CZECH REPUBLIC

NATIONAL MONITORING CENTRE FOR DRUGS AND DRUG ADDICTION

Coordination of Drug Policy in the Czech Republic

Coordination – Means for Effective and Comprehensive Action

AUGUST 2004

obsah

1 WHY COORDINATE DRUG POLICY?
2 BASIC STRATEGIES
3 LEVELS OF INTERVENTION
4 COORDINATION OF DRUG POLICY IN THE CZECH REPUBLIC
4/1 Horizontal coordination
4/1/1 Governmental Council for Drug Policy Coordination (GCDPC)
4/1/2 GCDPC's Committees
4/1/3 GCDPC's Working Groups
4/1/4 National Drug Policy Strategy
4/1/5 Annual Report on the Drug Situation
4/2 Vertical Coordination
4/2/1 Drug Policy Coordinators
4/2/2 Drug Commissions
4/2/3 Working Groups
4/2/4 Strategies and Plans
5 NEED FOR CHANGES

Summary

■ Drug policy is a set of diverse measures implemented by the representatives of a range of professions with often disparate interests. Coordination is essential to ensure that all the players involved respect a joint approach.

■ The idea behind the coordination of the drug policy is to initiate and promote widespread cooperation, to optimize the use and outputs of existing resources, and to help form and implement effective measures.

■ The Czech drug policy and the system of its coordination are rated by the competent bodies of the European Union as an example of good practices, but there is still room for improvement.

■ The basic strategy of drug policy, based on recommendations of the UN General Assembly, is to reduce drug supply, reduce drugs demand, and reduce risks related to the use of drugs.

■ There are three levels of drug policy intervention – structural, community, and individual. Behaviour of target groups can be influenced most effectively at community and individual levels. Thus, municipalities need to be motivated to join in actively with the implementation of the drug policy.

■ The Czech drug policy is defined by the National Drug Policy Strategy 2001–2004 and is coordinated at two mutually complementary levels – horizontal and vertical.

■ The main problems of the current drug policy lie in an outdated legislation, a failure to grasp the full extent of the problems connected with the use of all types of mind-altering substances icluding alcohol and tobacco, and politicization of the issue, leading to populist rhetoric and solutions.

1 WHY COORDINATE DRUG POLICY?

The use of psychoactive substances, no matter what the type, is a complex, multilayered phenomenon with a broad range of interlinking potential risks. The World Health Organization's concept of Health for All in the 21st Century (1998) defines drug use as a problem that may endanger public health. The reasons for it are possible adverse social, health, criminal, security, and economic effects related to drug use which can have an adverse impact on the healthy development of individuals and society in the broader social context. In order to prevent or lessen the possible effects of a phenomenon as complex as the use of mind-altering substances may be, a comprehensive set of procedures and measures – a drug policy – needs to be set up and put into practice.

Definition

A drug policy is a comprehensive, coordinated set of preventive, educative, therapeutic, social, control, repressive, and other measures implemented at structural (*macro*), community (*mezzo*) and individual (*micro*) levels (see Section – Levels of Intervention), the ultimate target of which is to reduce drug use and/or the potential risks and damage suffered by individuals and society as a result of drug use. (Radimecký, 2003; Stimson, 2003).

The **complexity** of the drug policy lies not just in the application and interconnection of knowledge and processes from *different scientific disciplines*, but also in the integration of *representatives of different professions* with a *focus on various forms of risky or dependent behaviour*, and in the *geographical area* in which the policy is implemented (Origer, 2004).
The main scientific disciplines in this sphere are medical care (physical and mental), psychology, sociology, education, epidemiology, criminology, economics, and ethics. The principal professions involved in the policy are healthcare personnel, social workers, teachers, civil servants, police officers, customs officers, judges, and prison officers. Drug policies concentrate on various forms of risk or dependent behaviour, including the use of illegal and legal drugs, prescription drugs, volatile substances, and non-substance dependent behaviour (such as gambling). The measures are implemented, ideally in line with the needs of a given area, on a local, regional, interregional, national, or international level.
It is quite clear, then, that the disparate, often contradictory, measures of drug policy (e.g. punishment versus treatment) in relation to the different forms of risky behaviour need to be *harmonized* in areas of varying size. We must *strive to achieve optimal cooperation* among the representatives of different professional groups which, entirely naturally, have different priorities, preferred procedures, and their own interests to defend. In this respect, harmonization and optimal cooperation are two key concepts defining **coordination** (Slovník cizích slov, 1996). In literature, it is difficult to find a uniform definition of a concept as widely bandied about as 'drug policy coordination', and that is presumably one of reasons why the coordination systems and mechanisms applied in the individual Member States of the European Union are so disparate. These differences are very likely also determined to some extent by differences in the historical, cultural, social, and economic context, in which the drug policies and the systems used for their coordination emerged in different countries. In EU Member States, there is at least agreement that 'Coordination is a difficult concept to define, but its absence can be felt' (EMCDDA, 2002).
Various institutions, at different levels, are responsible for the implementation of measures under the national drug policy. In the Czech Republic, the central level is occupied by the ministers of the competent departments, who are responsible for subsections of the drug policy (NSPP, 2000). However, the individual ministries have disparate interests and priorities as regards the implementation of the drug policy, a factor which understandably stems from their chief areas of responsibility and competence. This is a source of potential conflicts (Radimecký, 2003), as supported by the conclusions of a unique American study which assessed the significance of coordinating the drug policy (Murphy, 1997). The author of the study argues that the distribution of responsibilities – as in the Czech Republic – forms the basis for uncoordinated activities and therefore means there is the potential for duplicity or lost opportunities when drawing on activities of other entities. Based on a comparative study of five US states, Murphy concludes that the existence and activities of an interdepartmental body for drug policy coordination at national level contributes to more cohesive integration of individual processes than if there were no coordination. We can assume that the same conclusions would be reached if several parties at regional or local levels failed to coordinate their activities. In this respect, in their key **documents on drug policy (European Commission, 2000; NSPP, 2000) both the EU authorities and the Czech government have stressed the** need to coordinate activities at all international, central, and local levels. The competent EU institutions requested from all

