ELEKTRONICKÉ PUBLIKACE

Studentské
a jiné odborné
a vědecké práce

e Nº 03

INTERNATIONAL INSTITUTES
ON THE PREVENTION AND TREATMENT OF
ALCOHOLISM & DRUG DEPENDENCE

Substance Abuse in the Czech Republic

Selected Papers on Alcohol and Drug Abuse

Country Report on Drug Abuse

PRAGUE 1994

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PRINTED: ALFA Varšavská 12, 110 00 PRAHA 2
COVER ILLUSTRATION: Jan Piska (14)

Prague Women's Drinking Before and After the "Velvet Revolution": A Longitudinal Study

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Introduction

The term "velvet revolution" came into use as a designation of the relatively peaceful character of the sociopolitical changes in Czechoslovakia since 17th November 1989. The use of this term should not detract attention from the fact that the most dramatic sociopolitical transformations occurred in the country during the four years after November 1989. In addition, by January 1st 1993 the Czech and Slovak Federal Republic had been (again peacefully) divided into two independent states, the Czech and the Slovak Republics. By the end of 1992, when the data discussed in this paper was collected, the Czech Republic presented a very different picture, in comparison to its state before the "velvet revolution" started, politically, economically, and socially. (The Czechoslovak Communist imposed totalitarian rule over the country during the period of 1948—1989 with a short interruption in 1968). A parliamentary democratic political system has been successfully established in the years after the "velvet revolution"; it should be remembered that Czechoslovakia was a truly democratic country in the period 1918—1938. By the end of 1992 the economical system of the Czech Republic had been mostly changed into a market economy. All civil rights have been re-established. As far as drinking is concerned, all administratively imposed restrictions of the previous Communist government (imitating the Gorbatchov campaign) have been abolished. The picture should be complemented by the information that criminality in the Czech Republic was about three times as high in most Western European countries. This is similar to developments in other former Socialist countries. There is a similarity also in the increases of per capita alcohol consumption. The trends in per capita alcohol consumption in the Czech republic are shown in Fig. 1.

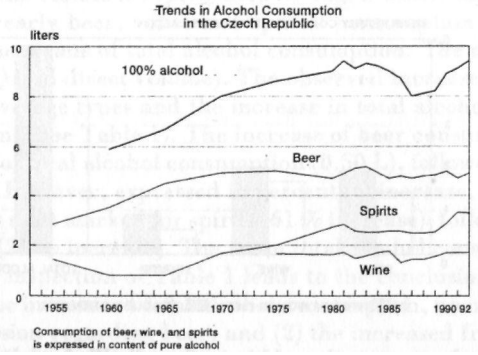

Fig. 1 • Trends in the per capita alcohol consumption in the Czech Republic

This paper is based on an analysis of interview data collected on a probabilistic sample of Prague women in 1987 and on the same sample in 1992. Its purpose is to show how the sociopolitical changes in the Czech Republic and the accompanying increase of per capita alcohol consumption are reflected in women's drinking. The more specific questions the paper deals with are: (1) Did women drink more in 1992 comparatively to 1987 and did women's drinking patterns change? (2) Supposing that Prague women have increased their alcohol consumption and/or have changed their drinking patterns, which explaining factors can be found for these changes in alcohol use, taking the Prague female population as a whole? (3) Which group or individual factors can explain differences in alcohol consumption changes? In other words, who are the women that change their drinking levels and patterns more than the average females?

Method

Subjects

The cohort of 608 Prague women aged 20^19 in 1987 at first interview and 25-54 at second interview in 1992 is based on a probabilistic sample of Prague women of the respective ages constructed in 1987 with the help of the General Population Register. 718 women have been interviewed in 1987 (a 77 % response rate). Of these 608 (85 %) have been reinterviewed in 1992, those who left Prague being excluded by definition.

Data Collection Methods

Face-to-face interviews were conducted in the subjects' homes. The interview schedule included 229 questions related to alcohol use, its context and possible correlates. In addition, the subjects responded to three paper-and-pencil questionnaires, namely (1) the Questionnaire on Attitudes to Drinking by Kubická, (2) the Mood Frequency Questionnaire by Kubíčka and Csémy, and (3) the Female Gender Role Questionnaire by Kubická and Csémy.

Results

Changes in Alcohol Consumption Levels and Patterns 1987-1992

The available data include beverage specific drinking frequencies and beverage specific quantities per occasion (separately for the last year and the last month) and

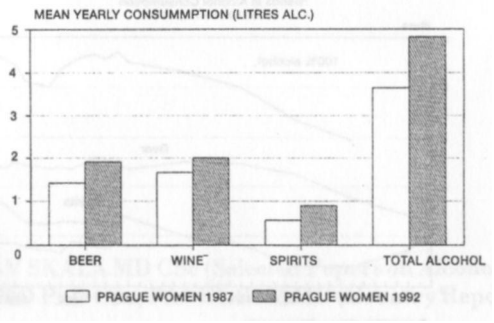

Fig. 2 - Mean yearly consumption of beer, nine, distilled spirits, and total alcohol in the Prague female cohort in 1987 and 1992 (All means expressed in pure alcohol content)

Table 1 - I»87 and I»92 Means and SDs of Drinking Indicators for the Prague Female Cohort

Indicator	1987 Mean	1992 Mena	1987 SD	1992 SD	T	PT	Wilcoxon P
Last year drinking days	119.4	130.6	136.5	144.3	2.07	.038	.046
Average quantity p.o. (ml ale)	30.9	33.0	16.6	18.4	2.66	.008	.011
Last year volume in litres ale.	3.66	4.83	4.54	6.71	5.03	.000	.000
Average daily grams alcohol	7.65	9.79	9.66	13.72	4.22	.000	.003
Last year drin. days - beer	92.7	96.1	135.5	137.7	.71	.477	.410
Last year drin. days - spir.	18.1	24.1	37.6	49.6	3.18	.002	.001
Quantity p.o. beer (ml ale)	14.5	17.4.	15.9	18.7	5.21	.000	.000
Quantity p.o. wine (nil ale)	43.0	42.9	22.7	24.6	0.10	.919	.650
Quantity p.o. spir. (ml air)	34.4	36.5	23.0	24.1	1.42	.158	.078
L.y. volume beer (litres ale)	1.42	1.92	2.98	4.24	3.53	.000	.000
L.y. volume wine (litres ale)	1.66	2.01	2.61	3.99	2.29	.022	.601
L.y. volume spir. (litres ale)	0.56	0.90	1.15	2.41	3.59	.000	.002

answers to beverages specific questions on average daily (weekly, monthly) volumes. From these data several indicators have been constructed. Table 1 summarizes results obtain from the comparison of 1987 and 1992 consumption indicators. The differences between 1987 and 1992 means have been evaluated by the paired T-test as well as by the nonparametric Wilcoxon test.

The main part of the results is represented by Fig. 2 which shows the means (for 1987 and 1992) of yearly beer, wine, and spirits' consumption expressed in pure alcohol, as well as the means of total alcohol consumption. The means are averages of two estimates (F/Q and direct volume). The observed increases in mean consumption of all three beverage types and the increase in total alcohol consumption are statistically significant (See Table 1). The increase of beer consumption contributes most to the increase of total alcohol consumption (0.50 L), followed by wine (0.35 L) and spirits (0.34 L). However, expressed in percentual increase, the increase of the mean consumption is most marked for spirits (61 % increase), followed by beer (35 % increase), and wine (21 % increase). The mean total alcohol consumption increased by 32 %. A detailed inspection of Table 1 leads to the conclusion that two changes contribute most to the increase of total alcohol consumption, namely (1) the increase of quantity per occasion regarding beer, and (2) the increased frequency of spirits' consumption. The pattern of female alcohol consumption changed in the sense that spirits played a larger role in 1992 than in 1987, the percentage of total alcohol

consumption contributed by spirits being 15 % in 1987 and 19 % in 1992. The contribution of wine dropped from 46 % to 42 %, beer contributing a constant 39 %.

In our judgment, our best estimate of each subject's total alcohol consumption is the average of three estimates, reflecting (1) the yearly F/Q questions, (2) beverage specific direct volume estimates, and (3) last month F/Q measures. Expressed as subjects' average daily consumption of grams of pure alcohol, the respective means for 1987 and 1992 are 7.65 and 9.79, the difference being highly significant by both the T-test and the Wilcox on test, as given in Table 1. This indicator will be frequently used in following analyses.

It should also be noted that with one exception, the variance of consumption indicators increased, very markedly for some indicators. (See Table 1). This concerns frequency, quantity p.o. and volume indicators. Fig. 3 representing the distribution of average daily consumption of grams of alcohol is given as an illustration. In the case of this volume indicator, the 1987 and 1992 means are 7.65 and 9.79. The standard deviation increased from 9.66 to 13.71, the variance in 1992 of 188.18 being twice the variance of 93.28 in 1987. If one defines the average daily consumption exceeding 20 grams of alcohol as heavy drinking in women's case, one observes that the percentage of heavy drinkers in the followed-up cohort of Prague women is twice as high in 1992 in comparison to 1987, the respective percentages being 7.2 and 14.0.

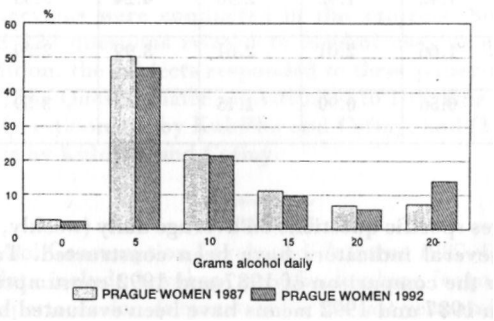

Fig. 3 - Distribution of average daily alcohol consumption in Prague females 1987 and 1992

General Explanatory Factors of Changes in Consumption Levels and Patterns

The followed-up women were five years older in 1992 than in 1987. Can increased age explain increases in consumption? We know from results of meta-analyses of many longitudinal studies by Fillmore, Hartka, Johnstone, Leino, Motoyoshi & Temple (1991) that in general both drinking frequency and especially quantity per occasion tends to decrease in the age groups we are considering. The results of Fillmore et al. (1991) are based on data from many different countries. One can object that growing older may have specific effects on Prague women. However, as no statistically significant linear or nonlinear age effects were found in the consumption indicators, neither in 1987 nor in 1992, this hypothesis is dismissed.

The prices of alcoholic beverages should be considered as a possible factor of increased consumption. The nominal price increase between 1987 and 1992 was lowest for distilled spirits. This might have contributed to the increase of spirits' consumption in our sample of women. (See also Fig. 1.). As however the price of beer more than doubled (whereas the average salary increased less), the increase of beer consumption cannot be explained by the price factor.

A possible explanation of the general consumption increase might also be sought in the changed attitudes of women to drinking. The same paper-and-pencil questionnaire on attitudes to drinking was given to the female cohort in 1987 and 1992. The questionnaire leads to four scores, reflecting the subjects' attitudes to four uses of beverage alcohol, (1) the social use (alcohol as a social lubricant) (2) the alimentary use (beverage alcohol as a complement to meals), (3) the anxiolytic use (alcohol as a supposed anxiolytic substance), and (4) the orgiastic use (alcohol used for intentional intoxication). The comparison of 1987 and 1992 scores shows that whereas the attitudes to the social and alimentary uses of alcohol did not change, the tolerance of drinking to intoxication increased markedly, the respective T-value being 5.18 ($p < .0001$). The tolerance of the anxiolytic use of alcohol also increased but less markedly ($T = 2.21$, $p < .05$). The observed increase of the tolerance of drinking to intoxication fits well with the reported changes in consumption indicators, especially with the increase of quantity per occasion, the increase of spirits' consumption, and especially with the almost 100 % increase of the percentage of heavy drinkers.

Finally, the reported increases in alcohol consumption should be seen in the context of the general social climate of Czech society. People feel free to behave according to their wishes and values no longer being controlled by the totalitarian state. This fits well with the observed increase of tolerance to alcohol intoxication.

