European Monitoring Centre for Drugs and Drug Addiction

THE NATIONAL HEALTH SERVICE

2011 NATIONAL REPORT (2010 data) TO THE EMCDDA by the Reitox National Focal Point

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

Reitox
2011

FOREWORD

2011 National Report, new developments, trends and in–depth information on selected issues is one of the national annual reports compiled by the National Focal Points in the European Information Network on Drugs and Drug Addiction (REITOX) which is co-ordinated by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The national reports form the basis for the EMCDDA's annual report *The state of the drugs problem in Europe*. The national reports are compiled in accordance with the guidelines provided by the EMCDDA.

The Latvian National Report consists of two parts. Part A discusses recent developments and research data from 2010 and early 2011. The sections that describe the drug situation during the past year (drug experimentation, problem drug use, health and social correlates and consequences, availability and supply of drugs) are linked with discussion on related societal interventions (prevention, treatment, harm reduction, social reintegration and control). Each section begins with background information on the subject and the latest data is discussed in the subsections. Part B discusses selected issues relating to drugs, this year's theme being drug related health policies and services in prisons (Section 11) and drug users with children (Section 12). The length of the sections in the report depends on the amount of data available on each subject area.

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

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

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

The report has been approved by the director of Research and Statistics Department of the National Health Service Ms. Iveta Gavare and the director of the National Health Service/ EMCDDA Management Board member Mr. Māris Taube.

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The National Health Service*
31 k-3 Cesu Street, Riga LV-1012, Latvia
Tel.: +371 67043700
Fax.: +371 67043701
e-mail: nvd@vmnvd.gov.lv
www.vmnvd.gov.lv

*The National Health Service was established on 1 November 2011. It tooks over all the functions formerly executed by the Centre of Health Economics and Health Payment Centre.

This report was written by:

Ieva Pūgule	Head of Latvian National Focal Point, The National Health Service
Mārcis Trapencieris	Researcher of Latvian National Focal Point, The National Health Service
Agnese Zīle	Public Health Analyst of Latvian National Focal Point, The National Health Service
Linda Sīle	Public Health Analyst of Latvian National Focal Point, The National Health Service
Aija Pelne	Head of Addiction Monitoring Division, The National Health Service
Anda Karnīte	Department of Public Health and Epidemiology, Riga Stradins University
Andris Kairišs	The Information Centre of the Ministry of the Interior
Marija Safonova	The Information Centre of the Ministry of the Interior

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Angelīna Gribova	The State Police
Inga Upmace	Infectology Centre of Latvia
Anda Lazdiņa	Infectology Centre of Latvia
Raina Ņikiforova	Infectology Centre of Latvia
Inga Martinova	Latvia State Centre for Forensic Medical Examination

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List of Abbreviations

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

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Summary

Drug policy: legislation, strategies and economic analysis

During 2010 changes were made to such important legislative instruments such as the law *On the time and arrangements for coming into force of the Criminal Law*, the law *On Precursors* and others, as well as a number of Cabinet Regulations.

On 14 March 2011, the Cabinet of Ministers approved the new *Drug Program for 2011-2017*. The new Drug Program is aimed at reducing the availability of illicit drugs, acceptability of their use in society and reducing the harm suffered by the community, by improving the availability and effectiveness of health services offered to drug users.

Three main lines of action are put forward for achieving the objectives defined in the Drug Program for 2011-2017: 1) prevention of drug addiction and drug use, 2) health care of drug users and drug addicts and 3) reduction of drug availability. These action lines include measures for which the coordination and monitoring of implementation is proposed by means of interdisciplinary action-policy coordination and information gathering and analysis.

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

Drug use in the general population and specific targeted groups

In 2010, a study of student health habits was undertaken in Latvia. This was the fifth such study to be undertaken in Latvia. This study is part of an international comparison study coordinated by the WHO on Health Behaviour among School-aged Children (HBSC).

In 2010 in Riga, a study was conducted among students from grades 9 and 10 on risk and protective factors associated with commencing the use of addictive substances. This study repeats the 2006 and 2008 studies in Riga, which were undertaken as part of the initiative of the European Cities against Drugs (ECAD) initiative.

An Internet study funded by the European Commission was implemented in Latvia on men who have sex with men (MSM) (EMIS – The European MSM Internet Survey). The study was conducted in a total of 38 countries (in 25 languages), interviewing more than 180 thousand members of target groups with the help of the internet. In Latvia the study was carried out during the period June - August 2010 and the sample size achieved was 708 men who have sex with men (MSM).

Prevention

In 2011 the Cabinet of Ministers approved the new *Drug Program for 2011-2017*. The prevention of dependence and use of drugs has been identified as one of the four main pillars for achieving the objectives of the Program.

As in previous years, activities in the drugs field are integrated into broader health promotion activities and are carried out in a decentralized manner, i.e. each municipality undertakes preventive work within the constraints of its own capacity and funding. In most cases, prevention activities are aimed at the dissemination of information.

In 2010 several awareness campaigns were undertaken nationally, mainly in the field of legal drugs (tobacco, alcohol). Selective prevention is insufficiently utilised In the Latvian districts, other than Riga. Nationally, indicated prevention measures are practically never undertaken, national prevention guidelines (standards, quality criteria) have not been developed, and program accreditation has not been undertaken. Only in rare cases is evaluation of the effectiveness of prevention interventions undertaken. This situation is explained by the lack of funding and capacity.

Problem Drug Use

2011 saw the continuation of work undertaken in previous years by specialists of the Centre of Health Economics on improving quality of treatment data, to enable the number of drug users treated during the year to be ascertained with greater accuracy, thus providing the possibility of making more accurate estimates of the number of drug users. Using the treatment multiplier method, the number of drug users in Latvia in 2010 was estimated as per the following groups: 1) problematic drug users, 2) heroin and other opioid users, 3) (meth) amphetamine users.

The estimates show that in Latvia in 2010 there were about 18888 problem drug users, of whom 10169 were users of heroin or other opioids and 6540 were problem users of amphetamine.

The major shortcoming of these estimates is that the method used does not allow the calculation of confidence intervals, and therefore the reliability of estimates is to a large extent subject to quality of treatment data and information established during the study.

Drug-related treatment: treatment demand and treatment availability

In 2011 the Cabinet of Ministers approved the new *Drug Program for 2011-2017*. The Program objective is to reduce the availability of illegal drugs and psychotropic substances, the acceptability of their use by society, and the harm done in society by their use, by improving the quality of health care services provided to drug patients and drug users. The health care of drug patients and drug users is identified in the Drug Program as one of three action lines for achieving the Program objective.

According to sector statistical report data, in 2010 there were 429 (or 19.2 per 100 000 population) first registered cases, i.e. patients with a drug-related diagnosis for the first time during their lifetime, of which 243 (10.9 per 100 000 population) were diagnosed with an addiction syndrome or psychosis-related diagnosis.

At the end of 2010, the registered prevalence of addiction or psychosis related to psychoactive substances (excluding alcohol and tobacco) was 3523 or 158.0 per 100 000 population. Compared to April 2009, prevalence has reduced by 73 patients. The reduction of prevalence to a large extent influenced the quality control of data undertaken in 2010, in which addiction specialists were asked to remove a substantial number of patients from their records.

Worthy of mention as a positive trend in 2010 is an increase in the number of clients in the methadone programs, as well as the expansion of geographical coverage of new programs. However, the number of patients being treated in the OST is still the lowest among the EU Member States. At the end of 2010, 237 patients were being treated in long-term pharmacological treatment programmes for opioid dependence, of which 193 patients were in the methadone program, and 44 patients were in the buprenorphine program.

Health correlates and consequences

By the end of 2010 a total of 4888 cases (4614 in 2009) of HIV infection had been recorded nationally, of whom 953 persons were diagnosed with AIDS. At the same point in time, 712 deaths were recorded among persons living with HIV. Thus, HIV prevalence in the country at the end of the year 2010 was 187 per 100 000 population (compared with 178 per 100 000 in 2009).

In 2010 85 cases of acute viral hepatitis B were recorded nationally (123 in 2009); of those, 44 (51.8%) were males. 22 cases (or 25.9%) were acquired via IDU. Chronic hepatitis B was identified in 43 persons, of which 3 cases (7.0%) were drug injectors.

In 2010 61 cases of acute viral hepatitis C were recorded in Latvia, which is less than in previous years (91 in 2009, 116 in 2008). Of the 61 cases, 9 cases (14.8%) were identified among injecting drug users.

According to GMR data, in 2010 there were 7 deaths recorded directly linked to drug use, or 12 cases less than in 2009. Of the recorded cases, as in previous years, the majority of deceased persons were aged 20-39 years, and were predominantly males (6 men and 1 woman).

Responses to health correlates and consequences

Programs for the pharmacological treatment of opioid-dependent patients have an important role in preventing drug overdose. Substantial changes in regulatory documents were adopted by Latvia in 2008, which provide opportunities for expanding the methadone programs. At the end of 2010 193 patients were being treated in 9 methadone programs.

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

In 2010 there were 18 HIV prevention points operating in 16 cities in Latvia. Each of these points offers a wide range of services and in each individual city is adapted to suit client needs: syringe exchanges, street (outreach) work, voluntary HIV counselling and testing, provision of disinfectants, information, education and counselling on various health, psychological and social issues.

In 2010 the HIV prevention network issued 310 774 syringes in 2010, exceeding the previous year's total of 282 701. Also increased is the number of returned syringes collected (from 242 555 in 2009 to 336 887 in 2010).

Social correlates and social reintegration

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

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

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

In 2010 there were a total of 4817 drug related offences reported. With regard to drug law offences 33.6 % were methamphetamine related offences, followed by 23.1 % for cannabis and 20.1 % for heroin related offences.

In 2010 study on drug use in prisons was conducted in 11 prisons in Latvia, surveying 1965 convicted persons. In addition to polling convicted persons, 10 expert interviews were conducted with professionals from this field, legislation was analysed and 166 prison staff were surveyed.

Data from the 2010 survey of prisoners, as in data from previous studies to date, indicate that the majority of convicted persons who have used drugs before imprisonment continue to do so during imprisonment.

The drug most often tried by convicted persons is marijuana or hashish; this had been used at least once in their lifetime before imprisonment by 61% of those convicted. The next most frequently used drugs (or drug groups) in lifetime before imprisonment were amphetamines (41%), sedatives and relaxants (37%), ecstasy (28%), heroin (25%), various opioids (21%) and cocaine (20%).

Drug Markets

Based on the number of methamphetamine seizures and quantities seized, its turnover throughout Latvia has increased. The substance is delivered to Latvian territory from neighbouring countries: Lithuania, Poland, Germany, Belgium, and the Netherlands, while the turnover of amphetamine within the country continues to decrease.

The number of marijuana farms detected has increased, as has the number of seizures and the quantity seized. It is thought that part of the output from the largest farm discovered in 2010 was intended for export to the Scandinavian countries.

Turnover in heroin has remained stable, but a decreasing trend in the market share for cocaine has been identified, as well as the gradual disappearance of the ecstasy group of substances from the market. Several major cocaine seizures in 2010 evidence Latvia's increasing role in the transit of cocaine to Russia.

With improvements in identification capabilities, there has been a significant increase in seizure rates and quantities for the "new" synthetic drugs. Substances from the piperazine, cathinone and synthetic cannabinoid groups are the most commonly found.

The average purity of methamphetamine during the past three years has remained stable at around 30%. The purity of heroin has reduced slightly each year, while the average purity of cocaine in recent years has steadily increased..

Drug related health policies and services in prison

As at 1 January 2011 there were 6780 prisoners in Latvian prisons, of whom 4749 were convicted, and 2031 detainees. At the beginning of 2011 there were 421 women in prison, 88 juveniles and 93 foreign nationals. According to Prison Administration data, during 2010 there were 5330 convicted persons incarcerated, along with 10258 arrested persons, and 5638 convicted persons, while 10227 detainees left prison for various reasons during the year, for example, due to changes in their security arrangements, completion of criminal proceedings, completion of sentence, etc.

According to Latvian Prison Administration data, the majority of prisoners at the end of 2010 (53.9%) were in closed prisons, 29.9% were in pre-trial investigation centres, 12.7% were in partially closed prisons, 2.8% in open prisons and 0.7% in juvenile correctional facilities.

Various preventive measures were taken in 2010 which included lectures and informative campaigns for prisoners, and events of a religious nature. Prisoners were involved in various resocialisation programs (2528 prisoners were involved in the programs, of whom 2097 completed the programs). During 2010, 37 resocialisations were undertaken in prisons (social behaviour corrections (14), social rehabilitations (16) and Christian instructional programs (7)).

Drug users with children

Families in which the parents are drug users are a relatively "hidden" phenomenon and it is virtually impossible to assess their prevalence and effects. Existing data from the Register of Births suggest that approximately 0.1% of new mothers have used drugs during pregnancy. A study carried out in 2008 found that women with treatment episodes (F10-F19) are more likely to be bear stillborn children and their new-born babies are more likely to die within 24 hours of delivery. It is not known what happens to the mother and child after they leave maternity hospitals. Results from Phase V of the cohort study show that approximately 13% of problem drug users live together with their children.

National legislation and regulations are created to protect the rights of the child and to ensure favourable conditions for the child's physical and psychological development. If development is impaired (violence, neglect of the child, etc.) the State has the power to isolate the child from the family, although drug use *per se* is insufficient reason to isolate a child from its family. National policy is aimed at eliminating drug use in the family altogether; hence policy planning documents focus more on prevention issues and the reduction of drug abuse among young people in particular. On the other hand, support groups have been formed for young people or families in which a user can be a child, as well as an adult or parent.

Part A: New Developments and Trends

1. Drug policy: legislation, strategies and economic analysis

1.1. Legal framework

During 2010 changes were made to such important legislative instruments such as the law *On the time and arrangements for coming into force of the Criminal Law*, the law *On Precursors* and others, as well as a number of Cabinet Regulations.

Cabinet Regulations and amendments to Regulations issued in 2010

Last year, new Cabinet Regulations were drafted. Cabinet Regulation No. 319 on *Procedures for Licensing of Pharmaceutical Activities*[1] came into force on 1 April 2010, stipulating the procedure for the issue, suspension, or revocation or re-registration of special licenses for pharmaceutical and veterinary- pharmaceutical operations permitted in relation to drugs, psychotropic substances and precursors controlled in Latvia and included in Schedules II and III in accordance with the law *Procedures for the Lawful Traffic in Drugs and Psychotropic Substances.*

Cabinet Regulation No. 704: *Regulations on border-crossing points and checks to be conducted at them*[2] came into force on 13 August 2010. The Regulation stipulates, inter alia, the border crossing points at which Customs controls are carried out (including Customs controls of movement across the external border of drugs and psychotropic substances, medications and precursors under the supervision of the Ministry of Health).

On 1 October 2010 Cabinet Regulation No. 757 came into force: *Procedures for Writing and Storage of Special Veterinary Prescriptions*[3], which stipulates the procedures for writing and storing special veterinary prescriptions for medications containing controllable drugs, psychotropic substances and precursors and medicinal substances included in Schedules II and III of controllable medications and substances in Latvia. Basically they involve changes in purchasing procedure for medications and substances used in veterinary medicine and which contain drugs, psychotropic substances and precursors included in Schedules II and III of controllable drugs and substances. Until now, such drugs and medications could only be obtained upon request by a practicing veterinarian. Henceforth, these substances and medications will be available to the animal's owner or keeper from pharmacies if a special prescription has been written.

On 29 December 2010 Cabinet Regulation No. 1142 came into force: *Registration and Licensing Procedures for Operators*[4]. The Regulation stipulates registration and licensing procedures for operators participating in the movement of precursors (relevant EU Regulations provide for the need for registration and licensing of precursor operators, but do not stipulate detailed procedures for registration and licensing, so these issues are stipulated in the national legislation).

Laws and amendments to laws adopted in 2010

Amendments to the Law *On the time and arrangements for coming into force of the Criminal Law* were adopted by the Saeima on 21 October 2010 and came into force on 1 January 2011[5], supplementing Schedule 2 with new drugs, the illegal distribution and use of which may be harmful to health, as well as stipulating the quantities below which they are considered negligible, and the quantities regarded as "large" (see Table 1.1).

[1] 2010. gada 1.aprīļa Ministru kabineta noteikumi Nr. 319 „Farmaceitiskās darbības licencēšanas kārtība"
[2] 2010. gada 13 augusta Ministru kabineta noteikumi Nr. 704 „Noteikumi par robežšķērsošanas vietām un tajās veicamajām pārbaudēm"
[3] 2010. gada 1. oktobra Ministru kabineta noteikumi Nr. 757 „Īpašās veterinārās receptes izrakstīšanas un uzglabāšanas kārtība"
[4] 2010. gada 29. decembra Ministru kabineta noteikumi Nr. 1142 „"Operatoru reģistrēšanas un licencēšanas kārtība"
[5] 2010.gada 21.oktobra likums "Grozījumi likumā "Par Krimināllikuma spēkā stāšanās un piemērošanas kārtību""

Table 1.1. 2010 controlled substances and their quantities

	Amount below which quantity regarded as negligible		Amount above which quantity regarded as large	
	dried	undried	dried	undried
CP 47.497 and its homologues C6, C8, C9	1g	100g	5g	1kg
HU-210	1g	100g	5g	1kg
JWH-018	1g	100g	5g	1kg
JWH-073	1g	100g	5g	1kg
JWH-250	1g	100g	5g	1kg
JWH-398	1g	100g	5g	1kg
leonotis leonurus	1g	100g	5g	1kg
nymphaea caerulea	1g	100g	5g	1kg

Source: Law On the time and arrangements for coming into force of the Criminal Law

These changes conform to the Schedules to Cabinet Regulation No.847 of 8 November 2005: *Regulations regarding Narcotic Substances, Psychotropic Substances and Precursors to be controlled in Latvia*. The changes also regulate the work of law enforcement agencies where relevant in determining penalty amounts.

On 1 December 2010 amendments to the law *On Precursors*[6] came into force, which provide for the harmonisation of precursor movement with EC Regulations (Regulation of the European Parliament and of the Council of 11 February 2004, Regulation (EC) No 273/2004 on drug precursors, and of the Council of 22 December 2004, Regulation (EC) No 111/2005 which provides rules for the monitoring of trade in drug precursors between the Community and third countries, etc.). The amendments also clarify the definition of the term "precursors" and stipulate that the terms "trade", "export" and "import" conform to the interpretation of those terms referred to in the said Regulations.

