European Monitoring Centre
for Drugs and Drug Addiction

THE CENTRE OF HEALTH ECONOMICS

2010 NATIONAL REPORT (2009 data) TO THE EMCDDA by the Reitox National focal Point

„LATVIA''
New developments, trends and in- depth information on selected issues

Reitox

FOREWORD

2010 National Report, new developments, trends and in–depth information on selected issues is one of the national annual reports compiled by the National Focal Points in the European Information Network on Drugs and Drug Addiction (REITOX) which is co-ordinated by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The national reports form the basis for the EMCDDA's annual report *The state of the drugs problem in Europe*. The national reports are compiled in accordance with the guidelines provided by the EMCDDA.

The Latvian National Report consists of two parts. Part A discusses recent developments and research data from 2009 and early 2010. The sections that describe the drug situation during the past year (drug experimentation, problem drug use, health and social correlates and consequences, availability and supply of drugs) are linked with discussion on related societal interventions (prevention, treatment, harm reduction, social reintegration and control). Each section begins with background information on the subject and the latest data is discussed in the subsections. Part B discusses selected issues relating to drugs, this year's theme being national treatment guidelines (Section 11) and mortality related to drug use (Section 12). The length of the sections in the report depends on the amount of data available on each subject area.

Head of Addiction Monitoring Division Aija Pelne (The Centre of Health Economics) wrote Section 3 and Subsections 5.1. and 5.2. Anda Karnite (Riga Stradins University) wrote Subsection 6.1 and 7.2. In addition, experts Andris Karišs and Marija Safonova (The Information Centre of the Ministry of the Interior) wrote Section 9. We thank them warmly.

The report was compiled and the remaining sections written by Ieva Pūgule, Mārcis Trapencieris, Agnese Zīle and Linda Sīle at the Latvian Reitox National Focal Point, which operates at the Centre of Health Economics.

Research data and comments from experts on different areas of the drug issue were used in drafting the report. We thank all the experts for their contribution and comments.

The report has been approved by the head of Public Health Department/EMCDDA Management Board member Māris Taube and the director of the Centre of Health Economics Daiga Behmane.

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List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral treatment
BST	Buprenorphine Substitution Treatment
CA	Court Administration
CHE	The Centre of Health Economics
CM	Latvian Cabinet of Ministers
CRPI	Children's Rights Protection Inspectorate
DHPP	Department of Health Promotion and Prevention
DRD	Drug related deaths
DRID	Drug-related Infectious Diseases
EC	European Commission
ECAD	European Cities against Drugs
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ESPAD	European school survey project on alcohol and other drugs
EU	European Union
GMR	General Mortality Register
GPS	General Population Survey
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human Immuno-deficiency Virus
HSD	Health Statistics Department
IDU	Injecting drug use
ICD-10	International Classification of Diseases (10th revision)
ICL	Infectology Center of Latvia
INCB	International Narcotics Control Board
LaSPAD	National School Survey on Alcohol and other Drugs
LNFP	Latvian National Focal Point
LPA	Latvian Prison Administration
LSCFME	Latvian State Centre for Forensic Medical Examination
MCA	Monitoring Centre for Addiction
MI	Ministry of the Interior
MMT	Methadone maintenance therapy
NAF	National Armed Forces
NFP	National Focal Point
NGO	Non-Governmental Organisation
PDU	Problem Drug use
PLHIV	People living with HIV/AIDS
PREDA	Patient REgister DAta
RPAC	Riga Psychiatry and Addiction Centre
RRCA	Riga Rehabilitation Centre for Addicts
SEA	State Employment Agency
SPS	State Probation Service
STD	Sexually transmitted diseases
STSDA	Sexually Transmitted and Skin Diseases State Agency
TDI	Treatment Demand Indicator
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

Table of contents

Summary

Drug policy: legislation, strategies and economic analysis

During 2009, several significant changes were made to Latvian legislation, including new psychoactive substances being made subject to control. That step led to the withdrawal from entrenched sale of various smoking mixture products from both local Internet web sites and stores - kiosks, the number of which had increased noticeably since late 2008. During the past year, several other important normative enactments were adopted and came into force.

On 13 October 2009 the Cabinet of Ministers issued Regulation No. 1178 *"Regulations for development of planning documents and impact assessment,"* which includes several government innovations and constraints to be taken into account in drafting, implementing and evaluating new policy planning documents. Based on these conditions, and taking into account the results of the evaluation of the previous National Program, a new medium-term National Drug Program for 2010-2016 was completed in 2010. The new Drug Program has to be approved by the Cabinet of Ministers in late 2010.

In 2009, the study on budget and non-budget social costs of drug abuse in Latvia was carried out. According to the estimate, social costs (budget plus non-budget costs) of drug abuse in Latvia in 2008 amounted to 68–72 mln LVL or approximately 0.4% of GDP. Budget costs amounted to 6.5–10.6 mln LVL or approximately 10–14% of total social costs, of which direct costs of drug abuse – to about 2%.

Drug use in the general population and specific targeted groups

Drug use prevalence indicators, as well as the availability of drugs and people's attitudes about drug policy issues are widely considered in the 2008 National Report, as well as in the Study Report. Therefore, only a brief summary of illicit drug use prevalence indicators is reflected in this section.

This section also presents a snapshot of the public health survey project implemented in 2008 by the Central Statistical Bureau (*European Health Interview Survey* - EHIS), within the framework of which more than six thousand young people aged 15 and over were surveyed, and the study included some questions about drug use.

Prevention

As in previous years, even now activities in the drugs field are integrated into broader health improvement programs and strategies, basically emphasising the provision of information. The activities are campaign-like in nature, but some individual institutions which utilise a public health prevention approach emphasise the vulnerability of their youth target audience. No system has been set up in the country to monitor the performance of prevention activities. Thus, the activities are carried out in a decentralized manner, that is, each municipal authority is working to its own capacity and funding, and with more emphasis on preventing the use of legal addictive substances.

In conditions of limited state and local government funding, it is not possible to carry out indicative prevention and this aspect has been neglected for several consecutive years. Development in this area would require professional, independent and systematic work, as well as stable and secure funding.

In Latvian regional areas and cities, selective prevention is carried out relatively slowly, however, a little progress has been observed, particularly with regard to undertaking prevention activities in the public environment.

Problem Drug Use

In Latvia the most recent estimates of PDUs by applying four source capture recapture models were carried out in collaboration with Dr. Gordon Hay (Glasgow University). Within the consultancy project a large number of data sources was analyzed and serious problems in

fitting log-linear models were experienced. Nevertheless, by excluding some of the data sources and splitting the sample in subgroups by gender and age groups consistent estimates were provided. The researchers were not successful in obtaining estimates for the whole country but rather for a subgroup of drug users (those using heroin) living in capital city Riga.

The estimated number of heroin users (5,912; 95% CI 3913–10164) in Riga can be extrapolated to all drug users in Riga or Latvia. Based on the estimated number of heroin users, Hay assessed there could be approximately 9,000 heroin and/or amphetamine users in Riga, while extrapolating furthermore there could be 18,000 opiate and/or amphetamine users in Latvia of which around 12,000 would be heroin users.

Drug-related treatment: treatment demand and treatment availability

In 2009 there were 435 (or 19.3 per 100 000 inhabitants) newly registered patients with a diagnosis related to drug use, of which 254 cases (11.3 per 100 000 inhabitants) were diagnosed with a dependency syndrome or a psychosis-related diagnosis.

In late 2009 the registered incidence of psychoactive substance dependence or psychosis (excluding alcohol and tobacco) in Latvia was 3468, or 153.8 per 100 000 inhabitants. In comparison with 2008, morbidity had decreased by 37%, while the incidence had increased by 7%

A methadone program was launched in 2009 outside of Riga at Jelgava, and in 2010, methadone programs also commenced in Liepaja, Jurmala, Olaine, Salaspils, Daugavpils, Kuldiga, Rezekne, and Tukums.

As at 31 December 2009 there were 109 patients being treated under a program administered by the Riga Centre of Psychiatry and Addiction Disorders, while 25 patients were being treated in Jelgava, and 5 in Liepaja. In 2009, 61 patients enrolled in the methadone program for the first time in their lives (54 men and 7 women), while 39 patients discontinued treatment.

Health correlates and consequences

As at 31 December 2009, 4614 cases of HIV infection (204 per 100 000 population) were registered nationally (4339 in 2008), of which 826 persons were diagnosed with AIDS. Overall, 275 new cases of HIV infection were registered nationally last year, which is approximately 23% less than in 2008 (n=358) and 2007 (n = 350). In 2009, 26.9% (n=74) of new HIV cases were acquired through injecting drug use.

In 2009 there were 123 cases of acute viral hepatitis B recorded (140 in 2008). Of these, 33 cases or 26.8% were acquired via IDU. Chronic hepatitis B was identified in 73 persons, of which 3 cases were acquired by the sharing of injecting drug paraphernalia.

According to General Mortality Register data, in 2009 there were 19 deaths registered as drug induced deaths. The number is slightly lower with that reported for 2008 (24 cases) and 2007 (20 cases). It is difficult to assess trends in drug induced mortality because of low number of deaths recorded annually and decreasing number of autopsies since 2007. According to data of the Special Mortality Register, in 2009 43 deaths were recorded as Selection D cases.

Responses to health correlates and consequences

Programs for the pharmacological treatment of opioid-dependent patients have an important role in preventing drug overdose. Substantial changes in regulatory documents were adopted by Latvia in 2008, which provide opportunities for expanding the methadone program.

Similarly, a significant role in reducing overdose is performed by syringe exchange advisory points, at which staff members inform users about safe use and appropriate action if an overdose is suspected.

In 2009 there were 18 HIV prevention points operating in 16 cities. Each of these points offers a wide range of services and in each individual city is adapted to suit client needs: syringe exchanges, street (outreach) work, voluntary HIV counselling and testing, provision of

disinfectants, information, education and counselling on various health, psychological and social issues.

In 2009, the HIV prevention network issued 282,701 syringes and collected 242,555 used syringes. It also conducted 1238 HIV tests (of which 109 tests or 8.8% were positive) and 129 tests for viral hepatitis C (of which of which 69 or 35.9% were positive).

Social correlates and social reintegration

The issue of social exclusion of drug users has not been widely studied, and therefore the Report only analyzes the general social conditions of dependent persons. The National Report utilises two sources: the treatment indicator, namely data provided by first-time treated patients, and the research results from the fourth stage of the annual cohort study of problematic drug users. Although both data sources are not exhaustive, it is possible to draw the major conclusions characterising the risks of social exclusion for drug users.

The majority of social reintegration cases are associated with social rehabilitation. Although programmes and measures have been developed in Latvia for the integration of individual groups into society, there is no specific program for the reintegration of drug users. It is possible to discuss individual projects and measures in general, but not regarding a nationally devised system which, by a reintegration process for addicts, would address issues such as place of abode, employment and education.

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

In 2009 there were a total of 4506 drug related offences reported. With regard to drug law offences 27.4 % were methamphetamine related offences, followed by 24.37% for cannabis and 22.9 % for heroin related offences.

As at 1 January 2010 there were 7055 prisoners in places of incarceration, 2.35% more than on 1 January 2009. There were 881 drug users identified i.e. 12.5% of all prisoners. In 2009 there were 1653 cases of drug dependence identified in prisons

The level of drug use and the substances used in prisons are also indicated by recent data from drug testing conducted in detention centres. From examination of the substances detected during the 2009 testing, it may be concluded that the most frequently detected substances were amphetamines (56% of cases), benzodiazepines (46%), opioids (35%) and cannabinoids (31%), while slightly less frequent were barbiturates (9%).

Prisoners who tested positive for the presence of drugs in the body most often (62.9%) tested positive for a single substance; 20.2% tested positive for two substances; 9.1% for three substances, while four or more substances were detected in 7.9% of cases.

Drug Markets

According to information provided by the State Police, a total of 1265 drug seizures were registered in 2009, 134 cases less than in 2008. In most cases (1143), drugs were seized by the State Police, while the SRS Customs Service registered 122 drug seizures in 2009. Compared with the previous year there was an increase in the number of seizures by the Customs Service, but a decrease in the performance indicators for the State Police. The drop in the number of State Police seizures can largely be attributed to the economic situation in the country and reforms in police structures

Available data for 2005 - 2009 show that the average drug purity has changed to around 20%. In general, the maximum purity of substances, compared to 2008, has decreased for ecstasy, amphetamines and cocaine.

History, methods and implementation of national treatment guidelines

The development history of the Latvian clinical guidelines is not ancient. The Latvian Addiction Disorders Specialists' Association working group of specialists developed the first *Guidelines for the Treatment of Drug-Dependent Patients* in 2005. A second set of guidelines: *Guidelines for the Treatment of Misuse and Dependence on Sedative and Sleep Medications* was developed a

year later, in 2006. However, the *Long-Term Pharmacotherapy of Opioid-Dependent Patients using Methadone and Buprenorphine* was developed in 2009. All the guidelines have been developed by the Latvian Addiction Disorders Specialists' Association working group of specialists.

Analysed within the framework of this section, based on a methodology developed by the EMCDDA, are the existing Latvian drug treatment guidelines, their historical development, their development and implementation process; and a comparison is made between the Latvian guidelines for long-term pharmacotherapy of opioid dependent patients with the pharmacotherapy guidelines developed by the WHO. Similarly, as part of the review process for the guidelines, seven interviews were conducted with experts in the field who have participated in the development process for the existing guidelines or are responsible for their approval and implementation.

Mortality related to drug use: a comprehensive approach and public health implication

This Selected Issue looks at mortality among drug users in Latvia, which can be direct (e.g. overdoses) or indirect (e.g. HIV/AIDS). This chapter includes data from several sources – available statistical data, data from retrospective cohort studies and published and unpublished information available in Latvia on this topic.

According to available statistical data in the period of 1999–2009, there have been 265 drug-related deaths in Latvia. Majority of these deaths (145) have been registered between 1999 and 2002, while since 2003 the mortality has remained at relatively low level, i.e. 12 to 24 annually registered cases. A number of deaths three times higher between 1999 and 2002 as compared with that recorded in after 2003 is related with differences in national definition used. By taking into account relatively small numbers of died persons it is diffult to come to reasonable conclusions on drug-related mortality trends in Latvia, e.g. if a decrease of five deaths in 2009 as compared with 2008 represents actual situation.

Part A: New Developments and Trends

1. Drug policy: legislation, strategies and economic analysis

1.1. Legal framework

During 2009, several significant changes were made to Latvian legislation, including new psychoactive substances being made subject to control, thanks to active cooperation between the Centre of Health Economics, the Ministry of Health and the Ministry of Interior. That step led to the withdrawal from entrenched sale of various smoking mixture products from both local Internet web sites and stores (kiosks), the number of which had increased noticeably since late 2008. During the past year, several other important normative enactments were adopted and came into force.

Cabinet Regulations and amendments to Regulations issued in 2009

During 2009, two amendments were made to Cabinet Regulation No.847 of 8 November 2005: *Regulations regarding Narcotic Substances, Psychotropic Substances and Precursors to be Controlled in Latvia*[1], supplementing Schedule I by the addition of Item 7 – "Substances and plants, whose illicit sale and misuse can threaten health." The list was supplemented with the following new substances and plants: 1-Benzylpiperazine (BZP), Catha edulis, 2,5-2,5-dimethoxy-4-bromophenethylamine (2C-B), 2,5-dimethoxy-4-ethylthiophenethylamine (2C-T-2), 2,5-dimethoxy-4-iodophenethylamine (2C-I), 2,5-dimethoxy-4-(n) propylthiophenethylamine (2C-T-7), Hydroxymitragynine, 1-(3-chlorophenyl) piperazine (mCPP), 1-(4-chlorophenyl) piperazine (pCPP), 1-(3,4-methylenedioxybenzyl) piperazine (MDBP), 1-(4-methoxyphenyl) piperazine (MeOPP), mitragynine, mitragyna speciosa (kratom), Salvia divinorum, Salvinorin- A, 1-(3-trifluormetilfenil) Piperazine (TFMPP) and 2,4,5-trimethoxyamphetamine (TMA-2). These amendments came in to force on 16 May 2009[2]. A second amendment took effect on November 28[3], supplementing Schedule I with several synthetic cannabinoids - HU-210, JWH-018, JWH-073, JWH-250 JWH-398, CP 47,497, and three of its homologues C6, C8, C9, as well as two plants - Leonotis leonurus and Nymphaea caerulea.

On 25 May 2009, the Cabinet of Ministers adopted Regulation No. 966: *Amendments to Regulation No. 726 of 16 December 2003: "Procedures for the Mandatory Medical Treatment of Children Having Mental Dysfunction or Behavioural Disorders Due to the Use of Alcoholic Beverages, Narcotic, Toxic or Other Intoxicating Substances and Procedures for the Provision of Mandatory Medical Treatment for Addiction to Alcohol, Narcotic and Psychotropic Substances at Social Correctional Education Institutions"*[4] to align it with the amendments of 29 June 2008 to the Protection of the Rights of the Child Law Section 48, Paragraph five, and Section 49, Paragraph three, which stipulate that if a child or his parents do not consent to mandatory treatment, it may be undertaken if approval has been received from the Orphans Court nearest the child's place of residence as well as in coordination with municipal administrative territorial reform. The Regulation came into force on 29 August 2009.

On 22 December 2009 the Cabinet of Ministers adopted Regulation No.1636: *Amendments to Cabinet Regulation No.15 of 11 January 2005: "Procedures for the Determination of Alcohol Concentration in the Blood and Exhaled Air and the Detection of the Influence of Narcotic and*

[1] 2005.gada 8. novembra Ministru kabineta noteikumi Nr. 847 „Noteikumi par Latvijā kontrolējamajām narkotiskajām vielām, psihotropajām vielām un prekursoriem"

[2] 2009.gada 12, maija Ministru kabineta noteikumi Nr.428 „Grozījumi Ministru kabineta 2005.gada 8.novembra noteikumos Nr.847 "Noteikumi par Latvijā kontrolējamajām narkotiskajām vielām, psihotropajām vielām un prekursoriem""

[3] 2009.gada 3. novembra Ministru kabineta noteikumi Nr. 1297 „Grozījumi Ministru kabineta 2005.gada 8.novembra noteikumos Nr.847 "Noteikumi par Latvijā kontrolējamajām narkotiskajām vielām, psihotropajām vielām un prekursoriem""

[4] 2009.gada 25. augusta Ministru kabineta noteikumi Nr. 966 „Grozījumi Ministru kabineta 2003.gada 16.decembra noteikumos Nr.726 "Kārtība, kādā veicama obligātā ārstēšana bērniem, kuriem radušies psihiski vai uzvedības traucējumi alkoholisko dzērienu, narkotisko, psihotropo vai citu apreibinošu vielu lietošanas dēļ, un kārtība, kādā sociālās korekcijas izglītības iestādēs bērniem nodrošināma obligātā ārstēšana no alkohola, narkotisko un psihotropo vielu atkarības""

Other Intoxicating Substances"[5] which provides the option that, when necessary, a medical practitioner may detect the effect of intoxicating substances (intoxication) clinically, if the use of intoxicating substances cannot be confirmed by laboratory testing. The Regulation came into force on 30 December 2009.

During the same period, the Cabinet of Ministers adopted Regulation No.1588: *Amendments to Cabinet Regulation No.394 of 2 June 2008: "Procedure for detecting the influence of alcohol, drugs, or toxic substances"*[6], which came into force on 30 December 2009. The new Regulation clarifies that a chemical toxicological examination shall be conducted by certified court experts; that if necessary a medical practitioner may detect intoxication (influence) clinically if the use of intoxicating substances cannot be confirmed by laboratory testing, or if the person being tested refuses a medical examination or attempts to take actions that could affect the results of the medical examination.

On 24 November 2009, the Cabinet of Ministers adopted Regulation No.1338: *Procedures to Ensure the Safety of Students in Educational Institutions and Activities Organized by Them*[7], which came into force on 28 November. The Regulation was adopted to improve the existing legal framework relating to the safety of children in educational institutions, sporting competitions and activities, excursions, hikes, walks and other events organized by educational institutions. The Regulation provides that an educational institution's internal rules should stipulate prohibitions on the acquisition, use, storage and sale of alcohol, cigarettes, drugs, toxic or psychotropic substances, gas bottles, gas pistols and firearms in an educational institution and its territory; the rules should stipulate what a child's action should be in a case where the child perceives a threat to their own safety, or the safety of some other person, presented by the activities of a person from outside the educational institution, and should stipulate the action to be taken by a supervisor or teacher in a case where physical or emotional violence against a child is evident. The educational institution's internal rules should also stipulate culpability for non-compliance.

Laws and amendments to laws adopted in 2009

In accordance with the amendments to Cabinet Regulation No.847 of 8 November 2005: *Regulations regarding Narcotic Substances, Psychotropic Substances and Precursors to be Controlled in Latvia*, which came into force on 16 May 2009, amendments were also passed to the law *On the time and arrangements for coming into force of the Criminal Law*[8], supplementing Schedule I by the addition of certain substances and defining the amount of substance, less than which is deemed small, and the amount as from which a quantity is deemed large (see Table 1.1).

Coming into force on 7 April 2010 were amendments to the law *On Restrictions Regarding Sale, Advertising and Use of Tobacco Products*[9]. Clause 8 of the amendments was supplemented by prohibiting "[t]he sale of plant mixture products, the smoking, sniffing, chewing or inhalation of which can cause psychiatric disturbances in the user similar to those caused by psychoactive substances, and the use of which could be addictive."

[5] 2009.gada 22.decembra Ministru kabineta noteikumi Nr.1636 „Grozījumi Ministru kabineta 2005.gada 11.janvāra noteikumos Nr.15 "Kārtība, kādā nosakāma alkohola koncentrācija asinīs un izelpotajā gaisā un konstatējams narkotisko vai citu apreibinošo vielu iespaids""

[6] 2009.gada 22.decembra Ministru kabineta noteikumi Nr.1588 „Grozījumi Ministru kabineta 2008.gada 2.jūnija noteikumos Nr.394 "Alkohola, narkotisko, psihotropo vai toksisko vielu ietekmes pārbaudes kārtība""

[7] 2009.gada 24.novembra Ministru kabineta noteikumi Nr.1338 „Kārtība, kādā nodrošināma izglītojamo drošība izglītības iestādēs un to organizētajos pasākumos"

[8] 2009.gada 19.novembra likums „Grozījumi likumā "Par Krimināllikuma spēkā stāšanās un piemērošanas kārtību""

[9] 2010.gada 4.marta likums „Grozījumi likumā "Par tabakas izstrādājumu realizācijas, reklāmas un lietošanas ierobežošanu""

Table 1.1. The new controlled psychotropic substances, by defined quantities

	Quantity less than which is deemed to be small	Quantity above which is deemed to be large
BZP	0.02 g	1 kg
Catha edulis	100 g	10 kg
2C-B	0.02 g	2 kg
2-C-T-2	0.018 g	1.8 g
2C-I	0.018 g	1.8 g
2C-T-7	0.02 g	2g
mCPP	0.02 g	1 g
pCPP	0.02 g	1 g
MDBP	0.02 g	1 g
MeOPP	0.02 g	1 g
mitragynine	0.03 g	3 g
mitragyna speciosa (kratom)	1 g	100 g
Salvia divinorum	1 g	100 g
Salvinorin-A	0.002 g	0.2 g
TFMPP	0.02 g	1 g
TMA-2	0.03 g	1 g
7-Hydroxymitragynine	0.03 g	15 g

Source: The Criminal Law

1.2 National action plan, strategy, evaluation and coordination

National action plan and strategy

With Latvia's accession to the EU, Latvia also became politically bound by the European Union's policy-planning documents in the field of drugs and limiting the spread of addiction to them. Currently in force are the *EU Drugs Strategy 2005–2012* and its revised *Action Plan on Drugs 2009–2012*.

On 17 August 2005, the Cabinet of Ministers adopted the *National Drug Programme 2005–2008.* 2008 was the last year of operation for this program. In 2009, the National program was evaluated and a new national program was drafted.

On 13 October 2009 the Cabinet of Ministers issued Regulation No. 1178 *"Regulations for development of planning documents and impact assessment"*, which include several government innovations and constraints to be taken into account in drafting, implementing and evaluating new policy planning documents. This Regulation stipulates that a four-year planning cycle no longer exists in respect of policy planning documents. Instead, the choice must be made between short-term policy planning (action plan for 3 years) and medium-term policy planning (guidelines for 5-7 years). All policy-planning documents should be consistent with the *Latvian Strategical Development Plan 2010–2013*, and they must also be in accordance with the fiscal policy consolidation, functional optimisation and institutional restructuring.

Based on the above conditions, and also taking into account the results of the evaluation of the previous National Program, 2010 saw the completion of a new medium-term policy planning document National Drug Program for 2011–2017. The new program has to be approved by the Cabinet of Ministers in late 2010.

The new program is consistent not only with the *EU Drugs Strategy 2005–2012* and the *EU Action Plan on Drugs 2009–2012*, but also with several Latvian development planning documents, which are closely linked with reducing drug abuse and the prevalence of drugs. For example: the *National Programme for Limiting HIV and AIDS in Latvia 2009-2013*, the *National Youth Policy Programme 2009–2013*, the *National Programme for the Prevention, Combating*

and Reduction of Organised Crime 2006–2010, the *Program for Professional Social Work Development (2005–2011)*, and other documents.

The program aims to:

- Reduce the acceptance of illicit drug use by society;
- Reduce the harm caused to society by illegal drug use, by enhancing the accessibility and effectiveness of health-care services provided to drug users;
- Reduce the availability of illicit drugs.

In comparison with the previous National Program, changes have been made in the new program regarding policy responses, namely, that prevention of drug addiction is treated as a separate course of action. However, the compilation and analysis of information is combined with policy development and implementation coordination, thus forming a unified course of action. Consequently, the following four courses of action are defined in the new document:

- Prevention;
- Health care;
- Reducing availability;
- Policy coordination and analysis of information.

Each of these courses of action includes a range of tasks to be carried out during the Program's period of operation. The tasks are defined on the basis of results from the evaluation of the previous program.

Implementation and evaluation of national action plan and strategy

2008 year was the last operational year of the *National Drug Programme 2005–2008*. Consequently, the Drug Control and Drug Addiction Restriction Coordination Council (hereinafter "the Council"), in considering the question of future government policy and planning to reduce the prevalence of drug addiction and of illegal drugs, acknowledged that the next medium-term policy planning document in the field of reducing drug addiction and of illegal drugs must be based on a total and comprehensive State policy, including the evaluation of the National Drug Programme *2005–2008*. As a result, 2009 was a transition period during which the evaluation of the former Programme was undertaken and a new program was developed.

Based on a decision by the Council, evaluation of the National Drug Programme *2005–2008* was undertaken by the Ministry of Interior. Several sources of information were utilised in the evaluation, namely:

- information provided by the 29 public institutions and organizations having direct or joint responsibility for performance of the tasks stipulated in the State Programme;
- information held by the Secretariat of the Council;
- the results of several studies undertaken in the field of drug addiction while the Program was in operation;
- information systems and aggregated statistical indicators maintained by various institutions;
- a panel of experts' discussion on the results of implementing the State Programme.

It should be noted that information on performance of the National Drug Program's tasks was based directly on information provided by the institutions and organizations involved, which mostly reflected quantitative indicators, rather than the results of action taken and policy outcomes. Consequently, the National Drug Program's level of achievement of its aims was mainly characterized by the results of research into drug use prevalence in different groups in society and trends reflected in statistical indicators, which characterize the areas of drug supply and demand throughout the country during the Program's operation *(Ministry of Interior Informative Report, 2009)*.

The final evaluation of the National Program and its results were taken into account in drafting the new Program for 2011-2017and for defining tasks and achievable results.

Coordination arrangements

The Council is the coordinating State body whose primary role is to coordinate the operations of government agencies, municipalities and non-governmental organizations in controlling the legal movement of drugs and precursors, and in preventing and restricting their illegal circulation, and addiction to drugs. The Council is also responsible for development, implementation and evaluation of the National Drug Programme 2005–2008. Council sittings are convened between two and four times a year.

1.3 Economic analysis

Public expenditures

In Latvia, data availability on labelled drug-related budget expenditures is very limited and fragmented. Drug-related programmes are implemented at different government levels, which make data systematisation a challenging task. In addition, drug-related expenditures often are part of broad-aimed expenditure programmes, which makes it problematic to isolate the expenditures related to drug use problem. Evaluation of the *Latvian National Drug Programme 2005–2008*, performed by the Ministry of Interior in 2009, represents a valuable source of information on drug-related budget expenditures, however, it has a number of limitations: first, the evaluation report covers only national level financing, whereas data on local government financing is not included (*Ministry of Interior, 2009*). Second, the report does not cover costs in all relevant categories, e.g., costs of inpatient medical services. Third, some drug-related expenditures are aggregated with expenditures on other types of dependencies – alcohol, smoking and other. To summarise the above considerations, more effort should be put to structure the drug-related budget costs and to make the expenditures more transparent at all government levels.

Social costs

In 2009, the study on budget and non-budget social costs of drug abuse in Latvia was carried out (*BICEPS, 2010*)[10]. The aim of this study was to provide an estimate of the social costs of illegal drug use in Latvia for 2008. International practice e.g. as outlined in the International Guidelines for Estimating the Costs of Substance Abuse, produced by the World Health Organization (*Single et al. 2003*) divides costs according to several criteria: tangible/intangible; health and welfare/productivity and output loss; law enforcement and criminal justice costs. In this study, there are two basic distinctions: budget cost and non-budget costs. Budget costs are further subdivided into direct budgetary costs and indirect ones. By definition budget costs are *tangible* costs i.e. resources used directly or indirectly in connection with drug abuse that could have been used for something else i.e. consumption or investment. Non-budget costs however may be tangible or intangible, where *intangible* means something that cannot be transferred e.g. the reduction of pain and suffering that lower use of drugs might generate cannot be translated into resources available to society for other uses.

The report is divided into two parts: the first part deals with budget costs and the second part with non-budget costs. For budget costs, the estimates based on Latvian data for almost all the relevant components but for non-budget costs, this is the case only for the loss of output resulting from a lower employment rate of drug users, from premature death and from incarceration. For other components such as the loss of output from unpaid work or the losses from absenteeism, researchers made guesstimates based on results from Australia reported by Collins and Lapsley (2008).

[10] Report in ENG is available online: http://www.vec.gov.lv/docs/new2010/Budget_and_Social_costs_of_drug_abuse_FINAL_26_03_2010.pdf

Main results

Estimated social costs (budget plus non-budget costs) of drug abuse in Latvia in 2008 amounted to 68–72 mln LVL or approximately 0.4% of GDP. Budget costs amounted to 6.5–10.6 mln LVL or approximately 10–14% of total social costs, of which direct costs of drug abuse – to about 2%. Remaining budget costs can be classified as indirect costs of drug abuse, i.e., these costs represent a fraction of spending on the government functions that would be financed irrespective of drug abuse situation, for example, health care, state police, etc.

When classified by COFOG, expenditures on public order and safety and expenditures on health represent two biggest groups of drug-related budget expenditures (59% and 25% of all drug-related budget expenditures, respectively, if investment expenditures are included). Law enforcement (71 – 70%) and harm reduction (24 – 18%) are the biggest expenditure categories, when Reuters classification is used for categorisation of expenditures. Structure of Latvian budget expenditures was found to be quite similar to the structure in other European countries for which similar estimations were made. The level of financing, however (0.07-0.04% of GNP or 0.17-0.10% of total general government expenditures) is considerably below that in other countries. The financing gap is even larger if one compares spending per problem drug user, which in 2008 in Latvia amounted to 382 – 764 EUR, while in, e.g., Czech Republic in 2006, spending was higher by approximately a factor of 10. Cross-country comparison of drug-related spending should be made with caution due to lack of a standardised methodology. However, such a notable gap in estimated financing allows concluding with a great degree of certainty that drug-related budget spending in Latvia is far below that in other European countries

Total non-budget costs of drug abuse in 2008 are estimated at 61.5 mln LVL or 0.38% of GDP. The estimated non-budget costs are mainly generated by employment losses, caused by the drug abuse. First, Latvian problem drug users are observed to be characterised by a considerably lower employment rate than general population in the same age group. Second, lower employment is caused by premature deaths of drug users, both directly related to drug use and related to concurrent infectious deceases. Another source of lower employment is represented by incarcerated persons convicted of drug-related crimes. Total losses stemming from lower employment are estimated at about 30 mln LVL, of which the biggest costs (23.4 mln LVL) are attributable to lower employment rate among drug users.

Apart from employment channel, other sources of non-budget costs of drug abuse include lost household output because of morbidity and mortality of non-workforce drug users, as well as increased absenteeism and reduced on-the-job productivity of drug users. Due to lack of national data it was impossible to base the estimate of the above two categories of costs solely on national data; thus the estimations were partially based on research results for other countries. Total non-employment costs of drug abuse in Latvia are estimated at about 32 mln LVL, of which a larger share (about 60%) was accounted for by increased absenteeism and reduced on-the-job-productivity.

Similar to cross-country comparison of budget costs, comparison of non-budget costs have to be made with great caution due to differences in underlying methodologies. However, comparison of some categories of non-budget costs to available results for Australia (*Collins and Lapsley, 2008*) suggests that, e.g., costs generated by lower employment as a share in GDP in Latvia exceeds that in Australia. To conclude, our results for 2008 suggest that non-budget economic burden of drug abuse in Latvia is likely to be higher than in some other countries, while the level of drug-related budget expenditures is considerably below that in other countries.

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

Drug use prevalence indicators, as well as the availability of drugs and people's attitudes about drug policy issues are widely considered in the 2008 National Report, as well as in the Study Report. Therefore, only a brief summary of illicit drug use prevalence indicators is reflected in this section.

This section presents a snapshot of the public health survey project implemented in 2008 by the Central Statistical Bureau (European Health Interview Survey – EHIS), under which more than six thousand young people aged 15 and over were surveyed and the study included some questions about drug use.

Preparations began in 2010 for the fifth phase of the *European School Survey Project on Alcohol and Other Drugs* (ESPAD) and the Latvian study to be launched under its auspices (LaSPAD) in 2011, within which it is planned to survey more than 10 thousand students in grades 7–12, which will provide an insight to policy makers, prevention specialists and other specialists on the prevalence of legal and illegal drugs, and its changes since the last nation-wide representative study of students in 2007.

Several of the measurements for prevalence of drug use and availability in the guidelines developed in 2010 included in the ESPAD study were included as policy performance indicators that will allow evaluation of tasks performed under the guidelines between 2011–2016.

It is planned to undertake the third stage of the study among students in Riga during the autumn semester of 2010 as part of the *European Cities Against Drugs* initiative. The aim of the study is to obtain data on the prevalence of drug use and risk and protective factors in using or trying drugs. This study of 9–10 grade students in Riga was undertaken in 2006 and 2008[11] and its results are used in the planning of prevention services and the evaluation of results in the city of Riga.

