning this, but there are no data pertaining to the whole of Poland. Many doctors and other persons from addiction medicine in Poland reported similar observations: a) the group of “brown sugar” users is quite different from former “kompot” users (younger, well educated, more affluent, with good or very good economic conditions, with different mentality, distancing from “injectors”), b) this groups prefers medical or psychological help from the private sector and thus are not included in statistics based on public sector data, and c) after a short period of “brown sugar” use the financial burden becomes too great and they begin to use “kompot” or other more dangerous substances intravenously.

Gender and age

The majority of dependent persons are male (75–80%), though in methadone maintenance programmes there is an over-representation of females (25–30%). There is an observed natural aging of the intravenous “kompot” using group due to the relatively low number of new cases. The “brown sugar” users are younger, better educated, with better social and economic status. When they move to public medical services they are typically injecting, or a combination of injecting and smoking.

Proportion of different users

Due to the dynamics described above, it is difficult to differentiate between injectors and non-injectors. Previously, injection was the main route of opioid administration, but a strong trend towards heroin smoking has been observed in the last two or three years. Almost all opioid-dependent patients are polydrug users but only a relatively small group fulfils the criteria of having a second drug dependence. No trend has been observed in that area. The number of stimulant users is under-represented amongst the treated population. Among patients participating in methadone maintenance programmes in Warsaw, over 43% abused stimulants (mainly amphetamine) while in other centres this number is lower.

Number of opioid/heroin users

The short window between episodic opioid use and the onset of dependence makes the number of occasional opioid users only slightly larger than the number of dependent users. In Poland there is some debate as to the real number of opioid dependents, but the most reliable estimates are based on observations that only about 20% of opioid dependents have contact with psychiatric services. Approximately 5500 patients are registered in psychiatric services, therefore the estimated number of all dependents is about 25 000 to 30 000.

In the year 2000 about 5500 patients in Poland were treated in public mental health institutions as well as non-public institutions (in collaboration with insurance companies) for opioid dependence. Within that number there are no patients from the infectious diseases sector and private commercial offices. Police data are not reliable as these registers record interventions rather than persons, so one patient can be registered many times. Due to a change in Polish law in 2000 making possession of an illicit drug punishable, as expected, there has been an increase in the number of cases registered by the police.

3. Health consequences

Seroprevalence of HIV

In Poland, injecting drug use is the main mode of HIV transmission. The rapidly increasing number of infections noted in the early 1990s was curbed in the late 1990s. This change of trend was observed in parallel with the introduction of harm reduction programmes (education, needles and syringes exchange, availability of condoms, and methadone maintenance programmes or MMP); however this is not necessarily known to be the cause of the reduced spread of HIV. The percentage of HIV infections amongst the population of opioid addicts is not known in Poland. There are substantial differences between cities depending on many factors. Seroprevalence is higher in populations of methadone programmes because older and more physically ill patients are included. In the methadone programmes in the city of Warsaw, HIV-positive patients account for 47% (psychiatric MMP) to 100% (infectious disease MMP) of the entire treatment group. However, that group is not representative of the whole population of opioid addicts. In the methadone programme in Poznan, prevalence of seropositivity is much lower (about 10%) because of rare usage of heroin intravenously. In the small town of Starachowice all identified opioid addicts qualified for admission into the MMP, and none of the patients are HIV-infected. There are no data concerning HIV infections within whole populations of drug users. Investigation of that can be made only with permission of patients. There are no reliable data available indicating the prevalence of hepatitis virus in populations of opioid addicts in Poland. Due to costs, blood tests are only taken from patients who are suspected of having liver disease. In the last two years three MMP programmes in Poland carried out tests for hepatitis C, and it was found that almost all intravenous users were hepatitis C virus (HCV) carriers, and 50% had different stages of progressive forms of hepatitis.

Number of overdose deaths

In recent years the number of fatal overdoses has been between 110 and 150 annually. There has been no trend observed.

4. Treatment of opioid dependence

Current treatment infrastructure

Current treatment infrastructure in Poland is very differentiated and complicated. The skeleton of the structure is the public health institution, but in recent years a rapid increase in the number of non-public (private, foundations) wards has been observed. All working people, pensioners and children are insured by one of 15 insurance companies. Jobless people can be insured by the local community or can pay insurance tax themselves. The Main Act on Counteracting Drug Use and Addiction (1997) states that treatment of drug addicts is free of charge and the Ministry of Health can cover the associated cost. Insurance companies should finance the majority of treatment needs, between other treatments of drug addiction. In practice, due to an insufficient budget for drug dependence services, treatment is inadequate and insurance companies limit the number of treated patients, longevity of stay and cost of treatment. The network of outpatient clinics is also inadequate to meet current needs, however the number of other non-medical advice or caregiving institutions compensate for this.

Detoxification of opioid-dependent patients is conducted mainly in hospitals: in specialized detoxification units, general psychiatric wards, intensive care units, toxicological units, and internal medicine wards. Except cases that need intensive care, detoxification in specialized wards is preferred. Due to the low number of places patients must wait for free beds. The main medications used in detoxification units are benzodiazepines, symptomatolytic drugs and clonidine. Methadone is not registered in Poland for detoxification and is used in a small number of units only. It is possible to undergo detoxification in some private units with full costs covered by patients. Detoxified patients are sent to outpatient units or to one of the rehabilitation units. The majority is outside the public sector but have contracts with insurance companies. Longevity of such treatment is differentiated from 3 to 24 months but insurance companies provide strong pressure for intensive treatment and shortening of stay.

The majority of rehabilitation units place strong emphasis on total abstinence and do not tolerate drug use. Rehabilitation of drugs addicts in Poland is strongly demedicalized but generally every unit has a consultant psychiatrist. Programmes are based on different theoretical backgrounds but the leading model is the therapeutic community. There are some specialized centres for specific groups of patients: for example, patients with a dual-diagnosis. There is a lack of programmes for specific groups (for example drug users with a mental disability). Some other patients are treated in fully paid private clinics, where naltrexone is used. Naltrexone is currently undergoing the process of registration. It is difficult to estimate the number of patients treated with naltrexone, but from analyzing the number of imported naltrexone tablets, the yearly number of such treated patients is estimated to be between 500 and 1000.

Hundreds of patients have the opportunity to participate in methadone programmes (detailed description below). There are various forms of connections between dependence treatment institutions and mental health or general medicine institutions. The majority of detoxification units or detoxification beds are within the structure of public mental health services. In contrast, most rehabilitation units are in the non-public sector and have no close contacts with the psychiatric or general medicine sector. Institutions should minimally have a consultant-psychiatrist. The majority of institutions try to foster close collaboration with GPs and, in this case, the introduction of direct payment for care of individual patients is preferable. There are concerns about the level of medical care given by GPs to drug-dependent patients. The dominating opinion is that GPs should suspect drug problems, diagnose them and refer patients to adequate specialized institutions.

Collaboration with the infectious disease sector is generally good. Methadone programmes are conducted in two HIV/AIDS centres. There are special finances for antiretroviral therapy from the government (not from insurance companies). Harm reduction programmes are still controversial in Poland but are becoming increasingly accepted.

Low threshold care

In the majority of hospital programmes even sporadic use of illicit drugs is not accepted. In methadone programmes, relapse to drug use more than three times during a six-month period results in discharge from the programme. Low threshold programmes are conducted mainly by nongovernmental organizations, but similar programmes are conducted in many public sector facilities. These are usually focused on harm reduction (education, syringe and needle exchange), basic medical help or social support (overnight lodging and provision of food).

Types of treatment available

Almost all types of basic treatment are available in Poland. Detoxification with methadone is limited by a lack of registration for that purpose. Rapid and ultra-rapid detoxification is not available. Outpatient clinics offer different kinds of programmes but availability for some can be difficult (in peripheral cities, especially) because of the rare network of such institutions. Different kinds of rehabilitation units are available, but these are often located many kilometres outside away from the residential area. Substitution therapy is made in Poland with methadone only, and access is limited to about 500 places in 11 programmes. Naltrexone is used in private practices and that type of treatment is fully payable by patients. Duration of detoxification is between 10 and 28 days (longer in methadone detoxification). Outpatient clinics do not impose a time limit on programmes, and care of patients is constant. Rehabilitation units offer different kinds of programmes between 3–24 months, but there is pressure from insurance companies for the shortening of all programmes. Substitution treatments do not have time limits.

Number of patients in treatment (year 2000):

In the year 2000 approximately 5000 opioid-dependent individuals were treated in psychiatric public and non-public institutions. This number does not include patients treated in private commercial cabinets and in the infectious disease sector.

Access to drug treatment

The majority of patients in the first stages of dependence do not feel the need for treatment and use denial mechanisms. Later for many of them the possibility of difficult and minimally effective treatment is not sufficiently attractive. It has been shown that there is a considerable difference between patients' needs or expectation and treatment offers. There are some organizational problems with access to treatment in small cities and villages, where there are too few users to initiate programmes. Offers of programmes based on therapeutic communities are often not accepted by patients. Localization of treatment facilities many kilometers outside residential areas are additional factors decreasing access to programmes. But there are too few places in rehabilitation units and patients must wait for a free space. The small number of places in rehabilitation units is caused by many factors, but the greatest of them is lack of finance. Insurance companies have a deficit of money and in determining the allocation of funding, companies frequently choose to finance "illnesses not caused by patients themselves". For a long time a major problem was the non-acceptance of drug treatment facilities by local communities, though this situation has improved considerably. The concern for substitution therapy now is developing a better social climate for introducing new methadone programmes. Unfortunately, there are many problems with undersigning contracts with insurance companies.

Legislative framework

Poland was probably the first post-communist country to introduce, in 1997, a parliamentary act permitting substitution therapy. Before this time, six programmes worked with the silent acceptance of authorities. Two years later, in 1999, the Minister of Health published an executive act giving details concerning substitution therapy. The regulations are relatively restrictive: MMP can be conducted by public medical institutions only; permission for funding the programme can only be given by the Vojevoda (Governor of Province); the programme can only include adults (over 18 years of age) with a long history of addiction and a minimum of three unsuccessful trials of treatment; methadone should be consumed daily in the presence of medical staff; patients should participate in all medical (urine testing for presence of drugs) and psychotherapeutic procedures of the programme;

and non-compliance with the programme's regulations can cause discharge. Due to ill-defined legislative acts it is not clear which institution should pay for opioid-dependent patients who are not insured. Fortunately, until now, the Ministry of Health has supported this. It is also unclear who should pay for methadone (insurance companies should finance medical procedures but not medications in outpatient clinics).

Drugs used in agonist treatment

Methadone is the only drug registered for maintenance therapy. In 2000 at the Medical University in Krakow, buprenorphine was used experimentally for a short time in twelve patients. All the methadone is bought centrally by the governmental Bureau for Drug Problems and later distributed according to the needs of the registered programmes. The price of methadone for MMP is three times cheaper than methadone used for analgesic purposes. Patients receive methadone at distribution points free of charge. It is impossible to buy methadone in drug stores for maintenance therapy as only licensed centres providing the treatment have the right to provide the drug.

Number of patients in agonist treatment

In 2000, in eleven MMPs in Poland there were about 500 places. Due to discharges from the programme and newly qualified patients, the number of treated patients is higher. In older programmes the number of new patients is very small (5–10 yearly) because of natural selection of patients benefiting from programme participation during many years.

Organisation of agonist treatment

The first experimental programme in Poland (1992) was very restrictive. The treatment was earmarked only for "hopeless" patients (diagnosis of opioid dependence, >21 years old, over five years of dependence, minimum seven unsuccessful treatments in the past). Current legislation in the field is much less restrictive (diagnosis of opioid dependence, minimum age 18 years, unsuccessful treatment in the past). Additionally, the head of the programme can qualify patients not fulfilling these criteria if there are extraneous medical circumstances.