In 2010, two laws came into force regarding cooperation between the Governments of the Republic of Latvia and the Republic of Armenia and the Council of Ministers of the Republic of Albania in the fight against terrorism, organised crime and illegal trafficking in narcotic substances, psychotropic substances and precursors, and other criminal offences. The laws came into force on 27 May 2010 and 23 June 2010 respectively.

[6] 2010.gada 1.decembra likums "Grozījumi likumā "Par prekursoriem"'

1.2 National action plan, strategy, evaluation and coordination

National action plan and strategy

On 14 March 2011, the Cabinet of Ministers approved the new *Drug Program for 2011-2017*.

The Drug Program for 2011- 2017 is a medium-term policy-planning document, developed in accordance with Regulation No. 1178: *Regulation for development of planning documents and impact assessment, and the Latvian Strategic Development Plan 2010-2013*. They include measures aimed at ensuring the continuation of the planned implementation of national policies for the reduction and control of trafficking and dependence on drugs.

The Program is aimed at reducing the availability of illicit drugs, acceptability of their use in society and reducing the harm suffered by the community, by improving the availability and effectiveness of health services offered to drug users.

Taken into account in developing the Program were the evaluation results and recommendations for the previous National Drug Programme 2005–2008, as well as proposals from social organizations and institutions responsible for the development and implementation of the Program, and their experts.

Three main lines of action are put forward for achieving the objectives defined in the Drug Program for 2011-2017: 1) prevention of drug addiction and drug use, 2) health care of drug users and drug addicts and 3) reduction of drug availability. These action lines include measures for which the coordination and monitoring of implementation is proposed by means of interdisciplinary action-policy coordination and information gathering and analysis.

The authorities stipulated as having responsibility for implementation of tasks set in the Drug Program are the Ministry of Defence, the Ministry of Finance, the Ministry of Education and Science, Ministry of the Interior, the Ministry of Welfare, the Ministry of Justice and the Ministry of Health. The institution responsible for monitoring performance under the Drug Program is the Ministry of the Interior.

The authorities stipulated as having responsibility for implementation of tasks set by the Drug Program are to be funded from the State budget. If the responsible authorities are unable to complete a task from State budget funding, the issue of supplementary funding is to be reviewed in 2013 and in subsequent years, together with the medium-term budgetary priority submissions from all Ministries.

It is anticipated that the results of implementation of tasks set by the Drug Program will be evaluated twice, namely in the central phase of operation of the Drug Program and at their completion. Consequently, the authorities stipulated as having responsibility for implementation of tasks set by the Drug Program must provide information on the performance and results of the tasks to the Ministry of the Interior by 1 April 2014 and 1 March 2018[7].

Implementation and evaluation of national action plan and strategy

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

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

[7] For more information see also SQ32_Drug policy, evaluation and coordination

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

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

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

Coordination arrangements

The Council is the coordinating State body whose primary role is to coordinate the operations of government agencies, municipalities and non-governmental organizations in controlling the legal movement of drugs and precursors, and in preventing and restricting their illegal circulation, and addiction to drugs. The Council is also responsible for development, implementation and evaluation of the National Drug Programme 2011- 2017. Council sittings are convened two times a year.

1.3 Economic analysis

Public expenditures

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

Social costs

In 2009, the study on budget and non-budget social costs of drug abuse in Latvia was carried out (BICEPS 2010). The aim of this study was to provide an estimate of the social costs of illegal drug use in Latvia for 2008. International practice e.g. as outlined in the International Guidelines for Estimating the Costs of Substance Abuse, produced by the World Health Organization (Single et al. 2003) divides costs according to several criteria: tangible/intangible; health and welfare/productivity and output loss; law enforcement and criminal justice costs. In this study, there are two basic distinctions: budget cost and non-budget costs. Budget costs are further subdivided

into direct budgetary costs and indirect ones. By definition budget costs are *tangible* costs i.e. resources used directly or indirectly in connection with drug abuse that could have been used for something else i.e. consumption or investment. Non-budget costs however may be tangible or intangible, where *intangible* means something that cannot be transferred e.g. the reduction of pain and suffering that lower use of drugs might generate cannot be translated into resources available to society for other uses.

Main results

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

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

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

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

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

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

The prevalence of drug use among the general population is one of the five key epidemiological indicators in the work of the EMCDDA. It reflects the prevalence of drug use among 15-64 year old population. This indicator incorporates the results of regular representative population surveys carried out using the range of questions approved by EU experts (European Model Questionnaire, EMQ) which has been extended to include questions of interest to Member States.

The most recent changes in development of the indicator, at both the national and international level, include the need to acquire extra information on intensive habits of drug use and drug availability. Similarly, in recent years, the question of statistical reliability of the data obtained has been raised increasingly often among researchers due to an increasing level of non-response, as well as the need to carry out methodological studies using new methods of data collection, such as conducting surveys via the internet, and possibilities for their generalisation.

Drug prevalence indicators, as well as the availability of drugs and inhabitants' general attitude to drug policy issues were widely considered in the 2008 National Report, as well as in a research report (Pugule et al. 2008; Koroļeva et al. 2008), and so this Chapter offers only a brief summary of illegal drug use prevalence indicators.

Preparations began in 2010 for the fifth stage of the European School Survey Project on Alcohol and Other Drugs (ESPAD) and the study to be carried out in 2011, as part of which more than seven thousand students from grades 8-10 were surveyed in 2011. The information acquired from the study will provide insight for policy makers and other professionals on the prevalence of legal and illegal drugs and changes in prevalence since the 2007 nation-wide representative survey of students.

As part of the ESPAD project a methodological study was also undertaken in 2011, aiming to clarify the differences between the responses according to the method of filling in the questionnaire. Accordingly, students from 40 classes completed the questionnaire using the *split-half* method in the traditional way (paper questionnaire) and also by means of a web survey. The survey results will be available in late 2011, and will provide information on the possibilities for implementing computerised school-based surveys in the future, and the extent to which results may be influenced by the method used to complete the questionnaire form.

In the new Drug Program for 2011–2017, several measurements of drug use prevalence and availability included in the ESPAD survey were included as policy performance indicators that will permit evaluation of Drug Program task performance in 2011–2017.

In the autumn semester of 2010 the third stage of a study was undertaken among students in Riga as part of the *European Cities against Drugs* initiative (Koroļeva et al. 2011). The aim of the study is to collect data on the prevalence of use of addictive substances and the risk and protective factors in using and trying them. This study was undertaken among students from grades 9-10 in Riga in 2006 and 2008[8] and its results are used in the planning of prevention services and performance evaluation in the City of Riga.

In 2010, a study of student health behaviour was undertaken in Latvia. This was the fifth such study to be undertaken in Latvia. This study is part of an international comparison study coordinated by the WHO on *Health Behaviour among School-aged Children (HBSC)*. The student questionnaire included traditional questions on the prevalence of use of the most commonly used drug (cannabis), during the lifetime, the last 12 months and the last 30 days. This section gives a brief overview of the 2010 survey results.

[8] The 2008 study also included Jurmala and Cēsīs.

2.1. Drug use in the general population

Latvia has so far conducted two large-scale representative surveys, which facilitate determination of the prevalence of drug use among the general population. These surveys were undertaken among residents aged 15–64 and carried out in accordance with the EMCDDA recommended methodology for Member States, thus to a large extent allowing comparison of the results obtained in Latvia to the situation in other EU Member States. In accordance with these methods, the survey included questions about substance use measured in three periods: during lifetime, during past year and during past month. In addition to questions about the prevalence of use for various substances, the range of issues being studied also included questions on personal attitudes and values, drug availability, etc. (EMCDDA 2002).

The first large-scale survey took place in 2003, while the other survey using comparable methodology was carried out in 2007. The survey target sample size exceeded 4500 respondents (4534 in 2003 and 4500 respondents in 2007), which permitted the measurement of prevalence for even relatively small phenomena among the population with a sufficiently high level of accuracy. The two research reports are published as separate reports and are available in both printed and electronic format (Koroļeva et al. 2003; Koroļeva, Goldmanis et al. 2008).

This section outlines below the main prevalence indicators for using any form of illegal drugs[9] in the mainstream age and gender groups, comparing the 2003 and the 2007 study results. (See Tables 2.1.and 2.2.).

The results of both surveys indicate that in comparing 2007 with 2003, there is a significant increase in indicators relating to trying drugs and recent use (within the past year) among the population in all age and gender groups. The most frequently tried and use substance among the general population is marijuana or hashish, followed by ecstasy and the amphetamines. Drugs were mostly used by juveniles and young adults. Urbanization has great significance in drug use or experimentation, i.e. more people had tried drugs in Riga and the other cities, but these differences, although statistically significant, have reduced compared to 2003 (Koroļeva, Goldmanis et al. 2008).

Table 2.1. Use of any illegal drugs, during lifetime, last year and last month in the 2003 and 2007 studies (%)

		Lifetime	Last 12 months	Last 30 days
15–64	2007	16,1	6,1	2,2
	2003	12,3	4,6	2,2
15–34	2007	27,9	11,9	4,2
	2003	21,9	9,7	4,7
35–64	2007	6,8	1,6	0,7
	2003	5,3	0,9	0,5
Males	2007	22,8	9,2	3,8
	2003	19,9	7,7	3,9
Female	2007	9,8	3,2	0,8
	2003	6,4	2,2	0,9

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

[9] Marijuana/hashish, ecstasy (MDMA), amphetamines, cocaine, heroin and/or other opioids, LSD and/or other hallucinogens

Table 2.2. Prevalence of various illegal drugs used during lifetime, by gender and age in 2007 (%)

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

Source: Koroļeva, Goldmanis et al. 2008

Data from the HBSC study

In 2010, a study of student health habits was undertaken in Latvia. This was the fifth such study to be undertaken in Latvia. This study is part of an international comparison study coordinated by the WHO on Health Behaviour among School-aged Children (HBSC). The study is undertaken every four years and includes students from three age groups (students aged 11, 13 and 15). The student questionnaire traditionally includes questions on the prevalence of use of the most commonly used illicit substance (cannabis), during the lifetime, the past year and the past month. In the 2010 survey, these questions were asked to 1312 students from grade 9.

According to the study results marijuana/hashish had been tried at least once during their lifetime by about every fourth (25.2%) grade 9 student (approximately 15 years old). The proportion of boys trying marijuana/hashish is higher than among girls, 29.6% and 22.3% respectively.

The study results show that marijuana/hashish had been tried relatively recently or within the last 12 months by 18.0% of gade 9 students, while 8.7% of juveniles had used it during the past month. A similar result was indicated for using cannabis, with more boys than girls indicating its use during the past year, and past month *(see Table 2.3)*.

Table 2.3. Prevalence of cannabis use among grade 9 students in Latvia, %

	Boys	Girls	Total
Lifetime	29.6	21.3	25.2
During past 12 months	22.0	14.5	18.0
During past 30 days	13.4	4.7	8.7

Source: Unpublished HBSC data 2011

2.2. Drug Use in the school and youth population

Risk and protective factors study

In 2010 in Riga, a study was conducted among students from grades 9 and 10 on risk and protective factors (Koroļeva, Mieriņa et al. 2010) associated with commencing the use of addictive substances. This study repeats the 2006 and 2008 studies in Riga, which were undertaken as part of the initiative of the European Cities against Drugs (ECAD) initiative. The study in Riga was funded by the municipality and implemented by researchers from the Institute of Sociological Research.

This section considers only the main prevalence indicators for illegal substance use among juveniles aged 15-16, while detailed analysis of risk and protective factors can be found in research publications. Sample size and methodology are described in Fonte ST30,[10] as well as technical reports on studies undertaken.

The target group of the 2010 study was students aged 15-16 in Riga. So that the study results would be comparable to the 2006 and 2008 data, the survey was carried out on students from grades 9 and 10. A total of 2820 student questionnaires were deemed valid in the 2010 survey and included for data analysis.

The questionnaire included questions about many of the best-known addictive substances, marijuana/hashish, amphetamines, LSD, ecstasy, cocaine, heroin and "magic" mushrooms, as well as substances that are not illegal per se, but can be used for the purposes of intoxication, e.g. medications, inhalants, and anabolic steroids. The 2010 survey questionnaire was supplemented with questions to ascertain the prevalence of use of the most popular illegal substances, marijuana/hashish, amphetamines and ecstasy, not only during lifetime, but also within the past year and the past month. In addition the questionnaire also included an open question on experimental experience with substances not listed in the questionnaire.

Results

The most commonly used illegal substance among school students in Riga is marijuana or hashish, which had been used by 23% of grade 9-10 students. As in the 2006 and 2008 ESPAD studies, a higher prevalence was observed among Year 10 students compared to those in Year 9 (28% and 18% respectively), as well as among boys compared to girls (30% and 16%). The highest proportion of students trying marijuana/hashish is among boys in grade 10 (39%), while the lowest is among girls in grade 9 (13%).

Compared to the 2008 study results, it is evident that in 2010, the proportion of grade 9 and 10 students trying marijuana/hashish in Riga has remained virtually unchanged, but has increased significantly compared to the results of the 2006 study. The proportion of students trying this substance in 2006 and in 2008 was 18 and 22 per cent respectively

Youth most often indicated that they had tried cannabis only once or twice; this response was provided by approximately every third student (37%), who had tried this substance. 22% who have tried cannabis on 3–5 occasions, 10% on 6–9 occasions, 11% on 10–19 occasions, 7% on 20–39 occasions, while 13% had used it more than 40 times during their lifetime. Boys, as well as students in Grade 10 had used cannabis on more occasions than girls and grade 9 students *(see Figure 2.1)*.

As evidenced in the earlier stages of the study and the ESPAD study, the amphetamine-type stimulants: amphetamines and ecstasy (MDMA) are the next most popular illegal substances among youth after marijuana/hashish (Koroļeva, Trapencieris 2005; Koroļeva et al. 2009). 4.7% of grade 9 and 10 students in Riga had used ecstasy during their lifetime, while 3.8% had used amphetamines. During the past year 3.0% and 2.7% respectively of juveniles aged 15-16 had used them, while 1.7% had done so during the past month.

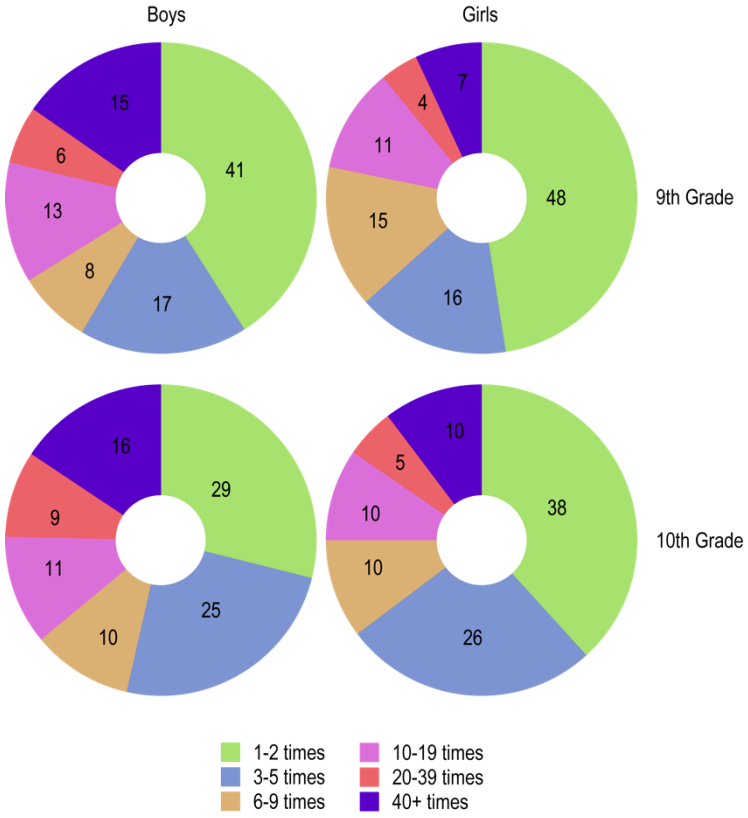
3.8% indicated that they had tried hallucinogenic mushrooms at least once during their lifetime, 2.9% had tried cocaine, 2.7% had tried LSD, and 1.5% noted that they had tried heroin at least once during their lifetime *(see Table 2.4)*.

Illegal substances that can be used for the purpose of intoxication, such as tranquillisers and sleeping pills without a medical prescription had been used by 9.5%; 13.9% had used inhalants, while 2.0% of students from grades 9 and 10 had tried anabolic steroids.

Other substances more often used during their lifetime are the so-called *Spice* products (referred to by 21 students), dexofan (9) and salvia (6).

[10] ST30_2011_LV_01; ST30_2009_LV_01; ST30_2009_LV_02; ST30_2009_LV_03

Figure 2.1. Number of times cannabis used during lifetime, % of those trying cannabis



Source: Koroļeva, Mieriņa, Sniķere, Trapencieris 2010

In analysing juvenile drug use experience, statistically significant differences are observed in the use/experimentation of all substances depending on respondent's gender, and class grade; boys compared to girls, and that grade 10 students had tried some of the MIN group of substances (medications, inhalants, illegal substances) more often in comparison to grade 9 students.

Table 2.4. Drugs tried by students, %

	2006			2008			2010		
	M	F	T	M	F	T	M	F	T
Marijuana/ hashish	26	11	18	27	17	22	29.7	16.2	22.7
Inhalants	6	2	4	5..4	5.0	5.2	12.0	15.7	13.9
Tranquilisers, sleeping pills	9	10	10	5.1	10.8	8.2	6.4	12.4	9.5
Ecstasy	8	5	6	4.7	5.1	4.9	5.0	4.4	4.7
Amphetamines	7	4	6	4.2	4.2	4.2	3.8	3.7	3.8
Mushrooms[11]	n.a	n.a	n.a	4.9	1.8	3.1	5.2	2.6	3.8
Cocaine	6	1	3	2.1	2.1	2.1	3.7	2.1	2.9
LSD	5	2	4	2.6	1.8	2.1	3.2	2.2	2.7
Anabolic steroids	6	3	4	2.6	0.8	1.6	3.3	0.8	2.0
Heroin	5	1	3	1.3	0.4	0.8	2.3	0.8	1.5

Source: Koroļeva, Mieriņa, Sniķere, Trapencieris 2010

[11] Due to a technical problem, the study results for 2006 and 2008 on use of hallucinogenic mushrooms are not comparable and are thus not included in the table.