The Explanation of Group and Individual Differences in Consumption Changes

Demographic Variables

The observed consumption changes have no statistically significant relation to the demographic variables of age, educational level and marital state. Fig. 4 shows the percentage of heavy drinkers (over 20 grams alcohol daily average) in 1987 and 1992 according to age group. The percentage increase is largest in the youngest age group, but the Age Group by Time interaction is not statistically significant. The increase of the percentage of heavy drinkers among the oldest women (and also the increase of the mean average daily consumption in this age group from 7.3 to 8.5) documents the generality of the trend.

The only demographic variable with significant relations to consumption changes is occupational status. This can be seen in Fig. 5. Four occupational categories are distinguished according to the women's reports of their status in 1992. As to drinking status, the females are divided into four categories: (1) Never heavy drinkers (percentages not shown in Fig. 5), (2) New heavy drinkers: those who were not heavy drinkers in 1987 but are heavy drinkers in 1992, (3) No longer heavy drinkers: women which were heavy drinkers in 1987 but are not heavy drinkers in 1992, and (4) Always heavy drinkers, i.e. those who were heavy drinkers both in 1987 and in 1992. One observes marked differences in the percentage of new heavy drinkers according to occupational category, the percentage being highest among free-lance workers (e.g. artists) and second highest among independent businesswomen (or small underta-

kers). A similar result is obtained if we take the subjects' average daily consumption as a quantitative dependent variable. In the respective analysis, the dependent variable was the standardized residual from a regression analysis, taking the 1987 daily consumption as predictor and the 1992 average daily consumption as dependent variable. The residuals are considered as adequate measures of consumption change, the 1987 consumption being controlled. The means of these standardized residuals for the four occupational classes are as follows: employees 0.02, free-lance workers 0.17, independent businesswomen 0.20, non working women -0.25. The F-value in ANOVA is 2.59 ($p = .052$). (Note: standardized residuals have mean equal to zero and SD equal to unity.)

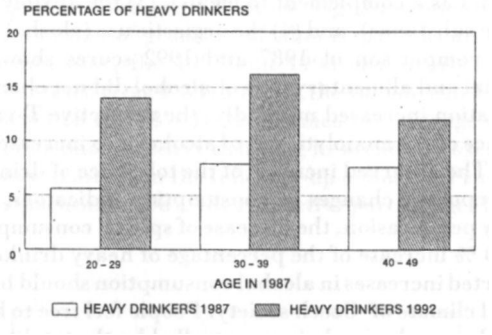

Fig. 4 - Percentages of heavy drinking women (over 20 grains alcohol daily average) in 1987 and 1992 according to age group

Life Style Variables

Of primary interest are possible relations of consumption changes to the individual differences in the impact of sociopolitical changes on the women's lives. The interview included eight questions exploring the subjects' reactions to the social changes of the past four years, quantitative scales being used for the coding of the answers. A principal components analysis of the eight obtained variables resulted in three

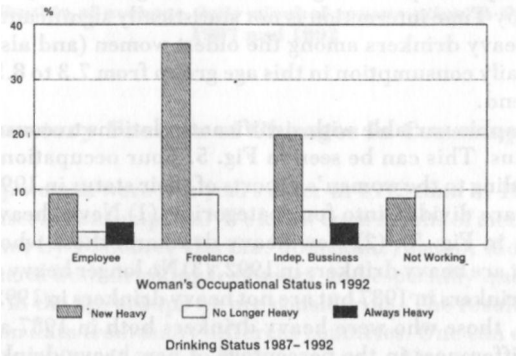

Fig. 5 - Changes in drinking status of Prague women 1987 - 1992 according to 1992 occupational status

orthogonal factors, labeled as (1) pro-reform political attitude, (2) expansion of social contacts (3) positive impact of social changes on personal life. To allow for possible nonlinear relations the individual women's factor scores on the mentioned factors have been transformed into variables having three values, e.g. low, average and highly pro-reform political attitude. The relations of these three "sociopolitical" factors to consumption change indicators are in general rather weak, although some are statistically significant. These relations point to the same general conclusion: women with highly positive pro-reform attitudes, women whose social contacts expanded, and those who experienced a positive influence of social changes on their personal lives — tend to increase their alcohol consumption more than women on the opposite end of the three scales reflecting women's positive reactions to political events. For example, there are 17 % more heavy drinkers among other women. New heavy drinkers are also most frequently found among women whose social contacts expanded during the past four years. And new heavy drinkers are rather rare among women who report a negative impact of the political events on their personal lives (4 % as against 12 % among women with high or average scores of positive impact). Similar results are obtained with the residuals as quantitative consumption change indicators. For example, the mean values of the standardized residuals of daily average consumption are 0.35, —0.04, and—.05 for women with high, average and low scores of social expansion respectively, a statistically highly significant result ($F = 4.72, p = .009$). Women with high, average, and low positive impact of political changes on personal life have mean scores equal to .00, .05, and -.22 ($F = 3.03$, $p = .049$).

The other life-style domain explored in our analyses is the woman's attitude to the female gender role. This attitude has been assessed by a paper-and-pencil questionnaire with 40 Yes/No questions. A general score of traditionalism-non-traditionalism showed no relation to drinking. A factor analysis of 37 items of the questionnaire resulted in five orthogonal factors, designated as (1) acceptance of traditional man dominated family, (2) liberal attitude to sex life, (3) radical feminism (4) occupational equalitarianism, and (5) hedonism. Factor scores on these five factors were computed and used in the analyses as independent variables. Whereas a global score of traditionalism in female gender role conception has no relation to drinking measures, three of the five factor scores are significantly related to drinking and changes in drinking. The strongest relation to drinking has the factor of hedonism representing the attitude that a modern woman should enjoy life in all its aspects as much as possible (none of the items asks about drinking). Women with high scores on the hedonism factor tend to relatively high average daily consumption and also their increases in consumption between 1987 and 1992 are larger. The percentage of new heavy drinkers is 20 % among women with high hedonism scores (one SD or more above the mean of the factor scores) as compared with 8 % among other women. The other gender role factor related to drinking is feminism: women with strong feminist attitudes tend to drink less than other women and they have also increased their alcohol consumption less since the democratic revolution started. We find only 4 % of new heavy drinkers among the toughest feminists, 11 % among women with average attitudes toward feminism, and 16 % new heavy drinkers among the strong opponents of feminism. The attitude to the traditional man-dominated family is related to drinking in such a way that the strong believers in traditional family have the highest percentage of chronic heavy drinkers among them, namely 10 % as compared with 2 % among women with an average attitude to traditional family and 1 % in the group of women rejecting the male dominated traditional family. The percentages of new

heavy drinkers in the three groups are 11 %, 12 %, and 4 %, the last smallest figure concerning the group of opponents of the traditional family. The 1992 heavy drinkers have a Gender Role factor score profile clearly different from the rest of the Prague female cohort as can be seen in Fig. 6. The heavy drinking women's typical attitude to the female role is a strange mixture of traditional values and of a hedonistic rejection of traditional female duties. We have also conducted a logistic regression analysis with the 1992 heavy drinking status as dependent variable. The independent variables included in the regression equation were the 1987 average daily consumption, educational level, and the five gender role factor scores. The 1987 consumption measure is, of course, the best predictor of the dependent variable: its inclusion in the equation should guarantee that the other independent variables can be regarded as correlates (predictors?) of change in the drinking status. The addition of the five gender role variables improves the model with high statistical significance ($p < .001$), the factors of hedonism, feminism, and traditional family having statistically significant partial regression coefficients (with a negative sign in the case of feminism).

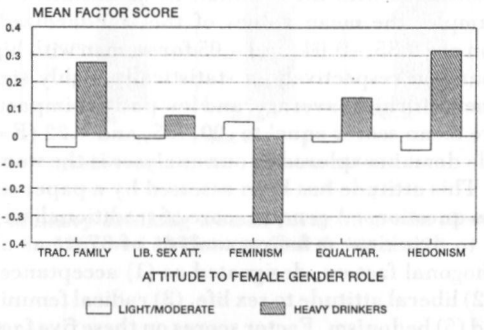

Fig. 6 - Attitudes to female gender role in heavy drinking women and in female light/moderate drinkers

Psychological Distress

The role of psychological distress (anxiety, tension, depression, negative life events) as a factor contributing to alcohol consumption is a frequent theme in the literature. We have included several indicators of psychological distress in our interview (related to occupation, family life, and life events) plus a pencil-and-paper questionnaire giving highly reliable and supposedly valid scores of anxiety and depression. Most of these distress indicators are without any relation to drinking or to drinking status changes. One of the two distress measures with statistically significant relations is the degree of perceived incompatibility between duties towards own family and job related duties. This distress measure's Pearson correlation with 1992 daily consumption is equal to .16 ($p < .001$) and its correlation with the standardized daily consumption residual is .15 ($p < .001$). There are 23 % new heavy drinkers among women reporting high role conflict, 11 % among those with a mild role conflict and 8 % in the group with no perceived conflict. (Only economically active women are considered.) The 23 stressful life events were divided into "fatal" and "non-fatal" (potentially self-inflicted) events and for each category the score was the sum of

negative impact ratings related to reported events. The reason for this categorization of stressful events was the consideration that some events (the "non-fatal" events) might be consequences of drinking rather than its causes whereas "fatal" events (e.g. deaths of close persons) can hardly be regarded as consequences of drinking. The results show that non-fatal events are related to drinking and its change (r = .17 with the standard daily consumption residual) whereas the fatal events have no relation to consumption change (r = .05), nor to 1992 consumption as such. This result indicates that psychological distress may be a consequence rather than a cause of increased consumption or that the direction of influence is both ways.

Discussion

Although the reported increase of alcohol consumption in Prague females between 1987 and 1992 cannot be regarded as a dramatic one, its existence is supported firmly by the data. Whereas decreasing consumption would be expected with growing age (Fillmore et al, 1991) we find the opposite. Several explanations of this "unnatural" consumption increase have been considered on age. One additional explanation could be found in the frequently mentioned convergence hypothesis, postulating a convergence of female drinking patterns toward those of men, this convergence being regarded as a part of the more general convergence of the gender roles. The finding that most of the observed alcohol consumption increase is contributed by increased frequency of spirits' consumption and by the increased quantity per occasion regarding beer, seems to support the convergence hypothesis, as heavy beer drinking and rather frequent spirits' consumption is typical for Czech males. The relation of consumption increase to occupational status speaks also for this hypothesis, non working women reporting no consumption increase. We find however no relation between consumption increase and the masculinity of women's occupation. To be more clear regarding the convergence hypothesis we must await the results of our longitudinal data on males. The hypothesis that Czech women's increased alcohol consumption in the years following the "velvet revolution" is a reflection of the general and still progressing liberalization of Czech citizens' behavior following the fall of Communist totalitarian rule seems to be the most plausible explanation of the observed results. The markedly increased tolerance toward female drunkenness reported by the women fits well with this explanation.

The results concerning the relations between women's gender role conceptions and their drinking are rather surprising. We have decomposed an originally one-dimensional measure of traditionalism-nontraditionalism into five noncorrelated components (factors) after we found no relation of drinking to a general measure of female traditionalism. We now understand this negative finding: the attitude to female gender role is not one-dimensional and its components have different relations to drinking. Heavy drinking Prague women are characterized by a strange combination of three attitudes: they accept the traditional male dominated family, they reject the feminist movement and they favour a nontraditional hedonistic conception of the female gender role. Might this incongruent mixture of gender role attitudes in the minds of female heavy drinkers be one of the factors that lead to their heavy drinking? The finding that heavy drinking women also tend to perceive a strong conflict between their duties towards family and job seems to support this speculation.

It is hard to say what meaning the results of our study may have in contexts other than in Czech society. Many similarities (but also many differences) exist between

the recent sociopolitical developments of the Czech Republic, Slovakia, Poland, and Hungary - and in all four countries the per capita alcohol consumption increased between 1988 and 1992. However, no exact replication of our study in any of these countries can be expected as, to our knowledge, no longitudinal studies of a similar type have been conducted. A better understanding of the meaning of our results is expected from an analysis using the data archives of the Collaborative Alcohol-Related Longitudinal Project.

