



National Monitoring
Centre for Drugs
and Addiction

Drug situation in the Czech Republic in 2018



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Drug situation in the Czech Republic in 2018: Collection of processed EMCDDA workbooks

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National Monitoring Centre for Drugs and Addiction

nábřeží E. Beneše 4, 118 01 Praha 1

Tel.: +420 296 153 222

www.drogy-info.cz

Authors: Viktor Mravčík, Pavla Chomynová, Kateřina Grohmannová, Barbara Janíková,
Tereza Černíková, Hana Fidesová

Responsible editor: Johana Kozová

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1 Drug Policy

1.1 Summary

The main political document guiding the drug policy in Czech Republic was the National Drug Policy Strategy for the Period 2010–2018 (approved 10th May 2010 by the Government). Since the year 2010 two revisions of the National Strategy were approved – in December 2014 and January 2016. The originally drug focused strategy incorporated the issues of alcohol and gambling (in 2014) and the issue of tobacco (in 2016). The National Strategy was further developed by action plans that are drafted for a shorter period and set more specific priorities and activities in drug policy. In 2016 four action plans of the National Strategy were in force - action plan focused: on illicit drugs (2016-2018), on alcohol issues (2015-2018), on tobacco control (2015-2018) and on gambling (2015-2018). The action plan on alcohol issues and on tobacco control – both are also the implementation instrument of the strategy Health 2020. In 2018, the National Strategy 2010–2018 expired.

In May 2019, the Czech government approved a new National Strategy for the Prevention and Reduction of Harms Related to Addiction Behaviour 2019-2027 (National Strategy 2019-2027), which fully integrates the themes of legal and illegal addictive substances and behavioural addictions. The main strategic objective of the National Strategy 2019–2027 is to prevent and reduce health, social and economic harms resulting from substance use, gambling and other addictive behavior and from the existence of legal and illegal markets for addictive substances, gambling and other addictive potential products. The National Strategy 2019-2027 focuses on the following topics: strengthening prevention and awareness-raising, ensuring a high quality and accessible network of addictology services, effective regulation of the markets for addictive substances and addictive products, strengthening governance, coordination and effective funding of drug policy. Special topics are abuse of psychoactive medicines, overuse of modern technologies and cannabis and cannabinoids. The objectives, activities and tools of the 2019-2027 National Strategy will be elaborated in more detail in the Action Plan for the Implementation of the 2019-2027 National Strategy for the Prevention and Reduction of Addiction Behavior, which will be common to all areas (alcohol, tobacco, illicit drugs and psychoactive drugs, gambling and behavioural addiction).

In 2019, the previous National Strategy 2010–2018 and its Action Plans were evaluated. The evaluation has shown that the strategic goals have been achieved only to a limited extent, both in reducing drug use and gambling in the population and in reducing the prevalence of problematic forms, and in reducing negative health and social impacts. The objectives were not met even in the area of substances supply.

The development and enforcement of the national drug policy is the responsibility of the Government of the Czech Republic. The implementation and coordination of the Czech Republic's drug policy takes place at two non-interchangeable levels, central and regional (local), while employing instruments for horizontal and vertical coordination

The main Government advisory and coordination body for drug-related issues is the Government Council for Drug Policy Coordination (GCDPC). Its main spheres of activity are the development of a comprehensive national strategy, its coordination, and collaboration in practical implementation at the central and local levels. The members of the GCDPC are the heads of the relevant ministries involved in dealing with the issue of integrated drug policy as well as members of civil society - regions, NGOs, professional society of addictive diseases, society of addictologists, expert on drug issues nominated by the chairman. For specific tasks and areas of drug policy the GCDPC has established 6 committees and 7 working groups.

The executive body of the GCDPC, responsible for day-to-day coordination is the Secretariat of the GCDPC established at the Office of the Government of the Czech Republic. Head of the Secretariat is the National Drug Coordinator who is also at the same time the vice-chair of the GCDPC. In 2018, there was a change in the position of the National Drug Coordinator. Secretariat of GCDPC is also responsible for GCDPC's working groups and committees. Part of the Secretariat of GCDPC is the National Focal Point. The NFP has its own working groups on specific area of monitoring.

The core means of the coordination of regional and municipal drug policies are drug coordinators, drug commissions and working groups, drug policy strategies and action plans, and evaluations/monitoring of the drug situation on the regional level. These coordination mechanisms exist in each region of Czech Republic. The regional drug coordinators form one of the GCDPC committee where they meet regularly.

In 2018, expenditures on integrated drug policy (all areas: alcohol, tobacco, illicit drugs, gambling) from the budgets of state administration and local government totaled CZK 2121.6 million (CZK 1755.6 million in 2017), of which state budget expenditures amounted to CZK 1771.0 million and expenditures from budgets of municipalities CZK 350.6 million (regions CZK 259.2 million and municipalities CZK 91.4 million). In 2018, expenditure increased at all levels and for all types of services and policy areas in the area of addiction.

State budget expenditures increased year-on-year by CZK 317.5 million, of which the highest increase was recorded by the Police of the Czech Republic (by CZK 180.6 million), MLSA (by CZK 84.4 million) and GCDPC (by CZK 45.6 million). CZK 9 million). Expenditures from local budgets (regions and municipalities) increased in total by CZK 48.4 million, most notably in the Hradec Králové (CZK 22.6 million), Karlovy Vary (CZK 9.3 million) and Liberec (CZK 4.8), a year-on-year decrease was recorded in the Olomoucký (CZK 5.6 million) and Pardubický (CZK 0.4 million) regions.

In addition, health insurance expenditures for treatment of substance abuse disorders in 2017 (latest available data) amounted to CZK 1798 million (CZK 1818 million in 2016), of which CZK 1195 million was spent on alcohol-related disorders and for the treatment of disorders caused by other drugs CZK 603 million. Addictology (AT) programs received CZK 275 million (CZK 270

million in 2016) from health insurance expenditures for the treatment of substance abuse disorders.

1.2 National profile

1.2.1 National drugs strategies

Table 1 - All past national drug strategies and supporting action plans

Timeframe	Title and web link	Scope (main substances / addictions addressed)
1993-1996	Conception and programme of drug policy for the period 1993–1996 (not published on website)*	Illicit drugs
1998-2000	Conception and programme of drug policy for the period 1999–2000 (not published on website)*	Illicit drugs
2001-2004	National Drug Policy Strategy for the period 2001-2004 (not published on website)*	Illicit drugs, very partially focuses also on alcohol and tobacco
2005-2009	National Drug Policy Strategy for the period 2005-2009: EN - https://www.drogy-info.cz/data/obj_files/1611/306/Strategy_05-09_EN_web.pdf CZ - http://www.vlada.cz/assets/ppov/protidrogova-politika/dokumenty/publikace/Strategie_05-09_CZ_web.pdf	Illicit drugs
2005-2006	Action Plan of the National Drug Policy Strategy Implementation for the period 2005-2006: https://www.drogy-info.cz/data/obj_files/1610/304/AkcniPlan_web.pdf	Illicit drugs
2007-2009	Action Plan of the National Drug Policy Strategy Implementation for the period 2007-2009: EN - http://www.vlada.cz/assets/ppov/protidrogova-politika/dokumenty/ACTION_PLAN_2007-2009_web.pdf CZ - https://www.drogy-info.cz/data/obj_files/1609/303/akcni_plan_realizace_narodni_s_strategie_protidrogove_politiky_2007-2009_web.pdf	Illicit drugs
2010-2018	National Drug Policy Strategy for the period 2010-2018: EN - https://www.drogy-info.cz/data/obj_files/1606/627/National_Drug_Polici_Strategy_Czech-Republic_2010.2018_v2.pdf CZ - http://www.vlada.cz/assets/ppov/protidrogova-politika/dokumenty/narodni-strategie/nspp_2010-2018_v02.pdf	Illicit drugs
	National Drug Policy Strategy for the period 2010-2018 (first revision in 2014): http://www.vlada.cz/cz/ppov/protidrogova-politika/strategie-a-plany/revize-narodni-strategie-protidrogove-politiky-na-obdobi-2010-az-2018-125887/	The first revision focused on inclusion of gambling and alcohol
	National Drug Policy Strategy for the period 2010-2018 (second revision in 2016): http://www.vlada.cz/assets/ppov/protidrogova-politika/strategie-a-plany/NSPP_revize_II.pdf	The second revision focused on inclusion of tobacco
2010-2012	Action Plan of the National Drug Policy Strategy Implementation for the period 2010-2012: http://www.vlada.cz/assets/ppov/protidrogova-	Illicit drugs

	politika/dokumenty/akcni-plan/Akcni_plan_realizace_Narodni_strategie_protidrogove_politiky_2010-2012.pdf	
2013-2015	Action Plan of the National Drug Policy Strategy Implementation for the period 2013-2015: http://www.vlada.cz/assets/ppov/protidrogova-politika/media/akcni_plan_2013_2015.pdf	Illicit drugs
2015-2018	The Action Plan to reduce the harm caused by alcohol in the Czech Republic 2015-2018: http://www.mzcr.cz/Admin/upload/files/5/akcni%20plany%20-%20přilohy/AP%2004c_rev%20AV.pdf	alcohol
2015-2018	The Action Plan for tobacco control in the Czech Republic 2015-2018: http://www.mzcr.cz/Admin/upload/files/5/akcni%20plany%20-%20přilohy/AP%2004b_rev%20AV.pdf	tobacco
2015-2018	The Action Plan for the Drug Policy in the Area of Gambling 2015-2018: http://www.vlada.cz/assets/ppov/protidrogova-politika/strategie-a-plany/AP_hazard_2015_2018_31052017.pdf	gambling
2016-2018	Action Plan of the National Drug Policy Strategy Implementation for the period for the area of illegal drugs 2016-2018: http://www.vlada.cz/assets/ppov/protidrogova-politika/strategie-a-plany/AP_nelegalni_latky_2016_2018.pdf	Illicit drugs
2019-2027	National Strategy for the Prevention and Reduction of Harms Related to Addiction Behaviour 2019-2027: http://www.vlada.cz/cz/ppov/protidrogova-politika/strategie-a-plany/narodni-strategie-prevence-a-snizovani-skod-spojonych-se-zavislostnim-chovanim-2019_2027-173695/	Integrating all addiction topics: illicit drugs, alcohol, tobacco, gambling and other behavioural addiction

* See more about the previous strategies in the fact sheet *Zaostreno na drogy* (2009) Czech Drug Policy and its Coordination http://www.vlada.cz/assets/ppov/protidrogova-politika/dokumenty/publikace/Zaostreno_coordination_2009_www.pdf

1.2.1.1 Current national drugs strategy

On 13 May 2019, the Government approved the National Strategy for the Prevention and Reduction of Harms Related to Addiction Behaviour 2019-2027 (National Strategy 2019-2027). Like the previous strategy, the current one is conceived as a long-term strategy document for a period of 9 years.

The main strategic objective of the National Strategy 2019-2027 is “to prevent and reduce, in particular, health, social, economic and intangible damage resulting from substance use, gambling and other addictive behaviour and the existence of licit and illicit addictive substance, gambling and other addictive products markets through a sustainable set of modern, effective, coordinated and evidence-based educational, preventive, therapeutic, social, legislative, economic, repressive and other measures.

As a priority, the National Strategy 2019-2027 will focus on the following topics: strengthening prevention and awareness raising, ensuring a quality and accessible network of addictology

services, effective regulation of addictive substances and addiction products markets, strengthening management, coordination and effective funding of drug policy and 3 special topics (1) Abuse of psychoactive medicines, (2) Abuse of modern technology and (3) Cannabis and cannabinoids.

The main principles of the strategy are:

- European values
- an integrated approach to addiction
- scientifically proven effective measures and good practice
- a balanced approach between individual freedom and protection of society
- a balanced approach between law enforcement and preventive measures
- a differentiated approach according to the risk potential of addictive substances
- gambling and other addictive behaviour
- targeting available resources as a priority where there is the greatest damage or where the highest public health gains can be expected
- increased protection of minors
- coordinated action
- strengthening the role of self-governments
- participation of professional societies, service providers for persons with addictological disorders, other responsible institutions and clients
- shared responsibility, a rational, balanced and scientifically proven approach in international drug control.

The National Strategy 2019-2027 is based on the application of 4 basic strategic areas: (1) prevention, (2) risk and harm minimization, (3) treatment and re-socialization, (4) market regulation and supply reduction. These strategic areas are complemented by the following 4 support areas: (1) coordination and cooperation, (2) funding, (3) monitoring, information, research, evaluation, (4) international commitments, good practice, experience, international cooperation.

Objectives, activities and tools will be elaborated in more detail in the Action Plan for Implementation of the National Strategy for Prevention and Reduction of Harms Related to Addiction Behaviour 2019-2027, which will be common to all areas (alcohol, tobacco, illicit drugs and psychoactive drugs, gambling and behavioural addictions)

The main strategic documents for prevention in the education sector are the **National Strategy of Primary Prevention of Risky Behaviour of Children and Youth for the Period 2019-2027** and **the Action Plan for the Implementation of the National Strategy of Primary Prevention of Risky Behavior of Children and Youth for 2019-2021** adopted by the government in March 2019. <http://www.msmt.cz/vzdelavani/socialni-programy/strategie-a-koncepce-ap-msmt>

National Health 2020 strategy on the protection and health promotion and disease prevention, including their action plans - https://www.mzcr.cz/Verejne/dokumenty/zdravi-2020-narodni-strategie-ochrany-a-podpory-zdravi-a-prevence-nemoci_8690_3016_5.html

The Social Inclusion Strategy 2014-2020

https://www.mpsv.cz/files/clanky/17082/strategie_soc_zaclenovani_2014-20.pdf -

Defines the priority themes for the social inclusion of persons in the period to the year 2020 and for public budgets and the use of the European structural and investment funds of the European Union (EU) in the programming period 2014 - 2020. It also contains an overview of measures affecting social inclusion and combating poverty and of relevant materials and resources.

Addiction is perceived as one of the reasons for social exclusion. The aim (among others) is the reduction of economic, health and social effects associated with the abuse of drugs.

The Czech Republic 2015–2025 concept of social housing

https://www.mpsv.cz/files/clanky/27267/Koncepce_socialniho_bydleni_CR_2015-2025.pdf - the framework document, which defines the direction of building social housing for people in housing need in the Czech Republic. The concept is composed of several parts (introduction and conceptual considerations, analytical, strategic and Annex) and added is the regulation impact assessment (RIA). Drug addiction is identified as one of the risks associated with homelessness.

Crime prevention strategy in the Czech Republic for the years 2016 to 2020

<http://www.mvcr.cz/clanek/strategie-prevence-kriminality-v-ceske-republice-na-leta-2016-az-2020.aspx> The Strategy identifies the objectives, principles and priorities in the field of crime prevention and defines the system of crime prevention in the CZ at the level of the state, counties and municipalities. The issue of drug crime is defined in detail by 2010–2018 National strategy and its action plans. The Crime prevention strategy, due to effective coordination of drugs policy, includes only activities aimed at crime perpetrator, assistance to victims of crime, working with children and young people and prevention of crime in socially excluded locations.

Crime prevention action plan for the years 2016 to 2020 - <http://www.mvcr.cz/clanek/akcni-plan-prevence-kriminality-2016-2020.aspx>

- The Action Plan is divided into chapters that reflect the main priorities strategy / strategic objectives, which are: 1. Crime prevention system in the CZ. 2. Assistance to victims of crime, working with children and young people. 3. Work with the perpetrators of crime. 4. A comprehensive approach to prevention of crime in high-risk locations. 5. New threats and approaches to crime prevention. Further the Action Plan also contains chapter describing the coordination and control mechanisms of this material and the financing of tasks.

Concept of the development of the Police of the Czech Republic by 2020 (update 2017)

<http://www.ceska-justice.cz/wp-content/uploads/2017/04/Koncepce-rozvoje-Policie.pdf>

The document defines drug issues as one of the further development of police in the given period, and defines in this field 8 objectives: 1) an increase in the number of detected primary drug crime offences; 2) to reduce the availability of illegal drugs; 3) reducing the secondary

crime; 4) to cover new forms of criminal activities in the drug field; 5) to have sufficient capacity to cover all forms of drug crime, in particular in the public space, street and club distribution; 6) to provide active access to new types of synthetic drugs and chemicals in the environment and international trade in precursors, chemical substances and products used in the manufacture of drugs; 7) improving cooperation with foreign partners (in particular with law enforcement); 8) focus on new forms of committing a drug crime in virtual space, in particular the markets "DarkNet" and "Tor".

Concept of the fight against the organised crime up to the year 2023 (and its action plan) -

<http://www.mvcr.cz/clanek/bezpecnostni-hrozby-337414.aspx?q=Y2hudW09Mg%3d%3d>

Concept is based on an analysis of the current situation in the area of organised crime by proposals for measures aimed at creating long-term conditions for public authorities in the prevention, detection and sanctioning of organized crime on the territory of the Czech Republic. Proposed tasks are divided into several key areas that are: monitoring organized crime on the territory of the Czech Republic, the development of cross-border cooperation, strengthening national cooperation and systemic measures.

Concept of Prison System by 2025 - <https://www.vscr.cz/wp-content/uploads/2017/06/Koncepce-vezenstvi.pdf>

The concept includes 9 areas including drug issues. In the field of drugs, the main strategic objectives are: 1) to define a standardised system of effective and coherent support for drug users, that motivates to abstinence not only in the prison, but even after the end of the sentence, 2) effective protection of the prison environment from the in-leak of illegal substances, decrease the level of use of narcotic drugs and psychotropic substances and the prevention of the spread of drug addiction.

The strategic objectives are further elaborated in the following 5 specific objectives: 1) to ensure sufficient information and technical data from the field of adictology and security, 2) defend effectively the penetration of drugis into prisons and monitor the system penetration, 3) strengthen and prolong the care of drug users also after the completion of sentence, 4) to analyse and develop the existing system of care, 5) strictly enforce the law in the field of substance abuse.

Table 2 - Drug strategies and action plans at the regional level

Region	Year	Title and web link	Scope (main substances / addictions addressed)	Pillars / action areas
Prague Region	2014-2020	Drug Policy of the Capital City of Prague for the period 2014-2020 http://www.praha.eu/public/2d/46/78/1813594_456870_Protidrogova_politika.pdf	Illegal drugs, alcohol, tobacco, gambling	Prevention/treatment/resocialization/harm reduction
Zlín Region	2015-2019	Drugs policy concept in the region of Zlín Region for 2015 – 2019, http://www.kr-zlinsky.cz/docs/clanky/dokumenty/10832/konce	Illegal drugs, alcohol, gambling	Treatment/monitoring/prevention

		pce-protidrogove-politiky-zk-2015-19-fin.pdf		
Vysočina Region	2016-2019	Drug Policy strategy of the region of Vysočina Region for 2016-2019, https://www.kr-vysocina.cz/assets/File.ashx?id_org=450008&id_dokumenty=4071104	Illegal drugs, alcohol, tobacco, gambling	Primary prevention/harm reduction/treatment and social reintegration/supply reduction of psychoactive substances and gambling activities
Vysočina Region	2018-2019	Action plan for the implementation of the Drug Policy strategy of the region of Vysočina Region for 2018-2019 (not published)	Illegal drugs, alcohol, tobacco, gambling	See above
Ústí Region	2015-2018	Drug Policy strategy of the region of Ústí Region for 2015-2018, https://www.kr-ustecky.cz/assets/File.ashx?id_org=450018&id_dokumenty=1688473	Illegal drugs, alcohol, tobacco, gambling	Prevention/harm reduction/resocialization/coordination
Central Bohemian Region	2016-2020	Drugs policy concept in the region of Central Bohemian Region kraj for 2016 – 2020, https://www.kr-stredocesky.cz/documents/20875/5328045/Koncepce+PP/28013c2b-dc03-4dc9-8133-919e58c5b895	Illegal drugs, alcohol, tobacco, gambling	Coordination/prevention/harm reduction/treatment and aftercare/education
Central Bohemian Region	2017-2018	Action plan for the implementation of the Drug policy concept of the region of Central Bohemian Region for 2017-2018, https://www.kr-stredocesky.cz/documents/11836670/12409906/Ak%C4%8Dn%C3%AD%20PI%C3%A1n+2017-2018/3d0198ed-85c3-4660-9322-433ff55d5e49	Illegal drugs, alcohol, tobacco, gambling	see above
Pilsen Region	2017-2020	Concept of crime prevention and other risk behaviour of Pilsen Region region for 2017-2020, http://www.plzensky-kraj.cz/cs/clanek/koncepce-prevence-kriminality-a-socialne-patologickych-jevu-plzenskeho-kraje-na-leta-2017-202	Illegal drugs, gambling partially alcohol and tobacco	Criminality prevention/coordination/financing/prevention of risk behaviour/treatment/
Pardubice Region	2012-2018	Drug Policy strategy of the region of Pardubice Region for 2012-2018, https://www.pardubickykraj.cz/protidrogova-politika/69011/strategie-protidrogove-politiky-pardubickeho-kraje-na-obdobi-2012-2018	Illegal drugs, alcohol, tobacco	Prevention/coordination/harm reduction/treatment and resocialization/education, coordination and finance/law enforcement
Olomouc Region	2015-2018	Drug Policy strategy plan of the region of Olomouc Region for 2015-2018, https://www.kr-olomoucky.cz/strategie-koncepce-vyrocnizpravy-cl-281.html	Illegal drugs, alcohol, tobacco, gambling	Prevention/coordination/financing of drug prevention/international cooperation

Olomouc Region	2017-2018	Action Plan Action plan for the implementation of the Drug policy strategy of the region of Olomouc Region for 2017-2018	Illegal drugs, alcohol, tobacco, gambling	see above
Moravian-Silesian Region	2015-2020	Drug Policy strategy of the region of Moravian-Silesian Region for 2015–2020, https://www.msk.cz/assets/socialni_oblast/strategie-markova-2015-2020_1.pdf	Illegal drugs, alcohol, , gambling	Financing/evaluation/prevention/harm reduction/health and social services
Liberec Region	2015-2018	Drug Policy Plan of Liberec Region region for 2015-2015, https://odbor-socialni.kraj-lbc.cz/getFile/id:329463/lastUpdateDate:2015-11-04%2008%3A18%3A42	Illegal drugs, alcohol, tobacco, gambling	Prevention/treatment and resocialization/harm reduction/coordination and finance/law enforcement
Karlovy Vary Region		No Strategy or action plan. In 2019 in preparation.		
Hradec Králové Region	2017-2021	Strategy of the prevention of socially undesirable phenomena in the region of Hradec Králové Region 2017-2021, http://www.kr-kralovehradecky.cz/assets/krajsky-urad/socialni-oblast/socialni-prevence/prevence-kriminality/Strategie-prevence-socialne-nezadoucich-jevu-v-Kralovehradeckem-kraji-2017---2021.pdf	Illegal drugs, alcohol, tobacco, gambling	Monitoring/law enforcement/treatment /prevention/harm reduction
South Moravian Region	2010-2018	Drug Policy strategy of the region of South Moravian Region for 2010–2018, https://www.kr-jihomoravsky.cz/Default.aspx?ID=160292&TypeID=2	Illegal drugs, alcohol, gambling	Prevention/treatment and resocialization/harm reduction/repression/coordination/financing
South Bohemian Region	2018-2020	Drug Policy strategy of the region of South Bohemian Region for 2018–2020, https://www.kraj-jihocesky.cz/346/informace_k_drogove_problematice_v_jihoceskem_kraji.htm	Illegal drugs, alcohol, gambling	Prevention/finance/coordination/education/research and evaluation

1.2.1.2 Drug policy of the capital city of Prague for the period 2014-2020

The drug policy strategy of the capital city was adopted in March 2014. It is divided into conceptual and strategic part. The conceptual part maps actual situation, needs and possibilities of development, the strategic part addresses specific steps in individual years.

More specific objectives of the strategy:

(I) to reduce or at least to stabilize the number of problem drug users (II) move aside the experimental and recreational use of licit and illicit drugs and to emphasise on a healthy lifestyle without drugs (III) to maintain and to develop basic network of services (IV) to ensure the availability of missing services in system of care or to modify existing services in order to increase their accessibility to a broad clientele (V) to ensure the increase of professional competence level of services and to ensure the increase of their social prestige (VI) to increase

the quality of life for users of all types of drugs, their parents and relatives by ensuring the availability of all types of services in system of care based on comprehensive access to the personality of the client/patient (VII) to raise background facilities of service providers through adequate working opportunities and improve the prestige of the profession of teachers, workers in social services and addictologists (VIII) to improve the professional competences of local drug coordinators, service providers, to create synergies and promote mutual cooperation based on communication (IX) to improve the professional competences of district and school methodists for prevention of risk behaviour of children and youth (X) to develop appropriate economic and organizational conditions for service providers and to prevent the departure of skilled professionals to other areas of job opportunities. (Prague municipality, 2014)

This strategic document is accompanied by action plans. Year 2016 was the last year of the Action plan of drug policy of the capital city of Prague for 2014-2016¹ to be in force.

A new action plan has been drafted The Action plan of drug policy of the capital city of Prague in the year 2017 with the outlook for the year 2018². This action plan will be approved by the city municipal council in September 2017. The action plan contains in summary the evaluation of the previous action plan and then objectives and activities in the drug policy area that correspond to the 4 pillars of National Drug Policy Strategy and it's supporting cross-cutting areas.

The evaluation of previous action plan is based mostly on the analysis of situation described in the Annual report on the drug policy situation in the region (every region prepare this Annual report –see the coordination section 1.2.3). The evaluation is conducted by the Drug Policy Commission of the City of Prague.

Strategic drug policy documents of the City of Prague including the Annual reports on the drug situation can be found here:

http://www.praha.eu/jnp/cz/o_meste/magistrat/odbory/odbor_zdravotnictvi_socialni_pece/proti_drogova_politika/strategicke_dokumenty/index.html

The National drug strategy 2019-2027 explicitly states that it is based on EU Drugs Strategy (2013-2020) and Action Plan on Drugs (2017-2020), however no specific elements are mentioned. On the other hand there are certainly overlaps between EU and national documents.

1.2.1.3 Evaluation of national drugs strategies

In 2019, the previous National Strategy 2010–2018 and its Action Plans (illicit drugs, alcohol, tobacco control, gambling) were evaluated. The evaluation has shown that the strategic goals have been achieved only to a limited extent, both in reducing drug use and gambling in the population and in reducing the prevalence of problematic forms, and in reducing negative

¹ http://www.praha.eu/public/f1/ba/e/1897303_519645_Akcni_plan_2014_2016.pdf

² http://www.praha.eu/public/13/3/22/2524749_813821_Akcni_plan_2017_2018.pdf

health and social impacts. The objectives were not met even in the area of addictive substances supply.

In 2019, the National Strategy 2010–2018 and its Action Plans were evaluated. The subject of evaluation was both the implementation of action plans (process evaluation) and the achievement of strategic objectives of the National Strategy 2010–2018 (evaluation of results). This was an internal evaluation carried out by the Secretariat of the Government Council for Drug Policy Coordination (GCDPC). The Evaluation Report was approved by the GCDPC on 18 June 2019.

The evaluation of the action plans showed the following:

- The Action Plan for the implementation of the National Drug Policy Strategy 2015-2018 for illicit drugs contained a total of 102 activities in 7 areas: Specific Primary Prevention of Substance Use, Treatment of Substance Use, Risk Reduction, Reduced Availability of Legal and Illegal Drugs, Coordination and Financing monitoring, research, evaluation and international cooperation. 63 (62%) activities were fulfilled, 24 (24%) were partially fulfilled and 15 actions (15%) were not fulfilled.
- The Action Plan for the implementation of the National Drug Policy Strategy 2015-2018 for Gambling contained 65 tasks. 40 (62%), 11 (17%) partially completed, 13 (20%) missed, and 1 (2%) failed. The lowest level of performance was in the areas of risk reduction and prevention in the gambling population and public information and prevention in the general population - see Annual Report on Gambling in the Czech Republic in 2018 (Mravčík et al., 2019b).
- The Action Plan on Tobacco Control in the Czech Republic for 2015-2018 set medium-term objectives to contribute to protecting against the negative health, social and economic consequences of tobacco consumption and exposure to tobacco smoke. 56 activities were evaluated, of which 27 activities (48%) were completed by the end of 2018, and 28 other activities (50%) were partially fulfilled. 1 activity (2%) remained unfulfilled.
- From the Action Plan to Reduce Alcohol Damage for the period 2015 to 2018, out of the 54 activities assessed, 18 activities (33%) were completed by the end of 2018, and 26 other activities (48%) were partially fulfilled. 10 activities (19%) remained unfulfilled. 1 activity (2%) was not rated due to its elimination.

The National Strategy 2010-2018 set 4 basic objectives, which correspond to the 4 pillars of drug policy:

- reduce the level of experimental and occasional substance use, particularly by young people, reduce the level of gambling among children and young people,
- reduce the level of problem and intensive substance use and problem gambling,
- reduce the potential risks associated with substance use and problem gambling for individuals and society,

- reduce the availability of addictive substances, especially for young people, strengthen the legal regulation of gambling.

Evaluation of strategic objectives The National Strategy 2010–2018 showed that the strategic objectives were achieved only to a limited extent.

Evaluation of the fulfilment of the objective of reducing the level of experimental and occasional substance use, especially by young people, reducing the level of gambling among children and young people:

Area	Rating	Comments
Illicit drugs	+	Decrease in substance use, especially among children and young people, but the Czech Republic still ranks among the countries with the highest lifetime prevalence of cannabis use among children and young people.
Alcohol	+/-	In recent years, there has been a decrease in alcohol use among children and adolescents. However, alcohol consumption in the Czech Republic is very high and alcohol use is one of the most widespread risk behavior of adolescents.
Tobacco	+/-	The smoking rate in the adult population has been declining in the long term, stagnating in recent years. Experience with tobacco smoking among adolescents is decreasing, experience with electronic cigarettes is increasing.
Gambling	+/-	The prevalence of land-based gambling (with the exception of lottery playing) has decreased. On the other hand, there has been an increase in the prevalence of lottery playing and a significant increase in on-line betting.

Note: + indicates goal completion, +/- indicates partial goal completion, and - indicates non-goal completion. Source: http://www.vlada.cz/assets/ppov/protidrogova-politika/strategie-a-plany/Evaluace_Narodni_strategie_protidrogove_policy_2010-2018.pdf

Evaluation of the achievement of the goal of reducing problem and intensive substance use and problem gambling:

Area	Rating	Comments
Illicit drugs	-	The estimated number of problem drug users is on the rise, but is still below the European average.
Alcohol	+/-	Daily alcohol consumption in the adult population is very high and does not change significantly. The results of ESPAD indicate a decrease in (intensive) alcohol consumption among adolescents.
Tobacco	+/-	The prevalence of daily smoking in the adult population has been slightly decreasing over the long term, but has stagnated in recent years. Among adolescents there is a marked decrease in the rate of regular smoking.
Gambling	+/-	No long-term trends are available. The estimated number of problem players is relatively stable. The proportion of problem gamblers that play mainly EGMs is decreasing and the proportion of problem gamblers that play mainly table casino games and of problem gamblers that mainly bet on sports is increasing. The proportion of problem gamblers that gamble mainly on-line is also increasing.

Note: + indicates goal completion, +/- indicates partial goal completion, and - indicates non-goal completion. Source: http://www.vlada.cz/assets/ppov/protidrogova-politika/strategie-a-plany/Evaluace_Narodni_strategie_protidrogove_policy_2010-2018.pdf

Evaluation of meeting the goal of reducing the potential risks associated with substance use and problem gambling for individuals and society:

Area	Rating	Comments
Illicit drugs	+/-	The incidence of infectious diseases (especially HIV) among drug users and the number of overdose deaths have been low over the long term. The high estimated proportion of drug users' crime remains.
Alcohol	+/-	Mortality from alcohol use increased. On the other hand, a slightly decreasing trend in the number of hospitalizations, traffic accidents and drunken offenses can be observed.
Tobacco	+/-	There are insufficient data on trends in health impacts related to tobacco use in the Czech Republic. In lung cancer, there is a decrease in morbidity and mortality in men, but an increase in women, in chronic obstructive pulmonary disease, an increase in morbidity and mortality.
Gambling	Gambling cannot be evaluated	No long-term trends are available.

Note: + indicates goal completion, +/- indicates partial goal completion, and - indicates non-goal completion. Source: http://www.vlada.cz/assets/ppov/protidrogova-politika/strategie-a-plany/Evaluace_Narodni_strategie_protidrogove_policy_2010-2018.pdf

Evaluation of the fulfilment of the goal of reducing the availability of addictive substances, especially for young people, strengthening the legal regulation of gambling:

Area	Rating	Comments
Illicit drugs	-	The subjectively perceived availability of illicit drugs remains relatively high, especially for cannabis, ecstasy, pervitin and hallucinogenic mushrooms. Easier accessibility is perceived by men and respondents aged 15-29.
Alcohol	-	Act No. 65/2017 Coll., On health protection against the harmful effects of addictive substances, introduced some measures to reduce availability, yet alcoholic beverages are relatively readily available to minors and there was no significant reduction in the availability of alcohol during the reporting period.
Tobacco	-	Act No. 65/2017 Coll. has introduced some measures to reduce availability, yet tobacco products are relatively easily accessible to minors; there has been no significant reduction in the availability of tobacco products during the reporting period.
Gambling	+	Act No. 186/2016 Coll., On gambling, has contributed to the reduction of availability of electronic gaming machines, and has strengthened the regulation of gambling.

Note: + indicates goal completion, +/- indicates partial goal completion, and - indicates non-goal completion. Source: http://www.vlada.cz/assets/ppov/protidrogova-politika/strategie-a-plany/Evaluace_Narodni_strategie_protidrogove_policy_2010-2018.pdf

1.2.2 Drug policy coordination

1.2.2.1 Coordination at the national level

The main coordination body for the issues related to the drug policy is **The Government Council for Drug Policy Coordination** (GCDPC). Its main spheres of activity are: the development of a comprehensive national strategy, its coordination, and collaboration in practical implementation at the central and local level. The members of the GCDPC are the heads of the relevant ministries involved in dealing with the issue of integrated drug policy as well as the members of professional associations.

The mandate (Statute) of GCDPC is officially approved by the Czech Government. This mandate has been changed in 2014 in relation to the change in drug policy definition (mentioned above in T1.1) - the mandate has been extended to the so called integrated drug policy - one policy on substance abuse and compulsive gambling, associated dependency disorders and other health and social impacts and consequences.

Following above mentioned also the number of members increased in 2014. The GCDPC was expanded to three new members - Ministry of Agriculture, Ministry of Industry and Trade and the Czech Association of addictologists. In July 2016 the Government approved the expansion of the membership for other two members - Minister of Foreign Affairs and the Association of providers of social services.

The members of the Government Council for Drug Policy Coordination in 2016 are:

- Prime Minister (Chairman of the GCDPC),
- National Drug Coordinator (Vice-Chairman of the GCDPC),
- Minister of Health, minister of the Interior, minister of Education, Youth, and Sports, minister of Labour and Social Affairs, minister of Justice, minister of Defence, minister of Finance, minister of Agriculture, minister of Industry and Trade, minister for Human Rights and Minorities (if appointed by the government), Minister of Foreign Affairs
- Association of Czech Regions, Association of professional NGOs working in the prevention and treatment of addictions, Society for Addictive Diseases of the J. E. Purkyne Czech Medical Association, Czech Association of addictologists, Association of Providers of Social Services, expert on drug issues nominated by the chairman of the GCDPC.

The GCDPC has established 5 Committees to facilitate the implementation of key drug policy initiatives/activities and to analyse the development of the drug situation in the Czech Republic. The committees involved in the implementation of the key drug policy initiatives/activities include:

GCDPC's Committee of Departmental and Institutional Representatives – a committee where the members of staff responsible within their ministries for the implementation of measures and activities related to drug policy meet on a regular basis to discuss issues concerning procedures and cooperation in public administration, particularly at the central level.

GCDPC's Funding Committee – discusses funding/project applications for drug policy programmes and submits proposals to the GCDPC for approval. A subsidy for services subject to certification is conditional upon the provision of a valid quality certificate

Certification Committee – makes proposals to the GCDPC for granting, not granting, or removing professional certifications which guarantee the quality of a service.

Committee of Regional Representatives – established to facilitate better coordination between the state and local government.

GCDPC's Advisory Committee for Addiction-Related Data Collection – oversees the National Monitoring Centre's activities in monitoring the situation in the field of drug use and gambling and its consequences. The committee also discusses and approves the Annual Report on the Drug Situation in the Czech Republic and the Annual Report on the situation in gambling in the Czech Republic.

Further to the above mentioned Committees the GCDPC has also established a **working groups** that deal with specific drug policy issues or needs and deliver the tasks laid down in the Action Plan for implementing the National Drug Strategy. In connection with the extension of the mandate of GCDPC on integrated drug policy a new organization of working and advisory bodies was approved in 2015 as follows:

- Working group for the issues of illicit drugs
- Working group for alcohol issues

- Working group for the issue of gambling
- Working group for the issue of tobacco
- Addictological Forum
- Working group for the medical use of psychoactive substances and plants
- Working group for funding of drug policy
- And further 6 working groups NMC:
 - for population and school surveys
 - for deaths associated with drug use
 - for law enforcement data
 - for problem drug use and addiction services
 - for infectious diseases associated with drug use
 - for monitoring gambling and its effects
 - The early warning system on new drugs.

The executive body of the GCDPC, responsible for day-to-day coordination is the Secretariat of the GCDPC established at the Office of the Government of the Czech Republic. Head of the Secretariat is the National Drug Coordinator who is also at the same time the vice-chair of the GCDPC. Secretariat of GCDPC is also responsible for GCDPC's working groups and committees. Part of the Secretariat of GCDPC is the National Focal Point.

Important note:

The implementation of drug policy and its coordination mechanisms had its legislative framework (defined in the legislation) since 2005 in the act no. 379/2005 Coll., on measures to protect against damage caused by tobacco products, alcohol and other addictive substances. In the year 2017 a new law no 65/2017 Sb. for the protection of health against the harmful effects of addictive substances was adopted by which the area of the implementation and coordination of drug policy was modified (see also WB on legislation).

Law no 65/2017 Sb. newly gives the obligation to the Government to adopt at least once every 10 years the National drug strategy. The Government on the basis of this act may establish its advisory body for drug policy (this provision is the same as in the previous legislation), **and may establish the function of a national coordinator for drug policy** (this provision is new). In the field of financing of drug policy the law imposes on the government and ministries to participate in "ensuring measures" provided for in the National strategy of drug policy. This provision is rather weaker than the previous one (the previous provision stated directly that "the ministries are responsible for financing the drug policy measures..."). New provision in the law is considered by the professional society to be a threat for the future for the implementation and financing of drug services and other drug policy measures (see also 1.3).

1.2.2.2 Coordination at the local level

The core means of the coordination of regional and municipal drug policies are drug coordinators, drug commissions and working groups, drug policy strategies and action plans, and evaluations/monitoring of the drug situation on the regional level. Regional drug coordinators prepare annual reports on the implementation of regional drug policies.

The **Regional Drug Policy Coordinator** provides the key link in transferring information and measures from the national level to the regional and local levels and vice versa. The coordinators are employed by the respective regional authorities. Their position in the structure of the regional authority is not unified and in most cases the drug policy coordinators, despite being appointed on a full-time basis, cover other areas as well, e.g. crime prevention or regional grant schemes. Regional drug policy coordinators draft Annual Reports on the Regional Implementation of the Drug Policy that have the same structure across all the regions. They submit these to the GCDPC Secretariat on a voluntary basis.

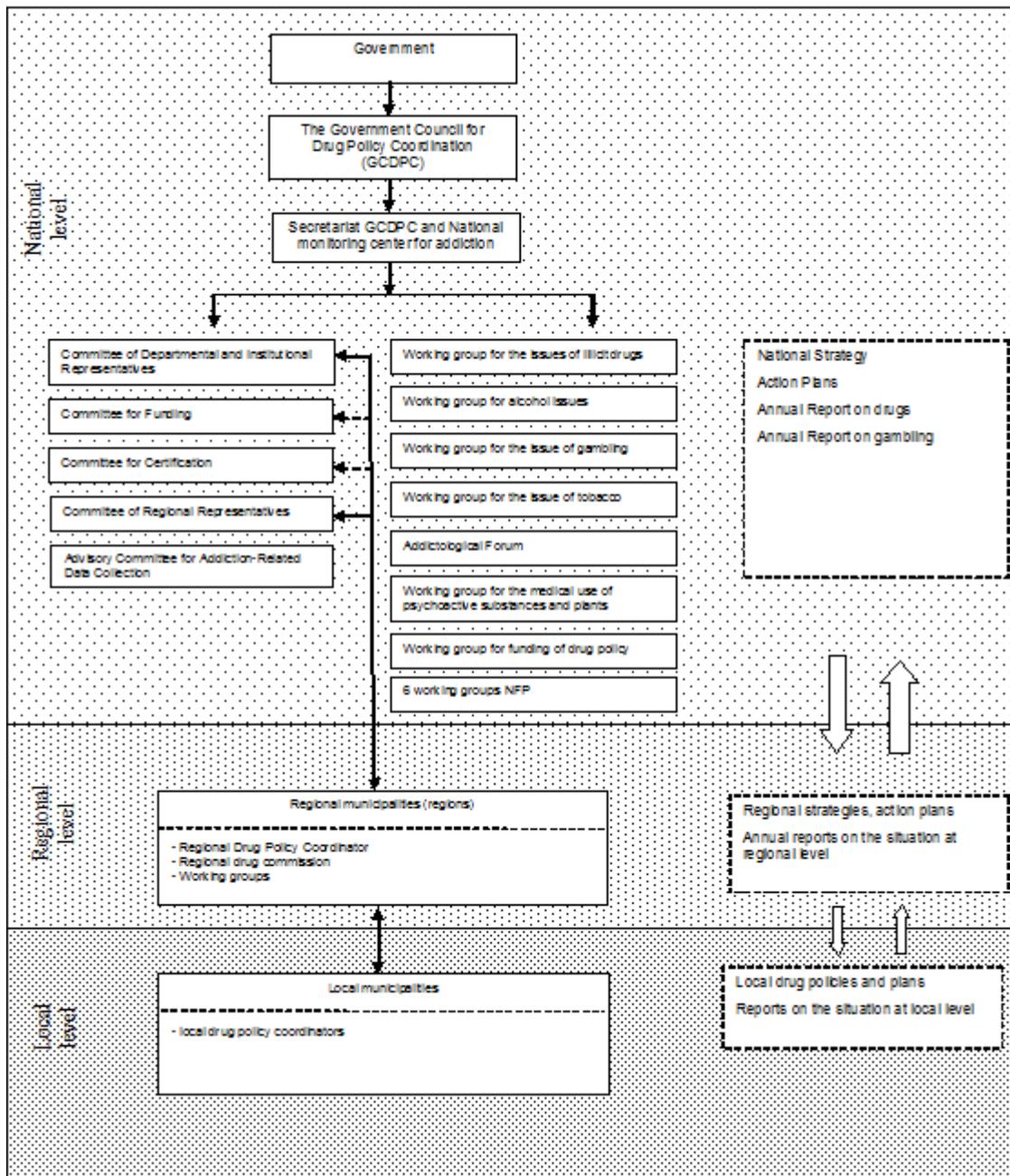
The **regional drug commission** is an important instrument for the implementation of drug policy in a region. Drug commissions have been established in almost all the regions, often as advisory bodies to the mayor/president of the region or to the vice-mayor/vice-president of the region or to the regional council. In some regions, drug policy is in the remit of advisory bodies covering a wider range of issues, e.g. social and health, negative social phenomena including crime prevention etc.

Working groups in the regions usually participate in dealing with the current and specific drug issues of the region at an expert level. Their set-up varies but most often follows the pillars of the drug policy (primary prevention, harm reduction, treatment and rehabilitation, and supply reduction). Major service providers willing to participate in tackling problems and to share their own experience and skills should be represented on them.

All the regions have drawn up their **regional drug policy strategic documents** – it is either a specific drug policy document (strategy, programme, action plan) or the drug policy is part of a strategy document that covers other areas such as social issues or prevention of criminality.

Similarly to their regional counterparts, **local drug policy coordinators** or drug policy contacts make arrangements for drug policy coordination and the implementation of measures at the local level, and the transfer of information between the regional level and the community level. The position of local drug policy coordinator is appointed in most of the municipalities with extended competencies, but usually not on a full-time basis.

Image 1 - Drug policy coordination mechanisms



Important note:

The organization of drug policy and its coordination mechanisms at local level had its legislative framework (defined in the legislation) since 2005 as defined in § 22 and § 23 of act no. 379/2005 Coll. Adoption of the new law no 65/2017 Coll. for the protection of health against the harmful effects of addictive substances, brings a change to the legal definition of coordination of drug policy at the local level.

While in the act no. 379/2005 Coll. it was the county's obligation to coordinate and implement the drug policy in its territory, to cooperate with state authorities and with municipal authorities, to adopt the county's drug strategy, to participate in the financing of drug policy programmes/drug services, to establish the regional drug coordinator, to set up their own initiative or advisory bodies for drug policy, and collect and evaluate the situation in the field of substance use on their territory, so in the new act no 65/2017 Coll. remained only duty to conduct a drug policy in its territory, and once every 10 years to accept the county's drug strategy. The establishment of the regional drug coordinator remained in the law only as an option.

Similarly, the municipality with extended competence pursuant to act no. 379/2005 Coll. set up the above described coordination mechanisms if needed. In the new act no 65/2017 Coll. remained only the obligation to carry out a drug policy in its territory and the possibility, if necessary, to establish the function of local drug coordinator.

1.2.3 Drug related public expenditure

Drug policy in the Czech Republic is funded from central (the national budget) and regional sources (regional and municipal budgets). Since 2014, it has been integrated, so covers illicit as well as licit drugs and gambling. So also expenditures may contain all these domains. It is impossible to separate them from each other.

Planned and identifiable expenditures earmarked for drug policy programmes are referred to as "Labelled". Additionally, there are made estimations of costs incurred by health insurers in relation to the F10 and F11-19 diagnoses according to the type of care, and the estimations are referred to as "Unlabelled".

The sources of data needed for the annual monitoring of labelled expenditures from the state budget are the final accounts of the ministries and additional information provided by the representatives or contact persons of individual ministries and governmental institutions. Regional data (expenditures from regional and municipal budgets) is obtained from annual reports on the implementation of drug policies in the individual regions. The structure of the reporting of costs is divided between preventive, low-threshold, outpatient, and inpatient addiction treatment services.

Drug policy as an independent budgetary programme is accounted for in the budgets allocated to the Office of the Government of the Czech Republic, specifically to operate the Secretariat of the Government Council for Drug Policy Coordination (GCDPC), the Ministry of Education, Youth, and Sports (the Ministry of Education), the Ministry of Defence, the Ministry of Health, and the Ministry of Justice.

In addition to the above ministerial portfolios, the Ministry of Labour and Social Affairs is also involved in the funding of the drug policy. While not having an independent chapter dedicated to the drug policy in its budget, it provides support to services specifically targeted at substance users as part of its grant proceedings. Neither does the budget of the Ministry of the Interior

include an item specifically intended to cover drug policy-related costs. There is also budget for the National Drug Squad of the Criminal Police and estimated costs of the Police of the Czech Republic in relation to the psychoactive substances including alcohol (including e.g. traffic police street testing). The Ministry of Foreign Affairs supports international cooperation projects in the field of drug policy.

The expenses incurred by health insurers in relation to the treatment of substance use disorders are provided with a year's delay using health account statistics compiled according to the international System of Health Accounts. They comprise directly identifiable costs, i.e. those reported as incurred in relation to the treatment of primary diagnoses, and unidentifiable costs, with no link to a diagnosis, the proportion of which spent in relation to the F10-F19 diagnoses is estimated.

In 2018, expenditures on integrated drug policy (all areas: alcohol, tobacco, illicit drugs, gambling) from the budgets of state administration and local government totaled CZK 2121.6 million (CZK 1755.6 million in 2017), of which state budget expenditures amounted to CZK 1771.0 million and expenditures from budgets of municipalities CZK 350.6 million (regions CZK 259.2 million and municipalities CZK 91.4 million). In 2018, expenditure increased at all levels and for all types of services and policy areas in the area of addiction.

State budget expenditures increased year-on-year by CZK 317.5 million, of which the highest increase was recorded by the Police of the Czech Republic (by CZK 180.6 million), MLSA (by CZK 84.4 million) and GCDPC (by CZK 45.6 million). CZK 9 million). Expenditures from local budgets (regions and municipalities) increased in total by CZK 48.4 million, most notably in the Hradec Králové (CZK 22.6 million), Karlovy Vary (CZK 9.3 million) and Liberec (CZK 4.8), a year-on-year decrease was recorded in the Olomoucký (CZK 5.6 million) and Pardubický (CZK 0.4 million) regions.

In addition, health insurance expenditures for treatment of substance abuse disorders in 2017 (latest available data) amounted to CZK 1798 million (CZK 1818 million in 2016), of which CZK 1195 million was spent on alcohol-related disorders and for the treatment of disorders caused by other drugs CZK 603 million. Addictology (AT) programs received CZK 275 million (CZK 270 million in 2016) from health insurance expenditures for the treatment of substance abuse disorders.

The table 3 presents drug related public expenditure published in the Annual Report on Drug Situation in the Czech Republic in 2019. These data are for available years 2018 and 2017. These data are divided according to supply, demand and transversal initiatives. There is an effort of inclusion of the expenditure into the classification COFOG. The national accounting classification is replaced by the national division of the Purpose of the Expenditure which is extending version of the Reuter's classification. The data are also divided on labeled and unlabeled expenditure.

Table 3 - Break-down of drug related public expenditure

Expenditure (million CZK)	Year	Supply / demand	COFOG	Purpose of the Expenditure (extended version of Reuter's classification)	Trace (Labelled, Unlabelled)	Comments
85.5	2018	Demand	Health	Primary prevention	Labelled	Funded by the GCDPC, Ministry of Education, Ministry of Defence, Ministry of Labour and Social Affairs, Ministry of Health, Ministry of Justice, regions and municipalities
112.5	2018	Demand	Health	Harm Reduction: Outreach programmes	Labelled	Funded by the GCDPC, Ministry of Labour and Social Affairs, Ministry of Health, regions and municipalities
160.5	2018	Demand	Health	Harm Reduction: Drop-in centres	Labelled	Funded by the GCDPC, Ministry of Labour and Social Affairs, Ministry of Health, regions and municipalities
37.1	2018	Demand	Health	Harm Reduction: Integrated and other programmes	Labelled	Funded by the GCDPC, Ministry of Health, regions and municipalities
40.5	2018	Demand	Health	Outpatient services: Health Services	Labelled	Funded by the GCDPC, Ministry of Labour and Social Affairs, Ministry of Health, regions and municipalities
36.4	2018	Demand	Health	Outpatient services: Social Services	Labelled	Funded by the GCDPC, Ministry of Health, regions and municipalities
8.1	2018	Demand	Health	Outpatient services: Others and unspecified	Labelled	Funded by the GCDPC, Ministry of Health, regions and municipalities
11.7	2018	Demand	Health	Prison-based services	Labelled	Funded by the GCDPC, Ministry of Justice, regions and

						municipalities
13.4	2018	Demand	Health	Residential services: Inpatient health services	Labelled	Funded by the Ministry of Health, regions and municipalities
91.4	2018	Demand	Health	Residential services: Therapeutic communities	Labelled	Funded by the GCDPC, Ministry of Labour and Social Affairs, regions and municipalities
65.7	2018	Demand	Health	Residential services: Homes with special regime	Labelled	Funded by the Ministry of Labour and Social Affairs, regions and municipalities
22.4	2018	Demand	Health	Residential services: Others and unspecified	Labelled	Funded by regions and municipalities
74.3	2018	Demand	Health	Aftercare services	Labelled	Funded by the GCDPC, Ministry of Labour and Social Affairs, regions and municipalities
0.0	2018	Demand	Social Protection	Social businesses	Labelled	Funded by regions
77.3	2018	Demand	Health	Sobering-up stations	Labelled	Funded by regions and municipalities
0.4	2018	Supply	Public order and safety	Prevention of drug criminality	Labelled	Funded by municipalities
265.8	2018	Supply	Public order and safety	Law enforcement	Labelled	Costs on the National Drug Squad of the Criminal Police
823.3	2018	Supply	Public order and safety	Law enforcement	Unlabelled	Estimated costs on the Police of the Czech Republic in relation to the illegal drugs
121.6	2018	Supply	Public order and safety	Law enforcement	Labelled	Costs on drug testers for the Police
0.0	2018	Supply	Public order and safety	Law enforcement	Labelled	Detection devices for customs
8.3	2018	Supply	Public order and safety	Law enforcement	Labelled	Detection devices on drugs and other law enforcement in prison
25.0	2018	Transversal	General public services	Coordination, research, evaluation	Labelled	Funded by the GCDPC, Ministry of Health, Ministry of Justice, Ministry of Foreign Affairs, regions and

						municipalities
41.0	2018	Transversal	General public services	Others, unspecified	Labelled	Funded by the Ministry of Labour and Social Affairs, Ministry of Justice, regions and municipalities
917.3	2017	Demand	Health	Treatment services (cost of diagnosis F10)	Unlabelled	Estimated costs incurred by health insurers
460.0	2017	Demand	Health	Treatment services (cost of diagnosis F11-F19)	Unlabelled	Estimated costs incurred by health insurers
1.1	2017	Demand	Health	Rehabilitation services (cost of diagnosis F10)	Unlabelled	Estimated costs incurred by health insurers
0.6	2017	Demand	Health	Rehabilitation services (cost of diagnosis F11-F19)	Unlabelled	Estimated costs incurred by health insurers
31.0	2017	Demand	Health	Long-term care (cost of diagnosis F10)	Unlabelled	Estimated costs incurred by health insurers
4.5	2017	Demand	Health	Long-term care (cost of diagnosis F11-F19)	Unlabelled	Estimated costs incurred by health insurers
71.4	2017	Demand	Health	Supporting services (cost of diagnosis F10)	Unlabelled	Estimated costs incurred by health insurers
50.1	2017	Demand	Health	Supporting services (cost of diagnosis F11-F19)	Unlabelled	Estimated costs incurred by health insurers
160.8	2017	Demand	Health	Medication and medical equipment and supplies (cost of diagnosis F10)	Unlabelled	Estimated costs incurred by health insurers
81.2	2017	Demand	Health	Medication and medical equipment and supplies (cost of diagnosis F11-F19)	Unlabelled	Estimated costs incurred by health insurers
11.1	2017	Demand	Health	Prevention	Unlabelled	Estimated costs

				(cost of diagnosis F10)		incurred by health insurers
5.6	2017	Demand	Health	Prevention (cost of diagnosis F11-F19)	Unlabelled	Estimated costs incurred by health insurers
0.9	2017	Demand	Health	Unidentified care (cost of diagnosis F10)	Unlabelled	Estimated costs incurred by health insurers
0.4	2017	Demand	Health	Unidentified care (cost of diagnosis F11-F19)	Unlabelled	Estimated costs incurred by health insurers

1.3 New developments

On 31 August 2019, the Czech Pirate Party published its proposal for the legalization of recreational cannabis - for details see the Act on Addictive Substances (p. 15). The publication of this initiative also included the launch of the website www.regulacekonopi.cz, where details of the proposal were published and where a public consultation was held.