2.3. Drug use among targeted groups

The European MSM Internet Survey (EMIS)

In 2010, an Internet study funded by the European Commission was implemented in Latvia on men who have sex with men (MSM) (EMIS – The European MSM Internet Survey). The study was conducted in a total of 38 countries (in 25 languages), interviewing more than 180 thousand members of target groups over the Internet. In Latvia the study was carried out during the period June - August 2010 and the sample size achieved was 708 men who have sex with men (MSM). The survey questionnaire included 278 questions, including socio-economic indicators, questions about testing for HIV and STIs, condom use, use of various drugs, knowledge about STI's, experience of violence, satisfaction with own sexuality, etc.[12]

A small insight into drug use prevalence rates among MSM in Latvia is provided below. The age breakdown of respondents in the Latvian study is as follows: 26.1% were under the age of 25 years, 37.6% were aged 25-34 years and 36.3% were older than 34 years (median age of 30 years).

The drugs most commonly used by the interviewed MSM are the so-called poppers[13] and marijuana or hashish, which have been tried during their lifetime by 28.1% and 27.9% of respondents respectively. A relatively large number of respondents (17.5%) indicated having used sedatives or tranquillisers at least once during their lifetime. The next most popular drugs used by MSM during their lifetime were amphetamines (11.7%), cocaine (8.9%) and ecstasy (8.3%). The proportion trying other substances, although higher than among the population of the same age group, did not exceed five per cent, and is reflected in Table 2.5. (See also the section in Table 2.2 on drug use among the general population).

According to the study data, drugs had most commonly been tried by MSM aged 25-34 years as compared to respondents in other age groups.

Of those MSM polled who had tried any illegal drug, 47% had used only a single drug; 22% had used two drugs; 13% had used three drugs, while 19% had used four or more illegal drugs during their lifetime

During the past 12 months approximately every eighth (14.8%) respondent had used one illegal drug. Similarly, to the drugs-tried indicator, during the past year respondents had most frequently used the so-called poppers (15.5%). Slightly fewer respondents (13.7%) had used marijuana or hashish last year, while stimulants (amphetamines, cocaine and Ecstasy) had been used by 4.3%, 3.8% and 3.5% respectively. Other drugs were used during the past year by less than two per cent of respondents. A similar situation to the "used during lifetime" was also observed in the breakdown by age: higher usage prevalence rates were observed in 25-34-year old respondents; the rate was slightly lower in the youngest age group, while the lowest was among MSM aged 35 years and older.

During the past month, 4.5% had used poppers and 4.2% had used cannabis.

Various drugs (ecstasy, amphetamines, mephedrone, GHB, ketamine, and cocaine, which are usually associated with sex and recreation), were used at least once last year by 7.1%, while 3.3% had used them during the past month.

[12] A detailed description of the methodology and its results can be found on the project website http://www.emis-project.eu/.
[13] “poppers” or inhalants containing nitrites.

Table 2.5. Prevalence of various illegal drugs used during lifetime by MSM, by age (%)

	Aged 15-64	Younger than 24	Aged 25–34	Aged 35 and older
Any illegal substances[14]	29.9	29.1	41.3	18.8
So-called "recreational drugs"[15]	18.0	17.9	25.0	10.8
Poppers	28.1	19.8	32.2	29.7
Marijuana/hashish	27.9	25.7	40.0	17.1
Sedatives and tranquillizers	17.5	10.7	16.6	23.1
Amphetamine	11.7	11.7	18.5	4.8
Cocaine	8.9	6.1	12.8	6.8
Ecstasy	8.3	8.9	13.6	5.2
LSD	4.1	3.4	5.0	3.4
Methamphetamine	3.8	5.0	5.4	1.2
GHB (sodium oxybutyrate)	1.9	0.6	3.5	1.2
Ketamine	1.9	2.7	3.5	0.4
Crack	1.0	1.1	1.2	0.2
Heroin or other opiates	1.0	1.1	1.2	0.8
Mephedrone	0.7	0.6	0.8	0.8

Source: EMIS 2010

[14] Marijuana/hashish, amphetamine, cocaine, ecstasy, LSD, methamphetamine, GHB, ketamine, crack, heroin/other opiates or mephedrone

[15] ecstasy, amphetamine, methamphetamine, mephedrone, GHB, ketamine, cocaine

3. Prevention

In 2010 the Ministry of Health developed draft *Public Health Program for 2011-2*017 and submitted it to the Cabinet of Ministers for approval. The new Program was approved on 27 September 2011. *The Public Health Program for 2011-2017* represent the next stage of targeted implementation of the public health policy and the continuation of the previous *Public Health Strategy and its Action Programme for 2004-2010*. Defined as one of the sub-objectives of the Public Health Program for 2011-2017 is the reduction of morbidity and mortality from non-communicable diseases, by reducing the negative health effects of risk factors (dietary habits, insufficient exercise and unhealthy habits). The prevention of drugs is one of the target lines of action.

On 14 March 2011 the Cabinet of Ministers approved the new *Drug Program for 2011-2017*. The prevention of dependence and use of drugs has been identified as one of the four main pillars for achieving the objectives of the Program.

Highlighted as a specific problem within the *Drug Program for 2011-2017* is the lack of a mechanism and co-financing guaranteed by the state, thus hampering public organizations dealing with the prevention of HIV, including drug prevention, in attracting financial grants from the EU, and applying for other international projects. Despite financial problems, the role of NGOs in drug prevention must be noted. District municipalities actively involve professionals working in public organizations in undertaking informative educational activities.

Having regard to the circumstances of the Latvian financial crisis, the number of employees of state institutions whose working duties were directly related to the prevention of drug addiction continued to decline again nationally in 2010, a fact which significantly affected the scope and quality of prevention activities.

Activities in the drugs field are integrated into broader health promotion activities and are carried out in a decentralized manner, i.e. each municipality undertakes preventive work within the constraints of its own capacity and funding. In most cases, prevention activities are aimed at the dissemination of information.

In 2010 several awareness campaigns were undertaken nationally, mainly in the field of legal drugs (tobacco, alcohol). Selective prevention is insufficiently utilised In the Latvian districts, other than Riga. Nationally, indicated prevention measures are practically never undertaken, national prevention guidelines (standards, quality criteria) have not been developed, and program accreditation has not been undertaken. Only in rare cases is evaluation of the effectiveness of prevention interventions undertaken. This situation is explained by the lack of funding and capacity.

Data collection methods

Information on specific activities, in accordance with the classification of prevention implementation, is obtained primarily from government institutions which are directly or indirectly involved in prevention, secondly, from NGO reports; thirdly, from information published in the mass media and on the websites of information institutions.

To clarify the situation for drugs prevention in municipalities, in early 2011 experts from the Reitox NFP sent survey questionnaires to 109 municipalities and nine major cities. At the end of the survey, 39 questionnaires had been received, with four from the major municipalities and 35 from the other municipalities.

3.1. Universal prevention

The Ministry of Education and Science has drafted Regulations, approved by the Cabinet of Ministers, on national standards and curricula in primary education and secondary education. Within the framework of primary education curriculum reform, a new integrated subject has been introduced: "Social Science" (Grades 1-9). The content of the new Social Science subject also includes health education issues. Health-related issues are included in various subjects such as biology, chemistry, home economics, sports, physics, etc., and this enables students to acquire

knowledge, skills and abilities in matters of physical and mental safety, healthy lifestyles, stress and its management, types of addiction and co-dependency issues, growth, development and relationships (Velša 2005). To reinforce the acquired knowledge and skills, health topics are also discussed with students on a daily basis – in home class lessons and thematic events.

In 2010 the Ministry of Education and Science continued to introduce general secondary education standards and curricular standards, which also include the subject "Health Education". The "Health Education" subject aims to promote and implement the student's readiness to make decisions beneficial to their own physical, mental and social health and that of their peers. In the 2011-2012 school year, the learning process in all secondary school grade levels is organized in accordance with the new standard. Unlike the previous curricular standard, the new curriculum emphasizes the role of personality in decision-making; the social aspect of health and content issues are addressed in a close real-life context.

An approach to universal prevention still popular in Latvian schools (school-based intervention) is the engagement of various specialists: doctors, police officers, local government health promotion officers, and NGO representatives to hold discussions and lectures in home group classes. In 2010 many schools cooperated more frequently with NGOs to provide informative educational activities. Schools organized the *No Tobacco Day* and *International AIDS Day* events, which included drawing competitions, exhibitions, quizzes, etc. and other educational activities.

Informative lectures for parents on recognising drug use and the strengthening of mutual relationships within the family are organised regularly as part of school-based intervention.

Youth leader training programs continue to enjoy popularity, even though scientific evidence on the effectiveness of programs involving students in educating their peers is inconclusive (Sharp 1994).

The Riga City Council has implemented youth leadership training, in accordance with the established programs *Drug prevention education programs for training young people-peer educators* "*Guru: without prejudice*" (a training program of 26 hours over 10 classes). Similar training has been organized by other regional municipalities.

A major role in implementing prevention in schools is played by the teachers' knowledge, skills and interactive abilities in addressing addiction prevention issues. The improvement of knowledge, skills and abilities of teachers is undertaken by the Ministry of Education and Science, specialists of the Riga City Council, and health promotion coordinators from the Ministry of Health.

The association *Be Free* has been actively involved in educating teachers and in early 2011 launched a project *Video Stories 'Be free'*, which aims to improve the situation in the field of addiction prevention, by developing innovative methodological material for the education of younger school-age children. The development of this material involved 200 children and teachers, as well as young people who have had problems associated with drug use.

The development of alternative leisure opportunities is governed by policy planning documents: the *Youth Law* and the program *A Latvia fit for Children*. Enjoying popularity in Latvia are alternative extracurricular activities (sports, choir, drama groups, dancing, art groups, etc.) that are organized at school and serve as elements of addiction prevention. To help ensure a safe environment within the school, internal compliance audits are conducted, as well as the installation of CCTV, the provision of security services, and instructions for action to be taken following the discovery of drug use, distribution, or acquisition. Monitoring by local police authorities is provided in many schools in the major cities.

The bases of community-based prevention within municipalities are plans developed within the municipalities to restrict the prevalence of drugs. Some municipalities note that meetings of coordination groups are held regularly, attended by representatives from municipal administrations, education, social services, medical, law enforcement agencies and NGOs.

Municipalities in their questionnaire responses identify a popular form of action as being the organisation of campaign-like events in local municipalities: activities dedicated to *International Anti-Drug Day*, *International AIDS Day*, *WHO Tobacco-Free Day*, and exhibitions in libraries.

Other alternative measures are also used in the work of addiction prevention: nature camps, family sports day, etc. Municipalities actively promote leisure facilities such as youth centres, youth clubs, sports, music and art schools (outside the school environment).

3.2. Selective prevention in at-risks groups and settings

The new Drug Program for 2011-2017 notes that nationally, selective prevention measures are not being implemented to a sufficient extent, and that they are formal, and do not achieve the planned objective, particularly in leisure venues. *The Drug Program Action Plan* includes a number of prevention measures to be implemented at the national level, such as work with correctional institutions, students at orphanages and boarding schools, the development of an action plan to prevent drug use in leisure venues, based on cooperation between the public and private sectors, etc. Problems for risk groups in developing alternative leisure initiatives are highlighted in the *Program on Prevention of Juvenile Crime and Protection of Juveniles against Criminal Offences for the years 2009-2011.*

Selective prevention in schools

In analysing selective prevention measures in schools, it should be noted that these are based on individual work with students who miss school, who are kept back for a second year or who have socially disadvantaged living environments. According to a report published by the EACEA (EACEA 2011)[16], almost 11% of students in Latvia repeat a second year. In most European countries the practice of having students repeat a year has not been justified. Studies show that the long-term results of students required to repeat a school year are worse than those in whose education this method was not applied, so education experts and educators are invited to assess the effectiveness of this method of improving performance. Working with these children in Latvian schools are social work educators, psychologists and special educators, in cooperation with parents. It should be noted that due to the financial crisis, not all municipalities provide the work of such teacher support persons.

Selective prevention in municipalities

Selective prevention in regional districts and cities is implemented through the social services network, by organising consultations with individuals within individual risk groups. In Riga, a permanent psychosocial adjustment program is available, developed for "at risk" adolescents who have a tendency to violate rules of conduct. In some municipalities special bodies have been established within youth centres and some crisis centres to address these issues.

Significant work in drug addiction prevention is undertaken by the HIV prevention points, which, in addition to activities to reduce drug harm, visit educational institutions, implement various awareness campaigns, increase both the youth and drug users' knowledge of the dangers of drugs, HIV prevention, opportunities for obtaining assistance, etc. Many municipalities have assessed the work of the centres and endeavour to support them financially (The Drug Program for 2011-2017).

Selective approach to working with parents

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

[16] Publication available at: http://eacea.ec.europa.eu/education/eurydice/documents/thematic_reports/126EN.pdf

Selective approach in working with visitors to entertainment venues

A selective approach to working with persons attending leisure venues is generally limited to law enforcement raids at clubs and outdoor festivals. In some municipalities special campaigns are organized in cooperation with the venue administration e.g. *Stop AIDS!* and *No - to drugs!*, where visitors receive informative materials, individual consultations are organized, and quizzes and other activities take place.

3.3. Indicated prevention

2010 did not see an increase in indicated prevention coverage nationally. The development of indicated prevention is being hampered by funding models for treatment and prevention, in that the state pays for treatment, but the funding source for prevention for the most part is the municipalities, so all the *early intervention* programs in Latvia are treated as "treatment". Features of indicative prevention have been identified in children's support group programs, which operate in some addiction treatment facilities, but in this case, the children are diagnosed according to the ICD-10 classification.

3.4. National and local media campaigns

In 2010 the State Police in cooperation with the Latvian Association of Addiction Psychologists began implementation of the two-year project *Youth against Drugs*, with support from the European Union program *Prevention and Fight against Crime 2009*, which aims to reduce drug distribution and use among young people, as well as to educate young people about drugs and the physical and emotional consequences of drug use, and the legal liability attaching to the possession, distribution and use of drugs. The project is aimed at young people aged 16 to 21 years. EU Project funding of EUR 419 962 has been allocated to the project.

Project activities include: research, a public campaign in the media, the development of informative materials, the organisation of five regional simulation games and one finals game, the compilation of results obtained from the project and the distribution of prepared visual material to young people throughout Latvia.

One of the most important project activities is the organisation of a public campaign in the media: *You use drugs, drugs use you*, with TV spots, radio spots, outdoor advertising, film clips, online activities, skate park activities, etc. A special website was created: http://www.sargi-sevi.lv/.

4. Problem Drug Use

According to the EMCDDA definition, Problem Drug Use (PDU) includes the regular use of heroin and other opiates, cocaine and/or amphetamines and/or drug use by injection. This is one of the five EMCDDA key epidemiological indicators and as the indicators used in data mining methods are implicit, the quality of estimates is directly related to data acquired from other indicators, such as the treatment demand indicator data or data on infectious diseases associated with drug use, etc.

4.1. Prevelence and incidence estimates of PDU

Indirect estimates of problem drug users

Having regard to the nature of the data available, indirect estimates of problem drug use are mostly carried out using treatment, police and mortality multiplier methods, which is one of the EMCDDA's recommended methods for estimating the number of drug users. Two types of data are required to use the multiplier method:

1) in a data source, the number of drug users captured, for example, the number of drug users treated, or "captured" by the police during the year,

2) the established proportion of drug users who have indicated that within a specified time period, e.g. during a year, they had sought assistance (or had been captured) in a data source for which information had been obtained. This information may generally be ascertained from research among problem drug users.

The most important deficiency of the multiplier method is the fact that this method does not allow determination of the limits of calculation error confidence interval that may arise ether from not including the data on individuals in the data source being studied; or the proportion of drug users identified in the study as seeking treatment from a relevant service provider is not accurate, etc. Elsewhere in Europe the *capture-recapture* method of calculation is used, which provides error limits for the estimated number of drug users. This method provides for the combining of a number of data sources with the same identifier, for example consisting of gender, initials and date of birth, thus seeking overlays across three or more data sources and using log linear regression methods, a reliable mathematical model reflecting the data may be determined. The use of this method has been attempted on several occasions in Latvia, but in most cases it has not been possible to estimate the number of problem drug users.

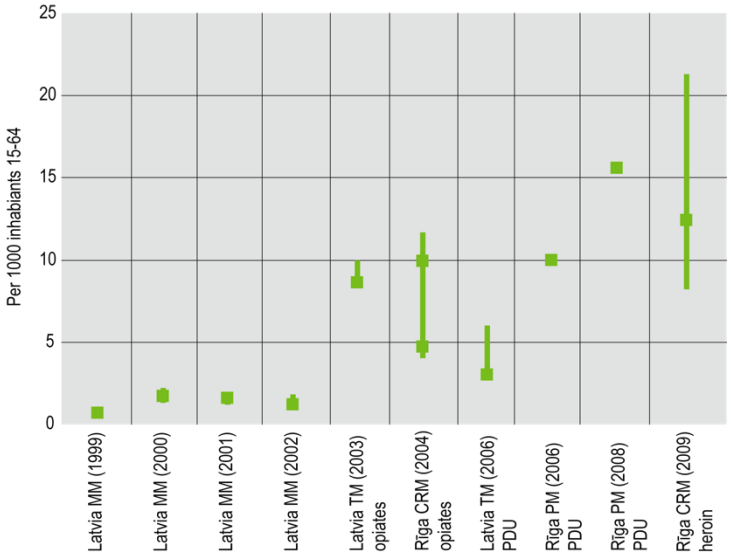
Figure 4.1 shows estimates of the number of drug users previously undertaken in Latvia and the methods used as described in the 2010 National Report (Centre of Health Economics 2010).