Definition

The idea behind the coordination of the drug policy is to initiate and promote widespread cooperation, to optimize the use and outputs of existing resources (information, financial, institutional, and human), and to help form and implement effective measures.

accession countries to adopt the EU best practice in the field of drug use and the need to improve their drug policy coordination (Reimen, 2003). Current assessments indicate that the Czech Republic's drug policy and system of its coordination meet EU requirements (Ballota, 2004). That is not to say there is nothing to improve. In this respect, as discussed below, it is necessary to concentrate efforts on making the whole system of coordination stronger and improving its quality, with a special emphasis on the local level.

2 BASIC STRATEGIES

A comprehensive, multi-disciplinary, and balanced approach was recommended by the Special Session of the UN General Assembly in its Political Declaration on the Guiding Principles of Drug Demand Reduction (1998) as an effective way to tackle problems connected with the use of mind-altering substances. This approach should draw on broad social, interdepartmental, interdisciplinary and intersectoral cooperation at all levels, and should be based on the comprehensive, balanced application of three basic strategies of modern drug policy, underscored by research. These strategies are:

- a reduction in the supply of drugs,
- a reduction in the demand for drugs, and
- a reduction in the risks potentially related with the drug use (so-called harm reduction).

These strategies are not intended to be interchangeable; instead, they complement each other. A comprehensive drug policy made up of all three strategies, according to the UN General Assembly, will make it possible to influence the problem of substance use, starting by deterring people from experimenting with drugs and ending with limitations in the potential adverse health, social, economic, and safety consequences of drug use. In practice, however, this often leads to conflicts of opinion among the supporters of the individual strategies of the drug policy, depending on where they are coming from, what their primary goals are, and what differing standard procedures and activities they apply. These disputes are counter-productive, and probably stem from misunderstandings based on the highly specialized focus that the advocates of prohibition, reduction in supply and use, and reduction in risks channel into their particular area of expertise (Caulkins & Reuter, 1997).

Despite the differences in the way the problem of substance use is viewed (e.g. crime, sickness, risky behaviour), the **representatives of the individual strategies do share a common ultimate goal. This goal is to prevent and/or to reduce the potential adverse consequences of substance use for individuals and society** (Stimson, 2003).

3 LEVELS OF INTERVENTION

Drug policies and their individual forms of intervention, i.e. action taken to reduce the potential adverse consequences of drug use, are usually implemented at three levels (adapted from Stimson, 2003):

- **structural** (macro) – focuses on the macro level, i.e. the structural context of a certain phenomenon. The purpose is to influence and control behaviour of the population by means of a broader 'policy', e.g. by passing laws and regulations. Intervention is designed to affect the conduct of the whole population or part of it (target groups). The parties typically implementing this intervention are international institutions, governments, parliaments, and regions.
- **community** (mezzo) – conduct at the mezzo level is influenced by opinions and behaviour of the social group to which the individual belongs and by the social context in which the target groups live and use drugs. Therefore intervention focuses on the social context in which the mind-altering substances are used, i.e. on the social norms of certain groups influencing the behaviour. The parties typically implementing activities at this level are municipalities and preventive and treatment service bodies.
- **individual** (micro) – at this level, conduct is influenced by the awareness and opinions of individuals regarding health risks, by their plans, their motivation, and their abilities in relation to a certain form of behaviour. Therefore intervention focuses on individual drug users or on potential drug users with the aim of changing their behaviour. The parties typically implementing this type of intervention are the employees of service providers.

TABLE 1: Main strategies of the drug policy and their goals (adapted from Caulkins & Reuter, 1995)

Strategy	Reduced supply	Reduced demand	Reduced risk
Main characteristic	combating the illegal distribution of drugs	prevention, treatment, and rehabilitation	exchange programmes and substitution treatment
Primary goal	restricting the use of drugs by limiting supply	restricting the use of drugs by reducing demand	restricting the consequences of drug abuse by reducing the risks
Ultimate target	preventing and/or reducing the potential adverse consequences of licit and illicit drug use for individuals and society		

Ideally, intervention takes place at two or more levels, and the forms of intervention complement each other rather than compete with each other. However, on a relatively frequent basis the drug policy defined at the structural level is implemented rather differently at community and individual levels due to local specifics and circumstances to which these levels respond more flexibly (Hartnoll, 2000; Dorn 1998). **This illustrates the fundamental significance of the *community level* in implementation of drug policy measures and in influencing behaviour of various social groups.**
In order to ensure a joint, mutually complementary approach by different entities involved in the drug policy implementation at one or more levels, the coordination of intervention plays a crucial role.

- ensure that drug policy intervention at central, regional, and local levels is implemented by means of quality services (with certification of professional eligibility in accordance with quality standards).

4/1 Horizontal Coordination

Horizontal coordination strives to harmonize the procedures of individual departments and to initiate and support their optimal cooperation in the fulfilment of tasks defined by the National Drug Policy Strategy at central level.