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In: Women and substance abuse, 1992, interim report

Nešpor, *ti...* Csémy, L.

WHO, GENEVA 1993
Case study
CZECH AND SLOVAK REPUBLIC

Introduction

There has been a sharp increase in substance related problems among women in the Czech and Slovak Republics in recent years. Alcohol related problems in women are not a new phenomenon in the Czech and Slovak Republics.

Konarik (1934) reviewed the activities of the Czech and Slovak Republics' only in-patient facility for alcohol dependents between 1924 and 1933. He wrote: "Seven women were admitted among 336 patients. We soon found that coeducation was not possible and we discontinued admitting women. There have been so many requests for admission, however, that I am sorry for that decision. We would have needed a small 15-bed unit at least. How many family tragedies could have been prevented if we had the facdity to treat women." Alcohol and drug related problems in women have grown considerably since then and 25 beds are nowadays insufficient even for treating just the women in Prague.

Alcohol

There is a greater risk of somatic complications in alcohol abusing women. Frankova et al. (1986) describe extreme alcohol concentrations in intoxicated women (5 and 9 g/kg). Women specific programmes are available in the Czech and Slovak Republics to meet the special needs of women but some women have to be treated at non-specialist psychiatric departments because of lack of more appropriate facilities.

Okruhlica (1987, 1989) studied alcohol abuse in Slovak Republic gypsies. The 600,000-strong gypsy community in the Slovak Republic suffer from a number of social problems. Yet surprisingly, according to this author, gypsy men drink less alcohol than their counterparts in the majority Slovak Republic population, while gypsy women drink about the same as the majority population. The author admits that the smaller amount of alcohol abuse among gypsies may have a greater socially disruptive effect on their community, while the majority population suffers greater health problems. There may, of course, be a problem with the validity of self-reported data about alcohol abuse in the gypsy population.

Krch & Faltus (1968) mentioned alcohol abuse in patients with eating disorders, while Birkasova, Blazcova & Heller (1985) described a set of 16 patients with anorexia who were dependent on alcohol and/or other drugs.

Brodska et al. (1987) studied the etiology of alcohol dependence in men and women. Social factors such as life style and friends are shown to be crucial for 81 % of men, with psychological factors (e.g., depression) being important for 68 % of women. Prevention must take into account the importance of social factors.

Other Drugs

Women's abuse of drugs other than alcohol has been studied much less than their problems related to alcohol. Most of these studies deal with the out-patient population. The classic paper by Rubes (1983) described 20 drug dependent women and identified three groups: those belonging to an anti-social criminal subculture, those with primary prostitute behaviour and those of the dope-abuse type. Women in the first group were the youngest, had the worst family background and the lowest education. Despite problematic terminology and the small number of subjects, this paper correctly distinguishes young drug dependent females and those of middle age (and often middle class) as very different.

Korinkova *et al.* (1989) reported glue sniffing in out-patient teenagers. Between 1977 and 1986 the authors met 151 patients, 10 % of them women.

Hampl (1991) describes a group of 17 drug dependent persons of whom six were women. In comparison with the men in the study, these women started with drug abuse earlier, abused for a shorter time before therapy and had slightly better therap}' results. The author mentions maturation as one of the factors that may improve the outcome of therapy.

Nespor (1988); Nespor & Csemy (1990) concentrate on methods of treatment of drug abuse and dependence. Middle-aged women dependent on orally abused drugs are very similar to middle-aged alcohol dependent women and can be treated together with them. On the other hand, young women dependent on injectable drugs derive more benefit from specific programmes.

Mudra *et al.* (1986) described the out-patient population of general practitioners and showed that 24% of female patients of general practitioners received psychotropic drugs. Novotna *et al.* (1990) described 25 children of drug dependent parents. Of

11 pregnancies in 10 drug dependent women, three were high-risk, three labours were premature, six children were disabled and one had eczema.

Studies on the general population

There are very few studies of alcohol and/or drug abuse among the general population in the Czech and Slovak Republics. There is no doubt, however, that the results of high-risk studies are important not only as a counterpart to clinical studies, but also as a basis for developing prevention programmes. The results of a longitudinal prospective epidemiological research programme on "Risk Factors of Alcohol Abuse in Young Adults" is presented there. Emphasis will be on the risk factors leading to alcohol abuse, and on the psychosocial context of alcohol consumption by women.

The study is based on a survey of three samples of Prague women aged 20 to 49. The general population sample of 718 women was selected on the basis of the Central Population Register. The second sample is of 139 female in-patients with the primary diagnosis of alcohol dependence (ICD-9), and the third sample is of 39 women admitted to the detoxification centre when intoxicated with alcohol. Identical structured interviews supplemented by psychological questionnaires were conducted with women from all three samples.

In the first series of analyses the epidemiological method of case-control study was used with the aim of evaluating relative risks of alcohol abuse/dependence (Kubická, Csémy, Kozeny (1991); Csémy, Kubická, Kozeny (1991).) The analyses compared percentages of risk factors in the samples of "cases" with the percentages in the control sample (general population).

Relative risks of value 2 or higher for both samples of cases (abuse with admission for detoxification as well as hospitalization for dependence) were found for the following factors: abuse or dependence in the father, upbringing in a single parent family, disciplinary problems during school age, dropout from high school/trade school and delinquency during adolescence. In both samples of cases the percentage of women with a heavy drinking husband or partner and the percentage of women with a heavy drinking closest female friend is much higher as compared to the control sample. Both case samples also include a higher percentage of women with the job of waitress than does the population average. A significantly higher percentage of physicians and nurses is found among the hospitalized dependent women. As a further risk factor for dependence the fourth life decade seems to be prominent. Women admitted for detoxification are very often younger than 30 years, tend to have only elementary education and often state they have been regular drinkers since age 15.

The second series of analyses (Kubická *et al.,* 1991a; Kubická, Csémy & Kozeny, 1991b) concerned only women of a general population sample and was intended to identify risk indicators rather than pathogenetic factors. A hierarchical explanatory model of variabdity of certain alcohol consumption indicators was designed and statistically tested: consumption frequency, quantity per session, average daily consumption and risk consumption. (There were 8% of women with the high-risk average dady consumption of 20g and more.) The model includes three categories of contextual variables: macrosocial (sociodemographic characteristics), microsocial (the drinking habits of a persons's social group) and attitudinal.

The hierarchical regression analysis with the average dady consumption as a criterion of consumption showed that a woman's socioprofessional category is the

most important macrosocial factor (economically active women in non-manual jobs and in traditionally male professions are the heaviest consumers). From the microsocial environment the most significant factor is the consumption frequency of the husband. The most important attitudinal variable are drinking to socialize and drinking with a meal.

Some sociodemographic variables acquire a different significance with women than with men. While consumption in males declines with the rise of educational level, in women the situation is just the opposite. However, as in the case of males, female consumption does not correlate with the indicator of anxiety, depression or dissatisfaction with the partner relationship. This is in contrast to the significant correlation of anxiety and depression with the consumption of anxiolytics.

In summary, substance abuse seems to be more an expression of a certain life style marked by a hedonistic value scale than the result of stress or anxiety. Serious forms of abuse or dependence are in many cases the continuation of a personality development with disinhibitive traits from childhood and adolescence.

Treatment Inrililie.s ami gender-related trends in treatment

Several indicators illustrate the growing importance of alcohol related health and social problems in the Czech and Slovak Republics. Treatment for alcohol and drug abuse/dependence represent only a part of the overall health problem caused by alcohol and other addictive substances. It is nevertheless, quite a reliable indicator of the increase of this problem in society.

Tabic 1 Trends in hospital admissions with alcohol and/or drug-related diagnosis in the Czech and Slovak Republics (1970 - 198«. age range 15-64 years)

Year	Alcohol and/or drug-related diagnoses per 100, 000 population	Czech Republic	Slovak Republic
1970	MALE	180	213
	FEMALE	11	21
	M:F	15	10
1975	MALE	208	265
	FEMALE	23	35
	M:F	9	7
1980	MALE	254	325
	FEMALE	34	41
	M:F	7	8
1985	MALE	264	383
	FEMALE	57	68
	M:F	5	5
1988	MALE	259	450
	FEMALE	62	82
	M:F	4	5

Out-patient Treatment Facilities

In 1990 there were 180 out-patient treatment centres in the Czech Republic and 67 in the Slovak Republic. These centres which are usually part of a psychiatric out-patient department, provide counselling, ambulatory treatment and follow up

care. In the Czech Republic in 1990, 38,245 males and 6,648 females (M:F ratio = 6) were first listed with the diagnosis of alcohol abuse/dependence. In the same year 2,466 males and 1,010 females (M:F ratio = 2) were listed with the diagnosis of drug abuse/dependence. In these centres in the Czech Republic there were 27,124 males and 1,595 females registered in 1970, with 127,836 males and 12,111 females registered for 1985 (M:F ratio for 1970 = 17, and for 1985 = 11).

Inpatient Treatment Facilities

Most people with alcohol or drug problems are treated in psychiatric hospitals or in the psychiatric wards of general hospitals. Trends in hospital admissions with alcohol and drug related diagnoses (males and females in age range 16-64) are summarized in Table 1. The general conclusion from this table is that the trend in alcohol and drug related hospitalization during the period of observation is much more sharply increased in women than in men.

Also important is that hospitalizations due to substance addiction increased considerably from 1970 to 1988 with respect to psychiatric hospitalizations as a whole. It represented an increase from 29% to 40% of all psychiatric hospitalizations in men and from 3% to 14% in women.

Detoxification Centres

There are more than 60 detoxification centres in the Czech and Slovak Republics. The number of persons detoxified since 1970 is shown in Table 2. Regarding gender differences we see the same general trend as in hospitalization. The male to female ratio is clearly narrowing.

Sharply increasing alcohol and drug abuse and dependence, as clearly evident from data on treatment, is not a phenomenon only in the Czech and Slovak Republics. Similar situations were reported in most western countries 10 to 20 years earlier. Findings support the importance of preventive programmes tailored for women.

Tabic 2 Detoxification centres in the Czech and Slovak Republics, and the number of detoxified males and females (1970 - 1990)

Year	Republic	Number of detoxification centres	Number of detoxified males	Number of detoxified females	Male: Female Ratio
1970	CR[1]	25	25,361	1,205	21.0
	S[2]	26	10,674	558	19.1
1975	CR	27	25,486	1,296	19.7
	S	31	13,988	723	19.3
1980	CR	32	28,109	1,792	15.7
	S	32	17,136	942	17.2
1985	CR	33	30,332	2,354	12.9
	S	33	21,399	1,306	16.4
1988	CR	34	27,150	2,701	10.1
	S	34	18,233	1,173	15.5
1990*	CR	29	17,265	2,392	7.2
	S	34	15,363	1,165	13.2

[1] Czech Repubbc
Slovak Republic
Preliminary data

Pilot survey report

What do substance dependent women think about factors and events influencing their problem? Because of lack of data about the impact of social and political change on substance related problems in women in the Czech and Slovak Republics, a pilot survey was conducted as part of this report. Self-report is useful as a basis for further investigation.

Material and Methods

An original questionnaire was prepared for this study. Questions that might hint at political and social changes were carefully avoided. Instead we mentioned the period of the last three years (in which radical political and social change took place). Respondents were asked to list 0 to 5 events and factors contributing to their substance related problem during their life and during the last three years. They were also asked to list events and factors helpful in overcoming their substance related problem during their life and during the last 3 years. Some 82 substance dependent women answered this questionnaire. Of these, 50 were in-patients and 32 were out patients. Their ages ranged from 17 to 58.

Results

Most commonly, the events and factors that contributed to substance related problems were linked with close relationships and family. The most prominent of these relationship problems were with husbands and lovers, followed by non-specified family problems, divorce, problems with parents, children, death, problems in the extended family and problems in childhood.

The second largest group was related to intrapersonal factors including various mental and physical problems. Forty-seven events and factors were related to friends and risky companionship, 35 to life style, 33 to occupation and 5 to political factors. The pattern of events and factors in the last three years was similar to those of previous years. This seems to indicate that the rapid socioeconomic-political changes that have occurred in the last 3 years did not have a direct influence on drug abuse.