There are no data concerning patients' characteristics for all MMP in Poland. Programmes are different in different cities and centres. In Warsaw, where programmes have the longest history, patients are older (mean age 33 years). In Krakow, the mean age is 30 years, and patients are more physically ill and more often HIV and HCV-infected. Primary health care in Poland is generally not involved in agonist treatment, though some informative papers are circulated to a wider range of medical staff.

Pharmacies (besides hospital ones) are not involved in agonist treatment in Poland. Pharmacists in institutions conducting methadone treatment are trained by the Institute of Psychiatry and Neurology, and ministerial pharmaceutical supervision take special care of those pharmacies.

In the first half of the 1990s the main problem affecting the development of methadone programmes in Poland was the conservative mentality of public health managers, politicians and public opinion. Strong opposition against ideas of substitution treatment meant that permission was only granted to treat "hopeless" patients, thereby restricting the inclusion criteria. In that time all programmes were under strong pressure and under special observation. Consequently, any negative effect associated with a programme (for example, the appearance of methadone on the black market with the availability of take-away dosing) became a pretext for closing down programmes.

Documentation and evaluation

Each patient has standard medical documentation including details of agonist-specific treatment needs. From the end of 2000, the Institute of Psychiatry and Neurology has maintained a Central Register of Patients Participating in Methadone Programmes. Due to the Act for Saving Personal Data restrictions, all data collected in the Register cannot be used for any purpose other than for medical reasons (not even for statistical purposes). The Institute of Psychiatry and Neurology collects for statistical purposes data from all public mental health services and from methadone programmes, however data from methadone programmes organized by infectious disease wards are not available. As only two programmes (in the Institute of Psychiatry and Neurology in Warsaw and in the Medical

University in Krakow) are academic centres there are few evaluations of effectiveness. The Institute of Psychiatry and Neurology published many papers concerning their own programme, and have reported that when limited to six months the methadone programme was sufficient for medical purposes but was too short for dependent patient rehabilitation. One-fourth of all patients were retained in the programme after thirty months. Participation in the methadone programme dramatically reduces psychoactive drug use, except alcohol, of which consumption is increased during the first year. None of the patients were infected with HIV at 6-months, 30-months, and eight years of participation in MMP. There had been no cases of significant overdose observed in patients at 6-months, 30-months, and eight years of participation in MMP. It was concluded, then, that physical status was improved as many physical illnesses disappeared or improved. Data have been published on the MMP in Krakow concerning improvements in hematological and biochemical parameters after one year of agonist treatment, as well as the influence of MMP on breathing parameters and nutritional status. In other centres the influence of MMP on immunological parameters has been investigated. All MMPs are regularly supervised by staff from the Institute of Psychiatry and Neurology.

5. Main problems and needs

The main problem for the future is to enlarge the number of MMPs and the number of places available. The development of maintenance therapy requires a source of funding for such programmes. There is a good basis for staff training. There should be intensified promotion of substitution therapy amongst medical staff, health policy makers, insurance companies and general public opinion. One of the main problems is lack of differentiated programmes for specific groups (for example, heroin smokers, patients who are well rehabilitated, or having problems with daily visits to the programme due to study or work commitments). There is also a need for change in legal regulation. Another concern is the need to introduce other drugs for maintenance therapy, such as buprenorphine.

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RUSSIAN FEDERATION

Professor Vladimir B. Altshouler
Research Institute of Addictions, Moscow

1. Country profile

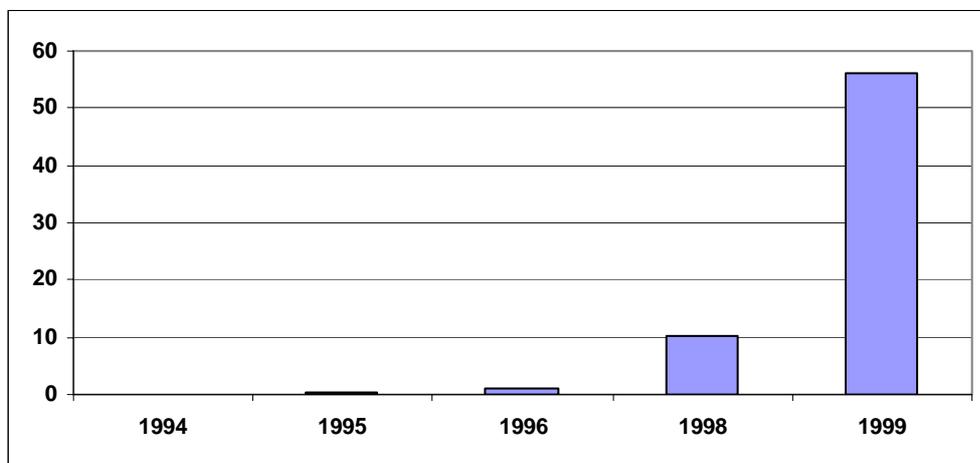
Size:	17 075 400 km ²
Inhabitants (2000)	145 542 000
Capital:	Moscow (pop: 8 638 100)

2. Epidemiological data available

There were only sporadic cases of opioid use and dependency in the Russian Federation before the 1990s. Soon after “Perestroika” (the programme of economic, political and social restructuring), when the country became open and its boundaries permeable, the Russian Federation began to suffer from the illnesses of the surrounding world, including drug dependence. From that time on there has been a very rapid growth of drug use, especially of opioids. During the last 3–4 years, heroin strongly prevailed over other opioids and has become one of the most frequently used drugs in big cities.

The drugs used in Russia are hashish, raw opium and homemade extracts, hallucinogens, volatile solvents, amphetamines and heroin. Of all drugs confiscated by police, the percentage of heroin is as follows: 1994 – 0.02%, 1995 – 0.3%, 1996 – 0.9%, 1998 – 10.4%, 1999 – 56.2% (Figure 1). In 2000, the percentage of inpatients being treated for opioid dependence was 97.6%, compared to 0.4% being treated for amphetamine dependence.

Figure 1. Percentage of police-confiscated heroin among all cases of drug confiscation by year



In the year 2000 there were 286 630 opioid-dependent patients treated in the Russian Federation, of whom 15.3% were female. The distribution by age was as follows: under 14 years – 0.1%, 15 to 17 – 4%, 18 to 19 – 12.4%, 20 to 39 – 76.1%, and 40 to 50 – 7.2%. Within these age groups, females constituted, correspondingly, 20.2%, 22.4%, 17.5%, 15%, and 10.2%.

Figure 2. Percentage of patients in different age categories under medical observation due to drug dependence

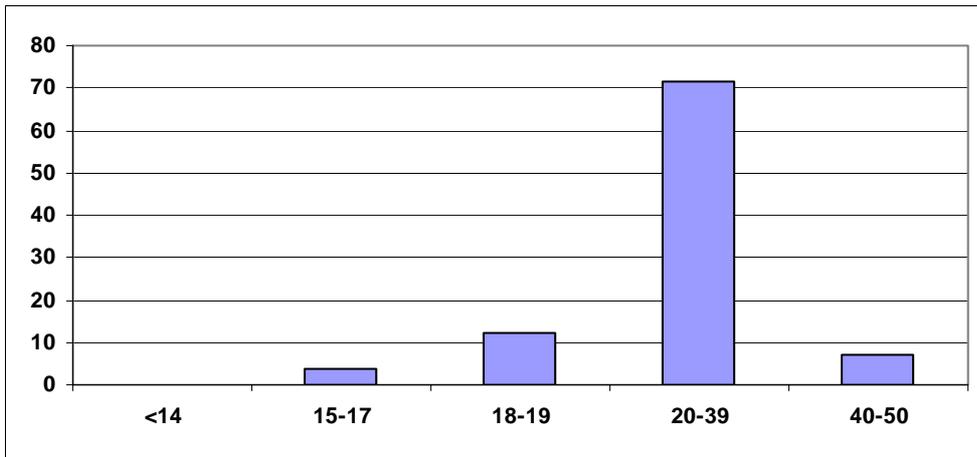
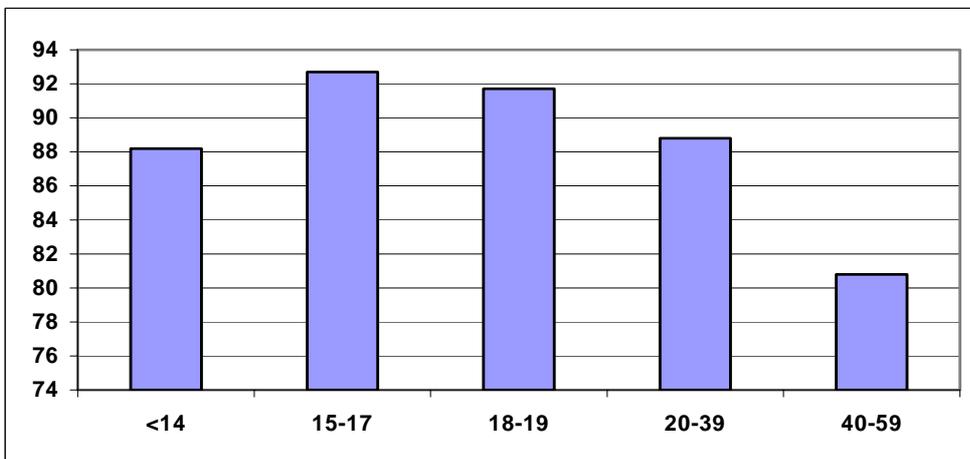


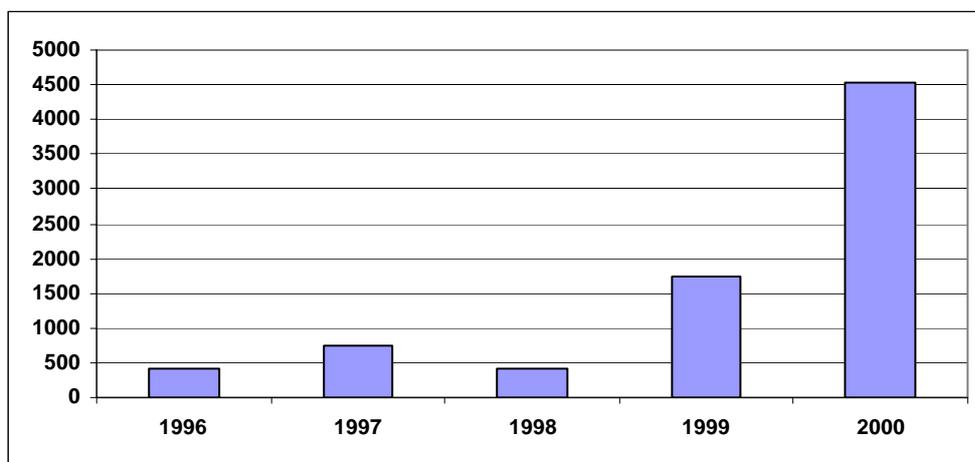
Figure 3. Percentage of opioid dependent among all drug-dependent people by age group



According to the thesis by K. V. Vyshinsky "Study of the incidence of psychoactive drug use based on the example of Moscow", the number of drug addicts registered by medical service should be multiplied by seven to get the true number of drug addicts in a population. Based on this premise, 254 385 opioid addicts are registered with a medical service – and when multiplied by seven – results in an estimated 1 780 695 drug addicts in the total population.

3. Health consequences

Figure 4. Number of HIV-cases per 100 000 drug-dependent people



4. Treatment of opioid dependence

There exists a large net of psychiatrist-addictionist offices throughout the country. They are incorporated in or directed by inter-district or regional narcological dispensaries and acting on the basis of common strategy and instructions elaborated by the Ministry of Health. Each rural district has its own narcologic office led by a psychiatrist-addictionist. In addition there are numerous private clinics and rooms licensed by municipal medical authorities.