TABLE 2: Examples of different types of intervention at the individual levels of the drug policy

Level/strategy	Reduction of risk of alcohol use	Reduction of risk of drug use
Structural (macro)	– inspections of the quality of products – a law banning driving under the influence of alcohol – laws regulating conditions for the places where alcohol is sold	– a law permitting the legal distribution and exchange of injection materials – funding for risk minimization programmes – minimum standards of professional services
Community (mezzo)	– training of the personnel at clubs and bars – improvements in the environment – design clubs and bars – focus on specific target groups (e.g. pregnant women)	– enlightenment and education for the group of drug users in contact with low-threshold services on the prevention of HIV and hepatitis – enlightenment regarding (and exchange of) injection materials in flats via drug users
Individual (micro)	– consulting on 'controlled' drinking (limit the amount of alcohol consumed)	– individual consulting, e.g. motivation to administer drugs other than by injection

4 COORDINATION OF DRUG POLICY IN THE CZECH REPUBLIC

The implementation of the Czech drug policy, as defined in the National Drug Policy Strategy (NSPP) 2001–2004 approved by Government Resolution No 1045/2000 and the coordination of the policy take place at two levels which are not interchangeable, but complementary each other – *horizontal* and *vertical*.

Main goals – what coordination is trying to achieve

- harmonize approaches, measures, and processes used to tackle potential problems related with drug use at national, regional, and local levels (strategy/action plans),
- ensure that drug policy is balanced and pragmatic (i.e. based on scientifically proven data) at central, regional, and local levels,
- ensure that drug policy is based on an analysis of situation (i.e. based on a knowledge of needs and resources) at central, regional, and local levels,

4/1/1 Governmental Council for Drug Policy Coordination

Responsibility for the creation and application of the national drug policy lies with the Czech government. Its main advisory and coordination body is the **Governmental Council for Drug Policy Coordination** (hereinafter GCDPC or Council), the members of which are ministers from the competent departments. The GCDPC meets approximately four times a year. It was set up on 18 August 1993 by Government Resolution No 446/1993 originally as the National Drug Commission[1]. The composition, competence, committees and working groups set up by the Council, and tasks of its secretariat, are defined by the Statutes and Rules of Procedure, last updated on 16 March 2003 under Government Resolution No 296/2003 (**www.vlada.cz**).

[1] In order to avoid any confusion this term is still used in international cooperation.

The activities of the Council (including activities of its committees and working groups) are organized by the GCDPC **Secretariat**, which is an organizational component of the Office of the Government of the Czech Republic. In order to ensure the fulfilment of tasks to collect, analyse and disseminate internationally comparable data on drug situation the **National Monitoring Centre for Drugs and Drug Addiction** (NMC) was established within the GCDPC Secretariat by Government Resolution No 643/2002 in June 2002. Therefore the Office of the Government has reorganized the GCDPC secretariat, splitting it into two units – the **NMC** and an **administrative unit**, with a total of 15 employees.

Instruments of horizontal coordination

- Governmental Council for Drug Policy Coordination (GCDPC)
- GCDPC Secretariat – administrative unit and National Monitoring Centre for Drugs and Drug Addiction
- GCDPC's committees
- GCDPC's Working groups
- National Drug Policy Strategy
- Annual Report on the Drug Situation

4/1/2 GCDPC's Committees

In order to ensure that its key activities are duly carried out, the GCDPC has set up three permanent interdepartmental, interdisciplinary, and intersectoral working committees:

- **Committee of Department Representatives** – a committee where the members of staff responsible within their ministries for the implementation of measures and activities related to drug policy meet on a regular basis to discuss issues concerning procedure and cooperation in public administration, especially at central level.
- **Funding Committee** for the Provision of Special-Purpose Subsidies from the National Budget – discusses applications for the provision of financial subsidiaries for programmes within the drug policy and submits its proposals to the GCDPC for approval.
- **Advisory Committee for Data Collection on Drug Situation** – oversees the activities of NMC related to the monitoring of the situation in the field of drug use and its consequences, and supervises the use of scientifically validated standard processes.

In the phase of preparation there is a so-called **Certification Committee** for granting of certificates of professional eligibility for services provided to drug users and funded from the state budget. This Committee was supposed to be set up by a decision of the GCDPC from January 2004. Based on a political agreement of heads of governmental parties in March 2004 – it has not yet been established and the launch of service certification has also been suspended.

4/1/3 Working Groups

In order to fulfil the tasks required under the National Drug Policy Strategy 2001–2004, the GCDPC sets up permanent or ad hoc working groups in accordance with its Statutes, in particular

4/1/3/1 Permanent Working Groups

- **Vertical Coordination** – working group members are the regional drug policy coordinators (see 4/2 – Vertical Coordination).
- **Population and School Surveys on Attitudes towards Drug Use** – this group specializes in the methodological aspects of preparing and running surveys on drug use among the population. In 2003, it monitored the implementation of the international school survey ESPAD 2003.
- **Evaluation and Quality of Drug Services** – the main goal of this group was to create uniform, interdisciplinary service standards and a process for the certification of professional eligibility to guarantee the quality of these services. The group's proposals were approved by the GCDPC in October 2003.
- **Crime Statistics** – this group specializes in issues aimed at unifying the collection, analysis, and distribution of data from drug supply area, and ensuring their quality and comparability at national and international levels.

4/1/3/2 Ad Hoc Working Groups

- **EWS – Early Warning System** – this group prepared a proposal for the creation of a system for the rapid exchange of information on the emergence of new synthetic drugs with the aim of reducing potential adverse effects of their use in the Czech Republic and the EU. The proposal will be presented to the GCDPC for discussion.
- **Prevention of Synthetic Drug Use** – this group has been set the task of analysing the situation regarding the use of new synthetic drugs and of evaluating the existing preventive field activities (without analysing pill content). In May 2003, the group presented the GCDPC with its proposals and recommendations, on the basis of which the NMC was tasked with organizing the processing of a research project to assess the efficiency of these activities. The project has not yet been launched due some doubts about a meaning of programmes aimed at prevention of synthetic drugs use expressed by heads of governmental coalition parties in March 2004.