2.1. Drug Use in the general population

In Latvia until now two general population surveys aimed specifically at assessing illegal drug use among 15–64–year-old population have been carried out. The first study was conducted in 2003, while the second one – in 2007. The sample sizes for the survey were 4,534 and 4,500, respectively. Both surveys followed similar methodology and sampling thus are comparable in terms of comparison between cross-sectional surveys (*Koroleva et al. 2003 and Koroleva, Goldmanis et al. 2008)*. Data from both studies were reported in 2008 via EMCDDA Standard Tables and are available in Fonte[12].

Prevalence rates of any illegal drug use[13] by major age groups and gender are shown below *(see Table 2.1 and Figure 2.1)*.

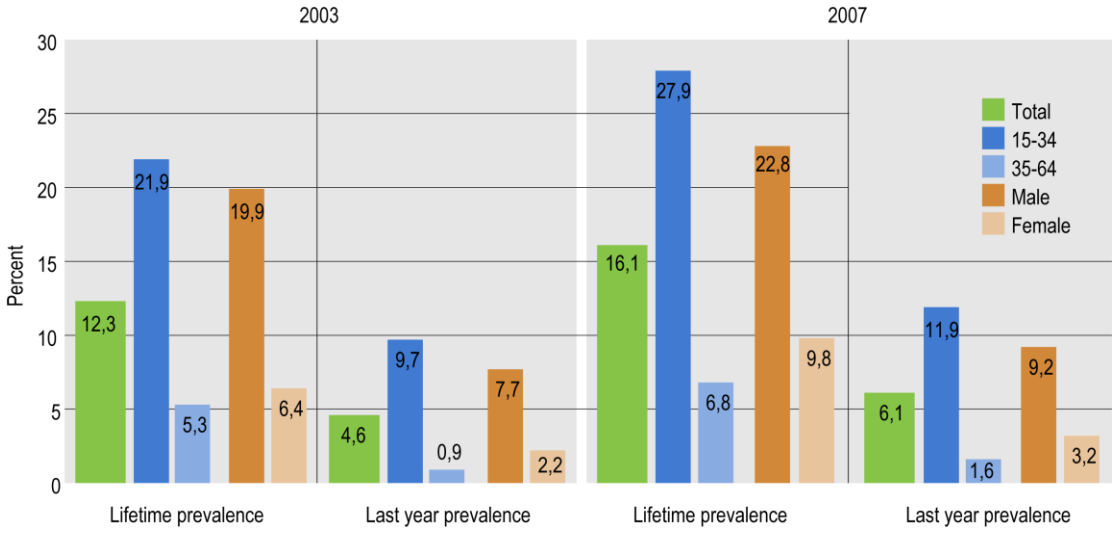
[11] The 2008 study was also undertaken in Jurmala and Cesis.
[12] ST1_2008_LV_01; ST1_2003_LV_01
[13] Cannabis, ecstasy (MDMA), amphetamines, cocaine, heroin and/or other opioids, LSD and/or other hallucinogens

Table 2.1. Lifetime prevalence of various illegal substances by age and gender in 2007, %

	15–64			15–34			35–64		
	M	F	T	M	F	T	M	F	T
Any illegal substances	22.8	9.8	16.1	37.5	18.1	27.9	10.3	3.8	6.8
Any illegal substances except cannabis	13.2	4.9	9.0	21.7	8.6	15.2	6.0	2.3	4.0
Cannabis	17.2	7.3	12.1	28.9	14.3	21.7	7.2	2.2	4.6
Ecstasy	7.2	2.3	4.7	12.3	4.6	8.5	2.9	0.6	1.7
Amphetamines	5.4	1.3	3.3	9.2	2.9	6.1	2.2	0.1	1.1
Cocaine	3.1	1.5	2.3	5.4	2.5	4.0	1.2	0.7	0.9
Heroin	0.8	0.3	0.5	1.5	0.4	1.0	0.2	0.2	0.2
Other opioids	4.7	1.1	2.9	5.7	1.6	3.7	3.9	0.8	2.2
LSD	2.1	0.8	1.4	3.6	1.0	2.3	0.8	0.6	0.7
Other hallucinogens	2.6	0.9	1.7	4.4	1.2	2.8	1.0	0.6	0.8

Source: Koroleva, Goldmanis et al. 2008

Figure 2.1. Lifetime (LTP) and last year (LYP) prevalence of any illegal drugs in 2003 and 2007 general population surveys, %



Source: Koroleva et al. 2003; Koroleva, Goldmanis et al. 2008

Latvian Health Interview Survey (LV EHIS)

In 2008, the Central Statistical Bureau (CSB), engaging in the European Health Interview Survey project (EHIS), conducted a health survey of the Latvian population. The survey methodology was developed on the basis of documentation prepared by Eurostat and based on a common European questionnaire. The data from the study are generalized to all Latvian residents who are older than 15 years. The survey was targeted at persons aged 15 years and older living in private households in the territory of Latvia. The survey does not include persons living in retirement homes, homes for people with disabilities, student dormitories, other collective accommodation establishments, or those in custody or serving a sentence in prison. Survey interviews were conducted between September–December 2008, and the information-gathering method used was to interview respondents in person. A paper questionnaire was also used during the study, as well as computer-based interviews. A gross sample was designed as a two-stage stratified random selection; gross sample size was 9,946, while the non-response rate was 29% (*Central Statistical Bureau, 2010*).

The survey included four questions to indicate the use of illicit drugs: two questions regarding personal acquaintance with drug users, and two questions regarding the incidence of drug use during the past year:

- Do you personally know people who use marijuana?

- During the past 12 months, have you used marijuana?
- Do you personally know people who use other drugs such as cocaine, amphetamines, ecstasy?
- During the past 12 months, have you used other drugs such as cocaine, amphetamines, ecstasy?

According to survey data, 1.5% of the Latvian population aged 15 years and older had used marijuana during the past 12 months. The ratio of men who had used cannabis during the past 12 months is higher than observed among women – 2.4% and 0.8%, respectively. The study found that the proportion using other drugs such as cocaine, amphetamines, ecstasy etc. was 0.5% (Central Statistical Bureau, 2010). By comparison: in the 2007 drug use study undertaken in accordance with the standards recommended by the EMCDDA, cannabis had been used during the last 12 months by 4.7% of 15–64–year-olds (7.3% men and 2.6% women) (*Koroleva et al. 2008*).

The data obtained as part of the health study of Latvian population indicate that marijuana (and hashish) use in the past year was significantly lower than in the results of the 2007 study into drug prevalence. It is believes that although including the issue of drugs into the health surveys is much cheaper than carrying out studies dedicated exclusively to this issue, the study context must be nevertheless taken into account, along with the time spent on drug issues, their priority among other health determinants, and that the need to ensure confidentiality and other circumstances can significantly affect the results of such sensitive issues as drug use. Consequently, although the study is undoubtedly representative, it is difficult to judge the extent to which the health survey results have been affected by the above considerations.

3. Prevention

In view of the circumstances of the Latvian financial crisis, national structural reforms were undertaken in 2009, which affected prevention activities, namely, the state authorities responsible for health promotion and prevention program development and implementation, including the area of drugs, were reorganised. Similarly, reorganization was undertaken in the only municipal government addiction prevention centre in Riga. Such fundamental changes affected both the extent of preventive measures, and their quality.

As in previous years, even now activities in the drugs field are integrated into broader health improvement programs and strategies, basically emphasising the provision of information. The activities are campaign-like in nature, but some individual institutions which utilise a public health prevention approach emphasise the vulnerability of their youthful target audience. No system has been set up in the country to monitor the carrying out of prevention activities. Thus, the activities are carried out in a decentralized manner, that is, each municipal authority is working to its own capacity and funding, and with more emphasis on preventing the use of legal addictive substances. There are no established national guidelines (standards, quality criteria) and the programs are not accredited. Only in rare cases is any assessment made of the effectiveness of preventive interventions, mainly because of lack of funding and capacity.

In conditions of limited state and local government funding, it is not possible to carry out indicative prevention and this aspect has been neglected for several consecutive years. Development in this area would require professional, independent and systematic work, as well as stable and secure funding.

In Latvian regional areas and cities, selective prevention is carried out relatively slowly; however, a little progress has been observed, particularly with regard to undertaking prevention activities in the public environment.

3.1. Universal prevention

One of the sub-objectives of the drug control program *National Drug Programme 2005–2008* proposed to "Ensure the development of a long term prevention program, for use in different target groups and its continuous operation, coordination, funding, and the allocation of implementation tasks within this program". Similar objectives were also proposed in the planned program to limit and control dependency on drugs and their distribution action plan for 2009.

Since 2005, an integrated subject "Social Sciences" (for grades 1-9) has been introduced into the school curriculum in primary schools, replacing the current fragmented and limited acquisition of social science subjects. Health education issues are also included in the course content of this social science subject. Individual health issues are included in the course content of several primary education and general secondary education subjects. In addition, the knowledge and skills of health topics related to life and old age are reinforced in subject classes, as well as class home group lessons and thematic activities, thus implementing universal prevention.

Since 2008 the Ministry of Education has gradually begun to introduce the new general secondary education standards, where health issues are arranged into one of six areas: "Sport and Health". Changes have been introduced into the standard for the subject "Health Education" (70-hour program). They relate to the aim and tasks, and content, which is based on health psychology theories on the factors that influence individual decisions about behaviour that affects their health (using planned conscious behaviours, theoretical models for health beliefs). There is more emphasis in the tasks on the acquisition of generic skills or life skills, as well as reinforcement of healthy everyday habits. The secondary school course does not offer instruction, but offers the opportunity of arriving at reasoned conclusions by actively engaging in the learning process. Unlike the simple explanation of a healthy lifestyle in primary school, the secondary school health education course pays more attention to the personal decision-making

process and preconditions, as well as the influence of the social environment on decision-making and implementation.

Most of the activities in the area of drugs that have taken place in schools outside the school programs, have been discussions, lectures in class home group periods, participation by a variety of professionals: physicians, police officers, NGO representatives, and health promoters. In some regional municipalities discussions have been augmented with video screenings, information placed on school websites, drawing competitions, lectures for parents, activities in Project Week and other activities that form an informative educational activity package with a specific objective and quantitative outcome indicators. Also involved in universal prevention in schools are the state and municipal police, for example, the Riga Municipal Police Juvenile Crime Prevention Unit. To inform pupils about the regulatory framework governing the use of addictive substances, the police unit has created several short educational films: "Choose your Path Correctly", "Fifteenth Birthday", etc. In addition, the police provide a safe environment by patrolling the school area, particularly in the major city schools.

In Riga and Latvian country schools, informative lecture cycles were given for parents on recognizing drug use and the strengthening of mutual relationships within the family. They were held within the framework of universal school-based intervention and can not be classed as a structured program of family-based intervention. Attempts to create a structured program of family intervention (not a risk group for parents) have been unsuccessful in Riga due to lack of parental motivation.

The *Children's Rights Protection Law* prohibits children smoking, consuming alcoholic beverages, and using drugs. Practically all educational institutions have developed internal rules, which reinforce these prohibitions. The *Law on Handling of Alcoholic Beverages* prohibits the retail sale of alcoholic drinks in educational institutions and on their territory. The *Law on Restrictions of Tobacco Product Sale, Advertising and Use* prohibits the sale of tobacco and herbal smoking products in educational institutions.

In order to improve prevention and coordination in relation to drug and alcohol abuse in educational institutions, in 2010 the Cabinet of Ministers adopted Regulation No. 277 *"Procedures for providing preventive health care and first aid in educational institutions."* These include the requirement for educational institutions to establish procedures to be followed in cases where the consumption, possession or distribution of alcoholic beverages, narcotics, psychotropic or other intoxicating substances, has occurred among students.

A major role in the further implementation of prevention in schools is the knowledge, skills and interactive abilities of teachers in addressing addiction prevention issues. To increase the knowledge and improve the skills and abilities of teaching staff, in 2009 the Ministry of Education held regular seminars and published methodic teaching materials. At the municipal level educational seminars were organized in the districts, involving NGOs competent in training and specialists from government institutions.

A peer educational approach is being implemented in several Latvian cities, thereby increasing the knowledge and skills of the target audience to help people take charge of their health and choose a drug-free lifestyle. The Riga City Council Welfare Department Public Health Promotion and Prevention Unit, which, after the reorganisation of the Riga Addiction Prevention Centre (from 1 July 2009) has taken over the functions of the reorganised institution, is undertaking the training of young leaders in accordance with established programs.

Alternative extracurricular activities popular in Latvia (such as sports, choir, drama society, dancing, etc.) are organized at school and serve as elements of addiction prevention. Alternative community-based leisure facilities are provided by municipal authorities, such as youth centres, youth clubs, sports, music and art schools. Development of opportunities for alternative leisure activity opportunities is stipulated in the policy planning documents in the Youth Law and the program "A Latvia suitable for children".

Community Based Prevention is based on plans developed by local governments to limit the prevalence of drugs. Analysing the results[14] of municipal surveys it may be concluded that the programs are for the most part designed by permanent steering groups in the major city municipalities, involving experts in education, health, social assistance, and from the state or local police and NGOs. The groups are led by representatives from the municipal administration, but overall coordination is undertaken by permanent multi-disciplinary teams[15].

3.2. Selective prevention in at-risks groups and settings

The *National Drug Programme 2005–2008* mainly emphasized the importance of universal prevention, while the new guidelines for restricting the addiction to and prevalence of drugs and psychotropic substances for 2010-2016 set out activities for selective prevention interventions in working with social work correctional institutions, children's homes and students at boarding schools. The problems in creating alternative leisure initiatives for risk groups are addressed in the “Programme for prevention of juvenile crime and the protection of children against criminal offending 2009-2011".

Selective prevention in schools

Selective prevention in schools is working individually with students who miss school and who live in adverse family conditions. Traditionally this work is undertaken by social pedagogues and psychologists. In practical terms, this work is carried out in most Latvian schools. Individual measures are undertaken by the social services.

Selective prevention in municipalities

A permanent psychosocial adjustment program is being implemented in Riga, designed for at-risk adolescents who are prone to violating rules of conduct. The program includes assertiveness training, the establishment of motivation and objectives, adjustment of behavioural myths, and special anger management programs for aggressive adolescents. For the most part selective prevention in rural districts and cities is addressed via the social services network, by organising individual counselling for at-risk individuals. In some municipalities special bodies or centres have been established to address these issues.

One type of selective prevention utilised in municipalities (public environmental control) is checking of youth gatherings and entertainment venues, including gaming halls, and internet cafes, to detect the presence of minors being out late at night, smoking or being intoxicated in a public place. These raids are conducted by non-governmental organizations, sometimes in cooperation with the municipal police, reinforcing the control on 1 September when school starts, or on Fridays, etc.

Selective approach to working with parents

Selective approach to working with parents (outside school) is common in only a few cities such as Riga, where the group "Parents for Children" operates, which is designed for parents who need to improve relations within the family, or when a child's behaviour indicates a change in attitude, use of substances or processes (computer, mobile phone, etc.) and other problems. The group's session structure consists of both educational content and interactive lessons. The sessions give parents the chance to see from outside situations associated with the child which may be difficult to resolve, thereby revealing a variety of means of resolving disputes and difficulties, and identifying their options in resolving them.

[14] Information on specific activities, according to the levels of prevention implemented (universal, selective, indicative), are provided firstly, from information provided by national authorities, directly or indirectly involved in prevention, secondly, from NGO reports, and thirdly, the information published in mass media and informative websites. To obtain more information on preventive measures implemented by district municipalities, questionnaires were sent to municipalities in 109 districts and nine major cities. At the end of the survey 32 replies to the questionnaire were received.

[15] For more information on universal prevention measures implemented in Latvia, see SQ25_2010_LV_01

Selective approach in working with visitors to entertainment venues

Based on the results of drug use in recreational settings (*Koroleva, Kārkliņa et.al. 2007*), recommendations were drafted in 2008: "Recommendations for the creation of a safe drug free environment at entertainment venues." The main aim of these recommendations is to restrict the bringing in, distribution and use of drugs in entertainment venues (clubs, festivals), to create a safe environment and to reduce psychoactive substance-related disorders and the risk of accidents for all visitors at entertainment venues. These recommendations were taken into account in designing new guidelines for restricting the addiction to and prevalence of drugs and psychotropic substances for 2010-2016, in which it is planned to continue the regular police raids carried out in entertainment venues (festivals), and it is also planned to implement the project "Drug-free club", while at the same time assessing[16] the effectiveness of the project.

3.3. Indicative prevention

Given the need to invest independent work, and to ensure stable, guaranteed annual funding, the need for professional specialists to provide such programs, and taking into account that the programs are already being hailed as the line between prevention and treatment (early intervention), it must unfortunately be noted that this approach has not been implemented in Latvia for several years now.

Implementation of the programs is also being delayed because of the funding models for treatment and prevention, namely, that treatment is paid for by the State, but prevention is funded mainly by the municipalities, and as a result all the Early Intervention programs in Latvia are treated as medical treatment. Indicative prevention features are present in children's support group programs, operating in some addiction treatment facilities, but in that case, these children are diagnosed in accordance with the ICD-10 classification.

However, In 2009 Riga Council Wellfare departament and NGO “Education centre for family and school” participated in European Early Intervention Project “FreD goes net”[17]. The European project “FreD goes net” seeks to make available a prevention measure for young drug users who have come to notice as such for the first time, with the aim of intervening early so that a slide into addiction can be prevented. Predominant settings where these youngsters are first noticed are the police, school or the workplace (*FOGS, 2010*).

Latvia participated as pilot country, and it is planned that local profesionals will continue the project in long term. Project took places in Riga city and town Valmiera (60 111 inhabitants).

During whole project in a period of 13 months in participant countries a total of 1,284 users were reached. Of the 939 who took advantage of the course, 90.6% completed it. The overall satisfaction rate was 82.4%. Taken together, results indicate a high degree of acceptance of the intervention in the young persons reached. The average age of those that were reached was 16.9 years. The survey of consumption patterns shows that the great majority were not yet addicted. 75.1% had not made use of any support in connection with drugs or alcohol up to this point. Results show that the intended target group of the project could be reached and that the intervention is indeed a form of early intervention.

[16] For more information on selective prevention measures implemented in Latvia, see SQ23_2010_LV_01
[17] More about project: http://www.lwl.org/LWL/Jugend/lwl_ks/Projekte_KS1/Fgn-english/

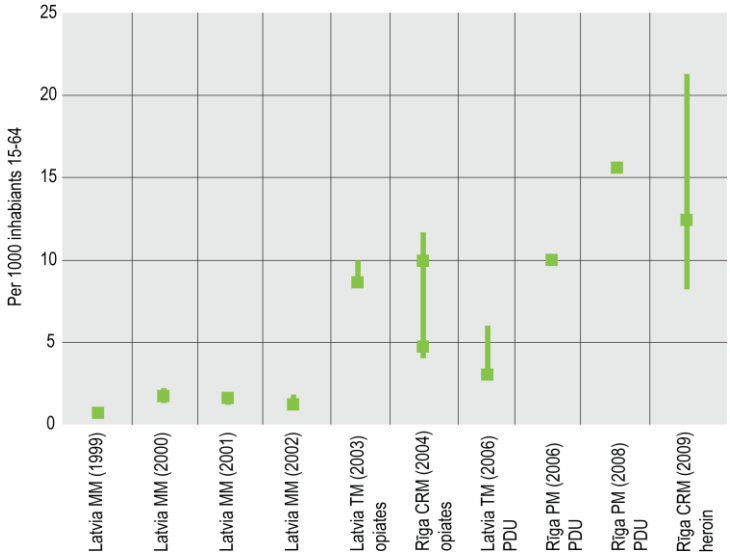
4. Problem Drug Use

4.1. Prevelence and incidence estimates of PDU

Indirect estimates of problem drug users

Problem drug use estimates in Latvia have been carried out by applying treatment or police multiplier methods. As there are data sources holding individual level data available in the country over the last few years several attempts on using capture recapture methods have been made without great success. The following paragraphs briefly looks on previously conducted estimates in Latvia *(see also Figure 4.1)*.

Figure 4.1. Problem drug use estimates in Latvia 1998-2008, per 1,000 inhabitants



Source: Trapencieris, 2010

In 2002 first IDU estimates for Riga city were carried out by Hay by applying truncated poisson method to client data from largest syringe exchange facility in Riga. The best estimated number of IDUs was around 1,500 and it did not correspond well to data from treatment sources or police, which showed larger number of IDUs using the services for drug users.

In 2003 within the framework of Phare 2000 Programme estimated number of problem opioid users in Riga city by applying different treatment multipliers was between 4,108 and 4,786 (*Lace and Trapencieris, 2003*).

With the support of EMCDDA in 2004 Trapencieris aimed to estimate problem drug users by mortality multiplier and capture recapture method with various data sources. By applying different mortality multipliers (1.2–2.3) the number of PDUs in Latvia in 2002 was estimated to be between 1,521–2,917. Capture recapture estimates with three or more sources were not possible due to no overlaps between any of three sources (treatment, blood donors, tuberculosis, mortality) and various two source overlap patterns provided PDU estimates ranging from 2,254 to 4,788 for Riga in 2002.

In 2006 Trapencieris estimated the number of PDUs in Riga by applying three source capture recapture method to data from treatment, police and cohort study; the estimated number of PDUs was obtained (12,382) but was not published as no scientifically sound overlap patterns were found.

Between 2006 and 2009 the number of problem drug users was estimated by applying treatment and police multiplier methods to available data. As it is estimated a great number of persons are underreported in the treatment data (up to 50%) the estimates by applying

treatment multiplier method might vary up to two-fold, e.g. in 2007 the estimated number of PDUs in Latvia was 4,794 but if underreporting is taken into mind could be up to 9,588 (*Trapencieris, Sniķere et al. 2008*). By applying police multiplier method in 2006 the number of PDUs in Riga was 4,757, while estimates obtained from the same data sources in 2009 suggested there were 7,456 PDUs in Riga and surrounding areas.

The most recent estimates for Latvia by applying four source capture recapture models for 2008 were carried out in collaboration with University of Glasgow (Hay, 2009). Within the consultancy project a large number of data sources was analysed and serious problems in fitting log-linear models were experienced. Nevertheless by excluding some of the data sources and splitting the sample in subgroups by gender and age groups consistent estimates were provided. The researchers were not successful in obtaining estimates for the whole country but rather for a subgroup of drug users (those using heroin) living in capital city Riga. The data sources that made possible estimating the number of PDUs were: 1) out-patient treatment in 2007, 2) out-patient treatment in 2008, 3) in-patient treatment in 2008, and 4) identifiers obtained within the cohort study in 2008, while the police data was dropped for analysis as it was thought as causing the main problems in fitting models due to violating definition used for analysis. The table below summarises the estimated number of heroin users in Riga *(see Table 4.1[18])*. It must be mentioned that none of the models that were fit to data allowed estimating the number of females thus the number of female heroin users was obtained by subtracting the male estimates from the total estimates (without 95% confidence intervals).

Table 4.1. Estimated number of heroin users in Riga city in 2008

Age Group	*Gender*	Known	Estimated Total	Lower	Upper
All	***All***	**1609**	**5912**	**3913**	**10164**
All	***Males***	**1185**	**3791**	**2517**	**6585**
15-24	*Males*	321	1287	625	4278
25-34	*Males*	616	1886	1110	4271
35-64	*Males*	248	532	289	2008
15-24	*All*	477	2585	1182	9070
25-34	*All*	817	2683	1613	5670
35-64	*All*	315	669	366	2502
All	***Females***	**424**	**2121**	**n.a**	**n.a**
15-24	*Females*	156	1298	n.a	n.a
25-34	*Females*	201	797	n.a	n.a
35-64	*Females*	67	137	n.a	n.a

Source: Hay, 2009

The estimated number of heroin users (5,912; 95% CI 3913–10164) in Riga can be extrapolated to all drug users in Riga or Latvia. Based on the estimated number of heroin users, Hay assessed there could be approximately 9,000 heroin and/or amphetamine users in Riga, while extrapolating furthermore there could be 18,000 opiate and/or ampetamine users in Latvia of which around 12,000 would be heroin users. Some researchers elaborated extrapolations furthermore, e.g. by different assumptions Trapencieris' extrapolations were slightly higher because of different fractions used (*Trapencieris, 2010*). These extrapolations suggested the number of PDUs in Latvia could be between 19,706 and 24,130, of which in between 9,853 and 12,065[19] would be living in Riga.

4.2. Data on PDUs from non-treatment sources

Mathodology of Riga Drug Users' Cohort study has been described in previous national reports as well in tehcnical project reports. The fourth wave of the study was conducted in 2009 and is

[18] More information also in: ST7_2010_LV_01

[19] The central 'figures'. The lowest arising by assuming 60% (based on data provided within the TDI data) of drug users use heroin, while the highest – by assuming 49% (data obtained within Riga Drug Users' Cohort Study) drug users use heroin.

described in this chapter below. Moreover, some data on risk behaviour from this study as well as from the ENCAP[20] study is included in Chapter 6 on Infectious Diseases.

Lifetime use of substances

According to the results of the cohort study, hanka[21] is the most commonly mentioned substance tried for the first time among the oldest members of the cohort, while among the younger population it is amphetamines, which indicates that over the past ten years, hanka's popularity among drug users has decreased, but the popularity and availability of amphetamine, heroin and other industrially produced substances has increased. These findings are also consistent with other observed drug-related indicators.

Since, as far as possible, the same people are surveyed throughout the cohort study, the percentage distribution of the substances tried for the first time is practically the same as that observed in previous phases of the study. Most often the first illicit substance tried is cannabis, which was mentioned by approximately one-third (35%) of respondents; the next most often mentioned substances are amphetamines (19%), hanka (12%), heroin (10%), ephedrine (9%) and ecstasy (6%) *(see Table 4.2)*. The most significant change is the rapid decrease in the number of users for whom *hanka* was the first-time-tried substance.

Table 4.2. First-time-tried substance, %

	Surveyed in previous waves	Newly-included in 2009	**Total**
Cannabis	33	52	**35**
Amphetamines	18	26	**19**
Hanka	12	2	**12**
Heroin	10	6	**10**
Ephedrine	9	6	**9**
Ecstasy	6	0	**6**
Other substances	12	8	**9**
Total	100	100	**100**

Source: Trapencieris, Sniķere et al. 2009

As in the previous three phases of the study, the most frequently mentioned age at which any illicit substance was tried was 16 years. In 2009 there is a slight decrease in the proportion of persons below the age of 13 trying illicit substances (2009, 2%; 2008, 7%; 2007 9% and 2006 - 11% of respondents). The earliest age of trying drugs (the lowest median age) occurs among those trying ecstasy and cannabis, while the median age for those trying the "problematic"[22] substances: heroin, hanka, and amphetamines, is slightly higher *(see Table 4.3)*.

Table 4.3. Age of first use of various substances by gender

	Age *(mean)*			Age *(median)*			Youngest	Oldest
	M	F	T	M	F	T	T	T
Ecstasy	14.5	15.6	15.4	16	16	16	10	20
Cannabis	16.0	16.8	16.2	16	16	16	12	35
Hanka	17.8	17.7	17.7	17	18	17.5	12	26
Amphetamines	19.2	19.2	19.2	18	18	18	10	35
Heroin	19.7	19.2	19.5	18	19	18	14	53
Ephedrine	20.4	19.4	20.0	19	18	19	14	41

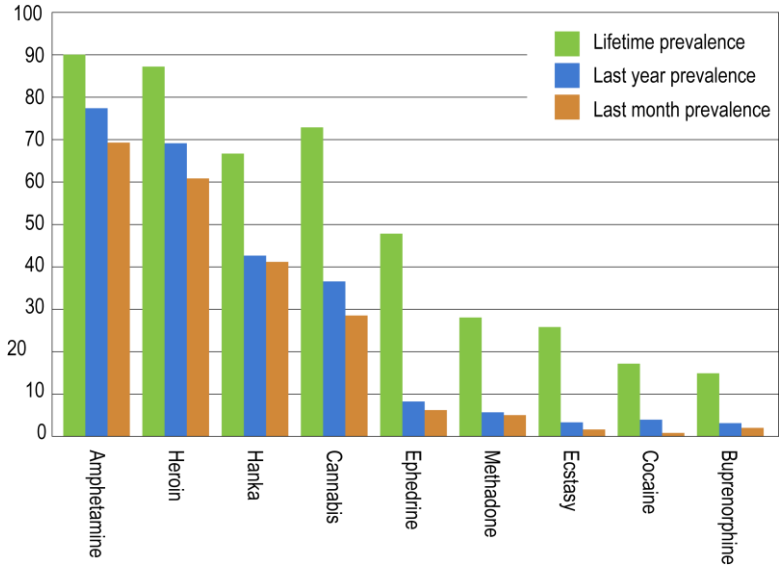
Source: Trapencieris, Sniķere et al. 2009

As in previous stages of the study, the substances most often used during the past year and past month by respondents in the fourth cohort of the study are amphetamines followed by heroin, which had been respectively tried during their lifetime by 90% and 87% of respondents

[20] European Commission funded Project Expending Network for Comprehensive and Coordination Action on HIV/AIDS prevention among IDUs and Bridging Population Nr 2005305
[21] "Homemade" opioid
[22] According to the EMCDDA definition, 'problematic' drug use includes regular or long-term use of opiates, cocaine and/or amphetamines

and during the past year by 74% and 66%; during the past month amphetamines had been used by 65% and heroin by 57% of drug users. Other substances used in their lifetime by cohort members, ranked in descending order, are cannabis (73%), hanka (67%), ephedrine (48%), ecstasy (26%), cocaine (17%). LSD or other hallucinogens and inhalants had been tried by approximately one in ten drug users, while substances used in replacement therapy (methadone and buprenorphine), had been used by 28 and 15 per cent of drug users respectively *(see Figure 4.2)*.

Figure 4.2. Lifetime, last year and last month substance use among 2009 cohort participants, %



Source: Trapencieris, Sniķere et al. 2009

Statistically significant differences in substance use have been observed for amphetamine, ephedrine, ecstasy, hanka, methadone, and LSD use during the respondents' lifetime according to their age. Younger respondents significantly more often mentioned amphetamines and ecstasy, while older respondents more often mentioned they have used ephedrine, hanka, and methadone in their lifetime *(see Table 4.4)*.

Table 4.4. Lifetime use of substances by age groups, %

	Younger than 24 years	25-29 years	30-34 years	35-44 years	45 and older	Total
Amphetamines*	97.6	95.1	92.2	81.2	72.9	90.0
Heroin	78.2	94.4	85.4	89.1	88.1	87.2
Cannabis *	71.0	68.1	69.9	79.2	83.1	72.9
Hanka*	41.9	70.1	68.0	80.2	84.7	66.7
Ephedrine*	27.4	26.4	56.3	76.2	79.7	47.8
Methadone*	8.9	25.7	29.1	40.6	50.8	28.1
Ecstasy*	29.8	38.9	23.3	11.9	13.6	25.8
Cocaine	12.1	20.1	16.5	18.8	18.6	17.1
Buprenorphine	17.7	16.7	11.7	14.9	10.2	14.9
Inhalants	8.1	13.2	9.7	14.9	15.3	11.9
Lsd	10.5	11.1	11.7	5.9	11.9	10.2
Mushrooms	6.5	7.6	3.9	7.9	5.1	6.4
Methamphetamine	8.1	2.8	2.9	6.9	11.9	5.8
Crack	2.4	4.2	3.9	1.0	1.7	2.8

* Statistically significant differences

Source: Trapencieris, Sniķere et al. 2009

Most often used substances

Data from the cohort study indicate that young drug users use amphetamines more often within the last month as compared with older drug users who report using heroin or *hanka (see Table 4.5)*.

Table 4.5. Last month use of selected substances by age groups, %

	Younger than 24 years	25-29 years	30-34 years	35-44 years	45 and older	Total
Amphetamines*	81,5	76,1	73,3	55,4	37,5	69,3
Heroin*	55,5	62,3	52,5	69,6	70,8	60,8
*Hanka**	18,5	42,8	34,7	62,0	66,7	41,2

* Statistically significant differences

Source: Trapencieris, Sniķere et al. 2009

Most of the re-interviewed cohort participants did not change their most frequently used substance. Within the range of one year of the study (for example, differences between the second and third, or third and fourth phases of the study), approximately one in five users of amphetamine or heroin had changed their most frequently used substance, but within a two-year range (from 2007 to 2009), about a third of heroin users had "exchanged it" for amphetamines or *hanka*. Possible explanations include: 1) lower availability of heroin as opposed to a higher availability of amphetamine, 2) low quality of heroin, which had been diluted so that "it's not worth 'taking' it because there is no point."

So, for example, 82% of those who used amphetamines most frequently in 2008 said they did so again in 2009, while for heroin users, the figure is 75%. The greatest changes were seen among the proportion of *hanka* users, of whom only 38% used it most frequently in 2009. Other substances such as ephedrine and methadone were identified as the substances most commonly used in the past 12 months by less than ten respondents, so it is difficult to draw unequivocal conclusions, but they are nevertheless reflected in the table below *(see Tables 4.6 and 4.7)*.

Table 4.6. Substance most frequently used by surveyed respondents in 2008 and 2009 waves, %

2008 \ 2009	Amphetamines	Ephedrine	Heroin	Hanka	Methadone	Buprenorphine	Cannabis	N/A	**Number**
Amphetamines	82	0	16	1	1	0	0	0	**213**
Ephedrine	63	25	0	13	0	0	0	0	**8**
Heroin	17	1	75	6	0	0	0	1	**160**
Hanka	14	0	38	38	3	3	3	0	**29**
Methadone	0	0	14	0	29	0	0	57	**7**
Buprenorphine	33	0	33	0	0	33	0	0	**3**
Cannabis	0	0	0	50	0	0	50	0	**2**
Number	**213**	**5**	**166**	**25**	**5**	**2**	**2**	**6**	**426**

Source: Trapencieris, Sniķere et al. 2009

Table 4.7. Substance most frequently used by participant respondents in 2007 and 2009 waves, %

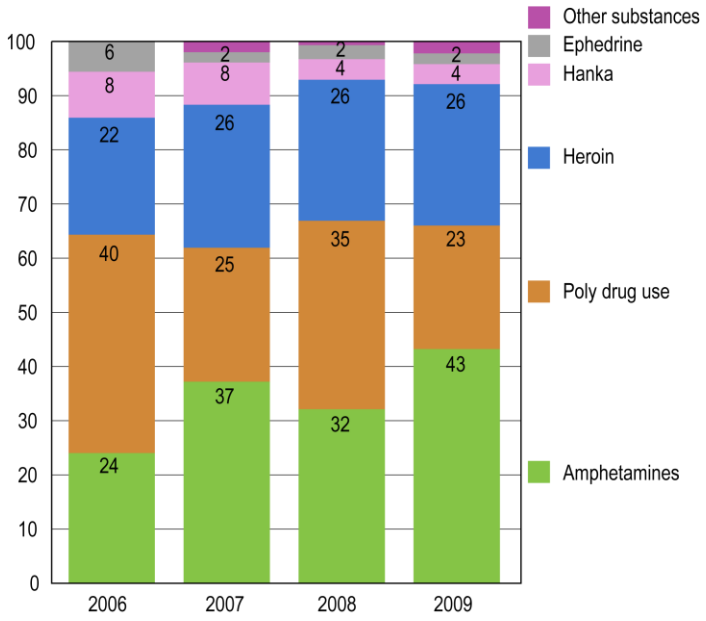
2007 \ 2009	Amphetamines	Ephedrine	Heroin	Hanka	Methadone	Buprenorphine	Cannabis	N/A	**Number**
Amphetamines	78	0	19	2	0	0	1	1	**128**
Ephedrine	50	25	25	0	0	0	0	0	**4**
Heroin	23	2	65	5	2	0	1	2	**96**
Hanka	12	0	44	35	3	0	3	3	**34**
Methadone	22	0	22	11	11	0	0	33	**9**
Buprenorphine	0	0	100	0	0	0	0	0	**1**
Cannabis	50	50	0	0	0	0	0	0	**2**
N/A	10	20	20	0	20	0	0	0	**10**
Number	**132**	**6**	**107**	**20**	**6**	**0**	**3**	**10**	**284**

Source: Trapencieris, Sniķere et al. 2009

According to questions regarding the most frequently used injectable substances during the past six months, it may be concluded that about two-thirds (69%) of cohort participants used only one substance, and did not change their choice, while one-third used whatever was most readily available, or also sought to achieve a variety of drug-induced effects, e.g. they used heroin to "calm down" or fall asleep after amphetamine-induced insomnia.