2011 saw the continuation of work undertaken in previous years by specialists of the Centre of Health Economics on improving quality[17] of treatment data, to enable the number of drug users treated during the year to be ascertained with greater accuracy, thus providing the possibility of making more accurate estimates of the number of drug users. Using the treatment multiplier method, the number of drug users in Latvia in 2010 was estimated as per the following groups:

- problem drug users[18]
- heroin and other opioid users[19]
- (meth) amphetamine users[20].

[17] See 2010 National Report and Chapter 5 therein
[18] ST7_2011_LV_01
[19] ST7_2011_LV_03
[20] ST7_2011_LV_02

Figure 4.1. Number of problem drug users as estimated by various methods in Latvia, per 1000 population aged 15-64



Source: Trapencieris 2010

The number of unique drug users treated during 2010, was determined using three databases: 1) PREDA, 2) the Health Payment Centre database APANS and 3) the Health Payment Centre database SPANS. In total, 2044 problem drug users were identified in the treatment databases,[21] who had received assistance as outpatients or inpatients in 2010. Used as the multiplier was the proportion of drug users who had sought drug assistance (10.8%[22]) obtained from the 2010 Cohort Study stage (Trapencieris, Snikere, Kaupe 2011) The number of problem opioid and amphetamines users in Latvia was estimated separately, as was the estimated number of problem drug users in three age groups (15-24 years, 25-34 years and 35 years and older).

The estimates show that in Latvia in 2010 there were about 18 888 problem drug users, of whom 10 169 were users of heroin or other opioids and 6 540 were problem users of amphetamine.

According to these estimates, the majority of problem drug users are aged between 15-24, slightly fewer (6995) are aged 25-34 years, and relatively fewer (4214) are aged 35 years or older *(See Table 4.1.)*.

The data show that amphetamine users are significantly younger drug users, while opioid users are aged 25-34.

Table 4.1. Estimated number of problem drug users in 2010, in absolute numbers and by relevant age group per 1000 population

	Total		Opioid users		Amphetamine users	
	Number	Per 1000 pop.	Number	Per 1000 pop.	Number	Per 1000 pop.
Total (15-64 years)	18888	12.3	10169	6.6	6540	4.3
15–24 years	7679	24.8	3530	11.4	3749	12.1
25–34 years	6995	21.2	4290	13.0	1644	5.0
35–64 years	4214	4.7	2349	2.6	1147	1.3

Source: Centre of Health Economics 2011

[21] Selected for the PREDA database are those drug users for whom at least one treatment episode was recorded in the APANS database in 2010 and for whom the primary substance used was indicated as heroin, methadone or other opioids, cocaine, amphetamines or other stimulants. Selected for the APANS database were those drug users with diagnoses of F11, F14 or F15 and they were not included in the PREDA database. Selected for the SPANS database were drug users with diagnoses of F11, F14 and F15. Multiple substance users (ICD-10 diagnosis F19) are not included in this total because it was not possible to determine whether they met the definition of problem drug users.

[22] 14.2% of opiate users and 8.5% of amphetamine users

The major shortcoming of these estimates is that the method used does not allow the calculation of confidence intervals, and therefore the reliability of estimates is to a large extent subject to quality of treatment data and information established during the study.

4.2. Data on PDUs from non-treatment sources

Cohort study of drug users in Riga

The cohort study of drug users in Riga has been undertaken five times since 2006. This study is longitudinal and as part of it and to the extent possible the same drug users are interviewed each year. Interviews with cohort participants are conducted by specially trained street and social workers from the DIA+LOGS society. The biggest advantage of this kind of research is the opportunity to evaluate various changes within the cohort, for example, in morbidity or incidence rates since the previous study phase, changes in the use of drugs, including discontinuing drug use, and mortality. The study methodology is described in detail in the previous study reports and the annual National Reports (Trapencieris, Snikere, Kaupe 2011; Centre of Health Economics 2010; Public Health Agency 2008).

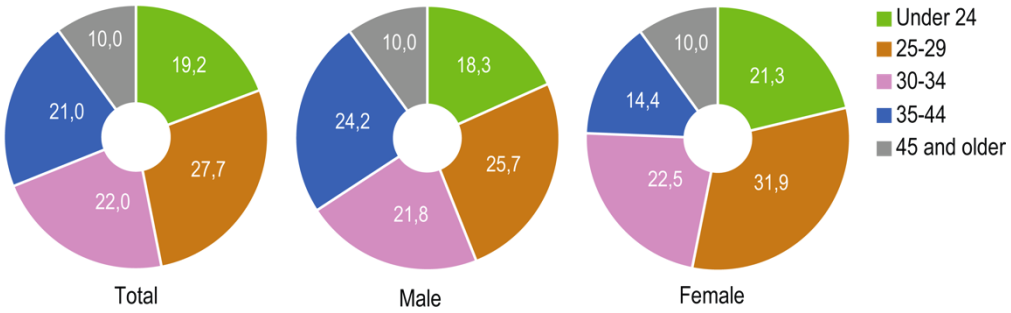
A total of 1309 daily problematic injecting drug users has participated in the five phases of the study, of which 57 have participated in all five phases of the study, 179 in four phases, 271 in three stages, 267 in two stages, and 578 have only participated once. A significant proportion (n=124) of the one-time interviewed drug users were not re-interviewed, as the cities which initially participated in the cohort study have for various reasons no longer participated in subsequent study phases. 2010 survey data shows that since the becoming involved in the cohort study. 12 drug users have died, 47 have been imprisoned, 17 have moved elsewhere in Latvia, 13 have moved abroad, 13 no longer wish to participate in the survey, while information is missing for a significant proportion of drug users (n=558) recruited in at least one phase of the study. It is possible that some of these drug users have died, are imprisoned or have left the country.

Socio-demographic profile of drug users

Survey data show that approximately one-third of drug users are women (32.1% per 2010 survey data, and 32.7% across five phases of the study). The proportion of women is lower in medical or law enforcement data, which may suggest: 1) orientation of the clinical program to men, 2) women find it easier to deal with addiction problems, 3) the need to introduce specific treatment programmes for women, 4) women are less likely to come to the attention of law enforcement authorities.

The average age of drug users polled in 2010 is 31.8 years (standard deviation 8.3). The highest proportion of respondents is the 25-29 year age group. Slightly fewer (22.0%) are aged 30-34 years, 21.0% are aged 35-44 years, and 19.2% are under the age of 24 years, while 10% are aged 45 years or more (see Figure 4.2.).

Figure 4.2. Age of respondents of 2010 study, %



Source: Trapencieris, Snikere, Kaupe 2011

The majority of non-Latvian cohort participants, (67%) are of Russian nationality, 10% other nationalities, and only 23% are Latvian. As no statistically significant differences in terms of nationality are evident for trying drugs, it is likely that other circumstances exist for the proportion of

problem drug users being considerably higher among non-Latvians (for example, a higher risk of social exclusion, social, psychological or biological risk factors).

Roma respondents form the major part of the other minorities, greatly exceeding the number of drug users in this ethnic group compared with other minorities.

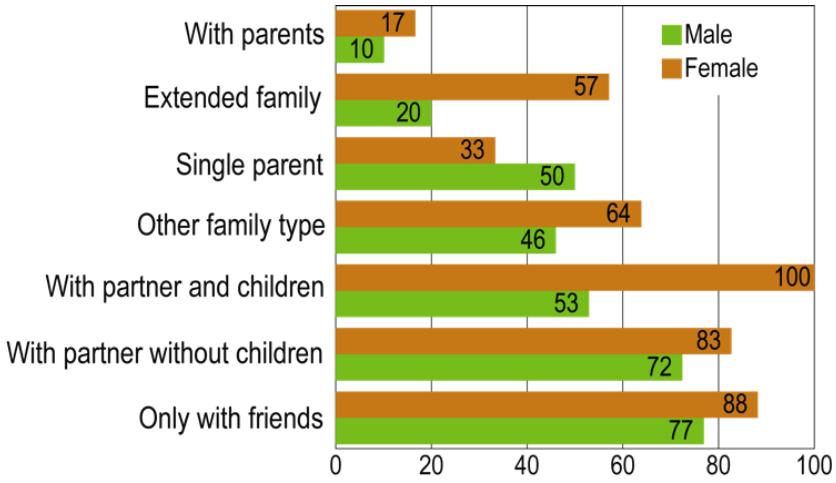
As in previous phases of the cohort study, most respondents surveyed in 2010 again gave their marital status as "unmarried". This was indicated by approximately two-thirds of respondents (67%, of whom 30% were living together with a partner); 15% of drug users are divorced; 12% are married (of which 2% have re-married); 4% are married, but live separately, while 2% of respondents indicated that they are widowed.

According to the composition of households, about half (46%) of respondents indicated they live with a partner; 31% live with parents; 20% with friends or acquaintances; 13% with their children, while 7% indicated other family members living in their households. In comparison with previous study phases, there is a slight increase in the proportion of respondents indicating they live together with friends or acquaintances.

Almost two thirds of drug users (62%) live with someone who either drinks excessively or also uses drugs, and so breaking loose from this drug-using environment can be extremely difficult. Women significantly more often than men indicated that they were living together with others who use drugs (OR 2.26; 95% T.I. 1.53–3.33).

Drug users who had been living together with friends or acquaintances, more often than in other types of family or household, indicated that someone in the household used drugs; while those who lived with a parental family did so the least (see Figure 4.3.).

Figure 4.3. Drug use in family among respondents from the 2010 study, %



Source: Trapencieris, Sniķere, Kaupe 2011

Descriptive indicators for education and employment among drug users are described in also in NR Chapter 8.1. on Social Exclusion.

Drug use

The most frequently cited reasons for trying drugs are interest and curiosity (30%), pressure from friends (25%) and "*Just wanted to try it*" (16%). Other reasons given for experimentation can be viewed in the Cohort Study Results Report.

The drug most commonly tried first is marijuana or hashish, which was tried first by about every third respondent (39%). The next most frequently mentioned include amphetamines (17%), hanka (13%), heroin (5%), ephedrine (7%) and ecstasy (6%). Other drugs were nominated as the first drug tried by less than five per cent of respondents (*see Table 4.2*).

Table 4.2. First drug tried by drug users (by respondents surveyed at least once in the 2010 and 2007-2010 phases of the study), %

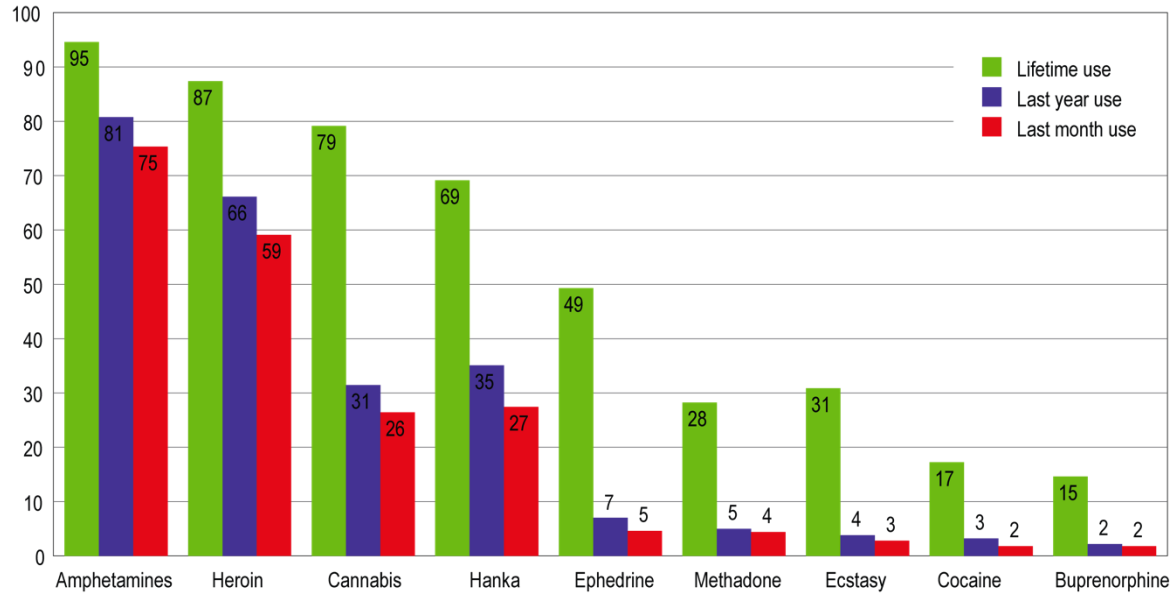
	Polled in 2010		Polled in 2007-2010	
	Number	%	Number	%
Marijuana, hashish	193	38,7	308	32,0
Amphetamines	84	16,8	200	20,7
Hanka	64	12,8	103	10,7
Heroin	40	8,0	85	8,8
Ephedrine, ephedrone	37	7,4	87	9,0
Ecstasy	29	5,8	58	6,0
Tablets	12	2,4	40	4,1
Buprenorphine	10	2,0	23	2,4
Inhalants	7	1,4	20	2,1
Cyclodol	6	1,2	11	1,1
Cocaine	4	0,8	6	0,6
Various other drugs	9	1,8	22	2,2
Don't remember	4	0,8	5	0,3

Source: Trapencieris, Sniķere, Kaupe 2011

As in previous phases of the study, the substances most used by respondents in their lifetime, last year and last month are amphetamines and heroin which had been used respectively by 95% and 87% of respondents in their lifetime; 80% and 66% during the past year, while 74% of drug users had used amphetamines in the last month, and 59% had used heroin (*see Figure 4.4.*).

Statistically significant differences in drug use were observed in use during lifetime by respondent age for amphetamine, ephedrine, ecstasy, heroin, hanka, methadone and LSD. Younger respondents mentioned amphetamines, ecstasy and LSD significantly more often, while older respondents mentioned ephedrine, hanka, and methadone. Statistically significant differences for drug use in the past year by age were observed for only two drugs: amphetamines, which were used significantly more often by younger drug users, and hanka, which was used by older users.

Figure 4.4. Lifetime, last year and last month substance use among respondents in 2010 study, %

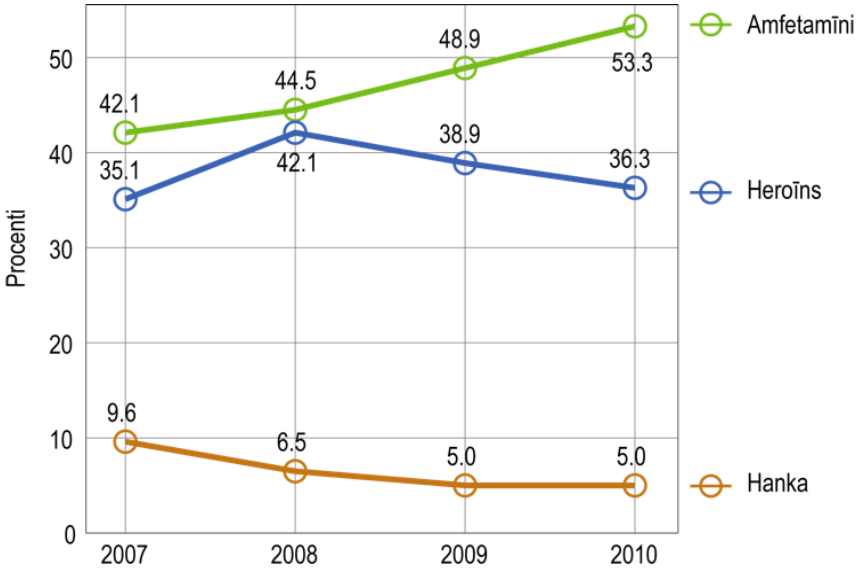


Source: Trapencieris, Sniķere, Kaupe 2011

As in previous phases of the study, drugs preferred by problematic drug users in 2010 were amphetamines and heroin. According to 2010 cohort study data, about every third drug user (32.1%) used several substances during a day.

As mentioned in reports for previous cohort study phases, there is an increase each year in the proportion of respondents who indicated amphetamines as their primary drug used. For example, in the 2007 study, 42% mentioned amphetamines as the primary drug used in the last 12 months; 45% in 2008; 49% in 2009, and 53% in 2010; while since 2008, due to the growing proportion of amphetamines users, there is a decrease in the proportion indicating heroin as the primary drug, which in the 2010 survey was 36% (see Figure 4.5.).

Figure 4.5. Most often used substance in 2007-2010, %



Source: Trapencieris, Sniķere, Kaupe 2011

Analysing users of various drugs over the duration of the four phases of the cohort study it can be inferred that about a third (30.7%) of drug users, during all the stages in which they were surveyed, may be classified as current multiple substance users or as having used both amphetamines23 and opiates24 in the last month before the survey. 17.9% of drug users had used amphetamines in the last month before interviewing, but 12.7% had only used opiates. It is difficult to classify the majority of drug users (38.7%) in terms of changes in drug use habits, because in the last month before the interview in one phase of the study they may be classified as amphetamine users, while in another stage, as users of opiates or multiple drugs.

Treatment for drug addiction

2010 survey results show that approximately every second cohort participant (53%) has been treated for problems associated with drug use during their lifetime. 11% were treated in the last year, while only three drug users were treated in the last month. It should be noted that relatively many, (45 or 9%) of drug users polled, did not indicate whether or not they had been treated in the last year or last month.

No statistically significant differences are evident in terms of respondent gender; respondent age is significant for those treated during lifetime ($p < 0.001$), due to the cumulative nature of this indicator, i.e. more older respondents had been treated during their lifetime than younger respondents. Among drug users interviewed, the most frequently mentioned age of first treatment is 25 years.

The most frequently mentioned medical establishment in which interviewed drug users had been treated during the past year is the *Riga Centre of Psychiatry and Addiction Disorders* (25 or 46% of those treated in the past year). A significant proportion of drug users have been treated in two private institutions: *Bikur-Holim* and *Detox*, treating 17 and 7 respondents respectively.

As in previous phases of the cohort study, 15% and 4% of cohort participants respectively had enrolled in methadone and buprenorphine programs at some point.

[23] Amphetamines, methamphetamine or ephedrine
[24] Heroin, hanka, methadone or buprenorphine

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

5.1. Strategy and policy

In 2010 there were no significant changes in drug patient treatment policy, which was discussed in detail in the 2010 National Report (Centre of Health Economics 2010), and so this Chapter only reflects current policy changes.