The objective of the proposal is to regulate the cultivation and handling of hemp and hemp products in small quantities for their own use and their free transfer. The petitioners propose to allow the cultivation, processing and storage of up to 5 cannabis plants for their own use in dwellings up to 1250 g dry matter or products derived therefrom with a total content of up to 250 g THC, outside dwellings up to 30 g dry matter or total content up to 6 g THC. The proposal also allows the transfer of not more than 30 g of hemp dry matter or of this amount of derived products to another adult free of charge. In December 2018, the Government expressed its disagreement with the proposed amendment. Currently, the proposal is "parked" in the Chamber of Deputies.

1.4 Additional information

In June 2019, a discussion was held on the government's intention to move the Drug Policy Coordinating Body (GCDPC) and its executive from the Office of the Government of the Czech Republic to the Ministry of Health (the previous attempt took place in January 2018 - for details see VZ 2017). In particular, the expert public opposed the transfer of the GCDPC, and two protest petitions were launched, national and international. The proposal was then abandoned.

<http://www.vlada.cz/cz/media-centrum/aktualne/urad-vlady-upousti-od-presunu-protidrogove-agendy-pod-ministerstvo-zdravotnictvi-174900/>

Since September 2016, the Department of Drug Policy of the Office of the Government of the Czech Republic has been implementing the project Systemic Support for the Addictological Services Development within the Integrated Drug Policy (RAS project), supported by the European Social Fund (ESF) through the Employment Operational Program. It is the first

independent and extensive project in the Czech Republic financed by the ESF in the field of drug policy. The project focuses on the definition of addictological services, the definition of parameters and tools for creating a network of addictological services and the system of their financing. The aim of the project is to streamline and improve the network of addictological services. An important part of the project is the enhancement of competencies of workers in addictological services and selected employees of public administration. The project will run until August 2021. In 2018–2019, the first analytical outputs were published, focusing on the systemic and legislative framework of addictological services in the Czech Republic as compared to the situation in foreign countries, on methods and tools for determining the availability and networking of addictological services in the Czech Republic. and to compare models of quality assurance of addictology services abroad. The RAS project presented a draft version of the Conceptual Framework for the Development of Addictological Services, which integrates all partial activities of the RAS project related to the conceptual development of the network of addictological services.

<https://www.rozvojadiktologickychsluzeb.cz/>

2 Legal Framework

2.1 Summary

The basic legal framework of Czech drug laws is based on criminal law, i.e. Act No. 40/2009 Coll., the Penal Code and Act No. 141/1961 Col., the Code of Criminal Procedure. General definition of "drug" is a part of the Penal Code and special law Act. No. 167/1998 Coll., on addictive substances. Lists of addictive substances are contained in secondary legislation, i.e. Governmental Regulation No. 463/2013 Coll., on the lists of addictive substances. Unauthorized manipulation with precursors is under control of criminal law too. Special law is defined precursors (Act No. 272/2013 Coll., on drug precursors). List of precursors is contained in secondary legislation too, i.e. Government Regulation No. 458/2013 Sb., on the list of initial substances and adjuvants and their yearly threshold quantities. The Penal Code defines 5 drug law crimes: section 283 – Unauthorised production and other handling of narcotic and psychotropic substances and poisons; Section 284 – Possession of a narcotic or psychotropic substance or poison; Section 285 – Unauthorised cultivation of plants containing a narcotic or psychotropic substance; Section 286 – Manufacturing and possession of an article for the unauthorised production of a narcotic or psychotropic substance or poison, and Section 287 – Promotion (Propaganda) of drug use. Possession of drugs for personal use and cultivation of plants and mushrooms containing a narcotic or psychotropic substance are excluded from criminal prosecution. These violations of law are punished by administrative law as a misdemeanour (Act No. 167/1998 Coll., on Addictive Substances). Use of drugs is not mentioned as an offence or a misdemeanour. For drug offenders, the same alternative punishments as for other offenders can be used, with the specific option of imposing the obligation to treat or prohibit the use of drugs as part of probation supervision.

Penalties vary by drug only within crime Possession of drugs for personal use (Penal Code, s. 284) and crime unauthorized cultivation of plants with narcotic or psychotropic substances for personal use (Penal Code, s. 285). The possession of cannabis or other substances containing cannabis/ the cultivation of cannabis is punished lighter than possession of other drugs/cultivation of other plants. A quantity of drugs determines a boundary between misdemeanour and crime in case of possession of drugs for personal use and cultivation of plants (cannabis and other plants with narcotic and psychotropic substance) for personal use. The amount of drugs is part of the scale of crime as part of aggravating circumstances. Recidivism is generally aggravating circumstance. As regard drug crimes, penalties vary by recidivism within Drug supply (Penal Code, s. 283 (2b)). i.e. special recidivism Punishment range extends to min. 2 max. 10 years imprisonment for the second offence committed within three years from the previous conviction. Penal Code, art. 283 (2b). Penalty range is not influenced by the addiction factor. If the offender started treatment during the criminal proceedings, the court does not have to regard his general recidivism as an aggravating circumstance (it is impossible in case according Penal Code, s. 283 (2b)).

There is no special legislation for NPS regulation in the Czech Republic.

2.2 National profile

2.2.1 Legal framework

Basic legal framework of drug legislation are composed:

- Act No. 40/2009 Coll., the Penal Code
- Act No. 141/1961 Coll., the Code of Criminal Procedure
- Act No. 200/1990 Coll., Act of Violations (effective to 30th June 2017 – it was included drug misdemeanours /administrative offences – see Act No. 167/1998 Coll.)
- Act No. 250/2016 Coll., Act on Violation Responsibility and Violation Procedure (effective from 1st July 2017)
- Act. No. 167/1998 Coll., on addictive substances (from 1st July 2017 contains drug misdemeanours, i.e. drug possession for personal use in small amount and cultivation of small amount plants for personal use)
- Government Regulation No. 463/2013 Coll., on the lists of addictive substances
- Act No. 272/2013 Coll., on drug precursors
- Government Regulation No. 458/2013 Sb., on the list of initial substances and adjuvants and their yearly threshold quantities
- Government Regulation No. 455/2009 Coll., setting out for the purposes of the Penal Code which plants and mushrooms should be considered plants and mushrooms containing a narcotic or psychotropic substance and what quantities of them should be considered greater than small in accordance with the Penal Code
- Government Regulation No. 467/2009 Coll., specifying or the purposes of the Penal Code what constitutes a poison and defining the quantities greater than small for narcotic substances, psychotropic substances, any preparations containing such substances, and poisons.

Use of drugs is not mentioned as an offence or a misdemeanour.

2.2.1.1 Drug possession

Possession of small amount of drugs for personal use is a misdemeanour punished by a fine up to 15,000 CZK according Act on Addictive Substances (Act No. 167/1998), section 39.

Possession of drugs for personal use in "a quantity greater than small" is punishable under the Penal Code, but varies by drug. Possession of cannabis (or other substances containing THC) is punished by up to 1 year imprisonment; possession of other drugs is punished by up to 2 years imprisonment. The imprisonment extends to 6 months-5 years if the amount of drugs is "larger", and to 2-8 years if the amount is "significant". Penal Code (Act No. 40/2009), section 284.

Czech Penal Code has no alternatives to punishment specifically related to drug offences. However, a range of probationary measures is provided in the criminal law: conditional desisting from punishment without / with probation, and conditional discontinuation of prosecution

without/with probation. Probation measures are ordered by criminal court and include being sent to drug treatment and refrain from drug use. These probation measures are applicable for all offenders of drug-related crimes not only for offenders of drug law offences. Penal Code (act no 40/2009), s. 46- 48, 81-83, 84-87, 88-91, Code of Criminal Procedure s. 307, 308.

2.2.1.2 Drug supply

Drug supply is a criminal offence punished by min. 1 max. 5 years imprisonment. Punishment range extends to 2–10, 8–12, 10–18 years of imprisonment in case of aggravating circumstances, e.g. involvement of minors, larger/ significant/ large scale of act/benefit, injury or death, or involvement of (international) criminal organisations. Penal code, art. 283 (1).

2.2.1.3 Penalties

No **alternatives to punishment** specifically related to drug offences. However, a range of probationary measures is provided in the criminal law: conditional desisting from punishment with probation, and conditional discontinuation of prosecution with probation. Probation measures include being sent to treatment and refrain from drug use Penal Code (act no 40/2009), s. 46- 48, 81-83, 84-87, 88-91, Code of Criminal Procedure s. 307, 308

Penalties vary by drug only within crime Possession of drugs for personal use (Penal Code, s. 284) and crime Unauthorized cultivation of plants with narcotic or psychotropic substances for personal use (Penal Code, s. 285).

The possession of cannabis or other substances containing cannabis/ the cultivation of cannabis is punished lighter than possession of other drugs/cultivation of other plants.

Penal Code s.284 (1): Possession of a quantity "greater than small" of cannabis or other substances containing THC is punished with up to 1 year imprisonment; s. 284(2) possession of other drugs punishable by up to 2 years.

Penal Code s. 285(1): Unauthorized cultivation of plants for personal use a in "a quantity greater than small" is punishable under the Penal Code, but varies by drug. Cultivation of cannabis is punished by up to 6 months imprisonment; s. 285(2) cultivation of other plants than cannabis is punished by up to 1 year imprisonment.

The imprisonment extends up to 3 years if the extent of crime is „larger“, and to 6 months-5 years if the extent of crime is “significant”.

In connection with s. 284 and s. 285, aggravating circumstances that increase sentence ranges do not include mention of type of drug.

A quantity of drugs determines a boundary between misdemeanour and crime in case of possession of drugs for personal use and cultivation of plants (cannabis and other plants with narcotic and psychotropic substance) for personal use.

Possession of small amount of drugs for personal use is a misdemeanour punished by a fine up to 15,000 CZK Act of Violations, s. 30. Possession of drugs for personal use in "a quantity greater than small" is punishable under the Penal Code, s. 284 (1),(2).

Limits of "small amount" were set out in Government Decree n. 467/2009 effective from January 2010 to August 2013. Government Decree n. 467/2009 was abolished by Constitutional Court with effect from 23.8.2013. For police, prosecuting and judicial practice the Supreme Court of the Czech Republic passed opinion of criminal division with interpretation of term "quantity greater than small" (file number: Tpjn 301/2013, passed on 13th March 2014, publicize on 9th April 2014). The opinion include a tab with amount - very similar as previous government decree ("only" decreasing of amount of cannabis - from 15 to 10 g, and methamphetamine from 2 to 1,5 g). This court view is not binding on a practice but in fact it has significant impact on practise.

Likewise, cultivation of small amount of plants (cannabis and other plants with narcotic and psychotropic substance) for personal use is a misdemeanour punished by a fine up to 15,000 CZK Act On Addictive Substances, s. 39. Cultivation of "a quantity greater than small" is punishable under the Penal Code, s. 285 (1),(2).

Limits of "small amount" were set out in Government Regulation No. 455/2009 Coll., setting out for the purposes of the Penal Code which plants and mushrooms should be considered plants and mushrooms containing a narcotic or psychotropic substance and what quantities of them should be considered greater than small in accordance with the Penal Code, effective from January 2010.

Penalties vary by recidivism within Drug supply (Penal Code, s. 283 (2b)). Punishment range extends to min. 2 max. 10 years imprisonment for the second offence committed within three years from the previous conviction. Penal Code, art. 283 (2b). Furthermore recidivism is a general aggravating circumstances in the Penal Code.

Penalty range is not influenced by the addiction factor. If the offender started treatment during the criminal proceedings, the court does not have to regard his general recidivism as an aggravating circumstance (it is impossible in case according Penal Code, s. 283 (2b)).

There is no special legislation for NPS regulation in the Czech Republic. Nevertheless, the year 2013 witnessed substantial changes in the legal framework governing the issue of addictive substances and precursors. With effect from 1 January 2014 the list of substances is no longer included in the schedules of Act. No. 167/1998 Coll., on addictive substances, as was the case from 1999 to 2013, but has been incorporated into Government Regulation No. 463/2013 Coll., on the lists of addictive substances. What the Government and the Parliament expect from this measure is a more rapid and effective response to the emergence of any new addictive substances on the drug market.

2.2.1.4 Drug driving

Driving under the influence of drugs is punishable as a misdemeanour in the Czech republic. Driving in a state that excludes the ability to drive (incapacity) is a criminal offense. Before April 2014 legal acts or subordinate legislation did not determine clear measures for drug influence of drivers.

As regards the issue of driving under the influence of addictive substances, threshold levels of specific substances in the driver's blood are now set out in Government Regulation No. 41/2014 Coll., on the determination of other addictive substances and their threshold quantities which will be considered as impairing a person's ability to drive when reached in their blood sample. This new regulation came into effect on 2 April 2014. For the purposes of misdemeanour (administrative) proceedings, a person will now be deemed to have driven a motor vehicle under the influence of an addictive substance if their blood sample showed the levels determined by the above-cited regulation. The threshold quantities are specified for the following selected substances: THC (2 ng/ml), methamphetamine (25 ng/ml), amphetamine (25 ng/ml), MDMA (25 ng/ml), MDA (25 ng/ml) and benzoylecgonine (25 ng/ml), and cocaine (25 ng/ml) and morphine (10/ml). As for the remaining substances, the extent to which a specific driver may be impaired by a substance that has been detected still needs to be further examined on an individual basis by means of expert opinions or, ideally, forensic reports.

In the event of criminal prosecution for an offence under Section 274 of the Penal Code, endangerment under the influence of an addictive substance, it is always advisable to have forensic reports produced in order to assess whether a driver was incapacitated because of having used the substance. In 2019 with aim to facilitate application practice the Prosecutor General issued new Instruction of Prosecutor General (No. 5/2019 Coll. of Instruction of Prosecutor General, 29th April 2019, http://www.nsz.cz/images/stories/PDF/POP/trest/1_SL_732-2018.pdf) to determine the limits of other addictive substances than alcohol at which the person is founding a condition excluding eligibility for employment or other activity within the meaning of Section 274 (1) of the Criminal Code. The threshold quantities are specified for the following selected substances: THC (10 ng/ml), methamphetamine (150 ng/ml), amphetamine (200 ng/ml), MDMA (150 ng/ml), MDA (150 ng/ml), cocaine (150 ng/ml) and morphine (200 ng/ml). When these threshold quantities are reached, it is usually appropriate to initiate criminal prosecution. This instruction by the Prosecutor General does not divest the police, the prosecutor's office and the courts of taking evidence regarding a situation excluding the capacity to drive in specific cases.

2.2.1.5 Drug testing

New Act No. 65/2017 Coll., for the protection of the health from the harmful effects of addictive substances in comparison with the previous law deals in detail with the issue of the drug and alcohol testing. The act is newly defined persons who are required to undergo a screening test and a medical test (including blood and urine test). In addition to persons who are reasonably suspected of acting or doing an activity under the influence of an addictive substance that could

endanger life or damage property or are suspected of having endangered themselves, or others, by the possession of an addictive substance, including alcohol, whether public order or even damage to property or property damage in connection with the use of addictive substance, the law explicitly imposes an obligation to undergo testing regardless of the context of use of addictive substance to other groups of persons. Newly, there is an obligation to undergo an examination of persons under the age of 18 who are suspected of (i) drinking an alcoholic beverage or being sold or consumed or allowed to consume it in violation of the new law, or (ii) have consumed another substance or been its use is made possible. Other explicitly mentioned groups of persons who can be called for examination without being suspected of using an addictive substance are (i) persons in custody, in criminal court ordered detention, and imprisonment, and (ii) persons in in-patient or out-patient compulsory addiction treatment.

2.2.2 Implementation of the law

Data on actual sentencing practice related to drug law crimes is available. The source of this data is Ministry of Justice. The Ministry of Justice publishes statistical lists on the web including criminal statistics with main information about crimes, criminal proceedings and punishments (<https://cslav.justice.cz/InfoData/prehledy-statistickyh-listu.html>). The Ministry of Justice provides a special data for purpose of National Report on Drug Situation (i.e. number of persons indicted in relevant year, by main drug type and drug offence type). These data is available too, but published only as a part of National Report on Drug Situation (Chapter 9: Drug Law Offences, <https://www.drogy-info.cz/publikace/vyrocnizpravy/vyrocnizprava-o-stavu-ve-vecech-drog-v-ceske-republice-v-roce-2017/>).

Data on actual decision making practice related to drug law misdemeanours (administrative offences) are available too. The data on misdemeanours are collected by county regional offices. From 2015 are available more specific data by types of drugs collected by National Drug Headquarter. The new Central register of misdemeanours has operated from 1st October 2017. Among other things, drug offenses are also recorded for 5 years. These data is published only as a part of National Report on Drug Situation (Chapter 9: Drug Law Offences, <https://www.drogy-info.cz/publikace/vyrocnizpravy/vyrocnizprava-o-stavu-ve-vecech-drog-v-ceske-republice-v-roce-2017/>).

If the NPS is specified in the Government Regulation No. 463/2013 Coll., on the lists of addictive substances, offender is sentenced for drug crime listed in s. 283 to 287, Penal Code.

In the case of NPS, which have not yet been included in the list of addictive substances, offender can be punished for Promotion (Propaganda) of drug use (s. 287, Penal Code).

In the context of NPS, 2 cases of death and 1 case of severe non-fatal intoxication were reported in 2017. In all cases, the new synthetic opioids were methoxyacetylfentanyl and furanylfentanyl.

In response to these fatal overdoses, the list of addictive substances has been extended (see Government Regulation No. 242/2018 Coll., changed the list of addictive substances in 2.4.

2.3 Trends

As is summarised by Mravčík (2015) the extent and nature of (de)criminalisation of minor possession of drugs has always been considered central issue of the drug policy in the Czech Republic in the last 25 years.

Following the amendment of the Criminal Code after the fall of the communist regime in 1989, the possession of narcotic drugs and psychotropic substances ceased to be a criminal offence in the Czech Republic in 1990, a situation that continued till 1998. With the dynamic development of the country's drug scene in the 1990s, social and political attention turned to the issue of drugs and moralistic and populist proposals calling for stricter legal regulations and repressive solutions appeared. As a result of this debate, the Czech government promulgated an amendment to the Criminal Code (Act No. 112/1998, Coll.), which introduced criminal penalties for drug possession effective from 1999, but only if the quantity was "greater than small", without further specifying the quantity and leaving its interpretation to judicial practice. The theme of a "greater than small" amount of drugs has since been at the centre of debates concerning the legal regulation of drug possession in the Czech Republic (Zábranský, 2004, Zeman, 2007, Radimecký, 2007).

A study entitled Impact Analysis Project of New Drugs Legislation (PAD) was conducted in 1999-2001, dealing with the issue of whether the criminalisation of drug possession introduced in 1999 had led to a change in the drug situation. The PAD study brought convincing evidence that the law did not work as predicted by its proponents, did not deliver the desired deterrent effect, had no health benefits for society, and was economically expensive for the country (Zábranský et al., 2001). The PAD study recommended, among other things, that the criminal law should distinguish between different types of narcotic drugs and psychotropic substances according to the different risks they posed. Following the PAD study, in 2001 the government adopted Resolution No. 1177/01, which ordered the Ministry of Health and the Ministry of Justice to consider the possibility of categorising drugs according to their social and health risks. Initially, drugs were grouped into three categories, but the Ministry of Justice subsequently came up with a proposal for two categories – cannabis and other drugs (Zábranský, 2004).

Because of the delay in the re-codification of the entire criminal law, key changes of drug law offences within recodification of criminal substantive law finished only in 2009.

The provisions of different penalties for cannabis were formalised by virtue of Act No. 40/2009 Coll., Criminal Code, which came into effect in January 2010.

Drug-related offences, which, until 31 December 2009, were provided for by the stipulations of Sections 187 to 188a of Act No. 140/1961, Coll., the Penal Code (the old Penal Code) are newly covered by Sections 283 to 287 of the new Penal Code, as specified below (the corresponding provisions of the old Penal Code effective until 31 December 2009 are indicated in brackets): Section 283 – Unauthorised production and other handling of narcotic and psychotropic substances and poisons (Section 187 of the old Penal Code); Section 284 – Possession of a

narcotic or psychotropic substance or poison (Section 187a of the old Penal Code); Section 285 – Unauthorised cultivation of plants containing a narcotic or psychotropic substance (not defined by the old Penal Code as a specific offence); Section 286 – Manufacturing and possession of an article for the unauthorised production of a narcotic or psychotropic substance or poison (Section 188 of the old Penal Code), and Section 287 – Promotion of drug use (Section 188a of the old Penal Code).

Although the definitions of offences partly correspond to the previous legal regulations, the new Penal Code introduces certain changes. In particular, the new law details the circumstances under which stricter sentencing guidelines or a specific type of punishment may be applied. An innovation is the offence defined by Section 285 – Unauthorised cultivation of plants containing a narcotic or psychotropic substance. The changes at the punishment level are demonstrated below by means of examples of amendments to sentencing guidelines governing unsuspended prison sentences; however, the definitions of the individual crimes also make it possible to impose alternative sentences.

For example, the stipulations of Section 283 (2) (b) of the new Penal Code newly prescribe that reoffending is to be considered as a circumstance conditioning the use of a stricter punishment range, i.e. according to this provision, an offender who repeatedly committed the offence of the Unauthorised production and other handling of narcotic or psychotropic substances and poisons under Section 283 of the new Penal Code, despite their having been sentenced or punished for such an offence in the past three years, may receive a prison sentence ranging from 2 to 10 years, unlike the 1 to 5 years which was the case until 31 December 2009. Among other implications, this modification may have a great impact on small-time dealers in narcotic and psychotropic substances and producers of methamphetamine who manufacture the drug in small makeshift labs or the kitchens in their homes and who are usually also problem drug users. The stipulations of Section 283 (4) of the new Penal Code raise the maximum sentence from the previous 15 years' imprisonment to 18.

The stipulations of Section 286 of the new Penal Code concerning the manufacturing and possession of an article for the unauthorised production of a narcotic or psychotropic substance or poison, namely Subsection 1 thereof, newly allows the offender to be sentenced to 0 to 5 years, in comparison to the previous punishment range of 1 to 5 years. In addition, Subsection 2, providing for the first-degree classification of the offence, i.e. carrying a stricter sentence, may now be used to sanction offenders who committed the crime as members of an organised group. A similar change in relation to members of organised groups is covered by the stipulations of Section 287 (2) of the new Penal Code defining the offence of the promotion of drug use. This provision also lays down a new circumstance conditioning a stricter punishment, namely the commission of the offence of the promotion of drug use involving a child under 15 years of age, for which, according to the new Penal Code, an offender may be imprisoned for 2 to 8 years; the previous legal regulation only provided for terms between 1 and 5 years.

The new Penal Code introduced substantial changes in the offences regarding the possession of narcotic and psychotropic substances and poisons for personal use and the unauthorised cultivation of plants containing a narcotic or psychotropic substance. These variations concern the partial division of drugs according to their health and social risks, which should facilitate the consideration of these offences. The stipulations of Section 284 of the new Penal Code, accounting for the criminal offence of Possession of a narcotic or psychotropic substance or poison, distinguish between the possession of cannabis and other drugs, but only when a quantity greater than small is concerned. As a result, the possession of cannabis in a quantity greater than small carries a sentence of up to a year's imprisonment (the previous legal regulation prescribed a term of up to two years), while an offender found guilty of the possession of other narcotic or psychotropic substances or poisons in a quantity greater than small may be sent to prison for up to two years. A person convicted of the possession of any narcotic or psychotropic substance or poison, i.e. including cannabis, to a significant extent may be sentenced to imprisonment for a term of between six months and five years (the previous legal regulation prescribed one to five years) and, in the event of the same offence being committed to a substantial extent, an offender may receive a prison sentence ranging from two to eight years (the previous legal regulation imposed a term of between one and five years).

The provisions of Section 285 articulate the merits of a totally new offence, Unauthorised cultivation of plants containing a narcotic or psychotropic substance, which concerns the growing of plants and mushrooms containing narcotic and psychotropic substances for personal use. These provisions also differentiate between cannabis growers and the growers of other plants and mushrooms containing narcotic and psychotropic substances, but only if such an offence was committed to a small extent. The new Penal Code no longer makes a distinction between the growers of cannabis and other plants containing narcotic and psychotropic substances if the offence involves cultivation to a significant and substantial extent. The cultivation of cannabis in a quantity greater than small carries a sentence of imprisonment for a term of up to six months, while the grower of a plant or mushroom containing a narcotic or psychotropic substance in a quantity greater than small may be punished by a prison term of up to one year. The cultivation of plants or mushrooms containing a narcotic or psychotropic substance on a significant scale is punishable by imprisonment for up to three years, and the same offence committed on a substantial scale carries a prison sentence ranging from six months to five years.

The possession of a narcotic or psychotropic substance in a small quantity and the cultivation of plants and mushrooms containing a small quantity of narcotic or psychotropic substances are sanctioned as misdemeanours – for more details see Section Changes in the Misdemeanour Act. Apart from specific definitions of drug-related crimes, the changes in the legal consideration of drugs presented by the new Penal Code also had a bearing on the general provisions. Under Section 42 of the new Penal Code, providing for aggravating circumstances, item p) lists reoffending as one such circumstance. At the same time, however, the law stipulates that the court is allowed not to consider such a circumstance as aggravating should this concern the

perpetrator of an offence committed by a drug user under the influence of or in connection to drugs in the event that the offender entered treatment or took other steps needed to start it. According to the previous legal regulation, the court could only disregard the aggravating circumstance of reoffending in the case of drug users who were repeatedly charged with the possession of a narcotic or psychotropic substance for personal use under Section 187a (1) of the old Penal Code. Thus, the new legislation explicitly underlines the role of the treatment of drug users in relation to their offending, in terms of both primary and secondary drug crime.

The new Penal Code authorised the Government to adopt a regulation specifying which substances should be considered poisons under Sections 283, 284, and 286 of the new Penal Code and what quantities of narcotic and psychotropic substances, products containing such substances, and poisons are to be regarded as greater than small. The Government was further authorised to issue a regulation setting out which plants and mushrooms should be considered plants and mushrooms containing a narcotic or psychotropic substance under Section 285 of the new Penal Code and what quantities of them are considered greater than small according to Section 285 of the new Penal Code. The Government fulfilled this task by adopting two regulations, namely No. 455/2009, Coll. and No. 467/2009, Coll. The formal stipulation of specific greater-than-small quantities of narcotic and psychotropic substances in a generally binding legal regulation is considered a ground breaking innovation, as until 31 December 2009 such quantities were only specified by internal guidelines intended for the police and public prosecutors for the purposes of criminal proceedings. Substantial parts of Government Regulation No. 467/2009 Coll., specifying or the purposes of the Penal Code what constitutes a poison and defining the quantities greater than small for narcotic substances, psychotropic substances, any preparations containing such substances, and poisons, was annulled on the basis of a decision of the Constitutional Court dated 23 July 2013, as it was found contradictory to the Constitution of the Czech Republic and the Charter of Fundamental Rights and Freedoms. The change came into effect on 23 August 2013, when the decision of the Constitutional Court was promulgated in the Collection of Laws under No. 259/2013 Coll. The possession of a narcotic or psychotropic substance or a preparation containing it in a quantity greater than small for personal use continues to be a criminal offence in accordance with the stipulations of Section 284 of the Penal Code – Possession of a narcotic or psychotropic substance or poison. A quantity greater than small of such a substance, however, was not formally defined by any legal regulation and needs

to be determined for the purposes of criminal proceedings by judicial practice, as was the case before 31 December 2009, i.e. prior to the coming into effect of the “new Penal Code.

Since 2000 the Czech criminal law has change significantly because of a recodification of a substantive criminal law. Facts of drug case were not change substantially but new special offence was defined by Section 285 – Unauthorised cultivation of plants containing a narcotic or psychotropic substance. New Penal Code includes great varieties of alternative sanctions. More precise formulation of penal conditions resulted in a reduction of any alternatives in practice

(e.g. community works, fines (see Scheinost, M. et al (2015) "Sanction policy and its implementation. Theoretical and penal-political aspects of the criminal law reform in the area of penal sanctions", <http://www.ok.cz/iksp/docs/429.pdf>).

Following the decision of the Constitutional Court (No. 259/2013 Coll.) a term "quantity greater than small" of drug for personal use was defined by the Supreme Court (see http://www.nsoud.cz/Judikatura/judikatura_ns.nsf/WebSearch/1F046995FAEAACC6C1257CB500409CC9?openDocument&Highlight=0,tpjn,301/2013 and Chapter T3.1).

Following the decision of the Constitutional Court (No. 259/2013 Coll.) a term "quantity greater than small" of drug for personal use was defined by the Supreme Court (see http://www.nsoud.cz/Judikatura/judikatura_ns.nsf/WebSearch/1F046995FAEAACC6C1257CB500409CC9?openDocument&Highlight=0,tpjn,301/2013 and chapter new development.

Data on sanctions for DLO offences presented in chapter Drug market and crime.

2.4 New developments

Table 4 - Laws which have changed in 2018

The regulatory document subjected to amendments / Initial version of the text	The amended regulatory document / Current version of the text		
Title. Hyperlink	Title. Hyperlink	Summary of change	Comments
Government Regulation No. 463/2013 Coll., on the lists of addictive substances	Government Regulation No. 30/2018 Coll., changed the list of addictive substances https://aplikace.mvcr.cz/sbirka-zakonu/SearchResult.aspx?q=30/2018&typeLaw=zakon&what=Cislo_zakona_smlouvy	change of lists of addictive substances	74 substances were added
	Government Regulation No. 242/2018 Coll., changed the list of addictive substances https://aplikace.mvcr.cz/sbirka-zakonu/SearchResult.aspx?q=242/2018&typeLaw=zakon&what=Cislo_zakona_smlouvy		8 substances were added

During 2018 the implementation of the law did not fundamentally deviate from the already court's practice in relation to the facts of drug offenses including punishments. As regards the interpretation of the facts of drug offenses, judicial practice is well established. New decisions rather clarify the current practice or comment on issues not yet resolved.

Interesting is the Constitutional Court's Decision concerning the finding of DNA on a syringe in relation to the issue of proving and presumption of innocence. In this case, the complainant was found guilty of a particularly serious robbery, on the basis of the DNA profile obtained from the syringe plunger found at the scene as direct evidence. The Constitutional Court, in its judgment No. III. ÚS 3579/17 of 3rd April 2018 concluded that the identified DNA profile of the defendant on the syringe plunger, which fell off the perpetrator in the pocket, is indirect evidence which alone cannot suffice to prove guilt.

As regard outcome data, a total of 2353 persons were sentenced for drug law offence in 2018. Of this figure most offenders were convicted in connection cannabis and methamphetamine drug production and dealing. A term of suspended imprisonment (62 %) was the most common sanction imposed in 2018 (2017, 65 %). Unsuspended imprisonment sentences represented the second largest group (26 %; 23 % in 2017) which means a slight increase in unconditional punishment at the expense of the conditional punishment.

Data on sanctions for DLO offences including methodology on collection and analysing data are presented in chapter Drug market and crime.

Table 5 - Sentences imposed for drug law offences in 2018 by type of offence (Source: Ministry of Justice)

Sentences for drug law offences	§ 283		§ 284		§ 285		§ 286		§ 287		Total	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Unsuspending imprisonment	649	28,7	54	12,6	2	2,9	24	32,9	3	17,6	732	25,7
Suspended imprisonment	1 393	61,4	263	61,3	48	69,6	43	58,9	11	64,7	1 753	61,6
House arrest	3	0,1	0	0,0	0	0,0	0	0,0	0	0,0	3	0,1
Community service	105	4,6	32	7,5	2	2,9	3	4,1	1	5,9	143	5,0
Prohibition of activity	0	0,0	0	0,0	0	0,0	0	0,0	0	0,0	0	0,0
Forfeiture of property	1	0,0	0	0,0	0	0,0	0	0,0	0	0,0	1	0,0
Fine	98	4,3	65	15,2	15	21,7	2	2,7	0	0,0	180	6,3
Forfeiture of articles (e.g. drugs)	4	0,2	9	2,1	2	2,9	0	0,0	0	0,0	15	0,5
Expulsion	15	0,7	6	1,4	0	0,0	1	1,4	2	11,8	24	0,8
Prohibition of entry and residency	0	0,0	0	0,0	0	0,0	0	0,0	0	0,0	0	0,0
Total	2 268	100,0	429	100,0	69	100,0	73	100,0	17	100,0	2 851	100,0

Notes: The Total value does not correspond to the total number of persons, as a person can be registered in the system in connection with multiple drugs and multiple crimes at the same year.

From 2015 till 2020 the Institute of Criminology and Social Prevention (http://www.ok.cz/iksp/en/e_aboutus.html) realised a study "Possibilities of determining the rate and structure of secondary drug crime in the Czech Republic"

Results of the study will be published here:

<https://www.rvvi.cz/cep?s=jednoduchevelyhledavani&ss=detail&n=0&h=VI20172019053> and http://www.ok.cz/iksp/en/e_studies.html.

During October 2019 the Czech Parliament will debate the draft on the change of the Act. No. 167/1998 Coll., on addictive substances. The proposal was submitted by MPs of the Pirate Party. The draft aims to regulate the cultivation and handling of cannabis and cannabis products in small quantities for their own use and their free transfer. Applicants propose to allow the cultivation, processing and possession of up to 5 cannabis plants for their own use in dwellings up to 1250 g dry matter or products derived therefrom with a total content of up to 250 g THC, outside dwellings up to 30 g dry matter or total content up to 6 g THC. The proposal also allows the transfer of not more than 30 g of hemp dry matter or of this amount of derived products to another adult free of charge. The Government expressed its disagreement with the proposed amendment.

Parliamentary Press 331, amendment to the Act on Addictive Substances, including the course of the legislative process, is available in full at <http://www.psp.cz/sqw/historie.sqw?o=8&t=331> [2019-10-24].

2.5 Additional information

During 2016 – 2019 the Institute of Criminology and Social Prevention realised a study “Drug users in prisons - evaluation of the effectiveness of therapeutic programs”. The study a) analysed relevant documents (legal acts, national strategies, guidelines, internal instruction, literature), b) analysed statistic data of Czech Prison Service, c) analysed anonymised reports of prison service databases and criminal records, d) collected and analysed semi-structured interviews with prison treatment programs staff, e) collected and analysed data from The Psychological Inventory of Criminal Thinking Styles (PICTS) – adapted Czech version. Results of the study will be published here: http://www.ok.cz/iksp/en/e_studies.html .

2.6 Sources and methodology

National Reports: The Czech Republic – Drug Situation (2008-2019)

<https://www.drogy-info.cz/publikace/vyrocnizpravy/>

Collection of Laws:

<http://aplikace.mvcr.cz/sbirka-zakonu/>

3 Drugs

3.1 Summary

The Prevalence of Substance Use in the General and School Population

Situation in the field of use of both licit and illicit substances in the Czech Republic has been relatively stable in the last years. Surveys carried out recently (National Survey on Substance Use 2016 and annual omnibus surveys Prevalence of Drug Use in the Population carried out since 2011) show the same pattern of substance use in the general population – cannabis is the most frequently used illicit drug (lifetime prevalence reaching over a quarter of the adult population and almost 10% of adults reported cannabis use in the last 12 months). The prevalence of use of other illicit substances has been significantly lower – in 2016-2018, use of ecstasy in lifetime was reported by 5-7%, 4-5% reported use of magic mushrooms, 1-3% pervitin (methamphetamine), 1-3% LSD and the use of other illicit substances has been below 1.5%. Last-year prevalence of ecstasy use reached 0.9-1.8% according to the study, the use of other illicit substances in the last year has been below 1% (pervitin and cocaine) and almost zero for other substances. Lifetime use of new psychoactive substances (either synthetic or herbal) was reported by 0.7-1.2% of adults. The peak of use of NPS was observed in 2011 and later has stabilized on lower levels; annual fluctuations in NPS prevalence rates might be related to changes in questionnaire formulation. Data from 2 omnibus surveys in 2018 showed lifetime cannabis use of 26.2–37.8%, followed by ecstasy use (5.3–6.3%), hallucinogenic mushrooms (3.5–4.7%), pervitin/methamphetamine (2.0–2.1%), LSD (2.9–3.5%) and cocaine (1.3–2.9%). Cannabis use in last 12 months reached 7.9–10.2%, and 2.3–3.5% reported cannabis use in the last 30 days.

Illicit substance use has been higher among males and young adults aged 15–34 years. Higher rates of substance use have been reported by subgroups of young adults in recreational settings or subgroups belonging to different subcultures or ethnic minorities. Compared to previous years, a decline of the both lifetime and last-year use of cannabis was observed among the 25–34 years olds; while some increase was observed in the age groups 15–24 years.

Illicit substance use (as well as tobacco and alcohol use) has been relatively frequent among Czech teenage population. Lifetime prevalence of cannabis use reached 17–20% among elementary school students aged 14–15 years and 37–47% among secondary school students aged 16 years (as shown by several national school surveys focusing on risk behaviour among the school population, HBSC study and ESPAD study). Studies among younger age groups (11–15 years) suggest prevalence of cannabis use around 9%; the increase of risk behaviour (including substance use) has been mostly reported between the age of 12 and 13, in case of substance use behaviour, the transition from elementary school to secondary school at the age of 15 years is regarded as a risk period.

In HBSC 2018, lifetime experience with cannabis use was reported by 17% of girls and 20% of boys aged 15, 7% and 8% used cannabis in the last 30 days, respectively. Compared to 2010 and

2014, lifetime cannabis use declined which is in line with previous ESPAD study findings showing a slight decline of cannabis use among 16-year-olds between 2007 and 2011. Further decline in cannabis use was observed in ESPAD 2015 (decline from 42.3% lifetime cannabis use in 2011 to 36.8% in 2015), and results were further confirmed by an ESPAD validation study in 2016.

Declines in substance use (smoking, alcohol consumption and illicit drug use) were especially seen among students of grammar schools and students of schools with final leaving exams.

However, the latest results of the ESPAD validation follow-up study carried out in 2018 on the same sample of students surveyed in 2016 (16 year-olds in 2016 and 18 year-olds in 2018) showed some interesting trends: 1) substance use increases between 16 and 18 years of age, especially among students of grammar schools and students of schools with final leaving exams, reaching comparable prevalence rates among students by type of school at the age of 18 years; 2) gender differences diminish at the age of 18, in both tobacco smoking, alcohol use and cannabis use; 3) students who already reached 18 years (i.e. minimum age for purchase of tobacco and alcohol) drink alcohol with higher frequency compared to their 17-year-old peers, but do not differ in tobacco smoking or illicit substance use.

Certain subgroups of children and teenagers have been in a higher risk related to substance use. One of the subgroups covers clients of low-threshold centres for children and young people (i.e. outpatient centres for youth at risk of social exclusion and socially negative phenomena, offering leisure time activities for any interested non-organized adolescents, including counselling, short intervention and social work targeted at at-risk individuals) – they are 3 times more often regular tobacco smokers and regular alcohol consumers, and they report about 2 times higher prevalence of cannabis use compared to the general school population of the same age. Other subgroups include children and young people in institutional care that are more vulnerable to substance use, experience lower satisfaction with life, higher rates of mental health problems and suicidality rates.

In the adult population, groups that are more likely to be at risk of higher substance use include e.g. young adults in nightlife setting, prison population or Roma population. Based on a study carried out in 2017, substance use among Roma population in contact with social services in socially excluded areas was 3–10 higher compared to the general population of the same age. Prevalence of substance use in prison population in 2018 was significantly higher compared to the general population – lifetime prevalence of cannabis use reached 41.9%, 24.0% reported use of Ecstasy in lifetime, 40.5% reported use of methamphetamine (pervitin), 19.2% cocaine, 18.5% hallucinogenic mushrooms and 16.6% LSD. Altogether 13.0% report lifetime use of buprenorphine and 13.0% heroin.

Data available come from large-scale GPS conducted every 4 years on randomly selected sample of the general population aged 15+ years, with data extracted for the population group of 15–64 years in line with the EMCDDA standards (the last was National Survey on Substance Use 2016) and annual omnibus studies Prevalence of Drug Use in the Population carried out

since 2011 on quota selected sample of the general population aged 15+ years (with data presented for the age group 15–64 years). School surveys providing nationally representative results include HBCS study (carried out in the Czech Republic since 2002), ESPAD study (carried out since 1995) and single studies with national coverage (e.g. from 2014). New wave of HBCS study was carried out in Spring 2018. A nation-wide representative school survey focusing on 11–18-year-olds was carried out in 2018 including few ESPAD-based questions on substance use, gaming and gambling behaviour. In 2018, the NFP carried out a follow-up study of 2016 ESPAD validation study focusing on 17–18-year-olds, i.e. ESPAD 2016 cohort students (students born in 2000). New wave of ESPAD data collection wave was carried out in Spring 2019, results will be available in 2020.

High Risk and Problem Drug Use in the Czech Republic

Based on CAST screening scale data from National Survey on Substance Use 2016, approximately 1.8% of the population aged 15–64 (3.3% of the men and 0.3% of the women) has been estimated to be at high risk related to their cannabis use. Another 2.7% has been at moderate risk (4.3% males and 1.1% females). This corresponds approximately to 125 thousand cannabis users at high and another 188 thousand users at moderate risk, respectively; as a result of their use of the drug. Cannabis-related problems are more likely to occur with increasing frequency of use. The prevalence of users at risk (in the population) was the highest among 25–34 and 15–24 age groups, while the highest proportion of users at risk of cannabis-related problems (among last-year cannabis users) was at the age-groups of 55–64 and 45–54 years. Compared to 2012, the proportion of population being at risk of cannabis related problems increased from 2.7% in 2012 to 4.4% in 2016 – the increase was seen in both the high-risk category (from 1.1% to 1.8%) and moderate-risk category (from 1.6% to 2.7%).

Estimates of intensive users of cannabis are also available from a series of studies among general practitioners and doctors for children (carried out every 2 years, the latest estimate from 2018). About 1.6% of the population aged 15–64 years in 2016 and 1.4% in 2018 was estimated to be at risk of cannabis related problems, which corresponds approximately to 94–112 thousand people.

Based on 2016 GPS data on prevalence and frequency of use, heavy pervitin (methamphetamine) and heavy cocaine users (who use it at least weekly) are estimated to account each for only 0.1% of the adult population in the Czech Republic; the situation being on stable level since 2012.

Of the group of amphetamines, methamphetamine (pervitin) is the drug that is used almost exclusively in the Czech Republic. Opiates/opioids included in the estimates of high-risk drug use in the Czech Republic are mainly heroin and, ever more frequently, diverted buprenorphine. There are signs from low-threshold centres and outreach programmes working with drug users of increasing misuse of opioid analgesics (fentanyl patches, morphine-based analgesic Vendal[®] Retard, hydromorphone-based Palladone[®] and locally oxycodone). This trend has continued in 2018, however, it is still limited to some regions of the country only. Cases of heroin production

from unrefined opium or morphine products have appeared; braun production from codeine products have been reported exceptionally, use of desomorphine (crocodile) has not yet been reported in the Czech Republic.

One phenomenon associated with recent years is the emergence of new synthetic drugs/new psychoactive substances (NPS) of the cathinone or phenethylamine group but their use is not widespread. NPS present only a supplementary drug for problem drug users. In relation to cathinone use, somatic and psychic problems among PDUs were reported.

New estimates of prevalence of high-risk drug use in the Czech Republic are available annually using the multiplication method based on data provided by low-threshold facilities. The estimated number of PDUs has been relatively stable in the last 3 years, including estimated numbers of injecting drug users (IDUs). In 2018, estimates for Prague region were revised for the whole period of 2009–2018 in order to take into account a probable overlap of clients being in contact with more than one low-threshold centre. In 2018 there were approximately 43.7 thousand high-risk (problem) drug users (the mean estimate) in the Czech Republic, including 33.5 thousand methamphetamine (pervitin) users, 3.4 thousand heroin users, and 5.2 thousand buprenorphine users and (newly estimated) 1.7 thousand users of other opioids, especially opioid analgesics (i.e. 10.2 thousand opiate/opioid users in total). The number of injecting drug users was estimated at 39.5 thousand. In the last ten years the mean estimate of the number of high-risk drug users has risen by more than half and in 2018 the prevalence of high-risk drug use in the Czech Republic reached 0.59% of the population aged 15–64.

Different estimates of problem drug users based on information provided by general practitioners and doctors for children (latest estimate from 2018) estimate around 20–24 thousand of problem opioid and pervitin users (32–41 thousand in 2016) (out of them about 3.5 thousand <18 years), out of them 9–11 thousand were users of opioids and 11–13 thousand were users of methamphetamine (pervitin). While the numbers of problem opioid users provided by general practitioners and doctors for children are probably overestimated due to the possibility of substitution treatment provision by general practitioners leading to higher contacts of opioid users with the doctors, the numbers of problem pervitin users are probably underestimated as there is no such treatment alternative provided by the doctors for pervitin users.

New estimates are available for the number of people using cannabis as self-medication for recent years. In 2016, the National Survey on Substance Use estimated approx. 7.9% using cannabis for medical purposes in the last 12 months (corresponding to 707 thousand people). Exclusively medical use of cannabis was reported by 3.9% of the population (approx. 350 thousand people) – including only people reporting medical use of cannabis without recreational use.

Clients Seeking Treatment (TDI)

Approximately one third of the clients in treatment are women, in various types of programmes, ranging from approximately 20% in low-threshold centres and sobering-up stations to almost 50% in day care psychotherapy centres and crisis centres. Clients in different programmes generally differ in terms of their primary drugs. Users of methamphetamine (pervitin) and opiates/opioids make up the majority of clients of low-threshold centres. Alcohol users constitute the majority of clients of outpatient and inpatient psychiatric facilities, but there is also a high proportion of users of methamphetamine, opiates/opioids, polydrug users, or people with problem use/misuse of sedatives and hypnotics. Users of alcohol are the predominant clients in sobering-up stations.

People seeking treatment for the first time (first treatment demands) make up approximately half of all treatment cases in the long term (44% in 2018, 41% in 2017, 30% in 2016 and 25% in 2015). Since 2015, new National Register of Treatment of Drug Users was launched, combining so far 2 existing registers – the Register of Treatment Demands and Substitution Treatment Register; data collection within the new register has brought several technical problems, thus it is still not fully operational and the new register does not cover data from an important part of the treatment system (for more details see chapter Treatment) – while it annually reported approximately 10 thousand people in treatment related to illicit substances only, between 2015 and 2017 it reported about 7–8 thousand people in treatment related to all substances, including tobacco, alcohol and problem gamblers (while the Register of Treatment Demands until 2014 covered only people entering treatment in relation to illicit drug use, including psychoactive medicines). New data for 2018 show 14 thousand people entering treatment, among them 6240 entered treatment for the first time. Among them, 5.7 thousand people entered treatment in relation to alcohol, 500 in relation to tobacco and 400 in relation to gambling.

The Register of Treatment Demands associated with drug use (operational until the end of 2014) where alcohol was not reported as a drug of choice was dominated by methamphetamine users (about 70% of all cases) and their number was increasing in the long run. In the long term, there is a noticeable decrease in the number of users of heroin, while the number of buprenorphine users (mainly injectors) is growing. The population of drug users is getting older; users of opiates/opioids have been the oldest (35–37 years on average), while cannabis users have been the youngest (28 years on average). The new National Register of Treatment of Drug Users includes information on people in treatment in relation to alcohol consumption, tobacco smoking and problem gambling as well – drug users were the youngest (32.0 years in 2018), followed by problem gamblers (34.7 years), tobacco smokers (36.5 years), while alcohol consumers belonged to the oldest (46.2 years) together with users of sedatives and hypnotics (47.3 in 2018).

Number of clients treated in opioid substitution treatment has been stagnating, or slightly declining, in the last 6 years. In recent years, about 4 thousand clients were in OST, out of them

approximately 3.3 thousand in buprenorphine treatment. However, the number of registered patients in substitution treatment was 2.3 thousand, while another 1500–3000 people are not registered in the substitution treatment register but only estimated based on information from other data sources, e.g. general practitioners. For more information see chapter Treatment. In average, about 22.6% of problem opioid users were registered in substitution treatment; however, there are regional differences – in some regions, the number of problem opioid users in substitution treatment is much lower. Moreover, an increase in opioid analgesics misuse has been reported in these regions.

The use of Alcohol, Tobacco and Prescription Drugs

The level of tolerance of the Czech population towards substance use has been very high in the long term. Public opinion polls since 2015 show slightly declining tolerance towards tobacco smoking and alcohol consumption, and especially towards their regular use.

The extent of regular smoking and risky alcohol consumption in the Czech adult population has been relatively stable in the long term. Based on National Survey of Substance Use 2016, about a quarter (26.6%) of population aged 15–64 smoked daily or almost daily (35.6% of males and 18.3% of females) which refers to approximately 2.4 million of daily smokers; these figures correspond to findings of the European Health Interview Survey (EHIS) carried out in 2014/2015 – daily smoking was reported by one fifth of the population (27.6% males and 15.7% females). According to 2016 data, daily smokers mostly smoke 11–20 cigarettes a day (47.9% of daily smokers), 31.7% of daily smokers reported smoking more than 20 cigarettes a day. Based on the Heaviness of Smoking Index (HSI) screening scale, about 92.3% of daily smokers were regarded as at risk of dependence. New estimates from 2017 are available for population aged 15+ years – daily smokers account for 18.4% (22.6% of males and 14.5% of females). A new study carried out within the scope of Global Adult Tobacco Survey (GATS) in 2018 confirmed that 28.5% of the population aged 15+ smoked cigarettes in the last 30 days, among them 21.1% smoked daily and 7.4% occasionally. Current smokers smoked 12 cigarettes daily in average. Trends in the last 6 years suggest a declining trend in smoking in the general population, both among males and females, though results for 2018 showed a slight increase.

About 19.2% of the population (15–64 years) have ever tried an electronic cigarette, 7.9% smoked electronic cigarette in the last 12 months. Higher prevalence was reported by males and younger age groups (15–24 and 25–34 years).

According to National Survey on Substance Use 2016, daily alcohol consumption was reported by 6.9% of the adult population (11.6% males and 2.4% females), mostly by respondents in the older age groups. Based on CAGE screening scale that was included in the National Survey of Substance Use 2016, about 18.1% of the population aged 15–64 years (and 16.8% of the population aged 15+) were categorized as risky alcohol consumers (26.5% of males and 10.2% of females), out of them 8.2% were at lower risk of alcohol consumption (7.8% of the population aged 15+), while 9.9% fulfilled the criteria of harmful alcohol consumption (15.2% of males and 4.9% of females) (9.0% of the population aged 15+).