The different treatments that are offered are:

- ❑ Detoxification
- ❑ Correction and restoration of mental and somatic functions of the craving for drugs by means of pharmacological treatment (pyrotherapy, neuroleptics, antidepressants, anticonvulsants)
- ❑ Psychotherapy (group or individual; rational; behavioural; 12-step programme)

Narcological clinics work in close cooperation with infections units to reveal HIV seropositivity in addicted patients and to treat them properly. Detoxification usually takes 10–12 days; the restoration therapy lasts nearly one month. The suppression of craving for drugs is an almost permanent process based on prolonged observation and re-examinations of a patient's condition.

Individuals with drug dependence hospitalized in the year 2000 numbered 118 841. They included 115 941 opioid (97.6%) and 424 amphetamine dependent patients. There were 7768 drug-dependent patients (7408 were opioid-dependent) from the countryside.

Access to treatment is not limited. It is either free or paid, where private clinics are concerned.

5. Main problems and needs

An adequate number of rehabilitation centres for supportive treatment offering various therapeutic and social services are needed.

SLOVAKIA

Dr Lubomir Okruhlica
Institute for Drug Dependencies, Bratislava

1. Country profile

Size:	49 034 km ²
Inhabitants (2000)	5 402 000
Capital:	Bratislava (pop: 447 345)

Slovakia was part of former Czechoslovakia until 1992. It has been an independent country since 1993. Slovakia has 5.4 million inhabitants. The largest (also its capital) city is Bratislava with approximately 450 000 inhabitants. Approximately 40% of the entire population were below the age of 29 in 1999, and 24% were between the ages of 15 and 29 years. Slovakia is a country in transition with the unemployment rate at 19% in 2000. There is a well-developed network of health care services, which is also undergoing transition. The majority of outpatient services are private, and the majority of inpatient health facilities are run by the state. The country has one of the lowest proportions of detected HIV seroprevalencies in the world, despite testing being readily available and free of charge.

2. Epidemiological data available

History of opioid use

Consumption of so-called "small" opioids such as codeine was widespread in the form of pain killer medicines prior to the fall of the iron curtain. Still, there was a steep decline in their usage after these medicines were put under strict prescription regulations in 1987. Illicit opioid use prior to the year 1989 was very rare. A significant increase in the use of illicit opioids started in 1992. It reached its peak in 1994–1996 and, after a decline, has been in a phase of stabilization from 1998 till present. The centre of the heroin epidemic is the capital city. The spread of heroin use throughout the country had a time lag of about two to three years behind the capital. Due to the fact that the majority (more than 50%) of the population lives in the countryside, illicit drug use has reached epidemic proportions only in Bratislava and is dispersed elsewhere. Heroin is not homemade; rather it is imported by traffickers from abroad. The incidence of illicit use of opioids according to treatment data has declined after its peak in 1995 in Bratislava. It is lower but in a steady state now (Figure 1 and Table 1). About 75% of patients treated for opioid dependence are male. The population of opioid users is slowly aging. The overall number of treated patients for opioid use has increased and is now steady (see Figure 3), but the proportion of first admissions among all patients entering treatment for drug dependence has declined from 48% in 1995 to 33% in 1999. Among them, the proportion of patients with opioid dependence was 75% in 1995 and 78% in 1999. The detected proportion of heroin users was about 2–3% in the general population (steady trend). There are indicators of an increase in the number of stimulant users, which was 3% (in 1999) and 5% (in 2000) of all patients treated in health care services for drug dependence. A slight but significant increase in polysubstance use has been observed in recent years, as well as a slight increase in the number of stimulant users. HIV prevalence is still low. It is below 0.5% (trend is steady). There has been a slight decline in drug overdoses in the country (Figure 4). It is not specified how frequently opioids were involved (trend is steady).

The estimated number of opioid/heroin users is based on a public survey of a representative sample, which is performed biannually. By estimating the total number of users one would obtain an approximate figure of between 3500 and 8000 regular heroin users, mostly with dependence, in the year 2000 in Slovakia. Thus the rate per 1000 inhabitants is between 0.6 and 1.5. The number of individuals treated in the health care system for opioid dependence was 2029, but only 1800 in sectors covered by Ministry of Health in the year 2000. The average age was between 20 and 24 years, and first experience with illicit opioids was predominantly between 16 and 19 years of age. The majority of opioid users were male (79%). Of all opioid-dependent patients in treatment the number of injecting users was 76% in 2000.

Figure 1. New admissions into drug treatment per 100 000 inhabitants in Bratislava and Slovakia

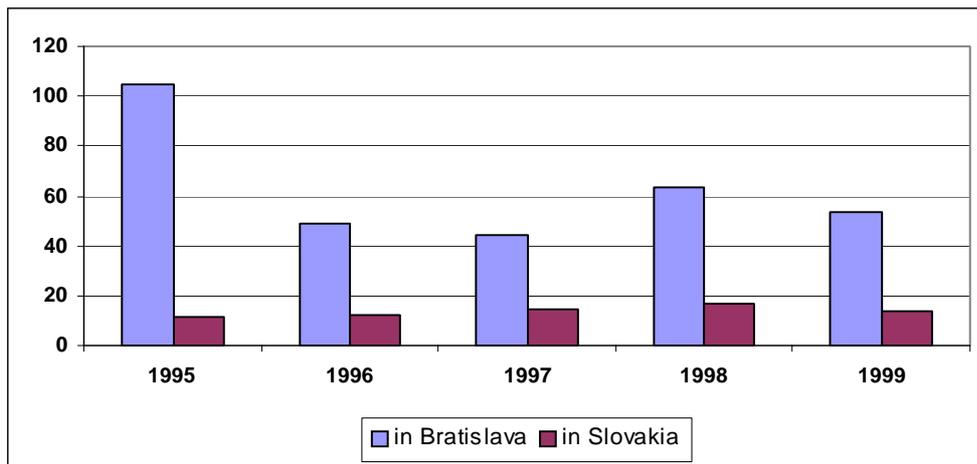


Table 1. Trends and characteristics of new drug treatment admissions (per 100 000)

Year	New Admissions		Age average age	Sex % males
	Bratislava	Slovakia		
1995	104.5	11.1	21.4	66
1996	48.8	12.0	22.3	76
1997	44.0	14.4	23.1	73
1998	63.3	16.6	22.9	74
1999	55.3	13.6	23.0	76

Figure 2. Number of patients treated for opioid dependence

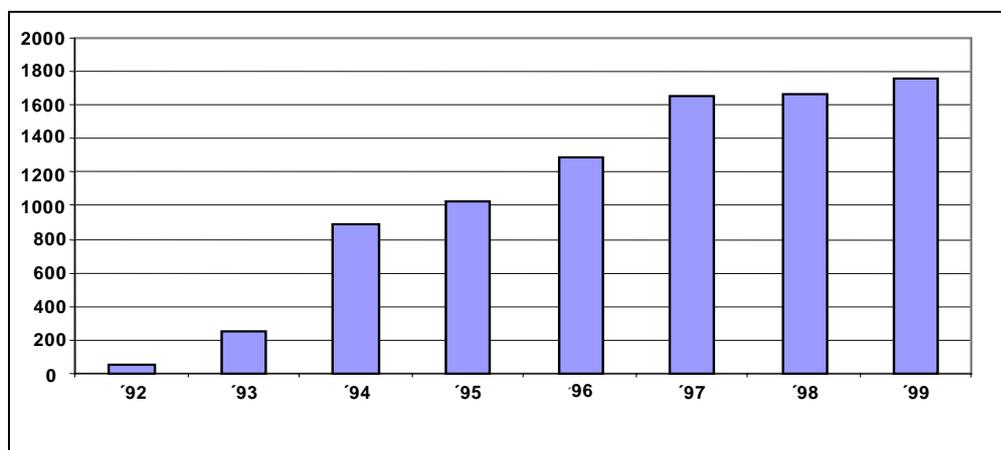
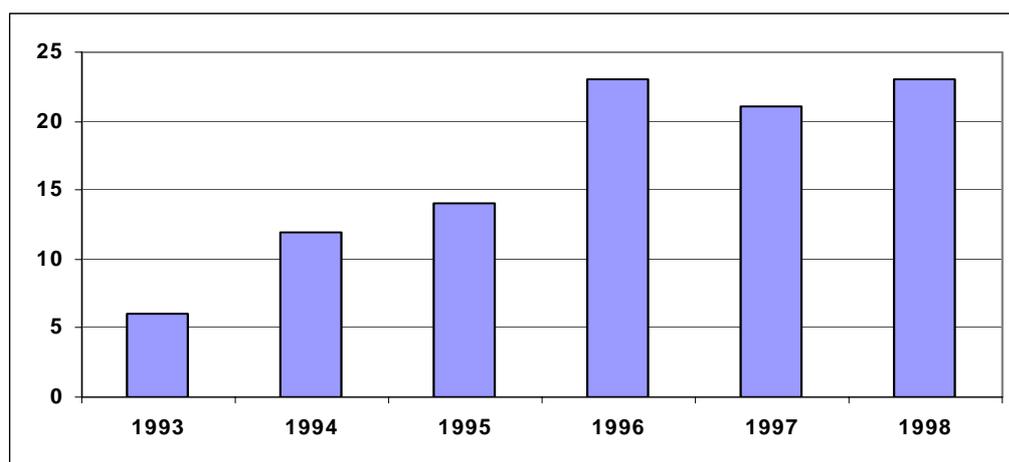


Figure 3. Mortality associated with drug use in Slovakia



Legal framework

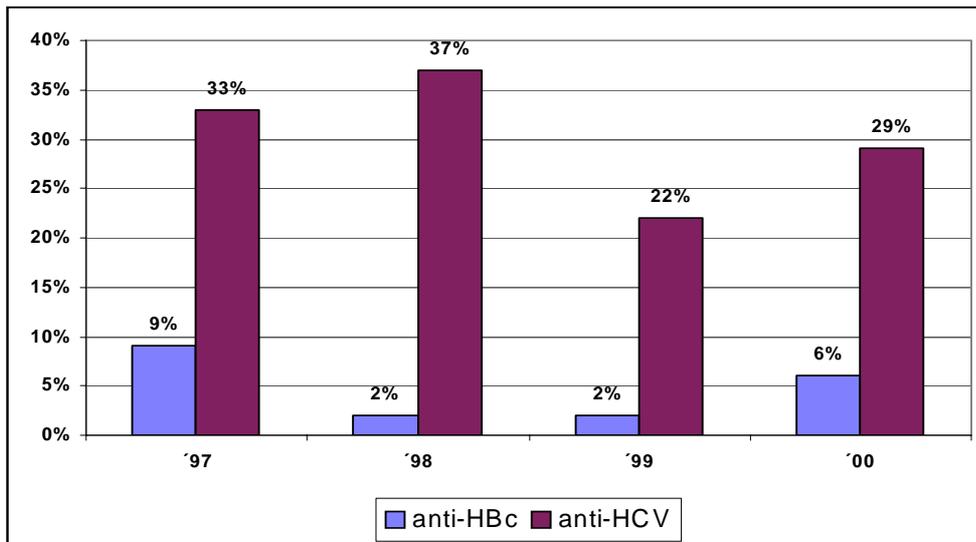
Slovakia has adopted UN international treaties on narcotics and psychotropic drugs from the years 1971, 1972, and 1988. The Penal Code, valid from October 1994, has incorporated paragraphs which apply a zero tolerance stance for possession of any amount of illicit drug. The Penal Code amendment also adapted a more severe punishment for distribution of illicit drugs in 1999.

The National Programme on Combating Drugs (NPCD) was created at a national level in 1995 and actualized in 1999. The Committee of Ministers for Drug Dependencies and Drug Control under the direction of the Deputy Prime Minister was established at the same time. The Minister of Health is one of two deputies. NPCD is responsible for outlining goals and strategic approaches on how to deal with the phenomenon of drug use in Slovakia. The Slovak Parliament accepted the following NPCD document: "Measures against emerging drug epidemic in capital city Bratislava, in the year 1996". One of the goals was the implementation of methadone maintenance programmes in the Centre for Treatment of Drug Dependencies (CPLDZ) in Bratislava. There is currently no special legal act for the regulation of treatment with opioids in Slovakia.