According to these data, 43% of respondents in the fourth phase of the cohort study used amphetamines exclusively, while only 26% used heroin exclusively *(see Figure 4.3.)*. Those who used only hanka or ephedrine were very few – namely four and two percent of respondents respectively. Among those who reported that over the past six months they had used more than one substance (23%), the most commonly mentioned combination was amphetamines and heroin. Interestingly, only the proportion of heroin users in all stages of the study has remained practically unchanged, while changes are observed only in the proportion of users of amphetamine and multiple substances.

Figure 4.3. Proportion of single-substance users[23] in four waves of the cohort study, %



Source: Trapencieris, Sniķere et al. 2009

Treatment for drug addiction

The results of the 2009 cohort study of drug users indicate that during their lifetime, one in two (51%) of cohort participants had received treatment for drug-related problems. 15% of drug users were treated during the past year, while two per cent had been treated during the past month. In comparison to 2008 survey data, the proportion of cohort participants treated during the past year has fallen significantly *(see Table 4.8)*. It should be noted that a relatively large number (38 or 7%) of drug users did not wish to specify whether they had been treated during the past year or the past month.

Table 4.8. Cohort participants treated for drug addiction, %

	2007	2008	2009
During lifetime	48	50	51
During past 12 months	17	26	15
During past 30 days	2	3	2

Source: Trapencieris, Sniķere et al. 2009

Slightly less than half (47%) of re-interviewed respondents who had been treated in 2008 had sought treatment in 2009.

[23] Have used during past six months

No statistically significant differences were observed in terms of respondents' gender. The age at which most surveyed drug users were first treated was 25 years; for amphetamine, users slightly lower than for heroin users, respectively, 23.4 years and 25.2 years.

Data from the 2009 study may indicate that the treatment system has become less accessible to drug users, i.e. from those treated in 2009, most (90%) had only done so on one occasion compared with the 72% of patients who sought assistance once during the previous 12 months in 2007, and 52% in 2008 *(see Table 4.9)*.

Table 4.9. Number of times treated during previous 12 months, %

	2007	2008	2009
One occasion	72	52	90
Two occasions	21	31	8
Three or more occasions	7	18	2

Source: Trapencieris, Sniķere et al. 2009

The most frequently mentioned treatment establishment in which slightly less than half (46%) were treated during the past year, was the Riga Centre of Psychiatry and Addiction Disorders, followed by two private treatment centres – *Detox* (14%) and *Bikur-Holim* (13%) .

As in the second and third phases of the cohort study, 14% and 4% respectively of cohort participants had enrolled in methadone and buprenorphine programs at some point. According to respondents' answers, 11 drug users were treated in the past month in the methadone program, while four had been treated in the buprenorphine program.

Evaluation of harm reduction programs

In comparison to the 2008 study data, the proportion of cohort participants ever to have visited a syringe exchange point has increased to 77% (74% in 2008; 61% in 2007). 94% of respondents had used the services of outreach workers at least once during their lifetime, while in Riga almost one in four (26%) drug users have visited mobile unit since it became available in 2008.

None of the harm reduction program options utilised by drug users during their lifetime indicates any statistically significant difference, by gender, ethnicity or age.

Examining the number of times the services of syringe exchange points, and outreach workers were utilised over the past six months, it may be concluded that 58% of cohort participants have attended a HIV prevention point, while 85% of drug users have used the services of outreach workers. By comparison, in 2008 and 2007 the indicators for attendance at HIV prevention points were respectively 62% and 57%, and for using the services of outreach workers, 80% and 78% *(see Table 4.10)*. The proportion of regular clients of fixed setting syringe exchange or that of outreach workers is much lower.

Table 4.10. Proportion of drug users using the services of HIV prevention points, outreach workers and mobile units, %[24]

	HIV prevention point		Outreach workers		Mobile unit	
	During past 6 months	During past 30 days	During past 6 months	During past 30 days	During past 6 months	During past 30 days
Have visited						
2007	57	41	78	76	n.a	n.a
2008	62	41	80	84	n.a	n.a
2009	58	40	85	80	24	20
Regular clients[25]						
2007	9	9	32	38	n.a	n.a
2008	6	3	35	47	n.a	n.a
2009	16	7	36	33	6	6

Source: Trapencieris, Sniķere et al. 2009

[24] Of those indicating number of times

[25] According to visits in relevant time period (past six months or past 30 days). Regular clients during the past six months may be regarded as those who have attended on more than 20 occasions, while during past 30 days – on four or more occasions (or approximately once a week).

Sharing injection paraphernalia

In the 2009 study questionnaire, adjustments were made to the possible answers in order to ascertain risky injection behaviour. Instead of the dichotomous indications ("Were paraphernalia shared or not during the past six months?") respondents were asked to answer about the use of shared injecting paraphernalia, as well as syringes or needles, during the past month, the past six months and the past year. As a result of these changes, the results are only partially comparable.

According to respondents' replies in phase four of the cohort study, one in four respondents (24%) has shared a syringe or needle during the past six months, while almost one in three (32%) has used other injecting paraphernalia such as cotton wool, spoon, water, etc. that someone has already used. Compared with observations in the earlier phases, there is a significant reduction in the proportion of respondents who have shared syringes/needles or other injecting paraphernalia, but here the changes in question wording and response formulations that have affected the comparability of results must be borne in mind.

The new wording of the question gives an indication of shared injecting habits during lifetime, in the past year, or in the past 30 days. According to this distribution, 40% of respondents have shared syringes or needles during their lifetime, 28% during the past year, 18% or nearly one in five drug users has done so during the past month; while 12% of respondents shared needles or syringes more than a year ago.

Among those respondents, who responded about the sharing of injecting paraphernalia in at least two phases of the cohort study (n=561), almost one in three (30%) drug users had not shared injecting paraphernalia in the past six months of any of the phases of the study. A third of drug users (33%) indicated sharing of injecting paraphernalia in one phase of the study, 29% had done so in two phases, while seven per cent of respondents had reported sharing injecting paraphernalia in all three phases of the study.

Across all phases of the study, younger drug users indicate significantly more often that they share injecting paraphernalia, compared with older drug users *(see Table 4.11)*.

Table 4.11. Use of shared injecting paraphernalia among repeat respondent drug addicts, %

	<24 years	25–29 years	30–34 years	35–44 years	>45 years	**Total**
Have not shared injecting paraphernalia	21	32	32	41	54	**34**
Indicated sharing of injecting paraphernalia in at least one phase of study	53	40	50	41	44	**45**
Indicated sharing of injecting paraphernalia in all phases of study	26	28	18	18	2	**21**

Source: Trapencieris, Sniķere et al. 2009

The observed negative correlation between age of respondents and sharing of injecting paraphernalia has remained unchanged since 2007, i.e. a significantly higher proportion of drug users among younger respondents shared some form of injecting paraphernalia in the last six months, as compared to older respondents *(see Table 4.12)*.

Table 4.12. Use of any form of shared injecting paraphernalia during past six months, %

	<24 years	25–29 years	30–34 years	35–44 years	>45 years	**Total**
2007	61	46	36	36	25	**45**
2008	68	65	59	41	32	**58**
2009	37	43	30	28	14	**33**

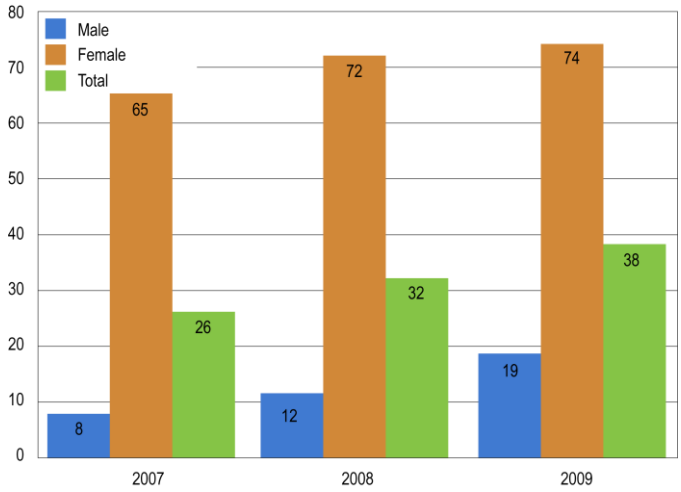
Source: Trapencieris, Sniķere et al. 2009

Sexual relations for money, for drugs

During their lifetime about one-third (38%) of drug users has had sexual relations for money, drugs or other material benefits, compared with the 2007 and 2008 phases of the study, in which respectively 26% and 32% of respondents indicated thus. Although the study data for

2009 indicate that 19% of men have had sexual relations for money, drugs or other material benefits, this proportion is significantly higher among women (74%) *(see Figure 4.4)*.

Figure 4.4. Sexual services provided for money, drugs or other material benefits by gender, %



Source: Trapencieris, Sniķere et al. 2009

31% of drug users had had sexual relations for money during their lifetime, of whom 28% had done so to receive drugs, and 17% of respondents said that they received other forms of material benefit. 22% of respondents indicated they had received money for sexual relations during the past year; 18% had received drugs, while 12% had received other material benefits.

No statistically significant differences were observed during the past year, in terms of respondents' age, for exchanging sexual services for various benefits; however, the figure is slightly higher among younger respondents – 26% for respondents aged below 29 years, compared with 15–20% for older age groups of respondents. Differences in terms of users of various substances are not statistically significant, but among sex workers, there is a slightly higher proportion observed of amphetamine users compared to heroin users (31% and 25% respectively).

Contact with law enforcement agencies

Drug testing

According to data from the fourth phase of the cohort study, approximately one quarter (26%) of drug users has undergone drug testing on at least one occasion during the past 12 months. A positive test result was recorded for almost all drug users (97% of those tested, or 25% of all cohort participants).

During the past year, more men than women were referred for testing (OR=1.69; 95% CI 1.09–2.60); there were no statistically significant differences observed in terms of age, i.e. users from all age groups came to the attention of the police with a similar degree of frequency and were referred for testing. As in the 2008 study, the data from the 2009 study indicate that heroin users were referred for testing more often than amphetamine users (33% and 26% respectively).

Compared with data from the three previous phases of the study, the level of testing by the police of problem drug users in the cohort has remained virtually constant *(see Table 4.13)*.

Table 4.13. Drug users referred for testing, %

	<24 years	25–29 years	30–34 years	35–44 years	>45 years	Total
2006	23	27	25	16	12	22
2007	30	34	23	7	13	24
2008	28	36	17	18	20	26
2009	26	26	25	30	17	26

Source: Trapencieris, Sniķere et al. 2009

5. Drug-related treatment: treatment demand and treatment availability

5.1. Strategy and policy

Treatment policy, coordination and monitoring are organized and provided at the national level by the Ministry of Health, but the state-determined funding model is implemented by the Health Payment Centre in accordance with signed agreements.

The treatment of drug users in Latvia is regulated by the Medical Treatment Act, together with Cabinet Regulation No. 429 of 24 September 2002: *Procedures for the Treatment of Patients Addicted to Alcohol, Narcotics, Psychotropic and Toxic Substances*. The compulsory treatment of children suffering from mental or behavioural disorders due to the use of narcotic, psychotropic, toxic or other intoxicating substances is regulated by the Rights of the Child Protection Act and Cabinet Regulation No. 726 of 16 December 2003: *Procedures for the Mandatory Medical Treatment of Children Having Mental Dysfunction or Behavioural Disorders Due to the Use of Alcoholic Beverages, Narcotic, Toxic or Other Intoxicating Substances and Procedures for the Provision of Mandatory Medical Treatment for Addiction to Alcohol, Narcotic and Psychotropic Substances at Social Correctional Education Institutions*

The foregoing Regulations determine the organisation of treatment institutions in which addiction specialist physicians are working and/or drug dependence-profile beds are available and the treatment of drug users is arranged. Treatment is based on a treatment system provided by medically-trained treating personnel (addiction specialist-physicians) who are authorised to make a diagnosis in accordance with the ICD-10 classification. Also involved in the treatment process are nurses, and in recent years, medical support personnel such as psychologists and social workers, thus forming a multidisciplinary treatment team.

The health care organization and financing arrangements, the types and amounts of medical services paid from the state budget or by the recipient of the service, the payment arrangements for these services, as well as arrangements for the formation of centrally planned waiting lists for health care services, is regulated by Cabinet Regulation 1046: *Health Care Organization and Financing Arrangements* of 19 December 2006

The social rehabilitation of drug users is regulated nationally by the Law on Social Services and Social Assistance and the Rights of the Child Protection Act. More detailed arrangements for the receipt of social rehabilitation services from the state budget are reflected in Cabinet Regulation No.914 of 6 November 2006: *Procedures by which Persons Addicted to Psychoactive Substances Receive Social Rehabilitation Services*.

On the 30th June 2009, a policy planning document was adopted, entitled On a control program to limit the spread of Human Immunodeficiency Virus (HIV) infection for 2009–2013. This program aims to limit the spread of HIV infection and ensure that there will be no further increase in the number of new HIV infections. One of the program's target groups is injecting drug users. To achieve the sub-goals set by the program, twelve courses of action have been identified, two of which are related to the national development of long-term pharmacotherapy for opioid users:

- to expand access to long-term pharmacotherapy and improve health care for injecting drug users;
- to provide harm-reduction measures, including the long-term pharmacological treatment of opioid addiction in prisons.

5.2. Treatment systems

In accordance with Cabinet Regulation 1046 of 19 December 2006, an outpatient addiction specialist is a direct access specialist. A fixed monthly payment (funding estimate), comprising salary and costs of maintaining the specialist's consulting rooms is applied to payments for the work of a direct access specialist. This means that the most important factor in payment for services is not the number of episodes, but rather the extent of access to the specialist at a particular location. In accordance with the said Regulation, conditions are to apply to this payment model as from 2010, namely, that the Health Payment Center shall twice a year assess the number of visits, and if that is less than 0.5 workload (one workload = 10 visits per day), then payment shall be in accordance with the set tariffs for care episodes.

Prior to 1 March 2009, patient contribution for a consultation with an addiction specialist was LVL 2. Due to the economic downturn, between 1 March and 31 December 2009, the patient contribution was increased to LVL 5. However, from 1 January 2010, it was again reduced to LVL 3. For patients being treated as inpatients for dependence on alcohol, narcotic psychotropic or toxic substances (diagnosis codes according to ICD-10: F10-F19), the patient's contribution for 24 hours' care is now LVL 5 (LVL 1 prior to 1 March 2009). These conditions do not apply to children, to whom patient fees do not apply, or patients being treated in methadone maintenance treatment.

Nationally, there are private institutions/physicians in private practice engaged in the treatment of dependent patients, staffed by addiction specialist physicians. In cases where a patient seeks assistance from a private physician, the patient himself meets all costs associated with treatment.

Inpatient assistance is provided for dependency patients in dependency-profile beds[26] in specialized psychiatric centres, regional multi-profile hospitals and other medical institutions.

It should be noted that drug users who are provided with emergency medical assistance, e.g. in drug overdose cases, are for the most part admitted to university hospitals, regional multi-profile hospitals and local multi-profile hospitals, which may not have specialized dependency-profile beds.

Overall, the treatment system, except for a significant increase in patient co-payment during 2009, which possibly reduced the access to services, has not changed significantly.

Outpatient psychosocial intervention

Nationally, outpatient psychosocial intervention is provided by addiction specialist physicians in cooperation with nurses; multidisciplinary teams involving psychologists have been established in some institutions.

Outpatient addiction aid services funded from the state budget were provided during 2009 by 39 treatment institutions (48 specialists). These state-funded specialists work in specialized psychiatric centres, specialised outpatient departments in psychiatric hospitals and multi-profile hospitals, local multi-profile hospital outpatient departments/consulting rooms, in municipal treatment institutions, addiction specialist physicians' practices and other institutions. Some of these specialists also provide long-term pharmacotherapy with methadone and buprenorphine.

In 2009, there was a decrease in the number of outpatient visits to addiction specialists. In 2009, there was an average of 2.7 outpatient visits[27] per one physician per day (in 2008 the average was 4.6 visits per day). It is possible that the reduction in visits was affected by the increase in patient contributions, as well as unemployment, population migration to other EU countries to seek employment, and other factors.

Outpatient psychosocial interventions utilises motivational interventions, cognitive behavioural therapy, and support therapy to address social issues (*see e.g. WHO, 2009*).

[26] Including detoxification beds, the *Minnesota Program*, a motivational program and medical rehabilitation
[27] Drug and alcohol treatment clients combined

In 2009, a special outpatient program was devised for children who are drug users, entitled: *Seminar activities for the Socio-Psychological training for Personality Growth in Adolescents*. The target audience is 12–18–year-olds with abnormal behavioural characteristics that are presently experiencing social adaptation difficulties. The adolescents are offered weekly structured lessons (90 minutes). There are 8–10 adolescents per group. The lesson plan includes tasks involving self-assessment, general values orientation, communication skills; discussions are held on social roles, conflict resolution and various forms of emotional expression. Classes are led in a way that is meaningful for young people, using games, images and movements, thus helping to strengthen confidence in saying 'no' if offered an addictive substance.

There are also support groups operating in parallel for parents of children who use addictive substances.

Other specialized treatment programs targeted to specific user groups, such as cannabis or amphetamine users, and in patients with dual diagnoses, are still not available in the country.

Inpatient psychosocial intervention and detoxification

Inpatient psychosocial interventions include treatment in hospital-type institutions ranging from short-term inpatient programs to therapeutic communities.

In 2009, inpatient assistance for drug dependence was provided in 350 drug dependency beds[28] in 10 treatment institutions; of those, 316 beds and five beds in prison hospitals were funded from the state budget, while the other 29 drug dependency beds were provided by private medical institutions.

Also declining in 2009 was the number of publicly funded beds in two medical rehabilitation programs, which were operating on the therapeutic community principle, and a structural reorganization process took place, reducing the availability of these programs to patients.

Social rehabilitation for children and adults, which also operates on the therapeutic community principle is offered by three institutions, which are under contract with the Ministry of Welfare. Some private and religious organizations operate throughout the country, offering social rehabilitation services.

Long-term pharmacological treatment of opioid addiction with methadone and buprenorphine

A methadone program has been running in Latvia since 1996, while a buprenorphine program has run since 2005. Until mid-2009, a methadone program has only been implemented in one place in Latvia, namely at the Riga Centre of Psychiatry and Addiction Disorders[29]. Compared with other European countries, Latvia has the lowest number of clients in methadone programs (EMCDDA, 2009). The incomplete understanding held by medical personnel and clients regarding the benefits of the program, the non-orientation of the service to clients, the relatively low level of funding that would allow the program to set up elsewhere in Latvia etc. are some of the reasons why the Latvian methadone program has not evolved sufficiently quickly while treating an increasing number of drug users[30].

Since 2006, the UNODC project *HIV/AIDS Prevention and Care among injecting drug users and in prison settings in Estonia, Latvia and Lithuania* has been operating in Latvia. One of the project's tasks in Latvia is to increase the number of clients in long-term pharmacotherapy, to broaden the operation of methadone programs and improve program quality, to allocate funding for them in terms of grants and the establishment of consulting rooms, as well as providing training and information for medical personnel and treatment assistants. With the support from

[28] All patients (alcohol and drug treatment clients) with diagnosis codes F10–F19 according to the ICD-10 classification are treated in a specialised dependency treatment profile.
[29] Except for the period during which the program operated in Jurmala. However, as it was unable to attract sufficient long-term clients, the program was closed.
[30] Compared to the other Baltic states, Latvia,has the lowest number of opioid users being treated in a methadone treatment program. For example according to EMCDDA data, in late 2008 Latvia had 103 patients being treated in a methadone program, Lithuania had 640, while Estonia had 1008 opioid users being treated (EMCDDA, 2009).

the project, a methadone program was launched in 2009 outside of Riga at Jelgava and Liepaja, and in 2010, methadone programs also commenced in Jurmala, Olaine, Salaspils, Daugavpils, Kuldiga, Rezekne, and Tukums. It is important to mention that during operation of the UNODC project, work of an informative and educational nature was undertaken with prison staff and prisoners, not only for HIV-related issues, but prison management staff also received instruction on the need for long-term methadone pharmacotherapy in prisons. During 2009, the necessary legislative changes were drafted to allow the implementation of methadone programs in prisons. During 2010, it is planned to start a methadone pilot program in one of Latvia's prisons.

5.3. Characteristics of treated clients

This section analyses data collected by PREDA, and by the Health Payment Centre Outpatient Service Payment Settlement System (APANS), as well as information compiled from industry statistical reporting. The information used in some places in this section is in accordance with the ICD-10 diagnosis F11–F19, with the exception of F17 (tobacco), but most data were analysed by substance and as far as possible in accordance with the EMCDDA Treatment Demand Indicator (TDI) definitions.

Treatment data recording system

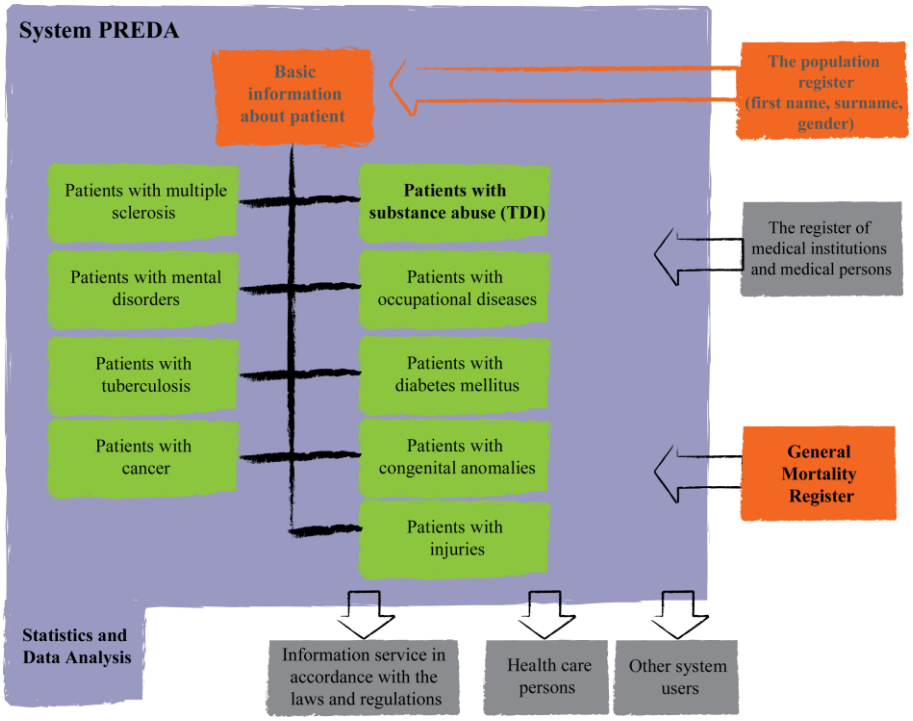
Over the last years huge efforts at the Health Statistics and Medical Technologies State Agency (as of October 1, 2009 – Department within the Centre for Health Economics) have been put into developing the new treatment data recording system PREDA (Patient REgister DAta). The system that is fully functional as of September 2008.

The data collection system is web-based and uses secure data transmission channel (SSL). It consists of the PREDA database itself, which is a MSSQL data base, Data input system, systems' public interface (XML Web service-access layer), PREDA Security, PREDA import program, and PREDA analysis system. Within the PREDA system data is collected not only about drug use but also about various diseases or conditions, e.g. mental health, cancer, diabetes mellitus, tuberculosis, injuries, congenital anomalies, occupational diseases; morover PREDA system is directly linked with the General Mortality Register (or Death Causes Database), which provides ICD-10 mortality codes automatically into the system for deceased persons. In Figure below the system is displayed graphically.

With the introduction of the new system changes in the treatment data reporting form took place with inclusion of additional TDI items – living status, family status, injecting, additional answer categories for frequency of use, and treatment modality – which were missing in the previously used TDI reporting form.

Irrespective of the achievements made in development and data quality improvements of the PREDA system, there are some flows in the data collection system in the country that does not allow providing precise estimates of the treated clients. The major issues that have been reported in several previous National Reports that country is facing as regards data collection on drug clients are still in place – most known problems and those arising from the planned TDI revision process were provided to the EMCDDA in 2010 and some issues the system has been dealing with is presented in a table 5.1.

Figure 5.1. Patient REgister DAta (PREDA) components and links with other data sources



Source: PREDA, 2010

Tretment data issues

Underreporting of clients

As the PREDA system serves, not only as register of treatment clients but also parts of the system (e.g. register of drug clients and register of mental health patients) can be accessed by the police, treatment specialists are reluctant in filling-in data on their patients. The access to the data by the law enforcement institutions is made according to the law, e.g. police/prosecutor might file an inquiry in the register(s) for someone facing criminal charges. The issue of police having access to the data has always been an issue in discussions with data providers on coverage and data quality. Being included in the register also is stigmatised among drug users themselves and they rather prefer treatment by those specialists who would not report to the register (e.g. private treatment centres)

There has not been an easy solution to this problem; currently this topic (law enforcement agencies' access to the TDI data) is discussed between PREDA administrator (CHE), Ministry of Health and Ministry of Interior.

Reporting of clients who have not sought out-patient treatment

As data registration procedures state that only out-patient treatment providers include the patients in the register, a similar situation with that reported above on drug testing arises on including the patients in PREDA without seeing the patients but rather from discharge forms sent by in-patient treatment facilities.

Within data quality improvement process all such cases in 2009 were acknowledged and the results were higher than expected – 75 clients were included based on in-patient discharge forms and additional 98 clients based in signal forms from drug testing of the 474 new TDI cases in 2009. The results of this analysis suggest data reported as out-patient in TDI not necessarily reflects this form treatment and rather many cases would be qualify for inclusion in reporting in the future.

The TDI working group has held several meetings and for reporting of 2010 data all known cases without actual treatment from the episodes' data in the Health Payment Centre (HPC)

registers will be excluded from reporting. The downside of the suggestion would be limited comparability with previously reported and collected data.

Out-dated information in the register

Currently within PREDA data is collected for the first-time "treatment"[31] and patients remain in the register until they are excluded from the register – thus providing prevalence figure. The criteria for keeping patients in the "treatment" prevalence are set by the regulations of the Cabinet of Ministers, for example, those with drug dependence syndrome might be kept in the register for three years after last treatment contact, those with intoxication or harmful use – for one year.

In 2010 the prevalence records of the patients were analysed by merging individual PREDA data with Health Payment Centre data suggesting many clients in the prevalence can be characterised as "ghost cases" and have not received any treatment in the last three years.

In the TDI working at the Centre of Health Economics and over the scope of coming TDI revision it is planned to gather data on actual treatment episodes that would allow better estimates of the drug clients in treatment.

Lack of data on all treatments

Historically in Latvia the system for planning and describing the situation at national level has used previously described measurements – incidence and prevalence – and TDI data from out-patient facilities has been lacking information on all treatments. In 2010 data analysis aimed assessing all out-patient treatment by merging PREDA data with HPC database on out-patient treatment. The analysis suggested there were many cases who have received treatment according to HPC data but were not included in the PREDA thus lacking detailed information on substances as well as more than 20% of clients had been diagnosed with ICD-10 diagnosis of F11-F19 by general practitioners, which according to the regulations in place in Latvia is not made possible. Thus provision of all treatments data in Fonte for 2009 was not possible due to these and other definitional considerations.

Over the planned TDI revision inclusion of the concept of episode of starting and ending dates would allow estimating of all treatments with detailed information within one dataset as inclusion of more than one data source in estimating of all treatments lead to two independent subsets of data thus violating definition of treatment.

Lack of in-patient data

As of 2009 detailed data on in-patient drug treatment is not available anymore. Previously this data was collected by the State Addiction Agency (and after its reorganization in 2007 by the RPAC for 2007 and 2008). With decreased funding allocated to data collection of in-patient treatment data at national level from 2009[32] onwards is not collected thus losing a valuable information source both for national purposes as well as for reporting to the EMCDDA.

The situation might change with improvements in the TDI revision at national level, where TDI data collection working group has plans on including data collection from in-patient facilities in PREDA system. Until then comprehensive in-patient data will not be available.

Industry statistical reporting data

According to industry statistical reporting data, in 2009 there were 435 (or 19.3 per 100,000 inhabitants) newly registered patients with a diagnosis related to drug use, of which 254 cases

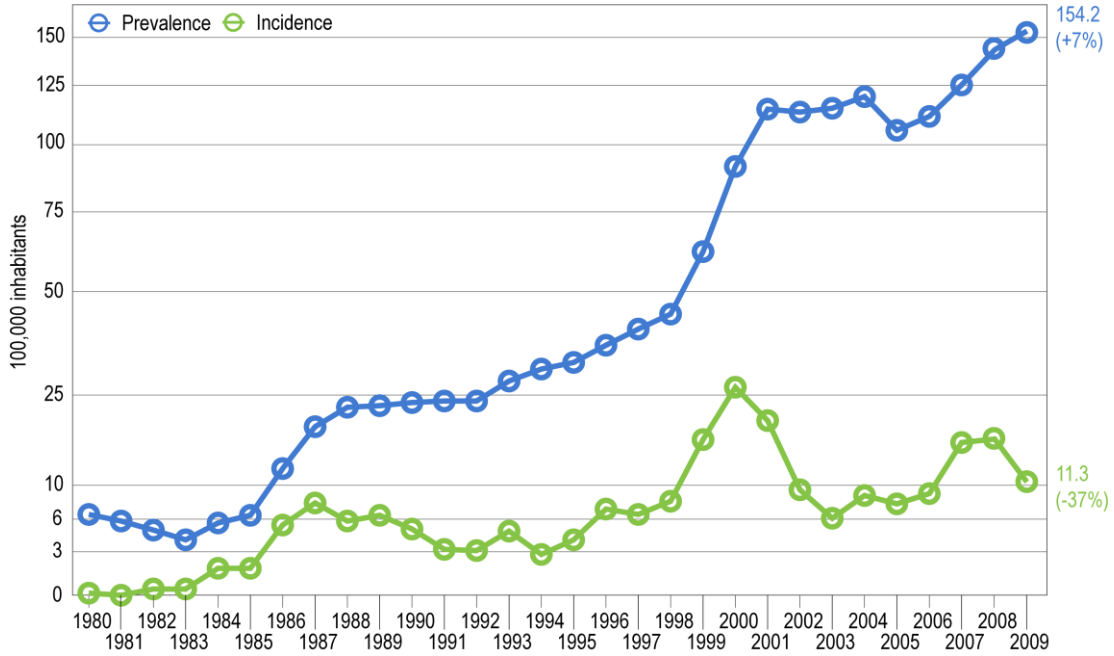
[31] For interpreting Latvian out-patient treatment data one should take into account the definition of tretment (or registering). In Latvian case data speaks rather of registering and not treating. Besides significant number of clients both at public and private treatement centres are not reported within data colelction system. Moreover the defition of a client as compared with the TDI definition is of limited comparability, i.e. those daignosed by addiction psychiatrists according to the ICD-10 criteria are incldued and those seeking social and/or psychological counseling minght be underreported or excluded from the data.

[32] No agreement has been made also for 2010 in-patient data and very likely in-patient data will not be collected also for 2011 due to the situation no institution is in charge for collecting corresponding data and no funding is made available by the MoH for this purpose.

(11.3 per 100,000 inhabitants) were diagnosed with a dependency syndrome or had a psychosis-related diagnosis.

As of December 31, 2009, the registered prevalence of psychoactive substance dependence or psychosis (excluding alcohol) in Latvia was 3,468, or 154.2 per 100,000 inhabitants. Compared to 2008, the incidence had decreased by 37%, while the prevalence had increased by 7% *(see Figure 5.2)*.

Figure 5.2. Registered prevalence and incidence of drug dependence syndrome and psychoses caused by use of psychoactive substances (F11–F19.2–9), 1980–2009 per 100 000 inhabitants



Source: Industry Statistical Report No.11

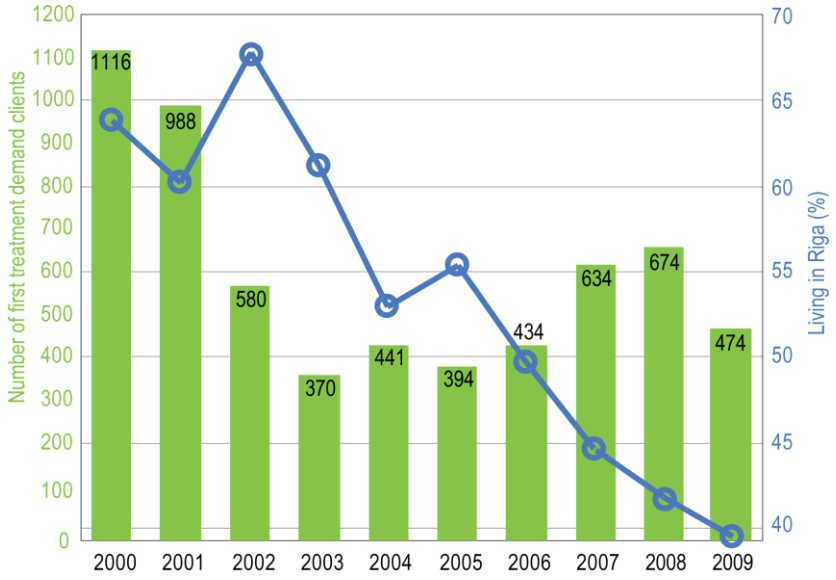
Outpatient treatment

Since the first patient was registered in 1976 until 31 December 2009, more than eight thousand (8,589) individuals have been registered in Latvia with a diagnosis related to intoxication, abuse of, and/or dependence on psychoactive substances (excluding alcohol and tobacco).