Previous studies (carried out every 2 years) showed that in 2018, about 7.8% of the adult population aged 15+ drank alcohol daily or almost daily. The total alcohol consumption was estimated as 7.4 litres per capita (6.8 litres in 2016). About 8.1% of the adult population fulfil the criteria of the OECD definition for harmful drinking (more than 60 g of alcohol for males and more than 40 g for females), and another 7.3% fulfil the criteria of risky drinking (consumption of 40–60 g of alcohol for males and 20–40 g for females) which corresponds to approximately 800 thousand, and 700 thousand people respectively, in the Czech Republic. Trends over the years show a constant increase in regular daily use, as well as in the prevalence of harmful and risky drinking. When extrapolated to the population of the Czech Republic, this corresponds to approximately 1.5 million of at risk alcohol users, out of them 800 thousand high-risk (harmful) consumers and another 700 thousand being at lower risk related to alcohol use.

Use of psychoactive medicines (sedatives, hypnotics or medicine containing opiates/opioids used without doctor's prescription and/or not in line with the doctor's recommendation) in the last 12 months was reported by 23% of the adult population (15–64 years). Estimated number of sedatives and hypnotics misusers reached 885 thousand, most of them create misusers of alprazolam (e.g. Neuro) – approx. 270 thousand and zolpidem (e.g. Stilnox) – approx. 125 thousand.

Tobacco smoking and alcohol use have been also relatively frequent among Czech teenage population. Regular smoking (at least once a week or more often) was according to HBSC study in 2014 reported by 2% of 11-year-olds, 5% of 13-year-olds and 16% of 15-year-olds, new data for 2018 showed 11% prevalence of regular smoking among 15-year-olds. Regular alcohol consumption has remained on the same level, drunkenness in the last 30 days was reported by 20% of the 15-year-olds in 2014 (new data for alcohol use in 2018 are not yet available). Compared to the previous wave of the study from 2010, a decline was observed in the extent of both regular smoking and regular alcohol consumption between 2010 and 2014, with regular smoking showing further declines in 2018. Data from ESPAD 2015 showed a significant decline in prevalence of tobacco smoking including daily and heavy smoking (11+ cigarettes a day), and prevalence of alcohol consumption including regular consumption and binge drinking among teenagers aged 16 years. The ESPAD 2015 findings were confirmed by an ESPAD validation study in 2016 showing further declines in frequent tobacco and alcohol use and risky forms of tobacco and alcohol consumption among students aged 16 years. New data for adolescents aged 11–18 available from a nationally representative school survey in 2018 showed a large increase in tobacco smoking and intensive alcohol consumption between the age of 15 and 16 related to the transition from elementary schools to secondary schools – while daily smoking was reported by 3.1% of 15-year-olds in the elementary schools, it reached 21.6% among 15-year-olds in the elementary schools. The prevalence of frequent binge drinking grew 4 times between the age of 13 and 15, and further doubled after the transition to the secondary schools.

The latest results of the ESPAD validation follow-up study carried out in 2018 on the same sample of students surveyed in 2016 (16 year-olds in 2016 and 18 year-olds in 2018) showed

that differences among students by type of school seen at the age of 16 still prevail at the age of 18 years in case of daily tobacco smoking, while they become less pronounced in case of frequent binge drinking. As mentioned above, students who already reached 18 years (i.e. minimum age for purchase of tobacco and alcohol) drink alcohol with higher frequency compared to their 17-year-old peers, but do not differ in tobacco smoking or illicit substance use.

3.2 Cannabis

3.2.1 National profile

3.2.1.1 Prevalence and trends

3.2.1.1.1 *The Relative Availability of Different Types of Cannabis*

Cannabis used in the Czech Republic includes primarily herbal cannabis that is both produced (grown) in the Czech Republic and imported from other countries; to a lower extent, hashish is used, as well as synthetic cannabinoids. Based on data from supply reduction monitoring systems, about half of the seized growing sites include “home” growing sites with less than 50 cannabis plants. The grown cannabis is targeted mainly for the domestic market.

Cannabis availability was surveyed for the last time within the National Survey on Substance Use 2016 – questions on subjectively perceived availability were included for all main drugs surveyed. About 43.0% of respondents (aged 15–64) reported they could (very or quite) easily obtain cannabis if they wanted (48.9% of males and 37.6% of females), the highest perceived availability was reported by the youngest age groups (63.1% of 15–24 year olds and 57.3% of 25–34 year olds). Compared to 2012, the subjectively perceived availability slightly increased (from 40.2% in 2012), while it remained relatively stable among the age groups 15–44, it increased among older age groups (45–54 and 55–64 years) (1). New data will be available in 2020 when the survey will be repeated.

Findings from the ESPAD 2015 study showed that 49.6% of the 16 years-old students perceive cannabis as easily available (48.2% boys and 51.0% girls). After an increase in perceived availability of cannabis between 1995 and 2007, the availability started to decline (from 63.6% in 2007 to 59.0% in 2011 and 49.6% in 2015). The decline is in line with decrease in (lifetime and last 12 months) prevalence of cannabis use among adolescents (2).

The National Survey on Substance Use 2016 covered also a topic of medical use of cannabis (see below in 3.2.3 section) and access to it – among those who use cannabis for medical purposes (15.2% in lifetime and 9.8% in the last 12 months), 6% reported they grew cannabis themselves and another 14% obtained cannabis grown by their relative or friend.

3.2.1.1.2 Cannabis use in the General Population

Cannabis has been the most frequently used illicit drug in the Czech Republic. According to National Survey on Substance Use 2016, the lifetime prevalence in the general population aged 15–64 years reached 26.6% in 2016 (34.6% among males and 19.1% among females), 9.5% of adults reported cannabis use in the last 12 months and 5.5% in the last 30 days. The last-year and last-month prevalence of cannabis use is significantly higher among young adults aged 15–34 (19.4% and 11.1% respectively). Similar results were reported by other two smaller-scale omnibus surveys (Citizen Survey 2016 and Prevalence of Drug Use in the Czech Republic in 2016) carried out in 2016, as well as in 2017 – see Table 6.

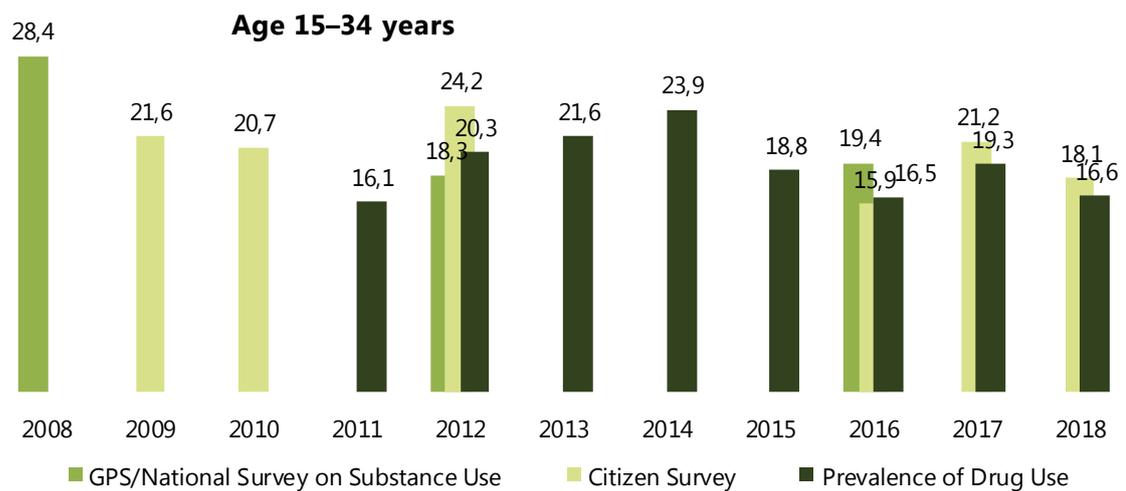
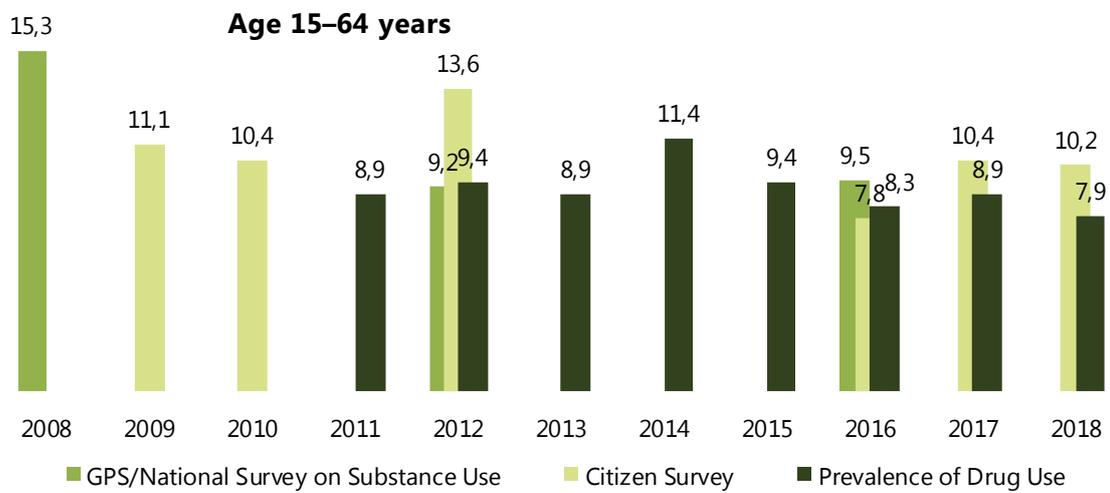
Table 6 - Prevalence of cannabis use in the general population (aged 15–64 years) in 2011–2018, in % (omnibus surveys Prevalence of Drug Use in the Population (PPM), compared to National Survey on Substance Use 2012 and 2016, and omnibus Citizen Survey 2016–2018)

	n	Lifetime prevalence				Last 12 months				Last 30 days				
		15–64			15–34	15–64			15–34	15–64			15–34	
		M	F	T	n	T	M	F	T	T	M	F	T	T
PPM 2011	(n=901)	30.8	18.8	24.9	(n=361)	35.6	12.7	4.9	8.9	16.1	4.4	1.8	3.1	6.1
PPM 2012	(n=854)	39.2	23.2	31.2	(n=345)	51.8	12.7	6.0	9.4	20.3	4.1	1.9	3.0	6.0
2012 - National Survey	(n=2134)	34.9	21.2	27.9	(n=824)	45.9	13.1	5.3	9.2	18.3	6.8	2.0	4.4	8.8
PPM 2013	(n=868)	29.6	15.8	22.8	(n=308)	40.7	13.2	4.5	8.9	21.6	3.5	0.7	2.1	5.3
PPM 2014	(n=870)	36.2	21.0	28.7	(n=313)	44.9	15.4	7.3	11.4	23.9	5.7	1.9	3.8	8.5
PPM 2015	(n=851)	37.6	21.3	29.5	(n=320)	42.0	13.4	5.3	9.4	18.8	5.2	1.4	3.3	6.7
PPM 2016	(n=849)	28.6	20.0	24.3	(n=323)	37.8	11.0	5.6	8.3	16.5	4.3	1.7	3.0	5.1
2016 - National Survey	(n=2875)	34.6	19.1	26.6	(n=1017)	43.8	14.2	5.0	9.5	19.4	8.9	2.2	5.5	11.1
Citizen Survey 2016	(n=1745)	37.8	22.7	30.4	(n=552)	43.5	10.1	5.4	7.8	15.9	3.9	1.7	2.8	5.3
PPM 2017	(n=1261)	36.0	21.1	28.6	(n=456)	44.2	11.9	5.9	8.9	19.3	2.1	1.8	2.0	3.9
Citizen Survey 2017	(n=1404)	42.0	31.6	36.9	(n=491)	53.8	13.1	7.7	10.4	21.2	5.1	2.6	3.8	9.0
PPM 2018	(n=1665)	31.8	20.6	26.2	(n=623)	39.9	10.0	5.8	7.9	16.6	2.9	1.7	2.3	4.9
Citizen Survey 2018	(n=1392)	43.8	31.6	37.8	(n=485)	50.7	11.0	9.4	10.2	18.1	4.1	2.9	3.5	6.2

Source: Chomynová (3), Běláčková, Nechanská (4), Národní monitorovací středisko pro drogy a drogové závislosti and INRES-SONES (5), Národní monitorovací středisko pro drogy a drogové závislosti and INRES-SONES (6), Národní monitorovací středisko pro drogy a drogové závislosti and INRES-SONES (7), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (8), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (9), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (10), Národní monitorovací středisko pro drogy a drogové závislosti and ppm factum research (11), Národní monitorovací středisko pro drogy a drogové závislosti and Factum Invenio (12), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (13), Národní monitorovací středisko pro drogy a závislosti and INRES-SONES (14), Národní monitorovací středisko pro drogy a závislosti and MindBridge Consulting (15), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (16), Národní monitorovací středisko pro drogy a závislosti and INRES-SONES (17), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (18), Národní monitorovací středisko pro drogy a závislosti and INRES-SONES (19)

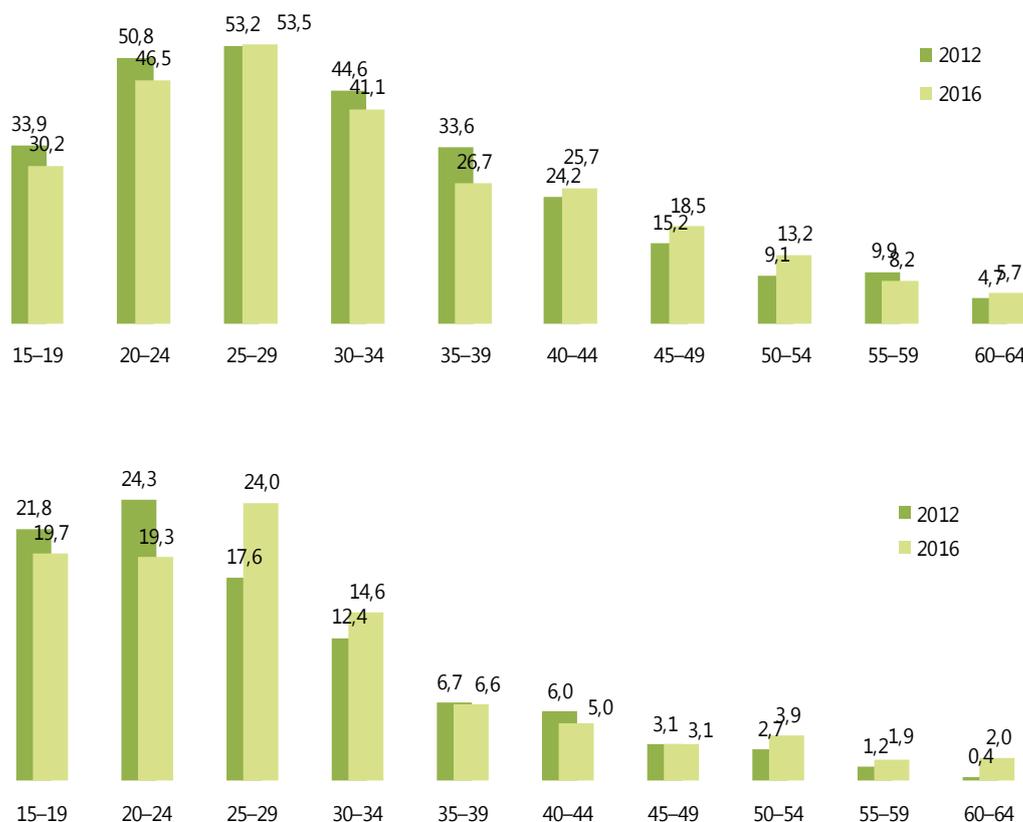
Long-term trends show stable situation, with some increasing trends in cannabis use in the general population observed between 2011–2014, especially among young adults aged 15–34, however, the trends have stabilized in the last years. National Survey on Substance Use 2012 (large-scale GPS conducted on randomly selected sample of general population aged 15–64 years) provided comparable results as regards the last-year prevalence rates and slightly higher last-month prevalence rates). New data from large-scale National Survey on Substance Use 2016 and two omnibus surveys confirmed the trends. Compared to National Survey on Substance Use 2012, a decline of the both lifetime and last-year use of cannabis was observed in 2016 among the 15–19 and 20–25 years age groups, while an increase was observed in the older age groups (see Figure 2), now being the rate of actual cannabis use the highest among 25–29 years age groups. New data from National Survey on Substance Use will be available for the year 2020.

Figure 1 - Prevalence of cannabis use among 15–64 and 15–34 years in the last 12 months – comparison of surveys carried out between 2008–2018, in %



Source: Chomynová (3), Běláčková, Nechanská (4), Národní monitorovací středisko pro drogy a drogové závislosti and INRES-SONES (5), Národní monitorovací středisko pro drogy a drogové závislosti and INRES-SONES (6), Národní monitorovací středisko pro drogy a drogové závislosti and INRES-SONES (7), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (8), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (9), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (10), Národní monitorovací středisko pro drogy a drogové závislosti and ppm factum research (11), Národní monitorovací středisko pro drogy a drogové závislosti and Factum Invenio (12), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (13), Národní monitorovací středisko pro drogy a závislosti and INRES-SONES (14), Národní monitorovací středisko pro drogy a závislosti and MindBridge Consulting (15), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (16), Národní monitorovací středisko pro drogy a závislosti and INRES-SONES (17), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (18), Národní monitorovací středisko pro drogy a závislosti and INRES-SONES (19)

Figure 2 - Lifetime and last-year prevalence of cannabis use by age groups – National Survey on Substance Use in 2012 and 2016, in %



Source: Národní monitorovací středisko pro drogy a závislosti and MindBridge Consulting (15), Chomynová (3)

Synthetic cannabinoids, when surveyed in population studies, are not questioned separately but only within a broader category of “new/other synthetic drugs” together with mephedrone, MDPV, ketamine and other NPS, thus no estimates on prevalence of use of synthetic cannabinoids are available. However, the use of synthetic cannabinoids in the general population is expected to be very low as the combined category of “new/other synthetic drugs” provides lifetime prevalence rate on levels such as 0.7% and 1.2% for age groups 15–64 years and 15–34 years respectively, and 0.2% in the last 12 months (0.3% among 15–34 years) and 0.0% prevalence in the last 30 days (data from 2016 National Survey on Substance Use). For more information on NPS see Section 3.5.

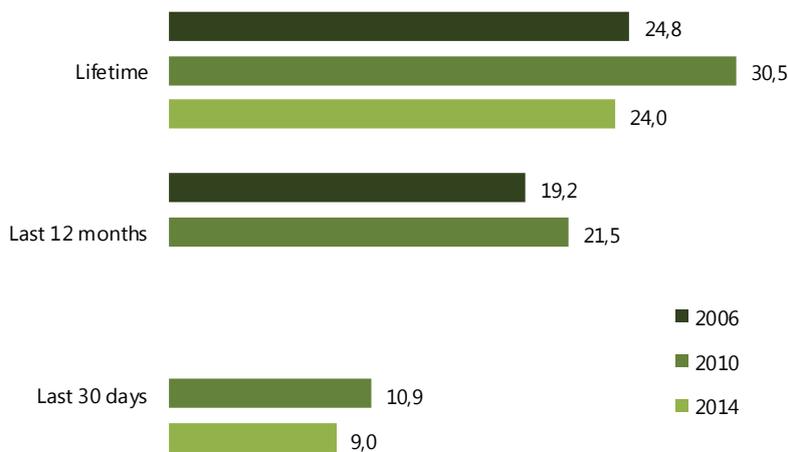
3.2.1.1.3 Cannabis Use in Schools and Other Sub-populations

Cannabis has been the most frequently used illicit drug among Czech adolescents – and the Czech Republic stands on top levels in cannabis use when compared across Europe in the long term (e.g. ESPAD study (20, 21). Overall, the lifetime prevalence of cannabis use reaches 17–20% among elementary school students aged 14–15 years and 42–47% among secondary school students aged 16 years. Studies among younger age groups (11–15 years) suggest prevalence of cannabis use around 9%; the increase of risk behaviour (including substance use) has been mostly reported between the age of 12 and 13, in case of substance use behaviour, the transition from elementary school to secondary school at the age of 15 years is regarded as a risk period. Data on cannabis use are available from HBCS study (carried out in the Czech

Republic since 2002), ESPAD study (carried out since 1995) and recent studies with national coverage carried out in 2014–2015. High rate of prevalence of cannabis use in the long run is in line with remaining high (subjectively perceived) availability of cannabis for students.

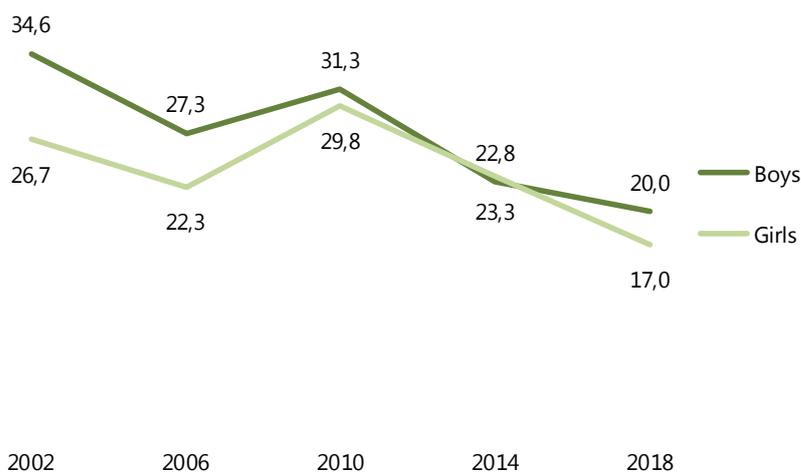
In HBSC 2018, the lifetime experience with cannabis use was reported by 17% of girls and 20% of boys aged 15, with 7% and 8% used cannabis in the last 30 days, respectively. Compared to 2010 and 2014, lifetime cannabis use declined (see Figure 3 and Figure 4) which is in line with previous ESPAD study findings showing a slight decline of cannabis use among 16-year-olds between 2007 and 2011.

Figure 3 - Cannabis use among students aged 15 according to HBSC study, trends in 2006–2014, in %



Source: Csémy and Sovinová (22), Kalman, Sigmund (23), Kalman, Baďura (24)

Figure 4 - Lifetime prevalence of cannabis use among students aged 15, by gender, according to HBSC study in 2002–2018, in %

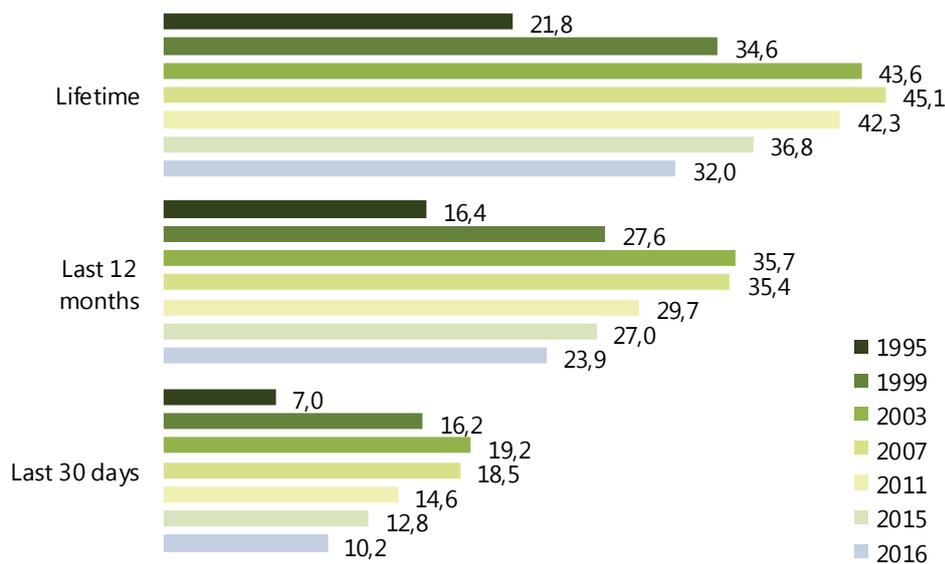


Source: Csémy and Sovinová (22), Kalman, Sigmund (23), Kalman, Baďura (24), Univerzita Palackého v Olomouci (25)

According to ESPAD 2015 study (N=2738), the lifetime use of cannabis was reported by 36.8% of students aged 16 years (nationally representative sample of students born in 1999), 36.1% of boys and 37.5% of girls, for the first time ever the prevalence among girls was higher than among boys. Cannabis use in the last 12 months was reported by 27.0% (25.8 % of boys and 28.2% of girls) and use in the last 30 days by 12.8% (13.5% of boys and 12.2% of girls).

Trends show that after an increase in cannabis use that was observed between 1995 and 2007, the lifetime prevalence dropped slightly in 2011 and further decline was observed between 2011 and 2015 (decline from 42.3% lifetime cannabis use in 2011 to 36.8% in 2015) (see Figure 5). Levels of last-year and last-month prevalence have been declining already since 2003. The declining trend in cannabis use was further confirmed by an ESPAD validation study carried out in 2016 using the ESPAD methodology on 2471 respondents from randomly selected schools (see also below). New data for the ESPAD study will be available for the year 2019.

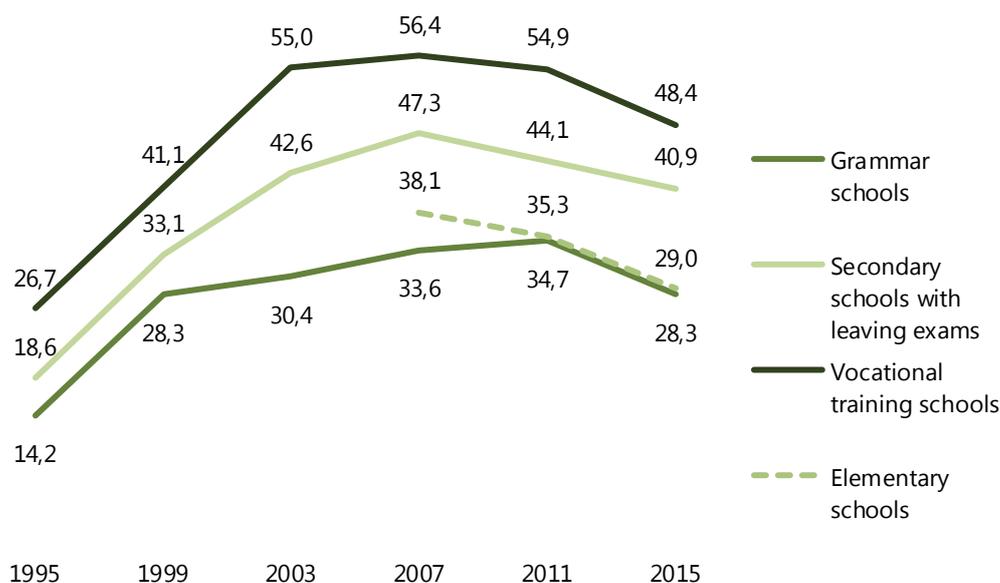
Figure 5 - Cannabis use among students aged 16 according to ESPAD study, trends in 1995–2016, in %



Source: Chomynová, Csémy (26), Chomynová, Csémy (2), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (27)

Significant differences were observed according to the type of school studied (see Figure 6) – cannabis use was reported by about 40% of secondary school students and 29% of elementary school students suggesting great changes undergoing with leaving the elementary level education system and entering secondary/high schools that are to a great extent related also to lower level of parental control and higher level of peer influence (2, 26). Declines in cannabis use observed in recent years were seen among students all types of schools.

Figure 6 - Trends in lifetime prevalence of cannabis use by type of school, trends between 1995–2015, in %



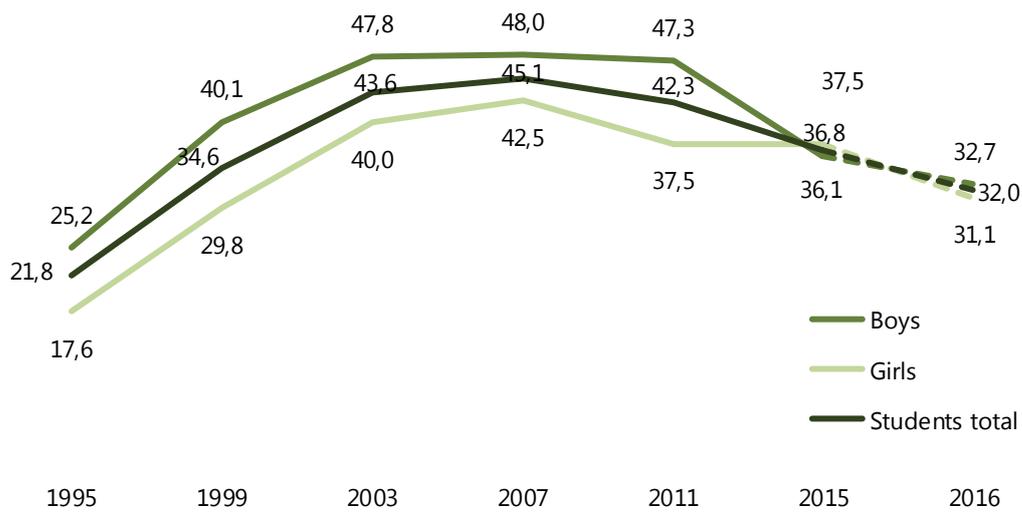
Source: Chomynová, Csémy (26), Chomynová, Csémy (2)

In 2016, a validation school study was carried out to confirm the results of ESPAD 2015, especially the significantly declining trends in tobacco smoking and alcohol consumption among the target group. The validation study was based on ESPAD methodology (random sampling of schools, cohort of students reaching 16 years, pen-and-paper questionnaire of the same content), sample size comprised of 2471 students born in 2000. According to the validation study 2016, lifetime prevalence of cannabis use among 16 year-olds reached 32.0% (32.7% boys and 31.1% girls), cannabis use in the last 12 months was reported by 23.9% (24.1% boys and 23.6% girls) and use in the last 30 days by 10.2% of students (12.0% boys and 8.0% girls) (see Figure 5 above). The validation study 2016 thus confirmed the findings of the ESPAD 2015 and declining trends in substance use among adolescents (both the use of licit substances and illicit substances) and the results showed that the declining trend in substance use has further continued between 2015 and 2016 (see Figure 7). The trend of narrowing the gap between boys and girls seen in ESPAD 2015 has also continued in 2016 showing practically no difference in the cannabis use between boys and girls.

In 2018, an ESPAD validation follow-up study was carried out on the same sample of students surveyed in 2016 (16 year-olds in 2016 and 18 year-olds in 2018, i.e. students born in 2000, N=1554). The lifetime cannabis use was reported by 53.5% of the students (55.2% of boys and 52.0% of girls), 40.8% used cannabis in the last 12 months and 14.6% in the last 30 days. No significant differences were observed in the lifetime experience with cannabis use by types of school, however, as regards the last year prevalence, higher prevalence of use was reported by grammar school students and students of secondary schools with leaving exams compared to their peers in vocational schools. As differences were observed among the students at the age of 16, this might mean that while students of vocational schools tend to experiment with cannabis earlier (have higher prevalence of use at the age of 16), students of other types of

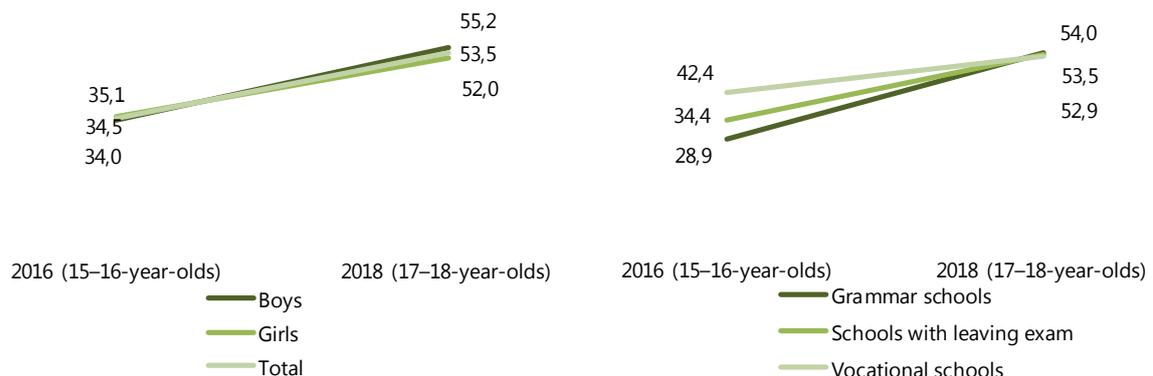
school initiate with cannabis use later and by the age of 18, their lifetime experience is on the same level. Slightly higher (but not statistically significant) lifetime and prevalence of cannabis use was observed by gender, which is further in line with the findings of general population surveys carried out among adult population reporting higher prevalence of substance use among males in the age group 15–24 years compared to females.

Figure 7 - Lifetime cannabis trends among students aged 16 according to ESPAD study, trends in 1995–2015 and validation study 2016, in %



Source: Chomynová, Csémy (2), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (27)

Figure 8 - Lifetime cannabis trends among students aged 16 according to ESPAD validation study 2016 and 2018, by gender and type of school, in %

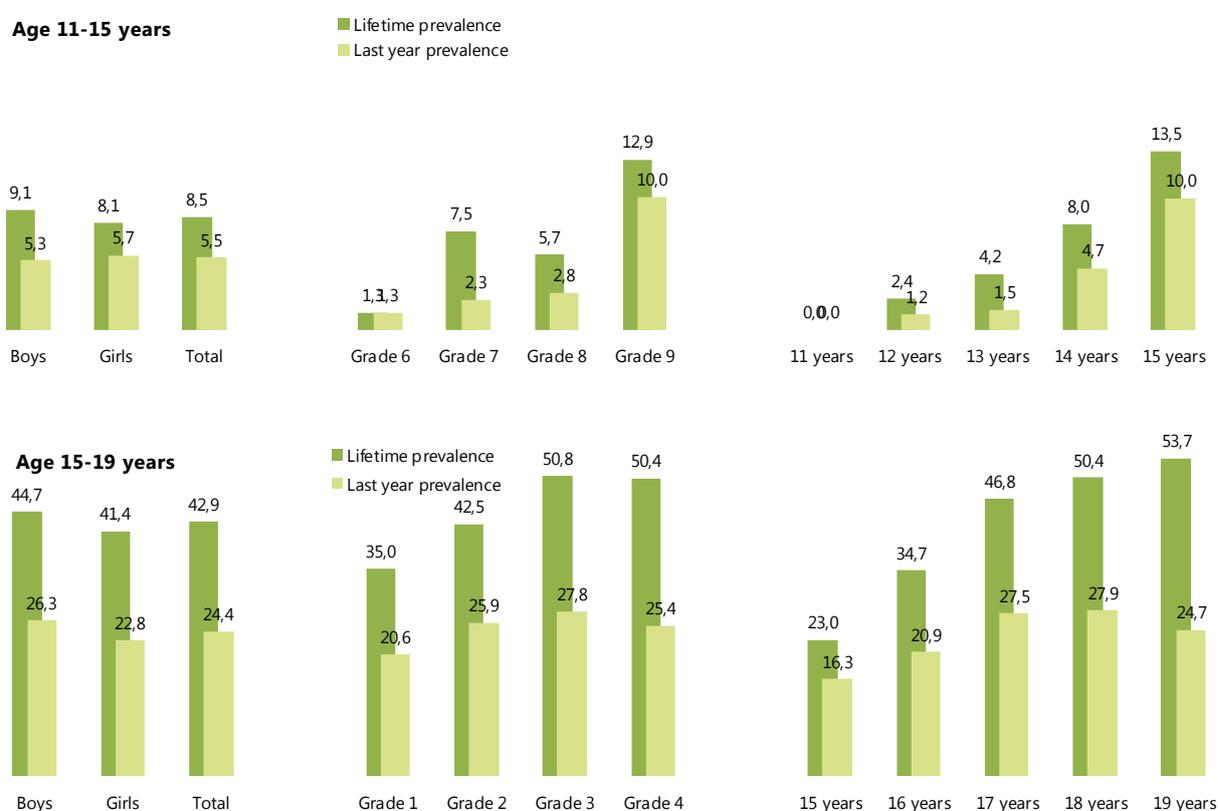


Source: Národní monitorovací středisko pro drogy a závislosti and ppm factum research (28)

Another nationally representative survey was carried out in the Czech Republic in 2018 among children from elementary schools and secondary school students aged 11–19 years old (N=3950) carried out within the scope of monitoring the risk behaviour among adolescents

(covering tobacco smoking, alcohol consumption and cannabis use), within a study focusing on digital gaming among adolescents. Lifetime use of cannabis was reported by 9.6% of elementary school students (aged 11–15 years) and 42.9% of secondary school students (aged 15–19 years). The lifetime and last-year prevalence of cannabis use increase with age and the grade of school studied (see Figure 9). The study confirmed earlier findings that the transition from elementary school to secondary school at the age of 15 years is regarded as a risk period for initiation into cannabis use, as well as other substances – while 15-year-olds that still study at the elementary school report 13.5% lifetime cannabis use, 15-year-olds already studying at any kind of secondary school report 23.0% lifetime cannabis use (see Figure 9).

Figure 9 - Lifetime and last-year cannabis use among students of elementary schools (11–15 years) and students of secondary schools (15–19 years), by gender, age and school grade, in %



Source: Chomynová, Dolejš (29)

3.2.1.1.4 Cannabis Use in Other Subpopulations

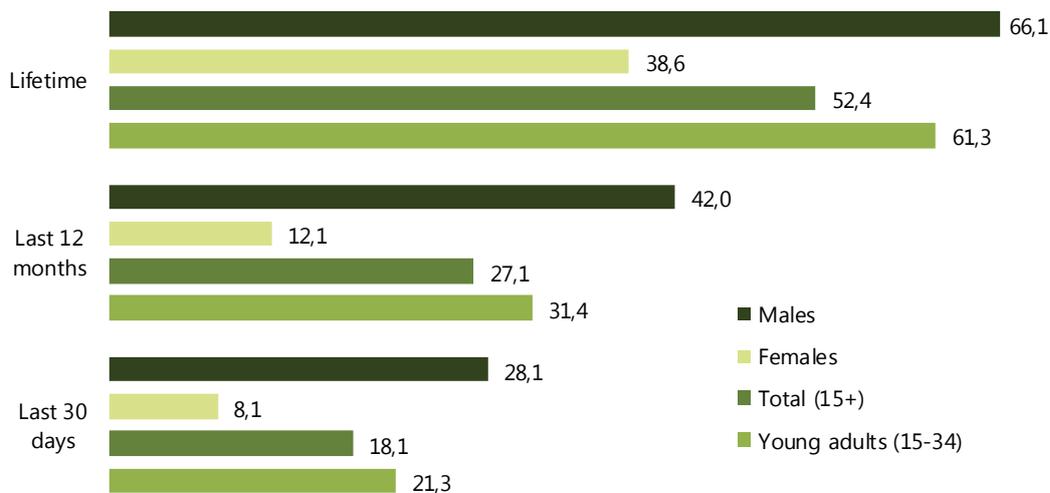
Specific studies were carried out among the prison population (5th wave of repeated study, data collected in 2010, 2012, 2014, 2016 and 2018) (30) and among Roma population in 2017 (single study) (31).

Results from the 2018 prison survey showed a significantly higher prevalence of substance use compared to the general population – lifetime prevalence of cannabis use reached 41.9%, altogether 28.3% used cannabis in the last 12 months before entering the prison sentence. Cannabis use at least once during the prison sentence was reported by 12.2% of the

respondents; 18% reported cannabis in prisons as easy or relatively easy to be obtained. The trends have remained relatively stable since the first wave of the study in 2010 (30). For more details see also chapter Prison.

Study focusing on Health and Substance Use Among Roma Population 2017 (N=546) showed that 52.4% of the studied population used cannabis in lifetime (66.1% of males and 38.6% of females), 61.3% among the age group 15–34 years. Cannabis use in the last 12 months was reported by 27.1% of the population, 18.1% used cannabis in the last 30 days (see Figure 10).

Figure 10 - Prevalence of cannabis use in the Roma population in contact with social workers in the socially excluded localities in 2017, in %



Source: Národní monitorovací středisko pro drogy a závislosti and ppm factum research (31)

Compared to general population, cannabis use is the highest among the youngest age group (15–24 years) – 36.4% of 15–24 year-olds used cannabis in the last 12 months compared to 27.7% of those aged 25–34 and 29.0% of those aged 35–44 years.

When weighted to the age and gender structure of the general population, cannabis use (in the last 12 months) among the Roma population was 2.5 times higher. A significantly higher prevalence of substance use among Roma population was seen after data weighting for all illicit substances, as well as tobacco smoking and alcohol consumption.

A study carried out in 2018 among children and young people in institutional care (with a focus on girls only, N=122) showed that girls in the institutional care are more vulnerable to substance use, experience lower satisfaction with life, higher rates of mental health problems and suicidality rates. Cannabis use in the last year was reported by 60.7% of girls aged 15–19 years being in 4 different facilities of institutional care which is twice as high as the prevalence of cannabis use in the last 12 months among girls in the general school population (28.2% age 16, 40.2% age 18) (2, 28, 32).

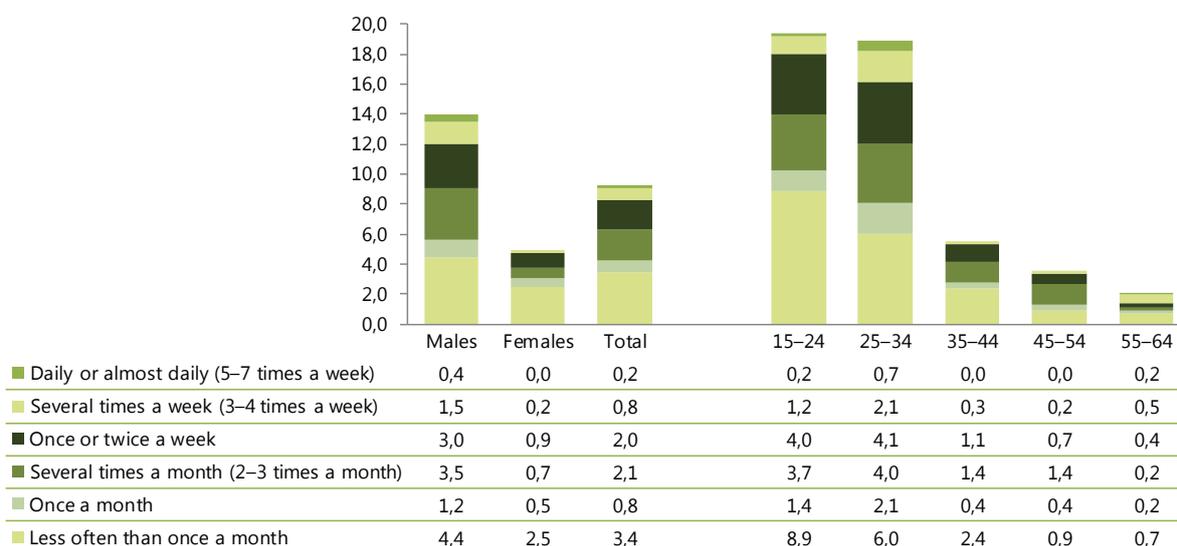
3.2.1.2 Patterns, treatment and problem/high risk use

3.2.1.2.1 Patterns of Cannabis Use

National Survey on Substance Use 2016, as well as study in 2012, collected data on frequency of cannabis use among the general population aged 15–64 years. Among those who used cannabis in the last 12 months (9.5%), about 3/4 used cannabis repeatedly and 2.3% daily (only males). Daily cannabis users created 0.2% of the general population, another 0.8% used cannabis several times a week (see Figure 11). More frequent cannabis users were among males and in the youngest age groups – the highest proportion of daily users and weekly users were in the age group 25–34 years.

Frequency of cannabis use is not monitored in the annual omnibus surveys; these surveys focus on prevalence of substance use only. New data from GPS will be available for the year 2020.

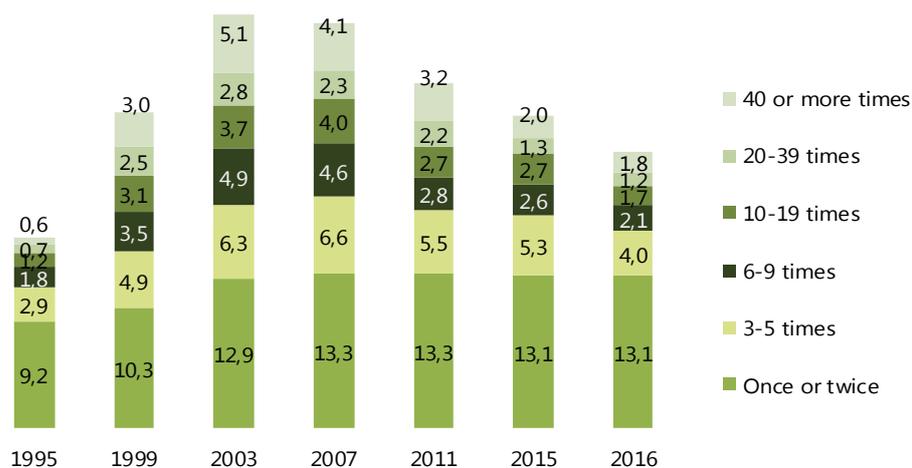
Figure 11 - Frequency of cannabis use in last 12 months among general population aged 15–64 years, in % (National Survey on Substance Use 2016)



Source: Národní monitorovací středisko pro drogy a závislosti and MindBridge Consulting (15)

Data collected within the ESPAD study allow for comparison of trends on frequency of cannabis use. Out of those students who reported use of cannabis in the last 12 months, about half of them used cannabis only once or twice. The proportion of students having used cannabis once or twice has remained stable since 2003, the proportion of students who report using cannabis more frequently has been decreasing (see Figure 12). Among those who reported last 12 months cannabis use, those having used cannabis only once or twice account for 55%, while 45% used cannabis 3 or more times in the last 12 months. Last-year cannabis users mostly reported use of marijuana (32.7% indoor-grown, 41.4% outdoor-grown), 2.6% of cannabis users reported use of hashish.

Figure 12 - Frequency of cannabis use in last 12 months among students aged 16 years according to ESPAD study, trends in 1995–2015, in %



Source: Chomynová, Csémy (26), Chomynová, Csémy (2)

Data from the 2018 ESPAD validation follow-up study showed that 19.1% of the students used cannabis only once or twice in the last 12 months (i.e. 47% of those who used cannabis in the last year) while 21.8% used cannabis 3 or more times in the last year (i.e. 53% of last-year cannabis users). The frequency of cannabis use was not questioned in other surveys.

3.2.1.2.2 Reducing the Demand for Cannabis

1. Until 2014, about 10 thousand people were annually asking for treatment in relation to their illicit substance use (all treatment demands), among them about 1 thousand (10–12%) reported cannabis as their primary drug; and about 700–800 people were asking for cannabis-related treatment for the first time (see Table 7). The number of treatment demands has been relatively stable since 2006, the proportion of cannabis-related treatment demands has been declining. The average age of people asking for (first) treatment has been increasing in the long run reaching almost 24 years in 2014. Compared to other people asking for treatment, cannabis users are the youngest. In March 2015, a new National Register of Treatment of Drug Users was launched combining now two previously independent registers – Treatment Demand Register and Substitution Treatment Register (for more details see chapter Treatment). The new register has been fighting with a couple of technical problems since its launch, and thus so far still does not cover all treatment centres that work with drug users. Data in the register are missing for an important part of treatment centres, and do not allow for more detailed trends analysis.

The current National Register of Treatment of Drug Users collects data on treatment demands related also to tobacco, alcohol and gambling problems, in three years for which are now data available, they include about 7–8 thousand people (including

tobacco, alcohol and gambling; compared to previously reported 10 thousand people asking for treatment only for illicit substances related problems).

In 2017, out of 8,647 people asking for treatment (all treatment demands), 1,141 (13.2%) reported cannabis as their primary drug; and 587 first demands for treatment were related to cannabis (16.7% of first TD). The average age of cannabis users asking for treatment in 2017 was 26.3 years, compared to 25.9 years in 2016.

In 2018, altogether 1,827 people entered treatment in relation to cannabis (out of 14,167 persons, 12.9%). 968 were first treatment demands, which accounted for 15.5% of first TD. The average age of cannabis users asking for treatment was 27.6 years in 2018.

Table 7 - Cannabis-related (all and first) treatment demands in 2003–2018

Cannabis	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
All TD	1403	1462	1238	1044	1083	1053	1121	1050	1214	1111	1077	1195	562	723	1141	1827
First TD	981	994	893	755	778	755	790	695	839	747	763	776	235	360	587	968
Cannabis among all TD	16.5	16.5	14.5	12.5	12.8	12.7	12.8	11.7	13.1	12.4	11.0	11.8	7.4	10.0	13.2	12.9
Cannabis among first TD	23.6	21.6	20.4	18.3	17.9	19.0	18.3	15.9	18.6	17.3	16.5	16.4	12.4	16.9	16.7	15.5
Average age (ATD)	19.6	20.1	20.0	20.0	21.0	21.3	21.0	22.4	22.8	22.9	22.8	23.9	25.4	25.9	26.3	27.6

Source: Füleová, Zónová (33), Ústav zdravotnických informací a statistiky (34), Ústav zdravotnických informací a statistiky (35), Ústav zdravotnických informací a statistiky ČR (36), Ústav zdravotnických informací a statistiky ČR (37)

2. About 2,300 cannabis users were in contact with low-threshold services in 2017, accounting for 5.9% of all low-threshold centres clients (compared to 3,000 in 2016 accounting for 7.5% and 2,400 in 2015 accounting for 6% of clients). The number of cannabis users in contact with LT services has been relatively stable since 2006, oscillating between 1600–3300 clients reported annually. About 2,100 cannabis users were in contact with low-threshold services in 2018, accounting for 5.5% of clients.

Since 2013, SANANIM civic association operates the website *koncimshulenim.cz* ("I'm Quitting Pot"), targeted specifically at cannabis users. It offers information about cannabis and the risks associated with its use, and advice on how to reduce consumption or quit. The site also offers a self-assessment test focused on detecting the rate of problem cannabis use and an online treatment programme for 8 weeks, the first of its kind in the Czech Republic.

3.2.1.2.3 High Risk Cannabis Use

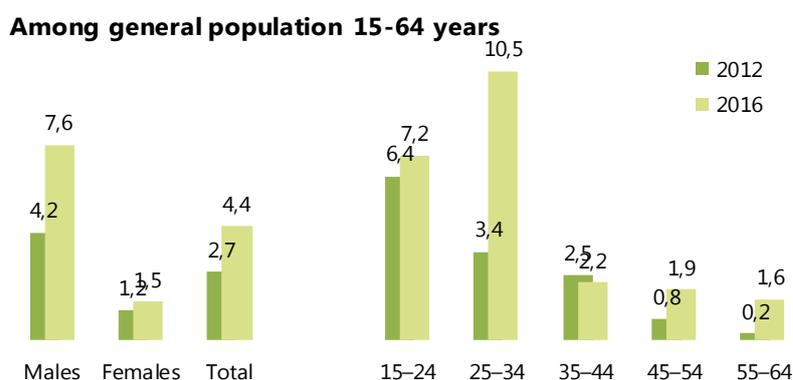
Information on high-risk cannabis use is available from National Surveys on Substance 2012 and 2016 as CAST screening test was included in the questionnaires, and from omnibus survey among general practitioners carried out in 2014, 2016 and 2018.

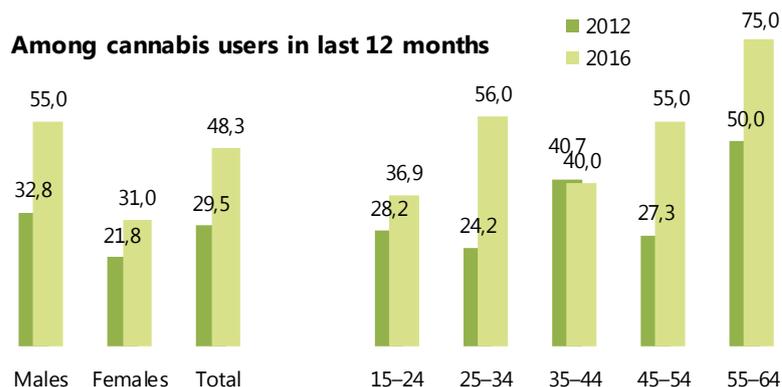
According to the National Survey on Substance 2016, a total of 28.9% of the respondents reporting cannabis use in the last 12 months (30.9% of males and 23.9% of females) fell into the moderate/medium-risk category (i.e. 3–6 points on the CAST scale) and another 19.4% of the users (24.1% of males and 7.0% of females) were identified as being at high risk related to their use of cannabis (i.e. 7 or more CAST points). Compared to 2012, the proportion of cannabis users at risk increased from 29.5% of users to 48.3% (55.0% of males and 31.0% of females). This means that together with stable or slightly declining prevalence of cannabis use, more users now use cannabis in more risky ways and are at higher risk of developing cannabis-related problems.