Events and factors helpful in overcoming substance related problems are also described. Family and close relationships are again the most frequently reported category. Next in importance is improved life style and treatment. Political factors were negligible (zero during life and one during the last three years).

Discussion and Conclusion

The small number of events and factors reflecting political and social changes surprised us but it may be deceptive. Balcar (1991) described the impact of political change on Czech families. He identified factors such as uncertainty, information overload, economic problems and unemployment, competitiveness and frustration as well as some factors with positive effects such as increased freedom, self-determination and responsibility. Family relationships are most often mentioned in our pilot survey both as contributing to substance related problems and as a way to cope with them.

Another area closely connected with social and political change is employment. It is certainly more difficult for people with substance abuse problems to find a new job than before, and employers are less tolerant with them.

Even so-called internal factors such as anxiety or depression may be partially triggered by social and political uncertainties and unpredictable developments. This may occur even without full awareness of those concerned.

There is little doubt that increased availability of alcohol and greater liberalization in all areas of social life, including alcohol and drug abuse, has an impact on life style. As a result, many women may develop substance abuse problems in the future. The comparatively modest number of helpful factors related to treatment may be related to the fact that most respondents (61%) were in-patients undergoing therapy who did not yet perceive its possible positive effect.

A cautious conclusion from our pilot study is that, according to the views of substance dependent women, political and social factors did not have a direct impact on their substance related problem. This does not, however, exclude the possdjility of indirect influences mediated by family relationships, job, life style or internal factors.

Conclusions

Possible Causes of Substance-related Problems

Most Western countries observed an increase in alcohol related problems in women after World War II, so the increase in the Czech and Slovak Republics cannot be considered a local phenomenon. Nevertheless there may be some factors specific to the Czech and Slovak Republics. One is the great number of employed women. Some workplaces are far from being alcohol-free. In addition, employment may cause conflict of roles (wife and mother versus employee) and it may cause considerable stress.

Another factor that is perhaps specific to the Czech and Slovak Republics is the disintegration of families, the large number of divorces and housing problems. The "empty nests" syndrome when adult children leave home is difficult to overcome without the social network and support which many women, especially those in big cities, lack. Lastly there is the high per capita alcohol consumption in the Czech Republic. Male and female drinking is interconnected; many women develop their alcohol related problems during life with an alcohol abusing husband or male friend.

The causes of drug abuse in middle-aged middle class women are similar. The indiscriminate overprescription of psychoactive substances, especially by general practitioners, has its impact too. Young women abusing drugs (often intravenously) are different from their middle-aged counterparts and their reasons for drug abuse may be different too. Factors that appear relevant include rebelliousness, problems in the families of origin, lack of success, insufficient integration into mainstream society and drug abusing friends. Increased availability of illicit drugs in the Czech and Slovak Republics should not be underestimated, especially in high-risk groups such as commercial sex workers.

Prevention of Substance-related Problems

The new political and economical situation brings not only problems and challenges but also possibdities. One effective strategy to prevent alcohol and drug related problems is peer intervention (e.g. Tobler, 1986). The peer does not have to be a person of the same age but may be a person of similar status, in a similar situation or possibly of the same gender. Gender-specific prevention may be especially appropriate in the situations that do not apply to men: prevention of foetal alcohol syndrome, prevention of drinking during maternity leave, drinking related to the menstrual

cycle, the "empty nest" syndrome. Gender-specific differences can be taken into account even in school-based programmes, especially in light of differences in social development between girls and boys (Maltz & Borker, 1982). Nespor recently reviewed peer prevention strategies for the National Centre for Health Promotion and we expect more use of these in our country.

High-risk and disadvantaged groups often benefit from social help and from positive alternatives to alcohol and drug abuse. This applies to girls who drop out from schools, those with risky family backgrounds, single mothers, women with physical and/or mental handicaps, and so on. A sensitive approach is clearly needed by these disadvantaged groups in this time of rapid economic transformation. Results from the questionnaire show that most women see families as the most important factor both in the development of their substance related problem and in coping with it. If this is the case, marital counselling, crisis intervention and prevention in families should be emphasized. In the place of risky addictive psychoactive substances, non-pharmacological approaches such as psychotherapy, relaxation, yoga or physiotherapy should be used wherever appropriate to counteract mental and physical discomfort.

The importance of workplace prevention has not been recognized by most employers in the Czech and Slovak Republics. It is hoped that the media will be able to present better gender-specific peer models for women in difficult situations and will promote healthy life-styles.

Non-governmental activities in the field of prevention is expected to grow in importance. The FIT IN campaign is one of them. We plan to send free information on the prevention of the foetal alcohol syndrome to Czech obstetricians and to publish a self-help manual for problem drinkers that will include a section for women.

Alcohol and drug related problems in men and women are interconnected and women suffer both direcdy and indirectly. We hope that women's non-governmental organizations such as Mothers Against Drunken Driving will eventually develop in our country.

Substance abuse is a global problem and international cooperation is crucial. The stimulating and coordinating impact of WHO in this area will be even more influential than before.

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CASE STUDY: CZECH AND SLOVÁK REPUBLICS

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An alcohologist's marathon run (1946 -1988)

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In 1946, shortly after my graduation 1 started to work as an intern of the psychiatric teaching hospital in Prague which was then and is now a part of the Faculty of Medicine of Charles University in Prague. Not even a month later I was nominated by the Czech Abstinents' Organization for a three-member delegation to participate at the first post-war conference on alcohol-related problems in Brussels. At that time I was right in thinking that these problems were of major and global importance. After that I never really left this track and I have followed it for 42 years. Taking a year for a kilometer it could be said that it has been a sort of a marathon run.

The beginnings

I was thirty. Psychiatry as a field of medicine was in a sorry state as far as therapeutic possibilities were concerned. My interest in alcohol-related problems grew and I recruited also my older colleagues in the hospital. I was helped a lot by scientific literature that brought me information about the aversive treatment with apomorphine and emetin as well as the first experience with the application of disurfiram. I also learned about the work of E. M: Jellinek, among other things about his phaseology based on the first ten years of experience of AA members. Every issue of Quarterly Journal of Studies on Alcohol was worth its weight in gold for me and my collaborators and still occupies a honorary spot in my library.

Inpatient treatment

The number of alcohol-dependent patients in the closed ward of the psychiatric hospital had been rapidly increasing. My superior, a wellknown professor and head of the hospital was not at all happy about it and he welcomed the origin of an independent ward in an old building nearby which had served for the chronic patients of the hospital. The new specialized ward for alcohol treatment was the first of its kind in Czechoslovakia. Within four years it had reached the present capacity of 50 beds not counting the beds in a rehabilitation branch for obligatory and recurrent patients' treatment. Today, Czechoslovakia with its 15 million inhabitants has 25 inpatient wards with and overall capacity of about 1500 beds.

Outpatient treatment

Simultaneously with inpatient wards there also gradually originated outpatient facdities.

Today they are active within every district health care administration, i.e., there are more than 200 of them in the country.

Clubs (AA)

In 1948 we adapted the example of AA to the structure of our health care system to create a sociotherapeutic club out of the former Apolinář patients. This year, the club celebrated 40 years of its activity and will hold the 1974th meeting this week. The discussion meetings of the Apolinář club are held every Thursday both for the current patients and for those who have already practiced abstinence and attend the club as

one of the recommended forms of the rehabilitation program. So far, there are close to a hundred of such clubs in the country, which are active for most part in outpatient treatment, less often in an alcohol treatment hospital ward.

Patients.

In the course of the next more than 40 years Apolinaf was frequented by patients (more than 13 000 so far) with the same diagnosis of dependency, above all on alcohol. Among other causes, they have also developed the dependency following events related to the development of our social system. From time to time there developed certain groups in which the individuals responded to particular important changes by alcohol abuse and dependency. Whichever side they had stood on, they were not able to carry the load, tasks or demands put on them and complicated their problems by drug abuse.

International contacts

The year 1956, when prevention-orientated alcohol treatment teams originated, a specialized scientific section of the Psychiatric Society was established and the first monograph on alcohol-related problems by this author was published, represented and important milestone. This year marked also the beginning of regular contacts with scientists abroad, in particular with ICAA and its director Archer Tongue, which still last. One of the European seminars of this institution took place in Prague in 1966 with the participation of more than 200 experts from Europe and America. It was the first time when a day was dedicated also to the problems of non-alcohol dependencies. Other international functions took place in Prague in 1973 (voluntary and obligatory inpatient treatment) and in 1977 (first congress of socialist countries for the prevention and therapy of alcohol and other drug dependence.

Personally I was lucky in being able to travel regularly. It was an opportunity for me to learn about and compare the problems of alcohol abuse and various models of alcohol treatment in a number of countries with different social systems on all the five continents. However, I spent most of my time with people with whom I shared the same goal — my brothers alcohologists. Today there are hundreds and hundreds of them, in the fifties there were only tens. Many of them had kept to their goal and did a lot of useful work in their life.

Brothers alcohologists

Brother alcohologists have helped each other and helped me wherever and whenever necessary including help of the kind provided to me by Vlado Hudulin from Yugoslavia when I had a heart attack at a congress in Mexico. The present president of ICAA David Archibald had repeatedly visited Czechoslovakia and in Canada applied on a broad scale an original Czechoslovak preventive institution — detoxication centers (the first one was opened in Prague in the Apolinaf Center for Alcohol Treatment in 1951). David then made my retirement more pleasant by sponsoringmy lecture tour through the Canadian provinces in the spring of 1983.

Families of the patients

In the sixties we emphasized the psychological and social aspects in our Apolinaf program and began paying attention to the family of the patient. For this purpose a center for children, youth and famdy was opened. In the following years this institution influenced preventive and research projects aimed at children and youth

on a national scale. Today, both inpatients and outpatients in Prague have the opportunity to consult experts and take their family -- wife and children — along. Unfortunately, this offer is utilized by only a small majority of those who would do well to accept it.

Therapists

At the end of the sixties we in Apolinaf realized that the reserves in treatment effectiveness primarily lie in the therapists themselves. Adopting a definition that the psychotherapist is a guide of the patient on his was to better selfknowledge we started educating psychotherapists (education and training) so that they would become not only sophisticated but also experience self-experience groups, acquire necessary skills in various techniques and methods but above all work on their relationship toward the patients. Such a training spread over at least 5 years represents 300 to 500 hundred hours of education. The trainees are physicians, psychologists but also nursing staff and social workers. Since 1982 both psychiatrists and physicians in other fields may earn a postgraduate credit in the prevention and treatment of drug dependencies. Starting with next year similar postgraduate specialization will be offered in psychotherapy.

Moving activities

Moving activities have been a part of the Apolinaf program, regimen and system from the very beginning. In the mid-sixties they gained on both intensity and extensity. In 1965 we opened a nine-bed unit for non-smokers and stopsmokers with real motivation. It was primarily to these but also to other patients that we offered locomotor activities, mostly in the form of jogging. Everybody was jogging in the large Apolinaf garden then, not only patients but also the head physician and some of the therapists. Experientially we thus predated a fact which is today being explained by the creation of endorphines and encephalines through adequately long and intensive movement. A number of patients stopped smoking. A minority already during the inpatient treatment, the majority later during rehabilitation. Not only jogging but also tourism, bicycle riding and aerobic exercise for women have brought about an alternative and riskless euphoria.

This was the happy time of the therapist getting closer to the patient, of shared experience that favorably influenced therapeutic process and contributed to the increase of treatment effectiveness. The comparison of permanent and consequent abstinence to a long-distance run where the important thing is not the time but a reliable completion of the distance provoked a concrete project. In several years we saved a considerable amount of money in the meetings of our club: this was used to order from an outstanding Czech glassmaker a crystal glass cup with a dedication to the first marathon runner in the world who will finish under 2 hours 6 minutes. The cup was officially presented by representatives of our club to the president of the IAAF Mr. Paulen in 1978. The best time in marathon run was then something over 2 hours and 10 minutes: within the last ten years it had been brought down to 2 hours 6 minutes and 55 seconds so that the cup will apparently soon pass over into the hands of the man who will have fulfilled its mission.