■ **Working Groups for the Preparation of the National Drug Policy Strategy 2005–2009** – GCDPC has set up nine working groups (primary prevention, treatment and rehabilitation, risk reduction, alcohol and tobacco us, crime, coordination, funding, public relations, international cooperation). These groups are responsible for preparing the strategy which will be presented to the Czech government for discussion, with contributions from more than 70 representatives of key public administration institutions at all levels whose activities cover drug use, and representatives of the professional public (from both governmental as well as nongovernmental organizations).

4/1/4 National Drug Policy Strategy

This is a key political document approved by the Czech government which defines the basic form of the national drug policy. It appoints the main basis, priorities, goals, principles, areas, and strategies, as well as responsibilities of the individual entities involved in the creation and implementation of the drug policy at all levels of public administration. In addition, recent National Drug Policy Strategy 2001–2004 set 84 specific tasks and a schedule for their implementation.
The National Drug Policy Strategy 2005–2009 will be a concise document containing priorities, main goals, principles, and strategies applied in the implementation of drug policy. It will be accompanied by a detailed Action Plan, which will draw up the main goals and interventions into a specific form of interlinked, chronological tasks which will be required to achieve the defined goals, including the bodies responsible for implementation of intervention. The strategy and the Action Plan are scheduled to be discussed by the government in August 2004.

4/1/5 Annual Report on the Drug Situation

This report is produced every year and presented to the government for its information by the National Monitoring Centre for Drugs and Drug Addiction. The report is structured in accordance with the binding structure and standards of the EU's specialist agency for drug issues – the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The annual report enables the Czech government to monitor trends in drug use and drug trafficking, and enables the EMCDDA to prepare documents for national bodies and EU bodies based on comparative analysis of the situation in EU Member States and Norway (i.e. countries in the REITOX network).

FIGURE 1: System of drug policy coordination in the Czech Republic

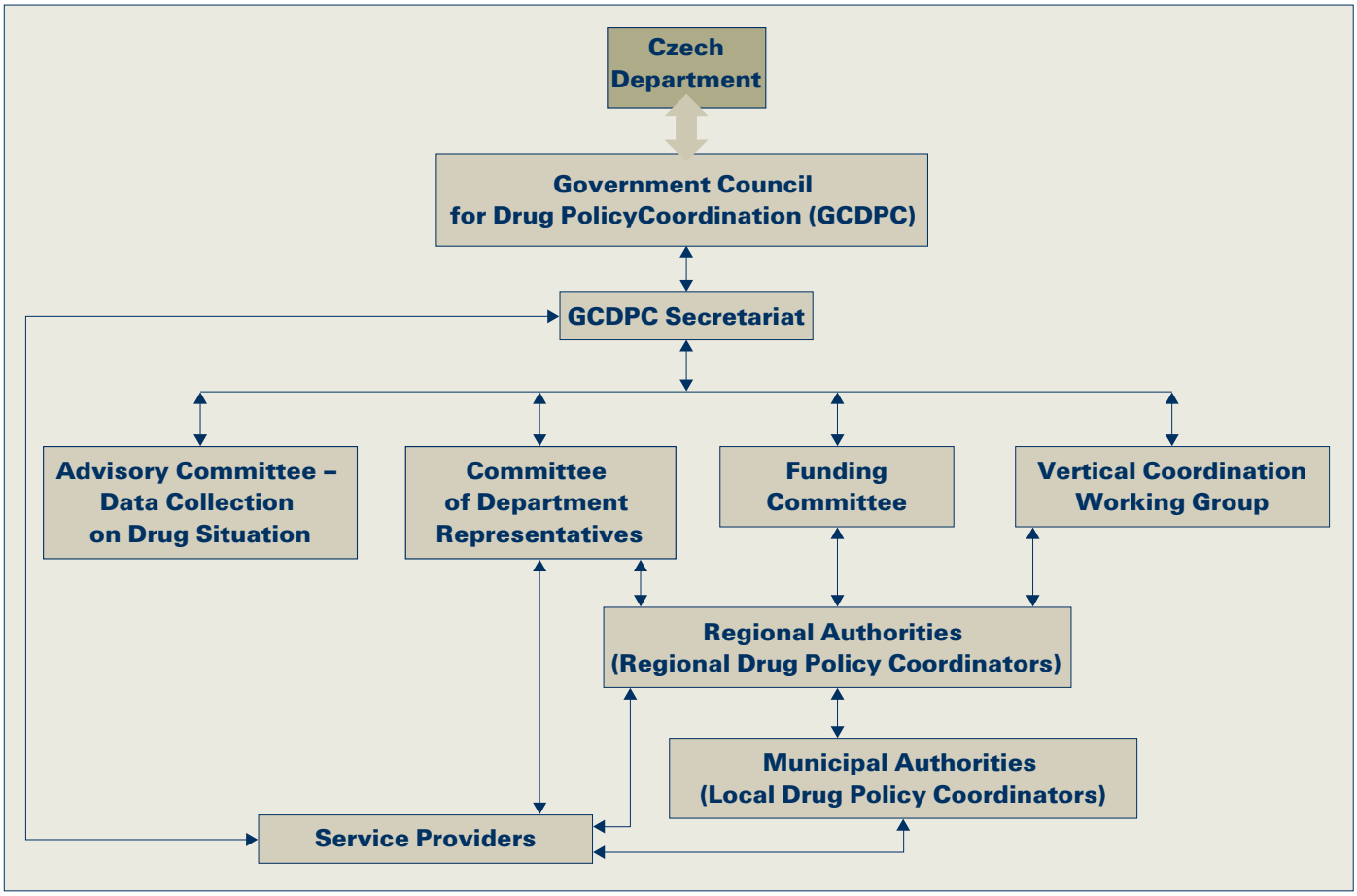


TABLE 3: Responsibilities of the Czech departments in particular areas of drug policy as defined in key governmental documents[1]