The proportion of individuals exposed to a high risk corresponds to approximately 1.8% of the population aged 15-64 (3.3% of males and 0.3% of females); those at moderate risk account for 2.7% of the population (4.3% of men and 1.1% of women). Compared to 2012, the proportion of population being at risk of cannabis-related problems almost doubled (increased from 2.7% in 2012 to 4.4% in 2016), the rates increased especially among males, and in age groups 25–34 and 45–54 and 55–64 years (see Figure 13 and Figure 14).

When extrapolated to the population aged 15-64, these rates are equivalent to about 125 thousand cannabis users at high risk and about another 188 thousand people exposed to a moderate/medium risk in relation to their use of the drug.

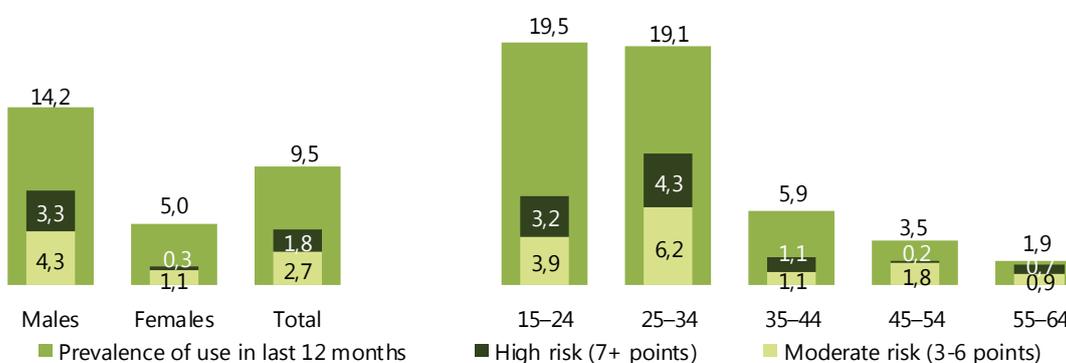
Figure 13 - Estimate of population aged 15–64 years and estimate of last-year cannabis users at risk of developing problems related to cannabis use (CAST screening scale), based on National Surveys on Substance Use 2012 and 2016, in %





Source: Národní monitorovací středisko pro drogy a závislosti and MindBridge Consulting (15), Chomynová (3)

Figure 14 - Prevalence of cannabis use in the last 12 months and estimate of cannabis users at risk of developing cannabis-related problems (CAST scale), National Survey on Substance Use 2016, in %



Source: Národní monitorovací středisko pro drogy a závislosti and MindBridge Consulting (15)

Omnibus survey among general practitioners carried out every 2 years included in 2012, 2014, 2016 and 2018 a question on the estimate of number of problem cannabis users, as well as question on estimate of problem alcohol users and problem gamblers. About 150 thousand individuals were estimated as intensive cannabis users in 2012, about 200 thousand in 2014 and 120 thousand in 2016, out of them 22–27 thousand were estimated to be younger than 18 years (based on information provided by the general practitioners for children) (38). While about 1.6% of the population aged 15–64 years in 2016 were estimated to be problem cannabis users, in 2018 the estimate reached 1.4% of the population being at risk of cannabis related problems, which corresponds approximately to 94–112 thousand people.

3.2.1.2.4 Synthetic Cannabinoids

Information is not available for synthetic cannabinoids specifically, they are included in the broader category of new psychoactive substances, see chapter Heroin and other opioids.

3.2.2 New developments

New Developments in Use of Cannabis

Cannabis use has been relatively stable in the Czech Republic in the long run. Some declines can be seen in the cannabis use in the youngest age groups (16-year-olds from ESPAD, age group 15–24 in the general population surveys, with increases seen among 25–34 year-olds and some increase in the older age groups. Increase was recorded for the estimate of high-risk cannabis users (based on CAST scale) – this may mean that together with stable (or slightly declining) prevalence of cannabis use, more users now use cannabis in more risky ways and are at higher risk of developing cannabis-related problems. Numbers of cannabis users entering treatment are slightly increasing as well, the average age of cannabis users in treatment has been increasing. Trends in more detail are described above.

3.2.3 Additional information

Additional Sources of Information

For the first time in 2018, the extent of use of CBD products was monitored within the framework of one of the annual omnibus surveys (Citizen Survey 2018). Use of the CBD products was surveyed among population aged 15+ years (N=1804).

Use of the CBD products (defined as CBD-herb or CBD-hash) was reported by 4.6% of the population aged 15+ (4.8% of males and 4.4% of females), 1.9% used CBD products in the last 12 months (1.5% of males and 2.4% of females) and 0.7% in the last 30 days (0.5% and 0.9% respectively). The use of CBD products was higher among the young adults aged 15–34 years – 6.6% reported lifetime use, 3.1% use in the last 12 months and 1.0% in the last 30 days. Comparison of prevalence of cannabis use in the last 12 months for recreational use, medical use and use of CBD products is presented in Figure 16.

Further Aspects of Cannabis Use

The National Survey on Substance Use 2016 covered a topic of medical use of cannabis – about 15.2% reported they have used cannabis for medical reasons in their lifetime (12.4% of males and 17.9% of females, 9.8% used cannabis for medical reasons in the last 12 months (see Table 8). Medical use of cannabis was also surveyed within the framework of one of the annual omnibus surveys in 2018.

Table 8 - Medical use of cannabis by gender and age – National Survey on Substance Use 2016 and Citizen Survey 2018, in %

Medical use of cannabis	Males	Females	Total (15+)	15-24	25-34	35-44	45-54	55-64	65+
National Survey on Substance Use 2016									
Lifetime	12.4	17.9	15.2	7.8	13.0	13.8	15.7	14.9	21.9
Last 12 months	7.8	11.6	9.8	5.1	8.0	8.0	9.5	9.1	15.7
Citizen Survey 2018									
Lifetime	14.6	13.4	14.0	15.4	15.8	13.0	11.4	11.0	16.5

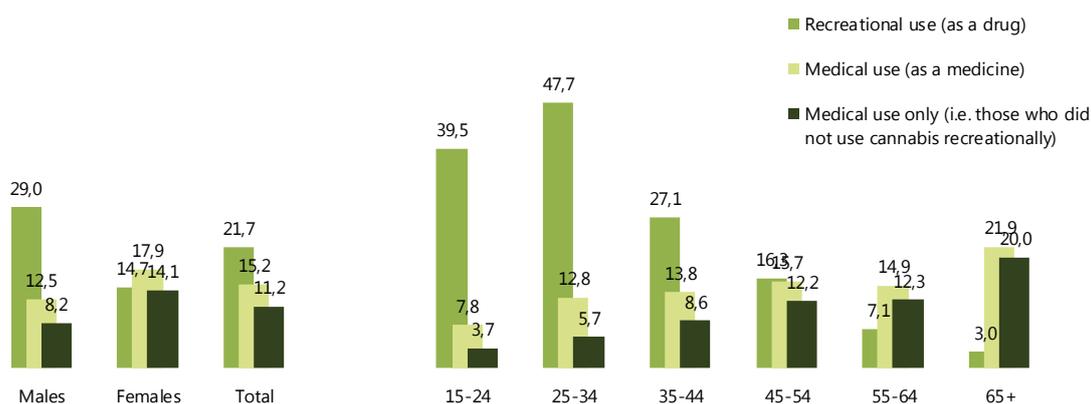
Last 12 months	8.5	7.2	7.9	9.5	9.2	5.1	5.5	6.1	11.4
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Source: Národní monitorovací středisko pro drogy a závislosti and MindBridge Consulting (15), Národní monitorovací středisko pro drogy a závislosti and INRES-SONES (19)

Medical use of cannabis was mostly reported by respondents in older age groups where the recreational use of cannabis was the lowest on the other hand (see Figure 15).

About 2/3 use probably psychoactive cannabis (not technical cannabis and its products). When extrapolated to the population aged 15+, it is estimated that about 880 thousand of people used cannabis for medical reasons in the last 12 months, out of them 570 thousand used cannabis with higher THC content. The source of cannabis is mostly out of official distribution – among those who use cannabis for medical purposes (15.2% in lifetime and 9.8% in the last 12 months), 6% reported they grew cannabis themselves and another 14% obtained cannabis grown by their relative or friend.

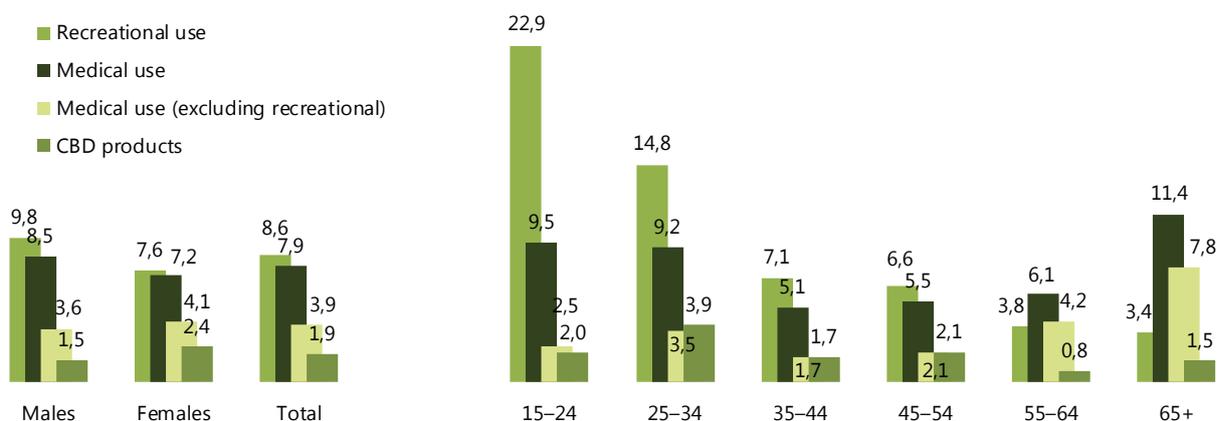
Figure 15 - Prevalence of cannabis use (lifetime) for recreational and medical reasons by gender and age, National Survey on Substance Use 2016, in %



Source: Národní monitorovací středisko pro drogy a závislosti and MindBridge Consulting (15)

Medical use of cannabis was similarly surveyed within the annual omnibus Citizen Survey in 2018. Medical use of cannabis in their lifetime was reported by 14.0% of the population aged 15+ (14.6% of males and 13.4% of females), and by 7.9% (8.5% and 7.2% respectively) in the last 12 months. Altogether 6.5% of the population used cannabis for medical purposes only (i.e. they did not report recreational cannabis use), 3.9% in the last 12 months. When extrapolated to the population aged 15+, it is estimated that about 707 thousand people used cannabis for medical reasons in the last 12 months (equivalent to 7.9%), among them 350 thousand for medical reasons only (equivalent to 3.9%), i.e. they did not report recreational cannabis use in the survey.

Figure 16 - Prevalence of cannabis use in the last 12 months – recreational use, medical use and use of CBD products – Citizen Survey 2018, in %



Source: Národní monitorovací středisko pro drogy a závislosti and INRES-SONES (19)

3.3 Stimulants

3.3.1 National profile

3.3.1.1 Prevalence and trends

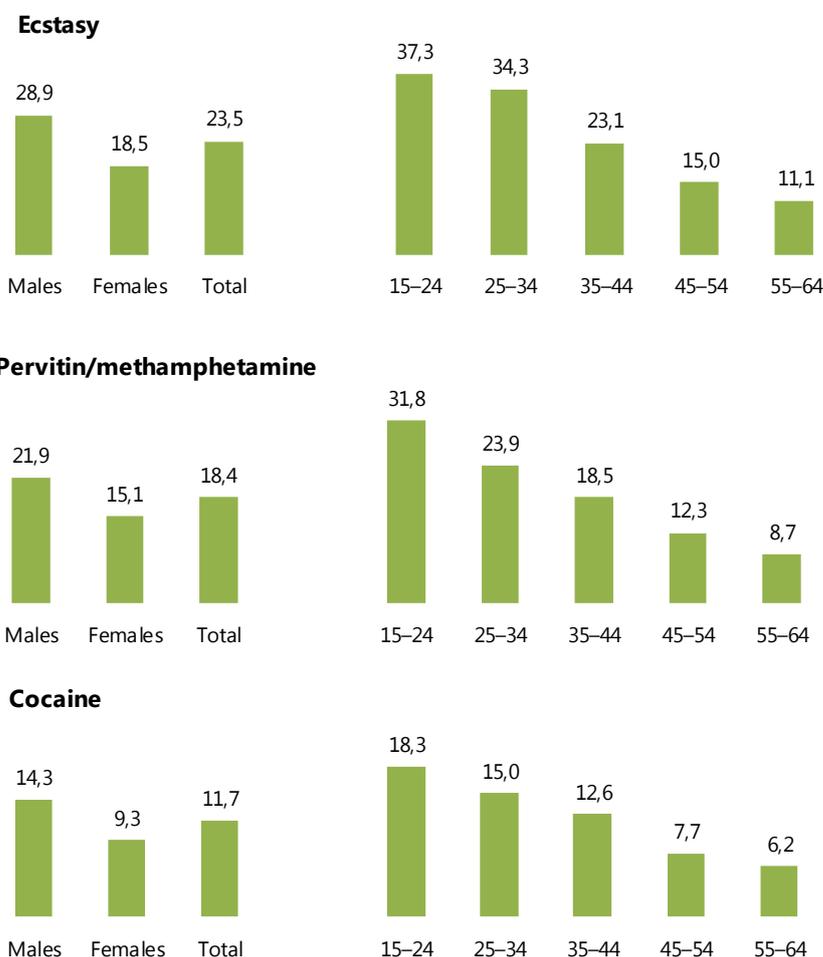
3.3.1.1.1 The Relative Importance of Different Stimulant Drugs

Among stimulants, ecstasy is the drug most prevalently used in the general population, especially among young adults, and in the school population. Pervitin/methamphetamine is the most prevalent problem drug in the Czech Republic, accounting for almost 80% of the estimated number of problem drug users, and most of them are injecting drug users. Cocaine is not included in the definition of PDU (or HRDU) and estimates of problem cocaine use are only based on frequent cocaine users; however, the prevalence of cocaine use is still relatively low in the Czech Republic, though there are signs of cocaine use in specific population groups and environment (e.g. nightlife settings). Synthetic cathinones are not widely used in the general population. In the last years, a significant share of the PDUs reports experience with synthetic cathinones, however, only a few report them as a primary drug. Synthetic cathinones are the most available from the group of new psychoactive substances, available mostly in internet shops, usually under the name "Funky".

Among the general population (aged 15–64) ecstasy is perceived as the most easily available stimulant – in National Survey on Substance Use 2016, altogether 23.5% of the respondents reported that they perceived availability of ecstasy as easy or very easy, 18.4% perceived pervitin/methamphetamine as easily available, and 11.7% cocaine. Perceived availability of all stimulants was higher among males, and the highest in the youngest age group and falling with age (see Figure 17). Compared to 2012, the subjectively perceived availability, measured by the percentage of population answering "quite easy" or "very easy" to obtain, increased for all three stimulants (from 15.8% to 23.5% for ecstasy, from 11.9% to 18.4% for pervitin and from 7.2% to

11.7% for cocaine). New data for the availability of substance will be available for 2020 National Survey on Substance Use that will be carried out in Autumn 2020.

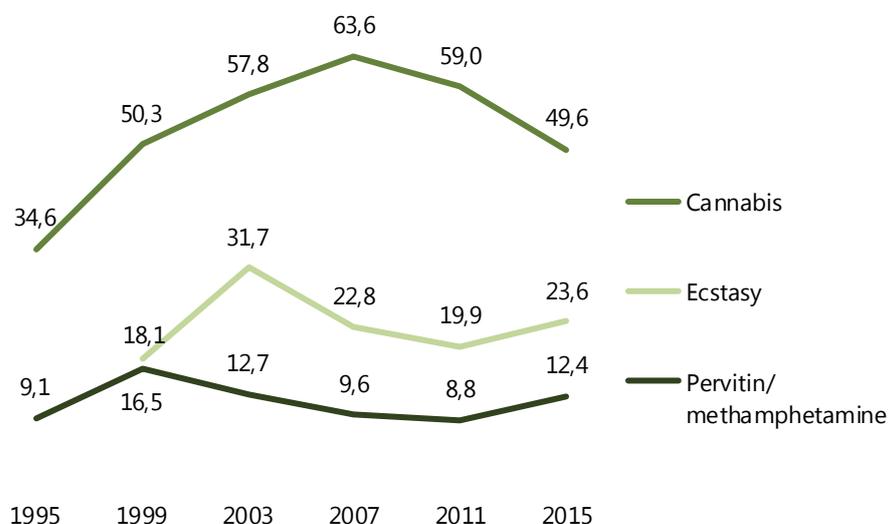
Figure 17 - Subjectively perceived availability of ecstasy, pervitin/methamphetamine and cocaine – National Survey on Substance Use 2016, % of answers “quite easy” or “very easy to obtain”



Source: Národní monitorovací středisko pro drogy a závislosti and MindBridge Consulting (15)

Findings from the ESPAD 2015 study showed that 23.6% of the 16 years-old students perceive ecstasy as easily available (22.7% boys and 24.5% girls). Pervitin/methamphetamine is perceived as easily available by 12.4% (11.6% boys and 13.2% girls). After an increase in perceived availability of ecstasy between 1997 and 2003 and pervitin between 1995 and 1999, the availability started to decline (for ecstasy from 31.7% in 2003 to 19.9% in 2011 and for pervitin from 16.5% in 1999 to 8.8% in 2011). The decline is in line with decrease in (lifetime and last 12 months) prevalence of ecstasy and pervitin use among adolescents (2). However, the perceived availability of both ecstasy and pervitin increased again between 2011 and 2015 (see Figure 18). The risk perception in relation to pervitin use has remained relatively stable, moreover, the proportion of students perceiving experiment with pervitin use (1-2times in lifetime) as very risky, declined between 2011 and 2015.

Figure 18 - Subjectively perceived availability of cannabis, ecstasy and pervitin/methamphetamine – ESPAD 1995–2015, % of answers “quite easy” or “very easy to obtain”



Source: Chomynová, Csémy (26), Chomynová, Csémy (2)

3.3.1.1.2 Stimulant Use in the General Population

Among stimulants, ecstasy is the drug most prevalently used in the general population, especially among young adults, and in the school population. Lifetime use of ecstasy reached 7.1% in 2016, and 14.3% in the age group of 15–34 years, and 1.6% and 0.3% prevalence in the last 12 months and last 30 days (4.0% and 0.9% in the age group 15–34 respectively) (see Table 9). Data from 2017 showed lifetime prevalence of ecstasy 4.3–5.8%, with 0.8–1.6% prevalence in the last 12 months and 0.2–0.3% prevalence in the last 30 days, and data from 2018 showed lifetime prevalence of ecstasy 5.3–6.3%, 0.9–1.8% in the last 12 months and 0.1–0.2% in the last 30 days.

Prevalence of pervitin/methamphetamine and cocaine in the general population reached lower levels – lifetime pervitin use reached 3.0% in 2016 and 0.8% in the last 12 months (see Table 10), while lifetime cocaine use reached 1.4% and 0.3% in the last 12 months (see Table 11). New data from 2017 showed lifetime prevalence of pervitin between 2.1–3.3% and lifetime cocaine use between 1.9–2.4%. Use of both pervitin and cocaine in the last 30 days was below 0.3%. In 2018, the lifetime prevalence of pervitin/methamphetamine use was 2.0–2.1%, and 0.3% in the last 12 months, and cocaine use reached 1.3–2.9% and 0.1–0.3% respectively.

Stimulants use in general was higher among men and in younger age groups (15–34 years). The last 12 months and last 30 days prevalence fluctuate over years and differ between the surveys as the omnibus population surveys catch only a small number of users of other drugs than cannabis.

Table 9 - Prevalence of ecstasy use in the general population (aged 15–64 years) in 2011–2018, in % (omnibus surveys Prevalence of Drug Use in the Population PPM), compared to National Survey on Substance Use 2012 and 2016, and omnibus Citizen Survey 2016–2018)

	Lifetime prevalence				Last 12 months				Last 30 days					
	15–64				15–34		15–64		15–34		15–64		15–34	
	n	M	F	T	n	T	M	F	T	T	M	F	T	T
PPM 2011	(n=901)	8.1	3.4	5.8	(n=361)	9.8	2.2	0.9	1.6	2.5	0.2	0.0	0.1	0.2
PPM 2012	(n=854)	7.6	3.4	5.5	(n=345)	10.1	1.4	0.2	0.8	1.8	0.5	0.0	0.2	0.6
2012 - National Survey	(n=2134)	5.0	2.2	3.6	(n=824)	7.2	0.7	0.5	0.6	1.2	0.2	0.0	0.1	0.1
PPM 2013	(n=868)	6.8	3.3	5.1	(n=308)	11.3	1.2	0.9	1.1	3.0	0.2	0.0	0.1	0.3
PPM 2014	(n=870)	9.0	2.8	6.0	(n=313)	12.8	2.3	0.9	1.6	3.6	0.0	0.0	0.0	0.0
PPM 2015	(n=851)	8.4	4.1	6.3	(n=320)	12.1	1.6	1.0	1.3	3.5	0.0	0.2	0.1	0.3
PPM 2016	(n=849)	6.4	3.9	5.1	(n=323)	9.5	1.4	1.0	1.2	2.5	0.5	0.0	0.2	0.3
2016 - National Survey	(n=2875)	10.0	4.4	7.1	(n=1017)	14.3	2.4	0.9	1.6	4.0	0.4	0.3	0.3	0.9
Citizen Survey 2016	(n=1745)	4.7	2.5	3.6	(n=552)	6.0	1.3	0.8	1.1	2.7	0.3	0.4	0.3	0.9
PPM 2017	(n=1261)	8.8	2.8	5.8	(n=456)	12.2	1.3	0.3	0.8	2.1	0.3	0.0	0.2	0.5
Citizen Survey 2017	(n=1404)	5.5	3.0	4.3	(n=491)	9.0	2.0	1.2	1.6	3.7	0.6	0.0	0.3	0.8
PPM 2018	(n=1665)	6.8	3.7	5.3	(n=623)	9.2	1.1	0.7	0.9	1.6	0.0	0.1	0.1	0.0
Citizen Survey 2018	(n=1392)	8.1	4.4	6.3	(n=485)	11.1	2.8	0.7	1.8	4.1	0.4	0.0	0.2	0.6

Source: Chomynová (3), Běláčková, Nechanská (4), Národní monitorovací středisko pro drogy a drogové závislosti and INRES-SONES (5), Národní monitorovací středisko pro drogy a drogové závislosti and INRES-SONES (6), Národní monitorovací středisko pro drogy a drogové závislosti and INRES-SONES (7), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (8), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (9), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (10), Národní monitorovací středisko pro drogy a drogové závislosti and ppm factum research (11), Národní monitorovací středisko pro drogy a drogové závislosti and Factum Invenio (12), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (13), Národní monitorovací středisko pro drogy a závislosti and INRES-SONES (14), Národní monitorovací středisko pro drogy a závislosti and MindBridge Consulting (15), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (16), Národní monitorovací středisko pro drogy a závislosti and INRES-SONES (17), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (18), Národní monitorovací středisko pro drogy a závislosti and INRES-SONES (19)

Table 10 - Prevalence of pervitin/methamphetamine use in the general population (aged 15–64 years) in 2011–2018, in % (omnibus surveys Prevalence of Drug Use in the Population, compared to National Survey on Substance Use 2012 and 2016, and omnibus Citizen Survey)

	Lifetime prevalence						Last 12 months				Last 30 days			
	15–64				15–34		15–64			15–34	15–64			15–34
	n	M	F	T	n	T	M	F	T	T	M	F	T	T
PPM 2011	(n=901)	3.1	1.1	2.1	(n=361)	3.8	0.9	0.7	0.8	1.4	0.0	0.0	0.0	0.0
PPM 2012	(n=854)	2.6	0.5	1.5	(n=345)	2.4	0.7	0.0	0.4	0.6	0.0	0.0	0.0	0.0
2012 - National Survey	(n=2134)	3.4	1.7	2.5	(n=824)	4.5	0.7	0.3	0.5	1.0	0.3	0.1	0.2	0.4
PPM 2013	(n=868)	1.4	0.7	1.1	(n=308)	2	0.2	0.2	0.2	0.7	0.2	0.0	0.1	0.3
PPM 2014	(n=870)	3.4	1.6	2.6	(n=313)	4.9	1.4	0.2	0.8	2.3	0.2	0.0	0.1	0.3
PPM 2015	(n=851)	5.9	2.9	4.4	(n=320)	7.3	0.7	1.0	0.8	2.2	0.0	0.2	0.1	0.0
PPM 2016	(n=849)	2.1	3.1	2.6	(n=323)	4.4	0.2	0.7	0.5	0.9	0.2	0.0	0.1	0.0
2016 - National Survey	(n=2875)	4.5	1.5	3.0	(n=1017)	5.9	1.0	0.6	0.8	1.7	0.7	0.1	0.3	0.9
Citizen Survey 2016	(n=1745)	1.9	1.0	1.4	(n=552)	2.2	0.7	0.3	0.5	0.7	0.1	0.3	0.2	0.4
PPM 2017	(n=1261)	4.2	2.3	3.3	(n=456)	5	0.3	0.3	0.3	0.7	0.0	0.0	0.0	0.0
Citizen Survey 2017	(n=1404)	2.7	1.4	2.1	(n=491)	3.3	0.7	0.7	0.7	1.4	0.3	0.3	0.3	0.8
PPM 2018	(n=1665)	2.3	1.6	2.0	(n=623)	2.5	0.1	0.5	0.3	0.5	0.0	0.2	0.1	0.2
Citizen Survey 2018	(n=1392)	2.4	1.8	2.1	(n=485)	2.3	0.3	0.3	0.3	0.8	0.1	0.0	0.1	0.2

Source: Chomynová (3), Běláčková, Nechanská (4), Národní monitorovací středisko pro drogy a drogové závislosti and INRES-SONES (5), Národní monitorovací středisko pro drogy a drogové závislosti and INRES-SONES (6), Národní monitorovací středisko pro drogy a drogové závislosti and INRES-SONES (7), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (8), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (9), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (10), Národní monitorovací středisko pro drogy a drogové závislosti and ppm factum research (11), Národní monitorovací středisko pro drogy a drogové závislosti and Factum Invenio (12), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (13), Národní monitorovací středisko pro drogy a závislosti and INRES-SONES (14), Národní monitorovací středisko pro drogy a závislosti and MindBridge Consulting (15), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (16), Národní monitorovací středisko pro drogy a závislosti and INRES-SONES (17), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (18), Národní monitorovací středisko pro drogy a závislosti and INRES-SONES (19)

Table 11 - Prevalence of cocaine use in the general population (aged 15–64 years) in 2011–2018, in % (omnibus surveys Prevalence of Drug Use in the Population (PPM), compared to National Survey on Substance Use 2012 and 2016, and omnibus Citizen Survey 2016–2018)

	Lifetime prevalence						Last 12 months				Last 30 days			
	15–64				15–34		15–64		15–34		15–64		15–34	
	n	M	F	T	n	T	M	F	T	T	M	F	T	T
PPM 2011	(n=901)	1.8	1.1	1.4	(n=361)	2.5	0.4	0.7	0.6	1.2	0.2	0.0	0.1	0.3
PPM 2012	(n=854)	0.2	0.2	0.2	(n=345)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
2012 - National Survey	(n=2134)	3.8	0.9	2.3	(n=824)	3.7	0.8	0.0	0.4	0.5	0.3	0.0	0.1	0.2
PPM 2013	(n=868)	0.7	0.0	0.4	(n=308)	0.7	0.2	0.0	0.1	0.3	0.2	0.0	0.1	0.3
PPM 2014	(n=870)	1.6	0.2	0.9	(n=313)	2.3	0.5	0.0	0.2	0.6	0.5	0.0	0.2	0.6
PPM 2015	(n=851)	2.6	1.0	1.8	(n=320)	3.5	0.0	0.2	0.1	0.3	0.0	0.2	0.1	0.3
PPM 2016	(n=849)	2.1	1.7	1.9	(n=323)	2.8	0.9	1.0	0.9	0.6	0.5	0.2	0.4	0.3
2016 - National Survey	(n=2875)	2.2	0.6	1.4	(n=1017)	2.4	0.4	0.2	0.3	0.7	0.3	0.1	0.2	0.6
Citizen Survey 2016	(n=1745)	1.9	1.0	1.4	(n=552)	2.0	0.7	0.1	0.4	0.5	0.1	0.1	0.1	0.2
PPM 2017	(n=1261)	3.2	1.5	2.4	(n=456)	4.6	0.0	0.2	0.1	0.2	0.0	0.0	0.0	0.0
Citizen Survey 2017	(n=1404)	2.1	1.7	1.9	(n=491)	3.3	0.6	0.7	0.6	1.4	0.1	0.0	0.1	0.2
PPM 2018	(n=1665)	1.3	1.4	1.3	(n=623)	2.3	0.1	0.1	0.1	0.2	0.1	0.0	0.1	0.2
Citizen Survey 2018	(n=1392)	4.7	1.0	2.9	(n=485)	4.7	1.4	0.3	0.3	0.8	0.0	0.0	0.0	0.0

Source: Chomynová (3), Běláčková, Nechanská (4), Národní monitorovací středisko pro drogy a drogové závislosti and INRES-SONES (5), Národní monitorovací středisko pro drogy a drogové závislosti and INRES-SONES (6), Národní monitorovací středisko pro drogy a drogové závislosti and INRES-SONES (7), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (8), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (9), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (10), Národní monitorovací středisko pro drogy a drogové závislosti and ppm factum research (11), Národní monitorovací středisko pro drogy a drogové závislosti and Factum Invenio (12), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (13), Národní monitorovací středisko pro drogy a závislosti and INRES-SONES (14), Národní monitorovací středisko pro drogy a závislosti and MindBridge Consulting (15), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (16), Národní monitorovací středisko pro drogy a závislosti and INRES-SONES (17), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (18), Národní monitorovací středisko pro drogy a závislosti and INRES-SONES (19)

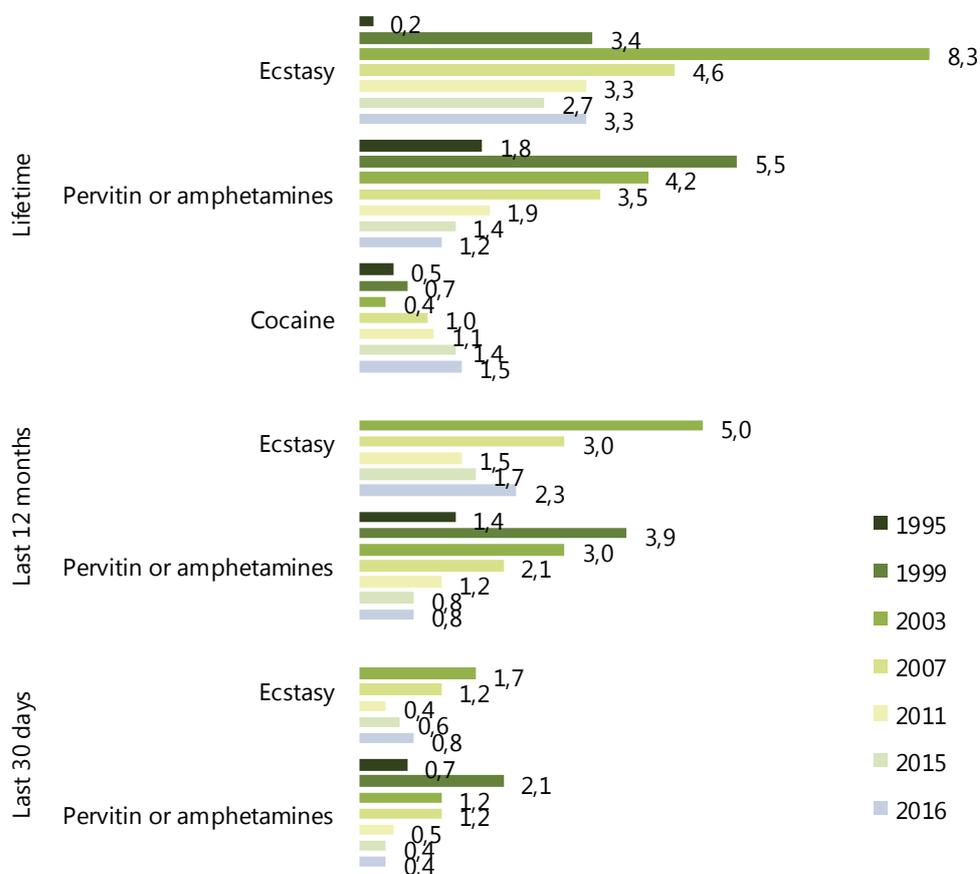
3.3.1.1.3 Stimulant Use in School Population

Among stimulants, ecstasy is the drug most prevalently used in the school population as well – lifetime prevalence reached 3.3% among 16-year-old students in 2016, while pervitin prevalence reached 1.2% and cocaine 1.5%. Based on long-term trends surveyed in ESPAD study, it seems that the use of ecstasy among school students peaked in 2003 and since then has been declining, with slight increase seen in 2016 ESPAD validation study.

The reported use of pervitin has been declining since 1999 – see Figure 19. Reported use of cocaine has stabilized around 1%, in the long run the trends suggest a slight increase in reported cocaine use. Last 12 months and last 30 days for cocaine are not available from the ESPAD study (data available for 2015 only).

The lifetime (and last 12 months) prevalence of ecstasy was higher among boys than girls (3.7% boys and 2.9% girls), while the lifetime prevalence of pervitin was higher among girls (1.1% boys and 1.4% girls). Prevalence of cocaine use in lifetime was on the same level in 2016 (1.5% boys and 1.5% girls).

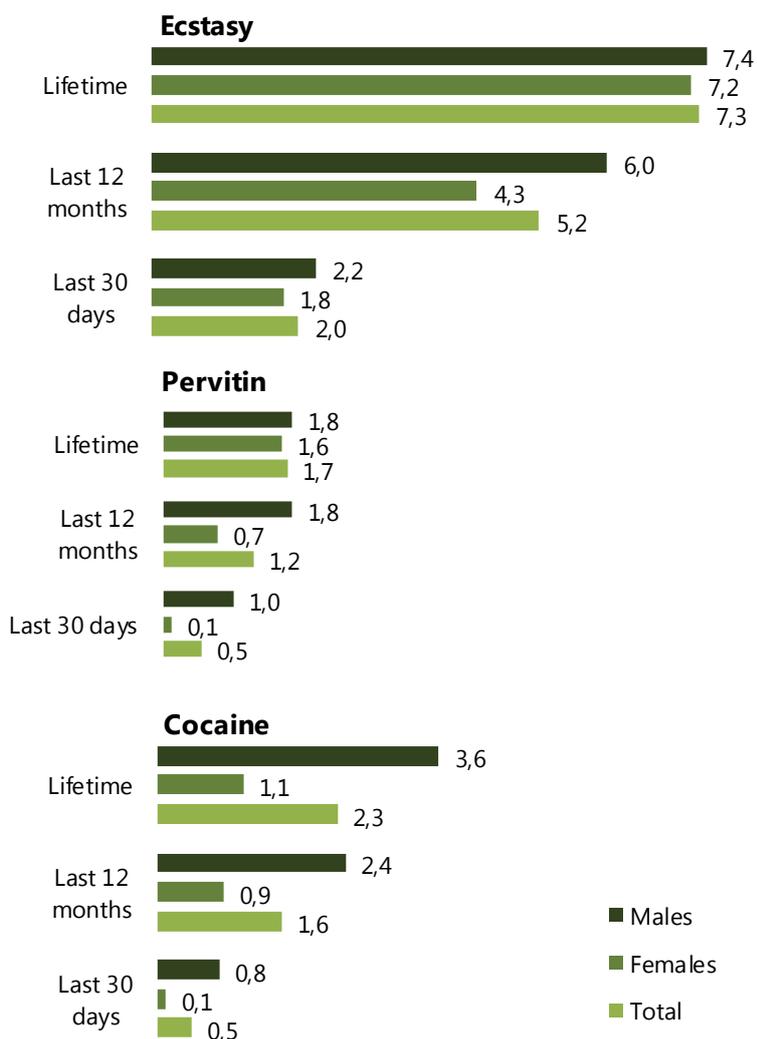
Figure 19 - Prevalence of stimulant use among 16-year-old students according to ESPAD study, trends in 1995–2015 and ESPAD validation study 2016, in %



Source: Chomynová, Csémy (26), Chomynová, Csémy (2), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (27)

In 2018, an ESPAD validation follow-up study was carried out on the same sample of students surveyed in 2016 (16 year-olds in 2016 and 18 year-olds in 2018, i.e. students born in 2000, N=1554). The lifetime ecstasy use was reported by 7.3% of the students, 5.2% used cannabis in the last 12 months and 2.0% in the last 30 days. Lifetime pervitin use was reported by 1.7% and cocaine by 2.3%, use in the last 12 months by 1.2% and 1.6% of students, respectively (Figure 20). Significant differences by types of school were only observed in case of lifetime use of ecstasy and last-year use of pervitin, with the highest prevalence of use being reported by students of vocational schools and lowest by grammar school students.

Figure 20 - Lifetime, last year and last month prevalence of ecstasy, pervitin and cocaine use among students aged 17–18 years – ESPAD validation study 2018, in %



Source: Národní monitorovací středisko pro drogy a závislosti and ppm factum research (28)

Data on stimulant use in the school population are not available in other school surveys listed above providing information on cannabis use.

3.3.1.1.4 Stimulant Use in Other Subpopulations

Specific studies were carried out among the prison population (5th wave of repeated study, data collected in 2010, 2012, 2014, 2016 and 2018) (30) and among Roma population in 2017 (single study) (31). New wave of prison survey was carried out in 2018, for detailed results see chapter Prison.

Results from prison survey showed relatively high lifetime prevalence of pervitin use (38.8%), last 12 months prevalence (29.9%), and last 30 days prevalence (before entering prison) (22.7%), resulting thus in a comparable level of pervitin (methamphetamine) use as cannabis use.

Comparing the 5 waves of data collection of the prison study, the last 12 months and last 30 days prevalence have increased, while lifetime prevalence moderately stayed relatively stable

over time (38.5% in 2010, 42.3% in 2016 and 38.8% in 2018). About 11% of prison population reported pervitin use while in the prison sentence (compared to 12% for cannabis use) (30).

Injecting (of any drug) (in 2016) was reported by 31.2% of the prison population in lifetime, 22.8% injected in the last 30 days before entering prison and 7.3% injected in the prison.

For more details see also chapter Prison.

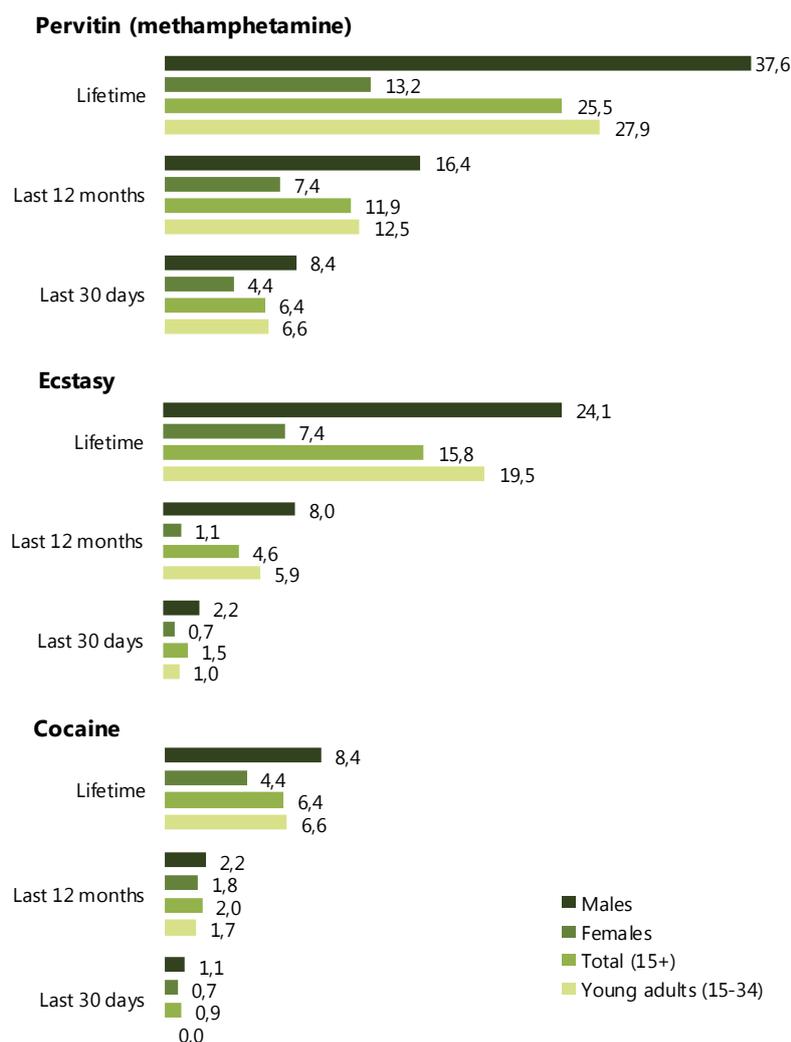
Ecstasy use in lifetime was reported by 21.4% of the prison population, 11.6% used ecstasy in the last 12 months prior to imprisonment (7.1% in the last 30 days). Cocaine use in lifetime was reported by 16.6%, 6.9% and 3.8% used cocaine in the last 12 months and last 30 days prior to imprisonment.

Study focusing on Health and Substance Use Among Roma Population 2017 (N=546) showed that pervitin (methamphetamine) is the most widely used stimulant drug in the Roma community. About 25.5% of the studied population used pervitin in lifetime (37.6% of males and 13.2% of females), 27.9% among the age group 15–34 years. Pervitin use in the last 12 months was reported by 11.9% of the population, 6.4% used pervitin in the last 30 days (see Figure 21). Ecstasy is the second most popular stimulant among Roma community with 15.8% lifetime prevalence (4.6% in last 12 months and 1.5% in last 30 days), while prevalence of cocaine use was on much lower level (6.4% in lifetime, 2.0% in last 12 months and 0.9% in last 30 days).

Compared to general population, pervitin use in the last 12 months was the highest among the age group 45+ years, while ecstasy use was the highest among 25–34 and 15–24 year-olds, and cocaine was the most prevalence among 35–44 year-olds.

When weighted to the age and gender structure of the general population, pervitin use (in the last 12 months) among the Roma population was 10 times higher, ecstasy use was almost 3 times higher and cocaine use among the Roma population was almost 6 times higher. A significantly higher prevalence of substance use among Roma population was seen after data weighting for all illicit substances, as well as tobacco smoking and alcohol consumption.

Figure 21 - Prevalence of stimulant use in the Roma population in 2017, in %



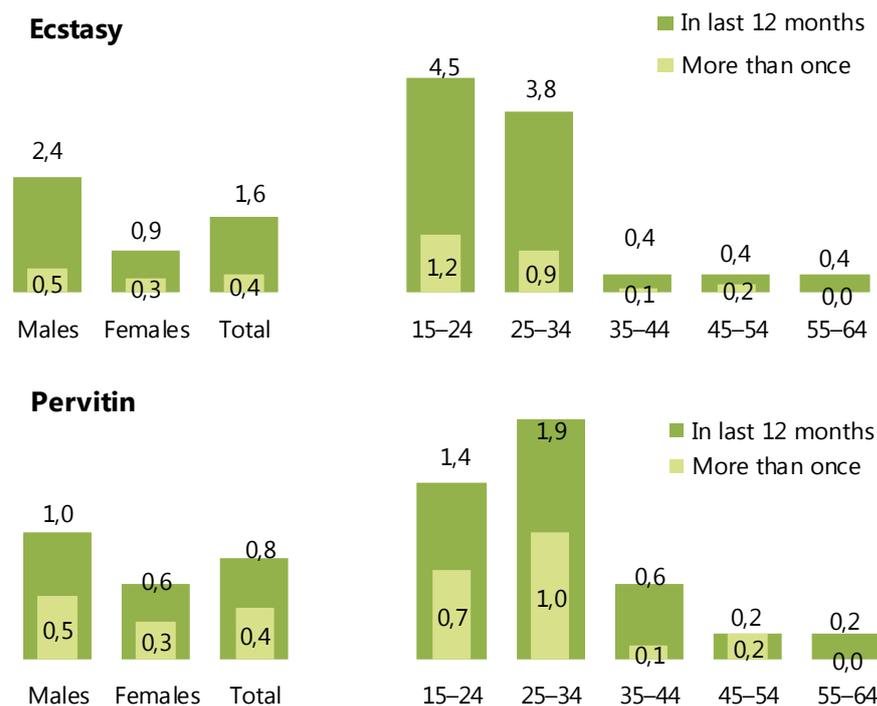
Source: Národní monitorovací středisko pro drogy a závislosti and ppm factum research (31)

3.3.1.2 Patterns, treatment and problem/high risk use

3.3.1.2.1 Patterns of Stimulant Use

National Survey on Substance Use 2016, as well as study in 2012, collected data on frequency of use of stimulants among the general population aged 15–64 years. Among those who used ecstasy in the last 12 months (1.6%), about 1/4 used cannabis repeatedly, while about 1/2 of last 12 months pervitin and cocaine users reported repeated use (see Figure 22). The highest proportion of users reporting repeated use was in the youngest age groups, but it should be taken into account that the population survey only caught a low number of last 12 months users. About 0.1% of the population reported use of cocaine with a frequency of once a week or more often, no weekly user of pervitin was recorded. New data will be available for 2020 from the next wave of National Survey on Substance Use; the patterns of stimulants use are not surveyed within the annual omnibus surveys.

Figure 22 - Prevalence of stimulants use in the last 12 months and prevalence of repeated use in the last 12 months, National Survey on Substance Use 2016, in %



Source: Národní monitorovací středisko pro drogy a závislosti and MindBridge Consulting (15)

3.3.1.2.2 Treatment for Stimulants

In 2014, out of 10,108 people asking for treatment (all treatment demands), 7,014 (69.4%) reported pervitin/methamphetamine as their primary drug; 3543 first demands for treatment were related to pervitin (75% of first TD). In the long run, the number of treatment demands has been relatively stable until 2009 and increasing since then, and the proportion of pervitin-related treatment demands among all TD has been increasing as well. The increasing number of pervitin users entering treatment was in line with increasing numbers (estimates) of problem pervitin/methamphetamine users. At the same time, more users were getting into contact with services for drug users.

The average age of pervitin users asking for treatment has been increasing in the long run reaching 28.5 years in 2014.

In March 2015, a new National Register of Treatment of Drug Users was launched combining now two previously independent registers – Treatment Demand Register and Substitution Treatment Register (for more details see chapter Treatment). The new register has been fighting with a couple of technical problems since its launch, and thus so far still does not cover all treatment centres that work with drug users. Data in the register are missing for an important part of treatment centres, and do not allow for more detailed trends analysis.

The current National Register of Treatment of Drug Users collects data on treatment demands related also to tobacco, alcohol and gambling problems, in both years for which are now data available, they include about 7–8 thousand people (including tobacco, alcohol and gambling;

compared to previously reported 10 thousand people asking for treatment only for illicit substances related problems).

In 2018, out of 14,167 treatment demands altogether 3,703 pervitin/methamphetamine users asked for treatment (26.1%), among them 1,684 for the first time (26.9% of first treatment demands). The average age slightly increased to 31.1 years in 2018 (see Table 12). Another 102 amphetamine users asked for treatment in 2018, among them 28 for the first time.

Only 51 cases of all TD were related to ecstasy use in 2018, and 32 were first treatment demands (accounting for about 0.4% of all demands for treatment). The number of ecstasy-related treatment demands has been relatively low in the long-run, with few individual cases in the last years.

53 cases of cocaine or crack-related TD were reported in 2018 (higher number compared to previous years – 19 in 2016 and 24 in 2017), out of them 25 were first treatment demands, accounting for about 0.4% of all TD. The numbers of all treatment demands related to cocaine has been oscillating between 10-30 TDs annually in the last years, the average age of cocaine users asking for treatment has been increasing in the long-run and cocaine users belong among the oldest (32 years in average in 2014; newer data are not available).

For more details see also chapter Treatment.

Out of 3,703 clients seeking treatment related to pervitin use, 65.4% reported only pervitin, while 34.6% reported use of other drugs as well (6.8% reported use of opioids, 26.0% cannabis, 1.2% sedatives or hypnotics and 3.9% alcohol).

Table 12 - Stimulants-related (all and first) treatment demands in 2003–2018

Pervitin	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
All TD	4490	4790	4855	4889	5177	4925	5209	5632	5999	5993	6860	7014	2592	1404	2317	3703
First TD	2281	2685	2605	2528	2749	2492	2626	2933	3116	3037	3428	3543	895	599	1012	1684
Pervitin among all TD	52.7	54.2	56.9	58.4	61.0	59.5	59.4	62.5	64.6	66.9	70.1	69.4	33.9	19.5	26.8	26.1
Pervitin among first TD	54.9	58.4	59.6	61.4	63.3	62.6	60.8	67.2	69.1	70.4	74.0	74.7	47.2	28.1	28.8	26.9
Average age (ATD)	23.6	24.2	24.5	24.2	25.0	25.4	25.5	26.7	27.1	27.5	27.8	28.5	29.6	29.5	30.1	31.1
Ecstasy	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
All TD	50	37	23	12	11	14	8	7	6	6	8	4	6	11	26	51
First TD	24	27	16	7	5	10	5	4	3	3	4	3	3	10	17	32
Ecstasy among all TD	0.6	0.4	0.3	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.0	0.1	0.2	0.3	0.4
Ecstasy among first TD	0.6	0.6	0.4	0.2	0.1	0.3	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.5	0.5	0.5
Cocaine	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018

All TD	22	18	15	12	22	24	38	23	30	19	18	27	13	19	24	53
First TD	15	13	5	5	13	15	24	15	14	10	12	12	7	13	13	25
Cocaine among all TD	0.3	0.2	0.2	0.1	0.3	0.3	0.4	0.3	0.3	0.2	0.2	0.3	0.2	0.3	0.3	0.4
Cocaine among first TD	0.4	0.3	0.1	0.1	0.3	0.4	0.6	0.3	0.3	0.2	0.3	0.3	0.4	0.6	0.4	0.4
Average age (ATD)		26.9	29.1	30.1	26.8	29.6	28.1	29.3	29.8	31.3	27.8	32.1	n.a.	n.a.	n.a.	n.a.

Source: Füleová, Zónová (33), Ústav zdravotnických informací a statistiky (34), Ústav zdravotnických informací a statistiky (35), Ústav zdravotnických informací a statistiky ČR (36), Ústav zdravotnických informací a statistiky ČR (37)

3.3.1.2.3 High Risk Stimulant Use

In 2018, a revision of the PDU/HRDU estimates was done, retrospectively for the years 2009–2018. This revision aimed to eliminate the overlap of clients in contact with different low-threshold centres in Prague, now the client should be only counted once. As Prague has a relatively high share of the HRDUs in the country, the total estimates have changed.

In 2018 there were approximately 43.7 thousand high-risk (problem) drug users (HRDUs) in the Czech Republic, including 33.5 thousand methamphetamine (pervitin) users, 3.4 thousand heroin users, 5.2 thousand buprenorphine users and 1.7 thousand users of other opioids (i.e. 10.2 thousand opioid users in total). The number of injecting drug users (IDUs) was estimated at 39.5 thousand (5.86 per 1,000 population aged 15–64 years). In relative numbers, the rate of problem pervitin users reached 4.97 per 1,000 population aged 15–64 years, while the rate of opioid users reached 1.52 per 1,000 population aged 15–64 years. The rate of injecting users reached 5.86 per 1,000 population aged 15–64 years.

Of the group of stimulants, pervitin (methamphetamine) remains the one that is used in the Czech Republic almost exclusively. Pervitin (methamphetamine) users account for 76.7% of all the high-risk/problem drug users. The long-term trends suggest an increasing number of PDU/high-risk users of pervitin in the Czech Republic since 2007; the proportion of pervitin users among all PDUs was increasing as well between 2002 and 2014 (while the number of heroin users has been relatively stable over this time period), however, a moderate decline was observed since 2014. The increasing estimated number of problem opioid users is to a certain level due to a new estimate of users of other opioids than heroin and buprenorphine, such as estimates of users of opioid analgesics, carried out since 2015.

Table 13 - Estimated number of PDU related to pervitin/methamphetamine use in 2002–2018

Pervitin PDU	Pervitin users	Pervitin users among all PDU
2002	21 800	62.1
2003	18 800	64.8
2004	20 300	67.7
2005	20 500	64.5
2006	19 700	65.2
2007	20 900	67.6

2008	21 200	65.2
2009	24 100	71.7
2010	26 600	76.0
2011	28 900	79.8
2012	28 100	78.1
2013	32 000	80.0
2014	33 600	80.2
2015	32 700	77.5
2016	31 600	77.5
2017	32 100	77.0
2018	33 500	76.7

Source: Národní monitorovací středisko pro drogy a závislosti (39)

Omnibus survey among general practitioners carried out every 2 years included a question on the estimate of number of problem pervitin users (40, 41). About 17-23 thousand individuals were estimated as problem/high-risk pervitin users in 2014 and 2016, out of them approximately 1.8 thousand were estimated to be younger than 19 years (based on information provided by the general practitioners for children) (38). New estimates for 2018 reached 13 thousand pervitin users (95% CI: 10–17 thousand), out of them 1.4 thousand were estimated to be younger than 19 years.