3. Health consequences

Prevalence of bloodborne infectious diseases among heroin users in the first half of 2001 was as follows: HIV antibodies – <0.5%; hepatitis B virus (HBV) antibodies – 4%; hepatitis C virus (HCV) antibodies – 29% among first admissions and about 40% overall (Figure 2). These figures are valid only for Bratislava, where testing is performed on a systematic basis. Trends are steady. There is still a very low seroprevalence of HIV (below 0.5%) and HBV (4–6%), reflecting the general situation amongst injecting drug users (IDU) in Bratislava. Patients who were tested as HBV negative were immediately vaccinated against HBV at the time of their intake into treatment. Between 1997 and the middle of 2001, there were 1894 such cases in Bratislava alone. HIV seroprevalence was 2.4 persons per 100 000 in Slovakia in the first half of 2001, of whom only 5% were drug users. The only probable significant difference and increase between serostatus at admission and later on is expected in the case of HCV, where significantly higher prevalence is expected among relapsing IDUs. This assumption was supported by unpublished data from the methadone maintenance treatment programme from Bratislava, where prevalence of HCV was 56% one year after beginning of treatment (n=63) (source: *Programme for protection of public health among IDUs in Bratislava*). Hepatitis A prevalence is generally low, but is not monitored among IDUs in Slovakia. In addition to the above-mentioned, systematic testing for tuberculosis (prevalence of which is close to zero) is performed at the CPLDZ in Bratislava. Syphilis testing is offered predominantly to women, many of whom are involved in prostitution.

Figure 4. Prevalence of HBV and HCV antibodies among new admissions



4. Treatment of opioid dependence

Currently the bulk of inpatient treatment is conducted in state health care specialized facilities, CPLDZ and at specialized wards in psychiatric hospitals.

Outpatient care for drug users is shared equally by state-run clinics (not for profit) and private psychiatrists. NGOs are involved in non-medical programmes of care, mostly in street work, in aftercare, and in social reintegration of patients following treatment. NGOs are referring and recommending health treatment facilities to their clients. There is good cooperation between specialized drug treatment services and other medical disciplines, especially with doctors from infectious diseases and pediatricians. The National Programme on HIV/AIDS and the National Programme on Combating Drugs are overlapping in the field of drug demand reduction, with specific regard to prevention and treatment of bloodborne diseases. Mutual willingness to cooperate was declared between public, state-run health sector agencies and NGOs working in harm reduction programmes such as needle-exchange programmes (NEP) and education of drug users.

Low threshold care for people with dependence is easily accessible and exists in the capital city. Two NGO agencies – Prima and Oddyseus – are doing street work with NEP in the capital and there are two additional NEPs in the other towns. CPLDZ is a treatment facility that also has a NEP. There is no low-threshold social care (drop-in) centre for drug users in Slovakia. In principle, there are a wide variety of medical and non-medical treatment programmes for opioid users available in the country, but this is not as developed in smaller towns and in rural areas.

Duration of drug-free inpatient treatment is up to 90 days per episode. There is no limit on the number of treatment episodes for the same person. Methadone maintenance is not limited in its duration, but the recommendation is that it should not be shorter than one year. Outpatient treatment is unlimited. Everything is free of charge for Slovak citizens. Expenditures are covered by health insurance companies. The same applies also for those who are treated by private specialists. There is no reporting of patients to the police by health personnel. Limited access to treatment exists among individuals who are in prisons, where only the drug-free treatment approach is available. It is not possible to continue with methadone maintenance treatment after incarceration.

One problem that exists is the limited amount of financial resources. Not all treatment options are available everywhere, with the exception of Bratislava. There are very few treatment programmes offering opioid antagonists such as naltrexone, or the partial agonist/antagonist buprenorphine, due to the high price of these substances. Provision of methadone is limited only to the Bratislava region. Discontinuity of methadone substitution after imprisonment is one of the problems. It is also difficult to attract a sufficient number of trained medical specialists to work in these services. The programmes

of after-care, such as social reintegration in therapeutic communities, are not free of charge and must be partially or fully covered by clients or their families.

There is a legal act on medicine in general and legal regulations on psychotropic substances, which was drafted according to international UN conventions and recently approved. There is also a legal framework for the provision of opioid agonists.

Detoxification

The range of medications used predominantly for detoxification of opioid-dependent patients in Slovakia is as follows: methadone (inexpensive, about US\$ 0.5 per day) and buprenorphine (partial agonist/antagonist, quite expensive, registered as Subutex), ethylmorphine, codeine (inexpensive), and slow-release morphine (medium price). All of these substances are, or have been, used for detoxification. The most extensive experience for substitution and maintenance treatment is with methadone and codeine. Detoxification is provided on an outpatient basis by psychiatrists or for inpatients at general psychiatric departments (only short-term medical detoxification) or in specialized wards for dependent patients, most of which are at the drug treatment centres and offer a comprehensive program. The opportunity to continue in other treatment programmes are recommended and offered for patients after detoxification. Patients do not need to wait for detoxification on waiting lists or, if so, only for a very brief period of time. The estimated number of patients who are detoxified with the use of opioid agonists is about 1000 per year.

Substitution and maintenance

Ethylmorphine and codeine were used for substitution in Bratislava before methadone was introduced. The main inclusion criteria for admission to the methadone programme is ICD-10 diagnosis of opioid dependence syndrome, age over 18 years, and a history of previous unsuccessful attempts in medical detoxification programmes. Methadone maintenance started as a pilot project in 1997 in Bratislava. It has been continuously evaluated and should be implemented elsewhere in the near future. The capacity of the programme is able to meet demand for methadone substitution in the capital at the moment. Methadone is provided in a liquid syrup form, and is dispensed under supervision at the clinic. Up to two take-away doses are permitted per week. Routine random urinalysis is performed for the purpose of patient and programme evaluation. There were 200 patients on methadone maintenance in 2000, and 350 in the middle of 2001. Clearly the trend is towards an increasing number of patients. The estimated target is about 2000 patients to be receiving this treatment in the near future.

Programme for protection of public health among drug users

Use of opioid agonists, especially in maintenance treatment, is one of the four subprogrammes in the agenda for the protection of public health among drug users in Bratislava that started in 1997. The other parts of the programme are: education of IDUs, needle-exchange programme, and free testing of IDUs for bloodborne viral diseases and hepatitis B vaccinations. This is a model programme for other parts of Slovakia. The spread of bloodborne viral infections among IDUs is one of the main outcome evaluation measures for maintenance programmes. Primary health care is not directly involved in the treatment of people with dependence. Pharmacies are involved in providing medicines on prescriptions, but only codeine and ethylmorphine. The relatively low buying power of most people and high prices of some of the medicines are the main limitations for their use. A second factor is geography, as it is difficult to access to specialized clinics in some regions. The distance required to travel to such clinics is far too great thus making it impossible for some people to attend these clinics on a daily basis.

Evaluation and documentation

A smaller comparative evaluation study of different medications used for detoxification was done at a psychiatric clinic in Bratislava.

The largest specialized institution with programmes for detoxification and maintenance, CPLDZ Bratislava is continually evaluating its programmes from both the therapeutic viewpoint and in terms of cost-effectiveness. There is a special department within CPLDZ - the Institute for Drug Dependencies that is responsible for this task. Evaluation becomes routine in this institution.

Different types of evaluation are conducted at the same time:

- ❑ Evaluation of the programme by patients;
- ❑ Evaluation of treatment effectiveness;
- ❑ Economic evaluation of costs allocated to the programmes.

From the methodological point of view, the results of the process evaluation are followed, however, the biggest emphasis is on outcome measures, where incidence and prevalence of bloodborne infections among opioid users have the highest significance.

The standard overall successful completion rate for short-term inpatient detoxification with codeine in CPLDZ Bratislava over a three-year period was 65%. Retention in methadone maintenance treatment at 12 months over the past 3.5 years was 84%. The proportion of negative urinalysis for morphine was 87% in the same period of time. The number of deaths was 0.2 per 100 persons a year. Approximately 38% of patients used benzodiazepines at least once. The employment rate has increased to 45% among methadone maintenance patients, compared to 23% at the time of entry.

Minimal HIV seroprevalence among IDUs in Bratislava is considered to be one of the most important outcome measures to which this programme is contributing. Significant decreases in criminal activities related to illicit drug use have been registered in Bratislava since the introduction of the methadone maintenance programme. A decrease in costs has also been observed with an increase in the number of persons in methadone treatment (from about US\$ 2 to US\$ 1.50 per patient in the year 2001). The results of a longitudinal cohort study of the outcome of patients admitted to CPLDZ for heroin dependence at three-year follow-up showed similar findings to other studies. Employment at time of intake was identified as a predictor of higher probability to achieve and to maintain abstinence.

Several reports and scientific papers have been published, or submitted for publication. Some of them are:

- ❑ Articulation of codeine treatment and methadone maintenance programmes
- ❑ Evaluation of detoxification with codeine in CPLDZ Bratislava
- ❑ Report on implementation of methadone maintenance programme
- ❑ Three-year follow-up study of heroin users in Bratislava.

Strong emphasis on good clinical practice and cost effectiveness resulted in a planned workshop in September 2001 attended by experts and policy-makers. This workshop was organized at a national level by the Institute on Drug Dependencies with the aim of preparing standardized guidelines and treatment protocols for assessment and treatment of patients with drug dependence, with standardized evaluation being a central component.

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SLOVENIA

Dr Andrej Kastelic
Centre for Treatment of Drug Addiction, Ljubljana, Psychiatric Clinic Ljubljana, Slovenia

Tatja Kostnapfel Rihtar, M.Sc.
The Sound of Reflection Foundation

1. Country profile

Size:	20 256 km ²
Inhabitants (2000)	2 000 000
Capital:	Ljubljana (pop: about 300 000)

2. Epidemiological data available

According to available estimates there are 5000 to 15 000 injecting drug users in Slovenia (25–75 per 10 000 population).

3. Health consequences

The sharing of injecting equipment (80%) and unsafe sex are common and dangerously increase the potential for the spread of HIV in this community. Several hundred intravenous drug users have been voluntarily and confidentially tested for HIV in recent years, and 14 have been found to be infected. However, the prevalence of the HIV infection among intravenous drug users may increase rapidly with the introduction of new cases of HIV. Thus, HIV harm reduction interventions related to unsafe intravenous drug use and unsafe sexual behavior among drug users are considered a high priority within the National AIDS Prevention and Care Programme.

For this reason the professional staff working at the regional Centres for the Prevention and Treatment of Drug Addiction received additional HIV training, which along with the early use of substitution treatment and syringe and needle exchange programmes in some centres in Slovenia may have contributed to the current low prevalence of HIV in this population.

4. Prevention and treatment of drug dependence

Eighteen regional Centres for the Prevention and Treatment of Drug Addiction have been established since 1995, and the professional staff working at the centres have received additional training. In addition, there are several nongovernmental organizations implementing harm reduction policy with drug users.

The law on the prevention of illicit drug use and treatment of drug users sets out the guidelines for medical treatment of drug users and for the establishment and operation of the Centres for the Prevention and Treatment of Drug Addiction, together with the National Centre for the Treatment of Addiction.

Centres for the Prevention and Treatment of Drug Addiction are linked, professionally and with regard to their organization, with the Centre for Treatment of Drug Addictions, where inpatient treatment takes place together with psychosocial therapeutic counselling, after care treatment, and general health rehabilitation. Formation of the network of Centres for the Prevention and Treatment of Drug Addiction is a significant step ahead in the inclusion of drug users in treatment programmes.

National guidelines for the treatment of drug addicts, including harm reduction strategy and methadone maintenance programme, were adopted by the Health Council at the Ministry of Health in 1994, and the methadone maintenance programme policy was adopted at the Symposium on Methadone Maintenance by the participants from the Ministry of Health, the Ministry of Internal Affairs, the Ministry of Labor, Family and Social Affairs, and by the Ministry of Justice.