As from 1993/1994, the number of first-time registered patients with diagnoses related to the use of psychoactive substances (excludingalcohol and tobacco), began to increase significantly. The number of first-time patients reached its maximum in 2000 and significantly decreased until 2003, while between 2005 and 2008 increased each year. The number of first-time registered patients has decreased significantly in 2009 compared to 2008, 474 and 674[33] individuals respectively *(see Figure 5.3.)*.

[33] According to Treatment Demand Indicator (TDI) data. Since the database structure and data entry procedures permit the input and amendment of historical data for patients treated in previous years, the information compared to that reflected in the previous National Report may vary slightly. For example, the 2009 National Report notes that 659 individuals were treated for the first time in 2008.

Figure 5.3. Number of first treatment demand cases in 2000–2009 and proportion living in Riga

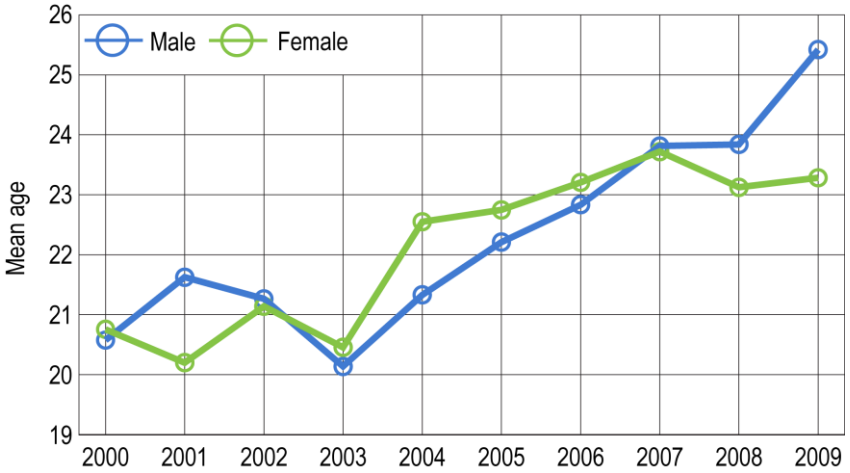


Source: The Centre of Health Economics, 2010

Some possible explanations for this include the national economic downturn, which adversely affected the number of patients seeking help, and the closure of several state-funded in-patient motivation and rehabilitation programs. It is undeniable that, as noted also in previous National Reports, information about patients is often not included in the PREDA system, but we do not considered that information on patients was included less frequently in 2009 than in previous years.

In 2009, the mean age of first-time treated patients was 25 years; it was slightly higher for men than women, respectively 25.4 and 23.3 years *(see Figure 5.4)*. Over the last decade there is a trend of increasing age among first treatment clients and as mentioned further in this chapter also possibly the severity.

Figure 5.4. Mean age of first-time treated patients, 2000–2009



Source: The Centre of Health Economics, 2010

The youngest first-time treated patient in 2009 was nine years old, while the oldest was aged 64. 12% of first-time treated were less than 15 years old; 19.8% were aged 15-19; 24.1% were 20-24; 18.1% were 25-29; 11.8% were 30-34; 7.4% were 35-39, while 6.5% were older than 40 years *(see Table 5.2.)*.

Table 5.2. Distribution of first-time treated patients by age groups in 2000–2009, %

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
<15 years	14.9	14.1	19.3	28.4	19.0	16.8	16.1	12.5	12.0	12.0
15–19 years	34.6	35.9	32.6	34.6	36.5	31.5	25.8	22.6	22.3	19.8
20–24 years	32.4	27.2	22.8	16.5	19.7	20.8	24.7	24.1	25.7	24.1
25–29 years	10.2	11.5	13.6	7.8	10.2	16.5	16.4	21.9	20.5	18.4
30–34 years	4.3	5.5	5.5	7.3	5.7	4.8	8.1	9.1	10.7	11.8
35–39 years	2.2	2.8	3.1	2.7	2.5	4.3	4.1	5.7	4.7	7.4
40 years and older	1.4	2.9	3.1	2.7	6.3	5.3	4.8	4.1	4.2	6.5

Source: The Centre of Health Economics, 2010

Of first-time patients treated in 2009, approximately one in five (21.5%) was female. In recent years, the proportion of women is slightly lower than observed between 2003 and 2005, but these small changes are difficult to explain *(see Table 5.3)*.

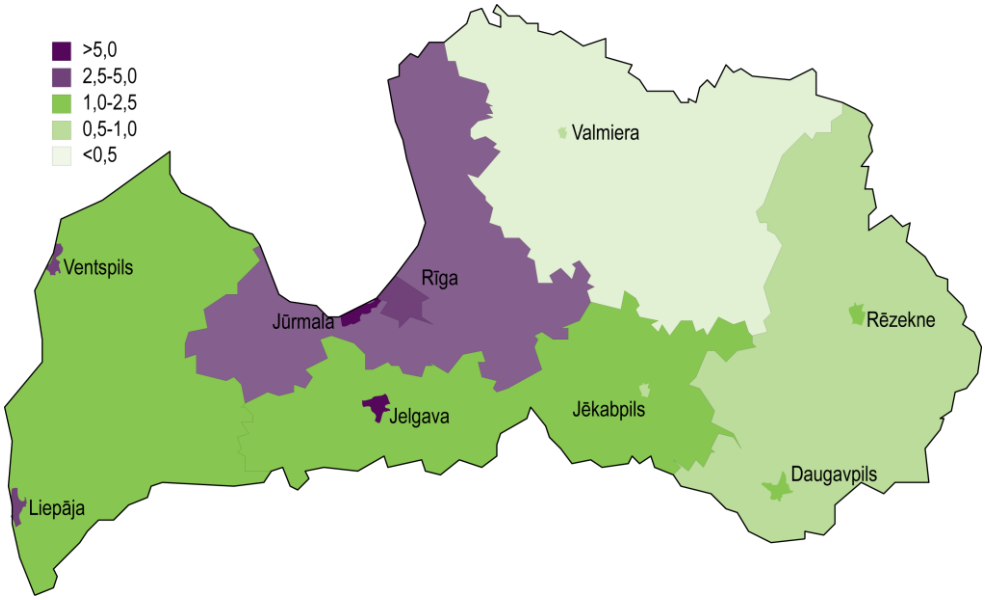
Table 5.3. Proportion of women among (registered) first-time treated patients in 2000–2009, %

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Proportion of women	20.5	20.2	22.1	24.3	24.7	24.1	20.0	21.5	19.1	21.5

Source: The Centre of Health Economics, 2010

The trend observed in recent years that an increasing proportion of patients living outside Riga is turning for help from an addiction specialist was maintained in 2009. The proportion of first-time patients resident in Riga has decreased from 67% in 2002 to 39% in 2009 (45% in 2007 and 42% in 2008) *(see Figure 5.3 above)*. Next in terms of first treatment demand cases is the Kurzeme planning region (18.1%), the Pieriga region (17.3%) and the Latgale region (13.5%), while the proportion of newly treated patients is significantly lower among those living in the Zemgale and Vidzeme regions in 2009, respectively 9.5% and 2.3%. Figure 5.5 shows number of first treatment demands per 1,000 inhabitants according to NUTS-3 level and in major cities.

Figure 5.5. Number of (registered) first-time treated clients in 2000–2009 according to NUTS-3 and in major cities in Latvia, per 1,000 inhabitants

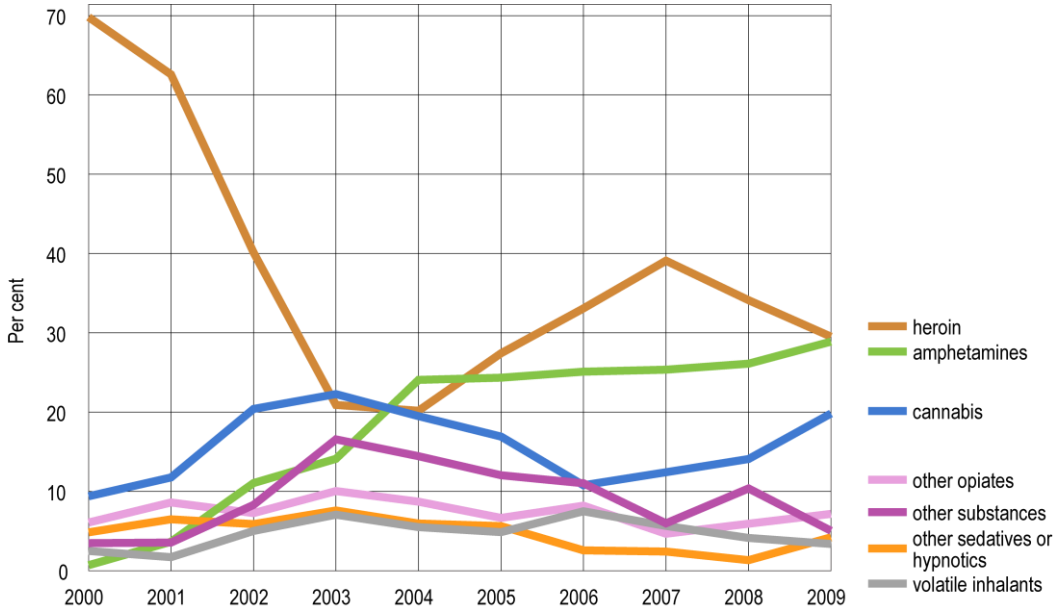


Source: The Centre of Health Economics, 2010

As previously, the most often mentioned primary substance among first-time treatment entrants is heroin, followed by amphetamines and cannabis. Out of 474 first-time out-patient treatment entrants in 2009 140 clients (or 29.5%) reported primary heroin use, 137 (28.9%) – primary

meth(amphetamine) use, for 94 clients (19.8%) primary cannabis use had been reported, while other opioids (mostly home-opioid *hanka*) have been reported among 34 (or 7.2%) first-time treatment clients. Use of other substances has been reported in less than 20 cases *(see Figure 5.6 and Fonte[34])*.

Figure 5.6. Number of first-time clients entering outpatient treatment centres by substance in 2000–2009, %



Source: The Centre of Health Economics, 2010

According to the ICD-10 diagnosis the most prevalent diagnosis is related with poly-drug dependence, withdrawal, intoxication or harmful use (F19 – 176 clients or 37.1%), in 118 cases (or 24.9%) – opioid-related diagnosis (F11), in 74 cases (or 15.6%) – stimulant-related diagnosis (F15), while in 64 clients (or 13.5%) have been diagnosed with cannabis-related diagnosis (F12). It is worthwhile mentioning that there has been a steady increasing trend clients who seek treatment for the first time with severe cannabis-related problems, i.e. 24.5% (or 23 clients) have been diagnosed with diagnosis of dependence (18 with F12 and five with F19). The percentage of first treatment clients by primary drug with dependence diagnosis is reported in Table 5.4 below.

Table 5.4. Dependece diagnosis among clients of selected primary substances in 2000–2009 (%)

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Heroin	75,5	72,0	62,1	90,9	95,5	96,3	95,0	97,9	94,3	93,6
Amphetamines	12,5	16,7	32,8	34,6	40,0	40,0	38,3	45,9	52,8	48,9
Cannabis	9,5	1,7	14,4	3,7	14,1	10,6	15,2	18,2	23,2	24,5

Source: The Centre of Health Economics, 2010

Clients in long-term pharmacotherapy using methadone

According to national statistics, as of December 31, 2009 there were 139 patients being treated in three methadone programs, of which 30 were women (*Centre of Health Economics, 2010*). 109 patients were being treated in Riga at that time, while 25 patients were being treated in Jelgava and five patients in Liepaja. In 2009, 61 patients enrolled in the methadone program for the first time in their lives (54 men and 7 women), while 39 patients stopped treatment (*see Table 5.5*).

[34] TDI_2010_LV_01

Table 5.5. Number of clients undergoing pharmacological therapy for opioid addiction in 2007–2009

		First-time admitted patients			Patients discharged from the program			Patients included in program			Patients in program on 31st December		
		T	F	M	T	F	M	T	F	M	T	F	M
Methadone	2009	61	7	54	39	7	32	163	37	126	139	30	109
	2008	44	13	31	41	14	27	132	38	94	103	27	76
	2007	45	11	34	29	8	21	85	24	61	75	21	54
Buprenorphine	2009	18	0	18	15	3	12	*n.a*	*n.a*	*n.a*	50	7	43
	2008	28	3	25	33	4	29	*n.a*	*n.a*	*n.a*	61	10	51
	2007	42	8	34	71[35]	16	55	*n.a*	*n.a*	*n.a*	59	11	48
Total	2009	79	7	72	54	10	44	*n.a*	*n.a*	*n.a*	189	37	152
	2008	72	16	56	74	18	56	*n.a*	*n.a*	*n.a*	164	37	127
	2007	87	19	68	100	24	76	*n.a*	*n.a*	*n.a*	134	32	102

Source: Centre of Health Economics, 2010, NFP estimates from Health Payment Centre data, 2010

According to Health Payment Centre data, 163 individuals had received methadone during 2009, of whom approximately one quarter (22.7%) were women. The youngest client in the methadone program in 2009 was 21 years of age; the oldest was 62; the modes of age were 25 and 32 years. Approximately 15% (or 27 patients) were older than 45 years (*see Table 5.7*).

Table 5.7. Age of patients treated in the methadone program during 2008 and 2009, %

	2008	2009
Younger than 20	0.0	0.0
20–24	12.1	8.0
25–29	29.5	38.0
30–34	18.2	21.5
35–39	8.3	6.7
40–44	9.8	9.2
45–49	11.4	8.0
50–54	8.3	6.1
55–59	2.3	1.8
60–64	0.0	0.6

Source: Centre of Health Economics, 2010; NFP estimates from Health Payment Centre data, 2010

According to Health Payment Centre data, in 2009, 39,571 doses of medication were distributed to the clients of the methadone program (a 32% increase as compared with 29,903 doses in 2008). In Latvia, the quantity of the methadone dose is determined for each patient individually by their treating physician and it can vary during the medical treatment process (*Public Health Agency, 2007*). Data on daily doses of methadone for individual patients is not collected in a single database, but the 2010 study of methadone clients undertaken by the CHE in collaboration with RAPC indicates that most patients are issued with 80 ml of methadone per day (the lowest dose indicated was 35 ml and the highest dose was 150 ml) (*Trapencieris, Pelne, 2010*).

MMT in Latvia also utilises *Contingency Management* elements *(see NIDA, 2009)*; for example, regular monitoring of urine tests, where in the event of a negative test, permission is given to take methadone home for several days at a time. Given that dependency treatment is provided by addiction-specialist physicians, who are also dealing simultaneously with the treatment of alcohol-dependent patients, and who are in most cases psychiatrists, medicinal treatments are widely utilised, using, for example, such as treatment with opioid antagonists (e.g. naltrexone) relapse prevention therapy, selective serotonin reuptake inhibitors (SSRIs), and other symptomatic medication.

[35] Of those, 53 patients of Finnish nationality (11 women and 42 men) were excluded from the program.

6. Health correlates and consequences

This chapter includes information on health correlates and consequences of drug use. It includes information from routine monitoring data collection systems, such as HIV, hepatitis and tuberculosis case registers for infectious diseases data, General Mortality Register, etc., as well as in-depth data analysis on psychiatric and somatic co morbidity of drug users. Besides data on non-fatal drug overdoses and profile of clients at emergency facility of Toxicology Centre in Riga is reported in this Chapter. Data included in this chapter is provided also in standard tables reported to the EMCDDA via *Fonte* system and if not discussed in this chapter is provided in the methodological remarks for the tables and topics of interest. Information on mortality cohort studies in detail is provided in the Selected Issue on Mortality related to drug use.

6.1. Drug-related infectious diseases

Notifications data

HIV/AIDS

The epidemiological monitoring of HIV/AIDS in Latvia has been undertaken since September 2009 by the State Agency: Infectology Centre of Latvia (ICL) HIV/AIDS control program coordination implementation department. In 2009, 134,919 blood samples (including blood donors) were tested nationally in epidemiological monitoring network laboratories and low-threshold centres (HPP) to diagnose HIV infection. Compared to 2008 (n=152,010), the number of persons tested had decreased by 11.2%. Of all blood, samples examined 176 were taken from injecting drug users (IDUs) *(see Table 6.1)*.

Table 6.1. Total number of blood samples tested for the diagnosis of HIV infection, and proportion of tested IDU blood samples in Latvia, 2003-2009

	2003	2004	2005	2006	2007	2008	2009
The total number of blood samples[36] for the epidemiological monitoring network of laboratories and HPP	164,936	155,128	142,333	153,193	148,619	152,010	134,919[37]
The total number of blood samples[38] for the epidemiological monitoring network of laboratories and HPP	82,424	84,054	85,538	85,117	79,279	72,444	59,331[39]
Number of IDU blood samples	987	212	363	349	386	357	176

Source: Infectology Centre of Latvia, 2010

According to LIC data, 4,614 cases of HIV infection (204 per 100,000 population) were registered nationally to the end of 2009 (4,339 in 2008), of which 826 persons were diagnosed with AIDS. At that point in time 559 deaths were registered among PLHIV. Overall, 275 new cases of HIV infection were registered nationally last year, which is 83 cases less than in 2008 (358 in 2008).

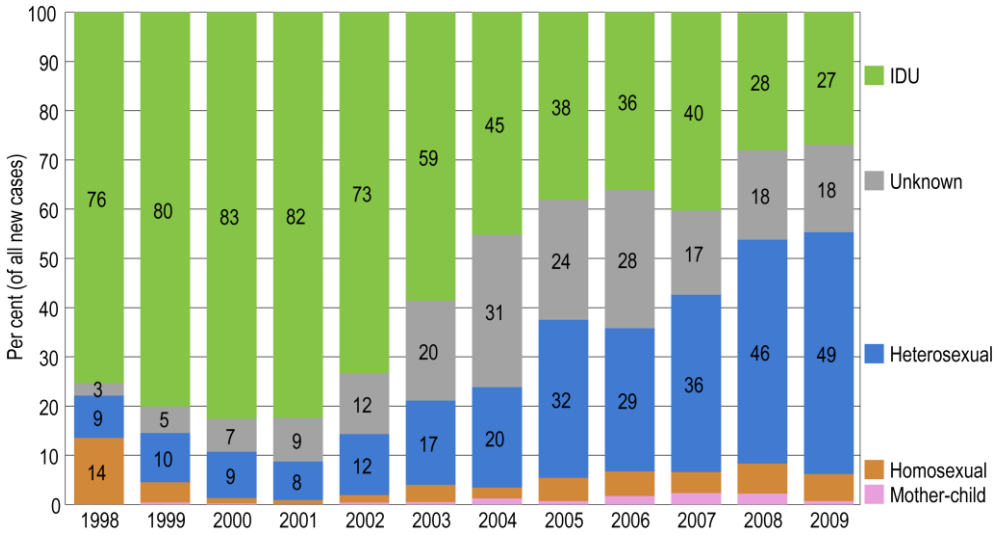
Comparing the average HIV prevalence rates in Europe, Latvia ranks among the European Union (EU) Member States where the prevalence of infection is high – in 2008 the registered HIV prevalence in Latvia was 158 cases per million population, while the EU average was 61 cases per million population (*UNGASS, 2010*).

Since 2008, the leading HIV transmission route is heterosexual sexual contact. Until then, most people were infected with HIV through the sharing of injecting drug paraphernalia. Therefore, in 2009, 49.1% (n=135) of new HIV cases were acquired through heterosexual transmission,

[36] Including state-funded tests, private tests, and testing of blood donors
[37] Including 1,238 tests for drug users at low threshold centres
[38] Excluding blood donors
[39] Primary HIV diagnostics within the laboratories of the epidemiological surveillance

26.9% (n=74) through injecting drug use, 5.5% (n=15) through homosexual contact, 0.7% (n=2) via vertical transmission and in 17.8% (n=49) of cases the infection route is unknown *(see Figure 6.1)*.

Figure 6.1. Annual distribution of new HIV cases in 1998–2009 by transmission groups, %



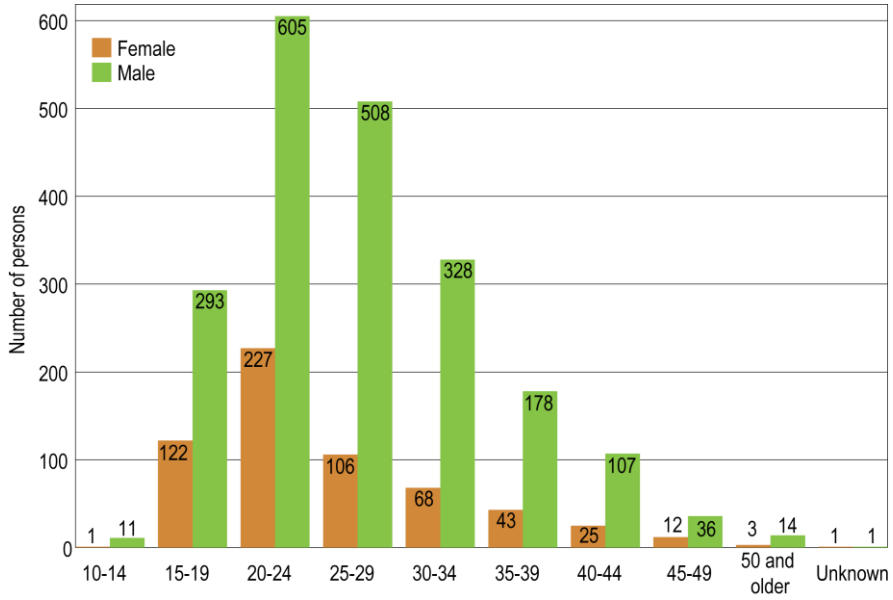
Source: Infectology Centre of Latvia, 2010

Of all new HIV cases in 2009, 61.8% (n=170) were men and 38.2% (n=105) were women. It is concluded that when the epidemic had reached its peak in 2000/2001, infection was more widespread among men. With each succeeding year, the number of new HIV cases recorded among men fell, but the number of new cases among women remained stable. This situation is considered typical in countries where the epidemic is concentrated within the injecting drug user (IDU) population. That is to say, men become infected by sharing drug-injecting paraphernalia, while women are infected during sexual contact with these men. This means that although the number of cases of heterosexual transmission is increasing, it would not be correct to say that this indicates the generalisation of an epidemic in the community, caused by sexual contact (de Joncheere et al., 2009). These heterosexual transmission cases may more accurately be described not as heterosexual contact, but as sex with injecting drug users. A true national sexual transmission epidemic would be observed if the female sex partners of IDUs served as a bridging group, and further spread the infection among men who did not inject drugs. In other words, the situation would arise that nationally men were increasingly often being infected, although they are not IDUs, and do not have sexual relations with male or female injecting drug users, and who are not infected either with virus hepatitis B or C. However, for the time being no such manifestations have been observed in Latvia (*UNGASS, 2010*).

One of the trends mentioned, namely, that a reduction has been observed in the number of new HIV cases acquired via IDU, could be due to the operation of an active HIV prevention network among injecting drug users in Latvia. Its activity has particularly increased in recent years thanks to the opportunity, with UNODC support, of increasing the number of HIV prevention points, and expanding the number and range of services provided (see also Chapter 7.2) (*UNGASS, 2010*).

Overall, at 31 December 2009, 2689 persons (58.3% of all recorded cases) who had acquired the infection through injecting drug use were registered in Latvia, of whom 77.4% (n=2081) were men. One third (30.1%, n=832) were between the ages of 20–24 at the time the infections were diagnosed *(see Figure 6.2)*.

Figure 6.2. Total number of cases of HIV acquired through injecting drug use by gender and age groups until December 31, 2009



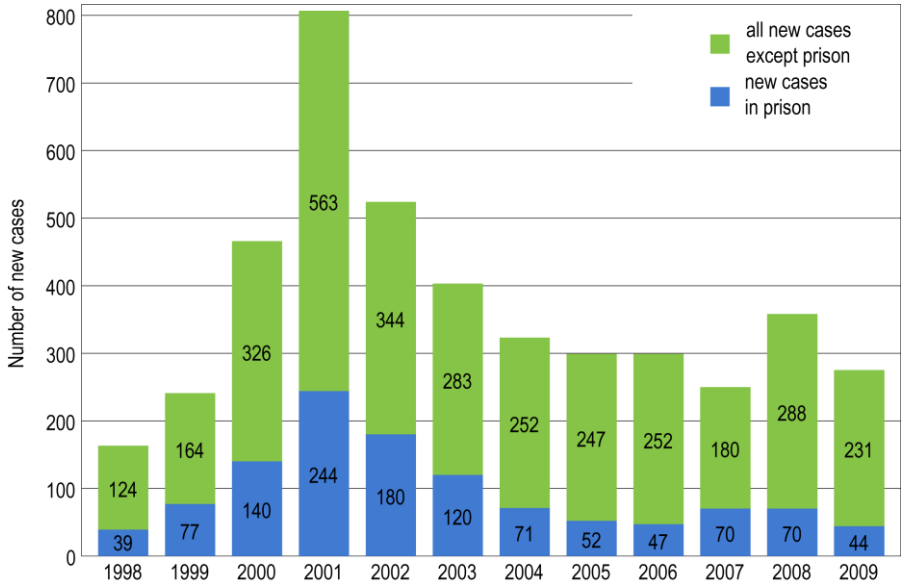
Source: Infectology Centre of Latvia, 2010

By examining the new cases transmitted via injecting drug use, it can be concluded that the breakdown by gender since 1999 has remained similar: of all persons infected each year via this transmission route, around 20–25% are women.

Of all persons infected via IDU until the end of 2009 (n=2689), 18.6% (n=499) were diagnosed with AIDS. 14.5% (n=390) persons who were HIV-infected via IDU had died. Of new HIV cases among IDUs recorded in 2009 (n=74), two were diagnoses in the AIDS phase. Two persons had died.

Until the end of last year, 1155 cases (or 25% of all registered cases) of HIV infection were diagnosed amongst individuals located in prisons. Of all new annual HIV cases recorded each year, 20–30% are diagnosed among inmates. So for example, in 2008, 20% of all diagnosed cases recorded for the year were in prisons, while in 2009 the figure was 16% *(see Figure 6.3)*.

Figure 6.3. Annual number of new HIV cases diagnosed nationally, and the proportion of cases in prisons, 1997–2009



Source: Infectology Centre of Latvia, 2010

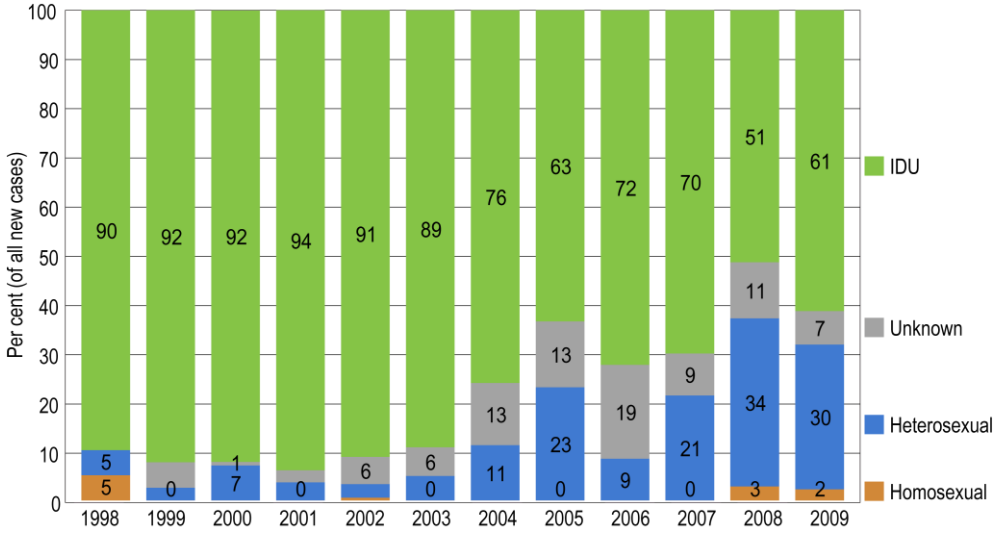
Examining cases of infection among prisoners in terms of transmission type, it must be concluded that trends are the same as for the general population: a reduction in the number

acquired as a result of injecting drug use, and an increase in the number of cases due to heterosexual contact (see Figure 6.4). From cases of infection recorded among the prison population in 2009 (n=44), 27 cases (61.4%) were acquired through IDU, 13 (29.6%) via heterosexual contact, one case via homosexual contact, and in three cases the transmission route was unknown.

The majority of HIV infection cases among prisoners are diagnosed at the moment of imprisonment when, in accordance with the procedures stipulated in regulatory enactments, prisoners undergo a medical examination, which includes being invited to undergo HIV testing (this intensified testing of prisoners is one of the factors explaining the high annual rate of newly diagnosed HIV cases registered in prisons each year). Repeated HIV tests are only carried out in individual cases according to clinical indications or by personal request. This means that the country has no information about how many persons acquire the infection while in prison (*UNGASS, 2010*).

According to MoH data, there were around 400–450 PLHIV in prison during 2008 and 2009. Thus, given that there were 7055 inmates in the 12 Latvian prisons as at 1 January 2010, the approximate prevalence of HIV in prisons is 6% (prevalence in the general population is 0.2%). Around 95% of infected prisoners have injecting drug use experience (*Prison Administration, 2010; UNGASS, 2010*).

Figure 6.4. Annual new cases of HIV among prisoners, by transmission groups, 1997–2009



Source: Infectology Centre of Latvia, 2010

In 2009 a study was published, which also confirmed that the Latvian penitentiary system could be one of the drivers of the HIV epidemic nationally. That is, by utilising the database from the Public Health Agency's 2007/2008 cross-sectional study, "Determining the prevalence of HIV and other infectious diseases and associated risk behaviour among injecting drug users and their sexual partners in Latvia, Lithuania and Estonia" (conducted as an EC project within the ENCAP framework, as described in the previous year's National Report), factors were identified that affect the prevalence of HIV among IDUs in Latvia. The prevalence of various factors was compared among HIV-positive and HIV-negative IDUs. The Odds Ratio (OR) and the adjusted Odds Ratio (sOR) were calculated using binary logistic regression analysis. One of the factors that closely and statistically credibly related to HIV-positive status among IDUs is the fact of being imprisoned during their lifetime (OR=1.70, 95% CI 1.1–2.7). In other words, those IDUs who reported having ever been in prison are 1.7 times more likely to be HIV-infected than those who have not been in prison. To rule out the possibility that this relationship could be explained by other factors, adjusted[40] OR was calculated: OR=1.87 (95% CI 1.0–3.4) (*Karnīte A. et al. 2009*).

According to the Riga Drug Users' Cohort Study data from 2009 as compared with previous waves of the study saw the highest ever proportion of hepatitis tests performed (70% in 2007;

[40] Adjusting for gender, age, length of injecting, the main injected drug, sharing of syringe with known HIV-infected person

74% in 2008; and 86% in 2009) *(see Table 6.2)*. According to respondents' replies, slightly less than one in two (46%) drug users could be classified as having recently undergone testing.

Table 6.2. Proportion of respondents tested for HIV and hepatitis across three phases of the cohort study (% of respondents)

	2007			2008			2009		
	HBV	HCV	HIV	HBV	HCV	HIV	HBV	HCV	HIV
Ever tested	70		87	74		89	86		96
Recently tested[41]	52		67	62		75	46		70
Self-reported status of infection from all tested	22	53	20	17	61	18	16	66	17

Source: Trapencieris, Sniķere et al. 2009

According to their responses, in 2009 16% and 66% of tested respondents believed themselves to be infected with hepatitis B or C respectively, while 29% and 10% did not know their hepatitis B or C status.

The results of the 2009 study show that the majority (96%) of drug users have undergone testing for HIV during their lifetime. Of those tested for HIV, 6% were unable to answer as to when they had most recently been tested for HIV, while 70% had done so relatively recently (39% in 2008 and 28% in 2009).

Only 2% of tested cohort participants did not wish to disclose their HIV status, while 2% did not know or had tested negative according to their replies. 17% of tested respondents admitted that the most recent test result had been positive. By comparison, in the 2006 survey 14% of respondents tested positive for HIV, 20% in 2007, and 18% in 2008, but as results obtained from the survey are not laboratory tested it is difficult to say to what extent the information provided by the respondents is accurate.

Hepatitis A/B/C

A sharp increase in hepatitis A in Latvia was observed as from November 2007. Overall, 2817 hepatitis A cases were confirmed in the period between 20 November 2007 and 31 December 2008. As mentioned in a published research study firstly the epidemic started among drug users (*Perevoscikovs et al. 2009*).

In 2009 the situation stabilized, but the overall morbidity during the year remained high; 2291 infected were registered, of whom 44.1% (n=1010) were women, while 55.9% (n=1281) were men.

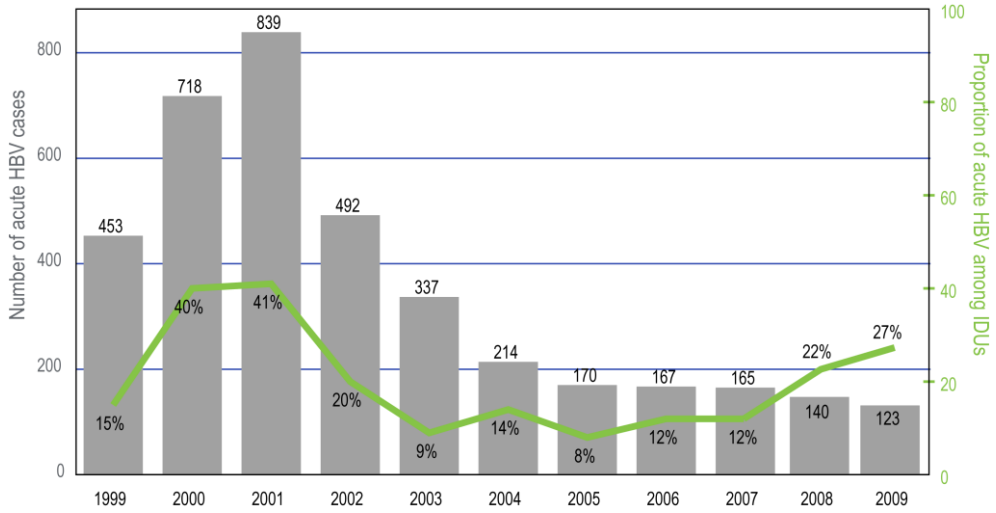
In 2009 there were 123 (140 in 2008) cases of acute viral hepatitis B recorded, of which 43 (35.0%) were women, and 80 (65.0%) were men. Of these, 33 cases or 26.8% were acquired via injecting drug use *(see Figure 6.5 and Fonte[42])*.

Chronic virus hepatitis B was identified in 73 persons, of which three cases were acquired by sharing injecting drug paraphernalia.

It should be mentioned that in a very high proportion of cases, the transmission route is not found: 29.3% (n=36) of acute cases and 84.9% (n=62) of chronic hepatitis. Perhaps for this reason, the proportion of IDU is underestimated because IDU may also be among the cases for which the transmission route remains unknown.