In 2011, the Cabinet of Ministers approved a new *Drug Program for 2011–2017*. The Program objective is to reduce the availability of illegal drugs and psychotropic substances, the acceptability of their use by society, and the harm done in society by their use, by improving the quality of health care services provided to drug patients and drug users. The health care of drug patients and drug users is identified in the Drug Program as one of four action lines for achieving the Program objective. The second action line of the Drug Program: the health care of drug patients and drug users, provides for the implementation of a range of specific measures: the creation of a specialised drug treatment facility for children and ensuring its operation; providing access to a constant rehabilitation program for drug users and addicts; the development and implementation of special drug treatment programs for patients with dual diagnoses; expanding the availability of long-term pharmacotherapy; development and implementation of the concept of coercive public security by providing for coercive measures, including the compelling of dangerous addicts to attend drug treatment programs.

In 2010, the Ministry of Health developed the draft *Public Health Program for 2011–2017* and submitted it to the Cabinet of Ministers for approval. It was approved on 27 September 2011. Two of the sub-objectives identified in the Public Health Program are: the reduction of morbidity and mortality from infectious diseases by reducing the negative impacts of risk factors on health, and the effective use of health care system management and resources, in order to ensure the optimization of expenditure and sustainability of the health care system, as well as equal access for all residents of Latvia to those health care services that are funded from the state budget.

The Public Health Program line of action: *Establishment of a quality health care system, ensuring the availability of services to all Latvian residents*, proposes by 2014 to develop outpatient care and reduce the duration of patient hospital stays, increasing the efficiency and cost effectiveness of the inpatient hospital operation and services provided.

In 2011, by amendments to Cabinet Regulation No. 1046 of 19 December 2006: *Procedures for the Organisation and Financing of Health Care*, which came into force on 6 July 2011, it is proposed to provide drug assistance by means of a drug profile day hospital. This legislation increases the patients' ability to receive drug assistance in situations where the complexity, risk and time constraints make it impossible to provide outpatient treatment, but inpatient admission is not required, while not restricting patients' access to 24-hour inpatient drug assistance.

Treatment of drug users in Latvia is determined by the *Medical Treatment Law*, as well as Cabinet Regulation No. 429 of 24 September 2002: *Procedures for the Treatment of Patients Addicted to Alcohol, Narcotics, Psychotropic and Toxic Substances*. The Ministry of Health has drafted a new Cabinet Regulation which provides a number of significant changes in the drug treatment system, with particular regard to ensuring long-term pharmacotherapy. The most important of these: long-term pharmacotherapy with methadone will now be provided not only by a drug addiction specialist, but also by a physician qualified in some other specialty that has mastered this method and is certified in accordance with the legislation for the diagnostic methods and treatment stipulated. Long-term pharmacotherapy with methadone can be provided for patients in prisons who had commenced such treatment before imprisonment. Long-term pharmacotherapy can now be prescribed by the Council of Physicians of any treatment institution, which includes among its members at least two drug addiction specialists.

5.2. Treatment systems

In 2010, there were no significant changes in the drug treatment system, which was considered in detail in the 2010 National Report (Centre of Health Economics 2010), so this Chapter only reflects topical issues.

State-funded outpatient services are provided by the addiction specialist, who is a directly accessible specialist and provides health care services to patients (diagnosis codes ICD-10: F10-F19; F63.0).

Nationally, private institutions/private medical practices with addiction specialists also treat addiction patients. When seeking treatment from a private physician, patients pay all costs associated with treatment themselves.

State-funded inpatient assistance for drug addiction is provided by means of drug profile beds[25], located in specialized psychiatric centres, regional multi-profile hospitals and other medical institutions.

It should be noted that drug users receiving emergency medical assistance, such as in cases of drug overdose (ICD-10 diagnosis codes: T40-T43, and F10-F19), are mostly admitted to University hospitals, regional multi-profile hospitals and local multi-profile hospitals, not all of which may be equipped with specialised drug profile beds.

The private hospital services network for drug addiction is not particularly developed, and is affected by the solvency of clients, and delivery of this service is not financially viable.

Outpatient psychosocial intervention

Outpatient psychosocial intervention is provided nationally by addiction specialists in collaboration with nurses. Multidisciplinary teams have formed in some institutions, and include psychologists in addition to the above specialists.

In 2010, state funded outpatient drug assistance services were provided by 38 treatment institutions having formal agreements with the Health Payment Center.

In 2010, outpatient drug assistance was provided by 55 addiction specialists under contract with the Health Payment Center. Some of these specialists also provide long-term pharmacotherapy with methadone and buprenorphine.

According to Health Payment Center data, the average number of care episodes per single patient was 2.45 (2.26 in 2009), while the average number of visits per single patient was 2.94 (2.82 in 2009).

Outpatient psychosocial intervention uses motivational intervention, cognitive behavioural therapy, support therapy for resolution of social issues (see, for example, WHO 2009).

In accordance with the amendments to Cabinet Regulation No.899 of 31 October 2006: *Procedure for Reimbursing the Purchase Costs of Drugs and Medical Equipment for Outpatient Treatment*, as from 2009, the list of diagnoses reimbursable from the state budget now includes medications used to treat children with mental and behavioural disorders due to use of psychoactive substances (hereinafter referred to as "children"). According to the Centre of Health Economics data, the number of unique patients – children who received reimbursable medication was 68 in 2010, compared to 57 in 2009. In 2009, LVL 470 was spent on reimbursable medication for dollars, with LVL 662 being spent in 2010.

According to the Centre of Health Economics data, the most common diagnoses in recent years related to multiple substance use (F19), which comprised 32% of first recorded patients in 2010. The next most frequently mentioned are respectively the opiates (F11): 27%, stimulants (F15): 19% and cannabinoids (F12): 11%. Despite these proportions, special treatment programs targeted to specific user groups, such as cannabis or amphetamines users, are still unavailable in this country.

[25] Which include detoxification beds, Minnesota program, motivation program, medical rehabilitation; Diagnoses ICD-10 -10: F10-F19

Inpatient psychosocial intervention and detoxification

Medical assistance for patients in acute emergency situations associated with drug use (ICD-10 diagnosis codes: basically T40-T43, as well as F10-F19), is provided to patients admitted not only to drug profile beds, but also in University hospitals, regional multi-profile hospitals, and local multi-profile hospitals having no specific drug profile beds.

The Hospital Bed Fund database provides information on the use of the Bed Fund only in respect of treatment institutions, which are identified in the Bed Fund as institutions providing treatment services in the drug profile (both publicly and privately funded, with ICD-10 diagnosis codes: F10-F19)[26].

In 2010 the national average of drug profile beds was 277 (including detoxification, Minnesota, motivation, medical rehabilitation beds), a reduction of 73 beds compared to 2009 when the average number of beds was 350. This service was provided by 10 treatment institutions. There were 245 state funded beds, while the remaining 32 were in private treatment institutions (in 2009 there were 316 state funded beds, 5 drug beds in prisons, with the remaining 29 drug beds being provided by private treatment institutions).

Due to the limited funding available nationally, detoxification is provided in the majority of inpatient drug profile beds

Inpatient psychosocial intervention includes treatment in short term inpatient programs (Minnesota and Motivational), as well as in therapeutic communes.

According to Health Payment Center data, the number of hospitalizations in the Minnesota program has decreased: from 447 cases in 2008 (including completion of the full course of treatment in 374 hospitalisations); to 325 in 2009, (full course of treatment completed by 270 patients); 249 in 2010 (full course of treatment completed by 177 patients). This could indicate a restricted availability for this service.

According to Health Payment Center data, in 2010 the estimated actual cost of drug addiction therapy for inpatients, including mandatory drug treatment for children, totals LVL 856 944[27]; the average cost per single patient treated as an inpatient is LVL 129. In 2009, LVL 1009 736[28] was spent on inpatient drug treatment, including the rehabilitation of addicts.

Medical rehabilitation for drug addiction patients is provided in two specialised psychiatric centres. The number of places in these programmes is limited - a total of 8 beds. The medical rehabilitation process is provided in accordance with the therapeutic community principle.

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

The treatment approach using methadone for long-term pharmacological treatment of opioid dependent patients has been operating nationally since 1996, and with the substitution of buprenorphine since 2005. As part of the UNODC project HIV/AIDS Prevention and care among Injecting Drug users and in Prison settings in Estonia, Latvia and Lithuania 2006-2010, 8 new methadone program bureaux in Latvia were established in various regions of the Republic. Long-term pharmacotherapy with methadone is funded from the State budget.

Methadone therapy is provided by a multi-disciplined drug addiction rehabilitation team, consisting of a certified addiction specialist physician, a psychologist, and certified nurses. All team members are specially trained in the administration of methadone therapy.

During the course of the UNODC project, while educating prison personnel on the need for long-term pharmacotherapy in prisons, a methadone pilot programme was expected to start in prisons in 2010. Having regard to legislative shortcomings (the Government has not accepted Cabinet Regulations providing long-term pharmacotherapy for the treatment of inmate patients who had

[26] All patients with diagnosis codes in accordance with ICD-10: F10-F19 are treated in a specialised drug treatment profile
[27] Health Payment Center News report No.19. Available electronically; http://www.vnc.gov.lv/files/VNC_Vestis_Nr_19_2010_www.pdf
[28] Health Payment Center News report No.18. Available electronically; http://www.vnc.gov.lv/files/VNC_VESTIS_Nr_18_par_2009_gadu.pdf

started it previously, nor is the funding model for inmates' health care being improved), long term pharmacotherapy for opioid dependent patients is not being provided in prisons.

Results of a study carried out in places of imprisonment (Sniķere et al. 2010) show that only 41% of the polled prison staff (survey response options: "know something" or "well informed") has any idea of the treatment program, while only 10% of polled prisoners provided such responses. The cost-effectiveness of the methadone and syringe exchange programs were rated as ineffective and not very useful in terms of measures to limit the prevalence of drug use and spread of blood-borne communicable diseases, compared to measures such as development of a drug-free program, intensive psychological assistance, availability of disinfectants, treatment as an alternative to imprisonment, noted both prison staff (average rating of 2.88 on a five point scale), and prisoners (average rating of 3.3 on a five point scale). Similarly to the findings of a 2003 survey (Sniķere et al. 2010), drug users are to a much greater extent convinced that methadone should be issued to opioid users. However, those who had not used drugs in prisons mostly thought that the most useful approach would be intensive psychological assistance. Comparing the responses of inmates and prison staff on the possibility of implementing a methadone program in prisons, they are sceptical (average rating less than 3 points).

In comparison with other European countries Latvia has the lowest number of clients in methadone programs (EMCDDA 2010). The incomplete understanding of treating personnel and clients on the benefits of the program, the non-orientation of the service to the client, and relatively low funding that precludes implementation of the program elsewhere in Latvia, are some of the reasons why the methadone program has not evolved sufficiently rapidly in Latvia, to treat the ever-increasing number of drug users.

The Latvian Addiction Disorders Specialists' Association has developed and is preparing for approval new medical technologies for the long-term pharmacotherapy of opioid dependent patients with methadone.

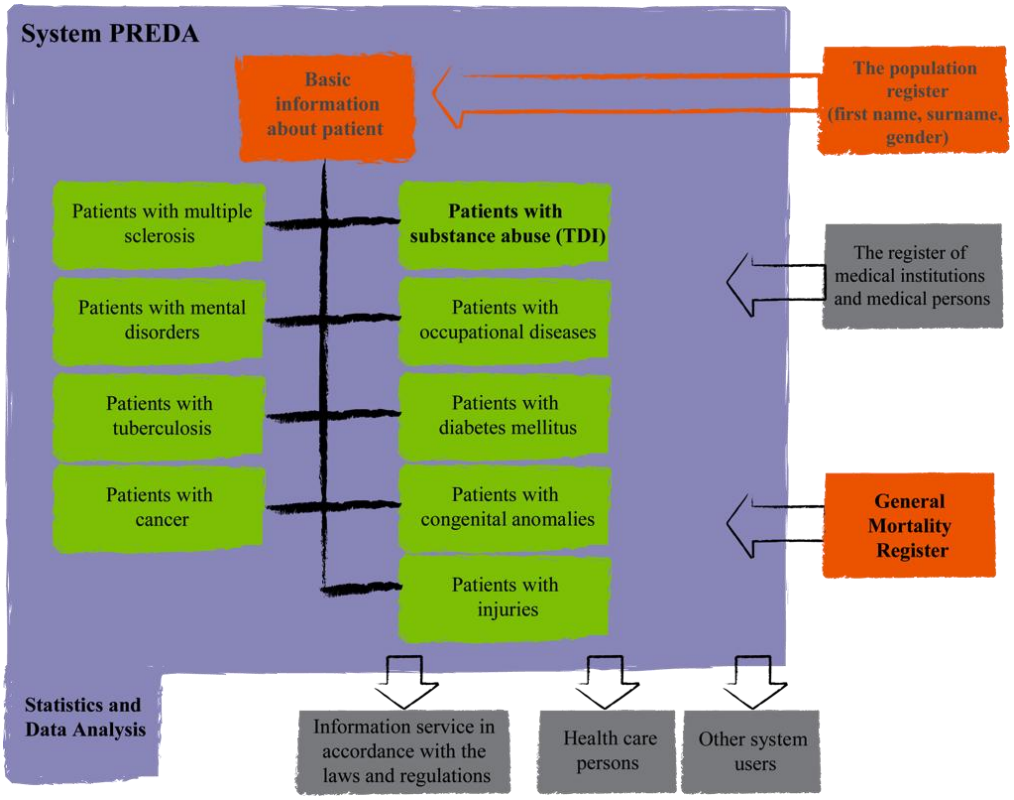
5.3. Characteristics of treated clients

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

In accordance with Cabinet Regulation No. 746 of 15 September 2008, the Centre of Health Economics maintains registers (PREDA) of patients suffering from certain diseases. One of the registers contains individualised information compiled on drug patients and persons using addictive substances. The records included in PREDA are depicted in Figure 5.1.

Detailed data on each patient registered with a drug-related illness has been collected in Latvia since 1997, when this register was created. The Register card includes socio-demographic information about the patient (gender, age, ethnicity, occupation, education, place of residence, family composition, characterisation of living conditions), information on the diagnosis, substance use (substances used, frequency of use, period of use, mode of administration), as well as the method of diagnosis, and results of a medical examination. This information corresponds to a large extent to the EMCDDA Treatment Demand Indicator (TDI) used in Member States, and the data are used annually for international comparisons, for example, in the EMCDDA Annual Report, and UNODC Reports. Some variables included on the Register card in Latvia do not align with the TDI definitions, but work is on-going to improve the quality of the Register data in terms of both the number of treatment institutions providing data, the provision of more detailed information about the patient, etc.

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



Source: PREDA 2010

The Centre of Health Economics provides information every year on diagnosis and planning by regional section from the PREDA system in annual statistical reports, and submits them to the Central Statistical Bureau.

The National Report for the previous year described the main differences and the necessary system improvements (Centre of Health Economics 2010). It is anticipated that most of these discrepancies will be resolved by the TDI revision process scheduled for 2011–2012, and that data quality will be improved.

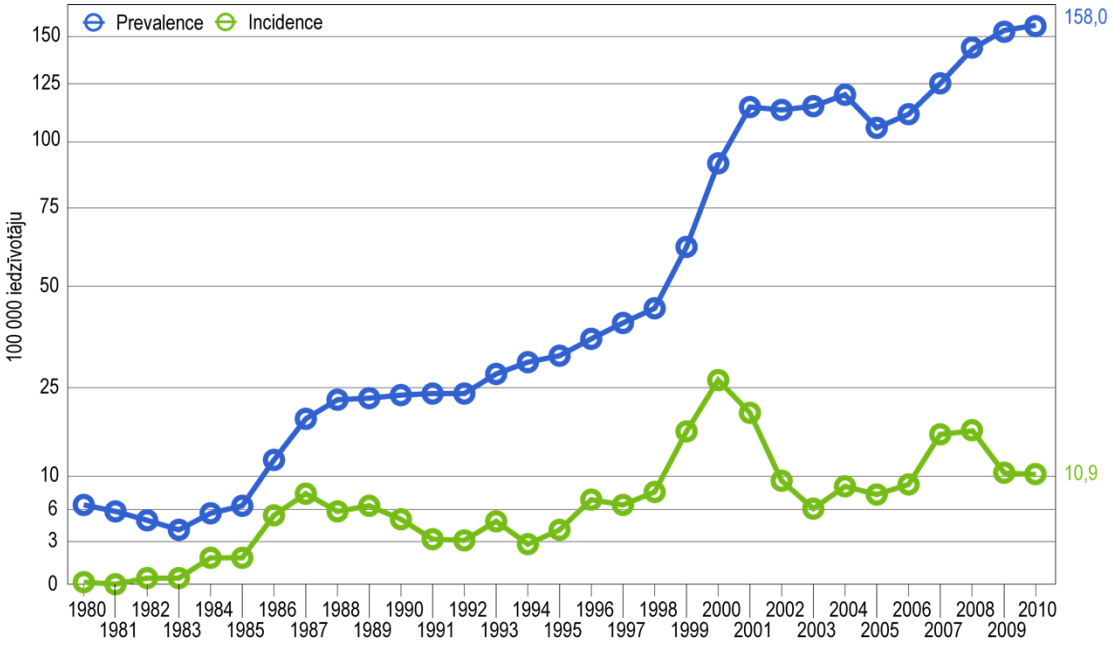
Sector statistical report data

According to sector statistical report data, in 2010 there were 429 (or 19.2 per 100 000 population) first registered cases, i.e. patients with a drug-related diagnosis[29] for the first time during their lifetime, of which 243 (10.9 per 100 000 population) were diagnosed with an addiction syndrome or psychosis-related diagnosis.

At the end of 2010, the registered prevalence of addiction or psychosis related to psychoactive substances (excluding alcohol and tobacco) was 3523 or 158.0 per 100 000 population *(see Figure 5.2)*. At the end of 2010 there were also 1290 patients (1437 in 2009) in the Registry records diagnosed with drug intoxication or overdose.[30]

[29] ICD-10 diagnoses F11–F19, except F17.
[30] ICD-10 diagnoses F11–F19.0-1, except F17.