The phenomenon associated with recent years was the emergence of new synthetic drugs of the cathinone or phenethylamine group. Very low proportion of HRDUs report them as their primary drug. According to the Multiplier study carried out among clients of low-threshold centres in 2013, in some regions in past (2013) a significant proportion (no less than one third) of high-risk drug users reported they had used them at least once in the last 12 months. e.g. in Prague. While the prevalence in other regions was much lower (10% in the whole sample) (42). Since 2013 the problem use of cathinones has been rarely reported, suggesting a declining trend in the recent years.

3.3.1.2.4 *Injecting and other Routes of Administration*

The number of (last-year) injecting drug users was estimated to 37.7 thousand in 2017 and 39.5 in 2018, however, these numbers do not distinguish injecting users of opioids and stimulants.

In 2014, based on TDI Register, altogether 78% of pervitin users were injecting the drug, 19% reported sniffing and 2.3% reported smoking. In 2015, the proportion of injectors among all pervitin users asking for treatment reached 71%, and 63% among pervitin users asking for treatment for the first time. 26 out of 27 cocaine users reported in the TDI Register in 2014 reported sniffing as the main route of administration.

Data on injecting drugs by type are available from the new National Register of Treatment of Drug Users launched in March 2015. However, the data and trends base on them must be interpreted with caution as the new register has been fighting with a couple of technical problems since its launch, and thus so far still does not cover all treatment centres that work

with drug users. Data in the register are missing for an important part of treatment centres, and do not allow for more detailed trends analysis (for more details see chapter Treatment).

In 2017, from 2,317 people asking for treatment in relation to pervitin (methamphetamine) use, 62.5% reported injecting (among them 37.1% injected in the last 30 days), injecting was reported by 57.5% of first treatment demands related to pervitin (39.0% injected in the last 30 days). Sniffing was reported by 30.2% of ATD (all treatment demands) and 35.4% of FTD (first treatment demands).

Information on routes of administration related to cocaine are not available in the new register. In 2018, injecting was reported by 55% of pervitin users (in the last 30 days) asking for treatment, and among 57% of pervitin users asking for treatment for the first time.

For more detailed information on injecting and other routes of administration see chapter Harms and Harm Reduction.

3.3.1.2.5 Infectious Diseases

For detailed information on infectious diseases see chapter Harms and Harm Reduction.

3.3.1.3 Synthetic Cathinones

Information is not available for synthetic cathinones specifically, they are included in the broader category of new psychoactive substances, see chapter 3.5.

3.3.2 New developments

New Developments in the Use of Stimulants

As already mentioned above, the phenomenon associated with recent years is the emergence of new synthetic drugs of the cathinone or phenethylamine group: still very low proportion of HRDUs report them as their primary drug. Synthetic cathinones are the most available from the group of new psychoactive substances, available mostly in internet shops, usually under the name "Funky".

3.4 Heroin and other opioids

3.4.1 National profile

3.4.1.1 Prevalence and trends

3.4.1.1.1 The Relative Importance of Different Opioid Drugs

Surveys in general (adult) population and school population report low prevalence of use of opioids. Opiates/opioids included in the estimates of high-risk drug use in the Czech Republic are mainly heroin and, ever more frequently, diverted buprenorphine. There are signs of increasing misuse of opioid analgesics (fentanyl patches, morphine-based analgesic Vendal® Retard and hydromorphone-based Palladone®) in the last years. Cases of heroin production from unrefined opium or morphine products have appeared, usually seasonally in Summer;

braun production from codeine products have been reported occasionally, use of desomorphine (crocodile) has not yet been reported in the Czech Republic.

3.4.1.1.2 Estimates of Opioid Use in the General Population

National Survey on Substance Use 2016 only covers heroin use in the questionnaire, while the annual omnibus surveys Prevalence of Drug Use in the Population of the Czech Republic, as well as the Citizen Surveys in 2016–2018, also surveyed the use of other opioids (e.g. methadone, buprenorphine or fentanyl without doctor's prescription). The use of opioid analgesics is questioned separately within the National Survey on Substance Use; in the omnibus surveys, these are a part of a question asking about the use of psychoactive medicines without doctor's prescription (i.e. use of sedatives or hypnotics and/or opioid analgesics without doctor's prescription).

The use of opioids in the general population has been on very low level compared to the use of cannabis or stimulant drugs. National Survey on Substance Use 2016 reported lifetime prevalence of heroin use as 0.7% (1.2% for males and 0.3% for females, with 1.3% among the age group 15–34 years. The prevalence of heroin use in the last 12 months reached 0.2%, the prevalence of use in the last 30 days reached 0.1%. Omnibus surveys Prevalence of Drug Use in the Population of the Czech Republic 2016 reported lifetime prevalence of 1.1% (1.6% for males and 0.5% for females), 0.2% for both last 12 months prevalence and last 30 days; the Citizen Survey 2016 reached even lower proportion of opioids users in the general population (0.5% lifetime, 0.0% last 12 months and last 30 days prevalence). Omnibus surveys carried out in 2017 reported lifetime prevalence of 0.2–0.4 % for heroin use and 1.1% for other opioids. Last year prevalence of opioids use was almost 0. Similar prevalence was observed in omnibus surveys in 2018 – lifetime prevalence reached 0.4–0.7% and prevalence in the last 12 months was 0.1–0.2%; respective figures for other opioids were 0.9–1.3% in lifetime and 0.1–0.4% in the last 12 months. Users of heroin in the last 30 days were not captured by the population surveys.

Prevalence of heroin and/or other opioids use in the school population has been very low as well, reaching 0.7% among 16-year-old students in ESPAD 2015 and 1.1% in the same age group surveyed within the ESPAD validation study in 2016. In 2018, an ESPAD validation follow-up study was carried out on the same sample of students surveyed in 2016 (16 year-olds in 2016 and 18 year-olds in 2018, i.e. students born in 2000, N=1554). The lifetime heroin (including other opioids) use was reported by 0.6% of the students, 0.5% used cannabis in the last 12 months and 0.1% in the last 30 days (28).

Other school surveys do not include questions on use of heroin or other opioids.

3.4.1.1.3 Estimates of Opioid Use in Sub-populations

Specific studies were carried out among the prison population (5th wave of repeated study, data collected in 2010, 2012, 2014, 2016 and 2018) (30, 43) and among Roma population in 2017 (single study) (31).

Results from prison survey in 2018 showed relatively high lifetime prevalence of heroin use (11.8%), last 12 months prevalence (6.5%), and last 30 days prevalence (before entering prison) (4.9%), resulting thus in a comparable level of heroin use as hallucinogens and cocaine use; in terms of last 30 days prevalence, heroin use was more prevalent than cocaine use.

Buprenorphine use was reported less often – 7.8% reported use in lifetime, 4.0% in the last 12 months and 2.9% in the last 30 days.

Comparing the 5 waves of data collection, the reported use of both heroin and buprenorphine in lifetime, last 12 months and last 30 days remained stable. About 3% of prison population reported heroin use while in the prison sentence, and 3% of buprenorphine use (compared to 12% for cannabis use and 11% for methamphetamine/pervitin use) (30, 43).

Injecting (of any drug) was reported by 30% of the prison population in lifetime, and 7% injected in the prison. About 28% of the prison population may be classified as problem drug users (i.e. injected drug or have used methamphetamine, opioids or cocaine regularly before entering prison), which, when extrapolated on the prison population, corresponds to approximately 5.7 thousand people.

For more details see also chapter Prison.

Study focusing on Health and Substance Use Among Roma Population 2017 (N=546) questioned use of heroin together with other opioids, and buprenorphine-based substances separately. About 7.1% of the studied population used heroin or opioids in lifetime (10.6% of males and 3.7% of females), 6.3% in the age group 15–34 years and 8.1% in the age group 35+ years. Use in the last 12 months was reported by 1.3% of the population, 0.9% used heroin in the last 30 days. Buprenorphine was reported by 5.3% in lifetime (1.0% in last 12 months and 0.3% in last 30 days). Compared to the general population, the use of heroin among Roma community was about 8.5 times higher (though it has to be noted that the prevalence of heroin use in the general population is very low) (31).

3.4.1.2 Patterns. treatment and problem/high risk use

3.4.1.2.1 Patterns of Heroin/Opioid Use

National Survey on Substance Use 2016 included a question on frequency of heroin use in the last 12 months and last 30 days – however the low number of users of heroin captured by the GPS does not allow further frequency analysis. The annual omnibus surveys do not include a question on frequency of substance use.

Based on the 2018 TDI Register data, out of 1,360 opiate/opioid users 55% were injecting the drug.

Out of the clients reporting injection as the main route of administration, about half of opiate/opioid users were current injectors, while a half has a history of injection but currently

prefer a different route of administration. For more detailed information on injecting and other routes of administration see chapter Harms and Harm Reduction.

Out of 1,360 clients seeking treatment related to opioid use, 67.4% reported only opioids, while 32.6% reported use of other drugs as well (18.2% methamphetamine (pervitin), 7.4% cannabis, 3.0% sedatives or hypnotics and 2.9% alcohol).

3.4.1.2.2 Treatment for Opiates/Opioids

In 2014, out of 10,108 people asking for treatment (all treatment demands), 1,720 (17%) reported opiates/opioids as their primary drug (out of them 818 were related to heroin, 8% of all, and 510 were related to buprenorphine, 5% of all TD); 333 first demands for treatment were related to opiates/opioids (7% of first TD). The number of treatment demands has been relatively stable until 2010 and then dropped to lower level. The proportion of opiates/opioids related treatment demands among all TD and first TD has been declining. The average age of opiates/opioids users asking for treatment has been increasing in the long run reaching 33.6 years in 2014 for heroin users and 32.9 years for buprenorphine users. For details, see Table 9.

In March 2015, a new National Register of Treatment of Drug Users was launched combining now two previously independent registers – Treatment Demand Register and Substitution Treatment Register (for more details see chapter Treatment). The new register fights with a couple of technical problems since its launch, and thus so far does not cover all treatment centres that work with drug users. Data in the register is thus missing, and do not allow for more detailed trends analysis. The current National Register of Treatment of Drug Users collects data on treatment demands related also to tobacco, alcohol and gambling problems, in both years for which are now data available, they include about 7–8 thousand people (including tobacco, alcohol and gambling; compared to previously reported 10 thousand people asking for treatment only for illicit substances related problems).

In 2018, out of 14,167 treatment demands altogether 1,360 opioids users asked for treatment (9.6%), among them 333 for the first time (5.3% of first treatment demands). The average age (combines together heroin and buprenorphine users) has slightly increased to 37.0 years (36.0 years in 2017) (see Table 14).

Table 14 - Opiates/opioids-related (all and first) treatment demands in 2003–2018

Opiates/opioids	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
All TD	2133	2169	2058	2126	1961	2063	2053	2084	1791	1615	1681	1720	2531	2534	912	1360
First TD	656	710	702	686	680	602	634	606	443	417	362	333	163	207	215	333
Opiates among all TD	25.0	24.5	24.1	25.4	23.1	24.9	23.4	23.1	19.3	18.0	17.2	17.0	33.1	35.2	10.5	9.6
Opiates among first TD	15.8	15.4	16.1	16.7	15.6	15.1	14.7	13.9	9.8	9.7	7.8	7.0	8.6	9.7	6.1	5.3
Average age – heroin (ATD)		25.1	36.4	26.2	28.1	28.7	28.6	30.3	31.0	31.6	32.1	33.6	35.7	36.6	36.0	37.0

Average age – buprenorphine (ATD)																		
		23.4	25.1	25.4	27.0	27.7	27.7	29.2	29.8	31.0	31.1	32.9						

Source: Füleová, Zónová (33), Ústav zdravotnických informací a statistiky (34), Ústav zdravotnických informací a statistiky (35), Ústav zdravotnických informací a statistiky ČR (36), Ústav zdravotnických informací a statistiky ČR (37)

3.4.1.2.3 High Risk Opioid Use

In 2018, a revision of the PDU/HRDU estimates was done, retrospectively for the years 2009–2018. This revision aimed to eliminate the overlap of clients in contact with different low-threshold centres in Prague, now the client should be only counted once. As Prague has a relatively high share of the HRDUs in the country, the total estimates have changed.

In 2018 there were approximately 43.7 thousand high-risk (problem) drug users (HRDUs) in the Czech Republic, out of them 10.2 thousand opioid users (3.4 thousand heroin users, and 5.2 thousand buprenorphine users and 1.7 thousand users of other opioids, mostly opioid analgesics). Opioid users account for 23.3% of the high-risk drug users.

The long-term trends suggest a relatively stable number of problem/high-risk users of opioids in the Czech Republic since 2002 but the share of heroin and buprenorphine users has been changing – see Table 15. Until 2011, heroin users dominated over buprenorphine users. Since 2012, there are more buprenorphine users among the estimated high-risk/problem users and their number between 2006 and 2014/2015 almost doubled. The proportion of opioid users among all PDUs has been declining since 2002. However, since 2015 the proportion of opioid users among all PDUs has been increasing again, which might be related to the new estimate of users of other opioids. In 2017, the relative number of opioid users reached 1.89 per 1,000 inhabitants aged 15–64 years.

Table 15 - Estimated number of PDU related to opioid use in 2002–2018

Opioid PDU	Heroin users	Buprenorphine users	Users of other opioids	Opioid users (total)	Opioid users among all PDU (%)
2002	–	–	–	13 300	37.9
2003	–	–	–	10 200	35.2
2004	–	–	–	9 700	32.3
2005	–	–	–	11 300	35.5
2006	6 200	4 300	–	10 500	34.8
2007	5 750	4 250	–	10 000	32.4
2008	6 400	4 900	–	11 300	34.8
2009	6 000	3 600	–	9 600	28.6
2010	4 900	3 500	–	8 400	24.0
2011	3 900	3 400	–	7 300	20.2
2012	3 300	4 500	–	7 900	21.9
2013	2 700	5 200	–	7 900	19.8
2014	3 100	5 200	–	8 300	19.8
2015	3 300	5 200	1 000	9 500	22.5

2016	2 500	5 200	1 500	9 200	22.5
2017	2 800	4 900	1 900	9 600	23.0
2018	3 400	5 200	1 700	10 200	23.3

Source: Národní monitorovací středisko pro drogy a závislosti (44), Mravčík, Chomynová (45), Národní monitorovací středisko pro drogy a závislosti (39)

Omnibus survey among general practitioners, that has been carried out every 2 years since 2003/2004, included a question on the estimate of number of problem opioid users among patients of GPs (38). About 24 thousand individuals were estimated as problem/high-risk opioid users in 2016 (95% CI: 16.6–30.8), out of them approximately 2.7 thousand were estimated to be younger than 19 years (based on information provided by the general practitioners for children). New estimates for 2018 reached 10.7 thousand problem/high-risk opioid users (95% CI: 7.5–13.9 thousand), among them approximately 1.3 thousand were younger than 19 years.

It should be taken into account that the prevalence estimates provided by the general practitioners are based on qualified estimates of individual doctors and thus might be biased in a great extent; the confidence intervals for the mean estimates are very broad. The numbers provided by general practitioners for opioid users are very probable to overestimate the real numbers of opioid users as the general practitioners provide buprenorphine substitution treatment which might lead to an elevated number of opioid users seeking the doctor.

The estimate of problem opioids users in 2015 was validated within a questionnaire survey among clients of low-threshold centres called 2016 Multiplier study. Respondents answered questions on number of users of opioids (e.g. heroin, methadone, buprenorphine - Subutex®, Suboxone®, Ravata® etc., and/or Vendal®, Palladone®, fentanyl, codeine, braun), and their proportion in substitution treatment. Based on the multiplier and data from substitution treatment, about 12.6 thousand opioid users were estimated in the Czech Republic (1.79 per 1,000 inhabitants aged 15–64 years) (46). Using the same benchmark, estimates for the following years was carried out.

3.4.1.2.4 *Injecting and Other Routes of Administration*

See above – parts on Patterns of Heroin/Opioid Use and High Risk Opioid Use.

For further information see also chapter Harms and Harm Reductio.

3.4.1.2.5 *Infectious diseases*

For detailed information on infectious diseases see chapter Harms and Harm Reduction.

3.4.1.3 *Synthetic Opioids*

Opioids included in the estimates of high-risk drug use in the Czech Republic are mainly heroin and, ever more frequently, diverted buprenorphine, obtained often in the Czech Republic via doctors' prescription which is then sold/redistributed on black market. There are signs from low-threshold centres and outreach programmes working with drug users of increasing misuse of opioid analgesics (fentanyl patches, morphine-based analgesic Vendal® Retard, hydromorphone-based Palladone® and locally oxycodone, legally produced medicines but

illegally obtained and/or misused, in most of these cases as a substitute to opioids). Cases of heroin production from unrefined opium or morphine products have appeared seasonally; braun production from codeine products has been reported occasionally, use of desomorphine (crocodile) has not yet been reported in the Czech Republic.

The first estimate of problem use of opioid analgesics was carried out in 2015 – see above section on High Risk Opioid Use.

3.4.2 New developments

New Developments in Use of Heroin and Other Opioids

As already mentioned above, there are signs of increasing misuse of opioid analgesics (fentanyl patches, morphine-based analgesic Vendal[®] Retard and hydromorphone-based Palladone[®]), especially in some regions of the Czech Republic, often corresponding to regions with lower availability of substitution treatment provision. Cases of heroin production from unrefined opium or morphine products have appeared; braun production from codeine products has been reported occasionally.

3.5 New psychoactive substances (NPS)

3.5.1 Prevalence and Trends in NPS Use

Data on prevalence of NPS are available since 2011 when there was a peak of both their use and supply in the Czech Republic, the NPS were available in smart shops known locally as Amsterdam shops. In that time, mainly synthetic cathinones and synthetic cannabinoids were present. After legislative change that placed tens of new substances under the control of criminal law in April 2011, new psychoactive substances have been available on internet and their use has been rather limited and decreasing (47). However, the use of new synthetic stimulants was recently reported locally among problem (injecting) drug users.

In 2017, altogether 48 new psychoactive substances were reported through EWS, out of them 16 appeared for the first time in the Czech Republic. The NPS mostly involved cathinones and phenethylamines. Substances that were seized in the highest quantities included synthetic cannabinoids 5F-MDMB-PINACA and cathinones 4-CEC. In 2018, altogether 65 new psychoactive substances were reported through EWS, out of them 11 for the first time. The NPS mostly involved synthetic cathinones (29 substances). Substances that were seized in the highest quantities in 2018 included synthetic cathinones 4-CEC and 4-methylpentadron. In relation to NPS, 1 case of death was reported in 2018 and 5 cases of severe non-fatal intoxication (48).

Formulation of survey questions regarding the NPS is methodologically complicated as NPS do not provide information on content, chemical names are complicated and no common name like in case of traditional drugs exists for NPS. The formulation of questions is thus not simple and has been slightly changing across different surveys. Formulation of the questions in the omnibus surveys Prevalence of Drug Use in the Population is similar (though not exactly the

same) to EMQ module on NPS (Q1 and Q2) covering lifetime, last 12 months and last 30 days prevalence.

Large-scale GPS (National Survey on Substance Use 2012 and 2016) use also very similar/compatible formulation of the questions on prevalence; the 2012 study also included questions on source of the substance (when combined, can provide answers compatible to Q4 of the EMQ module), but separately for synthetic and herbal substances. The 2016 study combines synthetic and herbal substances into one category and question was added on the appearance of the substance (compatible with Q3); source of the substance is not questioned.

According to an internet-based survey focusing on NPS in 2011 (N=1,091 aged 15-34 years, CAWI), the lifetime prevalence of NPS reached 4.5% (6% for males and 3% for females), and 3.6% reported use in the last 12 months (0.3% reported use in the last 30 days). The NPS used mostly included mephedrone and synthetic cannabinoids; users were mostly males aged 15-24 years, mostly those willing to experiment with in that time legal substances, usually cheaper compared to traditional drugs (49). A relatively high prevalence of NPS was confirmed by the Eurobarometer study (N=503, aged 15-24 years, CATI) – lifetime prevalence was reported by 4% of the respondents (50).

According to the National Survey on Substance Use 2016, the lifetime prevalence of NPS use was below 1% (for both males and females), similar results were provided by an omnibus study Citizen Survey. According to the omnibus surveys Prevalence of Drug Use in the Population that can also show a trend, the use of NPS has been on very low level since 2011, reaching 1.3% in lifetime and 0.5% in the last 12 months in 2014 – see Table 16. In 2015, lifetime prevalence reached 4.5% in adult population aged 15-64 years (and 6.8% among 15–34 years), and 1.2 % (1.6% respectively) in the last 12 months. The prevalence was significantly higher for herbal substances (3.9% lifetime vs. 0.7% for synthetic substances, and 1.1% for herbal vs. 0.1% for synthetic substances in the last 12 months). However, in 2016 again, the lifetime prevalence reported reached much lower levels (2.3% lifetime use among 15–64 and 3.8% among 15–34 year-olds). New data will be available for 2020 National Survey on Substance Use.

Data available do not show a clear trend in NPS use as the formulation of questions on NPS has been changing over time and across surveys. Until 2012, 1 question was asked on new synthetic drugs, while in 2013, 2 separate questions were included in the questionnaire regarding new herbal drugs and new synthetic drugs which might have led to an increase in reported prevalence of use in the general population. In 2014 again, 2 questions were asked on new herbal drugs (e.g. *Salvia divinorum*, cratom, kanna and *Datura stramonium*) and new synthetic drugs (e.g. mephedrone, 3,4-DMMC, MDPV, Funky, El Magico, ketamine, and synthetic cannabinoids JWH, AM). In 2015, question on herbal substances covered *Salvia divinorum*, cratom, kanna and *Datura stramonium*, and question on new synthetic drugs included examples: mephedrone, 3,4-DMMC, MDPV, MPA, MDAI, 3-MEC, α -PVP, Funky, El Magico, JWH, AM. The increase in the prevalence of NPS between 2014 and 2015 is probably primarily related to the change of the question formulation. In 2016, in all surveys the question on NPS covered both

synthetic and herbal substances, but the list of the examples provided for the respondents differed according to the space available in the questionnaire. In 2017 the annual omnibus surveys one question on NPS covered both synthetic and herbal substances together. The substances surveyed in 2017 included mephedrone, pentedrone, AB-PINACA, cathinones, Funky, El Magico, Cherry, synthetic cannabinoids, Salvia divinorum, kanna, cratom, and Datura stramonium. In 2018, the category of NPS surveyed in the omnibus surveys included mephedrone, pentedrone, Funky, El Magico, Cherry, synthetic cannabinoids, PINACA, CHMICA, Salvia divinorum, kanna, cratom, and Datura stramonium.

The prevalence of NPS use in the general population has remained on very low levels in 2017 – lifetime prevalence reached 1.0–1.7% among the age group 15–64 years and 1.2–3.2% among the young adults (15–34 years). Prevalence of NPS in the last 12 months and last 30 days has been very low in the long-term. In 2018, the lifetime prevalence of NPS use reached 0.7–1.2% among the age group 15–64 years, and 1.4–1.8% among 15–34 year olds.

The questions in the omnibus surveys Prevalence of Drug Use in the Population and Citizen Survey were not pilot-tested or validated; questions that were used within the National Survey on Substance Use 2012 and 2016 were pilot tested before the field data collection.

In recent years, the name Funky has started to spread as a general name for synthetic cathinones among drug users in the Czech Republic.

Table 16 - Prevalence of NPS use in the general population (aged 15–64 years) in 2011–2018, in % (omnibus surveys Prevalence of Drug Use in the Population PPM), compared to National Survey on Substance Use 2012 and 2016, and omnibus Citizen Survey 2016–2018)

	Lifetime prevalence						Last 12 months				Last 30 days			
	15–64			15–34			15–64		15–34		15–64		15–34	
	n	M	F	T	n	T	M	F	T	T	M	F	T	T
PPM 2011	(n=901)	1.8	1.1	1.4	(n=361)	1.6	1.1	0.0	0.6	0.6	0.0	0.0	0.0	0.0
PPM 2012	(n=854)	0.9	0.2	0.6	(n=345)	0.3	0.7	0.2	0.5	0.3	0.0	0.0	0.0	0.0
2012 - National Survey	(n=2134)	1.3	1.0	1.1	(n=824)	2.2	0.4	0.3	0.3	0.8	0.2	0.0	0.1	0.0
PPM 2013	(n=868)	2.8	1.4	2.1	(n=308)	3.7	0.7	1.0	0.8	1.3	0.2	0.2	0.2	0.7
PPM 2014	(n=870)	1.6	0.9	1.3	(n=313)	1.3	0.2	0.7	0.5	0.3	0.0	0.0	0.0	0.0
PPM 2015	(n=851)	6.4	2.7	4.5	(n=320)	6.8	1.7	0.7	1.2	1.6	0.2	0.5	0.4	0.3
PPM 2016	(n=849)	2.3	2.2	2.3	(n=323)	3.8	0.5	0.7	0.6	0.9	0.2	0.2	0.2	0.3
2016 - National Survey	(n=2875)	0.9	0.4	0.7	(n=1017)	1.2	0.3	0.1	0.2	0.3	0.0	0.1	0.0	0.1
Citizen Survey 2016	(n=1745)	1.1	0.7	0.9	(n=552)	1.6	0.3	0.3	0.3	0.5	0.1	0.0	0.1	0.2
PPM 2017	(n=1261)	2.6	0.8	1.7	(n=456)	3.2	0.3	0.0	0.2	0.0	0.0	0.0	0.0	0.0
Citizen Survey 2017	(n=1404)	1.0	1.0	1.0	(n=491)	1.2	0.3	0.0	0.1	0.2	0.0	0.0	0.0	0.0
PPM 2018	(n=1665)	0.9	1.5	1.2	(n=623)	1.8	0.0	0.5	0.2	0.5	0.0	0.1	0.1	0.2
Citizen Survey 2018	(n=1392)	1.3	0.1	0.7	(n=485)	0.3	0.0	0.1	0.4	0.0	0.0	0.0	0.0	0.0

3.5.1.1 Harms Related to NPS Use

The last study focusing on risk perceptions related to NPS among their users and strategies on prevention of these risks was published in 2014 (51). The study was based on qualitative content analysis of discussion forums for NPS users (altogether 16 on-line discussion forums containing 832 posts) and qualitative analysis of semi-structured interviews with 9 NPS users. As regards the risk perception, there is a group of users that perceive the risk of NPS as low which is

probably related to legal status of these substances. The risk perception is changing with the use of these substances – NPS users are more cautious as they have their own experience or get more information from the discussion forums. As a harm-reduction strategy, the NPS users chose the use of smaller quantities (especially when using the substance for the first time), and not combining the NPS with other drugs or substances. The study showed that internet forums for NPS users were a widely used source of information and might be used by harm reduction programmes as a possible means of interventions.

Few cases of intoxications and deaths have very recently (September 2018) occurred in relation to NPS use; more information has been provided via the Early Warning System.

3.5.1.2 Prevalence, Trends and Harms related to Other Drug Use

Surveys (both in general and school population) carried out regularly in the Czech Republic cover the following substances as well: LSD, hallucinogenic (magic) mushrooms, inhalants and psychoactive medicines. Ketamine and poppers were surveyed in GPS for the first time in 2016, and new data are available from omnibus surveys for 2017. In 2018 omnibus study called Prevalence of drug use among the general population, ketamine was taken out of the category of poppers and GHB/GBL and surveyed within the category of other hallucinogens (this category included other hallucinogens except for MDMA, ecstasy, magic mushrooms, LSD and ayahuasca); ayahuasca was surveyed separately.

The prevalence of LSD in the general (adult) population has been on a relatively low level, below 1% until 2014, while in 2015 and 2016, the reported lifetime prevalence of LSD reached 2–3% among the age group 15–64 (according to the study). Higher prevalence rates were observed among males and younger age groups (especially among 15–34 year-olds), last 12 months and last 30 days prevalence has stayed relatively low in the long run – see Table 17. On the other hand, the use of hallucinogenic mushrooms has been more prevalent in the Czech Republic, with mushrooms ranking usually as the third most popular (illicit) drug in the population, after cannabis and ecstasy. Last surveys from 2018 showed lifetime prevalence of LSD between 1.3–2.9%, with prevalence of 0.2–0.7% in the last 12 months.

The popularity of hallucinogenic mushrooms in the Czech Republic has been related to a long lasting tradition of the Czech population in seasonal picking of all types of edible mushrooms in the forests and general knowledge on types of mushrooms and their use in cuisine. As hallucinogenic mushrooms also grow seasonally in some parts of the country, people traditionally pick them and use to experiment with their effects; other factors that play a role are that no laws regulate the picking of mushrooms in the freely accessible forests and no finances are required to obtain them. The latest data from 2018 show lifetime prevalence of hallucinogenic mushrooms of 3.5–4.7%, however, the prevalence of use in the last 12 months was on significantly lower level (0.4–0.7%).

Table 17 - Prevalence of LSD use in the general population (aged 15–64 years) in 2011–2018, in % (omnibus surveys Prevalence of Drug Use in the Population (PPM), compared to National Survey on Substance Use 2012 and 2016, and omnibus Citizen Survey 2016–2018)

	Lifetime prevalence								Last 12 months				Last 30 days			
	15–64				15–34				15–64		15–34		15–64		15–34	
	n	M	F	T	n	T	M	F	T	T	M	F	T	T		
PPM 2011	(n=901)	2.6	1.6	2.1	(n=361)	3.0	1.1	1.1	1.1	1.8	0.0	0.0	0.0	0.0		
PPM 2012	(n=854)	1.2	0.2	0.7	(n=345)	1.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
2012 - National Survey	(n=2134)	4.4	1.2	2.8	(n=824)	5.4	0.3	0.2	0.2	0.6	0.1	0.1	0.1	0.2		
PPM 2013	(n=868)	0.9	1.0	0.9	(n=308)	2.3	0.2	0.2	0.2	0.7	0.2	0.0	0.1	0.3		
PPM 2014	(n=870)	1.4	0.0	0.7	(n=313)	1.6	0.2	0.0	0.1	0.3	0.0	0.0	0.0	0.0		
PPM 2015	(n=851)	4.0	2.1	3.1	(n=320)	5.7	0.0	0.2	0.1	0.3	0.0	0.0	0.0	0.0		
PPM 2016	(n=849)	1.9	1.0	1.4	(n=323)	2.2	0.2	0.2	0.2	0.0	0.2	0.0	0.1	0.0		
2016 - National Survey	(n=2875)	3.3	1.1	2.1	(n=1017)	3.6	1.0	0.3	0.7	1.4	0.1	0.0	0.1	0.2		
Citizen Survey 2016	(n=1745)	2.5	1.4	2.7	(n=552)	3.3	0.5	0.1	0.3	0.7	0.3	0.0	0.1	0.4		
PPM 2017	(n=1261)	2.9	1.0	2.0	(n=456)	3.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
Citizen Survey 2017	(n=1404)	4.6	1.4	3.1	(n=491)	5.5	0.7	0.1	0.4	1.0	0.1	0.1	0.1	0.2		
PPM 2018	(n=1665)	1.2	1.4	1.3	(n=623)	1.5	0.4	0.0	0.2	0.3	0.2	0.0	0.1	0.3		
Citizen Survey 2018	(n=1392)	4.2	1.6	2.9	(n=485)	5.4	1.1	0.3	0.7	1.6	0.1	0.0	0.1	0.2		

Source: Chomynová (3), Běláčková, Nechanská (4), Národní monitorovací středisko pro drogy a drogové závislosti and INRES-SONES (5), Národní monitorovací středisko pro drogy a drogové závislosti and INRES-SONES (6), Národní monitorovací středisko pro drogy a drogové závislosti and INRES-SONES (7), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (8), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (9), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (10), Národní monitorovací středisko pro drogy a drogové závislosti and ppm factum research (11), Národní monitorovací středisko pro drogy a drogové závislosti and Factum Invenio (12), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (13), Národní monitorovací středisko pro drogy a závislosti and INRES-SONES (14), Národní monitorovací středisko pro drogy a závislosti and MindBridge Consulting (15), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (16), Národní monitorovací středisko pro drogy a závislosti and INRES-SONES (17), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (18), Národní monitorovací středisko pro drogy a závislosti and INRES-SONES (19)

Table 18 - Prevalence of use of hallucinogenic mushrooms in the general population (aged 15–64 years) in 2011–2018, in % (omnibus surveys Prevalence of Drug Use in the Population (PPM), compared to National Survey on Substance Use 2012 and 2016, and omnibus Citizen Survey 2016–2018)

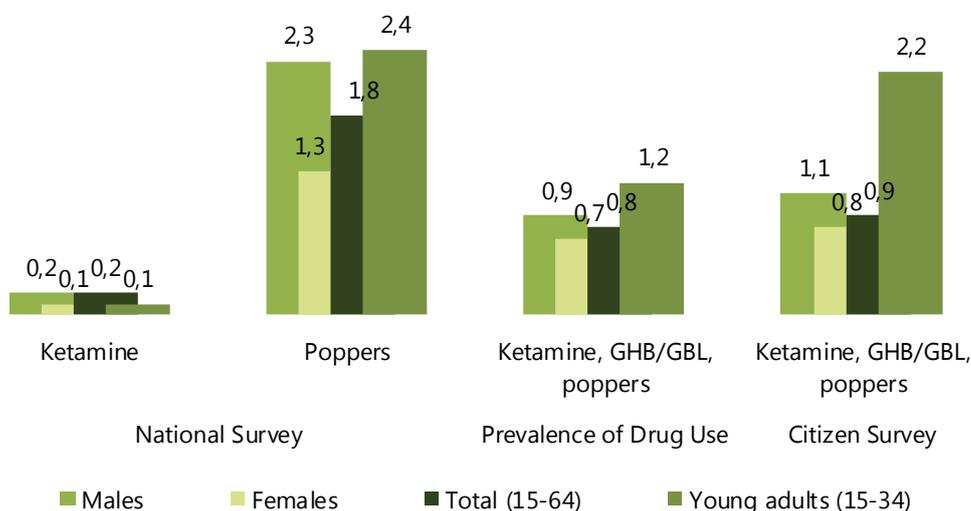
	Lifetime prevalence								Last 12 months				Last 30 days			
	15–64				15–34				15–64		15–34		15–64		15–34	
	n	M	F	T	n	T	M	F	T	T	M	F	T	T		
PPM 2011	(n=901)	5.5	2.7	4.1	(n=361)	6.7	1.1	0.9	1.0	0.9	0.0	0.0	0.0	0.0		
PPM 2012	(n=854)	7.5	1.2	4.4	(n=345)	7.3	0.5	0.0	0.2	0.6	0.0	0.0	0.0	0.0		
2012 - National Survey	(n=2134)	7.7	2.9	5.3	(n=824)	10.5	1.2	0.3	0.7	1.6	0.4	0.1	0.2	0.4		
PPM 2013	(n=868)	3.8	0.9	2.4	(n=308)	4.0	0.2	0.0	0.1	0.3	0.2	0.0	0.1	0.3		
PPM 2014	(n=870)	6.6	1.9	4.3	(n=313)	9.4	1.6	0.0	0.8	2.3	0.0	0.0	0.0	0.0		
PPM 2015	(n=851)	7.3	3.6	5.4	(n=320)	9.8	0.7	1.4	1.1	2.2	0.2	0.0	0.1	0.3		
PPM 2016	(n=849)	6.3	2.1	4.3	(n=323)	6.3	0.9	0.5	0.7	0.9	0.2	0.0	0.1	0.0		
2016 - National Survey	(n=2875)	8.0	3.0	5.4	(n=1017)	10.3	2.5	0.5	1.5	3.1	0.4	0.0	0.2	0.2		
Citizen Survey 2016	(n=1745)	3.3	2.1	2.7	(n=552)	4.3	0.7	0.6	0.6	1.3	0.1	0.1	0.1	0.2		
PPM 2017	(n=1261)	7.3	2.1	4.7	(n=456)	7.3	0.5	0.2	0.3	0.9	0.0	0.0	0.0	0.0		
Citizen Survey 2017	(n=1404)	6.7	2.0	4.4	(n=491)	7.3	1.4	0.4	0.9	2.0	0.3	0.4	0.4	0.8		
PPM 2018	(n=1665)	4.7	2.2	3.5	(n=623)	5.9	0.6	0.1	0.4	1.0	0.2	0.0	0.1	0.3		
Citizen Survey 2018	(n=1392)	6.6	2.6	4.7	(n=485)	6.0	1.3	0.1	0.7	1.2	0.0	0.1	0.1	0.0		

Source: Chomynová (3), Běláčková, Nechanská (4), Národní monitorovací středisko pro drogy a drogové závislosti and INRES-SONES (5), Národní monitorovací středisko pro drogy a drogové závislosti and INRES-SONES (6), Národní monitorovací středisko pro drogy a drogové závislosti and INRES-SONES (7), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (8), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (9), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (10), Národní monitorovací středisko pro drogy a drogové závislosti and ppm factum research (11), Národní monitorovací středisko pro drogy a drogové závislosti and Factum Invenio (12), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (13), Národní monitorovací středisko pro drogy a závislosti and INRES-SONES (14), Národní monitorovací středisko pro drogy a závislosti and MindBridge Consulting (15), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (16), Národní monitorovací středisko pro drogy a závislosti and INRES-SONES (17), Národní monitorovací středisko pro drogy a závislosti and ppm factum research (18), Národní monitorovací středisko pro drogy a závislosti and INRES-SONES (19)

For the first time in 2016 ketamine and poppers were surveyed in GPS. National Survey on Substance Use 2016 surveyed the substances separately; the omnibus studies asked ketamine together with poppers and/or GHB/GBL in one category – the lifetime prevalence ranged between 0.8–1.8% for the age group 15–64 years, and between 1.2–2.4% for the age group 15–34 years; it seems that poppers were much more prevalent compared to ketamine (see Figure 23). Use of ketamine and/or poppers was more prevalent among males and in the younger age groups, which is in line with the general pattern of illicit drug use in the general population. New data from omnibus surveys 2017 showed lifetime prevalence of ketamine, poppers and GHB/GBL of 0.6% and 1.8% respectively in the 15–64 years age group and 1.6% and 3.5% respectively in the 15–34 years age group. In 2018 omnibus study called Prevalence of drug use among the general population, ketamine was taken out of the category of poppers and GHB/GBL and surveyed within the category of other hallucinogens (this category included other hallucinogens except for MDMA, ecstasy, magic mushrooms, LSD and ayahuasca); ayahuasca was surveyed separately. In 2018, lifetime prevalence of ayahuasca use reached 1.0% (1.5% among young adults), use of other hallucinogens 0.6% (0.8% among young adults).

In the omnibus Citizen Survey 2018, standard formulation of questions was used. The lifetime use of ketamine, poppers or GHB/GBL was reported by 2.0% of the population (4.5% among young adults), while its prevalence in the last 12 months reached 0.2% (and 0.6%).

Figure 23 - Lifetime prevalence of ketamine, poppers and GHB/GBL in the general population (aged 15–64 years) in 2016, in %



Source: Národní monitorovací středisko pro drogy a závislosti and MindBridge Consulting (15)

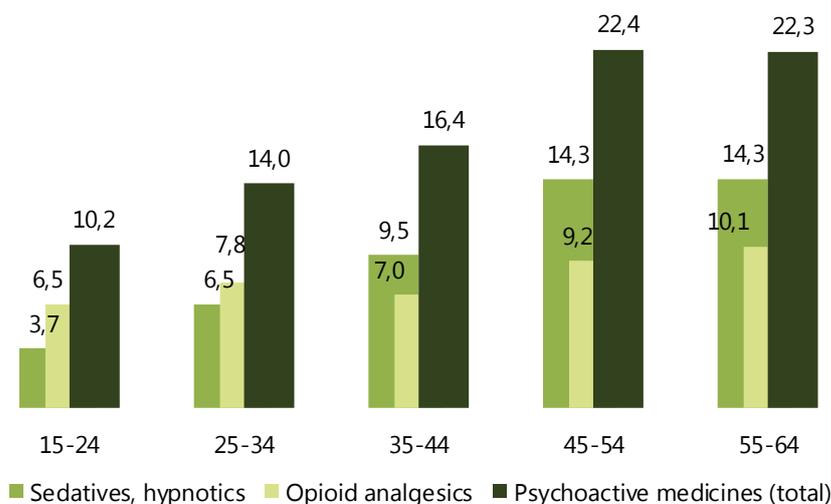
The use of inhalants in both the general adult has been relatively low in the long run, reaching 0.7–3.9% among 15–64 years age group in 2016 according to the study (and 1.3–4.7% among 15–34 age group); the highest prevalence being reported in the National Survey on Substance Use 2016 while the other two reported much lower rates of inhalant use. In 2017, the lifetime inhalant use reached 0.7–1.0% among 15–64 years age group and 0.8–1.6% among 15–34 age group, and in 2018, the prevalence was 0.9–1.5% and 1.7–1.9%, respectively.

Higher prevalence was reported by men (6.1% in National Survey 2016), and higher prevalence has been also observed among specific ethnic groups and subpopulations, e.g. in socially excluded areas, among homeless people or selected Roma communities.

The use of (prescribed) psychoactive medicines includes the use of sedatives, hypnotics or opiates/opioids based medicines (painkillers) obtained without doctor’s prescription, or used without doctor’s or pharmacist’s recommendation. The question on psychoactive medicines is different in National Survey on Substance Use 2016 where a specific block of questions was targeted at sedatives and hypnotics use in general with a specific question on the way the respondents obtained the drug (on doctor’s prescription or not) and a specific question whether the medicine was used in line with doctor’s or pharmacist’s recommendation to distinguish use of medicine from misuse; and a specific block of questions on use of opioid analgesics. The omnibus studies only ask a single question including both sedatives, hypnotics and opioid analgesics together, and only asked use of the medicines without doctor’s prescription or used without doctor’s or pharmacist’s recommendation.

According to the National Survey on Substance Use 2016, psychoactive medicines were used in the last 12 months by 17.3% of respondents aged 15–64 years (11.9% of males and 22.3% of females). Higher prevalence was reported by respondents in older age groups – however, while in the youngest age groups (15–24 and 25–34) the use of opioid analgesics is higher, respondents aged 35+ years reported more often use of sedatives and/or hypnotics – see Figure 24. Psychoactive medicine users mostly report use on doctor’s prescription but 33% of sedatives users and 53% of opioid users admitted they obtained medicines in other way than on doctor’s prescription (e.g. in bought in the pharmacy without prescription, got from friends or relatives, or obtained via internet).

Figure 24 - Prevalence of use of psychoactive medicines (sedatives or hypnotics, and opioid analgesics) in the last 12 months in National Survey on Substance Use 2016, in % (including use on doctor’s prescription)



Source: Národní monitorovací středisko pro drogy a závislosti and MindBridge Consulting (15)

In omnibus surveys that ask only psychoactive medicines use without doctor's prescription in 2016, about 11.8% of respondents reported use in the last 12 months, 3.5% used psychoactive medicines without prescription in the last 30 days. In 2017, the reported psychoactive medicines use without doctor's prescription reached 7.1–9.2% in the last 12 months and 2.8–3.1% in the last 30 days. Unlike the prevalence of illicit substance use, the use of psychoactive medicines was higher among females and older age groups. The latest data for 2018 showed 10.0–12.8% last year prevalence and 3.7–4.1% last month prevalence of psychoactive medicines use.

The trend analysis and comparison with previous years is complicated as there was a substantial change in the formulation of the question and the respondents were provided with a list of medicines monitored which might have led to higher prevalence reported. No substantial change in the formulation occurred between 2014 and 2015 – the prevalence of use of psychoactive medicines slightly increased from 18.3% to 19.5% in the last 12 months. However, the list of substances has slightly changed in 2016 yielding a prevalence of use of 11.8% in the last 12 months. The wording of the question on psychoactive medicines use has remained the same between 2016 and 2018.

3.5.1.2.1 Use of Other Drugs in School Population

In the school population, the ESPAD validation study conducted in 2016 showed higher lifetime prevalence of both LSD (3.4%) and hallucinogenic mushrooms (3.8%) compared to ecstasy (3.3%), confirming the situation seen in ESPAD 2015 – see Figure 25.

Among the school population, the lifetime prevalence of prescribed psychoactive medicines used without doctor's recommendation in order to get high had been stable around 10% of the 16-year-old students (ESPAD study), but increased to 15.7% in 2015 (10.7% boys and 20.5% girls). The ESPAD validation study in 2016 showed a prevalence of 14.7% (10.7% for boys and 19.4% for girls).

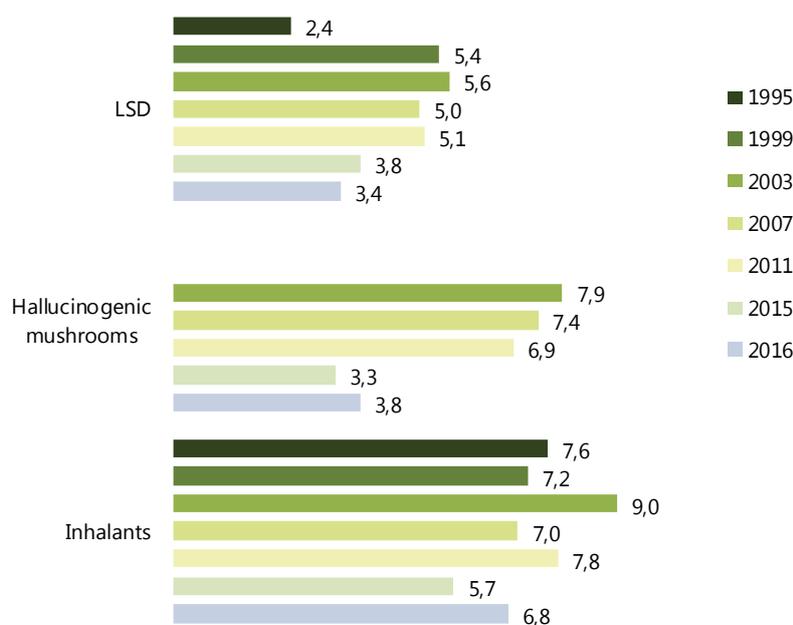
In the school population, the prevalence of inhalants use has been relatively stable between 1995 and 2011 on 7–9% level, about 3.5% of 16-year-olds report use of inhalants in the last 12 months and about 1.5% in the last 30 days. In 2015, lifetime prevalence of inhalants use among students aged 16 decreased to 5.7% and slightly increased to 6.8% in 2016, while 2.8% reported use of inhalants in the last 12 months and 1.0% in the last 30 days (and 3.4% in the last 12 months and 1.8% in the last 30 days, respectively, in 2016).

In 2018, an ESPAD validation follow-up study was carried out on the same sample of students surveyed in 2016 (16 year-olds in 2016 and 18 year-olds in 2018, i.e. students born in 2000, N=1554). The lifetime use of LSD or other hallucinogens was reported by 5.7% of the students (6.1% of boys and 5.5% of girls), use of hallucinogenic mushrooms by 4.1%. Use of inhalants was reported by 9.1% of the students, 2.1% used anabolic steroids in their lifetime. Altogether 17.4% used psychoactive medicines in their lifetime, 23.0% used painkillers together with alcohol.

Another series of nationally representative survey was carried out in the Czech Republic in 2017 on the sample of 2437 students of elementary schools and grammar schools aged 11–15 years

showed lifetime psychoactive medicines use (without prescription) of 7.4% of the students of this age group (52) (compared to 8.9% reported by the same age group of 11–15-year-olds surveyed in a similar study in 2014) (53). Even this series of surveys thus confirm prevalence and trends reported in ESPAD study.

Figure 25 - Prevalence of use of LSD, hallucinogenic mushrooms and inhalants among 16-year-old students according to ESPAD study in 1995–2015 and ESPAD validation study in 2016, in %



Source: Chomynová, Csémy (26), Chomynová, Csémy (2)

3.5.1.2.2 Use of Other Drugs in Specific Subpopulations

Specific studies were carried out among the prison population (5th wave of repeated study, data collected in 2010, 2012, 2014, 2016 and 2018) (30, 43) and among Roma population in 2017 (single study) (31).

The survey among prison population surveyed LSD, hallucinogenic mushrooms and inhalants as well. Lifetime prevalence of LSD was reported by 18.7% and hallucinogenic mushrooms were reported by 20.3% of the prison population. The use in the last 12 months prior to imprisonment was reported by 9.1% and 8.8%, respectively, and the use in the last 30 days by 4.4% and 3.9% respectively (see Figure 26). New data from 2018 wave of the study showed 16.6% lifetime prevalence for LSD and 18.5% for hallucinogenic mushrooms, with the use in the last 12 months prior to imprisonment reported by 7.0% and 7.3%, respectively, i.e. slightly lower compared to the previous wave carried out in 2016.

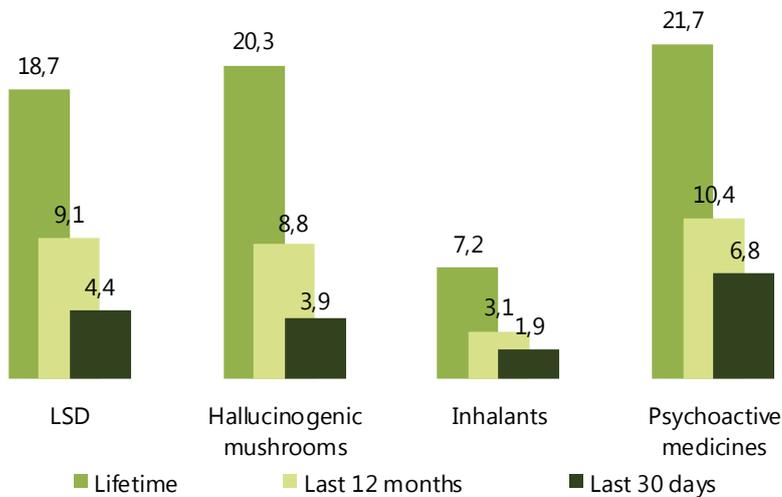
The use of psychoactive medicines (sedatives, hypnotics or opioid analgesics used without doctor's prescription) in the prison population was comparable to the use in general population – 20.6% used them in their lifetime; the reported use in the last 12 months was slightly lower (9.9% in 2018). About 6.2% of respondents reported use of psychoactive medicines in the last 30

days (before entering prison). About 13.1% reported use of psychoactive medicines in prison (the prevalence is comparable to the use of cannabis (12.2%) and methamphetamine (11.4%) in prison).

For more details see also chapter Prison.

Lifetime prevalence of inhalants use reached 6.1%, with 2.2% having used inhalants in the last 12 months (prior to imprisonment) and 1.7% in the last 30 days (30, 43, 54).

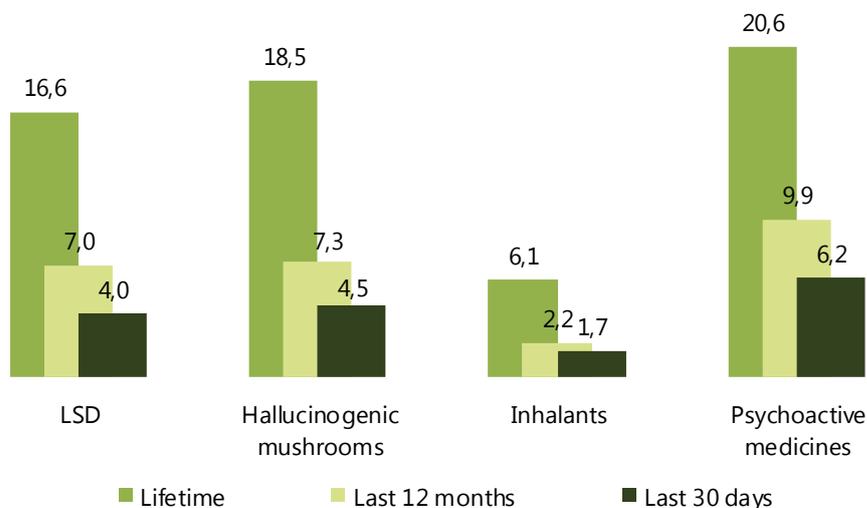
Figure 26 - Prevalence of use of LSD, hallucinogenic mushrooms, inhalants and psychoactive medicines among prison population in 2016, in %



NB: Data for last 12 months and last 30 days refer to the period before imprisonment.

Source: Grohmannová (54)

Figure 27 - Prevalence of use of LSD, hallucinogenic mushrooms, inhalants and psychoactive medicines among prison population in 2018, in %



NB: Data for last 12 months and last 30 days refer to the period before imprisonment.

Source: Národní monitorovací středisko pro drogy a závislosti a Generální ředitelství Vězeňské služby ČR (2018)

Study focusing on Health and Substance Use Among Roma Population 2017 (N=546) showed that lifetime prevalence of inhalant use in the Roma community reached 15.4% (23.0% among males and 7.7% among females), 5.5% used inhalants in the last 12 months and 2.9% in the last 30 days (31). When weighted to the age and gender structure of the general population, inhalant use (in the last 12 months) among the Roma population was 3–4 times higher.