The recommendations provide instructions for identifying drug use; the diagnostic and therapeutic methods in hospitals and at outpatient clinics; recommendations for the methadone maintenance programme and harm reduction strategies.

Support is provided not only for opioid addicts but also for people who abuse other drugs, including sedatives, hypnotics, stimulants, and hallucinogens, regardless of level of use (episodic or regular). The recommendations also provide guidance concerning the abstinence syndrome, the application of medication, the stabilization of opioid dependent patients, outpatient treatment, detoxification and a detailed description of the methadone maintenance programme.

The Guidelines were updated in 2000.

Interventions of the Centres for the Prevention and Treatment of Drug Addiction

These drug prevention and treatment centres provide the following services:

- ❑ individual, group, and family therapy;
- ❑ counseling services;
- ❑ community health services;
- ❑ substitution programmes;
- ❑ detoxification;
- ❑ preparation for inpatient treatment;
- ❑ rehabilitation and social reintegration;
- ❑ consultations for health, social, education services, and the police;
- ❑ cooperation with NGOs, TCs, self-help groups;
- ❑ education;
- ❑ research;
- ❑ publishing "Odvisnosti" (Addiction) journal.

In view of the complex nature of drug dependence treatment, the normal operation of a drug prevention and rehabilitation centre requires a multidisciplinary team of specialists including: a general medicine or social medicine specialist, a college-graduate nurse, a consulting or permanently employed psychiatrist, a psychologist, a social worker, a laboratory technician, and an administrative worker.

The outreach teams

Outreach field work has been established in some centres providing information on HIV and AIDS and safer drug use through both personal contacts and information leaflets trying to discourage drug injecting, or at least to encourage injecting drug users to take precautions for safer use. Outreach workers provide clean injecting equipment to injecting drug users not attracted by other harm reduction programmes or treatment schemes. Injection equipment vending machines have been installed in high risk areas. Safer sexual behavior is also promoted, including the promotion of condom use and their distribution.

Methadone maintenance programme

The methadone maintenance programme is considered one of the fundamental harm reduction programmes in the current national drug policy, which aims to protect drug users from possible harm by increasing the number of users who are in contact with treatment and management services.

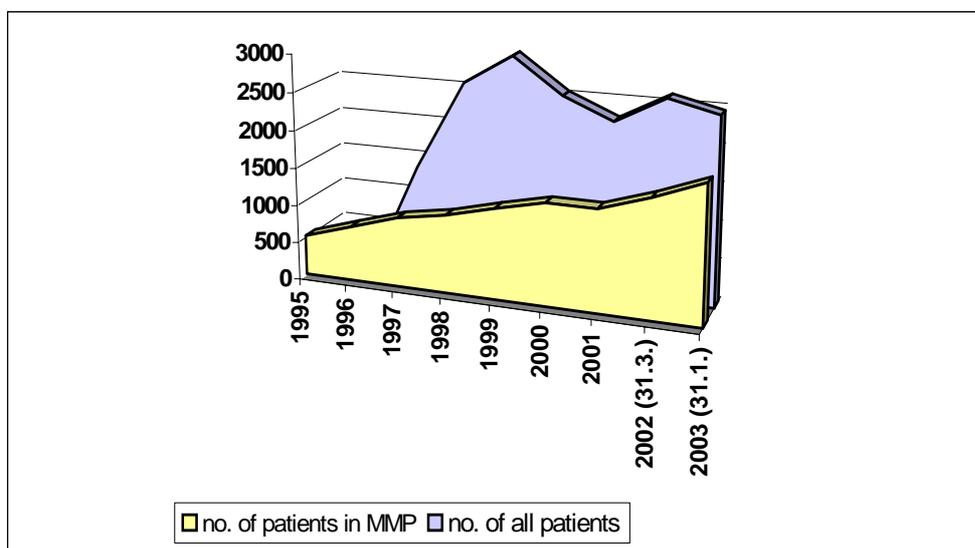
The final decision regarding the placing of the drug user in the methadone programme is made by the programme manager after consultations with the team. The minimum requirements are:

- ❑ opioid dependence for the duration of at least one year and current physical dependence;
- ❑ previous detoxification attempts;
- ❑ written consent for the inclusion on the MMP;
- ❑ minimum age of 16;
- ❑ permanent residence in the region where a drug prevention and rehabilitation center is located;
- ❑ link with family doctor;
- ❑ health insurance (free of charge).

Table 1. Number of patients in Centres for Prevention and Treatment of Drug Addiction from April 1995 to January 2003

<i>Year</i>	<i>Number of patients in the methadone maintenance programme</i>	<i>Number of all treated patients</i>
1995	530	-
1996	729	-
1997	926	1414
1998	1034	2599
1999	1198	3000
2000	1348	2540
2001	1347	2264
2002	1559	2617
31.1.2003	1814	2463

Figure 1. Number of patients in Centres for the Prevention and Treatment of Drug Addiction from April 1995 to January 2003



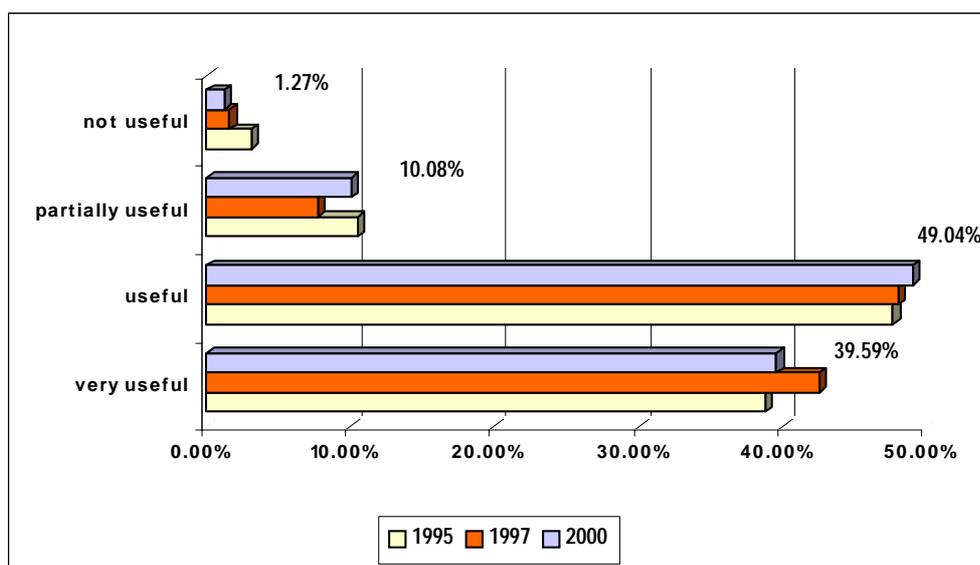
a. Relevance

Attracting the majority of drug users to contact treatment programmes as early as possible is an important goal. The low prevalence of HIV infection among injecting drug users may be due to early introduction of methadone maintenance. Thus, HIV harm reduction interventions related to unsafe injecting drug use and unsafe sexual behavior among injecting drug users are considered a high priority. The comprehensive programmes of the network of Centres for the Prevention and Treatment of Drug Addiction and the National Centre for Treatment of Drug Addicts have attracted a large number of drug users.

b. Effectiveness

The methadone maintenance programme was evaluated in 1995, 1997, 2000 and 2003. The evaluation data are available and have been partly published in the EUROPAD publication *Heroin Addiction and Related Clinical Problems*. The results show that the methadone maintenance programme was considered “useful” to “very useful” by more than 90% of the clients.

Figure 2. Usefulness of methadone maintenance programme



c. Efficiency

The network of Centres for the Prevention and Treatment of Drug Addiction provides health care and various forms of assistance for drug users. These services are available to all health insured persons in the Republic of Slovenia. The provision of health insurance is a mere formality and can be obtained at no cost to all citizens.

d. Ethical considerations

Accessibility and respect for individuality are basic principles of all the programmes offered at the centres. All patients included in the programmes are well informed about the operation and requirements of the programme and about other options, and sign an informed consent form.

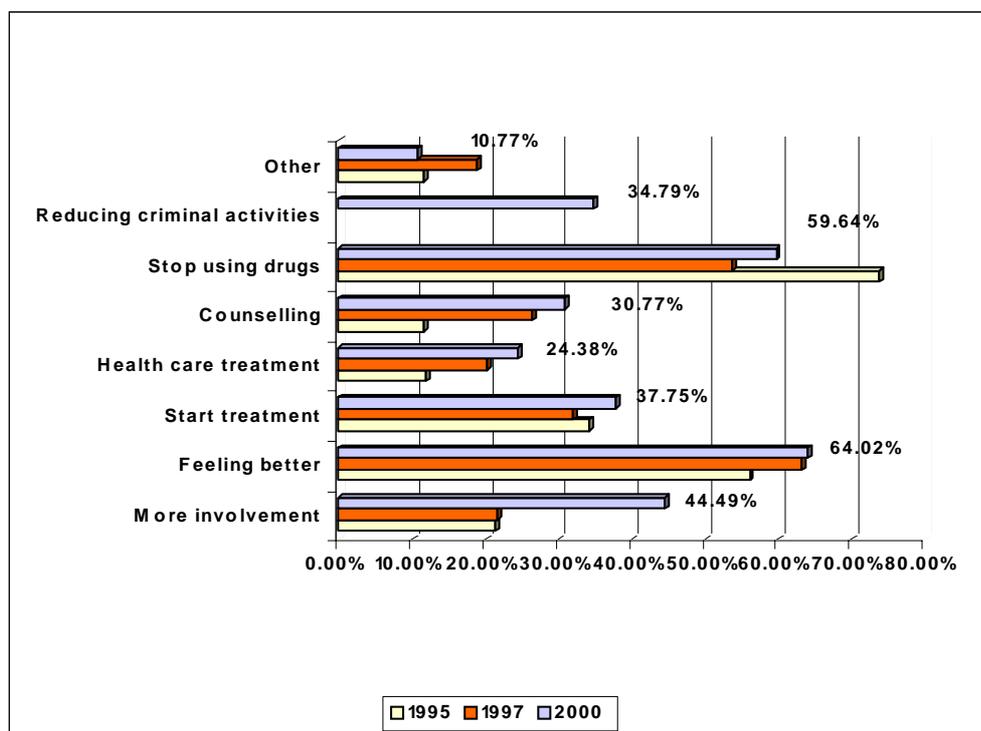
Special programmes for adolescents and drug dependent women are provided. The treatment of addiction is the centre's top priority, and there is almost no waiting period. Clients are encouraged to participate in the centre's programme planning and supervision consumer boards are being introduced. There is a possibility for free legal aid. The possibility for filing complaints regarding work in centres has been incorporated into the system.

e. Sustainability

Programmes for the treatment of addiction are defined by the law regarding the prevention of illicit drug use and the management of drug users. This law defines the forms of treatment and the establishment of centres for the prevention and treatment of drug addiction. The centres' programmes are supported by the Slovenian Ministry of Health and funded by the Health Insurance Institute. The financing is provided in lump sums and does not entirely cover the cost of full implementation of the programmes, primarily because the number of users seeking assistance is increasing.

To a smaller extent, the programmes are partly funded by public tenders for prevention projects. The Sound of Reflection Foundation has been established by the staff in charge of the centres with the hope of improving the funding of the programmes.

Figure 3. Expectations from the methadone maintenance programme



Goals achieved concerning HIV/AIDS

Some of the main goals already achieved concerning the HIV/AIDS epidemics in establishing the network of Centres for the Prevention and Treatment of Drug Addiction have been:

- To provide medical care to all persons with health insurance in the Republic of Slovenia.
- To further develop and strengthen the methadone maintenance programme and other substitution programmes.
- To develop community outreach harm reduction programmes.
- To assess the extent of HIV- risk behavior and HIV infection among injecting drug users.