[41] Of those tested and who had indicated the year of testing. Regarded as recently tested are those tested during the survey year or during the previous year.
[42] ST9_2010_LV_01

Figure 6.5. Annual number of cases of viral hepatitis B (in absolute numbers), and proportion of cases acquired from injecting drug use, 1999–2009



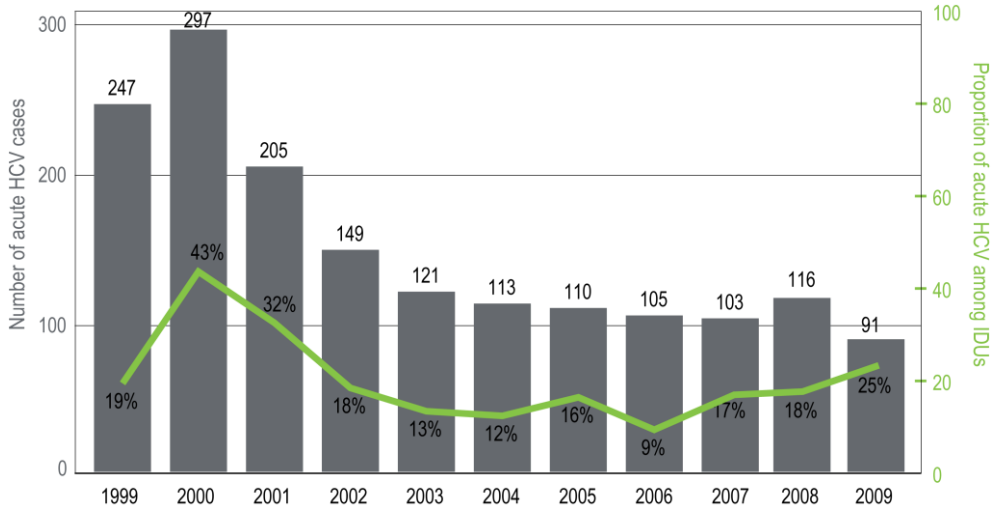
Source: Infectology Centre of Latvia, 2010

In 2009, 91 persons were registered with acute viral hepatitis C, of which 23 (25.3%) were infections acquired through injecting drugs. In 2008, acute hepatitis C was confirmed in 116 persons *(see Figure 6.6)*.

Chronic hepatitis C infection was identified for 1271 persons, of whom 112 or 8.8% had been injecting drug users.

Also observed was a very high level of viral hepatitis C cases that were acquired via unidentified infection route: 36.3% (n=33) in the case of acute hepatitis, and 77.2% (n=981) in the case of chronic hepatitis, and for this reason the proportion of IDUs is likely to be rated lower than it really is.

Figure 6.6. Annual new cases of acute viral hepatitis C (in absolute numbers) and proportion of cases acquired through injecting drug use, 1999–2009



Source: Infectology Centre of Latvia, 2010

Since 2001, a stabilisation is seen in the number of new hepatitis B and C cases, but since 2005, an increase has been observed in the proportion of cases acquired via IDU.

Sexually transmitted diseases and tuberculosis

In recent years, the national incidence of first-time tuberculosis (TBC) is decreasing *(see Table 6.3)*, as well as mortality from it, but it remains a pressing concern, particularly among drug users and PLHIV.

Table 6.3. Number of new first-time TBC cases in 2000–2009, per 100,000 inhabitants

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Incidence of TBC	70.5	72.9	65.4	63.3	59.0	53.5	49.7	47.2	40.3	36.6

Source: Infectology Centre of Latvia, 2010.

Overall, 830 new cases were recorded nationally in 2009. Higher indicators are recorded for men than women; in 2009 the number of first-time cases per 100 000 men was 53.5 (n=559), but per 100 000 women it was 22.2 (n=271); additionally 123 (5.4 per 100 000 population) TBC relapses were registered in 2009.

88 persons died from tuberculosis in 2009, (3.9 cases per 100 000 population.); of these, 68 were men (6.5 per 100 000 population) and 20 were women (1.6 per 100 000 population).

Of all cases (initial and relapse), 44 persons were identified in 2009 as drug users, of whom 34 were men and 10 were women.

The Infectology Centre of Latvia also lists those patients showing signs of a co-infection, namely, tuberculosis and HIV/AIDS. The number of patients co-infected with TBC and HIV since 2000 continues to increase. In 2009, 73 such persons were recorded (first-time cases and relapses) *(see Table 6.4)*, of which 45 are men and 28 are women.

Table 6.4. The number of persons co-infected with tuberculosis and HIV/AIDS in Latvia, absolute figures

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
absolute figures	14	27	25	40	40	53	46	56	72	73

Source: Infectology Centre of Latvia, 2010

The highest number of co-infection cases is registered in the age group 25 to 34 years (n=33).

The Infectology Centre of Latvia collects and compiles information not only on HIV/AIDS and viral hepatitis B and C, but also for other sexually transmitted infections. This information is currently not analysed in the context of drug use.

Compared with 2008, there has been a reduction in the number of cases of sexually transmitted infections such as syphilis registered in 2009 (2005: 192 cases per million population; 76.5 in 2009) and gonorrhoea (2005: 301 cases per million population; 191 in 2009), while there is an increased incidence of chlamydiosis (2005: 316 cases per million population; 498 in 2009) *(see Table 6.5)*. The increase in chlamydiosis cases in recent years is attributable to changes in the system of epidemiological monitoring (i.e. since mid-2008, diagnosed cases are reported not only by doctors, but also by laboratories).

Table 6.5. Number of cases registered for sexually transmitted infections in 2001–2009, absolute number

	Syphilis	Gonorrhoea	Chlamydiosis	HSV
2001	594	551	589	51
2002	679	555	582	49
2003	784	481	502	52
2004	584	537	528	59
2005	443	694	729	90
2006	483	746	820	67
2007	301	669	711	98
2008	234	487	704	94
2009	173	433	1127	74

Source: Infectology Centre of Latvia, 2010

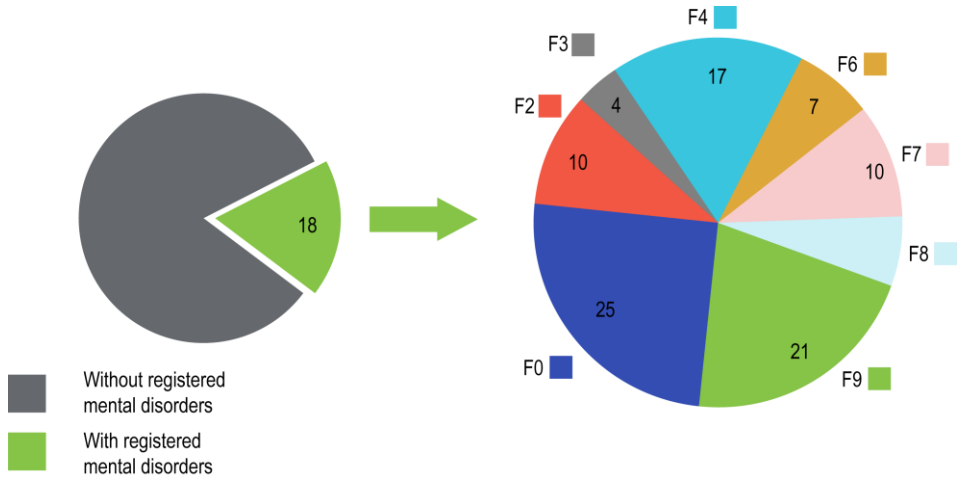
6.2. Other drug-related health correlates and consequences

Psychiatric co-morbidity

In 2009 National Report background information on a study looking at co-morbidity was reported, which was carried out by linking individual level TDI data with the data on mental health patients. Both databases are part of PREDA system, which uses a unique personal identifier thus allowing linking these sources (for PREDA compontents see also chapter on treatment).

The study design was a retrospective cohort study by employing data linkage between two databases and it covered 7,286 subjects who entered drug treatment between 1998 and 2008. Data analysis carried out suggest 18,4% of clients in drug treatment has been diagnosed with mental health disorders (other than F10–F19) (*Pulmanis, Trapencieris and Taube, 2010*). The most common reported incident mental health problem for co-morbid clients were organic mental disorders (25%), behavioural and emotional disorders with onset usually occurring in childhood and adolescence (21%), and followed by neurotic/stress-related disorders (17%) *(see Figure 6.7)*. Data also reveals 11% of clients with co-morbidities have been diagnosed almost simultaneosly (within six months interval between the two diagnoses), for about one-third (31%) of patients pyschiatric disorder was followed by a drug use disorder, while for the rest (58%) – drug use disorder was followed by psychiatric disorder. Data analyzed also reveals women have more often co-morbid situations as compared with men (OR=1.2; 95% C.I. 1.1–1.4; p<0.001), and Latvian speaking than non-Latvian speaking in treatment population (OR=1.5; 95% C.I. 1.3–1.7; p<0.001). Treated primary amphetamine clients more often than heroin patients have been also diagnosed with a mental health disorder (OR=2.1; 95% C.I. 1.8–2.7; p<0.001).

Figure 6.7. Percentage of drug treatment clients with co-morbities and respective ICD-10 groups, %



Source: Pulmanis, Trapencieris & Taube, 2010

Non-fatal overdoses and drug-related emergencies

The Riga Eastern Clinical University Hospital Toxicology Centre has compiled data on the number of cases of poisoning and non-fatal overdose in the period 2005-2009. Due to technical problems, no data are available for 2008. Information is limited to inhabitants from Riga and the Riga district who were treated for drug overdose in the Toxicology Centre during the relevant period.

Available evidence suggests that most frequently patients at the Toxicology Centre were treated for opiate and stimulant overdose *(see Table 6.7)*. Every year, some cases are registered for poisoning with cannabinoids, while between 2005-2009 three cases of cocaine overdose (2007-2009) and two cases of overdosing on hallucinogens (2007-2009) were recorded. Each year, patients arrive at the Toxicology Centre having been poisoned by unknown substances; e.g. in 2009 there were 42 cases of patients being treated for poisoning by unknown substances, while

38 patients were treated for overdosing on unknown drugs.[43] At the Centre, men are treated for drug overdose more often than women; in 2009 110 men and 33 women were treated.

Table 6.7. Number of overdoses in 2005–2009[44] by gender and substance

	2005			2006			2007			2009		
	M	F	T	M	F	T	M	F	T	M	F	T
Opioids	60	7	67	71	16	87	59	7	66	31	3	34
Cocaine	0	0	0	0	0	0	1	1	2	1	0	1
Stimulants (excluding cocaine)	22	2	24	38	9	47	48	12	60	13	8	21
Hallucinogens	0	0	0	0	0	0	0	0	0	0	1	1
Cannabinoids	3	2	5	6	1	7	4	3	7	5	1	6
Unknown substance	28	26	54	32	23	55	10	12	22	27	15	42
Unknown drugs (according to diagnosis at entry)	17	2	19	14	11	25	24	5	29	33	5	38

Source: Riga Eastern Clinical University Hospital Toxicology Centre, 2010

In some cases, patients were admitted at the Toxicology Centre who had used several substances simultaneously. The most commonly reported cases involve the use of other substances in combination with heroin and amphetamines *(see Table 6.8)*. In several cases, alcohol was consumed together with drugs.

Table 6.8. Most often found combinations of substances 2005–2009 by gender, absolute number

	2005			2006			2007			2009		
	M	F	T	M	F	T	M	F	T	M	F	T
Heroin and other substances	2	1	3	14	1	15	5	0	5	22	0	22
Amphetamines and other substances	1	0	1	14	0	14	10	3	13	7	3	10
Drugs and alcohol	5	1	6	15	2	17	21	4	25	13	2	15

Source: Riga Eastern Clinical University Hospital Toxicology Centre, 2010

Available data indicate that since 2005, patients treated at the Toxicology Centre for heroin and amphetamine overdose were mainly under the age of 40 years *(see Table 6.9)*. During the relevant period, not a single case is recorded of an adolescent below 15 years of age attending the Toxicology Centre. Most overdose cases were recorded in the 20-29 year age group. For example, in 2009, 20 patients in the relevant age group were treated for heroin overdose, and 9 patients were treated for amphetamine overdose. In amphetamine overdose cases, a relatively high figure is apparent for the age group 15-19 years (7 cases in 2009), while in the same age group only a few patients (1 case in 2009) were treated for heroin overdose; however, more patients over the age of 30 years were recorded: respectively, in 2009 there were eight cases of heroin overdose recorded and three cases of amphetamine overdose.

Table 6.9. Number of overdoses in 2005–2009[45] by gender and substance

	Amphetamines				Heroin			
	2005	2006	2007	2009	2005	2006	2007	2009
15–19 years	7	8	14	7	4	1	4	1
20–29 years	13	17	25	9	38	46	35	20
30–39 years	4	4	12	3	5	17	14	8
40 and older	0	1	4	0	3	1	1	0
Total	24	30	57	19	50	65	54	29

Source: Riga Eastern Clinical University Hospital Toxicology Centre, 2010

[43] According to ICD-10 diagnoses available at the Toxicology Centre
[44] Due to technical reasons 2008 data is not available
[45] Due to technical reasons 2008 data is not available

The question on overdosing in the 2009 study questionnaire included answer options that would allow better and more accurate analysis of the data, but with that, their comparability with previous phases of the study is limited.

The 2009 cohort study indicated that one in three (34%) drug users had overdosed at least once during their lifetime; of those, 24% had overdosed during the past year, and 76% had overdosed more than a year previously.

A comparison of women with men reveals the proportion of women overdosing during their lifetime is slightly higher than for men, but these differences are not statistically significant; 32% of men and 38% of women had overdosed during their lifetime.

Compared with the previous phases of the cohort study, the overdose rate (6%) for the past six months of 2009 is lower than previously observed (16% in 2006; 12% in 2007 and 13% in 2008), but these changes are most likely related to changes in the wording of the question. A further explanation of the reduced rate of overdosing is the increase in the proportion of amphetamine users in comparison to previous phases.

It was observed in 2009 that overdosing is less common among amphetamine users than among heroin users; 28% of current amphetamine users had overdosed once during their lifetime, compared to 43% of current heroin users.

During their last overdose episode, 57% had been helped by friends or acquaintances, 43% by health workers, and 15% had been helped by a family member.

6.3. Drug related deaths and mortality of drug users

Deaths associated with drug use are a complex phenomenon and comprise a significant percentage of all deaths among young people in many European countries. The European Monitoring Centre for Drugs and Drug Addiction in cooperation with national experts from member states has defined an epidemiological indicator having two components: deaths directly caused by illegal drugs, and overdosing and deaths among problem drug users.

In Latvia, information on cases of death associated with the use of drugs is compiled and analysed by two institutions: 1) the Centre of Health Economics[46] (CHE) is responsible for the data contained in the national *General Mortality Register (GMR)*, and 2) the Latvian State Centre for Forensic Medical Examination (LSCFME) is responsible for the data in the *Special Mortality Register (SMR)*. The *Causes of Death* database administered by the CHE includes national level data and is based on death certificates, which are initially forwarded from all parts of the country to the Central Statistical Bureau of Latvia and subsequently, on a monthly basis, to the CHE, where the received data is encoded, entered into the database and analysed.

The chief operational function of the Latvian State Centre for Forensic Medical Examination is conducting autopsies.

Both institutions cooperate, and throughout the year compare data bases of deceased persons, as initially the data held by both institutions are different, because when a person dies, a death certificate showing a possible cause of death is written immediately, but the result of a subsequent autopsy is received later. If the diagnoses (initially written and subsequently revealed) do not correspond, they are referred for amendment. For this reason, the databases of both institutions are regularly compared and essential amendments are effected to the very end of the current year.

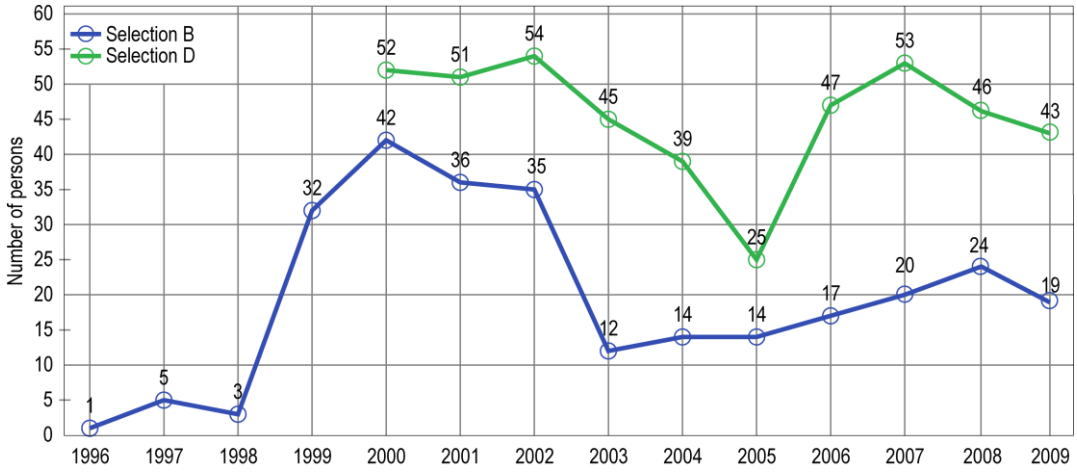
Statistical information

According to General Mortality Register data, in 2009 there were 19 deaths registered as drug induced deaths. The number is slightly lower with that reported for 2008 (24 cases) and 2007

[46] Established in accordance with Cabinet Order 509 of 29 July 2009. "On The Reorganisation of State Administration Institutions Subordinate to the Ministry of Health", assuming certain functions from the Public Health Agency, Medical Professional Education Centre, Health Compulsory Insurance State Agency, Health Statistics and Medical Technologies State Agency, which had until then maintained the GMR.

(20 cases). It is difficult to assess trends in drug induced mortality because of low number of deaths recorded annually and decreasing number of autopsies since 2007. Of the 19 cases 18 were male and one was female; the mean age of individuals among reported in 2009 was 28.1 years (in the range of 19 to 50 years of age); 13 deaths were registered in Riga city.

Figure 6.8. Cases of death involving the use of drugs 1996–2009[47]



Source: GMR and SMR, 2010

Of all drug-related deaths in 2009 no cases were classified as intentional poisoning, in three cases poisoning by undetermined intent (Y12) was registered, while the rest (16 cases) – were by accidental poisoning (X41 and X42) by various substances.

In 10 deaths (out of 19) morphine (T40.2) was determined to be the substance leading to death, one death was classified as due to heroin (T40.1), two cases of amphetamine/ methamphetamine related deaths (T43.6), while in six cases unspecified narcotics were mentioned (T40.6). Of the 11 opiate induced deaths in four cases no other substances were involved, in three cases opiates in combination with alcohol was recorded, in three cases opiates and benzodiazepines was recorded, while in one case opiates in combination with methamphetamine was mentioned.

Another 12 deaths[48] in 2009 had occurred involving psychotropic medicines (T42), of which all deaths were related with benzodiazepines as the leading cause of death. The mean age of these subjects was 43.8 years (ranging from 24 to 74 years of age); seven subjects were males and five were females.

According to data of the LSCFME[49], in 2009 43 deaths were recorded as Selection D cases. Of the 43 cases, 39 were males and 4 females. No significant changes in respect of number of persons deceased as compared with 2008 data were noticed.

According to the Selection D of 43 deaths, 18 cases were related with poisoning, in seven cases various injuries as the leading causes of death were registered, in five cases – suicides, in three cases – murder, in eight cases – nonviolent deaths, while in two cases ill-defined cause was mentioned. In 21 of the cases synthetic substances including combinations with alcohol or other psychotropic substances were mentioned, in 18 cases opiates were mentioned (of these 12 cases were with opiates alone, in two cases – opiates in combination with alcohol and synthetic drugs, and in four cases – opiates in combination with psychotropic substances), in one case cocaine in combination with psychotropic substances was mentioned, while in three cases unspecified narcotics were registered.

As mentioned in the previous national reports and by the institutions in charge of data collection or performing autposies, the number of deceased persons associated with the use of drugs could be higher; firstly for the reason that toxicological analyses were not undertaken for all the deceased, and secondly, it is possible that the existing equipment is unable to detect the

[47] See also Fonte ST5_2010_LV_01 (Selection B), ST5_2010_LV_02 (Selection D), ST6_2010_LV_01
[48] With psychotropic medicines as the substance leading to death. These deaths are not reported in ST5 as they do not fit criteria for inclusion in definition.
[49] Referred also as Special Mortality Register

presence of some new substance, and thirdly, the possibility exists that some substances evaporate more rapidly (*National Report, 2009*).

Autopsies are undertaken at the LSCFME; the need for an autopsy is determined by the police or a family physician. Cabinet Regulation No. 215 "Procedures for determining brain death and biological death, and for referring a deceased person for interment", which came into force on 12 April 2007, stipulates that a person's death shall be determined by a family physician, who shall also complete and issue a Death Certificate in the event of a "normal" death. In the case of an unnatural or violent death, the decedent's corpse is referred by the police for autopsy. In the case of an unnatural or violent death, the cost of the autopsy is funded by the State. The main problem and explanation for the fact that during the past year in particular, the number of autopsies conducted has sharply decreased, is the previously-mentioned Cabinet Regulation. There are concerns that not always does a general practitioner refer a corpse for autopsy and toxicological analysis, but instead registers some other cause of death. This could lead to a situation where the number of deaths attributed to drug overdosing in future periods could be "inexplicably" reduced.

7. Responses to health correlates and consequences

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

Emergency medical assistance provided in Latvia is free of charge to all its citizens, but as yet the Reitox Latvian National Focal point does not have data from the emergency departments. In the future, it is planned to commence work with those services, as well as the largest of hospital emergency departments in the country, to identify persons who have received assistance in drug overdose cases.

An important role in preventing drug overdose is played by the pharmacological treatment programs for opioid-dependent patients. Major legislative amendments were adopted in Latvia in 2008 to provide opportunities for expansion of methadone programs.

Similarly, a significant role in reducing overdose is performed by low threshold centres, where staff informs users about safe use and what to do in the event of a suspected overdose. Unfortunately, due to reduced funding there has been a sharp reduction in the number of street social workers.

7.2. Prevention and treatment of drug-related infectious diseases

Prevention

Since 1997, when the first syringe exchange point in Latvia was established in Riga, the range of HIV prevention and harm reduction services for IDUs has increased year by year. Thus, nationally in 2009 there are already 18 HIV prevention points (HPP) operating in 16 cities and towns. Each of these points offers a wide range of services and in each town, it is adapted to suit client needs: syringe exchange, street (outreach) work, secondary syringe provision, voluntary HIV counselling and testing, provision of disinfectants, information, education and counselling on various health, psychological and social issues and so forth (*UNGASS, 2010*).

According to information provided by Infectology Centre of Latvia, in 2009 outreach services were provided in nine cities (in three of them: for 12 months a year; in two: for 6 months; in one: 5 months and in another: 4 months). In six cities, outreach workers travel on foot, mobile units (minibuses) operate in two cities, and in one city (Riga), outreach work is performed both on foot and by minibus.

In 2009, the HIV prevention network issued 282,701 syringes and collected 242,555 used syringes[50]. It also conducted 1238 HIV tests (of which 109 tests or 8.8% were positive) and 129 tests for viral hepatitis C (of which of which 69 or 35.9% were positive).

In 2009, the HIV prevention network recorded 36,778 direct client contacts (contact between IDUs and HPP staff) and 21,118 secondary contacts (IDUs perform syringe/needle exchanges for other IDUs who do not come into direct contact with HPP staff).

The Latvian HPP network is an example of good practice in cooperation between the state, local governments and NGOs. The State provides network management methodology (undertaking capacity building and training of HPP staff) and coordinates its operations; besides it provides and maintains the technical equipment: syringes, needles, HIV tests, disinfectants, and informative materials (since 1 September 2009, the institution responsible is the Infectology Centre of Latvia (pursuant to Cabinet Order No. 509 of 29 July 2009 the State Agency "Public Health Agency" was reorganized and the above-mentioned functions were taken over by Infectology Centre of Latvia)). However, the municipalities (14 of 18 HPP are structural units of municipal social services) generally cover the cost of space and remuneration of employees.

[50] See also Fonte ST10_2010_LV_01

Two of the 18 HPP are state-funded and two are NGOs (*UNGASS, 2010; Infectology Centre of Latvia, 2010*).

Funds have not been allocated from Latvia's state budget for HIV prevention measures (information, education, etc.) and other health promotion measures in prisons. Such activities in prisons are mostly organized by NGOs within the frameworks of various projects, but they usually cease when the project ends. Harm reduction programs (pharmacological treatment of opioid addiction, syringe exchange, condom distribution, etc.) are not available at all in prisons (*UNGASS, 2010*).

One of the major transnational supporters of HIV prevention and harm reduction measures among IDUs and in prisons in Latvia since 2006 has been UNODC, implementing a four-year project entitled *"HIV/AIDS Prevention and Care among injecting drug users and prison settings in Estonia, Latvia and Lithuania"*. One of the main project activities is a small grants program. Grants are being implemented in three areas: the introduction of HIV prevention programs in prisons, capacity building of the syringe exchange program, and promoting access to pharmacotherapy.

Thus, during the period 2007–2009, 10 projects were implemented in detention centres; within the grants framework (5 out of 10 projects) detention centres have developed and implemented HIV prevention programs, most of which incorporate interactive information and educational programs for different groups of inmates and staff. NGOs such as "Apvieniba HIV.LV", "AGIHAS", and "Ecology of Consciousness" have implemented projects in prisons, during which various activities were implemented including informative educational sessions and counselling of prisoners by corresponding with them, preparation and issue of informative materials, voluntary HIV counselling and testing for prisoners, and seminars for prison staff, etc. (UNODC, 2009).

Also during the period 2007–2009, 23 projects were introduced to increase capacity of the syringe exchange program, including the establishment of new HPP in 5 cities: Saldus, Ventspils, Cesis, Jurmala and Riga (Infectology Centre of Latvia Tuberculosis and Lung Diseases in Riga outpatient department), as well as the establishment of a mobile unit (minibus) in the second largest city of Latvia – Daugavpils.

It is planned to continue project activities again in 2010. (*UNODC, 2009*)

It should be mentioned that on 30 June 2009 (by Cabinet Order No. 437) the Human Immunodeficiency Virus (HIV) Infection Control Program for 2009–2013 was adopted. The program includes measures to limit the spread of HIV including among IDUs and prisoners; providing HPP network operations and capacity building, expanding access to long-term pharmacological treatment for opioid dependence, improving the health care of IDUs, HIV diagnostic improvement in prisons, increasing knowledge about HIV/AIDS among prison staff and inmates, providing ART therapy for PLHIV and so forth. However, it should be emphasised that due to the economic recession in the country, sufficient funding has not been allocated for implementation of the program of measures (especially preventive measures). For example, the budget allocated for 2009 was approximately LVL 2.2 million (EUR 3.1 million), of which more than half (57%) was proposed for the provision of antiretroviral treatment and treatment for opportunistic infections, and 27% for the treatment and rehabilitation of IDUs, resulting in a relatively small proportion of funding being allocated to other essential preventive measures; for example, no funds at all have been allocated for professional training, involvement of NGOs, etc. It can therefore be concluded that the allocation of funding for treatment and prevention is disproportionate (*UNGASS, 2010*).

Furthermore, the program does not include financial support to local governments for maintenance of HIV prevention programs. So far, municipal authorities have voluntarily allocated funding for maintaining the HPP. This means that the financial responsibility between the state and local government in the area of remains indeterminate. And that is a serious threat to the sustainability of the HPP network. The situation is similar for other responsible authorities mentioned in the program: the Prison Administration Board, Ministry of Education and Science, etc. none of which has allocated additional funding, even though the responsibility for measures proposed in the program has been determined (*UNGASS, 2010*).

To be able to update, plan and implement prevention measures targeting drug-related infectiouys diseases in the future, it is necessary to systematically identify specific risk groups in which the prevalence of infection is high, and to identify the risk behaviours associated with transmission of infections. Thus, it is planned in the above-mentioned national HIV program to conduct such studies in various target groups: IDUs, MSM, PNP, and other populations.

Therefore, in 2010, Latvia plans to participate in the study entitled EMIS (European Men-For-Men Internet Survey), coordinated by the Robert Koch Institute in Germany. 27 member states will participate in the study and the questionnaire also includes questions about infection testing undertaken during their lifetimes, and their results, high-risk sexual behaviour, and preventive measures, compliance and accessibility, as well as drug and alcohol habits.

Also in 2011/2012 Latvia plans to participate in the study undertaken within the framework of the BORDERNET work project, coordinated by SPI Research gGmbH in Germany, on the prevalence of infection and associated risk behaviours (including drug use) among the PNP.

Treatment

In 2009, in the context of the difficult economic situation in the country, a fundamental reorganisation took place in Latvia in the field of infection monitoring and treatment. Notably, in accordance with sub-clauses 1.1 and 2.1.3.1 of Cabinet Order No.509 of 29 July 2009: "*On The Reorganisation of State Administration Institutions Subordinate to the Ministry of Health"*, on 1 September 2009, the State Agency "Public Health Agency" was abolished, and its functions in infectious disease prevention and monitoring, including HIV infection and sexually transmitted infections, were assumed by the State Agency "Infectology Centre of Latvia".

Likewise, in accordance with Article 1 of Cabinet Order No. 562 of 17 August 2009: *"On merging the Tuberculosis and Lung Disease State Agency with the State Agency "Infectology Centre of Latvia""*, as of 1 October 2009 the Tuberculosis and Lung Disease State Agency, which until then undertook TBC prevention, control and treatment, was merged with the State Agency "Infectology Centre of Latvia".

The diagnosis and treatment of viral hepatitis are also available at Infectology Centre of Latvia, however, these treatments are not fully covered by the State and patient co-payment is required, which, of course, limits the access to services, especially for IDUs (*UNODC, 2010*).

In terms of treatment services in prisons, it should be emphasized that the prison health care system is separate (the responsible authority is the Ministry of Justice) from the general health care system. This separation of functions has led to inequities in the quality of healthcare between inmates and the public. Since the health care budget for detention facilities is very low, and is insufficient to cover treatment costs for HIV or tuberculosis, the Ministry of Health has undertaken to provide this therapy to inmates from its own resources. The prisoners receive this treatment free of charge. However, the prisoners themselves have to bear a large share of the cost of care and treatment, including treatment for opportunistic diseases. It may also be concluded that ART is provided to an excessively small proportion of PLHIV in prison (about 5%), which may be linked both with the modest funding available nationally for the provision of ART, and the PLHIV prisoners' lack of knowledge about the care and treatment associated with this infection, and the problems with ART-related investigations and delivery of other services (*UNGASS, 2010*).

HIV treatment is included as one of the priorities in the national HIV program for the years 2009–2013, but it must be acknowledged that the funding allocated for it is insufficient, e.g. the amount allocated for the acquisition of ARVs in the 2009 budget has been reduced by 26% compared to 2008. Consequently, it is concluded that the state budget covers the cost of ART for only 50% of PLHIV who need it (*UNGASS, 2010, WHO/UNODC, 2009*).

Due to various problems related to the provision of ART in Latvia, in March 2009 a WHO/UNODC working group visited Latvia, and provided an opinion on HIV treatment and care in Latvia. The experts concluded that the cost of ART in Latvia is one of the highest in Europe, and this impedes the provision of therapy to all PLHIV who need it. Also identified is the limited availability of ART for IDUs and prison inmates due to stigmatisation and limited resources.

That is to say, that although most PLHIV in Latvia have acquired infections through IDU, fewer than one third of persons receiving ART have experience of IDU. Also identified is the highly individualised application of ART to HIV patients in Latvia. In 2009, the Infectology Centre of Latvia had assigned more than 67 different ART regimes, a factor that would also cause additional expense. Good practice is to use standardized treatment schemes, especially during conditions of limited resources. Problems were also found in ART drug procurement, which had repeatedly resulted in interruptions to therapy in recent years due to lack of medications.

It was also found that HIV treatment and care were highly centralised nationally; PLHIV health monitoring and ART medications can only be obtained in one place in Latvia i.e. at the LIC in Riga. However, the growing number of PLHIV in the country has revealed the need to broaden the access to ART, including making it available closer to the place of abode of PLHIV. It was also found that for PLHIV who need to receive ART, and who are participating in pharmacological opioid addiction treatment programs, both therapies are not available in one place/locality.

The experts' recommendations include reducing the cost of ART (to include all ART medications used on the list of state-funded medications, a reduction in prices in cooperation with pharmaceutical companies or by organizing parallel imports of medicines), promoting access to ART outside Riga, decentralization of treatment services, expansion of pharmacotherapy (including its introduction into prisons), as well as the integration of TB, HIV and pharmacotherapy and the possibility of obtaining all three therapies in one treatment facility/locality. It is also recommended that Infectology Centre of Latvia treatment guidelines be reviewed to bring them in line with the standardized WHO clinical protocol for European countries. It is also necessary to optimize drug procurement procedures (*UNGASS, 2010, WHO/UNODC, 2009*).

After receiving the results of that review, the situation has started to change in 2009. In April 2009 the Infectology Centre of Latvia HIV infection treatment guidelines were changed and approved following the expert advice from the WHO/UNODC, and they now approximate the treatment and care algorithms recommended by the WHO.

Also in late 2009 amendments were adopted to Cabinet Regulation No.899 of 31 October 2006: *"Procedure for reimbursing the purchase costs of drugs and medical equipment for outpatient treatment*". As from 1 January 2010 it is proposed to supplement the list of reimbursable diagnoses with those of the HIV diagnoses group, and to supplement the list of reimbursable medications with medications for the treatment of this infection in order to include them in a single reimbursement system covering the proposed costs of purchasing medication for outpatient treatment. As a result, ART treatment has become more decentralized. Still, ART can be initiated by the Infectology Centre of Latvia Council of Physicians, as was the case previously, but six infectologists in the major Latvian cities outside Riga are authorised to prescribe medication (for one month, or in the case of favourable response to treatment, up to 3 months), thus PLHIV medications can be obtained from a nearby pharmacy. Following talks initiated with family physicians, it is acknowledged that family physicians are not prepared to undertake care of PLHIV; it will firstly be necessary for them to undergo training in HIV/AIDS treatment and care issues (*UNGASS, 2010, WHO/UNODC, 2009*).

8. Social correlates and social reintegration

The issue of social exclusion of drug users has not been widely studied, and therefore the Report only analyses the general social conditions of dependent persons. The National Report utilises two sources: the treatment demand indicator on first-time treated patients, and the research results of the annual cohort study of problem drug users (*Trapencieris M., Sniķere S. et al. 2009*). Although both data sources are not exhaustive, it is possible to draw some conclusions characterising the risks of social exclusion for drug users.

The majority of social reintegration cases are associated with social rehabilitation. Although programmes and measures have been developed in Latvia for the integration of individual groups into society, there is no specific program for the reintegration of drug users. It is possible to discuss individual projects and measures in general, but not regarding a nationally devised system, which, by the reintegration process, would address issues such as place of abode, employment and education.