Study focusing on Health and Substance Use Among Roma Population 2017 (N=546) showed that 9.0% of the Roma community surveyed used LSD in lifetime, 15.4% tried hallucinogenic mushrooms and 15.4% used inhalants. In the last 12 months, the use of LSD was reported by 2.4%, 4.6% used hallucinogenic mushrooms and 5.5% inhalants, the prevalence of use in the last 30 days was relatively low (0.5% LSD, 1.6% hallucinogenic mushrooms and 2.9% inhalants).

Psychoactive medicines were reported by 30.2% of the Roma community with 17.9% having used them in the last 12 months and 9.0% in the last 30 days. Higher prevalence was reported among respondents in age groups 35+. Unlike the general population, the prevalence of use in lifetime, last 12 months and last 30 days was more often reported by males (20.4% of males and 15.4% of females in the last 12 months).

3.5.1.3 Treatment for Other Drugs

Out of 10,108 people asking for treatment (all treatment demands) in 2014, 7 (0.1%) reported hallucinogens as their primary drug, out of them 6 reported LSD. Inhalants as their primary drug were reported by 16 people asking for treatment (0.2% of all TD). Hypnotics and sedatives were reported by 64 people (0.6% of all TD), out of them 1 reported barbiturates, 39 reported benzodiazepines and 24 reported other sedatives.

In March 2015, a new National Register of Treatment of Drug Users was launched combining now two previously independent registers – Treatment Demand Register and Substitution Treatment Register (for more details see chapter Treatment). The new register fights with a couple of technical problems since its launch, and thus so far does not cover all treatment centres that work with drug users. Data in the register is thus missing, and do not allow for more detailed trends analysis. The current National Register of Treatment of Drug Users collects data on treatment demands related also to tobacco, alcohol and gambling problems, in both years for which are now data available, they include about 7–8 thousand people (including tobacco, alcohol and gambling; compared to previously reported 10 thousand people asking for treatment only for illicit substances related problems).

In 2018, out of 14,167 treatment demands altogether there were 20 people asking for treatment related to hallucinogens (16 in 2017), and 22 treatment demands were related to inhalants (15 in 2017). Altogether 310 users of sedatives and hypnotics asked for treatment (2.6%) compared to 221 in 2017, among them 129 for the first time (1.9% of first treatment demands); 216 out of the 310 cases were users of benzodiazepines, 70 users of sedatives/Z-drugs, 11 of other sedatives or hypnotics and 12 treatment demands were related to the use of barbiturates. The average age of sedatives and hypnotics users has reached 47.3 years. 57.7% of people ATD's related to

sedatives reported use of sedatives only, while 24.8% reported also use of alcohol, 11.0% reported use of opioids, 11.9% use of methamphetamine and 4.8% reported also use of cannabis.

3.5.2 New developments

Information on the emergence of NPS has been regularly provided via the Early Warning System.

3.6 Sources and methodology

Sources

The sources are listed in the bibliography section, and methodology is described in the following section.

Methodology

List of surveys:

National Survey on Substance Use 2012

- Large-scale GPS carried out every 4 years on randomly selected households, nationally representative for the general population aged 15-64 years according to gender, age, level of education, region, size of the place of residence, economic status; N=2134 in 2012; face-to-face interviews, PAPI
- Repeated study
- Carried out by the Czech NMC/NFP and SC&C research agency
- For more details see ST01 reported in 2013

National Survey on Substance Use 2016

- Large-scale GPS carried out every 4 years on randomly selected households, nationally representative for the general population aged 15+ years according to gender, age, level of education, region, size of the place of residence, economic status; N=3601 in 2016; face-to-face interviews, PAPI
- Repeated study
- Carried out by the Czech NMC/NFP and MindBridge Consulting research agency
- For more details see ST01 reported in 2017

Prevalence of Drug Use in the Population carried out in 2011–2018 (PPM)

- Annual omnibus surveys on representative sample of general population aged 15+, sample size annually approx. 1000 respondents, quota sampling according to age, gender, region, education, size of the place of residence; face-to-face interviews, CAPI
- Repeated study
- Carried out by the Czech NMC/NFP and ppm factum research agency

- For more details see ST01 reported in 2012, 2014, 2015, 2016, 2018 and 2019

Citizen Survey 2016–2018

- Annual omnibus surveys on representative sample of general population aged 15+, sample size annually approx. 1700 respondents, quota sampling according to age, gender, region, education, size of the place of residence; face-to-face interviews, CAPI
- Repeated study; questions on drug use included for the first time in 2016, same wording and format of the question used in 2017 and 2018
- Carried out by the Czech NMC/NFP and INRES-SONES research agency

ESPAD study 1995–2015

- Nationally representative school survey among 16-year-old students carried out every 4 years (for details see Hibell, Guttormsson (20)), sample size 2700–3900 students born in the given year
- Repeated study, every 4 years since 1995
- Carried out by the Czech NMC/NFP and Prague Psychiatric Centre/National Institute of Mental Health, in collaboration with INRES-SONES research agency (waves 1995–2011) and FOCUS research agency (2015)

ESPAD validation study 2016

- Nationally representative school survey among 16-year-old students based on ESPAD methodology (for details see Hibell, Guttormsson (20)), sample size 2471 students born in the given year
- Single study, fully comparable with ESPAD study
- Carried out by the Czech NMC/NFP and Prague Psychiatric Centre/National Institute of Mental Health in collaboration with ppm factum research agency

ESPAD validation study 2018

- A follow-up study carried out on the same sample of students surveyed in 2016 (16 year-olds in 2016 and 18 year-olds in 2018, i.e. students born in 2000)
- based on ESPAD methodology, same questionnaire used as in 2016
- Sample size 1554 students born in the given year
- Single study, fully comparable with ESPAD study
- Carried out by the Czech NMC/NFP and in collaboration with ppm factum research agency

HBSC study 2006–2018

- Nationally representative school survey among 15-year-old students carried out every 4 years (for details see e.g. World Health Organization (55))
- Repeated study

- Carried out in past by Prague Psychiatric Centre and National Institute of Public Health, and University of Palacky in Olomouc in 2010, 2014 and 2018

Research on Selected Personality Traits and Risk Forms of Behaviour among Czech Grammar School Students aged 11–19 years (2015)

- Nationally representative school survey among elementary school pupils and secondary school students (N=4120), randomly selected schools, PAPI
- Unique study
- Carried out by the Department of Psychology of the University of Palacky in Olomouc, in 2015

Nationally representative surveys on risk behaviour (VRCHA) 2017

- school survey among elementary school pupils and grammar school students aged 11–15 years (N=2437), randomly selected schools, PAPI
- Unique study, though in a series of studies focusing on risk behaviour – every time the age group or target group and main topic/focus of the study is slightly different, but includes same set of questions on risk behaviour (so called VRCHA questionnaire), thus providing comparable results
- Similar study carried out in 2014 (N=4198) among elementary school pupils and grammar school students aged 11–15 years (53)

Nationally representative survey focused on digital gaming/risk behaviour in 2018

- school survey among elementary school pupils and secondary school students aged 11–19 years (N=3950), randomly selected schools, PAPI
- Unique study, though in a series of studies focusing on risk behaviour (see above)

Omnibus survey among general practitioners

- Carried out every 2 years, in 2012, 2014, 2016 and 2018
- Repeated study
- Carried out by the Czech NMC/NFP and INRES-SONES research agency
- PAPI, N=1,201 doctors in 2018
- Omnibus study is carried out among randomly selected sample of all doctors/practitioners of all specializations in the Czech Republic (N=1200 doctors), the sample is representative by gender, age, type of practice (public, private etc.), regions and specializations; questions regarding estimates of problem alcohol and drug users and problem gamblers are included only among general practitioners and general practitioners for children. In order to have a sample big enough for carrying out estimates, the number of GPs and GPs for children was doubled (compared to their proportion among other specializations)

Questionnaire Study on Substance Use Among the Prison Population

- Carried out every 2 years (2010, 2012, 2014, 2016 and 2018)
- Repeated study
- Carried out by the Czech NMC/NFP and General Directorate of Prison Service in collaboration with ppm factum research agency
- PAPI, N=1,695 in 2018

Study on Health and Substance Use Among Roma Population 2017

- Single study
- Carried out by the Czech NMC/NFP and Council of the Government for Roma Community Affairs Office in collaboration with ppm factum research agency
- PAPI, N=546
- Data collected via paper questionnaire distributed among Roma community by social workers employed by selected municipalities (i.e. not random sample of municipalities across the country but only municipalities where the social workers are financed were surveyed) that are in daily social work contact with Roma population.

Estimate of Problem Drug Use in the Czech Republic

- Study based on the multiplication method of the number of problem users of opioids and methamphetamine in contact with low-threshold programmes in 2009-2016, new Multiplier study results available for 2018
- Repeated study; every year
- Carried out by the Czech NMC/NFP

Quantitative study on risk perception of NPS in 2014

- Qualitative content analysis of discussion forums for NPS users (altogether 16 on-line discussion forums containing 832 posts)
- Qualitative analysis of semi-structured interviews with 9 NPS users
- Carried out by the Department of Addictology of the 1st Faculty of Medicine of the Charles University and the General Faculty Hospital in Prague
- Single study (56, 57)

Multiplier 2013, 2016 and 2018

- Survey among clients of low-threshold centres
- Carried out repeatedly

Other data sources:

TD Register

- Regular data collection on clients asking for treatment related to substance use in in-patient, out-patient health care centres and low-threshold centres

- Until 2014 run by the Hygienic Service of the Capital Prague, since 2015 run by the Institute of Health Information and Statistics in Prague

In March 2015, a new National Register of Treatment of Drug Users was launched combining now two previously independent registers – Treatment Demand Register and Substitution Treatment Register (for more details see chapter Treatment). The new register fights with a couple of technical problems since its launch, and thus so far does not cover all treatment centres that work with drug users. Data in the register is thus missing, and do not allow for more detailed trends analysis. The current National Register of Treatment of Drug Users collects data on treatment demands related also to tobacco, alcohol and gambling problems, in both years for which are now data available, they include about 7–8 thousand people (including tobacco, alcohol and gambling; compared to previously reported 10 thousand people asking for treatment only for illicit substances related problems). In 2018, 14 thousand people asking for treatment were reported in the register.

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4 Prevention

4.1 Summary

The main strategic documents for prevention in the Czech Republic are National Drug Prevention Strategy for 2013-2018 (since May 2019 there a new strategy - National Strategy on Prevention and Harm Reduction of Addictive Behaviour 2019-2027), Concept of Youth Support for 2014-2020, Health 2020 convention - National Strategy on health promotion and disease prevention and Crime Prevention Strategy for 2016-2020.

The basic documents in the field of prevention education are the National Strategy for Primary Prevention of Risky Behaviour of Children and Youth for the Period 2019-2027 and the Action Plan for Implementation of the National Strategy for Primary Prevention of Risky Behavior of Children and Youth for 2019-2021, approved by Government Resolution no. 190 on March 18, 2019 (which build on previous National Strategy for Primary Prevention of Risk Behaviour for the period 2013-2018) and Methodological recommendations for primary prevention of risk behaviour among children and youth.

The system of prevention activities at the national level is coordinated by the Ministry of Education, Youth and Sports, by regional school prevention coordinators at regional level and by District prevention professionals based in Pedagogical-psychological counselling centres at municipal level. They are professionals appointed/responsible for methodological support of School prevention professionals (who are basically teachers responsible/appointed for coordination of Minimal prevention programme in the school). Each elementary and secondary school is obliged to formulate and realise Minimal prevention programme delivered usually both by the school and external provider(s).

NGO's are widely involved to provision of prevention in schools, especially those having specialised prevention centre or programme – they are involved mainly in universal and selective prevention activities. Minimal prevention programmes in general deal mainly with universal and selective prevention.

A network of aforementioned Pedagogical-psychological counselling centres plays important role in support of prevention activities in schools as well as in provision of indicated prevention activities and interventions in individual pupils at-risk.

However the complete picture of the quality and coverage of prevention activities in the Czech Republic is not available.

Ministry of Education run the system of Accreditation (certification) of prevention programmes (there is the National Institute of Education appointed to run the system in practice) based on defined Minimum quality standards in Prevention. Since May 2019, the system of certification is suspended due to its insufficient systemic anchoring.

4.2 National profile

4.2.1 Policy and organization

The main strategic documents for prevention in the Czech Republic are National Drug Prevention Strategy for 2013-2018 (since May 2019 there a new strategy - National Strategy on Prevention and Harm Reduction of Addictive Behaviour 2019-2027), Concept of Youth Support for 2014-2020, Health 2020 convention - National Strategy on health promotion and disease prevention and Crime Prevention Strategy for 2016-2020.

The basic documents in the field of prevention education are the National Strategy for Primary Prevention of Risk Behaviour for the period 2013-2018 and Methodological recommendations for primary prevention of risk behaviour among children and youth. On March 18, 2019 was approved by Government Resolution no. 190 new strategy and its action plan: National Strategy for Primary Prevention of Risky Behaviour of Children and Youth for the Period 2019-2027 and the Action Plan for Implementation of the National Strategy for Primary Prevention of Risky Behaviour of Children and Youth for 2019-2021, which build on previous strategy.

The specific goals of the National Strategy for Primary Prevention of Risk Behaviour for the period 2013-2018 are:

- A functional system of primary prevention coordination on horizontal and vertical level with clear coordination mechanisms, roles, responsibilities of individual institutions, including establishing rules of communication)
- A functional system of primary prevention in horizontal and vertical level with clear and transparent legislatively defined coordination mechanisms, roles, responsibilities of individual institutions and their activities.
- Setting up an effective system of education for the field of prevention of risk behaviour for all operators in the field, verification and subsequent implementation conceptual and methodical outputs of the VYNSPI project.
- Financial stability of primary prevention, maintaining a stable subsidy system
- The introduction of a national system for assessing the quality of primary prevention programs (certification) for all kinds of risk behaviour, which is designed for all providers of such programs and provides a comparable level of these programs throughout the Czech Republic.
- The main goal of the National Strategy for Primary Prevention of Risk Behaviour for the period 2019-2027 is through an effective system of primary prevention, operating on the basis of subjects, reduce the level of risky behaviour in children and youth and minimize its occurrence. The specific goals of the National Strategy for Primary Prevention of Risk Behaviour for the period 2019-2027 are:
 - To define and to establish an uniform terminology, to stabilize approaches, methods and tools of effective primary prevention, to unify parameters of interventions in primary prevention.

- To set up effective, systemic, interconnected, unified and cooperative cooperation of all subjects participating in primary prevention areas at both horizontal and vertical levels.
- To modify and to update the legal framework of the primary prevention of risk behaviour area in order to clearly define terminology, roles and competencies of individual actors.
- To improve and to streamline the education system of educational staff and other actors in the field of primary prevention of risk behaviour, which will increase the knowledge, skills and competences of children and others target groups.
- To ensure stable funding of the primary prevention system by the Ministry of Education.
- To ensure the provision of effective, quality and evidence-based primary prevention programs.

From 2012 all regions provide an overview of prevention activities in the county in an unified document: Regional prevention plan (tool to better manage and coordinate prevention activities in different regions). The content consists of: demographic situation in the region, key priorities in the field, specific prevention strategies, network of services and system of coordination of prevention activities, financing of prevention activities etc.

The system of prevention activities in schools and educational sector is coordinated by the Ministry of Education, Youth and Sports on national level, by regional school prevention coordinators on regional level and by prevention professionals in pedagogical-psychological counselling centres on district level. They are professionals appointed/responsible for methodological support of School prevention professionals (who are basically teachers responsible/appointed for coordination of Minimal prevention programme in the school). Each elementary and secondary school is obliged to appoint/have a School prevention professional and to formulate and realise Minimal prevention programme. Minimal prevention programmes in general deal mainly with universal and selective prevention activities delivered usually both by the school and external provider(s).

A network of aforementioned Pedagogical-psychological counselling centres plays important role in support of prevention activities in schools as well as in provision of indicated prevention activities and interventions in individual pupils at-risk.

NGO's are widely involved to provision of prevention in schools, especially those having specialised prevention centre or programme – they are involved mainly in universal and selective prevention activities. The prevention activities are also organized by other resorts such as Ministry of Health, Ministry of Transport, and Ministry of Interior. They are not well coordinated up to now at the central level; at the regional and local level a communication and coordination may be better since it is closer to the implementation level.

There are attempts to formulate the overall system of prevention of the risk behaviour in the Czech Republic involving all ministries and actors (promoted by the Department of Addictology of the 1st MF of CUNI).

Prevention activities are annually supported by Ministry of Education through its grant programs focused on risk behaviour and crime prevention. Ministry announces a grant procedure, in which institutions can apply for allocation of funds. Other financial sources for prevention activities are from the National Committee for Drug Policy Coordination (GCDPC) and regional and municipal budgets.

Currently, it is important that institutions applying for ministry (and GCDPC) grants have received or applied for a certification (= they have been assessed for the quality offered by the program in accordance with the minimum quality standards).

In the Czech Republic there is a national action plan which regulates and coordinates the drug prevention specifically for school. There is a specific prevention part of the National drug strategy and action plan linked to it. As regards strategic plans of Ministry of Education, there is a strategy and action plan for prevention of risk behaviour, which is not the drug specific.

Each elementary and secondary school is obliged to appoint/have a School prevention professional and to formulate and realise Minimal prevention programme. Minimal prevention programmes in general deal mainly with universal and selective prevention activities delivered usually both by the school and external provider(s). Each school is predominantly defining the contents of school-based prevention.

4.2.2 Prevention interventions

Act no. 65/2017 Coll. was approved in May 2017. This Act lays down measures for protection against the harm caused by the use of addictive substances and the competencies of administrative authorities and territorial self-governing entities concerning the adoption and implementation of the measures under this Act. The law on protection against the harm caused by the use of addictive substances shall also implements the following:

- Prohibition of smoking in a publicly-accessible interior space such as restaurants, bars, cafes and so on (except electronic cigarettes and water pipes)
- Prohibition of smoking on a covered platform and in a public transport shelter or waiting room
- Prohibition of smoking in a healthcare establishment and in spaces associated with its operation, in a school or educational establishment, in a public transport vehicle, in the interior of an entertainment space such as a cinema, theatre, exhibition or concert hall and sports hall, and in any other interior space during a cultural or dancing event, in a children's playground or sports ground intended primarily for persons under 18 years of age, in the interior space of any type of sports facility
- Mark that space at the entrance with a clearly visible graphic sign reading 'Prohibition of smoking;

- Prohibition and restriction of the sale and servicing of alcoholic drinks a person who is clearly under the influence of alcohol or other addictive substance, at events primarily intended for persons under 18 years of age, at a publicly-accessible sporting event, with the exception of alcoholic drinks containing not more than 4,3 % by volume of ethanol
- Prohibition and restriction of the sale and servicing of alcoholic drinks in a vehicle intended for the public transport of people, with the exception of long-distance rail, air, water and long-distance bus public transport
- It shall be prohibited to sell alcoholic drinks through a vending machine.
- It shall be prohibited to sell and manufacture food products and toys that mimic the shape and appearance of tobacco products or smoking accessories.
- It shall be prohibited to import food products and toys mimicking the shape and appearance of tobacco products or smoking accessories

In August 2019, total of 60 programs of universal prevention were certificated. Part of the 52 programs was prevention in addictology (i.e. they provide prevention in topic of addiction, including alcohol, tobacco, illicit drugs and gambling). No summary information on their implementation is available.

Since 2016, a unified reporting and data collection system in school prevention has been launched under the VYNSPI project. The National Institute of Education, the Clinic of Addictology of the First Faculty of Medicine and the General Teaching Hospital in Prague and the Ministry of Education, Youth and Sports cooperate on its development and implementation. On the practical level, it is an electronic report of implemented preventive activities of each school, which is usually processed by the School prevention professionals. Although schools are not obliged to use the system, it is the most widespread tool for monitoring preventive activities. Since the start of the system, 3545 primary and secondary schools (66% of all schools) have been registered into the system. In the school year 2018/2019, a total of 1280 primary and secondary schools registered and reported in the system, which represents 24% of all primary and secondary schools in the Czech Republic and is the first year-on-year decrease in the number of schools reporting into the system (Clinic of Addictology, First Faculty of Medicine, Charles University and the General Teaching Hospital, 2019). However, the system of reporting provides summary information on implementation of universal prevention activities in schools.

87.3% of schools reported general prevention implemented by independent preventive activities and programs in the school year 2018/2019. Prevention programs were paid by participants in 19.9% of cases, in 16.4% of cases by the school budget and in 12.8% by subsidies. Preventive program providers were most often non-governmental organizations (31.1%), schools themselves (21.4%) and the Czech police or municipal police (13.9% in total). Most of the implemented preventive programs were not certified (the system of certification of quality), 36.5% of schools reported the implementation of certified programs. The most frequent forms of the program were interactive group discussion (24.0%) and lecture (23.8%). Preventive programs implemented in schools focused mostly on prevention of bullying and aggression

(15.7% of programs), prevention of criminal behaviour (11.1%) and prevention of cyberbullying (9.4%). 7.7% of programs focused on alcohol use prevention, 6.9% on tobacco prevention and 7.5% on illicit drug use prevention.

There are partial information on the implementation of some evaluation or pilot preventive projects.

The nPrevence programme invented by Department of Addictology of the First Faculty of Medicine of Charles University in Prague has been trialled in Czech Republic. The programme is designed for 12-14 year olds and consists of 12 one-hour units delivered weekly by teachers who have been trained to deliver the intervention. In a randomized controlled prospective study, the efficacy of two independent preventive interventions (Unplugged and nPrevence) was examined in comparison with the one-off preventive intervention (Unplugged) and no intervention. Unplugged was realized in the 6th year in the school year 2013/2014, nPrevence one year later in the 7th grade. Between September 2013 and June 2017, 7 waves of data collection were carried out, with almost 15,000 questionnaires collected. The results were not available in October 2019.

Programs of selective prevention are implemented by PPC (pedagogical-psychological counselling centres), child and family counselling, diagnostic institutions, educational institutions, educational care centres (SEN) and non-governmental non-profit organizations. In the Czech Republic, in August 2019, a total of 24 selective programs were certified, of which 20 selective prevention programs were focused on prevention in the area of addiction. No summary information on their implementation is available.

Programs of indicated prevention are implemented by PPC (pedagogical-psychological counselling centres), child and family counselling, diagnostic institutions, educational institutions, educational care centres and non-governmental non-profit organizations. In the Czech Republic, in August 2019, a total of 10 indicated programs were certified, of which 8 indicated prevention programs were focused on prevention in the area of addiction. No summary information on their implementation is available.

In addition to methodological action towards school prevention methodologies, the prevention methodology in PPC also deals with diagnosis and counselling in individual cases. At present, 90 PPC and 43 educational care centres exist.

4.2.3 Quality assurance of prevention interventions

Since 2006, the system has been in place to verify the quality of primary risk prevention programs undertaken by outside bodies in education. It is the process of assessing the provider and his program according to the quality criteria set by the approved Standards (Pavlas Martanová et al., 2012) and granting or not granting the certificate of fulfilment. The certification system for prevention is coordinated by the National Institute for Education (NÚV) certification.

In August 2019, the NÚV registered a total of 62 organizations with 94 certified primary prevention programs (as in January 2018 it was 57 organizations and 94 programs and January 2017 it was 56 organizations and 90 programs). Of the total of 94 certified programs, 80 focused on addiction prevention, i.e. they included topics from the field of substance abuse prevention and addiction, including 52 universal, 20 selective and 8 indicated prevention programs. The list of certified prevention programs providers is available at NÚV website (http://www.nuv.cz/modules/catalog/index.php?h=product&a=index&id_catalog=15).

Standards of professional competence of providers of prevention programs of risk behaviour in school are divided into 2 parts: general part (which is the same for universal, selective and indicated prevention programs) and special part (which differs according to the type of prevention: universal, selective and indicated prevention programs).

Between 2016 and 2017, the Standards and the entire certification process were reviewed. The revised standards were not put into practice yet. Since May 2019, the system of certification is suspended due to its insufficient systemic anchoring. Programs with expired certificate were extended until the restoration of certification process. However, new programs cannot apply for certification.

4.3 Trends

Since 2007 a number of evaluation studies have been carried out in the field of universal prevention and family prevention. Also new prevention methods has been implemented into Czech conditions (e. g. the Unplugged programme) and settled down in many Czech schools.

In the period 2009 - 2015 a number of conceptual frameworks were presented and published, e. g. recommended structure for school prevention program, the draft of 4-level model in education of prevention workers (Charvát, Jurystová, & Miovský, 2012), glossary for unifying the terminology in primary prevention). In 2014 and 2015 the pilot evaluation of these concepts has been held and the first system of reporting in prevention has been set up (Gabrhelík, 2015).

Currently the topic of primary prevention is contained in several multi-resort and interdisciplinary concepts (approaches and programs are developed conceptually along several lines - educational, medical, social etc.). However, the boundaries between resorts are not clear.

In 2015 the Structure of an Implementation plan for the National System of School-based Prevention of Risk Behaviour in the Czech Republic for years 2015-2025 that should lead to harmonisation of the approaches by the Ministries of Health and Education has been conceptualized (Miovský & Gabrhelík, 2015).

Since March 2019, there is a new National Strategy for prevention of risk behaviour for period 2019-2027 and it's Action Plan for the period 2019-2021, which is actually the first action plan in the area of prevention of risk behaviour.

Since 2016, a unified reporting and data collection system in school prevention has been launched under the VYNSPI project. The National Institute of Education, the Clinic of Addictology of the First Faculty of Medicine and the General Teaching Hospital in Prague and the Ministry of Education, Youth and Sports cooperate on its development and implementation. On the practical level, it is an electronic report of implemented preventive activities of each school, which is usually processed by the School prevention professionals. Although schools are not obliged to use the system, it is the most widespread tool for monitoring preventive activities. Since the start of the system, 3545 primary and secondary schools (66% of all schools) have been registered into the system. In the school year 2018/2019, a total of 1280 primary and secondary schools registered and reported in the system, which represents 24% of all primary and secondary schools in the Czech Republic and is the first year-on-year decrease in the number of schools reporting into the system (Clinic of Addictology, First Faculty of Medicine, Charles University and the General Teaching Hospital, 2019). For summary information on implementation of prevention activities see above (in Universal prevention section)

The unified system monitors as well the number of solved cases of occurrence of risk behaviour. The most frequently cases of risk behaviours in elementary and secondary schools in the school year 2018/2019 were problems in relationships between children (22.2% of cases), tobacco use (14.6%) and serious offenses against school rules (11.3%). Risk behaviour occurrence at primary and secondary schools differs - at primary schools the most frequent cases were: problems in relationships between children (29.6% of cases), serious violations of school rules (12.6%) and bullying (8.0%). At secondary schools the most frequent cases were: tobacco use (30.3%), truancy (21.0%) and serious offenses against school rules (8.6%). The most frequent cases of substance use were tobacco use and alcohol use. The use of addictive substances was significantly more frequent at secondary schools. The most frequent cases of substance use were solved in the 3rd year of secondary school, the use of tobacco and cannabis was most often solved in the second year of secondary school.

Bullying and manifestations of aggression are also problems mostly dealt with on pedagogical-psychological counselling centres.

The unified system provides information about School prevention professionals. Most of the School prevention professionals have also other functions at school, most often a class teacher. In the school year 2018/2019, only 10.5% of the School prevention professionals did not have any other position in the school. 44.8% of the School prevention professionals completed accredited studies for the performance of specialized activities of School prevention professionals. 73.3% of the School prevention professionals did not have external professional supervision, of which 39.1% showed interest in it.

4.4 Sources and methodology

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5 Treatment

5.1 Summary

Nationale profile

The Act on the Protection of Health from the Harmful Effects of Addictive Substances (ZOZNL) from May 2017 newly, relatively generally and broadly, defines professional care for persons with addictological disorder. The law no longer lists the specific types of services as it has been so far, which the professional public assessed as an undesirable weakening of the legal framework for the provision of addictological services.

Amending Government Decree a new specialization in the field of addictology - a clinical addictologist - can perform certain listed activities without professional doctors' supervision.

Outpatient network consists mainly of four types: low threshold drop in centres, health care (psychiatric) care, addictological care and psychosocial support care (mainly social service). Inpatient network rely on network of health care (psychiatric) facilities and therapeutic communities.

Methadone OST is possible only in specialized centres, buprenorphine can be prescribed without any specialization.

Trends

The reports on the implementation of drug policy in the regions in 2017 (not available for 2018), indicate there are 272 (244 in 2016) specialized addictology centers in the Czech Republic (without the inclusion of preventive and outreach programs). Compared to 2016 there was a significant increase in the number of outpatient treatment programs (by 23) and aftercare programs (by 3). Most regions describe the existing network of services as minimal or insufficient. The geographical availability of low-threshold harm reduction services is assessed as relatively good, but significant shortage are reported in the availability of outpatient treatment (especially substitution treatment and care for dual diagnosis clients). Regions reports the lack of outpatient psychotherapists, psychiatrists and other doctors who are willing to work with drug users. There is also no capacity specializing in children and youth. Very low availability across types of services persists in the Karlovy Vary Region. On the other hand, in some regions, it has been possible to stimulate new or expanding existing services, in particular for gamblers.

According to the Czech Association of Addictologists, a total of 24 health but non-medical addictological outpatient clinics were registered in the Czech Republic in May 2017, but only 13 of them had a contract for payments with one of the health insurance companies. Outpatient addictological care is available in 17 out of 77 districts. Number of contracts in 2018 are not known.

The largest health insurance company (VZP) registered in 2015 in total 27 specialized AT outpatient clinics, approximately 10% of addictive drug users and 20% of pathological players were treated in the network of psychiatric outpatients in total.

In 2017, the Ministry of Health declared as one of the priorities the subsidies to support addictological services for children and adolescents. There are currently 9 children and adolescent addictological outpatient centres in the Czech Republic, 5 of them in Prague. In 2018 Section for children and adolescents under professional organization CLS JEP was established

Accessibility of addictological services in prisons is increasing, and since 2016 prison service starting establishing an addictologist position in prisons. Drug prevention counselors and drug-free zones were available in all 35 prisons. Treatment of addiction in prison is provided in 13 prisons, of which 3 were dedicated by the court as for the protective treatment. There were only 63 prisoners in six prisons in substitution treatment (OST).

As of August 2018, a total of 192 programs were approved by the GCDPC in certification process. There is a long-term increase in the number of certified programs.

The number of people treated in OST has been stagnated in the last 5 years. In 2018, a total of 54 healthcare providers (62 in 2017) registered their patients in substitution treatment and 2312 treated persons were enrolled (2249 in 2017), 31% women. 720 (31 %) were on methadone and 1592 (69 %) on buprenorphine preparations (787; 49% of them on Suboxone® and 805 (51 %) on buprenorphine mono-preparations). However, a significant number of patients in opiate substitution treatment are not reported to the registry (estimated total in OST 5000).

On average, 53,2 % of OST patients were registered in substitution treatment in the capital Prague the Czech Republic in 2018, but the share of the estimated problem opioid users is 17,6%, for whole republic 22, 6%. Also in other regions with a significant number of problem users (Středočeský, Jihočeský, Plzeňský and Ústecký) their share in substitution is very low. In these regions, there has also been an increase in the abuse of opioid analgesics in recent years. The availability of buprenorphine substitution remains a problem. Buprenorphine Monopreparats are not covered by health insurance, so the patient pays full price in the pharmacy. The combined Suboxone 8 mg formulation is the only mass-produced substitution preparation since 2010 covered by health insurance, but in practice, the number of patients treated with Suboxone® is estimated to be several dozen. In addition, financial accessibility declined further in 2018 as patients undergoing Suboxone® have to re-pay. The results of the questionnaire survey in 14 substitution centers in the Czech Republic showed the positive impact of substitution treatment on housing, financial income stability, debt management and the reduction of crime.

New developments

There is a growing range of treatment and counselling interventions provided via the Internet and new technologies, and web applications for users of tobacco, alcohol, illicit drugs, gamblers and their relatives. In 2017, national gambling and alcohol reduction were launched.

5.2 National profile

5.2.1 Policies and coordination

5.2.1.1 Main treatment priorities in the national drug strategy

Treatment and social reintegration and harm reduction are two of the four pillars of the currently applicable National Drug Policy Strategy for 2010–2018. Also applicable is the 2016–2018 Action Plan, a document building on the Strategy. The plan sets out four priorities, focusing on high rate of problem methamphetamine and opiates use, increase of local, time and financial availability of specialized addictology care and introduction of new evaluating system of availability and addictology service support, levels of drug use among young people, methamphetamine, issues of funding, including the funding of services, and the integration of various substances and addictive behaviour patterns into a single policy. The Action Plan addresses treatment in three areas: (1) the network of services for drug users and its accessibility and quality; (2) increasing quality of addiction services developing programmes for drug users in prison and maintaining their availability; 3) increasing the availability of health addiction services; and (3) supporting social rehabilitation of drug users developing and improving the quality of substitution treatment. Drug policy strategies are also individually developed by all 14 regions.

In May 2019 new National Drug Strategy 2019–2027 was approved by Government. New strategy integrates topics of legal and illegal substances and non-substances addictions. Treatment with social rehabilitation, and harm reduction are two of four strategy pillars. Strategy has 4 priorities and “quality and accessible network of addictology services” is included.

<http://www.vlada.cz/cz/ppov/protidrogova-politika/strategie-a-plany/narodni-strategie-prevence-a-snizovani-skod-spojnych-se-zavislostnim-chovanim-2019-2027-173695/>

5.2.1.2 Governance and coordination of drug treatment implementation

The development and enforcement of the national drug policy is the responsibility of the Government of the Czech Republic. Its advisory and coordination body is the Government Council for Drug Policy Coordination (GCDPC) with its system of committees and working groups.

However, there is a shared responsibility over provision of addiction treatment services. Addiction treatment services are funded by subsidies from the Ministry of Health (health services), the Ministry of Labour and Social Affairs (social services), the Government Council for Drug Policy Coordination (various types of services), and the regions and municipalities (various types of services); health insurance companies also contribute significantly to payments for care (health services). Ministry of Justice is in charge of provision of addiction treatment in prisons (prison services). Financial and other support, decisions on new services is provided by 14 regions municipalities.

5.2.1.3 Further aspects of drug treatment governance

In March 2017, Act No. 65/2017 Coll., On the Protection of Health from Harmful Substance Effects (ZOZNL) came into force. With effect from 31 May 2017, the ZOZNL changed provisions concerning the services provided to persons with addictological problems, which were listed in Act No. 379/2005 Coll., On Measures for Protection against Damage caused by Tobacco Products, Alcohol and other Addictive Substances. ZOZNL cancelled the detailed list of the types of professional care provided to patients with addictological disorders (addictology services); and redefining these services as professional care including prevention of addictological disorders, their early diagnosis and treatment, counselling, reduction of health and social risks, social rehabilitation and reintegration of persons affected by addictological disorders. Professional care is provided by both healthcare providers, social service providers and the prison service. The ZOZNL has also changed the provisions on drug policy coordination, including coordination at local level; the position of regional drug coordinator is not obliged. The expert community has expressed concerns about weakening the coordination of drug policy at the local level and weakening the legal framework for the provision of addictological services.

Amending Government Decree No. 31/2010 Coll. on specialization training courses and specializations of health professionals with specialized competence and amending Decree No. 55/2011 Coll., on activities of health workers and other professionals, a new specialization in the field of addictology - a clinical addictologist who can perform certain listed activities without professional supervision of medical doctor.

5.2.2 Organisation and provision of drug treatment

5.2.2.1 Outpatient network

5.2.2.1.1 Outpatient drug treatment system – Main providers and client utilisation

Outpatient addiction treatment services are provided mainly by low-threshold programmes and outpatient healthcare services. Most of these (LTS) programmes are registered as social services (some of them are also registered as health services) and mainly because of needle exchange they are specialised in working with users of drugs other than alcohol, but alcohol users as well as gamblers can use the service. The number of low-threshold programmes in the Czech Republic has been around 100 (107 in 2018) in recent years, around 54 are drop-in centres with stable office.

Outpatient health services, these are typically outpatient psychiatric clinics reporting the treatment of people with some kind of addictive disorders. Part of them are specialised only in the treatment of addictive disorders: so-called AT (old names of alcohol/toxicomania) clinics. The well-functioning and coordinated network of these alcohol/drug treatment outpatient facilities collapsed in the early 1990s.

Non specialized healthcare services – in 2018 in total 450 units reported 37 004 patients (dg.F10–F19), it means units with at least one client with this dg. Out of that 450 are 49 AT centres with 11 593 (31,3 %) treated. Today, the number of AT clinics is estimated up to 50. The

largest health insurance company (VZP) registered in 2015 in total 27 specialized AT outpatient clinics, approximately 10% of addictive drug users and 20% of gamblers were treated in the network of psychiatric outpatients in total. These specialised outpatient programmes are the main providers of buprenorphine substitution treatment in the Czech Republic.

Addictological out-patient centre - addictologist is a healthcare non-medical profession. They provide mainly counselling, case management etc., in total 24 centres in 2017, in 2018 contracts with health insurance companies increased, however the number for 2018 is unknown.

Outpatient counselling and treatment centres (with the majority of them registered as social services) and programmes that provide more structured care and that may also have the character of aftercare (they are operated mainly by NGOs).

The above addictological care is complemented by psychotherapeutic day care centres, some of which specialise in addiction clients, and crisis centres.

Prison – special units for addiction treatment, offer counselling, information, group and individual sessions. There are addictological NGO programs reaching in prison clients during imprisonment and offering help also before or after release.

Sobering-up stations are also considered outpatient treatment facilities, despite the fact that their clients stay in beds. These programmes provide diagnostic and therapeutic care to patients who – through the use of alcohol or other addictive substances – brought themselves into a state in which they pose a risk to themselves or to other people. However, there is no special standard of professional competency for these facilities, they have no links to other addiction treatment services, and their operation is associated with economic and ethical issues, respectively with economic and ethical principles and goals, as the clients of these units are often brought there from streets or other outside settings, which could be harmful to stay (alcohol) intoxicated to them and also it is preventing society from related public nuisance, thus to care about intoxicated is seen more as ethical issue than treatment. Therefore, in their current form, they are not considered as specialised addictological care by the professional community.

While the existing network of addiction treatment services covers the entire spectrum of problems associated with substance use, it essentially consists of three separate systems: (1) the network of low-threshold programmes and specialised outpatient treatment and aftercare programmes and therapeutic communities which predominantly have the status of social services and are operated by NGOs focusing particularly on users of illicit drugs other than alcohol and, on pathological gamblers; (2) the network of healthcare facilities specialising in psychiatry, or alcohol/drug treatment in particular, which provide outpatient and residential health services to users of both alcohol and non-alcohol drugs and, less often, to pathological gamblers, and (3) tobacco addiction treatment centres, formed largely in inpatient facilities dedicated to pulmonology or internal medicine.

Table 19 - Network of outpatient treatment facilities (total number of units and clients)

	Total number of units	National Definition (Characteristics/Types of centre included within your country)	Total number of clients
Specialised drug treatment centres	97	Psychiatric, addictology and non-health care programs	20269
Low-threshold agencies	54	Drop in centres	17535
General primary health care (e.g. GPs)			
General mental health care			
Prisons (in-reach or transferred)	14	Specialized units for drug treatment	876
Other outpatient units	36	After-care programs	1986
Other outpatient units	18	Sobering up stations	488

Source: Standard table 24.

5.2.2.1.2 Ownership of outpatient drug treatment facilities

Services focussed more on counselling and psycho-social care, individual and group therapy, are mostly NGOs with status of healthcare or (mainly) social service, paid via multisource model (MoH, MoLSa, GCDPC, donors, municipalities, regions etc.). There are different sizes of NGOs, some of them run one or two programs, others 10 and more facilities and programs combining outpatient and inpatient services. Services with predominant health care are mostly psychiatric health care facilities (paid via health insurance). The network is quite diverse. Also there is a (probably will be growing) offer in private centres recently.

Table 20 - Ownership of outpatient facilities providing drug treatment in your country (percentage). Please insert % in the table below. Example: about 80% of all outpatient specialised drug treatment centres are public/government-owned facilities and about 20%

	Public / Government	Non-government (not for profit)	Non- government (for profit - Private)	Other	Total
Specialised drug treatment centres	80	18	2		100%
Low-threshold agencies		100			100%
General primary health care (e.g. GPs)					100%
General mental health care					100%
Other outpatient units (1) aftercare	10	90			100%
Other outpatient units (2) Sobering up stations	100				100%

5.2.2.2 Inpatient network

Inpatient drug treatment system – Main providers and client utilisation

Hospital-based residential drug treatment, plus detoxification – public hospitals

Therapeutic communities – NGOs, 2 TCs are under one hospital for addiction treatment, 2 private TCs

Prisons – detox units within prison

Special units in the residential correctional/diagnostic facilities for children - under Ministry of

education

Detox units in community hospitals - detoxification from non-alcohol substances.

Table 21 - Network of inpatient treatment facilities (total number of units)

	Total number of units	National Definition (Characteristics/Types of centre included within your country)	Total number of clients
Hospital-based residential drug treatment	55	Abstinence oriented health care addiction treatment in residential facilities of psychiatry field, use pharmacology and psychotherapy approach, for all patients groups (alcohol, other drugs, gambling, cannabis...)	5787
Residential drug treatment (non-hospital based)			
Therapeutic communities	19	Residential treatment on the therapeutic community principle, target group mainly illicit drug users.	528
Prisons	6	Detox units in prisons	27
Other inpatient units (1.please specify here)	17	Detoxification	4541
Other inpatient units (2.please specify here)	6	Therapeutic units	149

Source: Standard table 24

Inpatient health care units are public, TCs mainly NGOs, less public or private.

Table 22 - Ownership of inpatient facilities providing drug treatment in your country (percentage). Please insert % in the table below. Example: about 80% of all Therapeutic communities are public/government-owned facilities and about 20% are non-government (not for profit) owned facilities

	Public / Government	Non-government (not for profit)	Non- government (for profit - Private)	Other	Total
Hospital-based residential drug treatment	100				100%
Residential drug treatment (non-hospital based)	90		10		100%
Therapeutic communities			80		100%
Prisons	100				100%
Other inpatient units (1 - detoxification)	100				100%
Other inpatient units (2- therapeutic units)	80		20		100%

5.2.3 Key data

Summary table of key treatment related data and proportion of treatment demands by primary drug

Table: Number of OST patients is underreported, the estimation according the consumption is 5000

Chart: the most used drug is methamphetamine, and also within the TDI is the highest proportion. For opioids heroin and buprenorphine, with others opioids are the main substances.

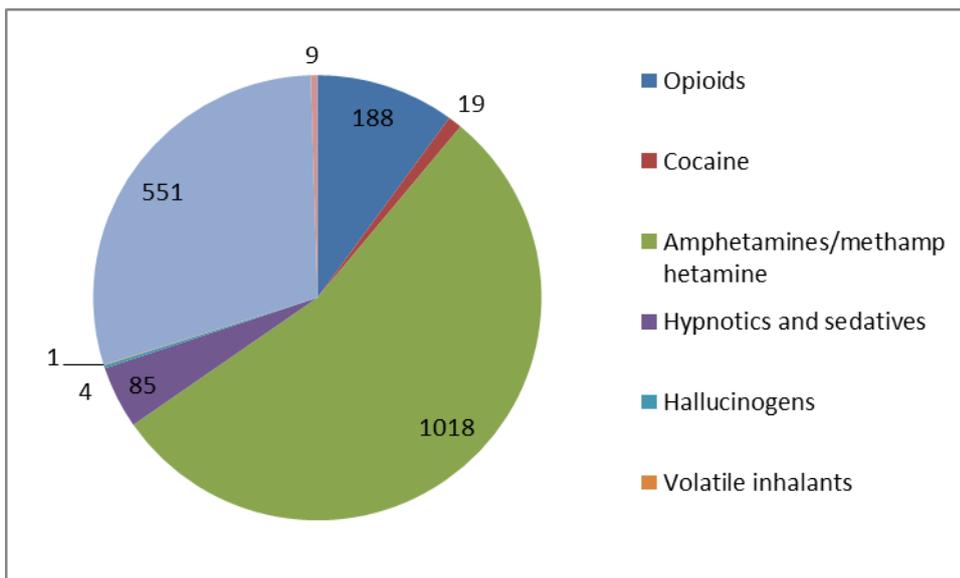
Note: TDI register still not fully operational, the coverage is still quite low.

Table 23 - Summary table - Clients in treatment

	Number of clients
Total clients in treatment	46133
Total OST clients	Estimation 5000, TDI register 2312
Total All clients entering treatment	TDI - 4363

Source: ST24 and TDI

Figure 28 - Proportion of treatment demands by primary drug



Source: TDI

5.2.4 Treatment modalities

5.2.4.1 Outpatient and Inpatient services

The psychosocial interventions are largely available, mainly because of a lot of NGOs involved in the field. OST is less available in general health care facilities. The provision in GPs is less known.

Table 24 - Availability of core interventions in outpatient drug treatment facilities. Please select from the drop-down list the availability of these core interventions (e.g. this intervention is available, if requested, in >75% of low-threshold agencies)

	Specialised drug treatment centres	Low-threshold agencies	General primary health care (e.g. GPs)	General mental health care
Psychosocial treatment/ counselling services	>75%	>75%		>75%
Screening and treatment of mental illnesses	>75%	<25%		>75%
Individual case management	>75%	>75%		>25%-75%
Opioid substitution treatment	>75%	<25%		>25%-75%
Other core outpatient treatment interventions				

Availability is high, however the intensity might differ. The highest intensity individual as well as group interventions are in the therapeutic communities. Hospital-based residential drug treatment is provided in larger groups of patients and thus the individual care might not be so intensive, however, is available. OST in inpatient facility is possible only in detox for short period of time, OST is not provided in hospitals or TCs. In prison, only some units offer OST (methadone) but only to patients who were involved in such a program before they have entered the prison.

Availability is generally high, OST in prisons is very limited.

Table 25 - Availability of core interventions in inpatient drug treatment facilities. Please select from the drop-down list the availability of these core interventions (e.g. this intervention is available, if requested, in >75% of therapeutic communities).

	Hospital-based residential drug treatment	Residential drug treatment (non-hospital based)	Therapeutic communities	Prisons
Psychosocial treatment/ counselling services	>75%		>75%	>75%
Screening and treatment of mental illnesses	>75%		>75%	>75%
Individual case management	<25%		>75%	not known
Opioid substitution treatment	Not available		Not available	<25%
Other core inpatient treatment interventions				

5.2.4.1.1 Targeted interventions for specific drug-using groups

Senior drug users (>40years old): Senior drug users (>40years old): CZ is took a part in BETRAD project. One TC is specialized at older users, they accept older clients (even above 50). The network for older users is not developed, there are no special services even the population is getting older, however treatment and services for older drug users is the topic for professionals (discussions at conferences), individual work with clients according to their needs (health, housing etc.)

NPS users: NPS diminished from PDU population, and its use is quite rare, thus NPS users are not visible in treatment.

Recent undocumented migrants (asylum seekers and refugees): There is no recent migrant population in CZ.

Women (gender-specific): mamaadrogy.cz – webpage for mothers (parents) using drugs

Under-aged children and adolescents: In 2017, the Ministry of Health declared as one of the priorities the subsidies to support addictological services for children and adolescents. There are in 2018 9 children and adolescent addictological outpatient centres in the Czech Republic, 5 of them in Prague. In 2018 Section for children and adolescents under professional organization CLS JEP was established.

5.2.4.1.2 E-health interventions for people seeking drug treatment and support online

- General drug counselling - <http://drogovaporadna.cz/>
- General drug counselling, started as party drug counselling (different provider)- https://www.extc.cz/poradna/?category_id=62&theme_id=64&&start=97
- BZD – <http://www.benzo.cz/>
- Counselling and on-line treatment for cannabis users - <https://koncimshulenim.cz/>
- Self tests, counselling in different topics and treatment for internet abusers (web-based application) poradna.adiktologie.cz
- Smoking-webpage of National help line, with self tests, basics advices etc. bezcigaret.cz.
- Smoking - Information and link to the national telephone helpline at national webpage koureni-zabiji.cz
- Gambling – national webpage with information and links [hazardní-hraní.cz](http://hazardni-hrani.cz)
- Alcohol – national webpage [alkohol-škodí.cz](http://alkohol-skodi.cz)
- mamaadrogy.cz – webpage for mothers (parents) using drugs
- fas.cindi.cz – webpage about alcohol fetal syndrome
- nudz-snasa.cz – webpage about risk use among youngsters, self test and study page.

LTS centres reported use of Facebook and others social medial in contacting active users.

All topics of social reintegration services (employment/housing/education) are included in the after-care programs, some of them offer also sheltered housing (22 out of 36 programs).

5.2.4.1.3 Opioid substitution treatment (OST)

The methadone is provided in specialized methadone centres, under hospital or NGO status.

Methadone is obtained centrally and financed by MoH. Geographical availability of methadone centres is limited and the capacity is in the long term full. The availability of buprenorphine substitution remains a problem. Buprenorphine Monopreparats are not covered by health insurance, so the patient pays full price in the pharmacy. The combined Suboxone 8 mg formulation is the only mass-produced substitution preparation since 2010 covered by health insurance, but in practice, the number of patients treated with Suboxone® is estimated to be several dozen. In addition, financial accessibility declined further in 2018 as patients undergoing

Suboxone® have to re-pay. Buprenorphine is prescribed mainly by AT psychiatrists, but could be prescribed also by GPs.

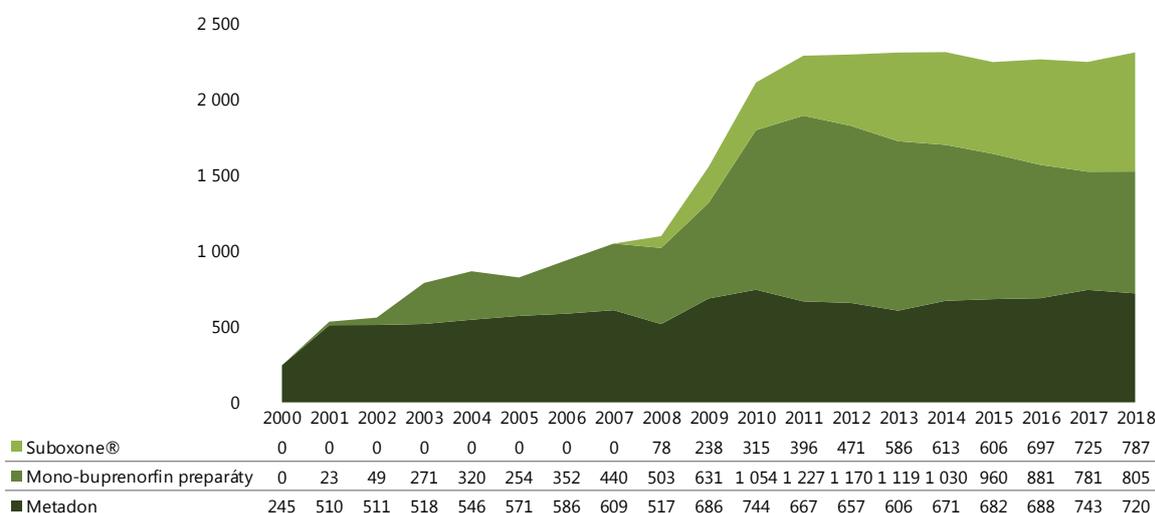
In 2015, a new National Drug Users Registry (NRLUD) was launched, integrating the Hygiene Service Applications Registry and the National Registry of Users of Medically Indicated Substitutes (NRULISL). 2016 was the first year of the routine operation of NRLUD, in 2017 the batch transfer of data to NRLUD was put into operation. The only region with no active reporting facilities remains the Pardubice Region (Institute of Health Information and Statistics, 2018c).

In 2018, 54 centres reported 2312 patients to register, 31% women. More than half of the population were aged 30-39 years and nearly one third 40-49 years, minor between 15-19 not even 1%.

Of 2312 patients on OST in 2018, 720 (31 %) were on methadone and 1592 (69 %) on buprenorphine preparations (787; 49% of them on Suboxone® and 805 (51 %) on buprenorphine mono-preparations). There is an increasing trend in Suboxone®, overall number of registered patients stagnates, numbers in methadone patients also stagnates.

Reporting to the register is not completed, not all patients are registered. Estimated, there are around 5000 patients in OST.

Figure 29 - Number in OST patients according to the substances used, 2000-2018



Results from the 2018 questionnaire based survey in OST centres on the impact of substitution treatment on the social status of patients (Popov et al., 2018) were published. The online survey was conducted in the period 22 April - 25 May 2018, comprising 310 patients from 14 centres. Of these, 72% of patients used methadone, 24% Suboxone® and 4% mono-buprenorphine. Patients treated with methadone had an average age of 39.5 years (range 22-61 years) and 68% of cases were men. The average dose of methadone was 101 mg (range 2.5-240 mg). The mean

age of patients treated with buprenorphine / naloxone was similar (39.4 years, range 21-65 years) and men in 72%. The mean dose of buprenorphine / naloxone was 8.38 mg (range 1-32 mg).