Recent developments in the area of prevention and treatment of drug dependence

- Development of the network with new centres and an expansion of the existing centres and outpatient clinics
- Development of prevention programmes
- Testing for hepatitis B, C, and HIV
- Immunization against hepatitis B infection
- Implementation of treatment for hepatitis C
- Treatment of drug-dependent pregnant women and their children
- Cooperation in developing the principles of treating drug users in prisons and military service
- Recommendations regarding the employment of drug users and their ability to drive
- Drug users involvement in making policy - "Consumer Boards"
- Publications
 - Hepatitis C
 - Instructions for immunisation against hepatitis B
 - What You Should Know About Methadone
 - Women and Drugs

- Urine Tests
- Overdose
- Club drugs
- Marijuana
- Scientific magazine "Addictions" (Odvisnosti)

Conclusions on the work of the Centres for the Prevention and Treatment of Drug Addiction

Accessibility and respect for individuality are basic principles of all the programmes offered at the centres. All patients included in the programmes are fully informed about the operation and requirements of the programme as well as their options, and sign an informed consent form. Special programmes for adolescents and drug-dependent women are provided. The treatment of addiction is the centre's top priority, and there are almost no waiting lists. Clients are encouraged to participate in the centre's programme planning and supervision consumer boards are being introduced. There is a possibility for free legal aid, and the possibility for filing complaints regarding the centres has been incorporated into the system.

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UKRAINE

Dr Anatoliy M. Viyevskiy
Ministry of Health, Ukraine

1. Country profile

Size:	603 700 km ²
Inhabitants (2000)	49 600 000
Capital:	Kiev (pop: 2 635 300)

The Ukraine is divided into 25 administrative units, which include 23 territories (oblasts), Sevastopil and Kyiv-city. All oblasts are divided into regions (generally more than 600). The biggest city is the capital of the country, Kiev (2 635 300 inhabitants). Other big cities and their total population are shown in Table 1 (data from the Ministry of Statistics):

Table 1. Population of big cities in Ukraine

<i>Kharkiv</i>	<i>- 1 575 900</i>	<i>Kyryvyj Rih</i>	<i>- 727 900</i>
Dnipropetrovsk	- 1 161 200	Mariupil	- 515 200
Donetsk	- 1 101 800	Mykolaiv	- 512 900
Odessa	- 1 059 500	Lugansk	- 493 300
Zaporizhya	- 887 400	Vinnitsya	- 387 200
Lviv	- 805 900		

Map 1. Map of Ukraine showing the various administrative units



The most inhabited part of Ukraine is the eastern area where approximately 12.5 million people are living. Approximately ten million live in the southern and western parts, respectively. The northern and central parts of the country have eight million people each.

2. Epidemiological data available

History of opioid use in the country

According to the existing regulations, the registration of drug-dependent people (drug abusers) by drug treatment institutions of the health care system takes place after clients (patients) appeal for medical help and have been clinically diagnosed by the doctors' commission. During the soviet rule the region of Dnipropetrovsk (south-east Ukraine) traditionally has been associated with a high level of drug use. Even the registered number of dependent people between 1950 and 1980 was considerably higher here than in the rest of Ukraine. In the mid-1990s, more than 95% of drug users were living in cities. Since 1993-94 there has been an increase in the proportion of the rural population using drugs for non-medical purposes. Since the beginning of 2000 it can be ascertained that there is no region with the absence of drug (opioid) problems in Ukraine. Nowadays an increasing number of dependent people can be found in both urban and rural areas. In Kryvyi Rih (central Ukraine) the increase in the number of registered drug-dependent individuals is the quickest in the country. The second group of territories with significant increases in drug abuse includes Odessa, Donetsk, Mykolaiv Regions and the city of Kyiv. The third group includes all other regions where registered drug abuse prevalence is lower though the increase of the drug dependence rate is high. There are some specific peculiarities in drug use in Ukraine that differentiates it from drug use in the other countries. Firstly, from examination of data from drug-dependent people in Kyiv, more than 50% of all drugs are not purchased but acquired by barter selling for different "services" (such as preparation, trafficking of drugs, and prostitution). Criminal behaviour is also common amongst drug users in Ukraine. In Ukraine in most cases drugs are used in groups (collectively).

Substances used

The constant increase of registered patients with drug dependence is the dominant trend in illicit drug use in Ukraine. Between 1991 and 1995 the prevalence of drug dependence increased by almost 50%, and between 1997 and 1999 there was an increase of 25%. At the beginning of the 1990s an explosion of drug dependence occurred with the experience of two interdependent processes: a stable increase in the number of dependent patients of 11-12% per year, and a sizeable increase in the range of substances used for non-medical purposes. At the beginning of the 1990s more than 95% of all registered drug dependent people used dimethylmorphine (dimitrol), a self-made substance prepared from the poppy straw. Cases of heroin, cocaine or stimulant use were very rare. Similar processes took place in all regions of Ukraine. A large proportion of users were injecting drugs two or more times a day. More than 10% of users combined "dimitrol" with other medicines, first of all with dimedrol (antihistamine medicine). During the last 3-4 years, the number of cases of heroin (often powder mixed with talc) use, cocaine and other "hard" drug use (such as "Ecstasy" and methamphetamine) and "soft" drug use (such as cannabis, hashish and anasha) has been rapidly growing (especially in Kyiv). Cannabis (hemp) became very popular among the youth (age from 12 to 20). Narcological services in Kiev-City examined 820 pupils of the Vocational Schools in Kiev. It was observed that 32% of the pupils reported that they had used cannabis ("smoked hemp") and 12% indicated that they use it regularly.

Characteristics of known opioid/heroin users

An age-analysis shows that more than 99% of drug-dependent people are of an active age and more than 88% are under 30 years old. The average age of drug users in the country is decreasing every year by between 0.1% and 0.15% per year. About 60% of drug dependent individuals are male, and the ratio between male and female users was 2:1 during the 1990s. The young age of drug dependents results in an overall low level of professional training. In the different regions of Ukraine, the number of people with drug dependence who have not completed any vocational training is between 50-77%, and between 38-45% do not have a permanent or even temporary job. Undoubtedly this problem is one of the main reasons why people with drug problems experience difficulties with social adaptation.

Number of opioid/heroin users; proportion of different users

According to the data from the Ministry of Health of Ukraine the number of registered drug-dependent people in treatment institutions in the country has exceeded 73 000 by 1 January 2001. The highest numbers of drug-dependent individuals have been registered in the regions of

Dnipropetrovsk (14 365), Donetsk (8490) and Odessa Region (7041). The highest rate of increase in Ukraine took place in Kryvyi Rih (Region of Dnipropetrovsk) during 1977–1999. The number of clients (patients) with drug problems who had appealed for medical help from state treatment institutions during the last ten years has increased from 22 466 in 1990 to 73 500 at the end of 2000. (See Figures 1 and 2).

*Figure 1. Number of registered drug users/addicts in Ukraine (1989 – 1999)
(Data of the Ministry of Health of Ukraine)*

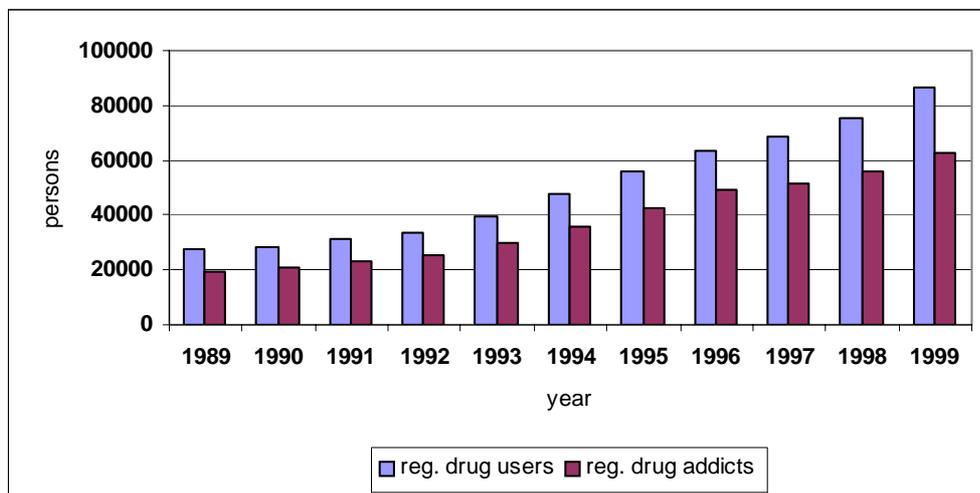
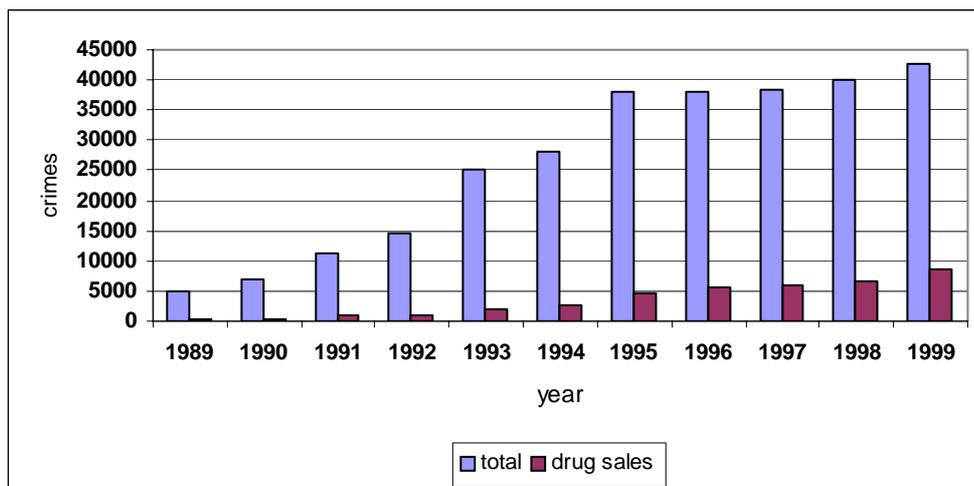


Figure 2. Number of drug-related crimes in Ukraine (1989 – 1999)



Number of opioid/heroin users

Evidently, only a small proportion of people with drug problems appeal for the necessary help, treatment and rehabilitation. The prevalence of drug dependence in Ukraine may be estimated by the approach proposed by specialists of *Ukrainian Scientific – Research Institute of Clinical & Experimental Neurology and Psychiatry* (Kharkiv) and *Scientific and Clinical Rehabilitation Centre on Chemical Dependencies* (Kyiv). According to this approach the true number of people in the country who are dependent on opioids (including self-made substances prepared from poppy straw and heroin) was approximately 175 000 at the beginning of 2000. At the same time, through practical observation it is evident that there are at least an additional 40% using opioids episodically (users who are not dependent). This entails, then, an additional 65 000 people. Thus, the general estimated number of people in Ukraine using opioids for non-medical purposes is between 210 000 to 220 000 people.

3. Health consequences

Seroprevalence of HIV, hepatitis B/C

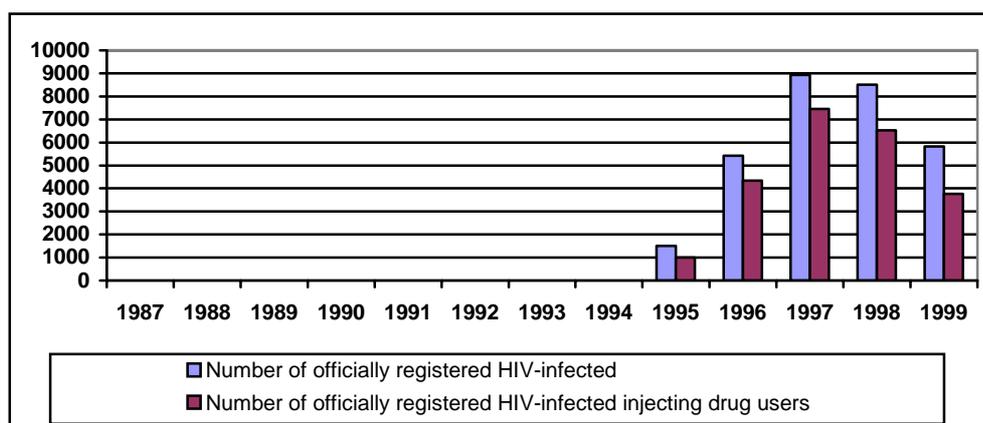
The first wave of HIV infection in Ukraine has been strongly connected to drug use. Approximately 80% of all HIV-infected people are drug abusers. Undoubtedly the history of the HIV epidemic in Ukraine, and especially the second wave of HIV spread, demonstrated a meaningful difference between two sensitive problems in Ukraine: HIV and drug use.