8.1. Social exclusion and drug use

Social exclusion groups and drug use

No research has been conducted in Latvia on the relationship between groups subject to the risk of social exclusion related and drug use, so there is only a hypothetical possibility of identifying certain marginal groups, among which there would be a relatively high proportion of drug users.

One of the most conspicuous marginalized groups in society is the homeless. From observations in night shelters, the homeless are characterised by long-term unemployment, no place of abode, insufficient qualifications, poor state of health, low income, lack of motivation (*Užule, 2010*). It is known that serious alcohol and drug problems exist among homeless people, but the lack of specific data precludes a more objective assessment.

Drug use has also been studied among people who have been in custody. In the cohort study, approximately 51% of drug users had been in prison on at least one occasion (*Trapencieris, Sniķere et al. 2009*)

The Roma people are another social exclusion risk group. In comparison to general national indicators, this minority is characterised by a low level of education and high unemployment. Furthermore, there is a widely held belief in the community that the Roma have links with criminal circles involved in activities such as theft, drug trafficking, fraud, etc. The Roma comprised 4.5% of all participants in the cohort study, the highest indicator among the other minorities[51].

The relationship between social exclusion and drug use may also be analysed from another perspective, namely, by analysing the social conditions of drug users, particularly those indicators which could help identify the risks of social exclusion, e.g. education, employment, family circumstances and income level.

531 problematic drug users participated in the cohort study in 2009. 66% of respondents were male and 34% female. The average age was 31.4 years. Regarding the nationality of respondents, as in previous years most respondents were ethnic Russians (68%), followed by ethnic Latvians (22%) and other minorities (10%), such as Roma (4.5%), Ukrainians, Byelorussians, etc.

Educational level

Of the cohort's respondents in 2009, more than one-third (39%) indicated that they had not completed their secondary education, 36% had completed secondary education, 18% had

[51] According to the Central Statistical Bureau, 8570 Roma live in Latvia, comprising 0.4% of all inhabitants.

completed general secondary/vocational education, while 5% had studied at higher (tertiary) level institutions, 1% had completed higher (tertiary) education. Of first-time patients, more than half (54.4%) stated that they had not finished high school, while 23.4% had completed secondary education. 1.9% had completed higher (tertiary) education, while a fifth of respondents or 20.3% did not indicate their level of education, a factor that hampered data analysis. The higher proportion of persons without tertiary education is explained by age differences, namely that first-time treated clients were on average younger than participants in the cohort studies (25 years and 31.4 years respectively). Furthermore, 27.8% of respondents have continued to study at school or university.

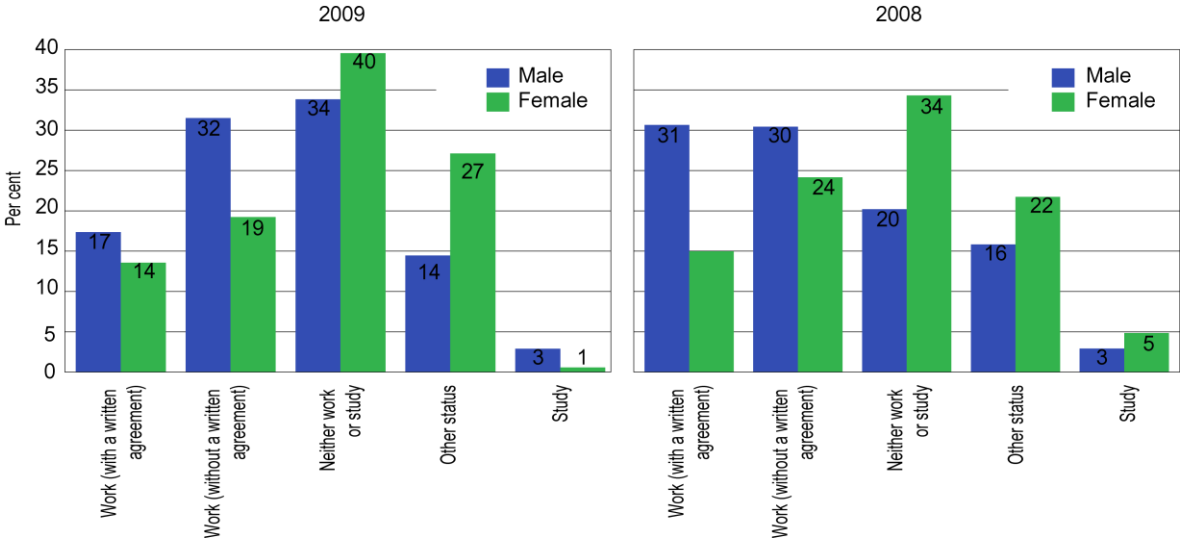
The average education indicators are higher nationally. Relatively fewer people have not obtained secondary school education, namely 26%, while vocational education and higher (tertiary) education indicators are substantially higher; on average in Latvia, 30.2% have acquired general secondary/vocational education, and 18.1% of the population have acquired higher education (*Central Statistical Bureau, 2007*). The data obtained confirm that the educational level of drug users is lower, which in turn reduces the possibility of obtaining official, well-paid work, and good income, and thus leading to poverty, crime, and social exclusion.

Employment

As elsewhere in the world, Latvia too has encountered serious economic problems. The Latvian unemployment rate at the end of 2009 was 200,700 unemployed, or 16.9% of the economically active population. By comparison, in 2008 91,600 people or 7.5% of the economically active population were officially registered as unemployed. Slightly more than one quarter (52,900 or 26.4%) of the unemployed population was long-term job seekers; their numbers compared to 2008 had increased by 29,800, or slightly more than double (*from Labor Force Survey Results for 2009, 2010*).

With the rising level of unemployment in the country, there is a corresponding increase of unemployed persons among drug users. As in previous years, in 2009 a relatively high level of unemployment was again observed among drug users. 36% of respondents in the cohort study indicated that they were not studying or working. Only 16% were working in an official job, while 27% were working under a verbal agreement, and 43% of respondents were employed, compared with 50% in 2008. It should be noted that almost one fifth (19%) of respondents did not disclose their employment type, and 2% indicated that they were studying.

Figure 8.1. Employment status of drug users by gender in 2008-2009, %



Source: Trapencieris, Sniķere et al. 2009

By contrast, 11.2% of first-time treated persons were employed, 17.3% were unemployed, 18.1% were engaged in other activities, 27.8% still attended school or were studying, 1.9% were an economically inactive group, while nearly one-third (23.6%) did not indicate their occupation. It should be noted that the first-time treated patients' data do not reflect the real situation, since the definition of "unemployed" would apply to a person who has acquired

unemployed status, but this information is unavailable; furthermore, the employment status of "other" is unclear, and the proportion of persons whose employment status is unknown remains high.

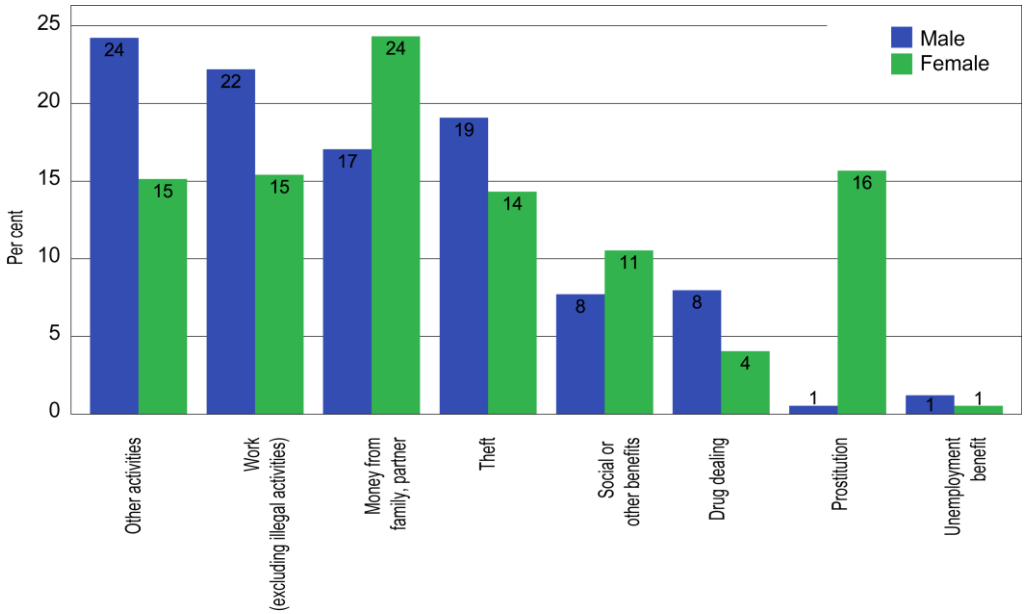
The cohort study includes the issue of occupation, and in 2009, 63% of those who work respondents disclosed their occupation. Nearly a third of respondents (25%) indicated that they worked in the construction industry, 8% of respondents were loaders, 5% were retailers, 3% were watchmen or security guards, 3% were unskilled manual workers, 3% were prostitutes. Another 6% indicated that they did casual work.

Income

Income and its sources is an indicator that could mark a drug user's risks of social exclusion: namely poverty, illegal income, and turning towards the marginalised groups in society. The cohort study included questions on the income and income sources of drug users. The study results reflect the more common sources of income. 20.7% of respondents stated that they obtained funds from their partner, family or friends, 18.8% of respondents cited official work as their source of income, 9.1% received social welfare benefits and 0.9% received unemployment benefits.

Percentage-wise there is a relatively high rate of illegality and offences associated with crime, namely theft (16.7%), prostitution (8.2%) and drug dealing (6.1%). Together such sources of income comprise 31%. One fifth (19.7%) of respondents noted that other sources of income also existed, apart from those mentioned. Disaggregated by gender, differences were observed. For example, more men noted that they were in paid employment (24% men and 15% women), while women more often obtained funds from their partner, family or acquaintances (24% women and 17% men). It is natural that prostitution was mentioned as a source of revenue effectively only by women (1% of men and 16% of women).

Figure 8.2. Types of income among drug users by gender, %



Source: Trapencieris, Sniķere et al. 2009

The study asked respondents to note their income during the previous 30 days. For men it was LVL 318.4, but for women it was LVL 282.2. Official statistics show that the national average monthly wage in 2009 was LVL 342 net. Although the difference between drug users' income and the official national average wage is low, it should be noted that this is only one indicator, and in no way represents the real affluence of drug-dependent persons. It must be borne in mind that drug users primarily spend their money to purchase drugs rather than on housekeeping. Furthermore, the cohort study also lists unofficial income, and that represents income during the previous month rather than the entire annual income, while nationally, the average wage would be higher if the impact of the underground economy was taken into account.

Family status

There is no data available for drug users' places of abode, but the cohort study included questions that reflected family circumstances. Thus only 10% of the respondents indicated that they lived alone, while the remaining 90% were living with someone. 11% lived with friends or acquaintances, while 79% lived with a partner or family. Women more often than men indicated they lived with a partner and/or children, while men more often noted that they were living with parents.

More than half of all drug users were living with someone who used alcohol or drugs excessively. Women significantly more often indicated that they were living with a partner who used drugs (58% of men and 40% of women). Traditionally, men three times less frequently than women indicated that someone in the family apart from the respondent, used drugs. This confirms that the drug user's environment and family circumstances are hardly favourable to quitting the use of drugs.

8.2. Social reintegration

Drug users have never been a group whose inclusion or social reintegration has been a primary focus in socially significant areas. Consequently, individual municipal authorities, private businesses and Christian organizations have more often addressed the social integration issues of drug users. Since information on this is often confidential, it is not possible to compile data. From analysing the combined information available, it can be concluded that social integration can be discussed in terms of individual cases rather than in terms of a fully developed system.

Several programmes have been developed to mitigate the risk of social exclusion. At the national level, drug users are identified as a group at risk of social exclusion. This is stipulated in the document adopted in 2008: *National Strategy Report on Social Protection and Social Inclusion 2008–2010* in which the specific risk groups prone to poverty and social exclusion have been defined:

- disabled persons and persons with functional disabilities,
- the unemployed (particularly the long-term unemployed),
- the homeless,
- prisoners and persons released from prisons,
- the Roma,
- victims of human trafficking,
- persons dependent upon psychoactive substances (alcohol, drugs, toxic or other intoxicating substances),
- persons with low or insufficient knowledge and skills for the labour market, and underprivileged persons.

During this period, the three main tasks to reduce the risk of exclusion were:

- to promote more effective participation and integration into the labor market,
- to improve income support systems;
- to facilitate access to higher quality services (*National Strategy Report on Social Protection and Social Inclusion 2008–2010*).

At the national level, social reintegration is closely associated with social rehabilitation, but fundamental differences exist between the two concepts. Rehabilitation may be regarded as one of the stages of reintegration. Latvia has two state-funded medical rehabilitation programs for adults: Riga Psychiatry and Addiction Centre and Hospital "Ģintermuiža", which provide treatment for drug-dependent patients in accordance with the therapeutic community principle for up to 12 months. Rehabilitation for adolescents and children is provided by the Straupe Addiction Hospital and SIA "Dzīves Enerģija"; and until September 2009, the state supported the Rindzele Addiction Rehabilitation Centre, which is currently attached to the hospital "Ģintermuiža". Rehabilitation for children takes between 3–18 months and for adults from 3–12

months. Rehabilitation is also offered by Christian communities (*Kalna svētību kopiena, Neatkarība Balt, Dieva ģimene*) and private rehabilitation centres (*Akron 12, Detox, Daytop*).Dependency prevention centres have opened in the larger municipalities, which, in addition to offering preventive measures, provide information about rehabilitation opportunities, develop individual reintegration plans, and form support groups for addicts and their families.

Although Latvian planning documents do not stipulate programs, which would provide housing support, employment or training programs specifically to drug users, with the worsening economic situation, activities and social support programs were developed at the national level that would mitigate the effects of the economic downturn and the risks of social exclusion. Compared with previous years, in 2009 there was an increase in the range of social benefits and services, and the public funds allocated for them. For example, there was an enlargement of the services base which offers social housing, assistance with paying utilities, and special courses for upgrading skills. Individual employment programs became available that were implemented both at the national level, and in municipalities. The target group of the said programs was not drug users and this group was not identified as potential participants in any of these programs. However, it is important to note that not infrequently drug users meet the criteria (poverty, unemployment) taken into account when offering social support or an educational or employment program. Namely, that there is no lawful impediment that would preclude drug users from making use of these options.

Project for Reintegration of Ex-Prisoners

The reintegration strategy for ex-prisoners and individual measures were covered in the report of the National Strategy Report on Social Protection and Social Inclusion 2008–2010. Municipalities and NGOs are implementing individual employment and education projects. One of the largest projects resulting from collaboration with the Bilateral Financial Instrument of the Norwegian government is the re-socialisation of prisoners from prisons in the Zemgale region, the implementation period of which is between 1 October 2008 and April 2011. Overall, the re-socialisation project encompasses the prisons in a single Latvian region, namely Zemgale (*Ministry of Justice, 2008*).

In relation to this project, Cabinet Order No 7 was adopted on 9 January 2009: Resocialisation Concept for Convicted Persons Sentenced to Imprisonment. The Concept provides that during the re-socialization process, a determination must be made as to whether the person is drug dependent or not. It is proposed to involve those who are dependent in additional activities, which provide motivational training, and addiction treatment. Overall it offers rehabilitation in accordance with Latvian law, and is therefore on a voluntary basis. For these people, as well as inmates without dependency problems, the following programs are proposed during the re-socialisation process:

- education;
- socially beneficial employment;
- organization of leisure time;
- development of life skills - the ability to live independently;

The forms of social rehabilitation for convicted persons include programs, counselling, and individual or group lessons delivered by appropriately qualified specialists, specially trained to work with inmates (*Resocialisation Concept for Convicted Persons Sentenced to Imprisonment, 2008*).

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

9.1. Drug-related Crime

Starting with the second half of 2008, offending trends (including in the trafficking of illegal drugs), and the response reactions from law enforcement agencies (including anti-drug cooperation) in Latvia have to some extent been determined by the economic crisis, which is primarily associated with two main factors. Firstly, a decline in the welfare level of the population resulting in drugs becoming less available to occasional users, and secondly reduction in resources available to law enforcement agencies, resulting in fewer measures being undertaken by the authorities to reduce the supply of drugs.

Drug law offences

Details of the descriptions of a crime (place, time, motive, whether the offence was committed in a state of intoxication, or under the influence of any substance) are compiled in the IS *"Register of Criminal Offences"*, whereas in the IS *"Persons Who Have Committed Criminal Offences"*, information is compiled about the penalties imposed on persons and does not provide a separate category to identify persons who have driven a motor vehicle while under the influence of drugs. Therefore, the information on persons convicted of driving under the influence of drugs is derived from the IS *"Persons Who Have Committed Criminal Offences"* partly by manual means[52].

Table 9.1. Distribution of persons charged, by section of the *Criminal Law* and the security measure imposed

Section of the *Criminal Law*	253	253² (Par. 1)	253² (Par. 2)	190¹	253¹	250	309	262	**Total**
Security measure applied (total)	**147**	**291**	**6**	**18**	**149**	**1**	**5**	**18**	**635**
prohibited from leaving country	3	3		2	1				**9**
required to live at a fixed place of abode	48	117	2	2	12	1	2	10	**194**
security bond	4			11	1				**16**
placed under police supervision	63	109	2		50		2	4	**230**
declaration of postal address	5	30		2	1			2	**40**
imprisonment	24	32	2	1	84		1	2	**146**

Source: Ministry of Interior Information Centre Integrated Interior Information System subsystem "Register of Criminal Offences", "Persons who have Committed Criminal Offences", 2010

[52] More information about the available databases and Sections of the Criminal Law and Administrative Violations Code is available in the National Report for 2008 expanded theme "Sentencing Statistics".

Table 9.2. Number of accused persons, by age, gender, and section of the *Criminal Law*

Section of the *Criminal Law*		253[53]	253² (Par. 1)[54]	253² (Par. 2)	190¹[55]	253¹[56]	250[57]	251[58]	256[59]	309[60]	262[61]	Total
Total number of persons charged		**363**	**778**	**11**	**39**	**339**	**1**	**4**	**3**	**20**	**43**	**1601**
gender	men	292	637	9	27	265	0	4	3	13	42	1292
	women	68	140	2	5	71	1	0	0	7	1	295
Age	15-18	6	10	1	0	4	0	1	0	0	0	22
	18-20	9	35	2	0	20	0	0	0	1	1	68
	20-25	108	184	3	4	76	0	1	0	5	7	388
	25-30	86	273	0	10	62	0	0	0	6	13	450
	30-35	73	168	0	7	60	0	2	2	2	13	327
	35-40	44	71	1	6	45	0	0	0	2	7	176
	40-45	22	24	0	4	31	0	0	1	2	2	86
	45-50	9	10	1	2	22	0	0	0	0	0	44
	50-55	6	2	3	4	11	1	0	0	2	0	29
	55-60	0	1	0	2	5	0	0	0	0	0	8
	60>	0	0	0	0	3	0	0	0	0	0	3

Source: Ministry of Interior Information Centre Integrated Interior Information System subsystem "Register of Criminal Offences", 2010

Table 9.2. Distribution of persons charged, by section of the *Criminal Law* and the security measure imposed

Section of the *Criminal Law*	253	253² (Par. 1)	253² (Par. 2)	190¹	253¹	250	309	262	**Total**
Security measure applied (total)	**147**	**291**	**6**	**18**	**149**	**1**	**5**	**18**	**635**
prohibited from leaving country	3	3		2	1				**9**
required to live at a fixed place of abode	48	117	2	2	12	1	2	10	**194**
security bond	4			11	1				**16**
placed under police supervision	63	109	2		50		2	4	**230**
declaration of postal address	5	30		2	1			2	**40**
imprisonment	24	32	2	1	84		1	2	**146**

Source: Ministry of Interior Information Centre Integrated Interior Information System subsystem "Register of Criminal Offences", "Persons who have Committed Criminal Offences", 2010

[53] CL Section 253. Unauthorised Manufacture, Acquisition, Storage, Transportation and Conveyance of Narcotic and Psychotropic Substances.
[54] CL Section 253.[2] Unauthorised Manufacture, Acquisition, Storage, and Sale of Narcotic and Psychotropic Substances in Small Amounts and Use of Narcotic and Psychotropic Substances without a Physician's Designation.
[55] CL Section 190.[1] Movement of goods and Substances the circulation of which is Prohibited or specially Regulated across the State Border of the Republic of Latvia.
[56] CL Section 253.[1] Unauthorised Manufacture, Acquisition, Storage, Transportation and Conveyance of Narcotic and Psychotropic Substances for the Purpose of Sale and Unauthorised Sale.
[57] CL Section 250. Unauthorised Dispensation of Narcotic and Psychotropic Substances.
[58] CL Section 251. Inducement to Use Narcotic and Psychotropic Substances.
[59] CL Section 256. Unauthorised Sowing and Growing of Plants Containing Narcotic Substances.
[60] CL Section 309. Unlawful Providing of Substances and Objects to Persons who are Confined in Places of Detention and Imprisonment, and Unlawful Receiving of Substances and Objects from Such Persons.
[61] CL Section 262. Operating a Vehicle while Under the Influence of Alcohol or Narcotic, Psychotropic, Toxic or Other Intoxicating Substances.

Table 9.3. Sentenced persons, by Section of the *Criminal Law*

Section of the *Criminal Law*	253	253² (Par. 1)	253² (Par. 2)	190¹	253¹	250	251	256	309	262	**Total**
deprivation of liberty (total)	**56**	**169**		**2**	**83**				**2**	**6**	**318**
deprivation of liberty (4-24 months)	23	110		1	5					2	**141**
deprivation of liberty (2-5 years)	20	42			33					2	**97**
deprivation of liberty (5-10 years)	12	17		1	45				2	2	**79**
deprivation of liberty (11 years)	1										**1**
deprivation of liberty suspended for period (total)	**93**	**52**	**4**	**3**	**51**		**2**		**5**	**2**	**212**
arrest (8 - 30 days)		**6**								**2**	**8**
enforced labour (community service) (total)	**5**	**74**		**2**	**3**					**4**	**88**
fine (LVL 180 - 1800)	**1**	**1**		**7**							**9**

Source: Ministry of Interior Information Centre Integrated Interior Information System subsystem "Register of Criminal Offences", "Persons who have Committed Criminal Offences", 2010

Table 9.4. Number of registered criminal offences

Section of the *Criminal Law*	249	250	251	253² (Par.2)	256	309	262***	190¹	253	253¹	253² (Par.1)	Total
Number of registered criminal offences	1	2	2	30	3	118	43	127	440	441	1292	2499

Source: Ministry of Interior Information Centre Integrated Interior Information System Subsystem "Register of Criminal Offences", 2010

Table 9.5. Persons dealt with in accordance with the Latvian *Administrative Violations Code*

AVC section	Number of protocols issued	Administrative penalty imposed	Released from liability (AVC Section 21)	Record-keeping finalised (AVC Section 239)
Section 46, Paragraphs 1-2	2654	2546	0	34
Section 46¹, Paragraph 1	14	7	0	0
Section 149[15], Paragraph 5	126	136	0	3
Section 149[15], Paragraph 7	78	79	0	0
Total	2872	2768	0	37

Source: Ministry of Interior Information Centre Integrated Interior Information System Subsystem "Register of Persons Who Have Committed Administrative Violations", 2010

*** Driving a motor vehicle under the influence of drugs

Table 9.6. Details of administrative penalties

AVC Section	Section 46, Paragraphs 1-2	Section 46[1], Paragraph 1	Section 149[15], Paragraph 5	Section 149[15], Paragraph 7	**Total**
Administrative arrest	188		130	76	**394**
Warning	9	1			**10**
Fine	2403	6	136	79	**2624**
Enforced corrective measures	1				**1**
Prohibited from obtaining licence to operate recreational vessel			19	3	**22**
Prohibited from obtaining drivers license			2	7	**9**
Disqualified from holding a licence to operate recreational vessel			4		**4**
Disqualified from holding drivers license			129	72	**201**
Total sum (LVL)	105886	150	65360	33800	**205196**
Sum collected (LVL)	29216.26	30	32530.91	18605.21	**80382.38**

Source: Ministry of Interior Information Centre Integrated Interior Information System Subsystem "Register of Persons Who Have Committed Administrative Violations", 2010

Other drug related crime

The relationship of prostitution with the illegal circulation of drugs

Individual prostitution is permitted in Latvia and regulated by Cabinet Regulation No. 32 of 22 January 2008: "*Regulations to Limit Prostitution*". Administrative culpability is provided for individual violations of the Regulation, but repeated violations during a single year are subject to criminal sanctions.

Data on the administrative penalties imposed for violations of the prostitution regulations are entered into the *"Register of Persons Who Have Committed Administrative Violations"*; criminal penalties are entered into the IS *"Register of Persons Who Have Committed Criminal Offences"*.

Table 9.8. Administrative protocols issued for violation of regulations limiting prostitution

	Total protocols	Issued by State Police	Issued by Municipal Police	Change	
				+/-	%
2007	44	44	0	-	-
2008	146	84	62	102	231.82
2009	69	56	13	-77	-52.74

Source: Ministry of Interior Information Centre, 2010

It should be noted that several administrative protocols may have been issued for the same person.

A significant decrease (more than 50%) is evident in the number of administrative protocols issued for offences relating to violation of regulations limiting prostitution, and is most likely due to law enforcement agencies focusing attention (due to lack of resources) on more serious forms of offending. Specific statistical reports on the relationship of prostitution with the illicit circulation of drugs (e.g. whether the same person committed offences both related to regulations limiting prostitution, and in connection with the illicit circulation of drugs) are not produced automatically, so the interrelationship of the data is currently determined manually. Statistical data show that about 50% of those who had been punished administratively for infringing regulations limiting prostitution have also been punished for offences related to the illicit circulation of drugs (furthermore, compared with 2008, in 2009 there was an increase of

eight per cent in the number of people subjected to criminal penalties for offences related to drug trafficking).

Table 9.9. Breaches by the same person in connection with violation of the regulations limiting prostitution and the illegal circulation of drugs

	Persons punished administratively for violation of regulations limiting prostitution	Of those: Persons punished administratively in connection with the illicit circulation of drugs	Of those: Persons punished criminally in relation to the illicit circulation of drugs	Proportion of offenders punished for violations in relation to the illicit circulation of drugs
2007	44	14	5	43.2%
2008	129	50	14	49.6%
2009	65	19	12[62]	47.7%

Source: Ministry of Interior Information Centre, 2010

It should be noted that the number of prostitutes that have not been administratively penalised for violation of the restrictive regulations limiting prostitution and who were not punished for offences related to illegal circulation of drugs, is unknown.

Juvenile offenders

In most cases, there is a direct relationship between juvenile drug users and offending, as the purchase of drugs requires financial resources not usually available to juveniles. As soon as there is insufficient money for the purchase of drugs, most juveniles turn to crime. Statistical data show a significant reduction in offences committed by juveniles, which can be explained by several factors:

- there is a significant reduction (by more than 10% compared to 2008) in the number of juveniles (aged 14–17 inclusive) (a smaller number of offenders are committing a larger number of offences);
- for the most part, juveniles commit offences of theft and robbery, i.e. moderate severity offences, and it is precisely those offences which are most frequently unsolved, as the main focus of law enforcement agencies (particularly during the economic crisis) is on solving the most serious cases. Cases tend to occur where people who have been robbed by juveniles do not turn to the police, believing that the stolen items were not sufficiently valuable;
- deficiencies in data registration, for example, it is not mandatory to append a note into the information system that an offence had been committed under the influence of drugs, so such an annotation is often not added.

It should be noted that the disproportion between the total number of offences committed and the total number of juvenile offenders is mainly because juveniles frequently commit offences while in a group.

[62] 2 people were punished for violation of Section 253 of the Latvian *Criminal Law* (Unauthorised Manufacture, Acquisition, Storage, Transportation and Conveyance of Narcotic and Psychotropic Substances); 10 people were punished for violation of Section 253[2] of the Latvian *Criminal Law* (Unauthorised Manufacture, Acquisition, Storage, and Sale of Narcotic and Psychotropic Substances in Small Amounts and Use of Narcotic and Psychotropic Substances without a Physician's Prescription).

Table 9.10. Juvenile offences

	Year			Changes (2008–2009)	
	2007	2008	2009	+/-	%
Total number of offences committed	1350	1397	1038	-359	-25.7
including under the influence of drugs	10	18	6	-12	-66.7
including thefts under the influence of drugs	3	2	0	-2	-100.0
including robberies under the influence of drugs	0	0	0	-	-
including intoxicated by alcohol	354	318	225	-93	-29.3
including under the influence of psychotropic substances	5	5	2	-3	-60.0
including under the influence of toxic substances	0	2	1	-1	-50.0
Total number of juvenile offenders	2191	1812	1383	-429	-23.7
including under the influence of drugs	0	14	3	-11	-78.6
including thefts under the influence of drugs	1	5	0	-5	-100.0
including robberies under the influence of drugs	0	0	0	-	-
including juveniles who are not working and not studying	284	344	193	-151	-43.9

Source: Ministry of Interior Information Centre, 2010

Crimes committed under the influence of drugs

In the Integrated Information Systems Subsystem "Register of Persons Who Have Committed Administrative Violations" and the subsystem "Register of Criminal Offences", it is possible to add a reference to the fact that the person committed the offences while under the influence of drugs, but as the adding of these references is not mandatory, it is generally not done.

Table 9.11. Offences committed under the influence of drugs

	Year			Changes (2008-2009)	
	2007	2008	2009	+/-	%
Total offences committed under the influence of drugs[63]	554	756	567	-189	-25.0
including thefts under the influence of drugs	69	66	89	23	34.9
including robberies under the influence of drugs	9	13	12	-1	-7.7

Source: Ministry of Interior Information Centre, 2010

Despite possible problems of data quality, the statistical data confirm a significant increase (around 35%) in the number of thefts committed under the influence of drugs; however, the total number of offences committed under the influence of drugs has decreased by 25%. One of the factors influencing the situation is related to the decrease in population nationally, e.g. there has been a reduction of more than 4.3%[64] in the population aged 14– 25 years compared to 2008.

9.2. Prevention of drug-related crime

Reduction of supply is directed towards reducing the supply of any illegal drug. The State Police, Customs and the State Border Guard Criminal Board are the main bodies operating in the area of reducing the supply of drugs, including cannabis. These institutions carry out their assigned measures, activities, and operational work in their fields, in collaboration with other relevant national authorities and among themselves, in cooperation with Europol and Interpol, as well as carrying out intelligence work, and involving dog handlers. Plans relating to the reduction of drug supply are developed based on problems in individual countries and the availability of intelligence information.

[63] It is not mandatory to make notations on the information system regarding offences committed while under the influence of drugs, and therefore such notations are frequently not made

[64] Latvian Central Statistical Bureau data http://data.csb.gov.lv

State Police measures

The State Police unit primarily engaged in anti-drug activities is the Drug Enforcement Bureau of the Organized Crime Enforcement Bureau of the of the Central Criminal Police Department of the State Police. The Drug Enforcement Bureau undertakes the role of monitoring and information gathering in respect of the general situation in the drugs field in all State Police institutions, as well as the methodical management functions for the State Police territorial institutions (at regional level) for established anti-drug units.

In 2009, a number of countries throughout the world (including the Baltic States, Scandinavian countries, the United States and Latin America States, Russian Federation, the Netherlands, Germany, the United Kingdom etc.) undertook active cooperation in the functions of information exchange and crosschecking in respect of natural and legal persons, vehicles and other information that could be linked to the circulation of drugs and psychotropic substances. Cooperation was maintained with the UNODC, Europol, Interpol and Eurojust. Thanks to the active cooperation and exchange of information, a significant quantity of drugs was seized abroad and members of organized criminal groups and drug couriers were arrested.

Individual activity plans were developed in State police territorial units for fighting and restricting the illicit circulation of drugs, taking into account the circumstances prevailing in the areas concerned.

The main operational directions of the State Police in the anti-drug field are:

- participate in UN, NATO and EU projects, programs, and other initiatives and activities in the development of cooperation with the Russian Federation, other countries of Eastern Europe, the Asian region and the European Union to combat the illicit circulation of drugs;
- in cooperation between Latvian and foreign law enforcement agencies, undertake operational and investigative activities, and joint operations to identify, verify and disrupt the activities of transnational criminal groups related to the contraband and transit of drugs and psychotropic substances;
- strengthen operational positions and increase the operational work related to obtaining information on individuals and organized groups who engage in the illicit circulation of drugs;
- continue to work and take the measures necessary to curb the distribution of drugs and psychotropic substances among young people.
- implement organizational measures to obtain better statistical data and eliminate its lack of clarity in relation to drugs and psychotropic substances.

Customs Criminal Board activities

The State Revenue and Customs Services have developed a number of internal planning and prioritization documents relating to the combating and prevention of the illicit circulation of drugs, the *State Revenue Service Customs Service Operational Strategy for 2005–2009*[65], the *State Revenue Service Customs Strategy for Prevention and Fighting of Smuggling 2005-2009*, and the Annual Strategy document describe the tactical objectives. Quarterly, progress reports are prepared relating to performance of the tasks defined in the State Revenue Service customs authorities smuggling and fraud prevention strategies 2005–2009 (including tactical objectives). Given the above, it must be concluded that the Customs Criminal Board regularly undertakes monitoring of the situation and the Agency reports regularly on measures taken and is aware of its performance efficiency and achievements.

The main indicator of the effectiveness of the Customs Service in the anti-drug area is the amount of drugs seized and the resulting damage to criminal organisations. The number of drug seizure events is not the key performance indicator for Customs, because that indicator

[65] State Revenue Service Customs Service Operational Strategy for 2005–2009, approved by Order No. 570 of the Director-General of the State Revenue Service.

alone only allows conclusions to be drawn regarding improved work performance of individual units of the customs service (dog handlers and individual customs control points).

The main performance indicator of the effectiveness of the anti-drug measures undertaken by Customs is the removal from illicit circulation of as large an amount of drugs (volume) as possible, and to cause the greatest detriment to organized crime groupings; this is determined by recording and analysis of factual information (detailed) on drug seizures, as well as the calculation of detriment done to organised crime groupings (including losses and lost profits) expressed in monetary terms.

State Border Guard Service activities

The jurisdiction of the State Border Guard Service in the prevention of illegal circulation of drugs is primarily stipulated in the *Border Guard Law*. The characteristic feature of the State Border Guard in limiting the illegal circulation of drugs is the transfer to other institutions of criminal proceedings that have been initiated; as the State Border Guard Service has no jurisdiction in progressing of criminal cases in this field, and seized substances are also transferred to relevant authorities. This fact also serves to explain why data on the State Border Guard participation in the anti-drug activities are not always included in relevant reports and statistical overviews.