The survey has shown a beneficial impact on housing, a permanent source of income, debts solving, and reduced crime rates. Concerning housing, during the treatment, the number of patients who did not have housing fell from 9% to 1% and the number of patients who lived in their parents place decreased from 32% to 19%. On the contrary, the number of those who rented flat increased from 34% to 44% and in their own flat / house increased from 16% to 27%.

Permanent employment had 25% of patients before treatment, and this proportion increased to 48% during treatment. The number of self-employed slightly increased (from 6% to 8%) and the proportion of patients receiving disability pensions (from 5% to 8%) also. The number of those who did not have a source of income decreased (from 14% to 2%), also in people with only occasional employment (from 24% to 17%) or on social benefits (from 19% to 13%).

During treatment, the number of patients who did not have any debts and executions increased from 29% to 48%.

30% of respondents experienced imprisonment before the start of treatment. In the treatment, the proportion of patients who have not been at the court for a criminal offense in the last year increased from 42% to 93%. There is also a comparison of the sources from which users funded addictive substance and the sources from which they funded substitution treatment. From the legal income source drugs were paid 1% and substitution treatment 88% respondents (Popov et al., 2018).

5.2.5 Quality assurance of drug treatment services

Please see the Best Practice chapter.

5.3 Trends

Long term trends in numbers of clients entering treatment and in OST

Long trends are due to register change problematic. Here please find the trend 2015-2018.

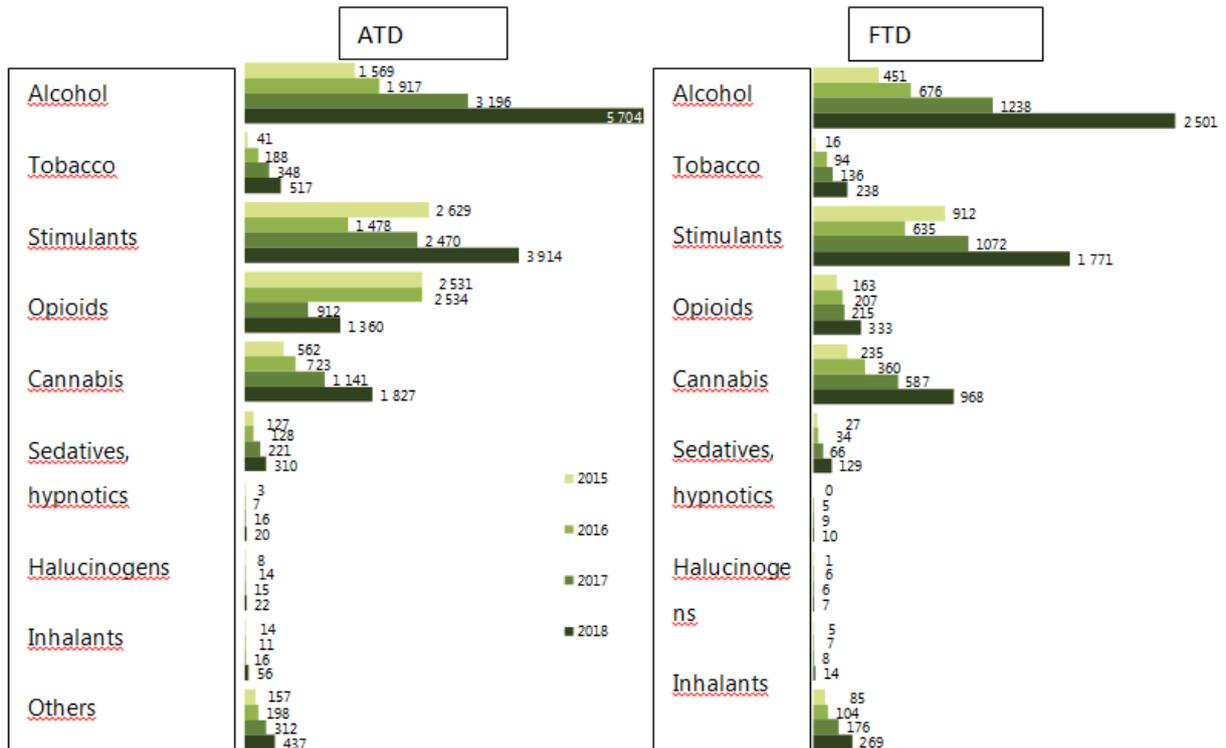
Until 2014, included, around 10,000 cases were reported in the TDI register (NRLUD) annually. FTD accounted for approximately half of all reported cases in the long term. Users of methamphetamine as a primary drug account for about 70% of all applicants over a long period of time, and their numbers have been growing for a long time, in opposite the number of opioid users (especially heroin) has declined.

In NRLUD, over 7,000 cases were reported in the year 2015-2016, including newly reported users of alcohol and tobacco as primary drug and gamblers who were not the subject of reporting till 2014, and about a quarter are the FTD cases.

In 2018 the reported cases increased, Alcohol users prevail, second largest group are methamphetamine cases. A comparison of 2015-2018 years by type of drug is shown in Figure below.

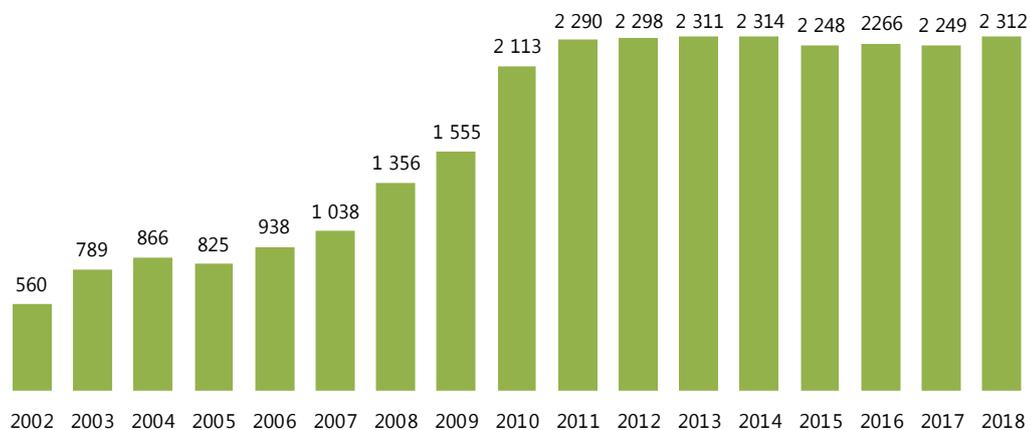
The difference in the proportion of opioid and pervitin users between the earlier registry of the hygiene service and the NRLUD is mainly due to the fact that NRLUD covers much more substitution treatment and less low-threshold services.

Figure 30 - Trend 2015-2018, according to drugs reported in TDI register, by primary drug



Source: TDI

Figure 31 - Trends in numbers of clients in opioid substitution treatment, 2003-2016



Source: ST 24

5.4 New developments

New webpages-please see above in chapter Treatment modalities.

Amending Government Decree a new specialization in the field of addictology - a clinical addictologist - can perform certain listed activities without professional doctors' supervision.

5.5 Sources and methodology

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6 Harms and harm reduction

6.1 Summary

Data of fatal drug overdoses in 2018 show 39 cases (20 opiates/opioids overdose, 14 stimulants (12 methamphetamine, 1 MDMA, 1 cocaine), 2 inhalants. Comparing previous year cases have decreased in opioids. Data for non-fatal intoxications were reported last time in 2016. with 1,101 cases. Number of hospitalizations for drug intoxication in emergency care hospitals is decreasing in long term, with 747 cases in 2018. Situation in infectious diseases is relatively stable. The transmission of HIV among IDUs is remaining low. In 2018, there were 7 newly diagnosed cases of HIV among PWID, i.e. persons who most probably contracted HIV through injecting drug use. 8 other newly diagnosed HIV-positive persons had a history of injecting drug use. The total number of newly reported cases of acute viral hepatitis B (HBV) has been declining in recent years, both overall and among PWID. The number of HCV cases among PWID was keeping around 560 in previous years, and increased in 2016 to 641 cases and to 580 in 2017, dropped down to 533 in 2018 (58,1%, resp. 58,5% and 50,8 %). In TDI register, seroprevalence of the infections among PWID in 2018 was in HIV 1,5%, HCV 45,6%, HBV 30,8 %, HAV 38,2%. HCV among patients of OST register was 75,5%.

Data from monitoring of low threshold facilities testing for infectious diseases is organized annually via on-line survey, 2018 results come from 52 questionnaires of 64 programs/facilities. Results: tested and prevalence: HIV- 1197 (0,1%), HBV (HBsAg) – 722 (1,1%), (anti HBc IgG) 116 (0,0%), HCV- 1414 (16,1%), syphilis -712 (0,4%).

Harm reduction stands as one of the four pillars of National Drug Policy in the Czech Republic. The network of harm reduction (low-threshold) programs is consisted of two main types of programs: outreach service and drop-in centre, these services are managed mainly by NGO and have status of social service. These services are mainly focussed on illicit drugs, in minor cases work with alcohol users or pathological gamblers. Programs offer wide range of services such as needle exchange, counselling, health care, referrals, hygienic services, DRID testing etc. DRIDs are monitored through standard reporting mechanisms to national Health Institution and National Institute of Health Information and Statistics. Direct survey in harm reduction services on provision of DRID testing is conducted by NFP annually. DRD are monitored via direct drug-induced deaths (fatal overdoses), and also indirect drug-related deaths (with the presence of drugs). DRD have been monitored on a routine basis by means of a special register kept by all thirteen departments of forensic medicine, with close collaboration between the National Focal Point and the Society for Forensic Medicine and Toxicology of the J. E. Purkyně Czech Medical Association.

There is relatively stable provision of low-threshold services including 108 of NSPs, additionally 2 vending machines were operating in two regions. Since 2014 the number of syringes distributed is about 6,4-6,9 million annually.

There is an increase in NGOs providing harm reduction information, education and counselling in nightlife setting (clubs) in long term and providing the clubs guidance on safer club rules, some offer also the certificate of the safer club.

Harm reduction programs under the umbrella of Association of NGOs started with shared database of known fatal overdoses and other deaths of their clients. The purpose is to compare the data with official register and also to see, what kind of interventions/information should be given to the clients.

6.2 National profile and trends

6.2.1 Drug-related deaths

6.2.1.1 Overdose deaths

The structure of fatal drug overdose from special mortality registry in 2018 by age, gender, and type of drug, is shown in bellow. 39 cases, 20 opiates/opioids overdose, 14 stimulants (12 methamphetamine, 1 MDMA, 1 cocaine) 2 inhalants.

Number of cases increased in opioids in 2017 (from 15 in 2016 to 27 in 2017), dropped down in 2018 to 20 cases. Numbers in methamphetamine are stabile, around 11-12 cases.

Table 26 - Fatal overdoses in 2018 in special registry, according to drugs, age and sex

Drug	Age Group											Sex		Total	
	<15	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	>64	Male		Female
Opioids	0	0	1	3	4	2	1	1	3	1	1	3	11	9	20
> only opioids	0	0	0	2	4	1	1	0	3	1	0	1	7	6	13
> more substances incl. opioids	0	0	1	1	0	1	0	1	0	0	1	2	4	3	7
Other drugs	0	0	1	2	4	4	4	2	1	0	1	0	14	5	19
> inhalants	0	0	0	0	0	1	0	1	0	0	0	0	1	1	2
> methamphetamine	0	0	0	1	4	3	2	0	1	0	1	0	8	4	12
> MDMA	0	0	1	0	0	0	0	0	0	0	0	0	1	0	1
> cocaine	0	0	0	1	0	0	0	0	0	0	0	0	1	0	1
> syntetic cannabinoid	0	0	0	0	0	0	0	1	0	0	0	0	1	0	1
> GHB	0	0	0	0	0	0	0	1	0	0	0	0	1	0	1
> Not specified	0	0	0	0	0	0	0	1	0	0	0	0	1	0	1
Illicit substances in total*	0	0	2	5	8	6	5	3	4	1	2	3	25	14	39
Psychoactive meds.	1	1	1	1	3	6	5	2	6	3	4	16	28	21	49
> benzodiazepines	0	0	0	1	0	3	3	0	0	1	3	3	7	7	14
Total	1	1	3	6	11	12	10	5	10	4	6	19	53	35	88

Note.: * selection D standard EMCDDA

Zdroj: Ústav zdravotnických informací a statistiky ČR (58)

Table 27 - Fatal overdoses in 2018, general mortality registry, according to drug, age group and sex

Droga	Age group												Sex		
	<15	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	>64	Male	Female	Total
Opioids	1	1	2	1	3	2	3	1	5	1	4	7	19	12	31
Cocaine	0	0	0	1	0	0	0	0	0	0	0	0	1	0	1
Other stimulants	0	0	1	2	5	3	2	0	2	0	0	0	11	4	15
Cannabis	0	0	0	0	1	0	0	1	0	0	0	0	2	0	2
Non specified drugs	0	1	1	1	2	2	0	0	0	0	0	3	7	3	10
Total illegal drugs*	1	2	4	5	11	7	5	2	7	1	4	10	40	19	59
Inhalants	0	0	0	1	2	1	0	1	0	0	0	0	3	2	5
Illicit substances in total*	1	2	4	6	13	8	5	3	7	1	4	10	43	21	64

Note.: * selection B standard EMCDDA

Source: Ústav zdravotnických informací a statistiky ČR (59)

6.2.1.2 Toxicology of overdose deaths

In special registry, there was identified 20 fatal overdoses by opioids (15 in year 2016, 27 in 2017). In 13 cases only by opioid-fentanyl (4), morphine (3), dihydrocodein (3), oxycodone (2). In 7 cases were combined with BZDs or others psychoactive medicines. Detected opioids were: morphine (5), oxycodone (1), codeine (1). Overall number of opioids overdose dropped down in 2018, however is higher than in 2016.

Methamphetamine was the cause of fatal overdose in 12 cases (no major changes over years), from that in 7 cases was detected alone or was detected combined with amphetamine (amphetamine as an methamphetamine metabolite). One case of MDMA fatal overdose and in cocaine, In 2 cases the cause of fatal overdose was the use of inhalants (3 in year r. 2017), both cases of toluene. Further, one case of synthetic cannabinoid (the case is probably connected to the Ostrava region intoxication of 3 people – one person died, there was detected 5F-MDMB-PINACA combined with heavy alcohol use – over 3 ‰) and one case of GHB. In one case the substance was not identified.

In a last five years, the situation in DRD is quite stable, with the nearly double increase in 2017 in opioids (from 15 in 2016 to 27 in 2017, but dropped down again in 2018 to 20 cases). The number of FO is rather low, however the opioids were detected in than half of the total number of DRD. The opioid of choice among PUD is still buprenorphine (2/3) and heroin (1/3). In the last years there has been increase in opioid medicines misuse (fentanyl patches, tablets with morphine or hydromorphone, oxycodone, etc.). In comparison with available data (2013-4 is missing) there was some increase in opioids fatal overdoses, with the highest number in 2017 (2011-6, 2012 – 12, 2015 – 20, 2016 – 15, 2017-27, 2018-20).

In 2018 in total 13060 autopsies were performed, out of 4458 (34,1%) with toxicological examination.

6.2.2 Drug related acute emergencies

There is information about the intoxications from National Hospitalizations Register, which serves for cases of hospitalization longer than 24 hours. Extracted cases are: accidental or intentional poisoning of undetected illegal drugs, i.e. the diagnosis of poisoning by non-alcohol drugs except medication; the toxic effect of alcohol and inhalants.

Table 28 - Number of hospitalizations for drug intoxication in emergency care hospitals in 2005–2018

Drug	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Heroin	24	18	31	41	19	20	17	4	13	8	14	10	7	8
Methadone	0	6	1	2	3	2	1	2	1	3	2	0	3	0
Other opioids	71	79	64	62	50	62	57	79	96	107	81	101	101	86
Cocaine	7	2	1	4	1	3	1	1	9	2	2	1	3	4
Cannabis	78	67	55	86	66	66	58	57	65	62	35	55	48	42
LSD	0	6	5	3	4	1	2	2	2	2	1	2	0	1
Methamphetamine and other stimulants	25	22	29	30	25	25	17	30	39	57	52	48	49	54
Other and unspecified drugs	116	146	136	83	94	77	79	87	98	107	77	93	113	78
Illegal drugs total	321	346	322	311	262	256	232	262	323	324	264	310	324	273
Alcohol	1 220	1 184	1 161	1 125	919	724	714	738	608	557	433	464	460	344
Inhalants	401	401	306	264	230	243	241	262	234	303	210	191	144	130
Total	1 942	1 931	1 789	1 700	1 411	1 223	1 187	1 262	1 165	1 184	907	965	928	747

Note.: heroin (T40.1), methadone (T40.3), other opioids (T40.0, T40.2), cocaine (T40.5), cannabis (T40.7), LSD (T40.8), methamphetamine and other stimulants (T43.6), other and not proved drugs (T40.4, T40.6, T40.9), alcohol (T51.0, T51.9), inhalants (T52.0–T52.9)

Source: Ústav zdravotnických informací a statistiky ČR (60)

Number of hospitalizations for drug intoxication in emergency care hospitals is decreasing in long term, main group of illegal substances were reported as opioids and not identified substances. The number of those for alcohol poisoning is declining in long term, but remaining higher than all illegal substances hospitalizations.

6.2.3 Drug related infectious diseases

6.2.3.1 Main drug-related infectious diseases among drug users

The transmission of HIV among IDUs is remaining low. In 2018, there were 7 newly diagnosed cases of HIV among injecting drug users (IDUs), i.e. persons who most probably contracted HIV through injecting drug use. 8 other newly diagnosed HIV-positive persons had a history of injecting drug use. Sexual intercourse between men is the dominant route of HIV transmission in the Czech Republic. The total number of newly reported cases of acute viral hepatitis B (HBV) has been declining in recent years, both overall and among IDUs. In viral hepatitis C (HCV), the number of cases among IDUs was keeping around 560 in previous years, and increased in 2016 to 641 cases and to 580 in 2017, dropped down to 533 in 2018 (58,1%, resp. 58,5% and 50,8 %). The number of new cases might be underreported. In the long term, the average age of infected PWID is increasing (39,8 for HBV, 32,5 for HCV). TDI register - there is a lack of information due to new electronical register, started in 2015. Data about testing for infections and test results in the TDI Register come in part from the clients themselves, which diminishes their information value, the absolute number of each reported disease was low comparing the trends before

register change and it has increased comparing previous years. Seroprevalence of the infections observed among injecting drug users in 2017 was in HIV 1,5%, HCV 45,6%, HBV 30,8 %, HAV 38,2%. As the number of reported patients in TDI register decreases, the results might be biased due to underreporting. HCV among patients of OST register was 75,5%. The reported data for OST patients might be biased, as the majority of the patients are not reported to the system (estimated OST patients 5000, reported 2312). Thus, patients in OST might be long term clients, with higher average age and higher rates of comorbidities. Data from monitoring of low threshold facilities testing for infectious diseases is organized annually via on-line survey, 2018 results come from 52 questionnaires of 64 programs/facilities. Results: tested and prevalence: HIV- 1197 (0,1%), HBV (HBsAg) – 722 (1,1%), (anti HBc IgG) 116 (0,0%), HCV- 1414 (16,1%), syphilis -712 (0,4%).

Low HIV new cases rate in long term

Table 29 - New cases according to way of transmission 1985-2018

Route of transmission	1985–2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	Total
IUD	56	8	4	4	6	5	6	9	5	7	5	7	122
> male	41	7	4	3	6	2	4	4	4	6	5	7	93
> female	15	1	0	1	0	3	2	5	1	1	0	0	29
MSM/IUD	20	4	3	3	6	5	4	6	6	4	3	4	68
Other with IUD in history	42	2	4	5	4	3	3	6	8	12	8	2	100
Other without IUD in history	920	134	145	168	137	199	222	211	247	263	238	195	3 078
Total	1 038	148	156	180	153	212	235	232	266	286	254	208	3 368

Source: Státní zdravotní ústav (2019b)

Figure 32 - The trends on new cases for HBV and HCV in a graphs

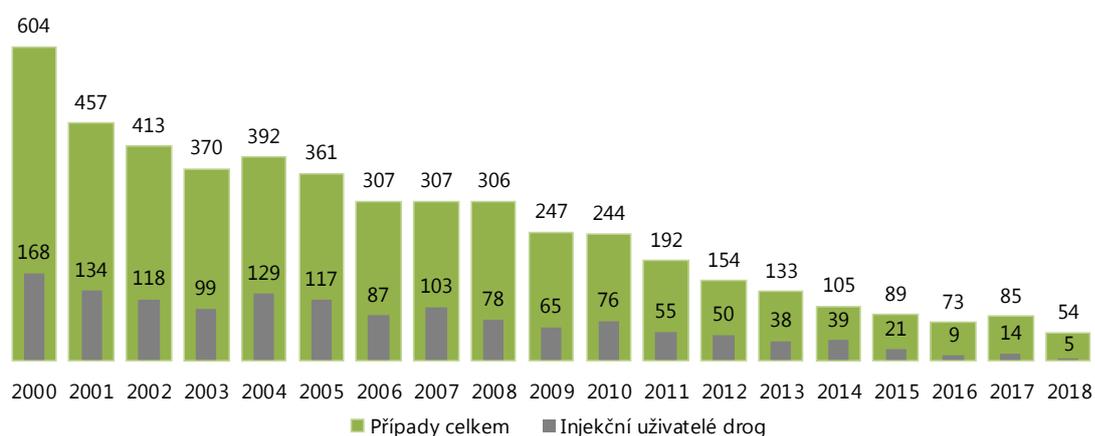
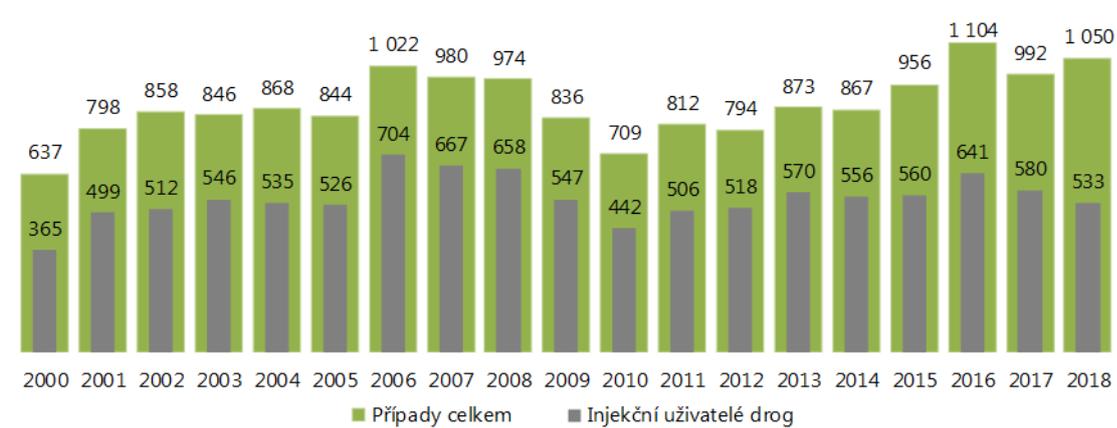


Figure 33 - Trend in HCV new cases, 1996-2018



Source: Státní zdravotní ústav (61)

Table 30 - HCV seroprevalence study among PWID in 2018, multi-centric questionnaire and rapid test study, n=709

Region	Number of respondents	Number of reactive tests	Share of reactive tests (%)
Praha	132	55	41,7
Středočeský	58	19	32,8
Jihočeský	13	3	23,1
Plzeňský	68	35	51,5
Karlovarský	43	21	48,8
Ústecký	72	39	54,2
Liberecký	36	6	16,7
Královéhradecký	21	8	38,1
Pardubický	29	4	13,8
Vysočina	15	2	13,3
Jihomoravský	47	24	51,1
Olomoucký	57	18	31,6
Zlínský	17	0	0,0
Moravskoslezský	101	29	28,7
Total	709	263	37,1

Table 31 - Sterile injecting equipment in Multiplier studies, 2010-2018

Year	Number of PWID	Use of sterile equipment in last injection	
		Number	%
2010	567	463	81,7
2013	1 701	1 509	88,7
2016	962	865	89,9
2019	867	796	91,8

Table 32 - Risk behaviour in HCV Seroprevalence study 2018

Category	Respondents (N=650)	Share (%)
Sharing in last 30 days		
needle and syringe	143	21,8
other paraferalia	265	40,6
sterile needle and syringe in last injection	593	90,3
To obtain sterile syringe with needle is easy	570	87,7
Mean of number syringes received	92	-

Source: Janíková and Mravčík (62)

Table 33 - Risk behaviour in HCV seroprevalence study 32018

Risk behaviour	Respondents (N=716)	Share (%)
Femoral injection in last 12 months	72	10,1
femoral injection in last 30days	48	6,8
injecting abroad	160	22,4
sharing of paraferalia with foreigner	79	11,1
tattoo or piercing in life	504	70,4
use of condom in lastsex. intercourse	139	19,6
sex for money or services in life	169	23,7

Zdroj: Janíková and Mravčík (62)

Trends in TB (Tuberculosis register) and syphilis (National register on STIs) among IDUs and alcohol users are available, please see graphs below.

Figure 34 - Trends of TB among drug users and alcohol users (new cases), 1997-2018

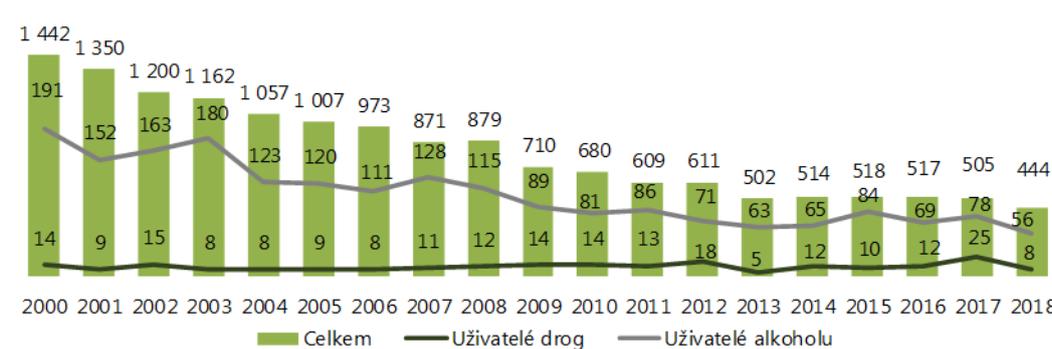
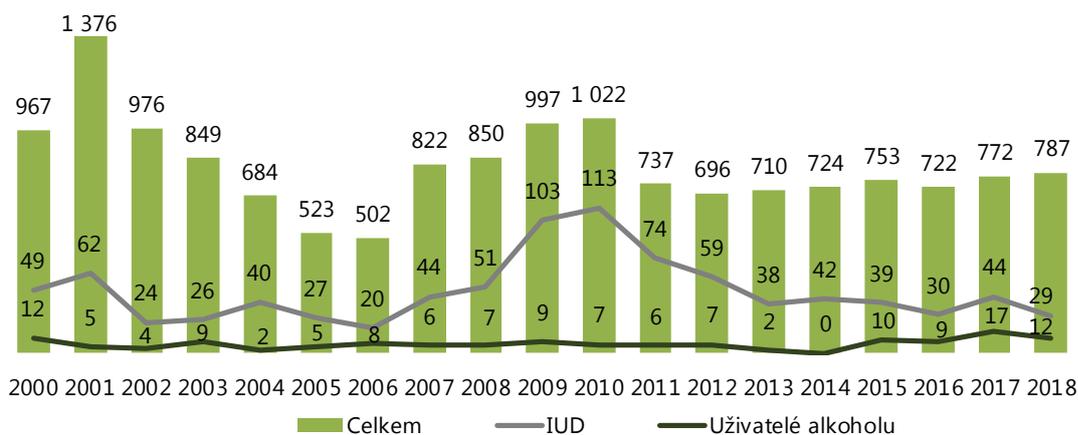


Figure 35 - Trends of Syphilis among drug users and alcohol users(new cases), 2000-2017



Source: Ústav zdravotnických informací a statistiky ČR (63)

6.2.4 Harm reduction interventions

6.2.4.1 Drug policy and main harm reduction objectives

The development and enforcement of the national drug policy is the responsibility of the Government of the Czech Republic. Its advisory and coordination body is the Government Council for Drug Policy Coordination (GCDPC) with its system of committees and working groups. In 2018 was the last year of the operation of the National Drug Policy Strategy for the Period 2010-2018 (the 2010-2018 National Strategy) and operation of its third action plan, intended for the period 2016-2018. New Strategy for 2019-2027 was approved 13.5.2019.

Harm reduction has been one of the main areas of the Czech drug policy in the long term. Harm Reduction is one of the four pillars (Treatment, Prevention, and Drug Supply Reduction) of The National Drug Policy Strategy.

Harm reduction interventions seek to minimise the adverse health and social consequences of drug use for both society and current drug users. They focus on:

- reduction of the risks of negative health consequences (both physical and mental) for drug users and those dependent on addictive substances; in particular, such consequences include overdoses, infectious diseases and other somatic and psychiatric comorbidities;
- reduction of the risks of negative social consequences for drug users and those dependent on addictive substances; in particular, such consequences include unemployment, problems in family life and social interactions and/or offending;
- reduction of the level of drug use and motivation to resume drug-free lifestyles in drug users and those dependent on addictive substances.

The prevention of infectious diseases is one of the key services provided by the low-threshold programmes. In addition, programmes aimed at drug users in the nightlife setting have also been implemented in the Czech Republic.

6.2.4.2 Organisation and funding of Harm reduction services

The network of harm reduction programmes in the Czech Republic consists of drop-in centres and outreach programmes which provide harm reduction services in the form of exchanging needles and syringes, distributing condoms, providing or mediating tests for infectious diseases, and disseminating information on the risks related to drug use, basic health care (others services and activities: hygiene: shower, clean clothes-providing or washing machine at disposal. Material as shampoo, razors, hygiene pads for woman etc.-, food service-providing packed food or cooking with clients in the service, free time activities, counselling for clients and their relatives and friends, referrals to treatment facilities, referrals to social and health services, help with filling forms, communication with police, social departments etc., community work etc.). The target population of the low-threshold facilities includes problem drug users, experimenters, and their families and friends. Low-threshold programmes are usually the first point of contact for those users who are in the process of deciding to enter treatment. There have been around 100 harm reduction programs operated in recent years, the situation is stabile. In 2018, there were 107 programs for drug users (54 drop-in centres and 53 outreach programs). Services are mainly NGOs and are financed via multiple-source (grant) system (MoH, MoLSA, Government, regional sources, donors, sponsors, etc.), one program (service) apply with several proposals to different donors.

Harm Reduction services operates in all 14 regions, however, in some of them (Karlovarsky and Pardubicky Region) the coverage is low. In cities these programs operates separately, in towns usually the team of drop in centre and outreach program is connected, in some towns the drop in centre, outreach program office and out-patient treatment is located on one building and as such is called integrated out-patient care. Connection between harm reduction and treatment programs are often within one NGO, which runs several projects, such as drop in centre, outreach, outpatient treatment and therapeutic community etc.

Table 34 - Equipment and drug use paraphernalia which are provided in low treshold programmes

Type of equipment	routinely available	often available, but not routinely	rarely available, available in limited number of settings	equipment not made available	information not known
pads to disinfect the skin	x				
dry wipes	x				
water for dissolving drugs	x				
sterile mixing containers		x			
filters	x				
citric/ascorbic acid	x				
bleach				x	
condoms	x				
lubricants			x		
low dead-space syringes	x				
HIV home testing kits				x	
non-injecting paraphernalia: foil, pipes, straws	x				
List of specialist referral services: e.g. drug treatment; HIV, HCV, STI testing and treatment	x				

6.2.4.3 Provision of HR Services

Testing: out of LTS 107 programs in 2018, offered HIV 82, HBV 64, HCV 90, syphilis 58.(see table below). In LTS mainly rapid test using capillary blood are used, saliva tests (Oraquick tests are not widespread because of the high price). In annual on-line survey in LTS testing programs (52 questionnaires representing 64 programs) only 3-5 programs use full blood samples and cooperate directly with lab. The testing is for all clients who would like to undergo it, also for the partners. Also, the testing is actively offered by service staff. As a motivation, small incentives are in some facilities provided (more/new/better HR material, snickers etc). There are legal barriers; according to the law the skin integrity can be interrupted only by health worker, the health worker is not among all programs staff teams. The practice in these examples shows, that pre and post-test counselling is done by service worker, the test itself is done by client under the supervision of the worker.

In the on-line survey (please see chapter 6.2.3.), low-threshold facilities reported testing experiences. Some services report difficulties with motivating clients to perform the test, mostly because they are afraid of the test result or they have a lack of interest in the HIV test, the fear of HIV infection is low. It is beneficial to provide incentives to get tested, offer the assistance to the specialised care. The greatest concern for clients is caused by VHC, services indicate that they encounter clients who do not test due to an earlier reactive test; part of these clients did not undergo further (PCR) diagnostics or treatment. To refer a client to diagnostic/ therapeutic specialized workplace is also problematic. Clients often do not take the opportunity to undergo PCR test in another facility.

Table 35 - Number of testing facilities and number of tests in LTSs, 2003-2018

Year	HIV		HBV		HCV		Syphilis	
	Programs	Tests	Programs	Tests	Programs	Tests	Programs	Tests
2003	64	2 629	21	739	60	2 499	4	209
2004	58	2 178	25	932	53	2 582	1	84
2005	54	2 425	28	1 370	55	2 664	2	54
2006	46	1 253	56	693	62	1 133	3	209
2007	53	609	19	370	24	401	4	62
2008	50	1 120	18	399	40	862	3	124
2009	47	1 592	23	560	43	1 501	4	143
2010	58	1 821	40	1 200	59	2 134	20	771
2011	78	2 833	69	1 598	80	3 158	66	1 516
2012	64	2 892	48	1 468	67	3 011	46	1 969
2013	72	2 952	52	1 756	78	3 278	51	1 811
2014	74	3 028	54	1 889	79	3 359	57	1 829
2015	67	2 964	51	1 713	74	2 975	50	1 845
2016	76	3 332	56	2 128	78	3 347	57	2 406
2017	81	3 068	59	2 021	81	3 099	60	2 046
2018	82	3 143	64	2 135	90	3 418	58	2 107

In other drug facilities, the rapid testing is usually not offered, but all the services cooperate with specialists. To undergo the tests (HIV, HBV, HCV and usually also syphilis) is required at the start of the treatment in all residential treatment units, incl. detox (the blood sample is taken at the beginning of detox program), TCs and also in the part of methadone programs. In outpatient services the testing is recommended to clients with referral to the specialists.

Programmes (mainly NGOs) of the distribution of needles, syringes, and other injecting paraphernalia were provided by 107 low-threshold programmes in 2018 (53 outreach programs and 54 drop in centres), regionally, in each region (14) is the service available, in two regions (Karlovarsky and Pardubicky Region) the coverage is low. Outreach programs in towns usually also cover whole area including town and villages with no other program available (few hours of service per week).

Regarding the numbers of material distributed, there is no major change comparing previous years and distribution is keeping around 6,5 mil./year since 2014, with increase in 2018 to 6,9mil. The trends in the number of programmes and the number of syringes distributed are shown in a Table below.

According to the information available from the final reports, each injecting drug user who visited a low-threshold facility in 2018 distributed 213 items of needles on average and counted with the estimation of IUD in the country the distribution rate is 176. The regional distribution of the needles and syringes provided in each region corresponds to the relative numbers of injecting (problem) drug users.

Take home naloxone is not available, in 2019 started preparation of pilot project in 2 regions with the Nyxoid product, but the availability on the Czech market is not confirmed yet.

Supervised drug consumption facilities are not available.

Post-release / transition management from prison to community provided by drugs facilities are limited. There are specialized NGOs programs at work with DUs in prison setting, they provide counselling and information for imprisoned DUs (it is independent NGO not paid by prison service, they have hour of consultations for inmates within the prison). They offer also post-release referrals, contact and assistance to the treatment facilities, e.g. therapeutic community. OST in prisons is very limited, out of 35 prisons 10 have the OST permission (methadone and for previously treated in community only), and out of that only 6 are providing OST in reality, number of patients is very low, 64 in 2018.

HBV vaccination is very limited, provided in hepatology/infectiology department or clinics, usually paid by MoH. Since 2001, there is a compulsory general vaccination, all persons younger than 30 should be covered.

Infectious diseases treatment and care, referral pathways or care partnership – treatment and care is available and paid by health insurance. Patient is referred to the specialised centre via

drug service, usually LTS offer also assistance to the specialised centre for appointment (usually outreach worker is going to the centre with client). The cooperation has been usually well established for several years, but may vary regionally. The cooperation has started by drug centre or sometimes also by active (HCV) treatment centre. There is also information about pharmaceutical companies contacting drug services and offering materials and contacts to specialists. Within the workshops organized by NFP (HA-REACT) there was a group face-face discussion between drug services workers and treatment specialists, contacts were established, also the launch of HCV seroprevalence study in June 2018 offered meeting of drug workers and specialists from different regions. The HCV elimination plan in PWUD was approved in 2019 by Government council for drug policy coordination.

In Autumn 2019, 6 regional seminars with the aim of strengthening cooperation between addictological and HCV centres is under realization. These are supported by pharma companies and organized by umbrella NGO association. NFP is helping with facilitation.

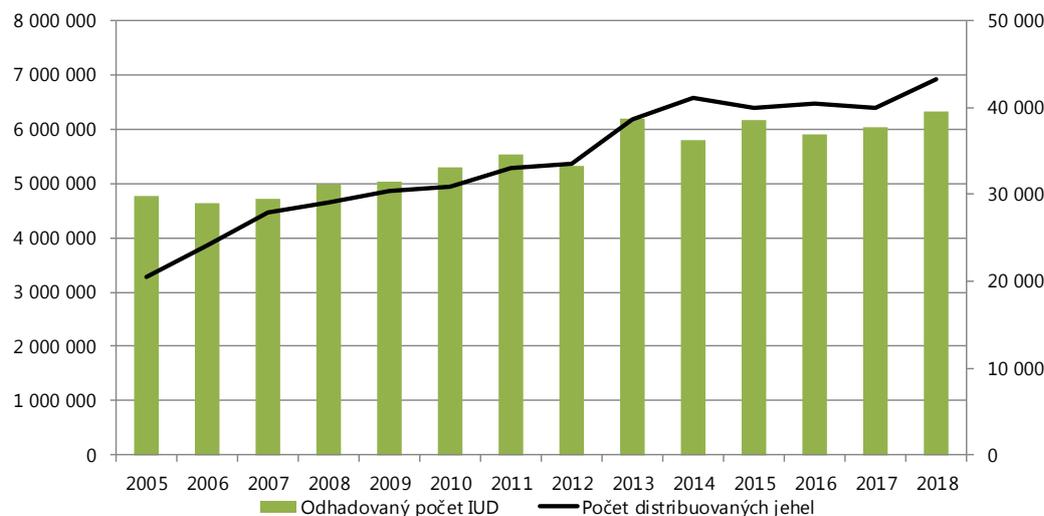
Sexual health counselling & advice, condom distribution - Safer sex advice and counselling in drug services is available, mainly in LTS, also free of charge condoms and (in some) lubricants. Prevention of STIs is provided via leaflets, individually mainly within the group of PWID who are involved in sex business. There are also specialised programs for MSM or female sex workers (mobile ambulance on the frequent roads, testing in clubs, brothels...), within their clients are also drug users.

Gelatine capsules for oral methamphetamine use are distributed, in 2018 estimated 75,2th in 88 programs. Intervention Break the cycle is provided in several sites.

Table 36 - Number of NSP and needles/syringes distributed in 1998–2018

Year	Number of programs	Number of needles distributed
1998	42	486 600
1999	64	850 285
2000	80	1 152 334
2001	77	1 567 059
2002	88	1 469 224
2003	87	1 777 957
2004	86	2 355 536
2005	88	3 271 624
2006	93	3 868 880
2007	107	4 457 008
2008	98	4 644 314
2009	95	4 859 100
2010	96	4 942 816
2011	99	5 292 614
2012	103	5 356 318
2013	110	6 175 118
2014	105	6 594 069
2015	104	6 403 404
2016	104	6 469 441
2017	108	6 401 662
2018	107	6 932 269

Figure 36 - Trends in syringes distributed, please see the graph below. The trend of needles distribution is following the trend of IUD estimations



There are two basic/general types of harm reduction service: outreach program and drop-in centre. In every NUTS3 region operate at least 2 services.

2 vending machines were operated in 2018 in two towns outside of Prague (there is one machine in a third town, but it was not in operation in 2018), 10,8 thousand needles distributed in 2018.

One program in Prague is running program with metal bins located in public space, where used needles could be discharged; there were 24 bins in Prague in 2018, with 6.3 thousand needles discharged.

There is no pharmacy exchange scheme, nevertheless, some HR services cooperate with local pharmacies in providing leaflets, information or syringe package to be distributed to clients via pharmacies and collected the used ones.

6.2.5 Quality assurance of harm reduction services

There is a system of quality assurance for drug services, and is described in Treatment workbook in detail.

The system for certifying the professional competences of drug services (the GCDPC certification system) was approved by the Government and is designed to ensure the minimal quality of addiction treatment services. By the end of July 2018, 204 programmes had a valid certificate, of which 53 Outreach programmes and Drop-in and counselling services 53.

There is also system of quality assurance for social services within MOLSA. Majority of harm reduction programs are registered as a social service and underwent both processes.

Within the internal processes, team meetings and external supervision of experienced therapist (with training in supervision) is required by both quality systems.

6.3 New developments

In 2017, harm reduction programs under the umbrella of Association of NGOs started with shared database of known fatal overdoses and other deaths of their clients. The purpose is to compare the data with official register and also to see, what kind of interventions/information should be given to the clients mostly.

In 2018, there was 29 cases registered, out of them 6 fatal overdoses (3 men with average age 35,3 and 3 women with average age 34,5). Cases were probably connected to use of methamphetamine (1), combination of meth and opioids (2), fentanyl (1), toluene (1), one case with not known substance.

In 12 cases was different cause of death than overdose (burning, organism failure etc.) In rest 11 cases resulted in non-fatal overdose or there was not clear result of the case.

6.3.1 New developments in drug-related infectious diseases

The HCV elimination plan in PWUD was approved in 2019 by Government council for drug policy coordination.

<https://www.drogy-info.cz/publikace/protidrogova-politika/eliminace-virove-hepatitidy-typu-c-mezi-uzivateli-drog-v-cr/>

In Autumn 2019, 6 regional seminars with the aim of strengthening cooperation between addictological and HCV centres is under realization. These are supported by pharma companies and organized by umbrella NGO association. NFP is helping with facilitation.

6.3.2 New developments in harm reduction interventions

Few programs started with additional distribution of coloured 1ml syringes (never share), however, 1ml insulin syringes are used mostly by PWID in long term.

Increasing number in nightlife projects, mainly attached to the existing outreach programs. The drug checking is not available.

6.4 Sources and methodology

In the Czech Republic, a forensic medical examiner carries out a mandatory autopsy in all cases of sudden death in which the examining practitioner could not determine the cause of death and in all cases of violent deaths (i.e. including all injuries and poisonings). Since 1998 direct drug-induced deaths (fatal overdoses), and since 2003 also indirect drug-related deaths (with the presence of drugs), have been monitored on a routine basis by means of a special register kept by all thirteen departments of forensic medicine, with close collaboration between the National Focal Point and the Society for Forensic Medicine and Toxicology of the J. E. Purkyně Czech Medical Association. Selection D has been used for Special mortality register.

On 1 April 2012, Act No. 372/2011 Coll., on health services and the terms and conditions governing the provision of these services (the Act on Health Services), came into force. This Act newly incorporates the National Register of Autopsies and Toxicology Tests Carried Out at the Department of Forensic Medicine, maintained by the Institute of Health Information and Statistics, which has replaced the special register of drug-related deaths since 2015.

When data on drug-related deaths are being extracted from the Deaths Information System (general mortality register), the EMCDDA criteria are used, based on the selection of an appropriate diagnosis as the cause of death, or a combination of causes of death and the mechanism of death. Selection B plus volatile substances (inhalants) is used as national definition.

Emergencies

The collection of data on non-fatal intoxications has been performed by the Public Health Service within a special warning (sentinel) system since 1995. However, there are considerable regional differences in the data collection systems, which complicates the interpretation of the current state of affairs and trends, 4 out of 14 regions are missing, including capital. In the system are reported cases of overdoses and also other health issues which demand hospitalization. Various types of healthcare facilities report to the system, particularly emergency units and intensive care units.

DRID

National data on HIV are collected by National Health Institute through National reference laboratory for HIV/AIDS, the only laboratory for HIV final confirmation. New cases of viral hepatitis are reported to the EPIDAT system, also in charge is National Health Institute.

Data about testing for infections and test results among treated clients for addiction are in TDI register. The Treatment Demand Register data come in part from the clients themselves. Since 2015 the register is electronic.

Since 2004 the National Monitoring Centre for Drugs and Drug Addiction (the National Focal Point) has conducted an annual survey of low-threshold programmes for drug users to map the availability of testing, the number and results of the tests, and basic characteristics of the clients tested. On-line questionnaire is used (LimeSurvey application).

Harm Reduction

Majority of harm reduction services are involved in a grant scheme of Council for Coordination of the Drug Policy, and as supported programs, they are obliged to report structured data annually (Annual Report). Programs not involved in the grant scheme are asked individually to provide some selected data for national overview.

7 Best practice

7.1 National profile

7.1.1 Policies and coordination

Action plan for illicit drugs 2016-2018 of the National drug strategy defined following actions related to the quality assurance system:

- to run the system of certification standards in prevention
- to revise a chart of the Certification system of GCDPC (basic reference document for certification system)
- to increase a compliance between the Certification system of GCDPC and system of inspection of quality of social services
- In the treatment area, the Action plan defines the goal “to increase the quality of the services provided” with following activities:
- To elaborate and publish interdisciplinary best practice guidelines in addictology (addiction services).
- To support utilisation and use of the guidelines for brief intervention among general practitioners for children and juveniles as well as GPs for adults.
- Systemic support of the networking between specialised and non-specialised services in addiction treatment
- To implement case management in services provision to drug users
- To revise a chart of the Certification system of GCDPC (basic reference document for certification system) – see also above

New Drug strategy 2019-2027 (under preparation) contains one of the main principles: evidence based measures and the best practice.

7.1.2 Organisation and functioning of best practice promotion

The National Organizations/Institution promoting quality assurance of drug demand reduction interventions:

- Government council for drug policy coordination (GCDPC) is the main coordination and advisory body to the government in the area of drug policy. It has inter-ministerial nature. It runs system of certification, promotes best practice publishing original or translated guidelines, monographs etc.
- Society for addictive diseases of the Czech Medical Association – in the draft chart of the Certification system of GCDPC, which is just being discussed, this society should guarantee the standards as such. It is also responsible for clinical guidelines.
- Ministry of Health.
- Ministry of Social affairs – for social services in addiction field
- Association of Non-Governmental Organizations providing Addictology and Social Services for People at Risk of Addictive Behavior

The Czech Republic has elaborated the type of guidelines (standards) governing the operation of centres, facilities, and programmes. Such guidelines are primarily represented by the so-called Certification Standards of the Government Council for Drug Policy Coordination (GCDPC) in operation since 2006. Compliance with these standards is tested as part of the certification process. Conceived as an inter-agency instrument, these guidelines cover a wide range of health, social health, and social services. Standards for primary drug prevention programmes developed by the Ministry of Education, Youth, and Sports were developed later and the certification system on the field of primary prevention exist in parallel to certification system of GCDPC. Czech examples of guidelines for case- and diagnosis-based procedures include the Recommended Treatment Procedures for Addiction Disorders and Pathological Gambling developed by the Psychiatric Society of the J.E. Purkyně Czech Medical Association. The only Czech methodological guidelines in the field of addiction, in fact, are the Health Ministry's standards for substitution treatment.

Government council for drug policy coordination coordinates system of quality assurance.

There is an external agency running audits. There is an advisory committee of GCDPC on certification reviewing audit reports. GCDPC approves and issues certificates at the end.

<http://www.vlada.cz/cz/ppov/protidrogova-politika/certifikace/certifikacni-rad--standardy--metodika-mistniho-setreni-a-eticky-kodex-certifikacniho-vyboru-69228/>

<http://www.cekas.cz/category/hlavni-nabidka/certifikace-rvkpp>

Originally, certification Standards were for 9 types of services. In 2015, GCDPC approved 10th one for for prison-based addiction treatment services There are 10 types of services defined in national quality standards:

1. Detoxification
2. Outreach programmes
3. Drop-in and counselling services
4. Outpatient treatment
5. Outpatient day care
6. Short- and medium-term institutional/inpatient treatment
7. Residential care in therapeutic communities
7. Aftercare programmes
8. Substitution therapy
9. Addiction treatment services in prison

The system runs as follows:

Certification agency (external contractor) has contracted auditors. Auditors have been trained in the special course organised by the secretariat of GCDPC and Institute for postgraduate studies in medicine.

Audit is run by certification team consisted of 3 auditors. Duration: 1-2 days. Certification is valid for ideally (without any insufficiency) 3 years. Then the audit is financed by 1/3 by service provider and by 2/3 from the state budget.

Recommendations and conclusions of the audit are discussed in the Advisory board for certification of quality of GCDPC (inter-ministerial, inter-disciplinary).

Advisory board proposes the final conclusion to GCDPC which finally decides. A certificate is then issued by the executive chairman of GCDPC (national drug coordinator).

Furthermore the authorized centres appear in a public list available at:

<http://www.vlada.cz/cz/ppov/protidrogova-politika/sit-sluzeb/seznam-drzitelu-certifikatu-odborne-zpusobilosti-sluzeb-pro-uzivatele-drog-102635/>

Table 37 - Elements of the Certification Standards of the Government Council for Drug Policy Coordination

A – General	B – Special (“type” standards)
1. Availability of professional services	1. Detoxification
2. Patient/client rights	2. Outreach programmes (including syringe and needle exchange programmes)
3. Admission and initial assessment	
4. Range of services and principles of their provision	3. Low-threshold and counselling services (including syringe and needle exchange programmes)
5. Human resources	
6. Professional leadership and development of staff and teams	4. Outpatient treatment
7. Accessibility, external relations	5. Day care programmes
8. Organisational aspects	6. Short-term and medium-term institutional treatment
9. Finance	7. Residential care in therapeutic communities
10. Environment and physical resources	8. Outpatient aftercare programmes (including sheltered housing and protected employment programmes)
11. Minimum safety	
12. Service quality and efficiency evaluation	9. Substitution treatment
	10. Addiction treatment in prisons

As of August 2019, a total of 204 programs had valid GCDPC certification. In particular, outpatient programs grew year-on-year. There is a long-term increase in the number of certified programs.

Table 38 - Overview of certified programmes by type of service in 2011–2019

Type of service	2011	2012	2013	2014	2015	2016	2017	2018	2019
Detoxification	2	1	2	2	3	3	3	3	3
Outreach programs	49	50	49	52	53	51	52	52	53
Contact and counselling services	52	49	50	52	52	52	53	52	53
Outpatient treatment	15	13	18	19	22	28	32	34	42

Day-care programmes	1	1	1	1	1	1	1	1	1
Short-term and medium-term residential treatment	2	2	2	5	6	6	6	6	7
Residential care in the therapeutic community	10	10	10	10	10	10	10	10	10
Aftercare programmes	16	17	17	17	18	19	18	19	19
Substitution treatment	8	8	7	7	8	8	8	8	9
Addictology services in prison	–	–	–	–	–	4	6	7	7
Total	155	151	156	165	173	182	189	192	204

Pozn.: in particular years by: 16. 5. 2011, 29. 5. 2012, 28. 6. 2013, 30. 6. 2014, 31. 3. 2015, 30. 6. 2016, 24. 7. 2017, 28. 8. 2018 a 15. 8. 2019

Certification system in prevention of Ministry of education operates in similar way. Since 2006, the system has been in place to verify the quality of primary risk prevention programs undertaken by outside bodies in education. It is the process of assessing the provider and his program according to the quality criteria set by the approved Standards and granting or not granting the certificate of fulfilment. The certification system for prevention is coordinated by the National Institute for Education (NÚV) certification.

In August 2019, the NÚV registered a total of 62 organizations with 94 certified primary prevention programs (as in January 2018 it was 57 organizations and 94 programs and January 2017 it was 56 organizations and 90 programs). Of the total of 94 certified programs, 80 focused on addiction prevention, i.e. they included topics from the field of substance abuse prevention and addiction, including 52 universal, 20 selective and 8 indicated prevention programs. The list of certified prevention programs providers is available at NÚV website (http://www.nuv.cz/modules/catalog/index.php?h=product&a=index&id_catalog=15).