Figure 5.2. Morbidity and prevalence of dependency syndromes and psychoses caused by drug use (F11–F19.2–9) 1980–2010, per 100 000 inhabitants



Source: Centre of Health Economics 2011

In recent years, the most common diagnosis was related to the use of multiple substances: (ICD–10 F19), which comprised 30.5% of first-time registrations in 2010. The next most frequently mentioned diagnoses are associated with opiates (F11), stimulants (F15) and cannabinoids (F12), recorded, respectively, in 26, 27 and 12 per cent of cases.

Treatment Demand Indicator (TDI) data

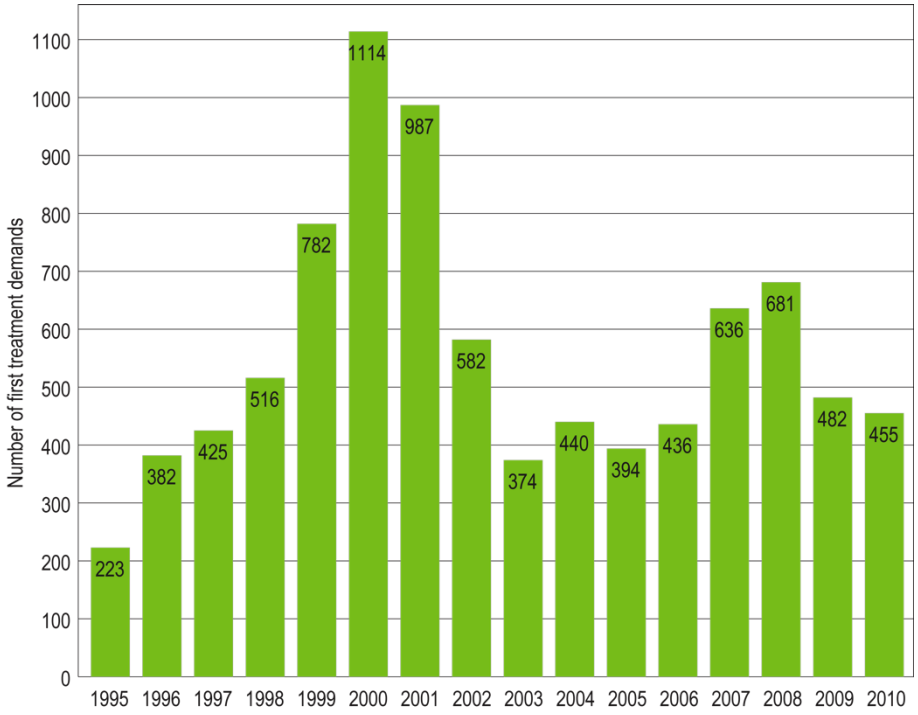
Since the first patient in 1976, as at 31 December 2010, 9 533 individuals have been recorded in Latvia as having diagnoses associated with psychoactive substance intoxication, harmful use and/or dependence.

From 1993–1994, the number of first-time recorded patients having a diagnosis related to psychoactive substance use (excluding alcohol and tobacco), began to increase substantially. The number of first-time treated patients reached a maximum in 2000 (and significantly decreased until 2003), while during the period 2005–2008 the number of patients increased each year. The number of first-time recorded patients in 2009 had significantly decreased in comparison with 2008. The number of first-time recorded patients also decreased slightly in 2010, compared with 2009, respectively 455 and 482 individuals *(See Figure 5.3)*.

The statistical data examined in this Section for treated clients may be seen in table format in the Fonte system[31].

[31] TDI Table – TDI_2011_LV_01

Figure 5.3. Number of first time treated outpatients[32] 1995–2010, in absolute numbers



Source: Centre of Health Economics 2011

In 2010, approximately one in four (22.9%) first-time recorded/treated patients was female. In recent years, the proportion of women among first-time recorded/treated patients is slightly lower than observed over the period of 2003–2005; however, these small percentage and numerical changes are difficult to explain *(see Table 5.1)*.

Table 5.1. Ratio of first time treated (recorded) women patients in 2000–2009, %

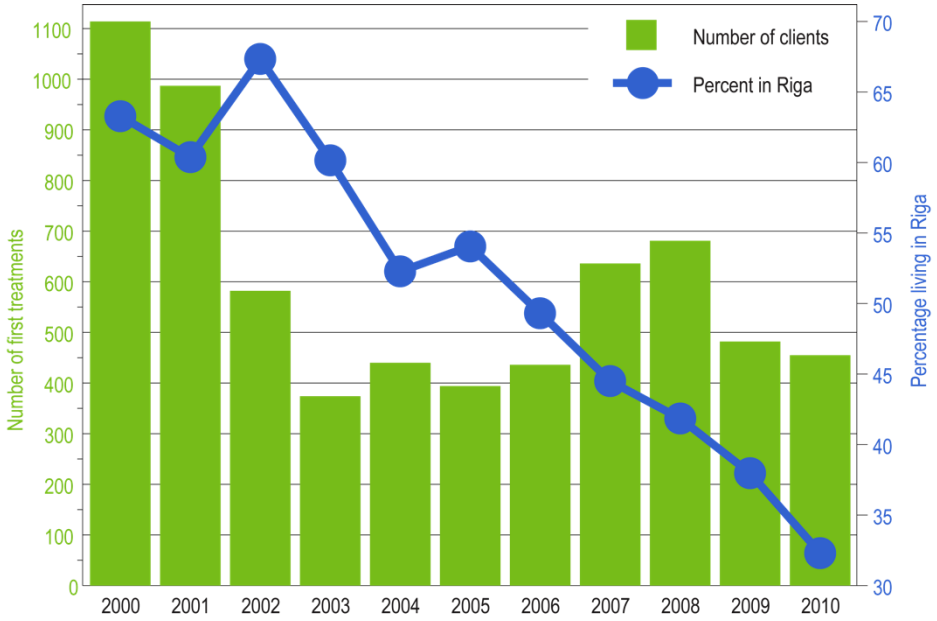
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Proportion of women	20.5	20.2	22.1	24.3	24.7	24.1	20.0	21.5	19.1	21.5	22.9

Source: Centre of Health Economics 2011

The trend observed in recent years that an increasingly greater proportion of patients living outside Riga is seeking assistance from an addiction specialist has also been maintained in 2010. The proportion of first-time treated patients living in Riga decreased from 67% in 2002 to 32% in 2010 (45% in 2007; 42% in 2008; 39% in 2009) *(See Figure 5.4).*

[32] In accordance with the Treatment Demand Indicator. The patient is considered to be "first time" when they are first included in the "Patients suffering from Certain Diseases" Register with any of the ICD-10 diagnoses F11-F19 (except F17-tobacco), and one of the listed substances is indicated. In accordance with the applicable definition, if a patient has been previously treated with alcohol problems and later with drug problems, the "first time" in this context is considered to be the registration that is related to drugs. In 2010, according to data from the Health Payment Center, a significant proportion of patients were registered on the basis of Outpatients' discharge cards and "signal" vouchers from medical testing - cases when there is no outpatient visit. Reflecting outpatient treatment in this country, these cases should not be classified as treated cases, but for the purpose of data comparison with previous years, this new evidence is not taken into account.

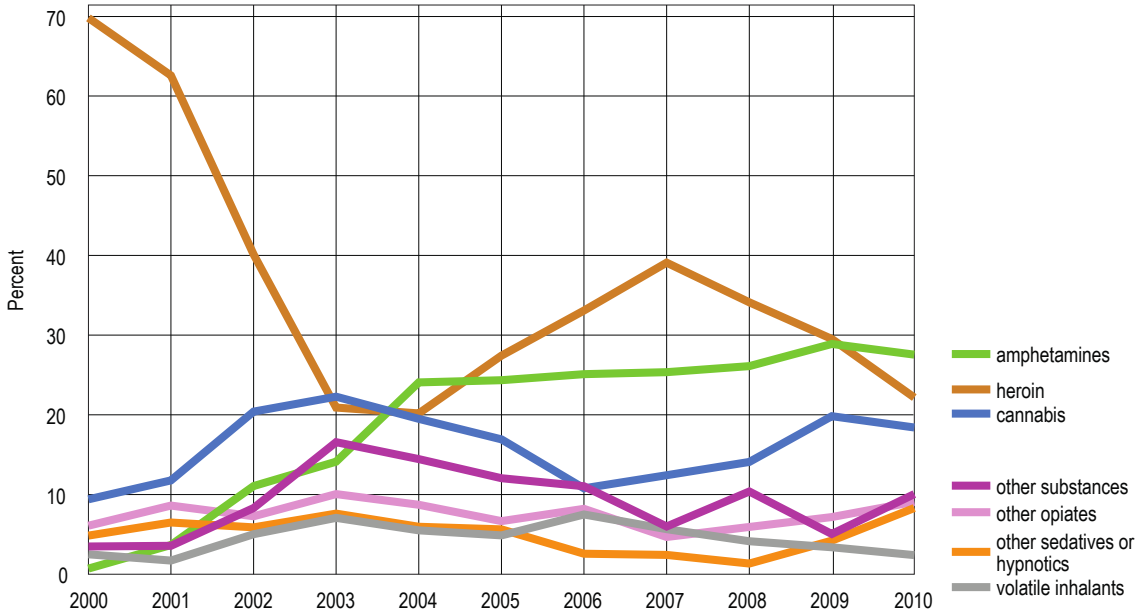
Figure 5.4. Ratio of first time treated (recorded) patients (%) in Latvia and Riga, 2000–2010



Source: Centre of Health Economics 2011

2010 data on primarily used substances among first-time recorded/treated patients indicates that the most frequently mentioned substance is amphetamine (131 patients, or 28.8%). Slightly fewer (103 patients, or 22.6%) indicated heroin as their primarily used substance, while 79 or 17.4% patients indicated cannabinoids. Other substances were mentioned by less than one in ten patients. 41 patients (9%) primarily used other opioids (mainly *hanka*[33]), 38 (or 8.4%), used sedatives or sleeping tablets; 13 used inhalants, 4 used LSD or other hallucinogenics, 4 used methadone; 3 used cocaine, 3 used other stimulants. 24 patients (5.3%) did not specify any substance as primarily used, while 12 patients did not indicate any substance used. Proportions of treated patients using various substances are shown in Figure 5.5.

Figure 5.5. Primary substance by first time treated (recorded) patients 2000–2010, %



Source: Centre of Health Economics 2011

In 2010, the average age of first-time treated patients was 26.7 years and was significantly higher among women than men, respectively, 29.3 and 25.9 years. The significant increase in mean age

[33] Opiates produced from poppies grown in domestic conditions.

of first-time treated women may be due to the relatively large number of older women recorded in 2010 being treated for problems caused by sedatives or calming medications.

In 2010 the youngest first-time treated patient was nine years old, while the oldest was aged 64. 10% of first-time treated patients were younger than 15, 17.6% were aged 15-19, 19.3% were aged 20-24, 21.1% were aged 25-29, 13.6% were aged 30-34, 7.7% were aged 35-39, and 10.5% were older than 40 years *(See Table 5.2)*.

Table 5.2. First time treated (recorded) patients, distribution by age groups 2000–2010, %

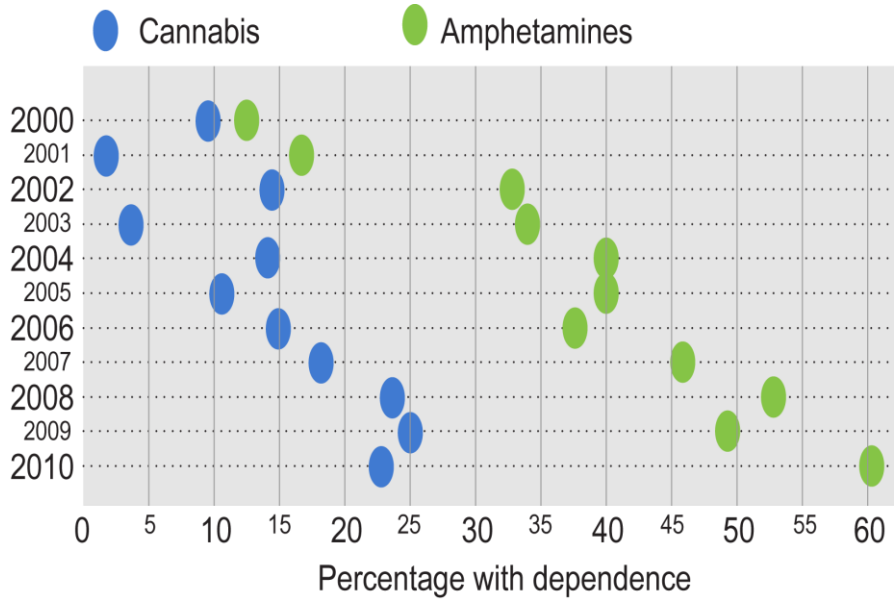
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
younger than 15 years	14.9	14.1	19.3	28.4	19.0	16.8	16.1	12.5	12.0	12.0	10.1
15–19 years	34.6	35.9	32.6	34.6	36.5	31.5	25.8	22.6	22.3	19.8	17.6
20–24 years	32.4	27.2	22.8	16.5	19.7	20.8	24.7	24.1	25.7	24.1	19.3
25–29 years	10.2	11.5	13.6	7.8	10.2	16.5	16.4	21.9	20.5	18.4	21.1
30–34 years	4.3	5.5	5.5	7.3	5.7	4.8	8.1	9.1	10.7	11.8	13.6
35–39 years	2.2	2.8	3.1	2.7	2.5	4.3	4.1	5.7	4.7	7.4	7.7
40 years and older	1.4	2.9	3.1	2.7	6.3	5.3	4.8	4.1	4.2	6.5	10.5

Source: Centre of Health Economics 2011

According to the data for first-time treated/recorded outpatient diagnoses it is seen that most patients are diagnosed with multiple substance overdose, intoxication or dependence (F19); the next most common diagnoses are associated with the use of opioids, stimulants and cannabinoids. It is important to mention that during the last ten years there has been an increase in the proportion of users primarily using marijuana or amphetamines, who are first diagnosed with an addiction-related illness.

So, for example, in the year 2000 every tenth (9.5%) marijuana/hashish user had an addiction-related diagnosis, while in 2010 approximately every fourth (22.8%) was so diagnosed. 2010 saw a dramatic increase in the proportion of amphetamine users with an addiction-related diagnosis compared with previous years (60% in 2010, 49% in 2009, and 38% in 2006). No significant differences are observed among heroin users diagnosed with addiction; a diagnosis of addiction has been entered on the Register card by the addiction specialist for virtually all (92.5–97.9% during the past five years). The proportion of addiction-related diagnoses among patients primarily using amphetamines and cannabis may be seen in Figure 5.6.

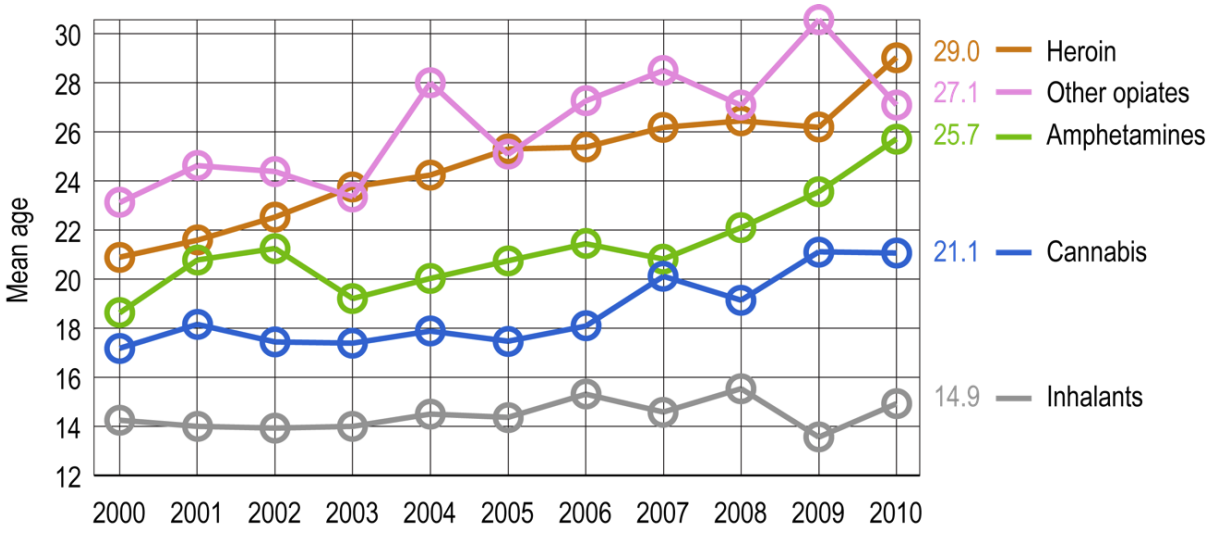
Figure 5.6. Ratio of addiction-related diagnoses among patients primarily using amphetamines and marijuana 2000–2010, %



Source: Centre of Health Economics 2011

Treatment data indicate that users of various substances have different first-time treated/ recorded age. So, for example, first-time users of inhalants sought treatment for the first time significantly earlier than users of other substances. In 2010 the average age was 14.9 years; cannabinoid users did so considerably later (at 21.1 years), amphetamine users (25.7 years), users of other opiates (27.1 years), while the oldest were first time treated heroin users who first sought treatment at age 29.0 years. Observations in recent years indicate that the initial treatment age is increasing for virtually all users *(see Figure 5.7).* This trend could indicate that drug users turn to the treatment system only when they already have relatively serious problems with drug use, and that the treatment system is unable to make an early diagnosis among young drug users, when they might possibly be easier to treat.

Figure 5.7. Average age of first time treated/recorded drug users, distribution by primarily used substances 2000–2010



Source: Centre of Health Economics 2011

The information contained on the Register card regarding mode of use of a substance indicates that approximately one in three (39.8%) of first-time treated patients in 2010 administered the primary substance used by injecting; 22.9% by eating, drinking; 19.1% by smoking and 5.7% by snorting[34]. Around one in eight (12.5%) had not specified the mode of administering the substance primarily used. The mode of administering a substance varies considerably depending on the substance primarily used:

- the most common method of using heroin is by injection (97% of patients).
- 24% of those primarily using amphetamine have not specified the mode of administering the drug, while of those who have so specified, little more than half (59%) used by injecting; 20% by snorting; 20% by eating/drinking, and 1% indicated they used the drug by smoking or snorting.
- among marijuana users the most commonly specified mode of use was smoking (99%).