Department/Period		1993–1996 (1997)	1998–2000i	2001–2004
Current members of the National Drug Commission	Education	- prevention of drug use in schools and school facilities - methodological activities in primary prevention for schools & school facilities - specific educational facilities for drug users	- prevention of drug use in schools and school facilities - support & development of leisure time activities - educational-health care in special facilities & prevention of socio-pathological phenomena	- primary prevention of drug use - quality guarantee of primary prevention programmes - training of pedagogues in prevention of use methods - early & crisis interventions, health-educational care
	Health	- prevention of drug use (health promotion & education) - treatment of drug users (secondary & tertiary prevention) - collection of epidemiological data on drugs - education of health workers in drug issues	- prevention of drug use (health promotion & education) - health care & early intervention for drug users - minimisation of health risks at drug users - drug information system & drug epidemiology	- health awareness & health education - treatment of drug users (secondary & tertiary prevent.) - training of professionals - health staff
	Health - IOPL[2]	- control of production & legal handling with drugs & precursors	- control of & legal handling with drugs & precursors, certification of import & export	- legislation on NPS, precursors & other substances - control of production & legal handling with drugs, precursors & other substances
	Labour and Social Affairs	- social & outreach workers activities - rehabilitation of drug users after treatment - other social services for drug users	- rehabilitation & after-care for drug users - outreach & social services with group at risks, early intervention & prevent. of socio-pathological phenomena - programmes of minimisation of drug use related risks	- solution of social problems in relation to drug use - social services for drug users, addicts and their families
	Home Office	- crime prevention - detection & prosecution of illegal production, possession & trade - detection & confiscation of means from illegal drugs trade - combating related drug crime	- community safety & crime prevention - supply reduction (petty crime, local distribution, organised crime related to drugs) - safety in traffic & decrease of drug use among drivers	- support of local crime prevention programmes - drug supply reduction - combating crime related to drug user - drug use detection among drivers
	Justice	- re-codification of penal codex - differentiated treatment programmes for drug users in prisons - avoid penetration of drugs into prisons	- drugs legislation - criminal & justice system activities incl. probation & alternative fines for drug users	- legislative proposals development - criminal & justice system including probation, alternative fines for drug users - prevention & help to drug users in prisons - education of professionals in CJS[3]
	Defence	- prevention of drug use in the army	- prevention of drug use in the army - avoid penetration of drugs into departmental field of activity	- prevention of drug use in the army - early identification of problems in relation to drug use - training of professionals soldiers in drug use issues
Finance		- legal conditions for drug policy funding (non-statutory organisations, multi-source funding, budgets)	–	- rules for funding of non-statutory sector - provision of funds from the state budget (for the NDC)
Finance - GDoC[4]		- detection of drug smuggling - control of production & legal handling with drugs, precursors & other substances	- fight against drug smuggling	- cooperation in detection of illegal trade with NPS
Industry & Trade		- control of production & legal handling with drugs, precursors & other substances	- prevention of drug use in departmental high schools	–
Agriculture		- control of drug plants cultivation - prevention of drug use in departmental high schools	- control of legal production of plants with NPS[5] and export - prevention of drug use in departmental high schools	- evidence of legal production of plants with NPS - prevention of use and training of teachers in prevention

[1] Conception and programme of the governmental drug policy 1993-1996; Conception and programme of the governmental drug policy 1998-2000; National Drug Policy Strategy 2001–2004.