Medical students and physicians

For several years, Apolinaf has been run by my successor. The center is still in a 200 years old building. The disadvantage of crowded premises is counterbalanced,

however, by the convenient position in the center of the town and contacts with the various teaching hospitals of the Faculty of Medicine. The center had been visited already in the beginning of the fifties — and is visited still — by medical students during their clinical exercises. I myself had been meeting them for more than 25 years. From time to time I meet some of them and learn after all those years how impressed they were with the visit in Apolinaf, its treatment program and meetings with the patients. Some of these former students are today wellknown physicians in various fields, some are even professors. Their retrospective appreciation brings pleasure even after all those years.

Some of the students did not fare as well and I met them as patients. Some of them developed dependency already during their studies; in most cases, however, they only came years later. A summary study on several tens of these Apolinaf patients showed that the results were good and even superior to those of other patients. I remember especially one of them. After a successful treatment lie became the head of an outpatient treatment center and sent subsequently several other physicians from there for treatment. When they made up nine they founded their own sociotherapeutic club. The club made it their job to win for treatment the remaining 5 physicians who sould need it but were still resisting.

Prevention

For the last 15 years I have devoted myself to preventive work with young people and students 12 to 18 years old. With two musical groups we have created an integrated program of music and spoken word. More than 100 000 young people saw the almost 400 performances of the program. Recently I had an opportunity to participate in a discussion with young people to which I was invited together with a wellknown young Czech writer and screenwriter. During the question and answer session I learnt that many years ago as a 16 year old student he visited with his class a meeting of the Apolinaf sociotherapeutic club. He informed the audience that 5 out of his 25 former classmates experience severe problems today, either with alcohol or with other habit-forming substances (drugs). My fellow participant in the discussion then confessed to the audience that he himself had underestimated the danger of a habit-forming drug and that it had taken him a major effort to overcome the whole thing. For several years now he has been very active in the mass media, in particular in the film and TV. In his work he has personally met a number of young people for whom dependency had become a major problem or even a tragedy.

Positive diagnosis

A person dependent on alcohol and other drugs is often considered a second class citizen in our country. Quite often the physician-alcohologist is evaluated in the same way. However, it is a part of the ethics and the therapeutic morale of an alcohologist to believe in his work and to assume not only a possibility of cure but also of personal growth in his patients. In short, he should be able to arrive at a positive diagnosis of the patient which enables him not only to cure the patient — to win him for life without the drug — but also to program the patient's life to be meaningful and happy.

A recipe for both patients and alcohologists

To my patients I have always recommended permanent and thorough abstinence, not as a goal, however, but as a mediating value. And what is my personal attitude

towards alcohol? I stdl remember a passionate discussion during an international conference in Amsterdam in 1961. I will quote the brief conclusions of several alcohologists:

1. Mastrangele of Milano: If I abstained I could not live with my colleagues.
2. Glatt of London: If I abstained my patients would think me ill.
3. Krauwell of Amsterdam: I don't abstain, I like to have a drink from time to time. However, I would never take a drink when a patient could see me. I am aware there's a bit of phariseeism in it.
4. Skala of Prague: I abstain even when the patients cannot see me. I have completely abstained (since 1951) because, among other things, the patients are worth it to me.

I don't think that abstinence is obligatory for an alcohologist but I believe that everyone should try it for at least two years and then decide what to do next.

"CZECH MADE" GAMBLING

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An analysis of 32 cases of gamblers, who were admitted to a Family Center ("clients") or to a psychiatrie hospital for three months of in-patient treatment ("patients"), has been made. The gamblers filled in many questionnaires and wrote autobiographies.

Findings:

In age distribution, there are two peaks: the first one around 24-25 and the second one arround 34 years of age.

The majority of patients were workers; if there was more education, it was achieved through evening school. This is not the case with the clients.

When compared with alcoholics, they surprisingly describe their childhood as a "good one" (in spite of many compulsive and agression disorders in the family). They have played very often some competitive sport, often on a high level. More than one half of patients have had serious problems with alcohol, but if we exclude extreme polymorphic psychopaths, there are no drug-addicts in this cohort.

There is often a tendency to affilliative behavior and also suppressed negativism with paranoid perception set.

Among other behaviors, they dislike most the lies of the others.

Factors affecting treatment:

The most important factors for entering treatment:

Threat of:
lenders
unemployment
divorce, detachment

Crisis factors for sustaining in-treatment program:

low frustration tolerance
dual diagnosis (with the exception of another dependence)

Factors affecting effectivenes of treatment:

partner insists on a divorce if patient leaves the treatment
confidence that he will get out of gambling
degree of insight into his life situation

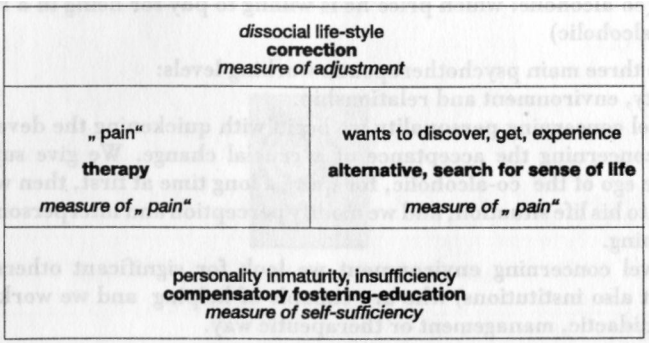
Sexuality of gamblers:

1. phase: without problems or without sex (a male virgin)
2. phase: blocked by alienation, conflicts
   complaints: lack of gambler's self-care
   lack of gambler's interest
3. phase: no sex or without any problems: "sex only"

Ascensive personality factors of Czech gamblers 1993 - 1994:

- smoking (but no drug-addiction)
- premorbid sex without problems, or male virgin
- "good childhood"
- active interest at sport, often at a high level
- frequent accidents, injuries
- want to "get on well with the others"
- overstepping the reference
- desire to "show, exhibit" to/in front of the world and himself

Conceptual model psychotherapy of gambling model (etiology, sort of intervention and symptom, what is important for effectiveness measurement)



Psychoterapeutu? intervention in alcoholic family.

PhDr. Magdalena Frouzová, MUDr. Eva Mráčková, Mgr. Jitka Lešetická

Psychiatric Hospital Prague 8, 181 02, Ústavní 91, Pa v. 35
Family Center Prague - west, Praha 5, Zborovská 11, 151 02

There are two trends in the development of an attitude towards alcohol dependence in the last decades. The first one searches for common characteristics of a dependence on various objects and processes. This conception can be expressed by a picture of expansionlfcne single process at the expense of others as we can see it with a cancer.

The second trend follow inner differentiation of the pathological or rehabilitative progress at various levels and stadia. In spite of the fact, that this "infection" expands across the individual by relation and misuses, communication to get this process going, we can use a surgical cut off just in very serious states. The consequence is, that we find ourselves in a space, where we meet - rather than an adequate theory - a message "here are lions", in the throat of psychoterapeutic adventurers which easily gets stuck.

The portion of Czech society met with in our practice has two main characteristics. The first is the speed of a change in relationships. We can notice their loosening on the level of concrete distance (the significants live in the other countries more often) and also at moral level (variability of moral codes increases). On the other hand there is the growth of the oposite phenomenon - too much narrow bindings, dependence.

The current knowledge of dependence allows us a big flexibility when choosing the appropriate psychotherapeutic approach. We use three basic questions for a quick diagnostic orientation in any of these cases (Picture **No.** 1):

1. to which extent an alcoholic (or co-alcoholic) can "stand on his own feet", how much he can on his own (quality of personality)
2. how big support gets the alcoholic (or co-alcoholic) from his social background, how much he can with the help **of** the others
3. an intensity of his relationship with alcohol, what price he is willing to pay for an alcohol (co-alcoholic: which price he is willing to pay for being in a relationship with an alcoholic)

There are three main psychotherapeutic working levels:
personality, environment and relationship.

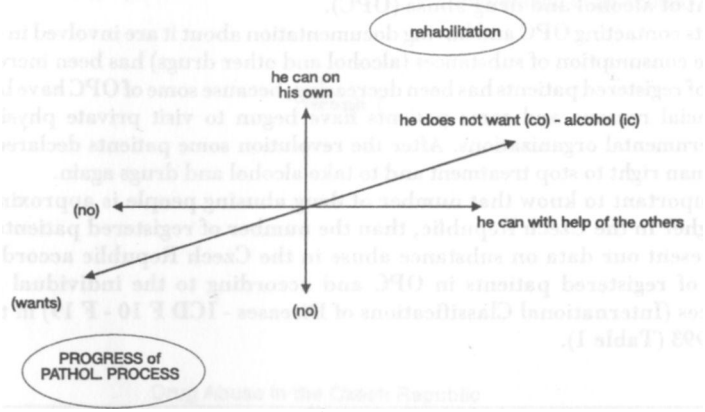
At the level concerning personality we begin with quickening the development of an insight concerning the acceptance of a crucial change. We give support by a fostering the ego of the co-alcoholic, for quite a long time at first, then we work out an insight into his life situation, and we modify perception and interpersonal patterns as the last thing.

At the level concerning environment we look for significant others (not only persons, but also institutions) who are capable of helping and we work with these people in a didactic, management or therapeutic way.

At the level concerning **relationship** we usually begin with the assessment of the difference between presentation at individual and conjoint sessions. We usually work on caiming the relationship with concrete advice concerning behavior. Because the relationship is overwhelmed by frustrations and agressions, we work on them at the individual sessions into which we interpose conjoint sessions as often as the stadium of therapeutic process concerning an individual allows. The focus in conjoint sessions is on modification of communicative patterns and on a preventing relapse in the future.

When working with the co-alcoholic, the procedure going from personality through environment to relationship seems to be most effective. In an acute family case we offer first aid by immediately cutting of an individual from the others. We can work on a relationship between the co-alcoholic and the alcoholic on a condition that these people can have or have enough support from their environment.

The relationship in a family is a horizon of our work and if we get on this level, we can look forward to a miracle, which is called in alcohology a rehabilitation and with which psychotherapists believe that they help to make a start.



Picture
I - Basic orientalion in (co-)alcoholic situation

SUBSTANCE ABUSE IN THE CZECH BEPUBLIC

Karel llampl

Board of Experts for Alcohol, Drugs and Tobacco Related Problems
Ministry of Health of the Czech Republic, Prague
Technical collaboration: J. Hajn, Outpatient Clinic, Melnik

Substance Abuse in the Czech Republic

Sociopolitical changes after the year 1989 have led, apart from other things, to the opening of the borders and to the development of private enterprise. This has also led to increased accessibility of alcohol and other drugs.

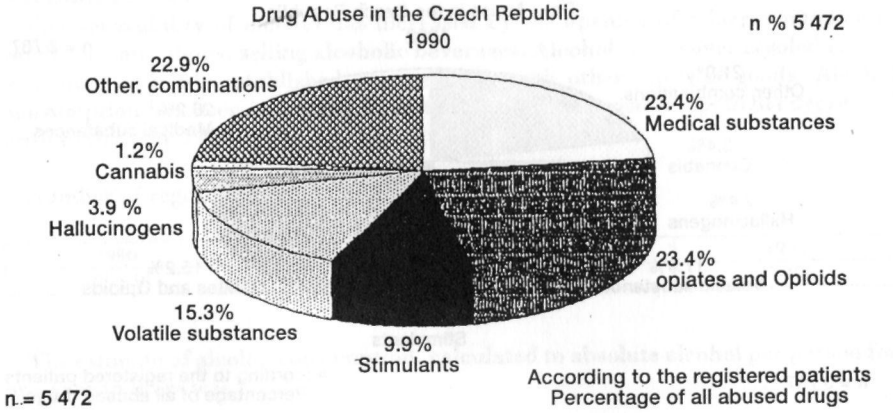
We have no statistical data about these phenomena from the common population, but we have health statistical data from the outpatient clinics for diagnosis and treatment of alcohol and drug abuse (OPC).