Significant differences in comparison to 2009 or earlier time periods regarding methods of drug use have not been observed.

Differences have been observed in frequency of use in the distribution of first time treated/recorded patients according to substance primarily used, and these are shown in Table 5.3. Of those individuals indicating the frequency of use, heroin is most often used: heroin is used every day by 74.5% of first-time treated heroin users, amphetamines are used every day by 28.2% of its users, and marijuana by 15%.

[34] See also TDI table Fonte (TDI_2011_LV_01).

Table 5.3. Frequency of use for most often indicated primarily used substance among first time treated (recorded) patients in 2010, %[35]

	Of those whose frequency of use is known				Frequency of use is unknown
	Has not used in past month	Once a week or less	2-6 days per week	Every day or several times per day	
Heroin	4.2	5.3	16.0	74.5	8.7
Amphetamines	12.9	16.5	42.4	28.2	35.1
Marijuana	13.2	43.4	28.3	15.1	32.9

Source: Centre of Health Economics 2011

Data about treated drug users from the Health Payment Centre

Data on treated drug users are also compiled in the Health Payment Center (HPC) Management Information System (VIS) databases APANS and SPANS respectively on patients receiving outpatient and inpatient services. These databases should reflect patients seeking publicly funded treatment specialists and include data about diagnoses according to the ICD-10 classification, gender and age. This data source does not include detailed information (as in TDI) about the patient, such as education, occupation, drugs used and their frequency of use.

In the TDI revision process it is planned to evaluate how it can be merged with the PREDA system, thus allowing estimating the number of drug users treated during the calendar year (all treatments) as at the moment country has been unable to provide this figure.

As indicated in the previous National Report, a significant proportion of drug-related diagnoses in the HPC system are provided by specialists who are not addiction specialists or psychiatrists, such as, for example, family physicians, paediatricians, radiologists, internists, medical laboratory physicians, and other specialists. It is difficult to estimate the extent to which diagnoses made by these specialists are accurate or if data has not been input, or whether other errors have occurred.

Out-patient treatment

According to the VIS APANS data, drug-related diagnoses (F11–F19, except F17) were recorded in 2010 for 2824 unique patients. According to this data the most frequently mentioned diagnosis[36] this year is associated with opiates (F11): 1142 or 40.4% of individuals; 747 patients (26.5%) were recorded with a diagnosis of overdosing, intoxication or addiction with multiple substances (F19); 346 (12.3%) had a stimulant-related diagnosis (F15), while 260 had a cannabinoid-related diagnosis (F12). Table 5.4. shows, according to VIS APANS data, the number of unique patients treated during the year and the distribution by diagnoses for the period 2007–2010. Available HPC APANS data indicate that the number of unique patients has remained virtually unchanged in 2010 compared to 2009 (by comparison: 2776 unique patients were recorded in the APANS system in 2009).

[35] See also TDI table Fonte (TDI_2011_LV_01).
[36] One patient can seek help from several physicians with various diagnoses. Hereinafter utilised and shown is the diagnosis made during the past year according to date.

Table 5.4. Number of unique individuals receiving outpatient services, distribution by diagnoses, for the period 2007–2010, by absolute numbers and %

	2007		2008		2009		2010	
	n	%	n	%	n	%	n	%
Opiates (F11)	1119	45.2	1296	41.3	1155	41.6	1142	40.4
Cannabinoids (F12)	197	8.0	282	9.0	267	9.6	260	9.2
Sedatives (F13)	194	7.8	169	5.4	151	5.4	163	5.8
Cocaine (F14)	28	1.1	47	1.5	43	1.5	46	1.6
Stimulants (F15)	265	10.7	362	11.5	287	10.3	346	12.3
Hallucinogens (F16)	38	1.5	51	1.6	38	1.4	30	1.1
Inhalants (F18)	128	5.2	142	4.5	108	3.9	90	3.2
Several substances (F19)	508	20.5	791	25.2	727	26.2	747	26.5
Total	**2477**	**100.0**	**3140**	**100.0**	**2776**	**100.0**	**2824**	**100.0**

Source: Centre of Health Economics, 2011; NFP calculations according to VNC VIS APANS data 2011

VIS APANS data indicate that about every fourth patient receiving outpatient services is a woman: 28.8% in 2007, 25.7% in 2008, 26.5% in 2009 and 2010. An approximately equal proportion of men and women (38.6% and 41.1%) sought assistance in relation to opiate use disorders (F11). A significantly higher proportion of men compared to women sought help for disorders following multiple substance use (F19) or cannabinoid use (F12), while women are more likely than men to seek help for problems related to sedatives (F13), or stimulants (F15) *(see Table 5.5.)*.

Table 5.5. Number of unique individuals receiving outpatient services in 2010, distribution by diagnoses and gender, %

	By any specialist			**By addiction specialist**		
	Total	Men	Women	Total	Men	Women
Opiates (F11)	40.4	41.1	38.6	43.5	45.4	36.9
Cannabinoids (F12)	9.2	11.1	4.0	8.5	10.1	2.9
Sedatives (F13)	5.8	2.7	14.3	6.2	2.1	19.6
Cocaine (F14)	1.6	1.8	1.2	0.2	0.1	0.5
Stimulants (F15)	12.3	10.8	16.3	10.5	9.6	13.5
Hallucinogens (F16)	1.1	0.8	1.9	0.4	0.3	0.7
Inhalants (F18)	3.2	3.5	2.4	2.2	2.7	0.7
Several substances (F19)	26.5	28.3	21.3	28.6	29.6	25.2
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Source: Centre of Health Economics, 2011; NFP calculations according to HPC VIS APANS data 2011

Approximately two-thirds (1934 or 68.5%) of the patients referred to above have sought assistance from an addiction specialist.

The average age of patients receiving help from an addiction specialist as an outpatient in 2010 is 29.6 years (standard deviation 11.0 years). The data indicates that the age of women receiving help as outpatients is greater than that of men, e.g., in 2010, the average age of men was 28.8 years (standard deviation 9.3), while for women it was 32.6 years (15.1). The age of users of various substances differs: the oldest are patients with problems due to sedative use (F13), followed by opiate users (F11) *(see Table 5.6)*.

Table 5.6. Mean age of unique individuals receiving outpatient services from an addiction specialist in 2010, distribution by diagnoses and gender, %

	Total		Men		Women	
	Mean age (SD)	*Unique patients*	Mean age (SD)	*Unique patients*	Mean age (SD)	*Unique patients*
Opiates (F11)	31.4 (8.4)	*841*	31.5 (8.3)	*677*	30.8 (8.6)	*164*
Cannabinoids (F12)	24.4 (8.6)	*164*	24.3 (8.1)	*151*	25.6 (13.1)	*13*
Sedatives (F13)	48.8 (17.8)	*119*	38.2 (19.0)	*32*	52.7 (15.7)	*87*
Cocaine (F14)	28.5 (9.4)	*4*	22.5 (7.8)	*2*	34.5 (7.8)	*2*
Stimulants (F15)	26.2 (8.8)	*203*	27.1 (9.0)	*143*	24.0 (7.7)	*60*
Hallucinogens (F16)	20.4 (7.1)	*7*	24.5 (6.6)	*4*	15.0 (2.6)	*3*
Inhalants (F18)	18.7 (5.2)	*43*	19.1 (5.1)	*40*	13.3 (3.2)	*3*
Multiple substances (F19)	26.7 (9.2)	*553*	26.9 (8.5)	*441*	26.1 (11.4)	*112*
Total	**29.6 (11.0)**	***1934***	**28.8 (9.3)**	***1490***	**32.6 (15.1)**	***444***

Source: Centre of Health Economics, 2011; NFP calculations according to HPC VIS APANS data 2011

In-patient treatment

According to the VIS SPANS data, in 2010 458 patients were treated as inpatients with F11–F19 diagnoses (except F17-tobacco). By comparison, in 2007, 2008 and 2009, there were 779, 798 and 625 unique patients. As in previous years, in 2010 the diagnoses for unique patients treated were again most commonly associated with opiates (F11), multiple substances (F19), and stimulants (F15) *(see Table 5.7)*.

Table 5.7. Number of drug users treated as inpatients in 2007–2010, in absolute numbers

	2007		2008		2009		2010	
	Episodes	Unique patients	Episodes	Unique patients	Episodes	Unique patients	Episodes	Unique patients
Opiates (F11)	**667**	**401**	**696**	**390**	**525**	**301**	**263**	**225**
Addiction, psychoses	656	390	689	385	515	292	260	223
Overdose, intoxication	11	11	7	5	10	9	3	2
Several substances (F19)	**373**	**193**	**400**	**250**	**346**	**216**	**176**	**151**
Addiction. psychoses	290	122	271	144	250	128	109	85
Overdose, intoxication	83	71	129	106	96	88	67	66
Stimulants (F15)	**129**	**84**	**126**	**82**	**104**	**48**	**60**	**53**
Addiction, psychoses	105	61	106	64	84	33	38	34
Overdose, intoxication	24	23	20	18	20	15	22	19
Sedatives (F13)	**20**	**20**	**37**	**33**	**20**	**20**	**26**	**22**
Addiction, psychoses	11	11	25	23	10	10	8	6
Overdose, intoxication	9	9	12	10	10	10	18	16
Cannabinoids (F12)	**22**	**22**	**20**	**18**	**18**	**17**	**19**	**18**
Addiction, psychoses	6	6	7	6	9	9	10	10
Overdose, intoxication	16	16	13	12	9	8	9	8
Inhalants (F18)	**48**	**39**	**19**	**16**	**18**	**15**	**13**	**12**
Addiction, psychoses	17	16	5	4	6	5	4	3
Overdose, intoxication	31	23	14	12	12	10	9	9
Cocaine (F14)	**8**	**8**	**5**	**5**	**4**	**4**	**2**	**2**
Addiction, psychoses	6	6	4	4	4	4	1	1
Overdose, intoxication	2	2	1	1	0	0	1	1
Hallucinogens (F16)	**13**	**12**	**5**	**4**	**4**	**4**	**12**	**11**
Addiction, psychoses	5	5	2	2	0	0	3	3
Overdose, intoxication	8	7	3	2	4	4	9	8
Total	**1280**	**779**	**1308**	**798**	**1039**	**625**	**571**	**494**

Source: Centre of Health Economics, 2011; NFP calculations according to HPC VIS SPANS data 2011

As in the APANS data, one in four hospital patients is a woman: 25.1% in 2009, 24.4% in 2008, 24.6% in 2007. The average age of patients treated as inpatients in 2009 was 27.3 years (standard deviation 9.8). Opiate and multiple substance addiction patients are of similar average age, respectively 28.2 (6.8) and 28.8 years (9.7). Patients diagnosed with stimulant addiction are significantly younger (24.9 years; standard deviation 7.8), as well as those overdosing on stimulants or multiple substances, respectively 23.3 (7.8) and 22.8 (9.8).

Clients in long-term pharmacotherapy using methadone

Worthy of mention as a positive trend in 2010 is an increase in the number of clients in the methadone program, as well as the expansion of geographical coverage of a new program (bureaux). However, the number of patients being treated in the methadone (and buprenorphine) program is still the lowest among the EU Member States. At the end of 2010, 237 patients were being treated in long-term pharmacological treatment programmes for opioid dependence, of which 193 patients were in the methadone program, and 44 patients were in the buprenorphine program. By comparison, at the end of 2009, 139 patients were in the methadone treatment program and 50 patients were in the buprenorphine program.

At the end of 2010, methadone program was operating in 9 cities.

The Riga Centre of Psychiatry and Addiction (RCPA) is responsible for methadone patient records in Latvia. This information is not recorded in detail in the electronic database, and so the data analysis capabilities are somewhat limited.

This section was compiled and data analysed using information from the Health Payment Center (HPC) database (VIS APANS) on patients receiving outpatient assistance. In accordance with funding regulations, institutions provide basic information about the patient: patient identification, gender, date of birth and diagnosis, and handling code[37]. The database does not list the amount of methadone dose given to the patient, but available information does show the number of days the patient received this medication as an outpatient. To obtain more detailed information about patients, personal data are combined with the PREDA system, which contains detailed information about the patient, such as the length of drug use and socio-demographic characteristics. However, in interpreting the results it is essential to take into account that information is not always updated in the PREDA system and the problems are described in the National Reports of previous years. (Centre of Health Economics 2010; Pugule et al. 2009).

According to data from the National Statistical Report, as at 31 December 2010, 193 patients were being treated in 9 methadone programs (in Riga, Jelgava, Liepaja, Kuldiga, Jurmala, Olaine, Salaspils, Rezekne and Daugavpils), of whom 37 (19.1%) were women (Centre of Health Economics 2011). 109 patients (88 men and 21 women) were enrolled for the first time in the methadone maintenance programme in 2010, while 88 patients stopped treatment (see Table 5.8).

According to HPC data (handling code 60012), 25538 patients received methadone in 2010, of whom 92 (or 36.1%) attended the program without interruption practically throughout the entire calendar year (358 and more manipulations). 207 (81.2%) men and 48 women (18.8%) attended the program during the year.

[37] The Handling code for dispensing methadone is 60012.

[38] Information on 253 patients is also included in the PREDA system.

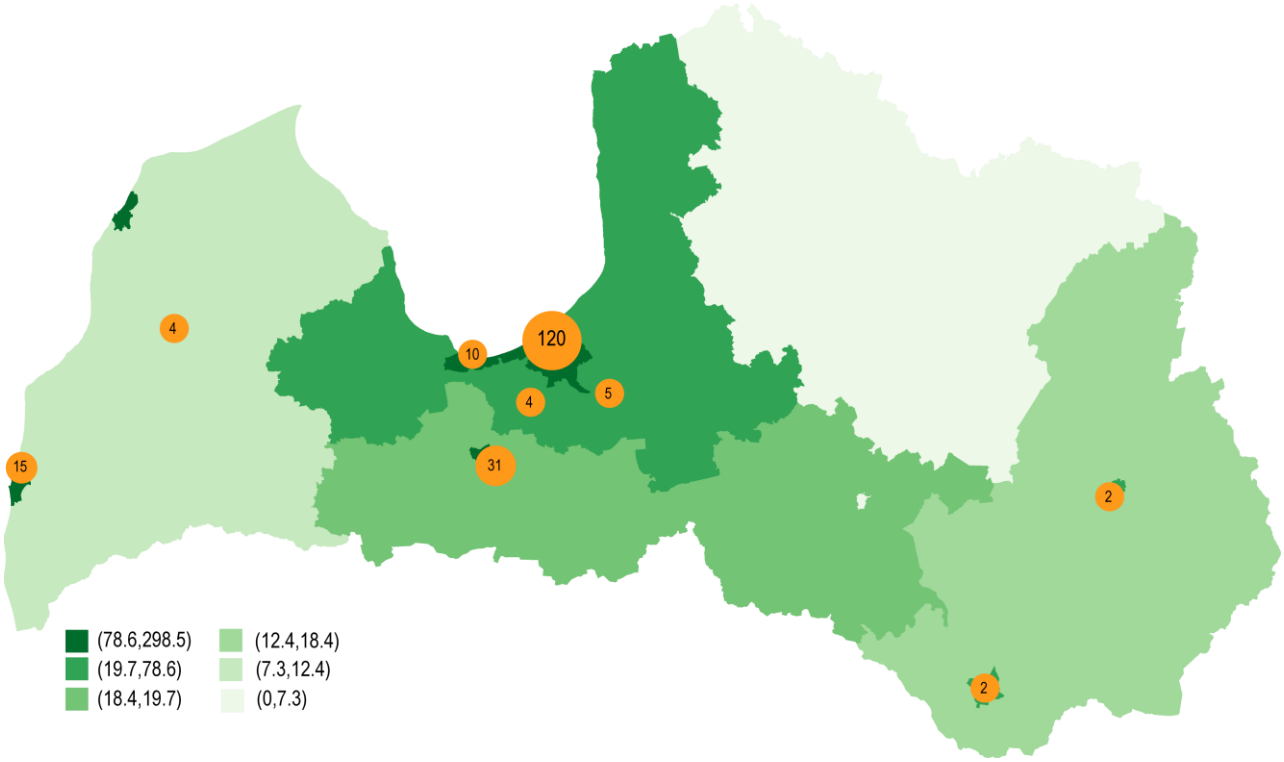
Table 5.8. Number of opioid dependent patients in pharmacological therapy 2007–2010

		Patients accepted into program during year				Discontinued program during year			Included in program during year			In program at end of year		
			First time in lifetime											
		Total	T	W	M	T	W	M	T	W	M	T	W	M
Methadone	2010	141	109	21	88	88	22	66	255	48	207	**193**	37	156
	2009	75	61	7	54	39	7	32	163	37	126	**139**	30	109
	2008	69	44	13	31	41	14	27	132	38	94	**103**	27	76
	2007	55	45	11	34	29	8	21	85	24	61	**75**	21	54
Buprenorphine	2010	17	12	1	11	16	0	16	n.a.	n.a	n.a.	**44**	8	36
	2009	19	18	0	18	15	3	12	n.a.	n.a.	n.a.	**50**	7	43
	2008	35	28	3	25	33	4	29	n.a.	n.a.	n.a.	**61**	10	51
	2007	45	42	8	34	71[39]	16	55	n.a.	n.a.	n.a.	**59**	11	48
Total	2010	158	121	22	99	104	22	82	n.a.	n.a.	n.a.	**237**	45	192
	2009	94	79	7	72	54	10	44	n.a.	n.a	n.a.	**189**	37	152
	2008	104	72	16	56	74	18	56	n.a.	n.a.	n.a.	**164**	37	127
	2007	100	87	19	68	100	24	76	n.a.	n.a.	n.a.	**134**	32	102

Source: Centre of Health Economics 2011; NFP estimates from HPC APANS data 2011

Most patients were in the RCPA-administered program in Riga, in which 120 patients were being treated at the end of 2010. Significantly fewer patients were being treated in methadone programs in other cities and their numbers are reflected in Figure 5.8.