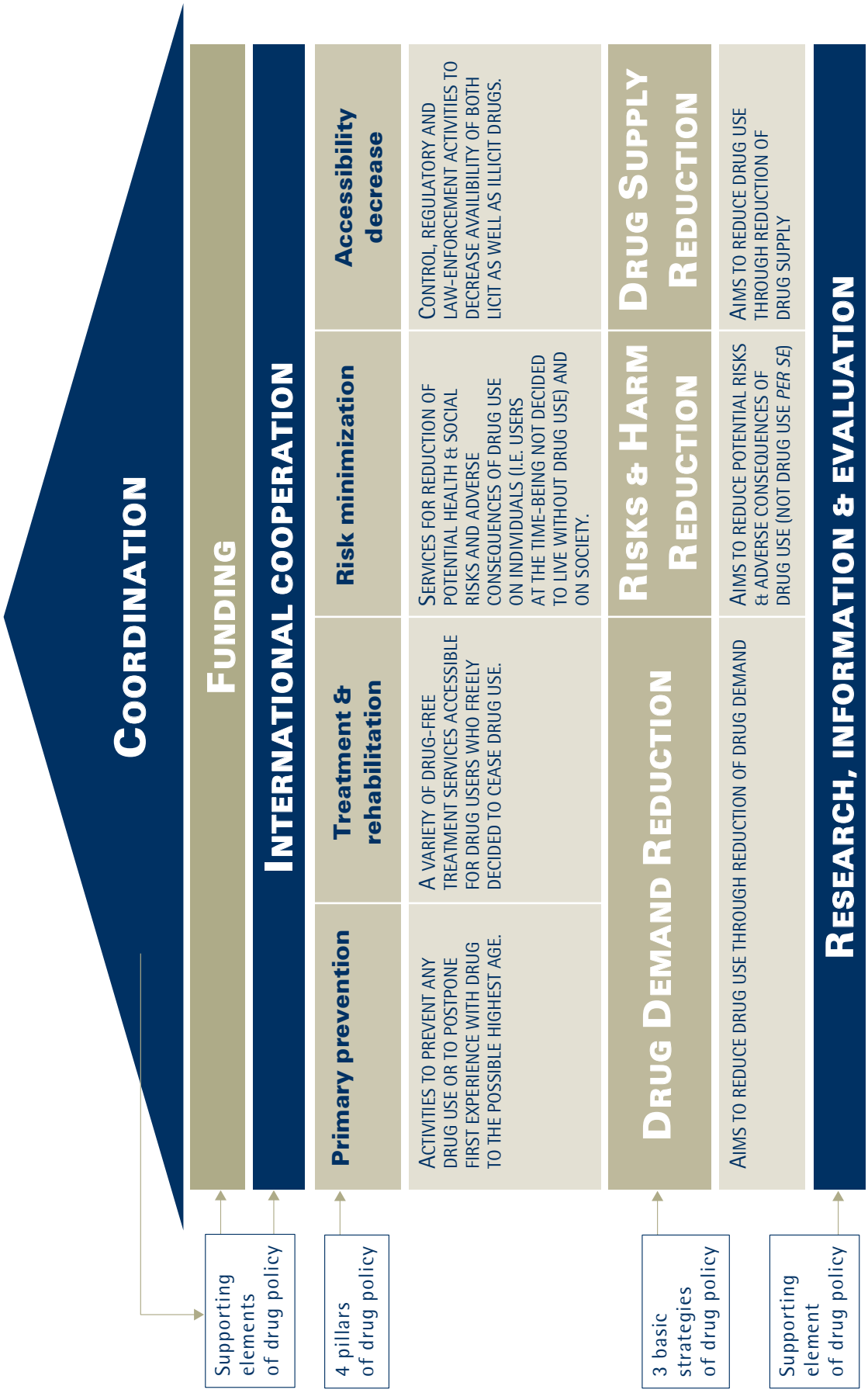
[2] IOPL – Inspectorate for narcotic and psychotropic substances of the Department of Health.

[3] CJS – Criminal and justice system.

[4] GDoC - General Directorate of Customs.

[5] NPS - narcotic and psychotropic substances.

FIGURE 2: Complex model of drug policy



4/2 Vertical Coordination

The purpose of vertical coordination is a permanent effort to harmonize individual activities of the drug policy at local level (i.e. at regional and municipal levels) so that local conditions and requirements are incorporated, and at the same time so that intervention and measures are carried out within a framework of the national strategy.
Regions also develop their own drug strategies and plans, and, to varying degrees, are active in their 'own' drug policy. The diversity of their approaches is reflected in a number of sub-aspects, but there are increasing signs of harmonization in their policies as they adopt proven practices and experience from other regions.

Changes in the structure of public administration have influenced the drug policy. Prior to public administration reform in 2001, the implementation of tasks in the scope of the national drug policy strategy at local level was based on the coordination of activities of networks of 73 district drug policy coordinators. This was a fairly flexible system based on the principle of the subordination of central and local state administration authorities. The network of district coordinators and district drug commission played a key role in the system at local level. Their main benefits lay in their integral (interdisciplinary and interdepartmental) approach to the issue, in the implementation of drug policy measures at local level in accordance with local requirements, in their following-up of the recommendations of central authorities and of individual workers in the field, in the regular communication between the entities involved at local level, in the creation and updating of a database of institutions and activities, in the collection of information from the field, in the possibilities and capacity to respond to the current situation, in the acquisition of further experts for cooperation, and in the provision of information to the public.
The dissolution of 73 district authorities as local bodies of state administration led to the disappearance of the network of district drug policy coordinators; in the wake of the emergence of the 14 administrative regions and the establishment of 205 'municipalities with extended competence', this system of coordination fell apart. Regional coordination was switched from the districts (district authorities) to the administrative regions (regional self-governmental authorities), and the number of drug policy coordinators was thus reduced to 14. As a result of the unfavourable effects of public administration reform, the system of vertical coordination of the Czech Republic's drug policy had to be redefined and restructured in an environment where an outdated law defines competences and responsibilities of particular entities involved in drug policy-making at all levels of the public administration.

Instruments of vertical coordination

- Drug Policy Coordinators
- Drug Commissions
- Working groups
- Strategies and plans
- Local certification and assurance of services quality of services (not established yet – see 4/1/2)

4/2/1 Drug Policy Coordinators

4/2/1/1 Regional Drug Policy Coordinator

The regional drug policy coordinator is a key element in the transmission of activities within a framework of the national drug strategy and of information to regional and local levels and vice versa. The position of coordinator has been set up in all fourteen regions, but their status in the organizational structure of the self-governmental regions, the accumulation of their functions, and the administrative apparatus at their disposal differ from region to region. Their workload is often rated at more than 1.0 (based on the number of municipalities with extended competence in the region, on the volume of specialist and conceptual work, administrative work affected, for example, by the number of prevention and treatment facilities in the region and the evaluation of their applications for subsidies) and this is a risk as regards the quality of their work and their motivation to stay in the position. As Miovský et al. (2003) states, the problem of alcohol and tobacco use, which should be an integral part of the drug policy, involves such a large number of other activities that the absolute minimum number of positions required to ensure the coordination of activities at regional level is three workers. However, in some regions the positions of regional drug coordinators are accumulated into the work of fewer persons.