Standards of professional competence of providers of prevention programs of risk behaviour in school are divided into 2 parts: general part (which is the same for universal, selective and indicated prevention programs) and special part (which differs according to the type of prevention: universal, selective and indicated prevention programs).

Between 2016 and 2017, the Standards and the entire certification process were reviewed. The revised standards were not put into practice yet. Since May 2019, the system of certification is suspended due to its insufficient systemic anchoring. Programs with expired certificate were extended until the restoration of certification process. However, new programs cannot apply for certification.

A medical specialisation of "treatment of alcoholism and other addictions" has existed since 1980. According to Decree No. 185/2009 Coll., on specialisation areas in the education of physicians, dentists, and pharmacists, and on the study areas of certified courses, it currently takes the form of an extension specialisation course of "addiction disorders" that a physician may attend only if they have passed an examination in the basic specialisation course in psychiatry (this system of medical specialisations has also been referred to as "attestation"). An attestation specialisation may be conditional on professional competency for the provision of a certain type of treatment (e.g. pharmacotherapy), for instance, or the execution of a contract

with a health insurer regarding reimbursement for medical interventions from public health insurance funds. Out of approx. 1,400 psychiatrists, around 30 have the extension specialisation in "addiction disorders".

In 2005, the Centre for Addictology was founded as a multidisciplinary research and training facility in the field of addiction treatment. Its foundation also marked the formal recognition of the discipline of addictology as an interdisciplinary field of study. A bachelor's academic programme in addictology was introduced; the first 15 bachelors in addictology graduated in 2008. The profession of an addictologist was established in 2008 (along with the professions such as a general nurse or midwife) in connection with these study programmes; it was made possible by the amendment to Act No. 96/2004 Coll. on non-medical health professions, as subsequently amended. In addition, the professional competencies required for the performance of this profession were defined. It has interdisciplinary (health-social) curriculum with emphasis on clinical care in addiction field. In the meantime, master's program as well as doctoral studies were founded and the Centre of Addictology became Department of addictology of the 1st Medical Faculty of the Charles University and General Faculty Hospital in Prague.

There is also accredited qualification course, entitled Addictologist (with over 900 hours of instruction), The course is intended to train participants for the work of health professionals who will provide preventive, treatment and rehabilitation care in the field of addictology without professional supervision. The training course covers theoretical knowledge (about two thirds of the sessions) as well as practical skills in addictology services through practice-oriented subjects and internships (about one third of the sessions). There are also specialisation courses for addictologists organised in the Department of Addictology.

Since 2017, new specialisation of clinical addictologist was introduced – this specialisation means that certain predefined interventions can be provided without indication and supervision of physician.

In 2018, specialized education in the new Clinical Addictology field was established. The preparation of the program of specialized education in the field of clinical addictology, which was entrusted by the Institute of Postgraduate Education in Health Care, continues within the working group consisting of representatives of addictology services and the Czech Addictology Association coordinated by the Department of Addictology of the 1st Medical Faculty of Charles University and the General University Hospital as a guarantor of addictology.

The professional competency of staff in the area of social services is defined in the Act No. 108/2006 Coll. on social services (see above), and, in principle, makes a higher vocational education or, if required, also an academic degree in study programmes such as social work, social policy, social pedagogy, social care, social pathology, law, or special pedagogy a prerequisite for the practice of the profession of a social worker; in all other cases, the practice

requires completion of an accredited course of at least 200 hours and 5-10 years of experience in the field.

The majority of professionals working in the area of services for drug users provided outside health care facilities hold the status of a social worker. In addition to the statutory qualification requirements, other competency criteria for working with drug users are also set out in the Standards of Professional Competences for Drug Services, regulations and standards issued by professional bodies, for instance the Czech Psychotherapy Society or the Czech Medical Association of Jan Evangelista Purkyně (ČLS JEP).

There are many training courses and educational events organised by number of institution including services providers. Some of them have specialised departments or organisational structures designed for training purposes.

7.2 New developments

In 2016 and 2017, the Association of Non-Governmental Organizations providing Addictology and Social Services for People at Risk of Addictive Behavior strengthened its organizational structure, newly set up the position of Director of the Office and Methodology Officer, coordinating the work of the six sections of A.N.O. Due to the structural changes of A.N.O. there is an increase in communication within A.N.O. also with external partners, especially with the Association of Social Service Providers, the Czech Association of Addictologists (ČAA) and the Society for Addictive Diseases (SNN) ČLS JEP.

See also here: <http://www.asociace.org/kontakty/>

Since September 2016, the Department of Drug Policy of the Office of the Government of the Czech Republic has been implementing the project Systemic Support for the Addictological Services Development within the Integrated Drug Policy (RAS project), supported by the European Social Fund (ESF) through the Employment Operational Program. It is the first independent and extensive project in the Czech Republic financed by the ESF in the field of drug policy. The project focuses on the definition of addictological services, the definition of parameters and tools for creating a network of addictological services and the system of their financing. The aim of the project is to streamline and improve the network of addictological services. An important part of the project is the enhancement of competencies of workers in addictological services and selected employees of public administration. The project will run until August 2021. In 2018–2019, the first analytical outputs were published, focusing on the systemic and legislative framework of addictological services in the Czech Republic as compared to the situation in foreign countries, on methods and tools for determining the availability and networking of addictological services in the Czech Republic. and to compare models of quality assurance of addictology services abroad. The RAS project presented a draft version of the Conceptual Framework for the Development of Addictological Services, which integrates all partial activities of the RAS project related to the conceptual development of the network of addictological services.

<https://www.rozvojadiktologickychsluzeb.cz/>

In 2017, preparation started for the research call for tender on development of best practice clinical guidelines in addictology. It will be administered by the Technological agency of the Czech republic, which administers research grants for ministries and bodies without budget for research, including Office for the Government, where drug policy coordination department and NFP is located. The project should start in 2019.

8 Drug market and drug-related crime

8.1 Summary

Czech Republic is a production country of cannabis and methamphetamine. In 2018, 202 indoor cannabis cultivation sites and 240 labs were dismantled. Low-volume home-based cultivation sites (to 49 cannabis plants) accounted for the largest share of the cultivation sites (63% in 2018, 56% in 2017, 54% in 2016). Methamphetamine (in the Czech Republic called pervitin) is made mainly in low-volume home labs. These labs mainly supply the domestic market.

Extracted from over-the-counter medicines, pseudoephedrine continues to be the main precursor for the production of methamphetamine. Demand from the producers is satisfied through illegal imports, originating mainly from Poland.

A total of 20.1 tons of cannabis were produced in the Czech Republic in 2016 (latest estimate). The production of methamphetamine was approximately 6.5 tones. Heroin was consumed in the quantity of 0.7 tones, cocaine in the quantity of 1.0 tones and ecstasy in the quantity of 1.2 million tons. Other drugs than cannabis and methamphetamine are imported into the Czech Republic. There is no evidence of the production of other stimulant drugs in the Czech Republic. Sporadically there are reported cases of production of opioids.

Reducing drug availability and controlling supply of addictive products is one of the pillars of the Czech Republic's addiction policy defined by the National Drug Policy Strategy 2010–2018 and the related National Strategy for the Prevention and Reduction of Damage Related to addictive behaviour 2019-2027.

In 2016, the government was presented with a strategy for the development of the Police by 2020. One area is also devoted to the reduction of drug supply. The strategy defines 8 goals and 8 measures to achieve them.

In 2018, the cooperation of repressive forces continued on international level, in particular in the border regions (České Budějovice, Plzeň, Ústí nad Labem, Brno and Ostrava).

A separate section is available on the National focal point web site – drogy-info.cz, which contains detailed information on the legal norms defining the handling of drugs and sanctions in case of unauthorized handling. Particular attention is paid to cannabis.

Since 2016, the national drug squad has been running a website with a map of dismantled methamphetamine labs and indoor cultivation sites. The aim is to raise awareness and involvement of citizens in the detection of drug-related crime. A similar web application is mapakriminality.cz, which has been operated by the Open Society organisation since 2012. Any crime recorded in the police evidence, including drug-related crime, can be displayed separately on the map.

8.2 National profile

8.2.1 Drug market

The source of information is evidence of the National Drug Squad (statistical data and annual report) and Customs Drug Unit (statistical data). There is no routine collection of data on contextual information on drug market in the Czech Republic. Some specific information is not available for strategic reasons. We are not aware of any scientific study focused on the drug market in the Czech Republic, even partially.

Czech Republic is a production country of cannabis and methamphetamine. In 2018, the Police of the Czech Republic and the Customs Administration of the Czech Republic detected 202 indoor cannabis cultivation sites, i.e. 103 less than in the previous year. Low-volume home-based cultivation sites (to 49 cannabis plants) accounted for the largest share of the cultivation sites (63%). On the contrary, the cultivation sites with the highest capacity (500 or more cannabis plants) represented 8%. The largest numbers of cultivation sites were detected in Moravia-Silesia and Central Bohemian region.

Methamphetamine (in the Czech Republic known as pervitin) is made mainly in low-volume home labs. These labs mainly supply the domestic market. In 2018 the police detected 240 labs, i.e. 24 less than in the previous year. The largest part consisted of labs with a production volume up to 50 g (62%). The highest numbers of illegal labs were detected in the South Moravia and Ústí nad Labem regions in 2018.

Extracted from over-the-counter medicines, pseudoephedrine continues to be the main precursor for the production of methamphetamine. The control of the sale of medicines containing pseudoephedrine in the Czech Republic keeps their domestic sales consistently low but the demand from the producers is satisfied through illegal imports from Poland. Poland has become an originating and transit country for pseudoephedrine, although there has been pseudoephedrine-containing drug control since 2015. In Poland, well-organized criminal groups focused on the illegal import of medicines containing pseudoephedrine, their extraction and distribution to the Czech Republic are operating. In addition to using pseudoephedrine were in 2018 also recorded cases of manufacturing methamphetamine from ephedrine, the most widely used precursor for the methamphetamine manufacture in the past.

The continuing trend is the shifting of the methamphetamine production, or part of it, to Poland in order to shorten the route for the delivery of pseudoephedrine drugs, thus minimizing the risk of detection and financial loss. Methamphetamine is transported to the Czech Republic either in liquid form (and the further production process takes place in the Czech Republic) or in powder or crystal form. The described procedure is based on close cooperation of organized groups in the territory of both countries. According to the National drug squad, methamphetamine is mainly smuggled to Germany, Austria, France, Norway or Sweden. There have also been reports of smuggling to Australia and Japan. For transport, couriers are often hired, often socially marginalized.

In 2018, 4 opioid illegal laboratories were dismantled in the Czech Republic. In all cases, an attempt was made to produce opium / morphine.

Ecstasy tablets are imported into the Czech Republic mostly from the Netherlands or Belgium. In the last 3 years, ecstasy production has also been recorded in the Czech Republic.

Illegal production of other psychoactive substances including NPS was not reported in the Czech Republic in 2018.

According to the latest estimates carried out in 2017, a total of 20.1 tons of cannabis were produced in the Czech Republic. The production of methamphetamine was approximately 6.5 tones. Heroin was consumed in the quantity of 0.7 tones, cocaine in the quantity of 1.0 tones and ecstasy in the quantity of 1.2 million tons (Vopravil, 2017). Czech Republic is a production country of cannabis and methamphetamine (in the CZ called pervitin).

In the last years ecstasy production has also been recorded in the Czech Republic. MDMA in crystalline form is imported from the Netherlands; other raw materials for tablets (colourants, binders, etc.) are available in the Czech Republic. Tablets are made using machines made from components purchased online from China or India. In production and distribution of ecstasy tablets are mostly involved citizens of the Czech Republic under the age of 35 years.

Sporadically there are reported some cases of production of opioids. In 2018, 4 cases were recorded.

Other drugs including NPS are imported into the Czech Republic.

Information on the routes of trafficking for drugs imported to the Czech republic is available from Customs Drug Unit.

Cocaine is imported from South America especially from Peru, Venezuela, Brazil or the Dominican Republic. Cocaine comes to Europe mainly through Great Britain, Spain, Portugal, France, Belgium, Croatia or the Netherlands. The highest numbers of seizures were those of shipments going on the routes Netherlands-Czech Republic-Slovakia (61 seizures), Netherlands-Czech Republic (34 seizures) and Brazil-Portugal-Czech Republic (7 seizures) in 2018. Cocaine is mainly transported in body cavities, postal items or luggage.

Heroin is imported in relatively small shipments of under 5 kg. Two routes, the Balkan Route and the Southern Caucasus Route (from Iran via Armenia, Azerbaijan and Georgia to Ukraine or Moldova) are the most important. The Czech Republic is a destination as well as a transit country, however it is not significant. The highest numbers of seizures were those of shipments going on the routes Netherlands-Czech Republic-Slovakia (8 seizures) and Netherlands-Czech Republic (5 seizures) in 2018.

Ecstasy is imported mainly from the Netherlands and Belgium. The highest numbers of seizures were those of shipments going on the routes Netherlands-Czech Republic-Slovakia (189

seizures), Netherlands-Czech Republic (40 seizures) and Netherlands-Czech Republic-Izrael (14 seizures).

8.2.1.1 Information of trafficking within the Czech Republic

8.2.1.1.1 Cannabis

The growing trend in the operation of medium-sized indoor cultivation sites (up to 500 plants) stopped; in 2018 a year-on-year decrease has been observed (27 cultivation sites up to 500 plants in 2017 and 16 in 2018). In order to minimize the detection and possible loss, cannabis cultivation by individual organized groups is divided into more cultivation sites (usually up to 5), each with about 300-500 plants. In order to ensure continuous production, cultivation sites have several parts with plants at different stages of growth. Cultivation sites are built on farm buildings, warehouses, but also in rented family houses and flats. Part of the indoor production is well organized and there is an important part of Vietnamese organized groups, the involvement of Czech citizens in large-scale cultivation with production for export increases. Cultivated cannabis is mainly directed to the domestic market; part is also intended for export, not only to neighbouring countries.

8.2.1.1.2 Methamphetamine

Large-scale production and distribution of methamphetamine is significantly associated with organized Vietnamese groups. The production process is divided into several phases that are often carried out at different locations. The locations are selected to minimize the threats of detection at each stage (e.g., remote sites for extracting pseudoephedrine due to the typical odour of the chemicals used).

8.2.1.1.3 Cocaine

In smuggling and distribution of cocaine are involved mainly people from Nigeria, but also from the Western Balkan countries (Serbia, Croatia, Bosnia and Herzegovina, and Montenegro) and to a lesser extent also the citizens of the Czech Republic. Couriers from central and eastern European countries (the Balkans and the Baltic countries), often from socially marginalized groups, are hired to transport cocaine to EU countries. Cocaine is transported in body cavities, postal items or luggage.

8.2.1.1.4 Heroin

Ethnic Albanians from Kosovo and Macedonia and the Turks are mainly involved in the smuggling and distribution of heroin. On the lower level of the market, the distribution network of the Roma and the users themselves is formed. Heroin is often trafficked in trucks carrying textiles.

The substances used as diluents and adulterants in individual drugs (found in samples of drugs seized in 2018):

Amphetamine

- Diluents: creatine

- Adulterants: caffeine, phenethylamine

Methamphetamine

- Diluents: methylsulfonylmethane
- Adulterants: phenethylamine

Cocaine

- Diluents: phenacetin, mannitol, lidocaine, lactose, metronidazole, levamisole, creatine, procaine, piracetam
- Adulterants: caffeine

Heroin

- Diluents: paracetamol
- Adulterants: caffeine

Available information on the retail drug prices and purities are reported in the fonte tables. Further information on wholesale drug and precursor prices is not available.

In addition to heroin, substitution agents in tablets containing buprenorphine as the active substance (Subutex®, Suboxone®, and Ravata®), morphine-based analgesics such as Vendal® Retard, and transdermal patches containing fentanyl were also available on the black market. The fentanyl patches either enter the black market through the relatives of seriously ill patients who use the patches for pain treatment, or used patches are obtained by the users from unprotected medical waste. The demand for other opiates is most probably stimulated by the lack and low quality of heroin at the end of the distribution chain.

8.2.2 Drug related crime

The data indicates that there were 3663 persons arrested for drug law offences and, according to two data sources, 3527 to 4276 persons were prosecuted for drug law offences in 2017. Of this figure, 15% were women and 4% were persons under the age of 18. 3211 persons were indicted and 2870 were sentenced. For definition of drug law offences see Legal framework. Police data (2016 and 2017) and the Ministry of Justice data (2008-2017) were adjusted for duplication.

Table 39 - Number of persons arrested, prosecuted, indicted and sentences for DLO in 2008-2018

Year	Arrested (National drug squad)	Prosecuted (Police)	Prosecuted (Ministry of Justice)	Indicted (Ministry of Justice)	Sentenced (Ministry of Justice)
2008	2 322	2 296	2 107	1 909	1 164
2009	2 340	2 415	2 411	2 158	1 209
2010	2 525	2 437	2 305	2 020	1 328
2011	2 759	2 782	2 750	2 404	1 531
2012	3 065	2 827	2 781	2 226	1 628
2013	3 701	3 568	3 385	2 466	1 953
2014	3 925	3 989	3 769	2 729	2 105
2015	3 752	3 816	3 915	3 174	2 180
2016	3 657	4 089	3 636	2 899	2 373
2017	3 663	4 098	3 855	3 068	2 233
2018	3 615	4 022	3 950	3 102	2 353

In 2018, compared to the previous year, there was a decrease in the number of DLO, their share in detected offenses increased and the number of detected DLO per 100,000 persons aged 15-64 remained unchanged.

Table 40 - Development of the number of DLO and their share in all detected criminal offenses in 2002-2018

Year	Detected criminal offences	Number of DLO	Share of DLO in detected criminal offences (%)	Number of detected DLO per 100,000 persons aged 15–64 let
2002	372 341	4 330	1,2	60,2
2003	357 740	3 760	1,1	52,0
2004	351 629	3 086	0,9	42,5
2005	344 060	2 915	0,8	40,0
2006	336 446	2 922	0,9	39,9
2007	357 391	2 865	0,8	38,8
2008	343 799	3 041	0,9	40,9
2009	332 829	3 069	0,9	41,4
2010	313 387	3 179	1,0	43,1
2011	317 177	3 834	1,2	52,8
2012	304 528	4 032	1,3	56,1
2013	325 366	5 117	1,6	72,0
2014	288 660	5 597	1,9	79,3
2015	247 628	5 549	2,2	79,3
2016	217 927	5 564	2,6	80,1
2017	202 303	5 599	2,8	81,2
2018	192 405	5 465	2,8	79,5

Criminal proceedings were most commonly instigated against persons for the unauthorised production or other handling of narcotic and psychotropic substances (81% in 2018, 79% in 2017, 81 % both in 2016 and 2015). The composition of the drug law offences by the type of offence did not change significantly in comparison with the previous year. Year-on-year changes

at all stages of the criminal proceedings did not exceed 3 percentage points. Drug offenders were most commonly arrested for the unauthorised production, smuggling, and sale of methamphetamine in 2018 (39% of all persons arrested). The second most common reason for arrest was cultivation, smuggling, and sale of cannabis (33% of all persons arrested). Production/plantation, trafficking and dealing were mostly related to methamphetamine (47% of persons arrested for production/plantation, trafficking and dealing). Possession and/or cultivation for personal use were mostly related to cannabis (63% of persons arrested for possession and/or cultivation for personal use).

Table 41 - Number of persons arrested broken down by individual drugs and type of drug crime in 2018

Drug	Production, plantation, trafficking and dealing		Possession and cultivation for personal use		Promotion of drug use		Total	
	Number	Share (%)	Number	Share (%)	Number	Share (%)	Number	Share (%)
Cannabis	1 182	39,7	396	63,0	5	55,6	1 583	43,8
Methamphetamine (pervitin)	1 406	47,2	150	23,8	0	0,0	1 556	43,0
Cocaine	75	2,5	15	2,4	1	11,1	91	2,5
Heroin	26	0,9	11	1,7	0	0,0	37	1,0
Other opioids	60	2,0	6	1,0	2	22,2	68	1,9
Ecstasy	77	2,6	29	4,6	0	0,0	106	2,9
LSD	2	0,1	2	0,3	0	0,0	4	0,1
Amphetamine	25	0,8	5	0,8	0	0,0	30	0,8
Other drugs	126	4,2	15	2,4	1	11,1	142	3,9
Total	2 979	100,0	629	100,0	9	100,0	3 617	100,0

Since 2015, data on the number of people who committed drug related administrative offence is also available. The source is the National Drug Squad (however, administrative offences do not fall within the scope of this specialized unit). In 2018, police record 7680 people who committed drug related administrative offence (6629 in 2017). The largest share was made by persons who committed an administrative offence in connection with cannabis (72%) and methamphetamine (16%).

8.2.2.1 Crimes undertaken under the influence of drugs

A total of 92.8 thousand offences were cleared up in 2018, according to the data of the Police of the Czech Republic reported from the Criminal Statistics Records System. 14.1 thousand (15%) of these offences were committed under the influence of addictive substances. Compared to the previous year, the situation remained essentially unchanged.

Figure 37 - Development of the number of cleared up offences and the proportion of offences committed under the influence of drugs in 2003-2018



A total of 11.5 thousand offences committed under the influence of alcohol, i.e. 82% of all the offences committed under the influence of addictive substances, were reported by the police in 2018. The offences of endangerment under the influence of an addictive substance and inebriation (50%, a total of 5754 offences).

A total of 2.6 thousand offences were committed under the influence of drugs other than alcohol in 2018, i.e. 18% of all the offences committed under the influence of addictive substances. The offenders most typically committed the offences of endangerment under the influence of an addictive substance (66%). In the long term, there is an apparent high percentage of offences committed under the influence of alcohol.

Year	Offences under influence of alcohol		Offences under influence of illegal drugs		In total offences under influence of addictive substances	Offences under influence of addictive substances per 100,000 of persons aged 15–64
	Number	Share (%)	Number	Share (%)		
2003	10 143	91,5	939	8,5	11 082	153,2
2004	10 916	93,0	816	7,0	11 732	161,6
2005	11 020	93,4	781	6,6	11 801	161,8
2006	14 075	95,0	735	5,0	14 810	202,2
2007	22 030	96,5	793	3,5	22 823	308,8
2008	22 826	95,7	1 019	4,3	23 845	320,9
2009	22 277	92,1	1 900	7,9	24 177	326,1
2010	17 290	88,4	2 277	11,6	19 567	265,2
2011	17 168	88,9	2 142	11,1	19 310	265,9
2012	16 130	87,6	2 289	12,4	18 419	256,2
2013	15 265	84,1	2 890	15,9	18 155	255,4
2014	15 466	78,4	4 250	21,6	19 716	279,4
2015	14 489	75,6	4 668	24,4	19 157	273,8
2016	12 753	79,9	3 200	20,1	15 953	229,8
2017	11 023	81,8	2 448	18,2	13 471	195,3
2018	11 541	81,6	2 601	18,4	14 142	205,8

Estimation of the economically motivated secondary drug crime is carried out by National focal point and Nation drug squad at a two-year interval. It is an expert retrospective estimate of the staff of the regional headquarters and territorial departments of the Police of the Czech Republic. The latest results are available for 2017 when a total of 119000 selected economically motivated offences were recorded, of which an estimated 35% committed drug users (52 thousand offences). Highest share was theft.

Economically motivated secondary drug crime was among others a topic asked in a cross-sectional questionnaire survey in prison population conducted in 2018 on a representative sample of 1695 people. Theft or other crime or misdemeanour for the purpose of acquiring funds for illegal drugs has sometimes been committed in the past by 23% of respondents.

8.2.3 Drug supply reduction activities

Key priorities are defined in the Strategy for the development of the Police by 2020. One area is also devoted to the reduction of drug supply. Following objectives are defined:

- to increase the number of identified DLO
- to reduce the availability of illicit drugs
- to reduce the prevalence of accompanying crime (secondary crime)
- to cover new types of crime
- sufficient capacity for covering all forms of drug crime, especially in public space - street and club distribution
- active approach to new types of synthetic drugs and chemicals in the Internet environment and to international trade in precursors, chemicals and drugs used by the production of drugs
- to improve cooperation with foreign partners (in particular law enforcement agencies)
- to focus on new forms of drug crime in a virtual space with a focus on illegal markets "DarkNet" and "Tor"

In 2018, the cooperation of repressive forces continued on international level, in particular in the border regions (České Budějovice, Plzeň, Ústí nad Labem, Brno and Ostrava).

8.3 Trends

Interpretation of trends concerning seizures, price and purity is very complicated, because we completely lack of data on the activities of law enforcement authorities. Law enforcement agencies do not release such data very probably for strategic reasons.

The most important drugs in the Czech Republic are cannabis and methamphetamine. As the data on cannabis shows, the number of seizures and seized quantities is increasing. The same trend is observed also in case of methamphetamine seizures. For both substances, exceptions to this trend may be observed in some years; however, the overall trend can be seen as increasing. One of the explanations could be that police is focusing on detection of cannabis and pervitin crime. In this context, for example, it is trying to motivate citizens to observe what is happening

in their neighbourhood and to report suspicion of a lab or plantation site. In this regard in 2016, the National Drug Squad launched a website with a map of the Czech Republic, which shows exposed methamphetamine labs and plantation sites: <http://mapavarenapestiren.cz>

As regards the purity and prices of cannabis and methamphetamine, the situation has been relatively stable for a long time. However, more detailed information is missing about tested samples. Both cannabis and methamphetamine are available on the black market in relatively high quality.

In general, criminal offenses related to the production, distribution and sale of drugs have been 80-86% and criminal offences related to the cultivation and possession for personal use 13-18% of drug offenses in recent 10 years.

The share of people arrested for:

- smuggling, trafficking and dealing has been between 77% and 81% of all people arrested for drug offenses in the last 10 years (on average 80%).
- cultivation for personal use has been between 3% and 5% of all people arrested for drug offenses in the last 10 years (on average 4%).
- possession for personal use has been between 10% and 15% of all people arrested for drug offenses in the last 10 years (on average 13%).

Reducing drug availability and controlling supply of addictive products is one of the pillars of the Czech Republic's addiction policy defined by the National Drug Policy Strategy 2010–2018 and the related National Strategy for the Prevention and Reduction of Damage Related to addictive behaviour 2019-2027.

The international cooperation of law enforcement agencies - Joint Investigation Teams - has greatly strengthened over the past years.

The strategy of the development of the Czech police was prepared and explicitly defines the goals in the area of drug supply reduction. Until then, supply reduction activities have been defined in the drug strategy and action plans, but not in a publicly accessible document of law enforcement agencies.

8.4 New developments

An important and continuing trend is the shift of production of methamphetamine, or part of it, to Poland.

Despite a number of control measures (in the Czech Republic since 2009, in Poland since 2015), methamphetamine production is well stocked with the main precursor, namely pseudoephedrine-containing medical products. It does not appear that even a change in the availability of pseudoephedrine-containing medical products in Poland affected the production of pseudoephedrine.

Concerning the production of methamphetamine there is a continuing trend of increasing the production volume within a single production cycle (in the order of tens of kilograms) and the production is usually organised into several shifts.

There are cases of detection of opioid laboratories. In 2018, four opioid laboratories were dismantled in the Czech Republic. In all cases, an attempt was made to produce opium / morphine.

Ecstasy tablets are imported into the Czech Republic mostly from the Netherlands or Belgium. In the last 3 years, ecstasy production has also been recorded in the Czech Republic.

8.5 Sources and methodology

8.5.1 Bibliography

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Cross-sectional questionnaire study in prison population (2010-2018, 5 rounds, 2-year interval)

The main source of data on drug use in prison population (prisoners serving a prison sentence) is a questionnaire survey, which is conducted every two years. The fifth round took place in 2018. The survey was conducted by the National Focal Point in cooperation with the Prison Service of the Czech Republic. Collection and acquisition of data was provided by the ppm factum research agency through trained administrators. The 2018 sample consisted of 2,100 individuals serving their prison sentence. The respondents were randomly selected from the

20263 individuals serving their prison sentence in the 35 prisons in the Czech Republic as of the date of selection. A total of 1695 questionnaires were returned, providing a response rate of 81%. The questionnaires were administered in groups. The questionnaire used in the first round of the study, modified with regard to the current trends and experience obtained from the previous study, was applied to collect the data. The questionnaire focused on several sets of issues. In addition to the demographic characteristics, the survey concerned areas such as the respondent's criminal career, experience with addiction treatment, prevalence of drug use, including problem drug use and drug use before and after entering prison, gambling, subjectively perceived availability of drugs in prison, overdose experience, severity of dependence scale (SDS), and availability of drug services in prison settings. Concerning drug use, the questionnaire covers following substances: tobacco, alcohol (in the question about drug use in prison, divided into alcohol produced in prison and brought to prison), cannabis, ecstasy, methamphetamine (in the CZ called pervitin), LSD, magic mushrooms, heroin, buprenorphine, cocaine, other synthetic stimulants, synthetic cannabinoids, solvents, sedatives or hypnotics without prescription, painkillers without prescription, anabolic steroids and other drugs.

9 Drug use and drug services in prison settings

9.1 Summary

The Prison Service of the Czech Republic administered 35 prisons in 2018. As of 31 December 2018, there were 21577 prisoners, 19677 of who had been sentenced and with 1816 awaiting trial (plus 84 in detention). Women accounted for 8% of the prison population and juveniles 0.3%.

A fifth round of the questionnaire study of drug use among prisoners serving a prison sentence took place in 2018. 53% of the respondents reported lifetime illicit drug use prior to imprisonment. In addition to alcohol, the respondents' experience was mostly with cannabis, methamphetamine and ecstasy. Over 44% had used an illegal drug in the last 12 months prior to imprisonment and 35% in the last 30 days prior to imprisonment. The prevalence of drug use among prisoners is much higher compared to the general population. By far the most striking difference between prison population and general population is the prevalence of heroin use. A total of 21% of the respondents had used an illegal drug during one of their previous prison sentences. The most commonly used addictive substances were alcohol made in prison (16%), medicines with a sedative effect and painkillers obtained without a prescription (13%) and cannabis (12%). According to the respondents, sedatives and alcohol made in prison were the most easily available addictive substances in prison.

A total of 30% of the respondents admitted having injected a drug at least once in their lifetime. Injecting drug use in prison was reported by 7% of the respondents. 5% of the respondents had shared a needle/syringe in prison.

Prevention, addiction treatment, harm reduction interventions, and efforts to minimise health and social impacts of drug use were carried out in prisons through drug prevention counselling centres, drug-free zones, specialised wings (departments), and programmes provided by NGOs. In 2018, addiction treatment was available in 14 out of 35 prisons in the Czech Republic; a compulsory treatment sentence could be served in 3 prisons. Substitution treatment was provided by 6 prisons (an authorisation had 10 prisons). A total of 31 prisons reported an intensive cooperation with an NGO (more than 10 visits per year) on the implementation of drug policy activities.

In 2018, cooperation between the Czech Prison Service and the NFP continued on the implementation of the Joint Action on HIV and Co-infection Prevention and Harm Reduction (HA-REACT) project. As part of the project, vending machines for condom distribution were installed. Condoms have been distributed free of charge and are available in the Prague-Pankrác prison and since April 2019 also in Prague-Ruzyně Remand Prison.

9.2 National profile

9.2.1 Organization

The Prison Service of the Czech Republic administered 35 prisons in 2018. As of 31 December 2018, there were 21577 prisoners (22159 in 2017), 19677 of who had been sentenced and with 1816 awaiting trial. Women accounted for 8% of the prison population and juveniles 0.3%. The share of foreign nationals was 8% of the prison population. Prison capacity is exceeded by an average of 4%.

The number of persons imprisoned for drug law offences increased to 2460 (2431 in 2017, 2284 in 2016, 1991 in 2015, 1670 in 2014). As in the previous year the increase in the number of prisoners occurred especially for the offence of unauthorised production and other handling of drugs and possession of drugs for personal use.

9.2.2 Drug use and related problems among prisoners

9.2.2.1 Drug use prior to imprisonment

53% of the respondents reported lifetime illicit drug use prior to imprisonment (all drugs including medicines with a sedative effect and painkillers obtained without a prescription). In addition to alcohol, the respondents' experience was mostly with cannabis, methamphetamine (in the CZ called pervitin), or amphetamines and ecstasy. A total of 39% had used cannabis, 39% methamphetamines and 21% ecstasy at least once prior to imprisonment. 44% had used an illegal drug in the last 12 months prior to imprisonment and 35% in the last 30 days prior to imprisonment. Most commonly, this concerned the use of methamphetamine, cannabis and ecstasy.

Table 42 - Prevalence of drug use prior to imprisonment - lifetime, in the last 12 months and in the last 30 days, in % (in 2018)

Type of drug	LTP	LYP	LMP
Any illegal drug	53,4	43,5	35,3
Tobacco	73,9	68,3	64,7
Alcohol	60,8	48,3	35,8
Marijuana/hashish	39,1	28,3	22,1
Ecstasy	21,4	11,6	7,1
Pervitin/amphetamines	38,8	29,9	22,7
LSD	15,9	7,0	4,0
Magic mushrooms	16,4	7,3	4,5
Heroin	11,8	6,5	4,9
Buprenorphine	7,8	4,0	2,9
Cocaine	16,6	6,9	3,8
Other synthetic stimulants	8,2	3,8	2,2
Synthetic cannabinoids	6,0	3,1	2,2
Solvents	5,5	2,2	1,7
Sedatives/hypnotics without prescription	16,5	9,9	6,2
Painkillers without prescription	17,1	9,9	6,3
Anabolic steroids	4,2	1,9	1,4
Other drugs	2,5	1,4	1,0

9.2.2.2 Drug use inside prison

A total of 21% of the respondents had used an illegal drug during one of their previous prison sentences. The most commonly used addictive substance were alcohol made in prison (16%), medicines with a sedative effect and painkillers obtained without a prescription (13%), cannabis (12%), methamphetamine (11%), alcohol brought into prison (6%), buprenorphine (3%) and heroin (3%).

9.2.2.3 Drug related problems

A total of 30% of the respondents admitted having injected a drug at least once in their lifetime. 20% of the respondents had injected a drug in the last month before entering prison to serve their current prison sentence. A total of 12% of the respondents had shared a needle or a syringe at least once during lifetime. Injecting drug use while serving one of their prison sentences was reported by 7% of the respondents. 5% of the respondents had shared a needle/syringe in prison.

Estimates of the number of problem drug users have been conducted regularly since 2002. As cocaine use prevalence is relatively low in the Czech Republic, cocaine users are not included in the estimates of problem drug users. To estimate the number of problem drug users in prison population, variables describing drug use prior to imprisonment were used. Thus, respondents who reported use of heroin, buprenorphine (without prescription) or methamphetamine 4 times and more during the last 30 days prior to current prison and / or those who injected drug in the same time horizon (injecting drug users).

Regular use of heroin, buprenorphine or methamphetamine in the last 30 days prior to imprisonment was reported by 20% of respondents, with opioids regularly using 4% of respondents. Injecting drug use in the same time horizon was reported by 20% of respondents. According to the above definition 28% of the prisoners, i.e. 5,700 when converted to the general prison population, can be referred to as problem drug users (i.e. injecting drug users or those who repeatedly used methamphetamine, opiates, or cocaine in the month before entering prison).

Table 43 - Estimated number of problem drug users in prison population

Problem drug users	Number in the sample	Share (%)	Calculation to prison population *
Regular users	333	19,6	4
- of whom are opioid users	71	4,2	800
Injecting drug users	343	20,2	4 100
Injecting and regular drug users (at the same time)	203	12,0	2 400
Problem drug users total	473	27,9	5 700

Note: * The data is rounded to hundreds.

9.2.2.4 Risk behaviour and health consequences

The Prison Service monitors the examinations of imprisoned injecting drug users for selected infections. The sample of prisoners is not representative and repeated tests on the same (positive) person in the various stages of serving a custodial sentence cannot be ruled out. Therefore, caution must be exercised in the interpretation and generalisation of the results and trends. The source of the data is Report on Drug Policy Activities in Prison in 2015, 2016, 2017 and 2018. For detailed information on infectious diseases among drug users please see Harms and harm reduction, chapter 6.2.3 Drug related infectious diseases.

Table 44 - Results of testing for HIV, HBV, and HCV among injecting drug users in prisons, 2015-2018

Year	HIV		VHB				VHC	
	anti-HIV		HBsAg*		anti-HBc IgG**		anti-HCV	
	Tested	Positive (%)	Tested	Positive (%)	Tested	Positive (%)	Tested	Positive (%)
At the entrance of prison sentence								
2015	694	0,3	2 300	3,3	1 067	23,7	1 733	56,1
2016	533	0,6	2 541	2,8	957	26,0	3 206	34,1
2017	363	0,6	2 761	2,9	1 088	21,5	3 276	34,8
2018	240	0,8	2 512	3,2	1 054	23	2 941	42,2
At the entrance of custody								
2015	872	0,1	1 729	9,3	1 007	17,2	1 414	46,7
2016	202	1,5	1 719	6,2	688	17,9	1 988	30,1
2017	237	1,7	1 973	3,6	633	17,7	2 070	28,3
2018	188	2,1	1 810	3,0	611	15,5	1 912	34,4
While in prison (serving prison sentence)								
2015	854	0,9	870	4,6	527	57,3	967	94,3
2016	285	0,7	758	8,8	672	33,9	1 336	49,0
2017	176	0,0	618	5,5	652	23,2	1 148	51,0
2018	204	2,5	717	5,7	638	29,6	1 177	53,3
Total								
2015	2 450	0,4	4 899	5,7	2 601	28,0	4 114	61,8
2016	1 020	0,8	5 018	4,9	2 317	25,9	6 530	35,9
2017	776	0,8	5 352	3,5	2 373	20,9	6 494	35,6
2018	632	1,7	5 039	3,5	2 303	22,8	6 030	41,9

Note: * an antigen indicating acute or chronic active HBV infection, ** antibodies generated during an acute HBV infection, but lasting even long after recovery

Figure 38 - Trend of selected serological markers of HIV, HBV, and HCV among tested injecting drug users in prison (%), 2010-2018



Note: * 2014 are only available data for the second half

According to the respondents, alcohol made in prison and medicines with a sedative effect and painkillers obtained without a prescription were the most easily available addictive substances in prison. Approximately 21% of the respondents considered medicines with a sedative effect and painkillers obtained without a prescription and 20 % of the respondents alcohol made in prison easily available. In terms of availability, these substances were followed by cannabis and methamphetamine, which were found easily available by 18% of the respondents.

9.2.3 Drug-related health responses in prisons

Drug-related prison health is explicitly mentioned in the Conception for development of Czech prison system until 2025, which is a general strategic document. To drug use is paid considerable attention (1 of 9 work packages). Concerning the National Drug Policy Strategy drug-related prison health is not explicitly mentioned in the strategy; however the action plans for the Implementation of the National Drug Policy Strategy contain specific tasks in this regard.

Prevention, addiction treatment, harm reduction interventions, and efforts to mitigate the social impact of drug use were carried out in prisons through drug prevention counselling centres, drug-free zones, specialised wings, and programmes provided by NGOs.

Drug prevention counselling is provided by prison staff. The scope of the services provided by the counselling centres in the individual prisons varied, depending on the specialisation and capacity of the professional staff. Nevertheless, provision of information and individual counselling services are available in all the prisons.

Table 45 - Number of prisons and provision of specific activities in 2014-2017

Type of activity	2014	2015	2016	2017	2018
Psychotherapy	13	12	13	14	13
Group therapy and counselling	19	25	26	28	27
Individual therapy and counselling	35	35	35	35	34
Sociotherapy	12	12	13	13	10
Primary prevention	25	27	28	28	27
Group discussion	25	29	26	31	31
Provision of information	35	35	35	34	35

Drug-free zones are special prison wings that operate in either the standard or therapeutic regimen. The main purpose of a standard drug-free zone is to motivate the prisoners to abstain and follow a drug-free routine. The target group for the drug-free zones with a therapeutic regime includes only drug users. The programme is aimed at supporting of drug-free life style either while in prison or after release.

Addiction treatment while serving a prison sentence could be provided by specialised wings, which were available in 14 prisons in 2018. In 11 prisons (Bělušice, Kuřim, Nové Sedlo, Ostrov, Pilsen, Příbram, Valdice, Všehrady, Horní Slavkov, Heřmanice and Hradec Králové), these specialised wings were intended for voluntary treatment, while in 3 prisons (Opava, Rýnovice, and Znojmo) they were used for serving court-ordered compulsory treatment.

The authorisation to provide **substitution therapy** was held by 10 prisons, 6 of which reported treating patients in 2018. In order to be included in a substitution treatment programme in prison, the clients need to have been included in a substitution therapy programme before they entered the prison to await trial in custody or to serve their prison sentence. Methadone is used as the substitution substance.

In 2018, a pilot project focused on extending the provision of substitution treatment in prison was under preparation. The extension of substitution treatment consists of: (1) initiation of substitution therapy in prison (to prisoners who have not yet been included in the substitution program outside prison) and (2) use of buprenorphine as a substitution preparation. The project is carried out in accordance with the current Action Plan of the Prison System. The project started in 2 prisons – Prague-Pankrác Remand Prison and Remand Prison and Security Detention Institute Brno. As the major problem seems to be that buprenorphine preparations are not normally covered by health insurance.

Detoxification was provided by 6 prisons in 2018.

The cooperation between prisons and **NGOs** was more intensive in 2018 than in the previous year, with a total of 31 prisons reporting 10 or more visits during the year (compared to 27 in 2017, 24 in 2016, 21 in 2015 and 17 prisons in 2014).

In 2017, **condom pilot distribution** as a harm reduction measure was carried out in the Czech Republic (1 prison – Prague-Pankrác Remand Prison). In 2019 condom distribution started in another prison (Prague-Ruzyně Remand Prison). Condoms are provided through dispenser machines. In general, condoms in all 35 prisons are available in canteens where prisoners can buy them. Free condoms are available only in some prisons (information about the number is not available), in rooms for "non-standard visits" - without visual and hearing control. These are rooms where a prisoner can stay alone with the visitor without the presence of prison staff. Condom pilot distribution was one of the activities of HA-REACT project.

Based on data from questionnaire prison study 2018 before entering prison to serve their sentence, 6% of the respondents had received alcohol addiction treatment, 11% had received treatment for addiction to another substance (10% in 2016), and 3% had received substitution therapy (4% in 2016) before they entered the prison to serve their current sentence. Concerning the availability of drug services in prison settings testing for HCV (by 16% of respondents in 2018 and 21% of respondents in 2016 always available) was rated as the most accessible service, on the contrary condom provision was the least accessible service (by 16% of respondents in 2018 and 33% of respondents in 2016 never available). Clean syringes are, despite the existence of injecting drug use in prisons unavailable.

Since 2013, the evaluation tool called SARPO (which is comprehensive risk and needs analysis) developed by the VS CR has been used extensively in all Czech prisons. The tool is used to assess the probability of recidivism based on data on criminal behaviour, 48 risk factors in 7 areas, motivation and self-assessment of prisoners and protective factors. One of the areas is

also the addictive behaviour. In this area nature and intensity of contact with drug users, the negative consequences of drug use, drug-related expenditure and the addiction according to the ICD-10. Data for 2018 was not published by the Prison Service.

9.2.3.1 Drug prevention counselling centres

A total of 11093 persons used the services of one of these centres in 2018 (10085 in 2017). The use of services refers to the provision of at least one intervention. Every individual is included only once in each year, regardless of the number of interventions provided to this person. The activities of drug prevention counselling centres across all Czech prisons were provided by 255 prison employees. The data does not take into account the level of involvement of the staff in the counselling in terms of full or part-time work.

Table 46 - Number of prison staff providing drug prevention counselling broken down by professional position

Staff	2014	2015	2016	2017	2018
Psychologist	42	41	52	52	50
Pedagogue (special needs)	42	46	57	55	60
Social worker	31	36	41	45	47
Trainer-therapist	17	19	20	22	24
Trainer	16	15	18	23	23
Worker educated in addictology	–	–	–	1	15
Physician	10	12	11	13	13
Nurse	20	24	24	25	23
Total	178	193	223	236	255

9.2.3.2 Drug-free zones

A standard drug-free zone was operated in all prisons (35 prisons), with a capacity totalling 1817 beds in 2018. A total of 4286 persons used the option of serving their sentence in standard drug-free zones in 2018 (2192 new entries). A total of 3 prisons (Příbram, Vlnařice, and Znojmo) operated a therapeutic drug-free zone. Their capacity was 92 beds. The opportunity to be placed in these zones was taken by 205 persons, 106 of whom were newly assigned to these zones. The activities of standard drug-free zones provided by 182 prison employees and of therapeutic drug-free zones 24 prison employees. The data does not take into account the level of involvement of the staff in terms of full or part-time work.

Table 47 - Number of prison staff of standard drug-free zones broken down by professional position

Staff	2014	2015	2016	2017	2018
Psychologist	29	26	28	34	36
Pedagogue (special needs)	35	35	32	32	37
Social worker	26	24	23	27	31
Trainers-therapist	9	6	8	14	15
Trainer	43	46	40	39	41
Worker educated in addictology	–	–	–	1	4
Physician	3	5	4	6	7
Nurse	7	9	9	11	11
Total	152	151	144	163	182

Table 48 - Number of prison staff of therapeutic drug-free zones broken down by professional position

Staff	2014	2015	2016	2017	2018
Psychologist	3	2	3	3	3
Pedagogue (special needs)	4	4	4	4	5
Social worker	3	3	2	4	5
Trainers-therapist	4	4	5	5	4
Trainer	5	8	5	7	6
Worker educated in addictology	–	–	–		1
Physician	0	0	0	0	0
Nurse	0	0	0	0	0
Total	19	21	19	23	24

9.2.3.3 Addiction treatment

The capacity of the voluntary treatment units was 340 in 2018. The opportunity to undergo voluntary treatment in any of the specialised wings was taken by 702 persons (with 362 new entries) in 2018. The capacity of compulsory treatment units was 93 beds. In 2018, the Prison Service registered a total of 174 persons assigned to one of the units (with 72 new entries).

Table 49 - The number, capacity and utilization of drug-free zones and specialized departments for voluntary and compulsory treatment in prisons in 2006-2018

Year	Drug-free zones			Voluntary treatment units			Compulsory treatment units		
	Nr. of prisons	Capacity	Nr. of persons	Nr. of prisons	Capacity	Nr. of persons	Nr. of prisons	Capacity	Nr. of persons
2006	31	1 665	3 201	6	286	625	3	105	162
2007	35	1 877	3 524	6	258	419	3	114	200
2008	33	1 998	3 646	6	262	422	3	120	206
2009	33	2 057	4 224	7	294	507	3	120	117
2010	33	2 075	3 443	7	300	437	3	109	128
2011	33	1 905	4 279	7	287	535	3	113	206
2012	34	1 918	4 549	7	287	537	3	128	184
2013	34	1 898	3 747	8	306	589	3	128	184
2014	34	1 889	3 528	8	287	504	3	129	188
2015	34	1 888	3 812	8	287	494	3	131	215
2016	35	2 035	4 014	9	335	578	3	131	213
2017	35	1 905	4 052	10	363	682	3	93	203
2018	35	1 817	4 286	11	340	702	3	93	174

The activities of voluntary treatment units were provided by 64 prison employees and of compulsory treatment units 24 prison employees. The data does not take into account the level of involvement of the staff in terms of full or part-time work.

Table 50 - Number of prison staff of voluntary treatment units broken down by professional position

Staff	2014	2015	2016	2017	2018
Psychologist	12	8	12	10	11
Pedagogue (special needs)	12	11	12	13	11
Social worker	7	7	7	8	8
Trainers-therapist	11	12	12	12	12
Trainer	17	16	18	19	19
Worker educated in addictology	–	–	–	–	1
Physician	1	1	1	1	1
Nurse	4	3	2	1	1
Total	64	58	64	64	64

Table 51 - Number of prison staff of compulsory treatment units broken down by professional position

Staff	2014	2015	2016	2017	2018
Psychologist	7	5	5	4	4
Pedagogue (special needs)	3	3	3	3	4
Social worker	3	3	2	3	2
Trainers-therapist	5	5	4	5	4
Trainer	4	5	4	4	2
Physician	3	3	3	3	3
Nurse	3	3	3	3	2
Worker educated in addictology	–	–	–	1	3
Total	28	27	24	26	24

9.2.3.4 OST

Substitution treatment programmes in prisons reported 64 clients (63 in 2017). The number of people in substitution treatment in prison has long been very low compared to estimated number regular users of opioids.

9.2.3.5 Detoxification

Acute withdrawal treatment was received by 27 persons. 17 of whom were men. Opiate/opioid users accounted for 1/3 of the persons detoxified. There was a significant decrease in the number of persons undergoing withdrawal management in comparison with the previous year (172 in 2017, 194 persons in 2016, 147 in 2015, 154 in 2014). This is probably due to the decreasing number of medical staff (psychiatrists).

9.2.3.6 Drug services provided by NGOs

A total of 9726 individuals on remand or serving a prison sentence were in contact with an NGO in 2018 (8921 individuals in 2017, 7090 in 2016, 7665 in 2015, 8073 in 2014 and 5035 in 2013).

9.2.4 Quality assurance of drug-related health prison responses

In 2012 quality standard for community drug services (NGOs) working in prison settings was approved. For the programs provided by the prison service quality system is not yet developed. However, the Prison Service is trying to harmonize the provision of drug services. In 2016, a guideline for drug prevention counseling centers and units for voluntary treatment were developed. Currently they have been piloting.

9.3 Trends

Trends or important developments in prison over the past 5 years

Between 2010 and 2012, the lifetime prevalence in the sentenced population decreased for all monitored substances. There was an increase in the two following waves, and the results of the last wave of the study show a decline in experience, with the exception of cocaine and non-prescription medicines. Prisoners are the most frequently experienced with cannabis or methamphetamine (average 42%, resp. 39%).

Concerning the last year prevalence, there has been a decline in the long-term experience with cannabis (from 16% in 2010 to 13% in 2018) and methamphetamine (from 15% in 2010 to 12% in 2018), but on the contrary, the increase in experience with non-prescription medicines (from 8% in 2010 to 10% in 2018).

Data on NPS prevalence are available from cross-sectional questionnaire study (LTP, LYP, LMP – prior to imprisonment, in prison) – the results are listed in the section 9.2.2; NPS are not an issue for the prison service. No single NPS seizure has been reported yet.

As a problem, the Prison Service is reporting misuse of medicines, especially Tramadol.

9.4 New developments

In 2017, condom pilot distribution as a harm reduction measure was carried out in the Czech Republic (1 prison – Prague-Pankrác Remand Prison). In 2019 condom distribution started in another prison (Prague-Ruzyně Remand Prison).

In 2018, a pilot project focused on extending the provision of substitution treatment in prison was under preparation. The extension of substitution treatment consists of: (1) initiation of substitution therapy in prison (to prisoners who have not yet been included in the substitution program outside prison) and (2) use of buprenorphine as a substitution preparation.

In 2018, the seizure of NPS (synthetic cannabinoid) was reported for the first time.

9.5 Additional information

Mravčík, V., Chomynová, P., Grohmannová, K., Janíková, B., Černíková, T., Rous, Z., Tion Leštinová, Z., Nechanská, B., Cibulka, J., Fidesová, H., Vopravil, J. 2019. Výroční zpráva o stavu ve věcech drog v České republice v roce 2018 [Annual Report on Drug Situation 2018 – Czech Republic] MRAVČÍK, V. (Ed.). Praha: Úřad vlády České republiky.

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9.6 Sources and methodology

Cross-sectional questionnaire study in prison population (2010-2018, 5 rounds, 2-year interval)

The main source of data on drug use in prison population (prisoners serving a prison sentence) is a questionnaire survey, which is conducted every two years. The fifth round took place in 2018. The survey was conducted by the National Focal Point in cooperation with the Prison Service of the Czech Republic. Collection and acquisition of data was provided by the ppm factum research agency through trained administrators. The 2018 sample consisted of 2100 individuals serving their prison sentence. The respondents were randomly selected from the 20263 individuals serving their prison sentence in the 35 prisons in the Czech Republic as of the

date of selection. A total of 1695 questionnaires were returned, providing a response rate of 81%. The questionnaires were administered in groups. The questionnaire used in the first round of the study, modified with regard to the current trends and experience obtained from the previous study, was applied to collect the data. The questionnaire focused on several sets of issues. In addition to the demographic characteristics, the survey concerned areas such as the respondent's criminal career, experience with addiction treatment, prevalence of drug use, including problem drug use and drug use before and after entering prison, gambling, subjectively perceived availability of drugs in prison, overdose experience, severity of dependence scale (SDS), and availability of drug services in prison settings. Concerning drug use, the questionnaire covers following substances: tobacco, alcohol (in the question about drug use in prison, divided into alcohol produced in prison and brought to prison), cannabis, ecstasy, methamphetamine (in the CZ called pervitin), LSD, magic mushrooms, heroin, buprenorphine, cocaine, other synthetic stimulants, synthetic cannabinoids, solvents, sedatives or hypnotics without prescription, painkillers without prescription, anabolic steroids and other drugs.

9.6.1 Bibliography

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