The first HIV cases in Ukraine were registered in 1987 after the beginning of population screening for HIV antibodies. At the end of that year, six citizens of Ukraine and 75 foreign citizens were found to be HIV-infected. The 75 HIV-positive foreign citizens were deported in accordance with the legislation at that time. The number of HIV-infected foreigners was decreasing somewhat prior to 1994, but HIV prevalence was increasing among Ukraine citizens. HIV transmission before the year 1994 can be characterized as slow, with heterosexual intercourse being the dominant mode of transmission. The number of HIV positive males and females was roughly equal. During that period, 183 HIV-infected citizens of Ukraine were registered.

At the end of 1994, two HIV-infected brothers, both injecting drug users were registered in Mykolaiv (southern Ukraine). It is likely that one of them had been infected in Poland where the level of HIV transmission among drug users was relatively high at that time. Further epidemiological investigation revealed more than 20 HIV positive drug users infected with a common syringe. In the beginning of 1995 the first cases of HIV were registered among drug users in Odessa. No epidemiological proof has been found of a connection between these cases and those in Mykolaiv.

The number of registered HIV-positive drug users continued to increase (Figure 3), with the spread of HIV to other regions. In 1997, cases of HIV infection among injecting drug users had been registered in all oblasts in Ukraine. The question of when HIV spread to the group of injecting drug users in Ukraine remains unresolved. Some argue that it occurred a few years before 1995, and by this time the critical mass of HIV-positive persons among this contingent resulted in the rapid transmission of the epidemic throughout the country. On the other hand, in accordance with the acting legislation during that period of time, every drug user (registered in treatment centres) was required to undergo testing for HIV antibodies. Taking into account the fact that testing was not only of injecting drug users but of all drug users admitted to treatment centres, the annual number of HIV tests in the drug-using population constituted 23 000 to 37 000.

Figure 3. Number of officially registered HIV-infected persons in total population and among injection drug users in Ukraine (1987 - 1999)

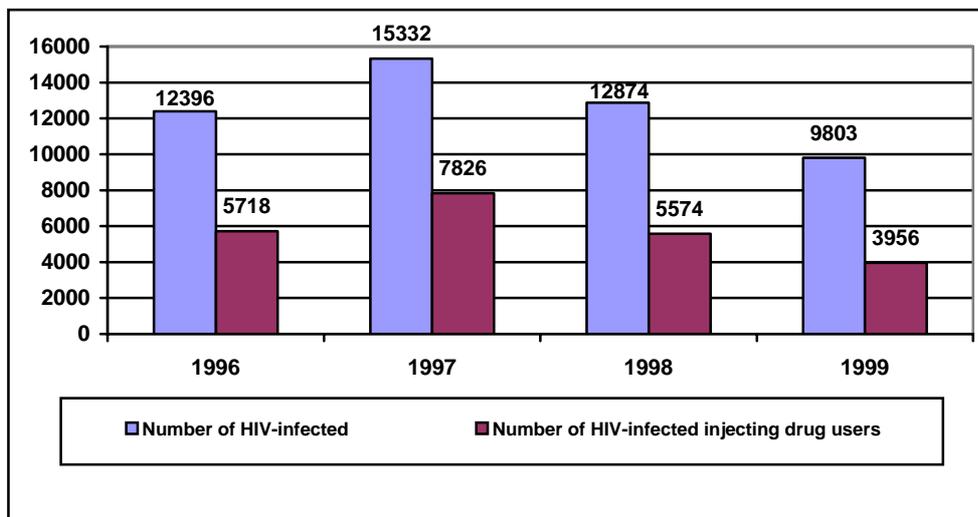


Returning to the first observed epidemiological chain of HIV-infected injecting drug users in Mykolaiv (over 20 persons) it should be noted that only approximately 30% of HIV-positive persons were registered and tested in drug treatment centres. The notion that the critical mass of HIV-positive persons was accumulating only among the so-called “episodic” drug users not registered in these treatment centres does not seem to be realistic. Almost all the people were examined by a medical

staff and underwent different blood tests. It is difficult to suppose that this “small cell screening net” could miss any of the HIV-positive drug users if any of them at that time had already existed.

The greatest number of HIV-positive individuals officially registered for the first time per year was observed in 1997 (8934 persons). From 1998 the number of new HIV infections registered started to decrease: 1998 – 8512 individuals, 1999 – 5434 individuals. At the end of 1999, 30 399 HIV-positive persons were officially registered, 70% of whom were male.

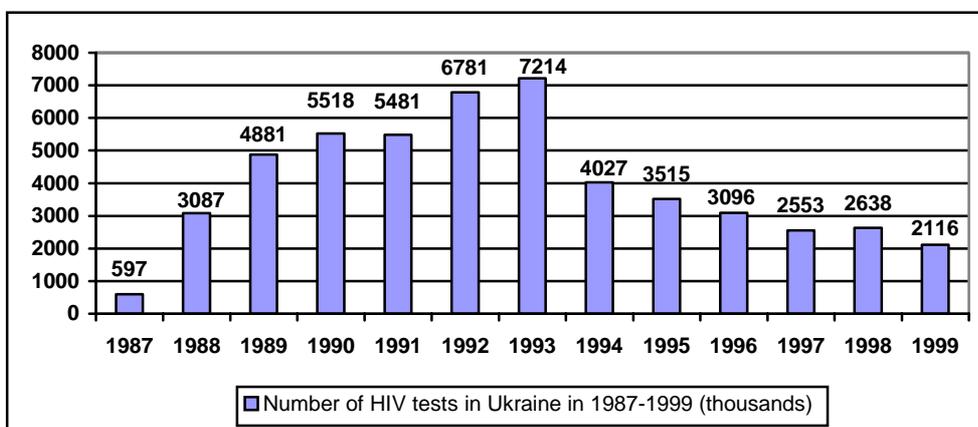
Figure 4. Number of HIV-infected, revealed by seroepidemiologic monitoring (general population and injecting drug users)



In Ukraine HIV-positive persons are officially registered only when diagnosed after the proper clinical examination. HIV-positive individuals who have been screened by seroepidemiological monitoring but avoid clinical examination are therefore not officially registered. However, this population is incorporated into the data on HIV-positive cases detected by seroepidemiological monitoring.

The reduction in the number of newly reported HIV cases since 1998 is most noticeable among drug users (for 23% in comparison with 1997 and for 42.1% – in 1999 in comparison with 1998) but this is not indicative of stabilization in HIV/AIDS prevalence in general. This fall is a result of a reduction in the total number of tests, and particularly in the level of testing of drug users. This reduction occurred as a consequence of the revision of the Ukrainian law “About prevention of sickness ratio by acquired immune deficiency syndrome (AIDS) and social defense of population,” which declared for the first time that HIV testing was voluntary.

Figure 5. Number of HIV tests in Ukraine in 1987-1999 (thousands)



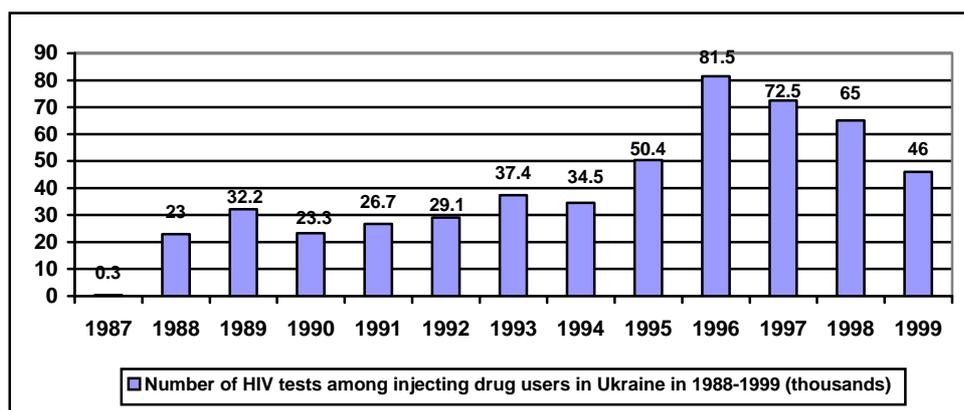
Signs for a further worsening of the situation are the increase in the percentage of HIV cases among:

- ❑ blood donors (from 0.06% in 1997 to 0.064% in 1999);
- ❑ venereal patients (from 0.50% to 0.63%);
- ❑ people who have many sexual partners (from 0.55% to 0.80%);
- ❑ HIV-infected pregnant women (from 0.09% to 0.16%).

It is suggested that these figures indicate that HIV infection is spreading more actively from injecting drug users to other groups of the population. According to statistics of the *European Centre of Epidemiological Monitoring on AIDS* regarding infection level, the Ukraine occupies the first place in Europe concerning possible infections by blood donors. This data indirectly confirms the leading positions of Ukraine in the level of HIV transmission among the population in general. The indirect marks of the start of HIV transmission to the general population are both the reduction of the proportion of HIV-positive individuals who are drug users (in 1997 it constituted 83.4%, in 1998 – 76.6%, in 1999 – 64.7%), and the growth in the number of HIV-infected females (in 1996, 1997, 1998 and 1999 the corresponding percentages were: 23.5; 26.3; 32.8 and 36.5 respectively). Furthermore, the official statistics showed that among reported drug users, 20–25% were female.

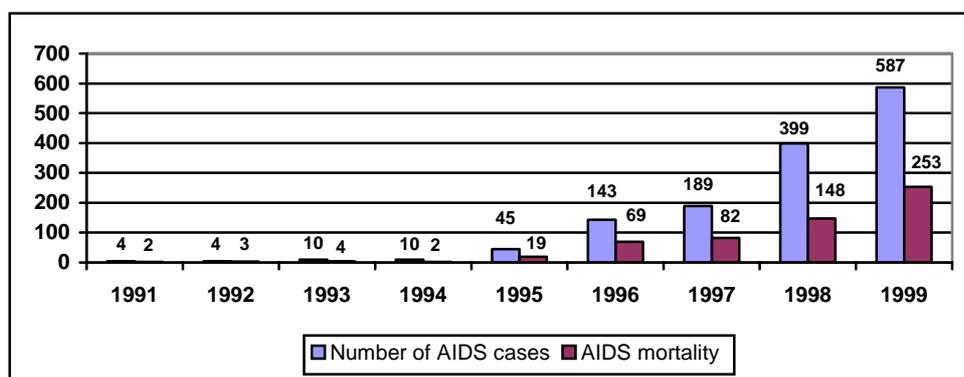
The significant reduction in the number of HIV tests conducted among injecting drug users reported in previous years (Figure 6) dictates the necessity of further investigation of the epidemic transmission of HIV to the general population.

Figure 6. Number of HIV tests among injecting drug users in Ukraine in 1988–1999 (thousands)



The growing prevalence of HIV among females inevitably increases the number of children born by HIV-positive mothers. Eight HIV-positive children with HIV-positive mothers were reported from 1987 to 1994. In the beginning of 2000 this figure grew to 972. Undoubtedly these data show the true HIV situation in Ukrainian society. The most demonstrative indication of a fast epidemic development in Ukraine is the sharp increase of AIDS cases and AIDS mortality during the last years (Figure 7).