4/2/1/2 Local Drug Policy Coordinator

Local drug policy coordinators are mainly appointed in Class-3 municipalities, however not in all of them. Potential risks related to drug use can have a direct impact on individuals, i.e. drug users and their families. In the case of risks connected with the spread of infectious diseases (especially Hepatitis A, B, C), crime, or an impairment of the feeling of security among the public, drug use can also affect the quality of life in **local communities**. At the same time, preventive and therapeutic measures and intervention to minimize risks, focusing on individuals and specific target groups of the population, are most effective at local level. Therefore, municipalities with extended competence need to be more involved into the coordinated system of drug policy, and measures need to be

taken which correspond to the local situation and identified requirements. In this respect, local drug policy coordinators can make a contribution as they are well informed about drugs scene and activities of the drug policy in the administrative circuit of municipalities. As already mentioned legislative requirement for local authorities' drug policy-making is rather poor due to a law agreed in 1989, this is at the time of communist regime when the situation in drug use and system of public administration differed significantly. So, cooperation between regional and local authorities and policy coordinators is impeded by the fact that so far the powers of the regions and of municipalities with extended competence have not yet been clarified. At the moment, cooperation is based primarily on whether or not municipalities are interested in tackling this problem, i.e. cooperation depends on informal relations with the regional drug policy coordinator and other specialists. However, it has been proven that the role of municipalities is of key significance in implementing effective measures under the drug policy.

Basic 'kit' of coordinators at all levels

■ They have complex information on:
the situation in their region (data)
problems and requirements (analysis)
problem-solving partners (institutional map)
■ They know:
what needs to be done and how (professional knowledge)
which of the partners to contact (decision-making ability)
where to find the necessary resources (financial and human)
■ They have the skills:
to design conceptual solutions (design work)
to negotiate and communicate (harmonization)
to offer mutually beneficial cooperation (motivation)

This basic coordinator's 'kit' reveals that very high demands are placed on drug policy coordinators, with an emphasis on professional and managerial skills which, in practice, do not correspond to their pay grade or to the amount of power they wield.

4/2/2 Drug Commissions

Regional drug commissions are an important instrument in implementing the drug policy in the regions. For coordinators, the commission is primarily a helpmate and a means of carrying out more demanding tasks requiring the consensus of several parties or institutions whose interested might be disparate in the sub-aspects of the drug policy. The commission contributes to situation analysis, to the creation of new proposals for partial or conceptual changes, to the identification of weaknesses in the system of the drug policy, and to the interconnection of key players involved in reducing drug supply and demand in the region. The commission is usually made up of public administration experts and the presence of representatives of service providers and, if at all possible, the political clubs in the region is also expedient.
Drug Commissions are set up at a **local level** but mostly in bigger towns with significant problems related to drug use.

4/2/3 Working Groups

As part of the institutionalization of cooperation between the GCDPC and the regions, the **'Vertical Coordination of Drug Policy' Working Group** was set up in May 2003. The members of the working group are regional drug policy coordinators and the member of staff from the GCDPC Secretariat responsible for vertical coordination. The purpose of the group is to produce opinions and recommendations for the GCDPC concerning the drug policy in relation to the regions, to contribute to the preparation of the national strategy, to harmonize the coordination practices in the individual regions in accordance with the strategy, and to harmonize processes for the data collection. The group meets regularly with the Committee of Department Representatives (at least twice a year), which offers room to exchange experience and harmonize the procedures of the central institutions of state administration and the regions in drug policy field.
Working groups in regions make contributions aimed at resolving the current and specific problems of regions at an expert level. They are created according to various keys, most often based on the pillars of the drug policy (primary prevention, risk minimization, treatment and rehabilitation, supply reduction). Members of these working groups should include the most significant service providers willing to make their knowledge and skills available and to make an active contribution to problem-solving within the region or town. The groups should be a platform for regular or ad hoc meetings of regional drug policy coordinators and experts in the field, providing a deeper insight into the given issue.

4/2/4 Strategies and Plans

Strategies and plans drawn up at regional level are not only an instrument for the coordination of the drug policy, but also a valuable source of information for the national level of the drug policy. Similar instruments at local level can be used for the local implementation of the drug policy and for the creation of regional strategies and plans.

4/2/4/1 Regional Drug Strategy

The creation of regional drug strategies is not a uniform process in all the regions. When forming these strategies, the regions tend to draw on the national drug policy strategy, modified to take into account regional and local features and requirements. In most cases, regional drug strategies follow much the same structure as the national strategy, and cover the same period.

4/2/4/2 Regional Prevention and Treatment Plan

The regional prevention and treatment plan is one of the means used to plan and implement activities, and to secure the institutional and financial requirements of these operations, in a region in a given year. It describes the situation regarding drug use, the prevention and treatment of users in the region, sums up specific epidemiological data, and offers an overview of current and planned activities in the region, including financing. From the aspect of the GCDPC, it plays the role of a regional annual report on the drug situation, and is an important yardstick in the assessment of applications for subsidies. Regional plans can also be used as a point of reference when assessing the regional drug policy (in relation to the surrounding area and in relation to the central institutions of state administration). These plans are produced by the regional drug policy coordinators in cooperation with other key players involved in the drug policy-making in the region.