Patients contacting OPC and having documentation about it are involved in our study. While the consumption of substances (alcohol and other drugs) has been increasing, the number of registered patients has been decreasing, because some of OPC have been closed for financial reasons and some patients have begun to visit private physicians and non-governmental organizations. After the revolution some patients declared that it is their human right to stop treatment and to take alcohol and drugs again.

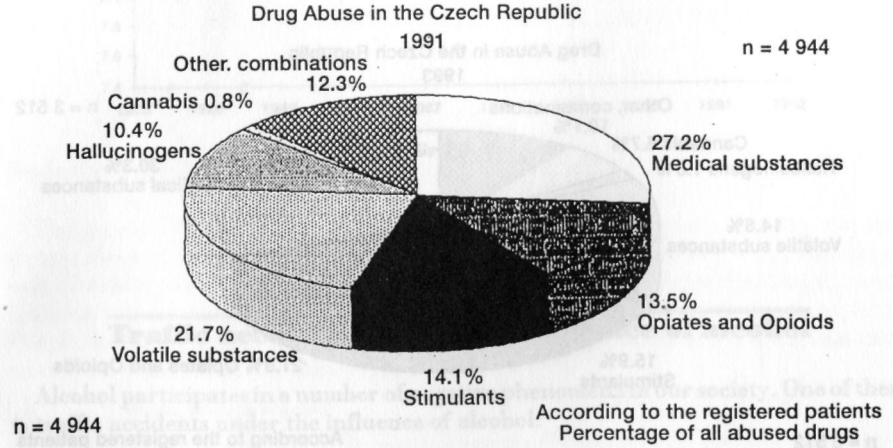
It is important to know that number of drug abusing people is approximately ten times higher in the Czech Republic, than the number of registered patients in OPC.

We present our data on substance abuse in the Czech Republic according to the number of registered patients in OPC and according to the individual groups of substances (International Classifications of Diseases - ICD F 10 - F 19) in the period 1990 - 1993 (Table 1).

Group of drugs	Number of patients and percentage							
	1990	%	1991	%	1992	%	1993	%
Sedatives,, hypnotics (F13)	1281	23,4	1343	27,2	1067	28,2	1065	30,3
Opiates and opioids (F11)	1281	23,4	665	13,5	576	15,2	771	21,9
Stimulants (F 15)	540	9,9	698	14,1	418	11,0	559	15,9
Volatile substances (F 18)	837	15,3	1077	21,7	676	17,9	512	14,6
Hallucinogens (F 16)	213	3,9	515	10,4	91	2,4	51	1,5
Cannabis (F 12)	66	1,2	40	0,8	130	3,4	201	5,7
Othercombinations (F 19	1254	22,9	606	12,3	829	21,9	353	10.1
Drugs total	5 472		4 944		3 787		3 512	
Alcohol total (F10)	105 588		57 794		40 820		47 436	
Percentage data are in circular graphs (Graph 1, 2, 3, 4)								

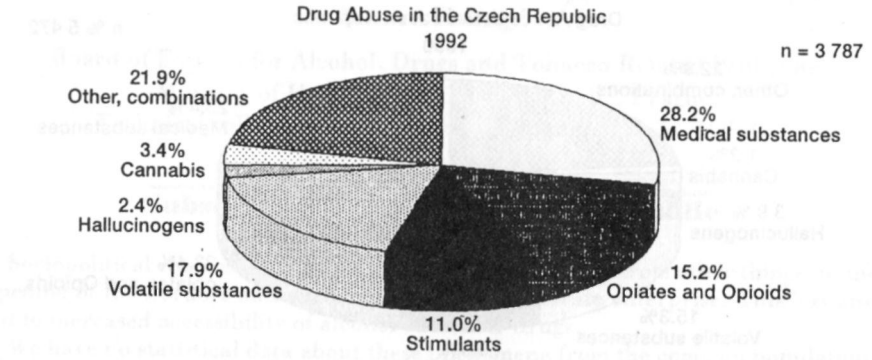


Graph 1

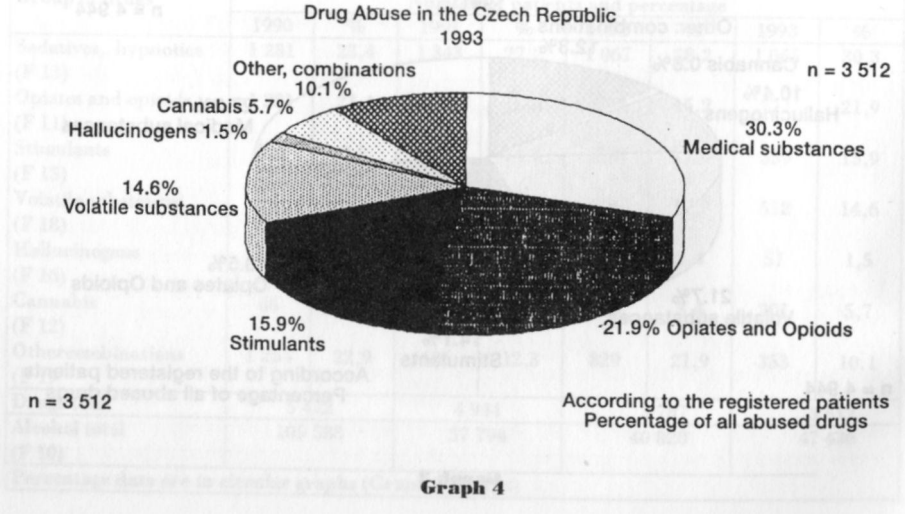


Graph 2

r



Graph 3



Graph 4

Individual groups of substances

Alcohol (F 10)

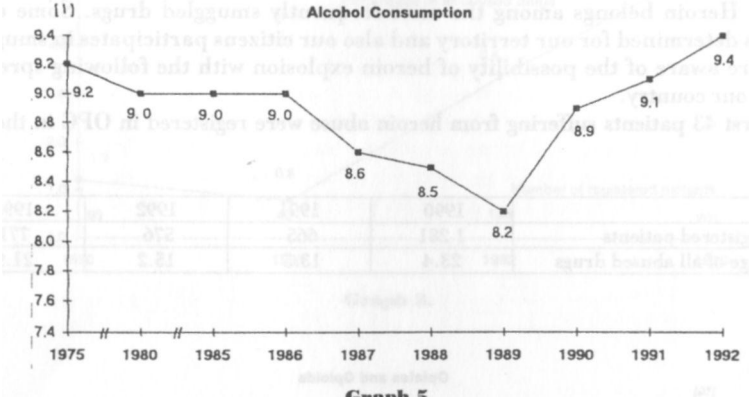
The accessibility of alcohol has increased by the opening of a larger number of small, private, shops, selling alcoholic beverages. Alcohol, more over is soled also in a number of newly established private shops with other kinds of goods. Alcohol consumption has been increased while the number of registered patients decreased until to the year 1991.

Number of registered patients:

1990	1991	1992	1993
105 558	57 794	40 820	47 436

The estimate of alcohol consumption, calculated to absolute alcohol per person for one year in liters was:

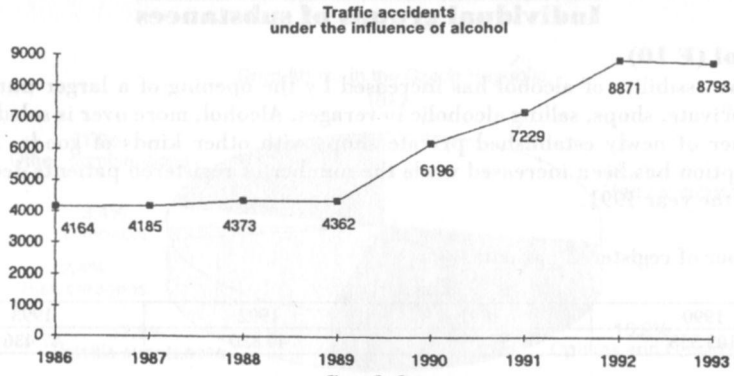
1936	1975	1980	1985	1986	1987	1988	1989	1990	1991	1992
3.4	9.2	9.0	9.0	9.0	8.6	8.5	8.2	8.9	9.1	9.4



Traffic accidents under the influence of alcohol

Alcohol participates in a number of negative phenomena in our society. One of them is traffic accidents under the influence of alcohol:

1986	1987	1988	1989	1990	1991	1992	1993
4 164	4 185	4 373	4 362	6 196	7 229	8 871	8 793



Graph 6.

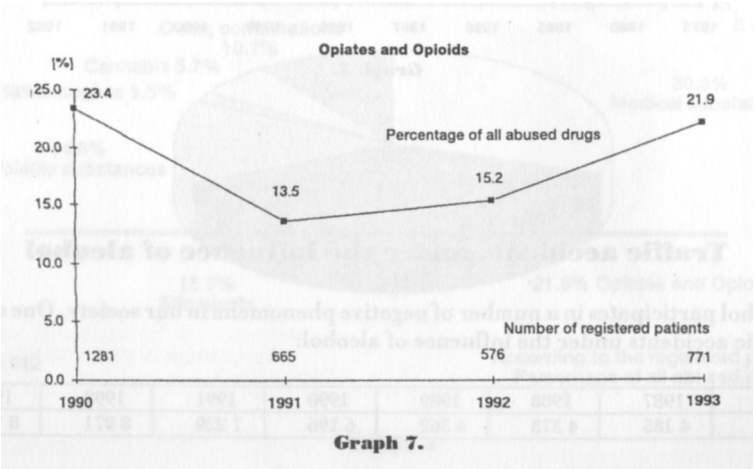
Opiates and opioids (F 11)

Most abused from among opiate substances was codein in the form of parenteral application. Together with the opening of the borders also the opportunities for smuggling of illegal, illicit drugs have been opened.

Our country lies on the transport line of drugs from production countries to western Europe. Heroin belongs among the most frequently smuggled drugs. Some of the heroin is determined for our territory and also our citizens participates in smuggling it. We are aware of the possibdity of heroin explosion with the following spread of AIDS in our country.

The first 43 patients suffering from heroin abuse were registered in OPC in the year 1993.

Year	1990	1991	1992	1993
No. of registered patients	1 281	665	576	771
Percentage of all abused drugs	23.4	13.5	15.2	21.9



Graph 7.

4 an ii a bin oui s (F 12)

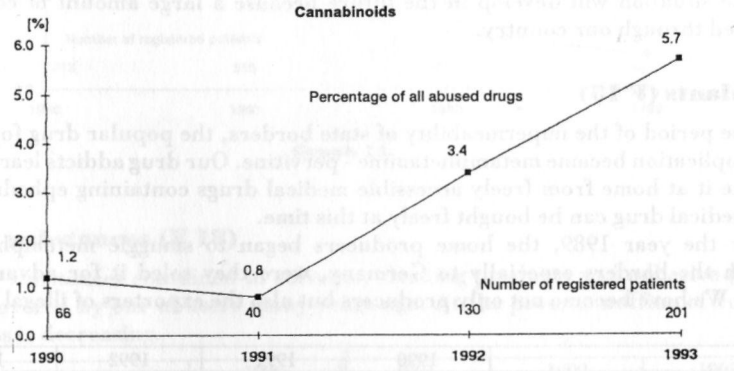
The number of marihuana smokers is growing very quickly but they have not attended health facilities so far.

Trends of promoting legalization and liberalization of marihuana as a soft drug, have occurred in our country during the years 1991-1993. The seeds of hemp are freely sold in our shops and a lot of young people grow hemp in their gardens.

While the sale of the seeds is unpunished, the growing of hemp for the preparation of the marihuana is forbidden and the grown plants are confiscated by the police.

Apart from home production marihuana continues to be smuggled from the old, known production countries. So far, the public does not have sufficient information concerning the harmful effects of smoking marihuana.