Illegal trafficking in drugs is identified and eliminated:

- in the course of operational activities (receiving relevant information about a planned shipment) – about 70% of information on planned illegal trafficking is sourced within the country;
- collaboration with other State authorities;
- cooperation with other countries' agencies (mostly – neighbours, mainly Lithuania, Belarus and Russia; occasionally the Estonian Border Guard);
- undertaking immigration control (in particular, with the assistance dog handlers).

Research and projects

Large-scale studies of drug offences related to the illicit circulation of drugs were not undertaken in 2009. Some issues have been investigated relating to data processing at the national level and the exchange of data at international level within the framework of information security projects to be developed:

The project "Geographical – analytical information systems for restricting the illicit movement of drugs" (co-funded by the European Union Program "Prevention of and Fight against crime") was launched in September 2009, and being implemented by the Ministry of Interior Information Centre. The study considered issues such as the inclusion of drug classification into the Ministry's Integrated Information subsystem "Property Search" (providing an inventory of substances seized), linkage with a database of test results, for crime data visualizations, and data exchange with the Lithuanian law enforcement agencies, etc.

With co-financing from the European Union Programme *"Prevention of and Fight against Crime"*, the project *"Establishment of an information system to support juveniles"* was launched in December 2009; the implementer being the Ministry of Interior Information Centre. During the study, work commenced on analysing issues related to online access (for cases prescribed by law) to data on drug dependent juveniles with the aim of providing them with essential support.

During the performance of their functions and tasks, the authorities involved in the reduction of drug availability have undertaken analytical work, e.g. the State Police, in relation to the annual report published by the U.S. Department of State on drug control strategies throughout the world in 2009, and the introduction of its requirements into Latvia and the United Nations Annual Report (*Annual Report Questionnaire Part III Illicit Supply Of Drugs*) on issues relating to the illicit supply of drugs; the Customs Criminal Board – in relation to the structure and trends in offences related to the illicit movement of drugs, psychotropic substances and precursors, as

well as potential threats, and a summary report on the illicit movement of drugs, psychotropic substances and precursors in Latvia during 2009.

9.4. Drug use and problem drug use in prisons

There is an annual increase in the illicit circulation of drugs in places of incarceration. According to data from the Latvian Prison Administration, as of December 31, 2008 there were 6,872 inmates held in Prison Administration prisons, of whom 836 (at 1 January 2008 – 731) had been convicted of a criminal offence in connection with the illegal circulation of drugs. Of the total number of prison inmates, 784 were officially registered as drug addicts (1 January 2008 – 529). In accordance with existing law, convicted persons who seek treatment for addiction can be treated at their own expense.

The last and only large-scale study of drug use in prisons was undertaken in 2003. As part of the study, all convicts in 11 selected prisons were surveyed, achieving a net sample size of 2867 respondents (or response rate of 61.2% among convicted persons) (Sniķere, Trapencieris, Vanaga, 2003). The study used a questionnaire, which included questions on the use of various drugs during and prior to imprisonment. This study established that 53% of prisoners aged 15–64 had tried some form of illegal drug[66] on at least one occasion before being imprisoned, while 38% and 29% of convicts respectively had used drugs in the last 12 months and last 30 days before current imprisonment. According to the self-reported drug use while in prison, about one third of those convicted (31%) had used drugs on at least one occasion while in prison, 17% had used them within the past year and 7% had used drugs within the past month. The substance most commonly used by the convicts during their imprisonment was cannabis (28%), followed by amphetamines (12%) and heroin (10%). The study also indicated a relatively high level of using various medications for the purpose of intoxication.

In the autumn of 2010, a methodologically comparable study with that of 2003 in prisons has started and the results of this study will be available for the next National Report.

Testing of prisoners

The level of drug use and the substances used in prisons is also indicated by data recently obtained from drug testing undertaken in prisons. In accordance with Cabinet Regulation No. 423 "Internal Regulations for Prisons", convicts may be tested on the basis of suspicion to detect drug intoxication. Drug use in prison is a criminal offence. The biological samples obtained are sent to the Riga Centre of Psychiatry and Addiction Disorders (RCPAD) at which the samples are tested using various methods such as GC/MS. These data were not previously collected in electronic format, but in 2010, with the support of UNODC and the National Focal Point, 2008 and 2009 data was entered in a database. According to these data, 490 (318 in 2008 and 172 in 2009) biological samples originating from inmates were tested for drugs. Of the samples tested, a little more than two-thirds (342 or 70%) indicated the presence of various substances in the body *(see Table 9.12)*. The reduction in the number of tests conducted in 2009 more likely reflects a reduction in funding allocated for drug testing, rather than a decrease in drug use in prisons.

Table 9.12. Number of tests on prisoners undertaken in 2008 and 2009 (in absolute numbers)

	2008	2009
Number of tests undertaken	318	172
Positive tests	215	127

Source: RCPAD data, 2010; NFP calculations, 2010

Prisoners who tested positive for the presence of drugs in the body, most often (62.9%) tested positive for a single substance, 20.2% tested positive for two substances; 9.1% for three substances, while four or more substances were detected in 7.9% of the drug-positive cases.

[66] Cannabis, amphetamines, ecstasy, heroin, other opiates, cocaine, LSD or other hallucinogens

The data indicates that there were more positive tests for more than one substance in 2009 than in 2008 *(see Table 9.13)*.

Table 9.13. Number of substances detected among prisoners, 2008 and 2009 (% of positive tests)

	2008	2009
One substance	67.7	54.3
Two substances	17.7	24.4
Three substances	7.0	12.6
Four or more substances	7.4	7.7

Source: RCPAD data, 2010; NFP calculations, 2010

From examination of the substances detected during 2009 it may be concluded that the most frequently detected substances were amphetamines (56% of cases), benzodiazepines (46%), opioids (35%) and cannabinoids (31%), while less frequent barbiturates were found in biological samples (9%). Comparing the data for 2009 and 2008 it is observed that in 2009 opioids and benzodiazepines were detected more frequently, while amphetamines were less common *(see Table 9.14)*. The most commonly detected combination of substances in a single test was amphetamines and benzodiazepines.

Table 9.14. Substances detected among prisoners in 2008 and 2009 (% of positive tests)[67]

	2008	2009
Amphetamine/methamphetamine and their derivatives/traces	63.7	55.9
Benzodiazepines and their derivatives/ traces	32.6	45.7
Cannabinoids (THC) and their traces	31.6	30.7
Opioids and their derivatives/traces	19.1	34.6
Barbiturates	7.9	10.2

Source: RCPAD data, 2010; NFP calculations, 2010

The mean age of prisoners showing signs of drug use is 30.7 years (mode 27 years; the youngest was aged 17; the oldest was aged 57). The testing was mainly undertaken on male prisoners; over the two-year period, women were tested in only four cases (of 490).

Drug use in prison according to Riga Drugs Users' Cohort Study

To understand the prevalence of drug use in prison, the questionnaires used in 2008 and 2009, in addition to the previous questions regarding the imprisonment of the respondent, also included some questions about drug use experiences during imprisonment (Trapencieris, Sniķere, 2009).

According to the respondents' answers, about half of respondents (51%) had been incarcerated during their lifetime. In the study phases for 2006, 2007 and 2008, these indicators were respectively 48%, 55% and 47%.

57% of men and 39% of women had been imprisoned during their lifetime ($p<0.001$), and naturally the older drug users had been in prison more often than younger drug users.

About half (49%) of the drug users surveyed in 2009 who were in prison had been there on one occasion; about one in five (20%) had been there twice, while 11% had been there three or more times. 20% of drug users did not indicate the number of times they had been in prison. 14% had been incarcerated within the previous three years.

According to information included in the survey, about one in three (39%) of imprisoned 2009 cohort participants had used drugs while in prison, while 15% of respondents did not wish to indicate whether they had used drugs. A significant proportion of respondents (25%) either refused or did not wish to indicate which substances they had used in prison, while of those who did indicate, an approximately similar proportion indicated heroin and amphetamines, respectively 23% and 20%.

[67] More than one substance can be detected during testing; the total may therefore exceed 100%.

9.5. Responses to drug-related health issues in prisons

Despite an increase in the number of drug dependent prisoners there is still no addiction treatment in prisons due to legal (and related financial) factors. Currently, detoxification[68] is the only assistance offered to drug dependent prisoners:

- prisoners have the right to refuse testing for drugs,
- physician-psychiatrists working in prisons are not authorised to make a diagnosis of drug dependence.

Various preventive measures were undertaken in 2009, including lectures and awareness campaigns for prisoners, and activities of a religious nature. Inmates are involved in various re-socialisation programs. In 2009, no special programs for reducing dependence were implemented in prisons, but several prevention-related programs for preventing of use of drugs and psychotropic substances were undertaken in several prisons. These included:

- "A motivation program for young people for the complete cessation of use of psychoactive substances in prison and after release",
- "Dance movement therapy" (aim: the application of movement therapy techniques to assist convicted persons to eradicate drug and alcohol addiction internally),
- "Value education and communication skills program" (one module is dedicated to the prevention of addiction);
- "Improving the quality of life for drug-dependent patients and those infected with HIV and AIDS patients through health and social care".

Prisoners are provided with counselling and psychological care by social workers and psychologists. It should be noted that there are few psychologists working in prisons, and the prison population is large, and therefore the psychologists usually do not respond to findings of drug dependency, and usually only become involved upon the receipt of the a relevant application from a prisoner or information from the prison administration/staff. Action taken by psychologists is related to:

- involving people in a relevant program (if the program is open to new members), undertaking individual counselling,
- a recommendation to refer to a psychiatrist (if a psychiatrist's competence has been established)
- crisis intervention (e.g. in calming a person in an agitated state).

Many convicts are employed in jobs created in businesses and in domestic service69 and employment is vital in curbing drug use by convicted persons - employed convicts (in particular, particularly those working in jobs created by businesses) almost never use drugs, since they lack the relevant motivation.

In evaluating the effectiveness of measures undertaken by the Prison Administration Board, it should be noted that at present there is no measurement of progress being undertaken in relation to participation by individuals in programs to reduce dependency, i.e. there is no comparison of whether persons who have participated in the relevant programs have resumed the use of drugs.

It should be noted that in 2009 a questionnaire: "Assessment of risk and needs of the convicted" was released for approval (the questionnaire was developed as the result of Finnish and German experience). The questionnaire consists of three parts: 1) in relation to the offence committed, the court process, the defendant's attitude to the process, etc. (the questionnaire is

[68] Addiction treatment wards in prisons were closed in the early 1990s, and there is no funding for the employment of addiction specialist physicians in prisons. There is no funding for implementation of dependency treatment programs (the only medical program related to drug use is the psychological support and education of prisoners with HIV/AIDS within the framework of the United Nations Office on Drugs and Crime project "HIV/AIDS prevention and care among injecting drug users and in prison settings in Estonia, Latvia and Lithuania"), and the introduction of methadone treatment to reduce the harm of drug addiction.

[69] In 2009, 1141 convicted persons were employed; of those, 632 were working in domestic service, 509 were working in jobs created by businesses. The average level of employment for convicted persons was 23% of those fit for work (nearly 5% less than in 2008). Latvian Ministry of Justice Prison Administration Board Annual Report (2009), p.18

completed by a senior inspector, who works with the said defendant); 2) social information, e.g. relating to education, family, documents, etc. (the questionnaire is completed by a social worker; 3) psychological information, including, relating to dependencies (for drug addiction the working data relate to history of drug use, main substances used, frequency of use, acts committed under the influence of drugs or with the intention of obtaining drugs, drug-related violence, impacts of drug use on employment, education, leisure, health, relationships with family, partner, friends, motivation for addiction treatment at time of imprisonment, opportunities to start treatment or to participate in relevant programs) - the questionnaire is completed by a psychologist. Initially the questionnaire was developed for use by adults, but action is in course to apply it to juveniles.

Since the questionnaire contains a great deal of data, and it is possible to misconstrue the data to be collected, a methodology has been developed for completion of the questionnaire. It is planned that regular assessment will be undertaken with the assistance of the questionnaire together with measurement of progress achieved (it is proposed to complete a questionnaire for each convicted person at least once per year).

Currently, the only follow-up of persons regarding drug use following their release from prison relates to court-imposed obligations on a person subject to a conditional release for the person to continue drug addiction treatment (this is administered by the State Probation Service), as the State Probation Service or Prison Administration Board may impose the requirement for an applicant to continue drug addiction treatment as a condition of conditional release. In order to determine the effects of the program on persons who are not obliged to continue dependency treatment, it would be necessary to produce statistics for offending by those persons (after release from prison) under the influence of drugs or in order to obtain drugs.

10. Drug Markets

10.1. Availability and supply

In 2009 there were no new changes of significance in the prevalence of drugs. Illicit trafficking continues to emerge with the deterioration of the general economic situation. A lack of available funds has been observed among persons engaged in these illegal activities. A decrease in the turnover of cocaine must be regarded as a known indicator in this regard, mainly due to the lack of funds among users. Indicating a relatively stable situation in the market for illicit drugs and psychotropic substances is the fact that an increase has been observed only for heroin, both in terms of quantity seized, and the number of seizures. The use of heroin has very negative social consequences, and this increasing trend has already continued for several years. It should be noted that even in the regional areas, the drugs most in demand are marijuana and amphetamine. Noted as a new aspect is that there has been an increased level of activity among incarcerated persons in coordinating the illicit circulation of drugs (State Police, 2010).

Major trends

Heroin: the seized proportion of this drug in the total dynamic of drugs and psychotropic substances seized indicates the constant or possibly even increasing presence of this substance in Latvia since 2006. Heroin maintains second place in terms of number of seizures, even surpassing the number of seizures of cannabis and amphetamine. A relationship is assumed between the general financial and psychological states of a certain part of society, which stimulates the demand for sedative drugs and psychotropic substances, a group to which heroin also belongs.

Mixtures of aromatic plants: Aromatic plant mixtures had acquired popularity among users in 2009; these were freely available and were traded via various websites. The prevalence of plant mixtures was found not only in the Riga area, but throughout the entire country. The exotic plant mixtures were delivered to Latvian cities and surrounding areas and distributed in night clubs, points of sale or by courier. In November 2009 a number of psychoactive ingredients found in vegetable mixtures was included in the list[70] of controlled substances, resulting in a drastically reduced availability of plant mixtures.

Ecstasy, amphetamine, methamphetamine: In 2009 a reduction was observed in the number of seizures of these substances, which is possibly linked with an increase in popularity among users for other substances having similar actions such as sodium oxybutyrate or piperazine, which were identified in the first seizure of a large quantity of ecstasy-type designer style tablets. From the dealers' income point of view the distribution of *ecstasy* in tablet form is less profitable than for substances in powder form.

Marijuana, hashish: In 2009, exotic plant mixtures, whose effect on the user's body is stronger than that of marijuana, were widely distributed. An increase was observed in the demand for marijuana and hashish, following the inclusion of several synthetic cannabinoids on the list of controlled substances in 2009.

Cocaine: There is a decrease in the turnover of cocaine, which indicates that the general economic situation continues to have an impact upon the illicit circulation of drugs.

GHB: Increased consumption of sodium oxybutyrate (GHB) was also observed, creating problems for law enforcement agencies because of difficulties in detecting the presence of this substance in the body (State Police, 2010).

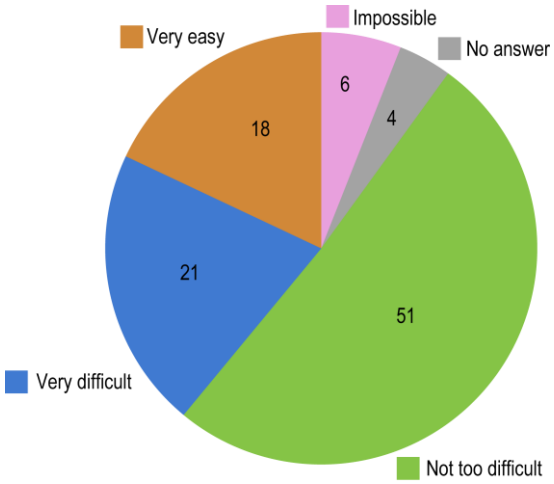
[70] On 28 November 2009 Cabinet Regulation No. 1297 "Amendments to Cabinet Regulation No. 847 of 8 November 2005: "Regulations regarding Narcotic Substances, Psychotropic Substances and Precursors to be Controlled in Latvia"", came into force, subjecting several synthetic cannabinoids to control: CP 47,497, and three of its homologues C6, C8, C9; HU-210; JWH-018; JWH-073; JWH- 250;JWH-398

A study on the availability of drugs

In 2010 a study was commissioned by the Latvian State Police under the auspices of the EU project "Youth against drugs" (Klaasons, Spurava, Mangusa, 2010). The aim of the study was to obtain data on young people's knowledge and awareness of the consequences and responsibilities associated with drug use. Among the tasks involved in the study was to ascertain young people's views on the availability of drugs and substances which are considered to be drugs.

A total of 1255 students were surveyed of which 48% (n = 598) were boys and 52% (n = 657) girls. Respondents were selected from 47 general and vocational secondary schools, and on average 27 young people were interviewed from each school. 82% of students came from schools of general education, 18% of respondents were from vocational high schools. The study included schools from all Latvian regions, i.e. 33% of respondents were studying in Riga, 43% in other urban areas and 24% in rural schools.

Figure 10.1. Self-preceived drug availability among general secondary and vocational school students, %



Source: Klāsons, Spurava, Mangusa, 2010

As part of the study, the question was asked "In your opinion, how easy or difficult would be to obtain drugs, for a young person from your school who would like to try them?" The question reflects young people's thoughts and perceptions of whether drugs are available. The majority of respondents stated drugs would not be too difficult to obtain for a young person who would like to try them. Specifically, 51% estimated that drugs would not be too difficult to obtain, while 18% said it would be very easy. Only 6% considered that it would not be possible to obtain drugs, while 21% thought that it would be very difficult. The average on a four-point scale (where 1 means – not possible, while 4 – very easy") is 2.8 points, indicating that drugs, on the assessment of young people themselves, are generally readily available. That drugs would be very easy to get, was more often claimed by 17 year olds (21%); those living in Riga (27%); and vocational school students (26%). By contrast, the view that drugs would be impossible to get was more often mentioned in the survey by 15–year-olds (9%), and those living in the Pieriga (9%) and Latgale (9%) regions.

Local drugs and imports

Drugs in Latvia are mostly imported. Available information indicates that the only locally produced drug is marijuana, other drug production sites have not been detected. In 2009 three cannabis plantations were discovered in various Latvian regional cities: Valmiera, Liepaja and Jelgava. In one case a youth was detained who had initially grown seedlings for his own use, but later expanded the enterprise, but a total of only three plants was identified. In a second case, a Lithuanian national was detained who was growing marijuana in a private home on Latvian territory. Police seized 5kg of plants and 70g of dried marijuana. The largest amount of marijuana seized was from a site discovered in 2009 when 194 plants were seized. Local production output is unable to meet the total demand, so marijuana is imported from neighbouring countries.

In relation to drugs being brought in to Latvian territory, it may be concluded that drug origin countries and transmission routes have not changed. Latvia, thanks to its geographical location and developed infrastructure (three major seaports and two international airports) is an attractive transit country to any form of drug trafficking.

The Customs Service performance analysis for 2009 shows that the proportion of cases of independently discovered drug smuggling varies between units staffing customs checkpoints. The largest number of drug seizures is registered at Riga airport, which also includes mail consignments; a significantly smaller number of drug siezures is registered at the Latvian sea ports, while not one drug seizure has been recorded on the EU's external borders with the Russian Federation, or the Republic of Belarus. This situation indicates that the day-to-day customs controls, particularly with regard to drug trafficking, are not always sufficiently effective.

According to information provided by the Customs of Latvia, high risk of drug importation applies to direct flights from those regions of the world which are internationally well known as sources of drugs, like Tajikistan, Turkey, and the Netherlands, which all operate direct daily flights to Riga, as well as an active ferry service between Latvia and other EU Member States.

Supply and transit, by individual substances:

- MDMA, or Ecstasy is imported from Western Europe and forwarded on to Scandinavia and the Russian Federation via the roads.
- Amphetamine and methamphetamine are imported from Lithuania, Poland, Germany, the Netherlands, and Estonia. The synthetic drugs are then forwarded on to Scandinavia and Russia. Transport is mainly by land and sea, and many more instances have been registered for methamphetamine.
- Marijuana is imported from Lithuania, the Netherlands and Spain, as well as from Russia's Astrakhan region, where cannabis is grown as a crop.
- Hashish is imported from Spain via a variety of routes in transit through other EU countries and then shipped to the Scandinavian countries.
- Cocaine is imported by land and sea from countries of both the Russian Federation and the European Union, and is then transported to the Scandinavian countries and the Russian Federation.
- Heroin enters from the EU (Lithuania), Turkey, Moldova, Tajikistan, Afghanistan, and Russia, utilising air and land transport and it is forwarded on to the Scandinavian countries. According to intelligence data, a trend has been observed during the past year that drug shipments are being undertaken by Romanian nationals using the Riga International Airport as a transit airport for consignments of heroin. The risk: direct flights into Riga International Airport from Tajikistan and Turkey.

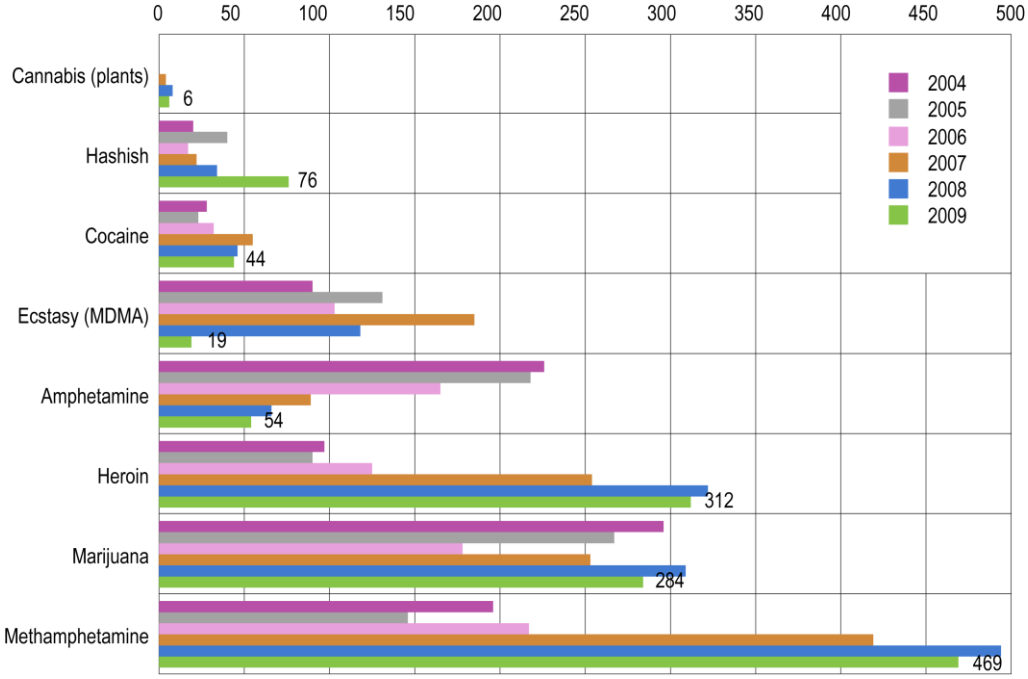
The main drug-distribution center within the country is the capital of Riga, from where drugs are distributed further to the major cities and rural areas. Drugs are supplied from major Latvian cities by courier or sometimes via the agency of students. They are sold at entertainment venues or by acquaintance with the drug couriers themselves. The trend has continued of using all possible means to reduce direct contact between dealers, drugs and clients; contact is maintained through telephone contacts, couriers, and hiding places.

10.2. Seizures

According to information provided by the State Police, a total of 1265 drug seizures were registered in 2009, 134 cases less than in 2008. In most cases (1143), drugs were seized by the State Police, while the SRS Customs Service registered 122 drug seizures in 2009. Compared with the previous year there was an increase in the number of seizures by the Customs Service, but a decrease in the performance indicators for the State Police. The drop in the number of State Police seizures can largely be attributed to the economic situation in the country and reforms in police structures.[71]

[71] ST13_2010_LV_01; ST13_2010_LV_02; ST13_2010_LV_03

Figure 10.2. Number of seizures by drug, 2004–2009



Source: State Police Forensic Department, 2010

The number of seizures of marijuana, hashish and cannabis plants has increased, but the quantity of substances seized has decreased *(see Table 10.1. and Fonte ST13)*. This is mainly explained by the discovery of a large-scale marijuana-growing operation in 2008. It should be noted that the quantity of substances seized by the State Police has decreased, but the total quantity of substances seized by the Customs Service has increased, a fact which may be explained by an increase in marijuana transit. The number of heroin seizures is similar to that in the 2008 data, but the quantity of substances seized has increased. This again confirms the trend that the circulation of heroin has increased. The reduction in the quantity of cocaine, ecstasy, and LSD seized can be attributed to a decrease in the amount of these substances in circulation. The decrease in the amount of methamphetamine and amphetamine substances may possibly be explained by the entrance into the market of new substances (piperazines, GHB) and a reduction in the number of seizures.

Table 10.1. Quantity of major groups of illegal substances seized in 2005–2009

	2005	2006	2007	2008	2009
Heroin (kg)	0.004	0.157	1.75	1.75	2.14
Herbal cannabis (kg)	25.92	5.9	17.84	42.44	17.88
Cannabis plants (kg)	N/A	N/A	34.48	157.52	34.28
Cannabis resin (kg)	1.55	0.358	0.254	6.88	1.45
Amphetamine (kg)	3.79	11.03	5.78	4.8	1.30
Methamphetamine (kg)	3.42	8.12	11.83	32.27	7.89
Ecstasy (tab)	21937	4600	94753	3945	281
Cocaine (kg)	0.68	1.12	11.9	5.15	0.44
LSD stamps	2190	3	146	2	1

Source: State Police Forensic Department, 2010

The Latvian State Police have also seized other substances. For the first time, substances and tablets containing piperazine were seized, and that can be explained by these substances becoming subject to control and the legal possibility of seizure. Existing information on seized substances indicates an increased popularity in the market for drugs of the piperazine and GHB groups.

Table 10.2. Various substances (newly controlled and country-specific) seized by the State Police in 2009

	grams	tablets	ml.
Substance/tablets containing 1-(4-Chlorophenyl) piperazine	122.1435	2274	
Tablets containing 4-methyl-ephedrone (Mephedrone)		678	
Acetyl opium	1.2806		
Substance/tablets containing buprenorphine	1.0793	13	
Tablets containing cyclobarbital/diazepam		76	
Substance/tablets containing diazepam	0.05	62	
Tablets containing dihydrocodeine		38	
Substance/tablets containing fenazepam	3.8641	143	
fentanyl	0.3591		
gamma-Butyrolactone (GBL)			25
Raw opium	1.9665		
Substance/tablets containing clonazepam	98.622	1754	
Poppy straw	39,277.33		
Substance containing mescaline	249.31		
Tablets containing methadone		5	
Tablets containing morphine		56	
Gamma hydroxybutyrate (GHB)	2673.5668		
Tablets containing nitrazepam		132	
Substance/tablets containing oxazepam	0.0512	25	
Home-made preparation made from ephedrine, containing ephedrone			9
Psilocibes mushrooms (dried)	1.9024		
Salvia divinorum (dried)	2.7778		
Substance/tablets containing trihexyphenidyl	4.223	266	
Substance/tablets containing zopiclone	0.1031	11	

Source: State Police Forensic Department, 2010

During 2009 the value of drugs and psychotropic substances seized in the country (in accordance with established black-market prices) is approximately LVL 447,305; the value of drugs and psychotropic substances seized abroad in collaboration with the State Police ONAP is approximately LVL 682,172,880.

10.3. Price and purity

Information on the retail prices of drugs is provided by the Drug Enforcement Bureau of the Organized Crime Enforcement Bureau of the Central Criminal Police Department of the State Police (ONAP), who obtains information from operational staff. Police advise that the information has been obtained from dealers, arrested persons and Informants, but fail to explain the calculation methodology and sample strategy used.

Because of the economic situation, several agencies within the State Police have been reorganized and staff have been laid off. Specialists who compiled information on retail drug prices were replaced, resulting in a break in the succession of information, i.e. data on prices for the second half of 2010 is very limited. Until September 2009, data on retail prices was provided by the majority of municipalities, as ONAP could officially request such information. After the reorganization, ONAP no longer had this right, so for 2009, information at the national level is compiled for the first nine months of the year. Consequently, the data on retail drug prices from late 2009 and for 2010 is territorially limited to Riga. The compilation of data for other regions is planned, beginning with the year 2011[72].

[72] ST16_2010_LV_01

The maximum and minimum price has been indicated for cannabis, cocaine and amphetamine, but the price is shown as an interval, and therefore the most common and the average price cannot be ascertained. A similar situation exists with regard to the prices of heroin, ecstasy and LSD, as the State Police have indicated a single fixed retail price. It is not possible to make an accurate analysis based on the available information, thus the main conclusions regarding retail price changes for drugs are provided from the observations of police officers. Compared to previous years, the situation has not radically changed. Cocaine prices have declined as the number of financially-stable users has decreased. A slight decrease in the price of heroin is explained by the economic situation in the country. A lower price has been determined for LSD, since methamphetamine has begun to replace LSD, ecstasy and amphetamines, because of the availability of raw materials, its production process is more cost-effective and it is more profitable. The prices of marijuana and amphetamine have remained at virtually the same level, as they continue to be among the drugs most in demand in Riga and in the regions (State Police, 2010).

Table 10.3. Drug prices, in euros, 2007- 2009

	2007			2008			2009		
	min	max	mode	min	max	mode	min	max	mode
Marijuana	5.7	14	10	14	17	14	10	14	
Heroin	64.2	185.7	157	100	142.9	100			114
Cocaine	43	86	71	85.7	128.6	100	57	100	
Amphetamine	7	14	14	10	14	14	10	14	14
Ecstasy	4.2	10	5.8	5.7	7	5.7	6	6	6

Source: State Police, 2010

The level of illegal drug or substance, or substance percentage by volume, is determined by the Latvian State Police Forensic Service Chemical Analysis Department.

Available data for 2005–2009[73] show that the average drug purity has changed to around 20%. In general, the maximum purity of substances, compared to 2008, has decreased for ecstasy, amphetamines and cocaine.

The THC level of cannabis products is not determined in Latvia as of yet.

Table 10.4. Mean purity (%)

	2005	2006	2007	2008	2009
heroin	N/A	38	33	29	28
cocaine	39	31	25	28	26
amphetamine	32	38	16	29	16
Metamphetamine	43	30	20	32	30
MDMA (mg/tab)	77	36	90	81	27

Source: State Police, 2010

[73] ST14_2010_LV_01

Part B: Selected Issues

11. History, methods and implementation of national treatment guidelines

In Latvia, treatment processes are stipulated in the *Medical Treatment Law*, in which two terms are defined, which stipulate and regulate treatment processes and their quality, namely, "medical technologies" and "clinical guidelines". According to the *Medical Treatment Law*, "medical technologies" are defined as methods and medical equipment used in treatment, whereas "clinical guidelines" are defined as a systematised description of the treatment process for a specific group of patients, which are established, observing evidence-based medical principles, and in which are set out the necessary actions required, the order in which they are to be performed, and important criteria for selection of preferred treatment tactics to achieve the best treatment outcome.

A medical technology is a technical document, which addresses all the possible manipulations, essential equipment for the therapeutic process, medications to be used, and so forth. Latvia has 16 approved medical technologies that apply to the treatment of drug-dependent patients. Observance of medical technologies approved by the Cabinet of Ministers is mandatory in the treatment process and in the receipt of public funding.

Clinical guidelines are a broader document, which, according to the definition in the *Medical Treatment Law*, is based on scientific evidence. One set of guidelines may encompass a number of medical technologies. However, in contrast to medical technologies, clinical guidelines are recommendatory in nature, and their implementation in medical institutions is dependent on the financial capability of the relevant institution. At the same time, the *Medical Treatment Law* stipulates that treatment should be in accordance with clinical guidelines or assessment of therapeutic methods and medication usage safety and therapeutic efficacy performed in accordance with evidence-based medical principles.

This chapter overviews existing the Latvian treatment guidelines for drug dependence, their historical development, design and implementation process, and compares the Latvian guidelines for long-term pharmacotherapy of opioid-dependent patients with the pharmacotherapy guidelines developed by the WHO. As part of the guidelines analysis process, seven interviews were conducted with experts in the field who had participated in the guideline development process or are responsible for the approval and implementation of the guidelines.

11.1. History and overall framework

The development history of the Latvian clinical guidelines is not ancient. The Latvian Addiction Disorders Specialists' Association (LADSA) working group of specialists developed the first *Guidelines for the Treatment of Drug-Dependent Patients* in 2005. A second set of guidelines: *Guidelines for the Treatment of Misuse and Dependence on Sedative Medications* was developed a year later, in 2006. However, the *Long-Term Pharmacotherapy of Opioid-Dependent Patients using Methadone and Buprenorphine* was developed in 2009. All the guidelines have been developed by the working group of the LADSA.

Historically, the specialty of addiction disorders was established in Latvia during the 1970s, when the first institution for treatment of addiction disorders was established. The specialty was created to reduce the growing prevalence of alcoholism throughout the Soviet Union. Even today, the addiction disorders sector encompasses the treatment of addiction to alcohol, drugs and psychotropic substances, tobacco, and gambling. Consequently, the first Guidelines include information not only about treatment for addiction to drugs and psychotropic substances, but also on alcohol and gambling addiction.

Like the addiction disorders sector during the Soviet era, the first guidelines developed for treatment of drug-dependent patients were also based on Russian practice, where the main role was focused on the treatment of withdrawal and the treatment of intoxication. Currently, experts in the field indicate that these guidelines should be redrafted with a greater focus on multidisciplinary teamwork, and psychosocial treatment, as well as specific treatment of different patient groups. At the same time, experts point out that although the first guidelines were not based on scientific evidence and international research, it is beneficial that they were developed, as supplementing and revising them now will be much easier than developing entirely new ones.

As recently as 2010, Latvia had no single procedure for how guidelines were to be developed, validated and implemented. All three Latvian existing treatment guidelines for drug-dependent patients were developed by the LADSA working group. The developed guidelines were presented at a meeting of the Association and disseminated to members of the Association, namely, addiction specialist physicians. Since in Latvia the guidelines are recommendatory in nature, their use is optional and therefore it is unknown how actively physicians are using them. The experts do hope that new Cabinet Regulations will form the basis for the guidelines to be taken into account in determining health care service charges and payment conditions in the future.

The specialists also unequivocally acknowledge that the existing guidelines should be redrafted to align with international practice. Furthermore, the development of new guidelines should involve a multidisciplinary panel of experts, consisting not only of addiction psychiatrists, but should also involve teaching staff. The specialists also point out that it would be much more appropriate to use guidelines already approved throughout the world, such as those already developed by the World Health Organization, and adapt those to the Latvian situation, rather than create something completely new.