5 NEED FOR CHANGES

SWOT analyses conducted by working groups within the preparation of the National Strategy for the 2005–2009 period reveal that the strengths of the current drug policy include the coordination system and its instruments at both the vertical and horizontal levels. The current network of regional drug coordinators is important in ensuring vertical coordination as it allows for mutual cooperation and for the transmission of information between the regions and both central institutions and local government authorities. The main challenge and opportunity to increase the efficiency of coordination at local level lies in the completion of a functioning network of regional drug policy coordinators in municipalities with extended competence and greater powers for the people in these positions. The main weakness of the current system is the outdated legislation, not only in the field of vertical coordination, but also with the drug policy in general. Act No 37/1989, on protection against alcoholism and other drugs, has become ineffective in the wake of the social changes after 1989, but is still in force today. This law does not sufficiently specify the obligations and powers of the central institutions of state administration, regions, or municipalities, nor does it define the system of new types of services arising following the regime change, the activities in the delegated and independent competence of the regions and municipalities, or the scope and provision of cooperation among central institutions, regions, and municipalities with extended competence. If the current situation is to change, an updated law needs to be adopted that will supersede the Act on Protection against Alcoholism and Other Drugs, and the Regions Act (Act No 129/2000) needs to be updated.
Awareness of, and interest in, the problems of the drug policy at central, regional, and local level vary considerably among the representatives of ministries and autonomous authorities in the individual regions and municipalities. This disparate approach is reflected, for example, in the allocation of funding for the issue at central, regional, and local levels, or in the assignment of other agendas to competent members of staff at ministries and the regional coordinators in the scope of a single job. A serious threat to the current system used for the implementation and coordination of the drug policy, preventing it from improving at a faster pace, is the politicization of this issue, leading to populist rhetoric and the promotion of short-sighted non-systematic intervention in a system which is otherwise becoming a more stable and better quality instrument.
One of the opportunities where weaknesses can be identified and the needs of the system for the coordination of the drug policy taken into account is the preparation of the national drug policy strategy for the upcoming period (2005–2009), which involves representatives of the ministries, as well as regional drug policy coordinators and service providers. However, to improve the current system of drug policy-making a support from open-minded politicians at all levels is necessary.

Main sources of information

■ Ballota, D. (2004) European Drug Policy – Main Characteristics and comparison, Presentation, Parliamentary Conference 'Is There a Need for Change in the Czech Drug Policy?'. Prague.

■ Caulkins, J.P. and Reuter, P. (1997) Setting goals for drug policy: harm reduction or use reduction? *Addiction* **92**, 1143–1150.

■ Dorn, N. (1998) Editorial: drug policies and the European Union. *Drugs: Education, Prevention and Policy* **5**, 5–13.

■ EMCDDA (2002) Strategies and coordination in the field of drugs in the European Union: A descriptive review. Lisbon.

■ European Commission (2000) EU-Action Plan on Drugs 2000–2004. Press release, Brussels Nr. 9283/00.

■ Hartnoll, R. (2000) International Trends in Drug Policy. In: Coomber, R., (Ed.) *Control of Drugs and Drug Users: Reasons or Reaction?* 2nd edn. pp. 233–252. Netherlands: Harwood Academic Publisher.

■ Group of authors (1996) Slovník cizích slov, Encyklopedický dům, Prague. Miovský, M., Broža, J. a Šťastná, L. (2003) Analýza systému koordinace a řízení krajské protidrogové politiky, pp. 15, 21, Liberec.

■ Murphy, P. (1997) In: RAND Drug Policy Research Centre, Coordinating Drug Policy at the State and Federal Levels, Research Brief, Santa Monica, California.

■ National Drug Policy Strategy 2001-2004 (2000), Office of the Government of the Czech Republic, Prague.

■ Origer, A. (2004) Co-ordination? Presentation, Conference 'EU Strategy on Drugs – The Way Forward', Dublin.

■ Radimecký, J. (2003) Rhetoric versus Practice in the European Union and the Czech Drug Policies, dissertation, London: Imperial College

■ Reimen, M. (2003) In: EU enlargement and drugs – Challenges and perspectives, *Drugs in Focus*, 8. European Monitoring Centre for Drugs and Drug Addiction, Lisbon.

■ Reuter, P. and Caulkins, J.P. (1995) Redefining the Goals of National Drug Policy: Recommendation from a Working Group. *American Journal of Public Health* 85, 1059–1063.

■ Stimson, G.V. (2003) Supply reduction, demand reduction and harm reduction - an introduction and review of concepts. Presentation. Centre for Research on Drugs and Health Behaviour, Imperial College, London.

■ World Health Organization – WHO (1998) Health for All in the 21st Century, www.who.int/en.

■ UN General Assembly (1998) Political Declaration on the Guiding Principles of Drug Demand Reduction and measures to enhance international cooperation to counter the world drug problem, A/RES/53/115.

Information on Web pages

www.vlada.cz (Advisory and Working Bodies/Government Council for the Coordination of the Drug Policy)
www.drogy-info.cz (drug information portal managed by the National Monitoring Centre)
www.emcdda.eu.int (European Monitoring Centre for Drugs and Drug Addiction)
EU Drug Strategy and Action Plan (2000–2004)
http://www.emcdda.eu.int/policy_law/eu/eu_actionplan.shtml

This document was prepared by the staff of the administrative department of the Secretariat of the Governmental Council for Drug Policy Coordination.
Editor: Josef Radimecký, MSc.

Published by the Office of the Government of the Czech Republic
Nábřeží E. Beneše 4, 118 01 Praha 1
Editorship address ■ Vladislavova 4, Praha 1, phone +420 296 153 222
Responsible editor ■ Ing. Eva Škrdlantová
Authors ■ Josef Radimecký, MSc., Bc. Hana Rendlová, Mgr. Vladimír Sklenář

Published on 30. 8. 2004
Not for sale. Distributed by the publisher.