Year	1990	1991	1992	1993
No. of registered patients	66	40	130	201
Percentage of all abused drugs	1.2	0.8	3.4	5.7

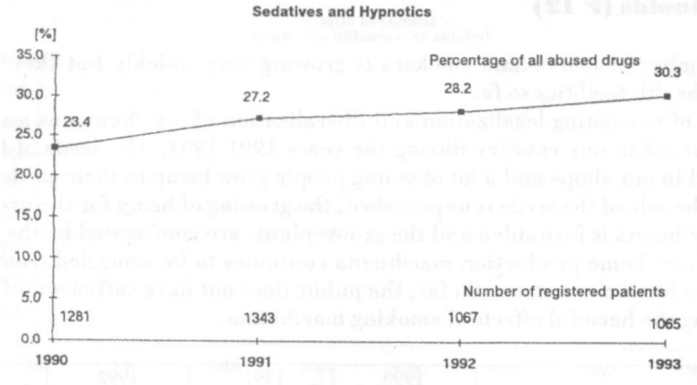


Graph 8.

Sedatives and hypnotics (F 13)

The greatest group among the registered patients are patients abusing medical drugs. Medical drugs involving some psychoactive substances are for prescription only. Barbiturates are a consistent part of some composite analgetics. Many people use some somnifacient preparations and the tranquilizers especially benzodiazepines. People do not recognize their dependence on these drugs, in spite of the fact that they have been taking them for many years.

Year	1990	1991	1992	1993
No. of registered patients	1281	1 343	1 067	1 065
Percentage of all abused drugs	23.4	27.2	28.2	30.3



Graph ».

Cocaine (F 14)

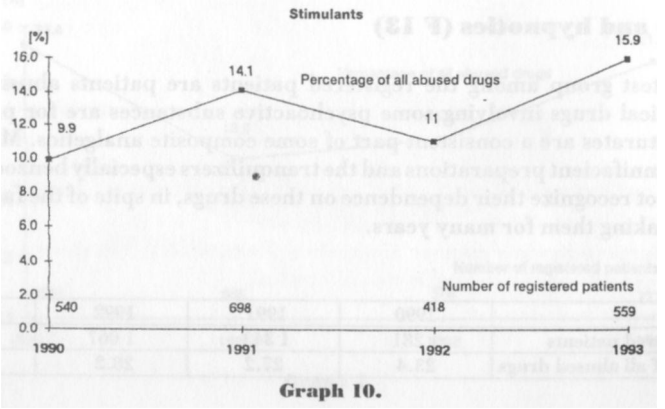
Cocaine has not been a problem in our country up to this time. But we do not know how the situation will develop in the future because a large amount of cocaine is smuggled through our country.

Stimulants (F 15)

In the period of the impermeability of state borders, the popular drug for parenteral application became metamphetamine - pervitine. Our drug addicts learned how to make it at home from freely accessible medical drugs containing ephedrine. No such medical drug can be bought freely at this time.

After the year 1989, the home producers began to smuggle metamphetamine through the borders especially to Germany, were they soled it for advantageous prices. We have become not only producers but also the exporters of illegal drugs.

Year	1990	1991	1992	1993
No. of registered patients	540	698	418	559
Percentage of all abused drugs	9.9	14.1	11.0	15.9

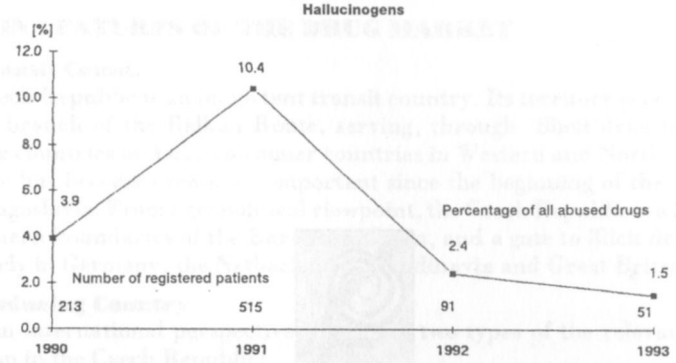


Graph 10.

Hallucinogens (F 16)

A popular drug in drug addict's subculture was Triphenidyl, causing optical hallucinations. It is available now by medical prescription only. The other hallucinogenic drugs are a peripheral matter. In the previous time dealers offered strips of filter paper impregnated by LSD or by other hallucinogens.

Year	1990	1991	1992	1993
No. of registered patients	213	515	91	51
Percentage of all abused drugs	3.9	10.4	2.4	1.5

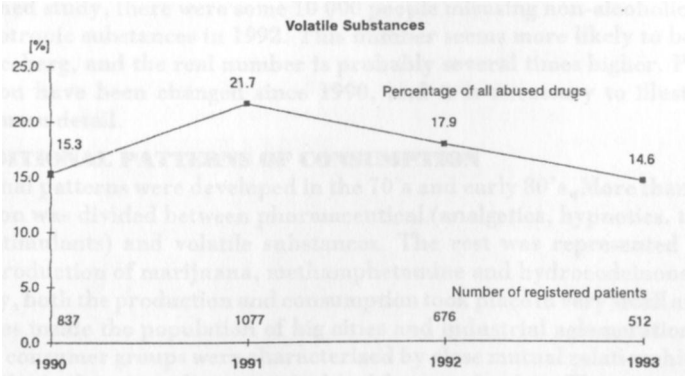


Graph 11.

Volatile substances (F 18)

Volatile substances contained in solvents, cleaning products and adhesive pastes were discovered by our abusers many years ago. At the present sniffing of volatde substances is decreasing.

Year	1990	1991	1992	1993
No. of registered patients	837	1 077	676	512
Percentage of all abused drugs	15.3	21.7	17.9	14.6



Graph 11.

Conclusion

The situation in substance abuse is very unfavorable in our country. The consumption of alcohol and other drugs is increasing and we do not have sufficient means to change it. But we hope that it will be changed in the near future.

DRUG PROBLEMS VXD DRUG POLICY I\ THE CZECH REPURLIC

Kami I Kalina, Pavel Bern
FILIA Foundation, Prague

1. SUPPLY AMD DEMAND CHARACTERISTICS

1.1. MAIN FEATURES OF THE DREG MARKET

1.1.1. Transit Country

The Czech Republic is an important transit country. Its territory is crossed by the northern branch of the Balkan Route, serving, through illicit drug transit from producing countries in Asia, consumer countries in Western and Northern Europe. This route has become even more important since the beginning of the civil war in former Yugoslavia. From a geopolitical viewpoint, the Czech Republic is a buffer state at the eastern boundaries of the European Union, and a gate to illicit drug markets particularly in Germany, the Netherlands, Scandinavia and Great Britain.

1.1.2 Producing Country

From an international perspective, there are two types of the relevant domestic production in the Czech Republic:

— Pharmaceutical and chemical substances, which leak from legal production and trade to the illicit market, and are particularly destined for trafficking and consumption in developing countries in Asia and Africa.

— Illicit opiates and psychostimulant drugs, as hydrocodeinone and methamphetamine. These drugs, made of pharmaceuticals countaining codeine and ergoffeine, and manufactured in clandestine laboratories, are increasingly popular in the markets of the West and North of Europe because of their quality and affordable price. Both types of production are notably rising and are not fully controlled by the Czech authorities.

1.1.3 Consumer Country

Increasingly, the Czech Republic is also becoming a consumer country. According to a combined study, there were some 10 000 people misusing non-alcoholic narcotic and psychotropic substances in 1992. This number seems more likely to be just the tip of the iceberg, and the real number is probably several times higher. Pattern of consumption have been changed since 1990, and it is necessary to illustrate this change in more detail.

1.2. TRADITIONAL PATTERNS OF CONSUMPTION

Traditional patterns were developed in the 70's and early 80's. More than a half of consumption was divided between pharmaceutical (analgetics, hypnotics, tranquilizers and stimulants) and volatile substances. The rest was represented by illicit domestic production of marijuana, methamphetamine and hydrocodeinone.

Typically, both the production and consumption took place in very small and closed communities inside the population of big cities and industrial aglomerations. These producer - consumer groups were characterized by close mutual relationships between the members; they were, however, isolated from each other. This was an appropriate way to survive in a society with a high degree of police control.

1.3. NEW DEVELOPMENT AFTER 1989

After the collapse of the communist regime, these traditional patterns underwent a profound change. Particular factors in this were as follows:

— Free travelling and free trade.

— Changes in values: adoption of s.c. "western" patterns of lifestyle, and identification of drug consumption with freedom, particularly among youngsters.

— Withdrawal of control by the police and state authorities in many aspects of life.

Characteristics of the new patterns development:

— While abuse of pharmaceuticals remained rather stable, an alarming increase in incidence of inhalant abuse and addiction has been reported, particularly in very young age groups.

— Supply and demand of domestic illicit drugs increased notably. Spreading and opening of the formerly closed production - consumption groups, higher organization of domestic illegal market and separation of supply side and demand side are characteristic features of the new era.

— Accessibility of imported drugs for s.c. recreational use (i.e. cannabis and hallucinogens increased, and consumers of these drugs have formed a new, specific culture linked to rock clubs and home parties).

— Traces of imported hard drugs (heroin, cocaine) in the sortiment of domestic supply have risen since 1990. This corresponds to the first heroin patients registered by the health services after 1991. Until now, heroin has appeared more as a spillover of transit along the Balkan Route, and the domestic market is still narrow. Compared with Slovakia or Hungary, development of a high problem group of heroin consumers is much slower, which cannot be explained by the lack of convertible currency alone. There is a hypothesis that persisting consumption of traditional home-made drugs like hydrocodeinone and methamphetamine might act to temporarily resist the use of imported hard drugs.

1.4. DREGS-RELATEDCRIME

Law enforcement statistics (police arrests and court cases) have been doubled since 1990. Drug related criminality is organized on a higher level than ever before. Domestic criminal networks have been spreading in big cities and urban aglomerations, partly in competition and partly in connection with international organized crime. There are signals that the international heroin and cocaine business has launched a marketing strategy to conquer new markets in Central and Eastern Europe, exploiting all the weaknesses of the "period of transition" in these countries.

I.5.CLIKi\TS- PROFILES

In spite of profound changes in the last five years, there are some trends in the clients profiles that can be traced backwards to the mid 80's. Most significant recent trends are as follows:

— The first contact with drugs moved down to lower age groups.

— Women's drug abuse is on the increase. It was estimated in 1992 that approximately 20% of all cases were women. However, other experts reported that in Prague the male:female rate was almost 1:1a year later.

— Multiple drug abuse is increasingly recognized. This polypragmatic consumption obviously reflects a tendency to combine the supply of various segments in the market.

— The number of suicide attempts related to drug abuse and the number of drug-related deaths is increasing.

— There is high psychiatric co-morbidity, particularly depression, anxiety disorders and personality disorders.
— The number of intravenous administrations has increased. Estimations vary from 25% (country-wide) to almost 70% (clients of special centres in Prague). Relations to HIV/AIDS infection have not been registered: in 1993 no case on the national register of HIV/AIDS infection was linked to intravenous drug administration.
— The hidden population increased significantly. The national health statistics shou the number of drug-related patients registered in state clinics for alcohol and drug treatment decreased notably in 1986-1992 period. Most new trends took place apart from statistical evidence, being reported only by individual experts and independent centres.

2. FORMATION OF THE NATIONAL DRUG POLICY

2.1 .YEARS OF AN "UNBALANCED APPROACH"

Under the communist regime before 1989, the problem of drugs was severely underestimated and hindered by taboo. There was neither political will nor space for an independent body to tackle the apparently increasing problems (though not increasing to the levels of developed European countries). However, the trend was obvious, and the country was not ready to confront it.

Comparatively better prepared were law enforcement agencies. In the final years of Czechoslovakia, special forces of the Police and the Customs were established, and after the "velvet divorce" of the Czechoslovak Federation, they were able to form a solid basis for drug enforcement in the Czech Republic. Of course these were only the fundamentals and not a completed system corresponding to usual standards in developed Europe; but even this was in strong contrast with the minimal readiness on the side of demand reduction.