It should be noted that the existing treatment guidelines for drug-dependent patients are very similar to medical technologies. Consequently, the need for such separate documents is unclear. The fact that the guidelines for long-term pharmacotherapy of opioid-dependent patients do not really correspond with the new World Health Organization guidelines, is also considered a negative feature.

According to experts, by late 2010, the *Guidelines for the Long-Term Pharmacotherapy of Opioid Dependent Patients using Methadone and Buprenorphine* will be revised, based on the World Health Organisation 2009 guidelines. Accordingly, it is also planned to develop new medical technologies for methadone and buprenorphine. In the future, it is also planned to revise the *Guidelines for the Treatment of Misuse and Dependence on Sedative Medications*, because new methods and medications are increasingly being used in the treatment of such patients, and renewal of the guidelines would be natural.

11.2. Existing guidelines: narrative description of existing guidelines

Latvia currently has three drug treatment guidelines, which have been developed and approved by the Latvian Addiction Disorders Specialists' Association:

- Guidelines for the Treatment of Drug-Dependent Patients, 2005;
- Guidelines for the Treatment of Misuse and Dependence on Sedative Medications, 2006;
- Guidelines for the Long-Term Pharmacotherapy of Opioid Dependent Patients using Methadone and Buprenorphine. Guidelines for Professionals, 2009.

The existing guidelines are mostly informative material, which provides an overview of the treatment of drug-dependent patients. The guidelines mostly contain information on medicinal treatment, with particular emphasis on detoxification. Experts in the field indicate that the guidelines should be redrafted in line with global practice, as the first two guidelines were drafted the basis of Soviet practice, where the major focus is on acute treatment forms. Experts point out that in redrafting the guidelines, greater attention should focus on psychosocial

aspects in the treatment of drug-dependent patients. Similarly, treatment for different patient groups and different substance addictions should be differentiated.

A more detailed analysis of each of the three guidelines follows.

Guidelines for Treatment of Drug-dependent Patients

Guidelines for Treatment of Drug-dependent Patients is a document in which attention is focused in condensed form on many addiction-related topics, ranging from addiction risk factors, pathogenesis, prevention, and clinical manifestations of addiction, to various forms of assistance: outpatient, inpatient hospital assistance, inpatient psychotherapy, rehabilitation, and anonymous movements (*State Addiction Agency, 2005*).

The chapter on outpatient assistance is dedicated to such topics as addiction-specialist advice on the use of or addiction to alcohol, drugs and psychotropic substances, tobacco, gambling and new technologies, when a decision is made on the need for addiction tracking and dynamic observation, as well as treatment of the withdrawal in mild and moderate consumption of alcohol, drugs and psychotropic substances. The guidelines precisely describe the symptoms of this condition and the appropriate medicinal therapies. Attention is also paid to medicinal assistance in cases of light and moderate withdrawal from opioid or psycho-stimulant substance addiction. Similarly, a brief insight is provided into the application of buprenorphine and methadone replacement therapy (when is it necessary to select methadone/ buprenorphine, drug dosage).

Separate sections of the guidelines are devoted to gaming and new technology dependence and outpatient therapy, inpatient psychotherapy (motivational program, Minnesota 12-step program), rehabilitation, and anonymous movements.

The largest section of the guidelines is dedicated to inpatient assistance in cases of acute intoxication (acute intoxication from alcohol, opioids, cannabis, sedatives, cocaine, drugs and non-narcotic stimulants, hallucinogens, and volatile organic solvents), which describe in condensed form the symptoms, tests and required medicinal therapy, as well as inpatient assistance in withdrawal cases.

The Guidelines conclude with notes on inpatient assistance in cases of psychotic, mental, cognitive, and personality disorder following the use of psychoactive substances (symptoms, tests, therapy).

Guidelines for the Treatment of Misuse and Dependence on Sedative Medications

Guidelines for the Treatment of Misuse and Dependence on Sedative Medications is in its structure and substance similar to *Guidelines of the Treatment of Drug Dependent Patients*, but its target group is much broader (State Addiction Agency, 2006). If the former guidelines are intended more for professional addiction specialist physicians, then the *Guidelines for the Treatment of Misuse and Dependence on Sedative Medications* are intended for a wider range of professionals including family doctors and other specialist physicians. Experts indicate that these guidelines are more like informative material, rather than clinical guidelines, because the sedative and sleep medications are widely distributed throughout society, and these medications may be freely prescribed by any physician, they are often prescribed improperly or in excessive doses and for excessive periods, causing substantial harm to the patient's health. Similarly, the use of sedative and sleep agents has always been prevalent among drug-dependent persons since Soviet times.

The *Guidelines for the Treatment of Misuse and Dependence on Sedative Medications* focus on several groups of sedative and sleep preparations i.e. barbiturates, benzodiazepines and GHB.

The guidelines describe the use of medications in the barbiturate group, phases of intoxication, acute intoxication (symptoms, examination and treatment), signs of overdose, clinical manifestations of dependency, developmental stages, the withdrawal state (symptoms, necessary examinations and applicable therapy), as well as possible complications.

Similarly, the guidelines provide the pharmacokinetics of benzodiazepines, a comparison of the most common benzodiazepines, information on the need for prescribing these drugs, indications for their use, adverse effects, and contra-indications. As in the section on barbiturates, the benzodiazepines are described in terms of acute intoxication (symptoms, tests and applicable therapy), benzodiazepine dependence and withdrawal state.

Similarly described is GHB intoxication, emergency assistance in case of intoxication and the principles of treatment in withdrawal cases.

The final section of the guidelines considers the psychotic, psychiatric, cognitive, personality and behavioural disorders following the use of sedative agents: acute intoxication with delirium, its symptoms, tests, and therapy; withdrawal state with delirium – its symptoms and available therapy. Attention is also drawn to the withdrawal state accompanied by delirium complications, psychotic disturbances, amnesic syndrome and psychotic disturbances, which begin long after the use of sedative and sleeping drugs.

The guidelines conclude by providing information on opportunities for receiving outpatient and inpatient assistance, rehabilitation facilities, anonymous movements and opportunities for consulting addiction specialist physicians.

Guidelines for The Long-Term Pharmacotherapy of Opioid-dependent Patients using Methadone and Buprenorphine

Guidelines for The Long-Term Pharmacotherapy of Opioid-dependent Patients using Methadone and Buprenorphine is intended for professionals in the field and is much more specific than the two previously-mentioned guidelines (Public Health Agency, 2009). It should also be noted that these are the newest guidelines, and are therefore more in line with international standards. The guidelines refer to international research and literature, and also take into account outcomes of the *Latvian Pharmacological Evaluation of Opioid Dependence Treatment* (*Sile, Pūgule, 2008*).

The guidelines briefly describe global practice in the use of methadone and buprenorphine in pharmacotherapy, epidemiological data, effectiveness and cost effectiveness of long-term pharmacotherapy, pharmacokinetics, and interaction with other medications, side effects and contraindications.

Further chapters in the guidelines are devoted to the description of long-term pharmacotherapy, defining examination of the patient, and indications, contraindications and precautions while using medications. Given the fact that the guidelines focus only on long-term pharmacotherapy using methadone and buprenorphine, they do not include information on the use of opioid antagonists in pharmacotherapy. The guidelines contain information on the commencement of treatment, using combinations of methadone/buprenorphine and buprenorphine – naloxone, the transition from methadone to buprenorphine or buprenorphine – naloxone combinations, and vice versa, discontinuation of those medications and overdosing. Guidelines also indicate criteria that determine a patient's exclusion from the therapy and the patient groups that are particularly important to involve in therapy (e.g. pregnant women and HIV/AIDS patients, patients with hepatitis B/C).

The final three chapters of the guidelines contain a short description of the work of pharmacotherapy in terms of organisation, the resources required and the evaluation methodology.

A detailed comparison of the Latvian guidelines for long-term pharmacotherapy of opioid-dependent patients with the WHO guidelines for long-term pharmacotherapy is given in the final chapter of this Selected Issue.

11.3. Implementation process

Until now, there has been no uniform procedure in Latvia for the manner in which guidelines were to be developed and implemented. Usually it was a matter of medical associations who developed the guidelines and subsequently also approved and distributed the developed

guidelines to their members. However, the current procedure for the development, evaluation, authorization and arrangements for implementing clinical guidelines is stipulated in Cabinet Regulation No. 469 of 25 May 2010: *Procedures for the Development, Evaluation, Registration and Implementation of Clinical Guidelines*, which firmly and specifically defines the development and implementation process for clinical guidelines. However, given the fact that the state has not allocated additional funding for development of guidelines, and that guidelines are more recommendatory in nature, there is no present mechanism to motivate the preparation of guidelines based on scientific evidence. Experts do point out that one motivation could be that the guidelines will in future be taken into account in determining health care service charges and terms of payment.

The aim of the new Cabinet Regulation is to facilitate the development of evidence-based national guidelines based on common criteria, their application in medicine, medical education training programs, and the drafting of tariffs and payment terms for health care services from the state budget, as well as in the monitoring and quality control of provision of health care services.

The Cabinet Regulation stipulates that the medical staff of professional organizations, and medical institutions and universities which offers academic and second level professional programs in medicine shall have the right to develop draft guidelines and submit them to the Centre of Health Economics for registration in the Clinical Guidelines Database.

In order for clinical guidelines to be approved and registered in the database, the developer must submit a full text of the draft guidelines, a summary of the draft guidelines, together with a description of the development process for the guidelines, including information on the developers and reviewers of the draft guidelines, their consideration by medical personnel in professional organizations, medical and scientific institutions, and in seminars or conferences. The developer must also provide information regarding the form of the draft guidelines, indicating whether they are original, adapted or translated. If the draft guidelines are adapted or translated, the developer is to submit a copy of the original guidelines.

The draft guidelines must include the following information:

- title of guidelines
- guideline developer;
- aim and objectives of the guidelines;
- intended users of the guidelines;
- benefits, side effects and risks that could occur by following the guidelines' recommendations;
- target group for application of the guidelines, indicating patient diagnoses or diagnosis groups and their corresponding codes, in accordance with the *International Classification of Diseases*, 10th edition endorsed by the World Health Organization;
- sources of evidentiary information and criteria for their selection;
- recommendations for medical treatment personnel for specific therapeutic activities, including diagnosis, prevention, treatment methods, observation tactics, rehabilitation and indication of which of the technologies mentioned in the guidelines (medications, medical equipment, methods, procedures) could be applied in Latvia;
- The evidentiary level for recommendations shall be in accordance with the following: Level A - highly reliable evidence obtained from several good-quality randomized clinical trials which have been the subject of meta-analysis;
- Level B - evidence of moderate reliability, which has been obtained from individual good-quality randomized clinical trials or meta-analysis of several well-organized studies of control groups (unrandomized clinical studies, case-control studies, cohort studies);
- Level C - evidence having low reliability, obtained in separate trials of a control group (unrandomized clinical trials, case-control studies, cohort studies);
- Level D - insufficient evidence, obtained in a series of case observations, or which have received the unanimous recommendation of experts.

- Links between guideline recommendations and evidence, indicating specific references;
- funding source for development of guidelines.

Following submission of the draft guidelines, the Centre of Health Economics assesses the documentation submitted by the developer for conformance with the above-mentioned guidelines. If discrepancies are found in the documents, the Centre of Health Economics requests additional information from the developer.

After evaluation of the submitted documents for compliance, the Centre of Health Economics forwards the draft guidelines for evaluation by key specialists in the relevant health sector of the Ministry of Health, and by the health sector strategic council[74]. Besides the said institutions, the Centre of Health Economics may forward the draft guidelines for evaluation to other healthcare institutions, professional organizations, or experts who are specialists in a particular branch of health care, and who meet at least one of the following criteria: that the expert has a doctoral degree in medical science; is a university assistant professor, associate professor, professor, or a person authorised to train other persons, or is a senior researcher, and/or the expert has at least five years' experience in a relevant medical specialty.

If, after one month, the above-mentioned institutions and experts have not submitted any comments or corrections of the draft guidelines to the Centre of Health Economics, then the draft guidelines shall be deemed to have been approved. Conversely, if the above institutions and experts have expressed reservations or comments regarding the draft guidelines, the Centre for Health Economics shall inform the guideline developer who shall within the period of one month evaluate the objections and clarify the draft guidelines or reject the complaints, providing a reasoned written explanation to the Centre.

Once the guidelines are approved, they are registered in the database maintained by the Centre of Health Economics.

By contrast, treatment institutions introduce guidelines according to the medical institution's financial capability, which means that the introduction of clinical guidelines is not yet mandatory, but is of a recommendatory nature.

11.4. Treatment guidelines comparison with the WHO guidelines

In Latvia, the guidelines for long-term pharmacotherapy of opioid-dependent patients were drafted in 2009. The main reason for their development was the enlargement of pharmacotherapy at the national level, which was organized by UNODC as part of the project: *HIV/AIDS Prevention and Care among Injecting Drug Users and in Prison Settings in Estonia, Latvia and Lithuania 2006-2010*. Also undertaken within the framework of this project was the *Pharmacological Evaluation of Opioid Dependence Treatment in Latvia* (Sile, Pūgule 2008), resulting in a recommendation to develop common guidelines for professionals for the long-term pharmacotherapy of opioid-dependent patients, which will provide pharmacotherapy at the national level.

The national guidelines for the long-term pharmacotherapy of opioid-dependent patients are based on scientific evidence and international research; however, it should be noted that the guidelines are more descriptive rather than advisory or recommendatory. To be precise, the guidelines provide extensive information on long-term pharmacotherapy, its efficacy and cost effectiveness, interaction with other medications, side effects etc., but do not provide recommendations as to what should be the preferred choice in any given case. As indicated by experts in the field, the physician is concerned to select the best and most appropriate treatment method, whereas the guidelines essentially describe all the possible options.

[74] The Council is an advisory body for formulating and implementing health policy, and is comprised of representatives from health associations, as well as state and municipal institutions. The Council is established and its bylaws are approved by the Minister of Health.

It is important to note that the national guidelines for long-term pharmacotherapy of opioid-dependent patients are narrower than the WHO guidelines, as they describe only long-term pharmacotherapy using methadone, buprenorphine and buprenorphine-naloxone combinations, and therefore do not include information on the use of opioid antagonists in the treatment of opioid dependence.

The following Table 11.1., which was developed on the basis of methodology developed by the EMCDDA, compares the WHO guidelines, or the recommendations described therein, to the Latvian guidelines and the information they provide for the long term pharmacotherapy of opioid-dependent patients. In the explanation section below Table 11.1, explanation is provided for cases where the WHO recommendations are not included in the Latvian guidelines or are not appropriate for a particular situation.

Table.11.1. WHO guidelines coherence

		Yes	No	Not applicable	*No answer*
1.	**Choice of treatment**				
1.2	For the pharmacological treatment of opioid dependence, clinicians should offer opioid withdrawal, opioid agonist maintenance and opioid antagonist (naltrexone) treatment, but most patients should be advised to use opioid agonist maintenance treatment. Do the present guidelines include this recommendation?			X	
1.3	For opioid-dependent patients not commencing opioid agonist maintenance treatment, consider antagonist pharmacotherapy using naltrexone following the completion of opioid withdrawal. Do the present guidelines include this recommendation?			X	
2	**Opioid agonist maintenance treatment**				
2.1	For opioid agonist maintenance treatment, most patients should be advised to use methadone in adequate doses in preference to buprenorphine. Do the present guidelines include this recommendation?			X	
2.2	During methadone induction, the initial daily dose should depend on the level of neuroadaptation; it should generally not be more than 20 mg, and certainly not more than 30mg. Do the present guidelines include this recommendation?		X		
2.3	On average, methadone maintenance doses should be in the range of 60–120 mg per day. Do the present guidelines include this recommendation	X			
2.4	Average buprenorphine maintenance doses should be at least 8 mg per day. Do the present guidelines include this recommendation?	X			
2.5	Methadone and buprenorphine doses should be directly supervised in the early phase of treatment. Do the present guidelines include this recommendation?	X			
2.6	Take-away doses may be provided for patients when the benefits of reduced frequency of attendance are considered to outweigh the risk of diversion, subject to regular review. Do the present guidelines include this recommendation?			X	
2.7	Psychosocial support should be offered routinely in association with pharmacological treatment for opioid dependence. Do the present guidelines include this recommendation?	X			
3	**Management of opioid withdrawal**				
3.1	For the management of opioid withdrawal, tapered doses of opioid agonists should generally be used, although alpha-2 adrenergic agonists may also be used. Do the present guidelines include this recommendation?			X	
3.2	Clinicians should not routinely use the combination of opioid antagonists and minimal sedation in the management of opioid withdrawal. Do the present guidelines include this recommendation?		X		
3.3	Clinicians should not use the combination of opioid antagonists with heavy sedation in the management of opioid withdrawal. Do the present guidelines include this recommendation?	X			
3.4	Psychosocial services should be routinely offered in combination with pharmacological treatment of opioid withdrawal. Do the present guidelines include this recommendation?	X			
4	**Pregnancy**				
4.1	Opioid agonist maintenance treatment should be used for the treatment of opioid dependence in pregnancy. Do the present guidelines include this recommendation?	X			
4.2	*Methadone maintenance should be used in pregnancy in preference to buprenorphine maintenance for the treatment of opioid dependence; although there is less evidence about the safety of buprenorphine, it might also be offered.* *Do the present guidelines include this recommendation?*	*X*			

Explanation

1.1. The Latvian guidelines apply to pharmacotherapy using methadone, buprenorphine and buprenorphine-naloxone combinations, and therefore the guidelines do not provide information on opioid antagonist (naltrexone) maintenance therapy. Similarly, the guidelines do not specifically indicate that opioid agonist therapy should be recommended for the majority of patients.

1.2. See. 1.1 explanations

2.1. The Latvian guidelines do not specifically indicate that for the majority of opioid-dependent patients, adequate doses of methadone should be used rather than buprenorphine. The guidelines provide a wealth of information on both drugs, their effectiveness, cost effectiveness, etc. They also indicate in what cases a particular drug would be more appropriate.

2.2. The Latvian guidelines stipulate that in long-term methadone pharmacotherapy, the initial daily dose is 10–40 mg.

2.3. In long-term methadone pharmacotherapy, the initial daily dose is 10–40 mg, which is progressively increased. The average daily methadone dose is 60– 120 mg. The maximum dose is 150 mg, but higher doses are also possible, following assessment of the patient's individual health criteria.

2.4. The initial daily dose of buprenorphine is 2–4 mg, with a maximum of 8 mg. The highest daily dose is 16 mg but the average therapeutic dose of buprenorphine is 8–12 mg per day.

2.6. The Latvian guidelines indicate that in cases where the patient has a medical certificate issued by a family physician certifying incapacity for work, it is possible to receive a methadone dose to take away, or the dose may be issued to family members after completion of issue/receipt documentation for the methadone received. Conversely, if the patient has an employment contract and a social worker has verified the place of employment, and if the patient has no history of offending during methadone therapy, it is possible to take methadone away at the physician's discretion.

3.1. The Latvian guidelines describe opioid withdrawal therapy and appropriate medications, but do not specifically state that it should be based on the use of opioid agonists in reduced doses.

3.2. The Latvian guidelines are oriented towards opioid agonist therapy, and thus do not indicate that in opioid withdrawal therapy, physicians should not regularly use opioid antagonists in combination with sedative preparations.

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

This Selected Issue looks at mortality among drug users in Latvia, which can be direct (e.g. overdoses) or indirect (e.g. HIV/AIDS). This chapter includes data from several sources – available statistical data, data from retrospective cohort studies and published and unpublished information available in Latvia on this topic.

From public health perspective one of the main causes for underage mortality is that among drug users, especially injecting drug users. Worldwide many studies have looked at mortality rates among known drug users and general population and have found that they are higher as compared with those observed among general population; some of the studies have found that in different countries these rates vary by gender, i.e. among females standardized mortality ratios (SMRs) are higher among females than males.

In Latvia there are numerous data sources holding information about drug users in contact with various institutions, e.g. drug treatment (in- and out-patient), police (those tested positive for drugs), infectious diseases (HIV, hepatitis), mortality data, etc.

Data on drug-related deaths In Latvia is carried out by the Centre of Health Economics[75], which is responsible for maintaining the Death Causes Databse (General Mortality Register). Data collection process and collaboration with the Special Register at the State Forensic Medicine Centre is described in several National Reports on Drug situation in Latvia (e.g., State Addiction Agency, 2006; Public Health Agency, 2007). According to the definition data collected in Latvia refers to the EMCDDA preferred data collection method "Selection B".

According to available statistical data in the period of 1999–2009 there have been 265 drug-related deaths in Latvia. Majority of these deaths (145) have been registered between 1999 and 2002, while since 2003 the mortality has remained at relatively low level, i.e. 12 to 24 annually registered cases *(see also Chapter 6.3 on Drug-related mortality and Fonte[76])*. A number of deaths three times higher between 1999 and 2002 as compared with that recorded in after 2003 is related with differences in national definition used. By taking into account relatively small numbers of died persons it is diffult to come to reasonable conclusions on drug-related mortality trends in Latvia, e.g. if a decrease of five deaths in 2009 as compared with 2008 represents actual situation.

12.1. Recent follow up mortality cohort studies among PDUs

The first cohort study on linking two data sources (out-patient TDI data and GMR) based on a unique personal identifier was carried out in 2007 with the technical assistance from the EMCDDA and Czech National Focal Point. The methodology for the study was similar to that in several other cohorts conducted in EU (*EMCDDA, 1999a; EMCDDA, 1999b*). Detailed results from the study were included in the 2008 National report (see *National Report, 2008*). This study included at all treated drug users (age 10-44 at entry), while the mortality rates were calculated for four groups of subjects: 1) all treated drug users (including cannabis), 2) treated heroin users, 3) treated other opioid[77] users, and 4) amphetamine users *(see Table 12.1)*. The subjects were classified in one of the substance groups according to the last known treatment episode, which was thought to be more relevant in comparison if they were classified according to the substance used at first treatment entry, e.g. if a subject entered cohort with cannabis-related problems but over the course of follow-up he/she would have a last episode of heroin use, he/she would be classified as heroin user.

[75] As of reorganizations in the Health System in October, 2009. Formerly – Health Statistics and Medical Technologies State Agency (HSMTSA)
[76] ST5_2010_LV_01 and ST6_2010_LV_01; ST6_2010_LV_02
[77] Mostly older drug users of *hanka*, which is a home-made opioid

In 2009/2010 preparations and data analysis of two new cohorts was conducted by taking into account experience and limitations of the first study, by employing a similar methodology. The major differences between this study and the previously conducted were a slightly different target group (opioid users in this instance), a longer follow-up period, and slightly different age group (15-49). Within the scope of the latter study two separate cohorts with were drawn and analysed: 1) drug users brought for drug testing by the police (referred as police data) and 2) treated opioid users in the out-patient TDI data (PREDA system as of 2009 – see also Chapter on Tretment for details and limiations of these data). These data sources were linked with the GMR. Further analysis by linking the Police and TDI data, to estimate mortality rates among those not in treatment, was carried out.

Both studies were made possible due to use of a unique personal identifier[78] in the data sources; data linkage itself was carried out by those responsible for the PREDA system. Those without a full identifier (as it would be not possible to assess their vital status) in the police data or in TDI were excluded from the data linkage with the GMR but the proportion of such cases was less than five per cent. Before the analysis the personal identifier was scrambled for privacy issues.

Results and methodology of these studies is also reported in the EMCDDA Standard Tables on Mortality cohort studies[79]; while description of the cohort studies is included in the Table 12.1 below.

Table 12.1. Description of the cohort studies (target groups)

Reference		Age	Study years	Target group	Number of persons; number of deaths; number of person-years	Non-standardized mortality (per 1,000 PY)
1	Trapencieris, 2007	11-44*	1999-2006	All treated drug users	5,323; 279; 19,566	11.29
1(1)	Trapencieris, 2007			Treated heroin users	2,592; 196; 13,379	14.65
1(2)	Trapencieris, 2007			Treated opioid (other than heroin) users	490; 33; 2,371	13.91
1(3)	Trapencieris, 2007			Treated amphetamine users	551; 13; 1,601	8.12
2(1)	Trapencieris, 2010	15-49**	2000-2009	Treated heroin and other opiod users	3,644; 341; 21,294	16.01
2(2)	Trapencieris, 2010			Arrested heroin and other opiod users	4,825; 416; 24,873	16.72
2(3)	Trapencieris, 2010			Arrested heroin and other opiod users***	2,711; 218; 13,699	15.91

Source: The Centre of Health Economics; 2010; NFP calculations, 2010

** Age at entry. Subjects were followed from their first-entry record after January 1, 1999 either up to their death or until end of the follow-up on December 31, 2006; ** Subjects were followed up from the first entry after January 1, 1999 either up to their death, the day before reaching 50th birthday, or until end of follow-up on December 31, 2009 (whichever came first); *** those without known treatment according to the database linkage between arrested and treated subjects*

Description of the results from 1999–2006 cohort(s)

Between 1999 and 2006 5,323 individual aged 11-44 enrolled the treated persons cohort, of these 4,209 (or 79.1%) were males. The mean age at the entrance into cohort was 20.95 years (21.15 for males and 20.16 for females). For slightly less than one half of cohort at the entrance the primary drug of abuse was heroin (2,566 or 48.2%), for 722 (or 13.6%) – cannabis, for 503 (or 9.5%) – other or unspecified opiates, for 496 (or 9.3%) – amphetamines, for 452 (or 8.5%) – sedatives or hypnotics, for 218 (or 4.1%) – inhalants or solvents, for 154 (2.5%) – other or unspecified stimulants, for 108 (2.0%) – hallucinogens, for 26 (or 0.5%) – cocaine, while the rest had not reported specific drug of abuse. In case of consecutive treatment episodes during the time of follow up, primary drug of abuse was taken from the last known treatment episode, thus individuals for the purpose of analysis were as follows: 2592 heroin users, 692 cannabis users[80], 551 amphetamine users, 490 other or unspecified opiate users; because of much

[78] A unique combination for each resident of Latvia, consisting of date of birth and a unique five-digit number.
[79] *see in Fonte ST18_2010_LV_01 and ST18_2010_LV_03*
[80] Cannabis users were also not separately anlysed in the study.

smuller numbers of users of other substances were in the cohort the were not analysed separately but were included in the total estimates of mortality rates.

Out of 5,323 cohort participants 279 (or 5.2% of all persons enrolled in cohort) had died during the follow-up; among them 234 (or 83.9% of those died at follow-up) were males and 45 (16.1%) females. Majority of them were classified as heroin users (196 or 70%), followed by users of other opioids (mostly home-made opioid *hanka*) (33 or 12%) and users of amphetamines (13 or 5%). The mean age at death was 27.08 years; it was higher for males (27.47) than that for females (25.04); about one-third (32.2%) of all deaths were in the age group 20-24, followed by age group 25-29 (22.2%).

Of those died during follow-up for 176 (or 63.1%) the underlying cause of death was external cause (ICD-10 V01-Y98), of which 48 (or 17.2%) had died because of drug overdose. For 13 subjects the main cause of death was AIDS-related death (ICD-10 B20-B24), while the most commonly classified main causes of death were related with circulatory system diseases (I codes) – 40 cases, related with diseases of respiratory system (J codes) – 19, digestive system (K codes) – 12 cases.

Within the cohort in 65 cases poisoning by drugs, medicaments and biological substances were mentioned (T36-T50) (except alcohol). The most commonly mentioned was poisoning by other or unspecified narcotics (T40.6) and poisoning by other opioids (T40.2). Poisoning by these and other drugs is displayed in Table 12.2.

Table 12.2. Substances mentioned in cause of death (T codes)

	Number
Total	65
Poisoning by other or unspecified narcotics (T40.6)	21
Poisoning by other opioids (T40.2)	19
Poisoning by heroin (T40.1)	4
Poisoning by opium (T40.0)	3
Poisoning by other and unspecified psychodysleptics (T40.9)	2
Poisoning by cannabis (T40.7)	1
Poisoning by psychostymulants with abuse potential (T43.6)	2
Poisoning by antiepileptic, sedative-hypnotic and antiparkinsonism drugs (T42)	6
Other (e.g. T50.9, T43.4, T39.3)	7

Source: The Centre of Health Economics; 2010; NFP calculations, 2010

Non-standardized mortality (crude) rate

Within the cohort the non-standardized mortality rate for eight years of follow-up was 11.29 per 1000 PYs; for males it was slightly higher (11.96 per 1000 PY) as compared with females (8.73 per 1000 PY). No cases of death were observed within the age group 11-14, while the lowest non-standardized mortality rate was within 15–19–year-old drug users (6.66 per 1000 PY), which increases with age and the highest was observed in the 45-49 year old drug users (56.79 PY).

The crude rates were higher among those classified as heroin (14.65 per 1000 PY) or other opoid (13.91 per 1000 PY) users as compared with those using amphetamines (8.12 per 1000 PY). Because of small numbers of died amphetamine users further analysis regarding substances at last treatment entry is limited and should be interpreted with caution.

Directly standardized mortality rates

The directly standardized (by five-year age groups and gender) mortality rate of drug users treated at out-patient treatment centres during cohort follow-up between 1999 and 2006 was 19.80 per 1000 PY; 21.87 per 1000 PY for males and 9.05 per 1,000 PY for females. Gender differences in standardized mortality rates were found to be statistically significant.

Standardized mortality ratio (SMR)

The standardized mortality ratio (SMR) is used as a risk measure of death among cohort of drug users when comparing mortality with members of general population. The formula used for calculating SMR include number of observed deaths of drug users within whole follow-up, which is divided by the number of expected deaths within the general population, and the number of person-years of cohort members at follow-up.

The SMR for all drug users in the cohort at follow-up was 7.50 (95% CI 6.65-8.43); this study suggests that the mortality among female treated drug users is higher than that for males (13.24; 95% CI 9.66-17.72 and 5.07; 95% CI 4.44-5.76).

Description of the results from 2000–2009 cohort(s)

Analysis of this cohort is still on-going and a publication of the results is being prepared. Some preliminary results are included below:

- as result of the data linkage three separate analysis was carried out: 1) for 3,644 (21,294 PY of follow-up) treated opiod users, of which 341 had died, 2) for 4,825 (24,873 PYs) arrested opioid users (416 died), and 3) for 2,711 (13,699 PYs) “untreated” opioid users (218 died);
- the non-standardized mortality rates of 15–49–year–old opioid users ranged between 16.01 (for treated opioid users) and 15.91 (for the “untreated” population);
- the age and gender standardized mortality rates were 20.35 per 1,000 PY (for arrested opioid users), 21.59 (for treated opioid users), and 18.5 (for “untreated”);
- the SMR for the treatment cohort was 9.09 (95% CI 8.15-10.11), for the police cohort – 8.5; 95% CI 7.71-9.36), while for the those in the police and not in treatment 7.45 (95% CI 6.50-8.51);
- all three cohorts showed similar results and it must be taken in mind that there is a significant overlaps between the treatment and arrested cohort;
- analysis carried out up till know has not shown any significant risk factors, except number of times treatment, e.g. those in treatment more times have slightly lower risk of dying than those who have only one episode (RR 1.12; 95% CI 1.07-1.17) but limitations of the treatment data source that have been described in the chapter on treatment must be taken in mind

Table 12.3 shows survival probabilities of the conducted cohort studies. Eight-year survival can be compared across all cohorts; the results suggest the highest survival probability is seen among amphetamine users, while the lowest among untreated opioid users.

Table 12.3. Survival probability 1, 2, 3, 5, 8 and 10 years after enrolment

Ref number	At 1 year	At 2 years	At 3 years	At 5 years	At 8 years	At 10 years
1	0,987	0,974	0,964	0,948	0,912	
1(1)	0,979	0,963	0,951	0,932	0,890	
1(2)	0,983	0,967	0,952	0,938	0,898	
1(3)	0,994	0,986	0,979	0,957	0,943	
2(1)	0,977	0,958	0,945	0,925	0,889	0,847
2(2)	0,982	0,966	0,955	0,928	0,876	0,828
2(3)	,979	0,962	0,952	0,925	0,869	0,825

Source: The Centre of Health Economics, 2010; NFP calculations, 2010

Table 12.4 shows ICD-10 codes of the underlying cause of death for the 2000-2009 cohort(s) and for all drug users from the 1999-2006 cohort.

Table 12.4. Underlying cause of deaths for the 2000–2009 cohorts, ICD-10 codes

Icdgrp		ICD 10	1	2(1)	2(2)	2(3)
0	Unknown		0	0	0	0
1	inf disease	A00-B99 (excl. B20_B24)	§	7	14	10
2	AIDS	B20-B24	13	47	68	31
3	neoplasm	C00-D48	7	3	4	3
4	blood diseases	D50-D89	0	0	0	0
5	endocrine/metabol	E00-E90	1	2	0	0
6	mental disorder	F00-F99	1	5	5	2
7	nervous system/eye/ear	G00-G99 & H00-H59 & H60-H95	2	3	3	2
8	circulatory	I00-I99	40	61	79	44
9	respiratory	J00-J99	19	16	15	6
10	digestive	K00-K93	12	18	21	10
11	genito/urinary	N00-N99	0	0	0	0
12	pregnancy	O00-O99	0	0	0	0
13	skin	L00-L99	0	0	1	1
14	musculoskeletal	M00-M99	0	0	0	0
15	congenital	Q00-Q99	0	1	0	0
16	perinatal	P00-P96	0	0	0	0
17	ill-defined	R00-R99	5	3	4	4
18	external/inj/poison	V01-Y98	176	174	202	105

Source: The Centre of Health Economics, 2010; NFP calculations, 2010

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Part D: Standard Tables and Questionnaires

Standard table	Title	Comments/ uploaded in
Standard Table 01	Basic results and methodology of population surveys on drug use	Fonte/ NNDA
Standard Table 02	Methodology and results of school surveys on drug use	Fonte/ NNDA
Standard Table 05	Acute/direct drug related deaths	Fonte
Standard Table 06	Evolution of acute/direct drug related deaths	Fonte
Standard Table 07/08	Problem Drug Use	Fonte
Standard Table 09 (P1;P2;P3;P4)	Prevalence of hepatitis B/C and HIV infection among injecting drug users	Fonte
Standard Table 10	Syringe availability	Fonte
Standard Table 11	Arrests/reports for drug law offences	Fonte
Standard Table 12	Drug use among prisoners	Fonte/ NNDA
Standard Table 13	Number and quantity of seizures of illicit drugs	Fonte
Standard Table 14	Purity at street level of illicit drugs	Fonte
Standard Table 15	Composition of tablets sold as illicit drugs	Fonte
Standard Table 16	Price in Euros at street level of illicit drugs	Fonte
Standard Table 18	Overall mortality and causes of deaths among drug users	Fonte
Standard Table 24	Access to treatment	Fonte
TDI data (in- and out-patient)		Fonte
Structured Questionnaire 25	Universal Prevention	Fonte
Structured Questionnaire 26	Selective and Indicated Prevention	Fonte
Structured Questionnaire 28	Social Reintegration	Fonte
Structured Questionnaire 31	Treatment as an alternative to imprisonment	Fonte

Table of figures and tables