Figure 7. Number of AIDS cases and of AIDS mortality in Ukraine in 1991–1999 (individuals)



The HIV infection prevalence throughout the different regions of Ukraine is variable. The oblasts situated in the eastern and southern parts of the country are the most affected: Dnipropetrovska, Donetsk, Odesska, Mykolaivska and also the Autonomous Republic of Crimea. It is important to mark the leading position of these oblasts in terms of the number of registered drug users and also for the prevalence of hepatitis B infection, which is similar to HIV in terms of mode of transmission. At the end of 1999, the greatest HIV infection prevalence was observed in Odesska oblasts (197.7 cases per 100 000 individuals and 4963 officially reported HIV-positive persons). The greatest number of HIV-infected individuals was registered in Donetsk oblast (6777 individuals), and slightly less in Dnipropetrovska (6268 individuals). In 1999, 59% of all HIV-infected individuals of Ukraine were concentrated in these three oblasts. It should be noted that in the cities of Kyiv and Sevastopol, HIV prevalence is higher in comparison to the neighbouring Kyivska oblasts and Autonomous Republic of Crimea. In Kyiv this index constituted 37.3 cases per 100 000 individuals, in Sevastopol the figure was 99.8. The lowest HIV prevalence was observed in the western oblasts of Ukraine: at the end of 1999 there were 5.4 cases per 100 000 individuals in Ivano-Frankivska oblasts, in Rivnenska oblasts – 5.6, in Zakarpatska oblasts – 6.4, and in Lvivska oblasts – 8.1.

Map 2. HIV prevalence in Ukraine regions by the end of 1999 (per 100 000 individuals)



4. Treatment of opioid dependence

Current treatment infrastructure

Until June 2001, according to Ukrainian legislation, treatment and rehabilitation of drug dependence had to be conducted in state (municipal) specialized institutions of the Ministry of Health (regional narcological treatment clinics and hospitals), which provide either outpatient or inpatient care. These institutions exist on a territorial basis, and are typically municipal property. Financing of these institutions is provided by the local budget. There are 27 territorial opioid treatment institutions in Ukraine, employing 5000 specialists, including medical doctors, narcological psychologists, social workers and nurses united in the All-Ukrainian Narcological Association. The content of treatment of opioid dependence provided by these institutions was not determined by any normative documents until 1995. Between 1995 and 1998, the Ministry of Health of Ukraine adopted unified standards of opioid dependence treatment in all Ukraine institutions. It should be noted that there is only one comprehensive, developed programme of psychosocial and medical rehabilitation for drug users and their relatives in the country, located in the narcological hospital of Kyiv city. This programme (“Sociotherapy”) was developed in Ukraine, but is highly regarded internationally also.

Until June 2001, the NGOs and private organizations could provide only psychological rehabilitation programmes for drug-dependent individuals. For this reason, only 35 institutions (mostly narcological

dispensaries) in all administrative territories (“oblasts”) proposed different legal detoxification programmes. As a result, a large number of clandestine detoxification opportunities appeared all over the country (estimated to be more than 250 throughout the country). The general professional level of detoxification in legal programmes was significantly higher, but the availability and anonymous status of illegal detoxification programmes enhanced their attraction. In three or four oblasts, mental health hospitals also provide detoxification for drug-dependent individuals, but the number of patients treated is not large. The detoxification of drug-dependent individuals in general hospitals and primary health care is provided illegally in most urban territories. According to new regulations introduced in June 2001, all medical and rehabilitation activities for drug-dependent individuals are permitted in all licensed institutions without any restrictions due to their non-state or private status.

The range of medical treatment programmes available in Ukraine includes all current approaches, from ultra-rapid opioid detoxification to more conservative medical activities, such as clonidine and buprenorphine programmes. All medical, psychological and social rehabilitation activities are included in The State Standards of Narcological Practice in Ukraine, which was adopted in 1998. These include different activities for detoxification and substitution therapy, urgent interventions, and psychosocial rehabilitative programmes (12-step and others). These standards are obligatory for opioid treatment professionals throughout the country, and are based on biopsychosocial principles, ICD-10 and harm reduction preventive approaches.

In August 2001 in Ukraine there were:

- ❑ one comprehensive rehabilitation programme in a state institution (in Kiev);
- ❑ 18 nongovernmental inpatient rehabilitation centres (four of them based on 12-step approach);
- ❑ nine therapeutic communities (one of them in a state organization, 8 in non-governmental organizations);
- ❑ more than 150 Narcotics Anonymous/Alcoholics Anonymous clubs in different locations;
- ❑ more than 45 AI-anon groups and
- ❑ upwards of 40 nongovernmental organizations with outpatient rehabilitative programmes for drug-dependent individuals.

Low threshold care

There are approximately ten needle exchange services in Ukraine (including Kyiv, Odessa, Poltava, and Mykolaiv). The main barrier to the implementation of such programmes is the low level of acceptance of such activities by local administrations in many oblasts.

Types of treatment available

All modern treatment approaches for drug dependence are represented in Ukraine, with the exception of methadone maintenance and lofexidine treatment. In institutions where State Standards of Narcological Practice are implemented, the duration of treatment is similar to international practice. Some narcological dispensaries (in 8–9 oblasts) are still working on biomedical approaches. The duration of treatment in the south facilities is usually 2–3 weeks for detoxification and 2–5 months for pharmacotherapeutic activities (mostly pharmacotherapy with psychotropic medication).

Access to drug treatment

The most significant factor in access to treatment is still the low level of responsiveness of narcological dispensaries to the needs of drug users in many territories. The traditionally repressive and primitive biomedical structure of their work is the basis of relationships with clients. Another significant concern has been the poor financial position of many narcological treatment institutions between 1995 and 1999, combined with the poor financial status of the majority of clients. Only between 1999 and 2001 did this situation start to improve, and free-of-charge programmes appeared in some places, firstly in Kyiv. At the same time there are a growing number of programmes with rational prices that are successfully working in many places (practically in all oblasts).

The agonist treatment of opioid dependence in Ukraine adheres to State Standards of Narcological Practice, and has the necessary legislative basis. The substance used most frequently is buprenorphine, though in a small number of cases morphine is used. In Ukraine injectable

buprenorphine is inexpensive as it is produced by a Ukrainian pharmaceutical factory. Buprenorphine for sublingual use is imported from India at ten times the cost of injectable preparations. Methadone is in the initial phase of the licensing process. In Ukraine no fewer than 3500 clients per year are involved in buprenorphine detoxification, and more than 300 per year are involved in the eight 6-month buprenorphine substitution therapy programmes (with administration of injectable buprenorphine in small doses). The number of clients enrolled in such programmes is growing rapidly. The only limitations in implementing buprenorphine (detoxification and substitution therapy) programmes are organizational. Primary health care involvement in agonist pharmacotherapy is planned as an experiment. The development of opioid agonist treatment programmes is still in the initial phase. The Ukraine needs more such programmes than are currently available. The demand for such programmes among clients is high and in no fewer than 30 different places, the institutions responsible are preparing to start such programmes.

The protocols and instructions of opioid agonist pharmacotherapy programmes are provided by the State Standards of Narcological Practice in Ukraine. The professional All-Ukrainian Narcological Association is providing the *Evaluation of Treatment and Rehabilitation Activities Project*, which includes the issue of treatment with opioid agonists.

5. Main problems and needs

The main problem is the reorganization of the education system for professionals in drug dependence (medical doctors, nurses, psychologists and social workers) in Ukraine. The greatest need is in international educational and informational support to strengthen the biopsychosocial approaches in Ukrainian narcological programmes.

APPENDIX

LIST OF PARTICIPANTS

Belarus

Dr Vladimir Maksimchuk

Chief Narcologist
Ministry of Health
Myasnikova 39
220048 Minsk
Belarus

Croatia

Dr Slavko Sakoman

Head of Department of Addictions
University Hospital
10 000 Zagreb
Croatia

Bosnia and Herzegovina

Dr Nermana Mehić-Basara

Director
Public Institute for Alcoholism and
Substance Abuse of canton of
Sarajevo,
Bolnička 25,
71000 Sarajevo
Bosnia and Herzegovina

Czech Republic

Dr Tomas Zabransky

c/o Meziřesortní Protidrogová
Komise
(National Drug Commission)
Urad Vlady CR
Nabr. E. Benese 4
118 00 Praha 1 – Mala Strana
Czech Republic

Bulgaria

Dr Georgi Vassilev

Director
National Centre of Drug Addiction
147, Stamboliiski blvd.
Sofia 1303
Bulgaria

Estonia

Dr Mari Järvelaid

National Drug Coordinator
Ministry of Social Affairs of Estonia
Department of Public Health
Gonsiori 29
Tallinn 15027 Estonia

Hungary

Dr József Csorba

Director of Ambulance
Drogambulance and Prevention
Center
Metropolitan Hospital NYIRO GYULA
1135. Hungary
Budapest, Jász u. 84–88.

Lithuania

Dr Emilis Subata

Director and Associate Professor
Vilnius Substance Abuse Treatment
Center
Vilnius University
Gerosios Vilties 3
Vilnius
Lithuania

Kyrgyzstan

Dr Tynchtykbek Asanov

Chief Narcologist and Chief
Psychiatrist
Ministry of Health of Kyrgyzstan
Moskovskaya 148
720405 Bishkek
Kyrgyzstan

Poland

Dr Boguslav Habrat

Head of Drug Treatment Unit
Institute of Psychiatry and Neurology
Al., Sobieskiego 1/9
02–957 Warsaw, Poland

Latvia
Dr Sarmite Skaida
Head Doctor
State Centre for Drug Abuse
Prevention and Treatment
(Narcology Centre),
Riga
Latvia

Russian Federation
Professor Vladimir B. Altshouler
Head
Department of Clinical Research
Research Institute of Addictions
Maly Mogiltsevski pereoulok, 3
Moscow
Russian Federation

Slovakia
Lubomir Okruhlica, MUDr., CSc.
Director
Centre for Treatment
of Drug Dependencies,
Institute for Drug Dependencies in
Bratislava, Slovakia

Slovenia
Dr Andrej Kastelic
Head
Centre for Treatment for Drug
Addiction,
Zaloska Cesta 29
1000 Ljubljana
Slovenia

Ukraine
Dr Anatoliy M. Viyevskiy
Chief Specialist in Narcology
Ministry of Health of Ukraine
5-A, Demiyivskiy Side Alley
Kiev, 252039
Ukraine

TEMPORARY ADVISORS

Austria

Professor Gabriele Fischer

Department of Psychiatry
Vienna University
Wahringer Gurtel 18–20
A–1090 Vienna
Austria

Switzerland

Professor Ambros Uchtenhagen

Institut für Suchtforschung
Addiction Research Institute (ISF)
Konradstrasse 32
8005 Zurich
Switzerland

United Kingdom

Dr Michael Farrell

Senior Lecturer
National Addiction Centre
4 Windsor Walk
London SE5 8AF
London
United Kingdom

OBSERVERS

Austria

Dr Juana Tomas-Rossello

Drug Abuse Treatment Adviser
Demand Reduction Section, UNDCP
Vienna International Centre
P.O. Box 5000
A-1400 Vienna

Austria

Dr Jean Paul Grund

UNAIDS Vienna Team
Vienna International Centre,
Wagramerstrasse 5
A-1400 Vienna,

Portugal

Dr Ulrik Solberg

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)
Demand Reduction Department
Rua da Cruz de Santa Apolónia, 23-25
P-1149-045 Lisbon

Slovenia

Ms Tatja Kostnapfel Rihtar

Vice President
The Sound of Reflection Foundation

SECRETARIAT

Dr Vladimir Poznyak

Medical Officer

Management of Substance Abuse Team (MSB)

Department of Mental Health and Substance Abuse (MSD)

World Health Organization

20 Avenue Appia

1211 Geneva 27

Switzerland