In this area the legacy of the regime before November 1989 was still severe. Primary prevention of drug abuse or special counselling, therapeutic and rehabilitation services at the stage of promising, but non-systematic and sporadic beginnings. A difficult problem was the absence of reliable data on medical and social aspects of drug-related problems. The relevant governmental departments (Ministry of Health, Ministry of Education, Ministry of Social Affairs) did not regard drug-related problems as their priorities. In the absence of a national drug policy (which failed to be drawn up also because of the Czecho-Slovak competence disputes during the last years of Czechoslovakia's existence), many domestic and foreign experts warned seriously that the danger of drugs was rising without appropriate measures being taken by the Government.

2.2 CHRISTMAS MEMORANDUM

In this sense, the FILIA Foundation, an influential NGO in the field of mental health and drugs demand reduction, sent in December 1992 the Christmas Memorandum on Drug Pohcy to the government of the Czech Republic. In the Memorandum, the Foundation addressed the Prime Minister and some relevant members of the Cabinet and asked them to initiate a national policy which the voluntary sector could join.

2.3. TNTERMFATSTERIAL COMMISSION ESTARLISHED

In January 1993, the Cabinet resolved to establish the Interministerial Commission for Narcotic Drugs and to charge it to act as an initiative, advisory and coordination

body and to prepare the necessary measures. In early March 1993, the Commission was established, being composed of representatives of eight governmental departments and chaired by the Minister of Interior who had taken up the initiative an provided an institutional basis for the Commission. Over several months, the Commission elaborated a draft of a basic governmental document, "The Principles and Programme of Drug Policy", which was later adopted by the Cabinet and passed through relevant Parliamentory Committees.

The Commission has also formed several working groups for providing consultancy and expertise in various areas of the comprehensive and multidisciplinary policy, e.g. in law enforcement, primary prevention, epidemiology, treatment and rehabilitation, legislation etc.

In accordance with the recommendation of Parliament, the government is preparing a higher status of the Commission, which should consequently consist of the Cabinet Ministers. This would mean more executive power for the body and could help essentially in implementation of the governmental programme.

2.4. PRINCIPLES OF THE GOVERNMENTAL DRUG POLICY

The main principles of the governmental drug policy, contained in the document "The Principles and Programme of Drug Policy in the Czech Republic" (1993), can be characterized as follows:

— Drug abuse and illicit manipulation with drugs represent danger to the building up of a free and democratic society in the Czech Republic.
— The central motif of the government drug policy must be the protection of citizens from the destructive impact of drugs and promotion of their individual decision to live without drugs.
— The government has adopted the balanced approach (in the sense of UNO, articulated particularly in the Global Action Plan, 1991). This approach will combine measures for both supply and demand reduction. Underestimation of which ever of these strategies is unjustifiable.
— The Czech Republic is far from using all the possibilities of the balanced approach. It is therefore incorrect and unsuitable in terms of time to make the legalization of drugs, though partial, a political principle. Itdoesnot mean to make legalization a taboo, but to assign to it a level of professional discussion and analysis of foreign experience. Any isolated step of the Czech Republic in this direction could afflict our position in Europe.
— Effective anti-drug policy must be interdepartmental, interdisciplinary and intersectoral, paying a prior attention to the geographical areas most at risk, and coordinated on appropriate levels.
— The international dimension of drug- related problems requires involvement of the Czech Republic in the international cooperation.
— Policy objectives have to be realistic. Drugs areaa reality in Europe as well as in the world we belong to. An absolute target of a "world without drugs" is not achievable in the near future. It is possible to determine the objectives for the nearest future (1993-1996) in the following way:
— to make use of the balanced approach to reduce the illicit drug supply and demand,
— to adopt measures for the sake of coping with the assumed growth of drug-related problems,
— to obtain valid knowledge of the drug scene and its dynamics.

3. SUPPLY REDUCTION

The intention of this report is primarily concerned with demand reduction strategies and measures. However, priorities in supply reduction set up by the government programme should be mentioned.

3.1. PRIORITIES OF LAW ENFORCEMENT AGENCIES

The main role in drug enforcement is played by the Police of the Czech Republic (i.e. the National Police) through its analytic, managing and executive sections. A partner of the Police is the Customs Administration. Both Agencies will focus on the development of their special sections, particularly in main risk localities and will modernize their organization, methods of work and mutual collaboration.

The priority will be in enforcement of higher stages of the organized crime (particularly the international criminal organizations). The street distribution of drugs cannot be tolerated but the forces and instruments of law enforcement agencies must be used with regard to the danger to the society.

Appropriate legislation will be adopted and measures implemented to restrict the penetration of illegal profits to the legal economy and public life.

3.2. ADMINISTRATIVE CONTROL

The aim of the administrative control of legal distribution of narcotic and psychotropic substances is to regulate their quantity in the legal market, monitor their movement and preclude their escape to the illegal market. This control was easy in the conditions of the state monopoly, whilst now, when the number of authorized producers, distributors and customers has grown considerably, it is becoming more and more difficult. Also the control of precursors, required by the UN Convention of 1988, demards new principles and organization of this activity. This will be the task of the Inspectorate of Narcotic and Psychotropic Substances, a new control agency, which is about to be established by the Ministry of Health in collaboration with other governmental authorities.

1.PRIMARY PREVENTION

4.1. AIMS OF THE GOVERNMENTAL PROGRAMME

The present situation in drug-related problems is a particular challenge for primary prevention, and this was also confirmed by the document "The Principles and Programme of Drug Policy". Priority must be given to primary prevention in children and youngsters through family, school, peers and attractive personalities of music, sports and games etc.

Primary prevention should be a field of interdisciplinary intersectoral cooperation. The National Centre for Health Promotion, a governmental agency run by the Ministry of Health should be focused on the methodology and model programmes. However, other governmental départements, e.g. Ministry of Education, Youth and Sports and Ministry of Defence have also been charged to develop programmes of primary prevention in their areas of competence. A wide activity of NGOs should be supported by the governmental grants. Coordination should be provided by the Interministerial Drug Commission and its working group for primary prevention.

•1-2. CURRENT ACTIVITIES AND PROBLEMS

In a very short time considerable work has been done. The National Centre for Health Promotion has developed many projects and launched the media campaign "Maják" (The Lighthouse), However the Centre with its restricted staff and limited resources cannot manage all, and actions of other governmental departments and agencies is still hardly visible. The network of health promotion units at district and regional hygienic stations and/or hospitals is moving ahead very slowly also, although several remarkable programmes in the field have been initiated.

There is a notable activity of NGOs mainly in Prague but also in other cities (Brno and elsewhere). Among them, FILIA, DROP-IN, Foundation of CHARTA 77, FIT-IN, SODA, SANANIM, PODANÉ RUCE and PASTOR BONUS should be mentioned. Similarly as the National Centre for Health Promotion, the NGO sector has been involved in programmes for schools, in projects of "teaching the teachers", in "peer programmes" and in production of printed materials, leaflets, brochures and resource books. Poster competitions, exhibitions and concerts of popular music have been also organized successfully.

Last Autumn, an international seminar on primary prevention was held in Prague in collaboration with WHO/EURO. According to the foreign experts, programmes of primary prevention in the Czech Republic were on a very high level and compared well with programmes in developed countries. However, a concerted activity and targeted intersectoral collaboration is still at the beginning, and also financial situation both of statutory and voluntary agencies does not allow them to do all necessary activities and to meet the needs of schools, communities, parents etc.

5.TItE\T>lENTAINl»ItEIIABII

.1.1 .Missing services

The past system of health care (hierachically managed,with 100% state provision and state financing)did not allow development of appropriate services for drug consumers and addicts. The care was provided by wards in psychiatric hospitals and by outpatient treatment centers together with the care of alcoholics. Only part of these ambulatory clinics was able to work successfully for patients with drug-related problems. Lack of specialized services for non-alcoholic substance abusers and addicts has remained glaring in the whole country.

5.2.Current development and problems

In present, the health care system is in a period of transition to a system based on the social health insurance, a public-private mix of services, decentralisation and free choice of providers. Under these conditions, some alcohol and drug clinics may develop special programmes for drug users, while many others will remain unattractive for them. A few non-governmental organizations offering more specialized care have emerged, e.g.DROP-IN, SANANIM, DOMUS, HARMONIE.

New types of services, particularly community based centres and centres for long-term rehabditation in the therapeutic community, will be needed in the near future. Although these services would not probably be provided by the state sector, the government has to insist on these services to be part of the range of health and social services , and to stimulate their development. The ministry of Health and Ministry of Labour and Social Affairs should provide the necessary conceptual, legal and financial framework for this.

6.1. STARTING FROM THE POINT ZERO

Working on the document "Principles and Programme of Drug Policy", the Interministerial Commission faced insufficient the invalid knowledge of the drug scene and of its dynamics. The absence of essential epidemiological and research data, and the imperfect health statistics did not allow building a policy on the basis of knowledge and the formulation of precise intentions and objectives. Therefore, to improve the quality and extent of information and its scientific processing became a prior objective in the Governmental programme.

Establishing a comprehensive and up-to-date drug epidemiology will enable qualified decision-making in the future. However, the necessary intervention cannot be postponed and introduced only after reliable data have become avaUable. Real knowledge of drug-related problems and managing them in practice are inseparable from each other.

6.2. RECENT ACTIVITIES

6.2.1. Institutional Framework

The National Centre of Drug Epidemiology has been established at the National Institute of Public Health (formerly the Institute of Hygiene and Epidemiology, run by the Ministry of Health). In regions and districts, centres for drug epidemiology will be formed at the respective hygienic stations, and this has already been done in Prague and in other bigger cities. The national coordinator of drug epidemiology has been appointed by the Minister of Health, while the Interministerial Drug Commission and its working group for epidemiology could also help substantially.

6.2.2. National Surveillance

The project of the national surveillance has proposed "standard" studies through-out the whole country, and specific surveys tailored to local needs. Both types involve an inter-agenoy approach and collaboration with law enforcement agencies, schools, health services and health insurance institutions.

6.2.3. Multi-C it v Project

Recently, the Capital of Prague has been accepted as a Member City of Multi-City Programme on Drug Abuse Trends, managed by the Pompidou Group of the Council of Europe. It is expected that this will help not only Prague but the whole country in improving quality and compatibility of data.

6.2.4. Rapid Assessment

The project of Rapid Assesment, developed in cooperation with UNDCP, will use also qualitative methods and should contribute considerably to the planning and decision making in demand reduction.

TTHARM REnfc^M^STRATEGDS

7.1. Public health approach to drug addiction

Intra-venous drug users and "hard core" drug addicts are being a substantial part of drug using population, in which the HIV risk behaviour including needle sharing and sexual promiscuity has been frequently reported. Moreover, many of intra-ve-

nous drug users have never been in contact with health or social care professionals, and therefore this hidden population is exposed to a high risk of health and social consequences from their drug using behaviour.

Even though the seroprevalence of HIV among intra-veneou drug users was reported 0% in 1993, the threat of an HIV epidemic is a driving force of HIV/AIDS prevention programmes throughout the country.

7.2. Recent activities

7.2.1. DROP-IN, FIRST CONTACT CENTRES:low treshold centres are operating in Prague and Brno, and most recently they are being introduced also in some other bigger cities. This is an alternative to the existing network of outpatient alcohol and drug treatment centres which are operating in other areas.

7.2.2. Legal access to sterile injection equipments covered by the syringe and needle exchange programmes which have been introduced at first in Prague, but recently they are being expanded into other "high risk" geographical areas. The expansion of over-the-counter sales in pharmacies is another HIV prevention possibility, particularly important outside the bigger cities.

7.2.3. Community outreach to intra-venous drug users to disseminate HIV/AD3S information and to build trust between drug users and health care workers is being introduced in Prague and Brno, and hopefully will be expanded in other geographical areas.

7.2.4. HTV Counselling and Testing as a way of AIDS prevention is recently more availble also to drug using population.

7.2.5. As methadone maintenance programmes are still waiting for an official approval, an experimental ethyunorphine maintenance programme has been developed in the DROP-IN centre in Prague.There is a lot of prejudices against this and the other components of harm reduction strategy, but a more pragmatic public health approach will be probably introduced very soon and extensively.

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