Figure 5.8. Methadone program locations in Latvia and number of clients at end 2010



Source: Centre of Health Economics 2011

The average age of methadone patients of was 32.96 (SD 8.49). The youngest patient to receive methadone in 2010 was aged 19 years, while the oldest was aged 62. Women in the methadone program in 2010 were slightly younger than men, but these differences are not statistically significant, being respectively 32.60 (SD 10.02) and 33.04 (SD 8.12) years *(see Table 5.9)*.

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

Table 5.9. Ages of patients treated in methadone program during years 2008–2010 (%)

	2008	2009	2010
Younger than 20 years	0.0	0.0	0.4
Age 20–24	12.1	8.0	7.1
25–29	29.5	38.0	36.0
30–34	18.2	21.5	26.9
35–39	8.3	6.7	9.1
40–44	9.8	9.2	7.1
45–49	11.4	8.0	5.9
50–54	8.3	6.1	5.1
55–59	2.3	1.8	2.0
60–64	0.0	0.6	0.4
Average age (standard deviation – SD)	34.64 (9.77)	33.32 (9.32)	32.96 (8.49)

Source: NFP estimates from HPC APANS data 2011

According to PREDA information, 5% of patients in methadone programmes have not completed primary education, 45% have completed primary education, 36% have secondary education, and 13% have general secondary/vocational education. In 2010 approximately one in four (25.5%) patients receiving methadone was Latvian, 66.3% were Russians, 4% other ethnicities, while 10 patients had not specified nationality.

Unsurprisingly, the majority of patients in the PREDA system have indicated various opioids as the primary drug used; however, 21 patients have shown other substances on their most recent registration card, which may suggest that the information on these patients has not been updated to indicate medication reflecting their current treatment or other socio-demographic characteristics. This is also evident from the fact that for about 84 (or 33%) patients receiving methadone in 2010 the most recent register card is dated 2004 or earlier.

Available data indicate that of the 315 patients in the methadone program in the period 2007-2010, 22 had died by the end of 2010. The most commonly indicated cause of death for clients of the methadone program is AIDS-induced death (ICD-10 codes B20-B24) (10 cases), while there were two cases of death caused by drug overdose (ICD-10 X42), and two cases of suicide by hanging (ICD-10 X 70).

According to HPC APANS data, 62201 doses of medication were administered to clients in the methadone program during 2010 (by comparison: in 2009 there were 39571 doses and 29903 doses in 2008). The amount of methadone dose is determined for each patient individually by his treating physician, and this may vary during the treatment process.

Alcohol use and quality of life among methadone clients

A study was conducted in 2010 on methadone clients' quality of life and its relationship to alcohol use. A total of 110 methadone program clients was interviewed between April and June. In addition to socio-demographic questions, the survey questionnaire also included WHO-drafted instruments AUDIT and WHOQOL. 83% of the methadone program clients surveyed were men; about half (51.8%) were Russians; about half (53%) were living in Riga. 3% of surveyed clients indicated that they were living with someone who used drugs, and 11% lived with someone who abused alcohol. Respondents indicated their daily methadone dose to be in the range 10 mg – 185 mg, while the average arithmetical dose was 87 mg/day.

Evaluating alcohol usage habits, a little over half (53.9%) of respondents indicated they did not use alcohol or used very little. 44.3% indicated they used alcohol often, while only a few respondents indicated problems with alcoholism. These patients who used alcohol often or excessively rated the psychological and social environment lower.

In general, quality of life was rated as relatively low. Respondents rated the environment the lowest and physical condition the highest. Respondents with alcohol use problems generally rated quality of life slightly lower than those who rarely or never used alcohol. Likewise, the smaller the dose of methadone, the higher was the rating given to quality of life. The more time had passed since

joining the program, the lower was the overall quality of life. Women also rated quality of life in general lower than men, especially in terms of physical condition.

The overall low evaluation for quality of life among patients in methadone replacement therapy suggests a number of negative factors, such as the poor state of health or social exclusion, which are not conducive to successful therapy results.

Evaluation of Methadone program

In 2011 the second evaluation of long-term pharmacotherapy with methadone in Latvia was undertaken (Pūgule, Sīle, Zīle 2011), with a view to evaluating the quality of existing services and to assess the program's future operational capability. The evaluation of methadone pharmacotherapy used methodology based on that developed by the Netherlands Institute of Mental Health and Addiction (Trimbos Institute) and the University of Ljubljana, which was used in making the first evaluation of pharmacotherapy in Latvia (Sīle, Pūgule 2008), and a similar evaluation of pharmacotherapy in Slovenia (Trautmann 2007).

As part of the study, to assess the quality and efficiency of pharmacotherapy, 11 interviews were conducted with staff of methadone bureaux and 7 interviews with experts in this field. However, to evaluate client satisfaction, 135 interviews were conducted with clients of the methadone program. Results of the assessment established the strong and weak points of the program, and recommendations were given for improving the work of pharmacotherapy and the provision of methadone pharmacotherapy in the future. Recommendations include issues related to legislation, guidelines, staff, clients and treatment.

The dose of methadone in Latvia is determined by the treating physician individually for each client, and may vary during the treatment process. The results of the study undertaken as part of the evaluation of the methadone program indicate that the average dose of methadone for clients in Riga is 75 mg, while the maximum dose is 180 mg/day. In Latvia's regional areas the average methadone dose is 75 mg, but the maximum is 230 mg/day.

Clients have access to various services and treatment options. Even in regions where a methadone bureau is localized in a treatment institution, clients have access to a wider range of other services: detoxification (including with buprenorphine), treatment with benzodiazepines and other medications (clonidine), counselling, psychological and social assistance, the opportunity of obtaining information on communicable diseases, the risks of overdose, as well as treatment with naltrexone after detoxification. It is also possible to submit samples for HIV and hepatitis C testing.

Overall, the results of the study suggest that methadone clients' health is rated as slightly or much better now than in the period prior to joining the program. This was indicated by a total of 87% of respondents. Also, in the period a year later, the majority of respondents (65%), indicated their health situation as slightly or much better (n=132).

6. Health correlates and consequences

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

6.1. Drug-related infectious diseases

Notifications data

HIV/AIDS

According to data from the State Agency Infectology Center of Latvia (ICL), 133 860 blood samples (including blood donors) were tested nationally in 2010 in laboratories of the Epidemiological Monitoring Network (EMN) and low-threshold centres to diagnose HIV infection; the number of people tested had therefore decreased by 0.8% compared to 2009 (n = 134 919)). Of all blood samples tested, 1.4% (n = 81) had been taken from injecting drug users (IDUs), which is about 1.6 % less than in the previous year. As shown in Table 6.1, there has been a decreasing trend in recent years in the number of blood samples tested. One explanation for this could be a reduction in the number of tests performed among prisoners. In recent years, to conserve financial resources, set investigation criteria have been introduced for prisoners to avoid retesting prisoners who had already been diagnosed with the infection. In 2010, 2506 HIV tests were done on prisoners, in 2009, 2160 tests were done, and in 2008, 3301 tests were done (Ministry of Health 2011).

Table 6.1. Total number of blood samples tested to diagnose HIV infection and proportion of tested IDU blood samples in Latvia, 2003-2010

	Number of blood samples tested in the EMN, other laboratories and HIV prevention points (including 1114 tests on IDUs at HIV prevention points.	Total number of samples tested excluding donors, in the EMN, other laboratories and HIV prevention points (including 1114 tests on IDUs at HIV prevention points	Total number of IDU blood samples tested in EMN laboratories
2003	164936	80487	987
2004	155128	83864	212
2005	142333	85538	363
2006	153193	85117	349
2007	148619	79279	386
2008	152010	72277	357
2009	134919	59331	176
2010	133860	58826	81

Source: Infectology Center of Latvia 2011

Similarly, the number of HIV tests carried out may have reduced because the number of women giving birth has decreased nationally in recent years, and consequently, so has the number of tests carried out on pregnant women (in 2010 there were 19 011 women giving birth (18 412 tested), in 2009 – 21 599 (20 608 tested), in 2008 – 23 834 (22 619 tested) (Upmace 2011). The number of tests performed may also have reduced due to a reduction in the number of blood donors; in 2010, 36 916 donors attended the State Blood Donor Center (SBDC) compared with 38 986 the year before and 44 619 in 2008 (State Blood Donor Center (SBDC) 2011).

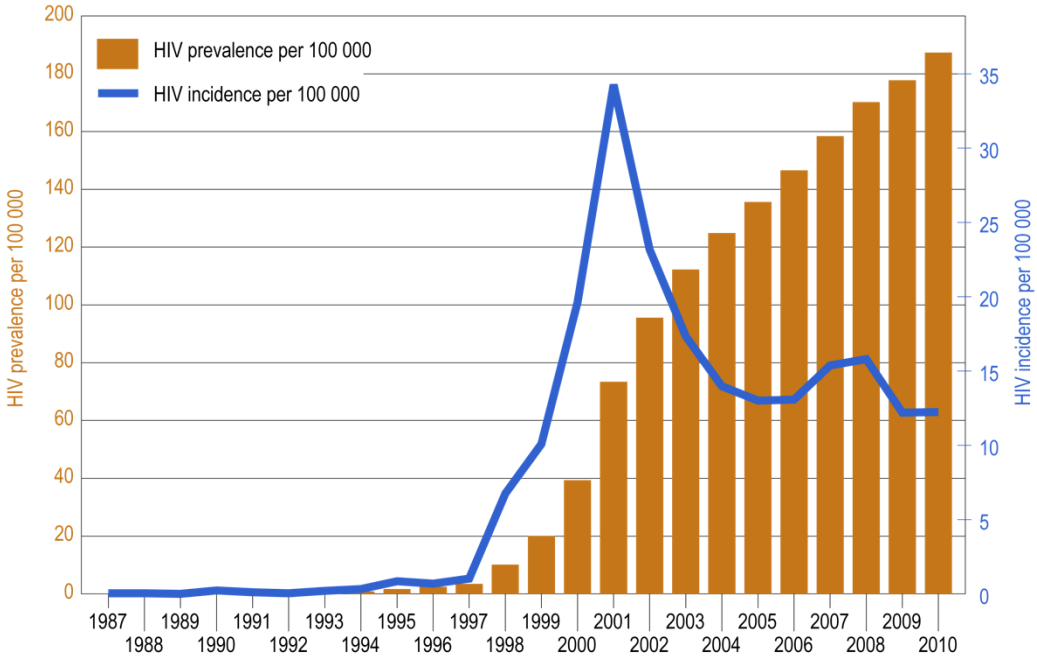
However, it would also be necessary to repeat the HIV testing incentive campaign, informing health care professionals who are responsible for assessing patients for clinical and epidemiological indications for HIV testing (paying particular attention to professionals in regional areas, since most HIV cases are diagnosed in Riga (82%) (Upmace 2011), and also informing members of increased infection risk groups.

By the end of 2010 a total of 4888 cases (4614 in 2009) of HIV infection had been recorded nationally, of whom 953 persons were diagnosed with AIDS. At the same point in time, 712 deaths were recorded among persons living with HIV. Thus, HIV prevalence in the country at the end of the year 2010 was 187 per 100 000 population (compared with 178 per 100 000 in 2009).

Last year, 274 new cases of HIV infection were recorded nationally (12.2 per 100 000 population) (275 in 2009). As shown in Figure 6.1, a stabilisation in the number of newly recorded HIV cases is observable nationally over the last seven years. However, compared to other European countries, Latvia is still among the countries with a high incidence of HIV (in 2009, the average indicator in Europe was 5.7; Estonia 30.7; Lithuania 5.4) (ECDC 2010; Ministry of Health 2011).

In terms of AIDS incidence rates Latvia ranks first in Europe (in 2010 there were 5.5 cases per 100 000 population; in 2009 4.3 per 100 000 population). (Ministry of Health 2011). (In 2009, the average for Europe was 1.0; Lithuania 1.1) (ECDC 2010; Ministry of Health 2011).

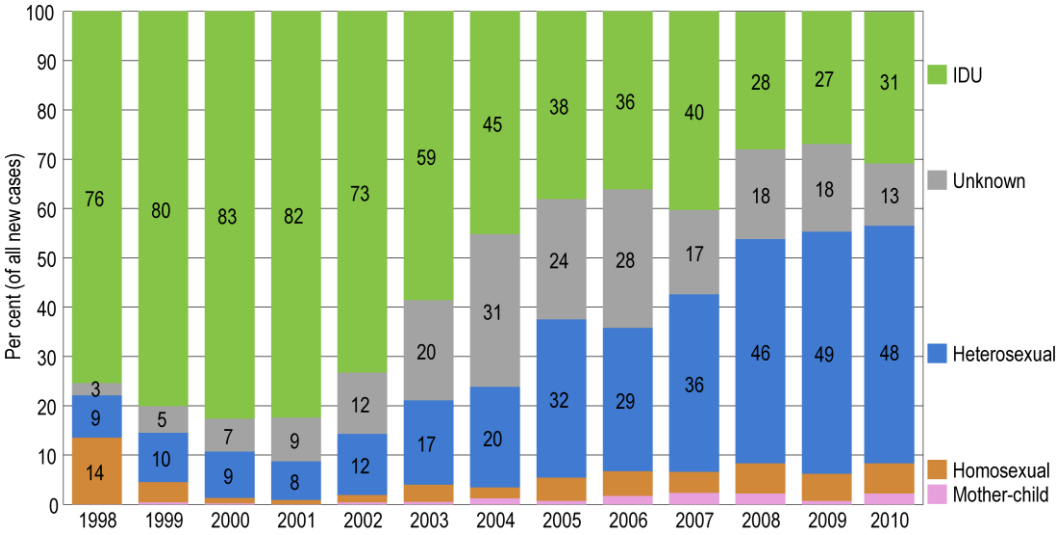
Figure 6.1. HIV prevalence (per 100 000 pop.) and new HIV cases recorded annually (per 100 000 pop.) in Latvia, 1987-2010



Source: Infectology Center of Latvia 2011

In 2010 the leading transmission route for HIV in Latvia was heterosexual intercourse. This situation has been observable in the country since 2008. The second most common infection route is the sharing of injecting drug use paraphernalia. In 2010 47.8% (n = 131) (49.1 % in 2009) of new HIV cases were acquired by way of heterosexual transmission, 6.5% (n = 18) (5.5% in the previous year), via homosexual contact, 1.5% (n = 18) (0.7%), by vertical transmission and in 12.8% (n = 35) (previously 17.8%), the infection route is unknown (See Figure 6.2.). A small increase is seen in the number of cases acquired by injecting drugs: in 2010 this was 31.4% (n=86); compared to 26.9% in 2009, but this difference is not regarded as statistically significant (p = 0.4).

Figure 6.2. Distribution of annual new HIV cases (in absolute numbers) by transmission groups, 1998–2010



Source: Infectology Center of Latvia 2011

Of all new HIV cases in 2010, 62.0% (n = 170) were men and 38.0% (n = 104) were women. The situation was identical in 2009. As concluded previously, HIV infection in Latvia continues to be concentrated among IDUs and their sex partners. Latvia still does not have a generalized epidemic, as HIV prevalence among pregnant women is less than 1%, which is one of the generalisation indicators for this infection (of all examined women giving birth in 2010, 0.39% were HIV positive) (UNAIDS 2011).

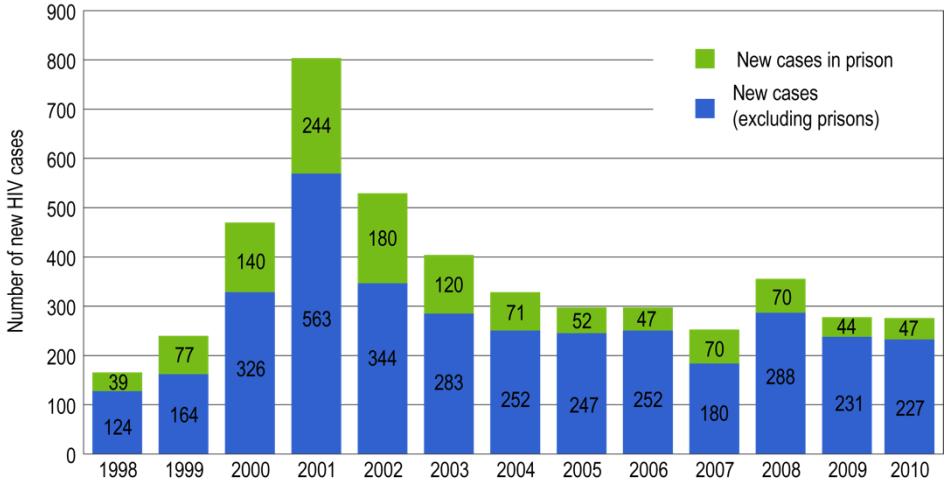
By 31 December 2010, 2775 persons (56.8% of all recorded cases) who had acquired the infection via injecting drug use were recorded in Latvia. Men predominate these cases at 77.5% (n = 2151) and the IDUs were most commonly aged 20-24 years at the time of diagnosis (30.2%, n = 838).

Also examining the new HIV cases recorded annually for IDUs, a mostly male proportion is observed (80.2% in 2010; n = 69). Young people continue predominate among the cases reported. Indeed, in recent years the age of IDUs at the time of diagnosis of infection was slightly higher: predominantly in the age group 25-29 years: (in 2010, they comprised 27.9% of all injecting drug use cases recorded during the year; n = 24; 23.0%; n = 17 in 2009,) and 30-34 years (25.6%, n = 22 in 2010; 25.7%, n = 19 in 2009).

Of all persons infected via IDU until the end of 2010 (n = 2775), 20.2% (n = 561) were diagnosed with AIDS and 17.7% (n = 490) of the HIV-infected IDUs had died. Examining new cases: of all new cases recorded in 2010 (n = 86), AIDS was identified in 13 people (compared to 2 cases of 74 in 2009) and 6 people had died (in the previous year, 2 cases of 74 had died).

Until the end of last year, 1202 cases of HIV infection were diagnosed among persons located in prisons (i.e. 25.0% of all recorded cases of infection in the country). Examining the annual infection cases, the previously observed trend has continued in 2010, namely that about a fifth of them will be diagnosed among prisoners; last year of 274 recorded cases, 17.2% (n = 47) were diagnosed among prisoners *(see Figure 6.3)*.

Figure 6.3. Total annual new HIV cases nationally and diagnosed cases in prisons, 1998–2010

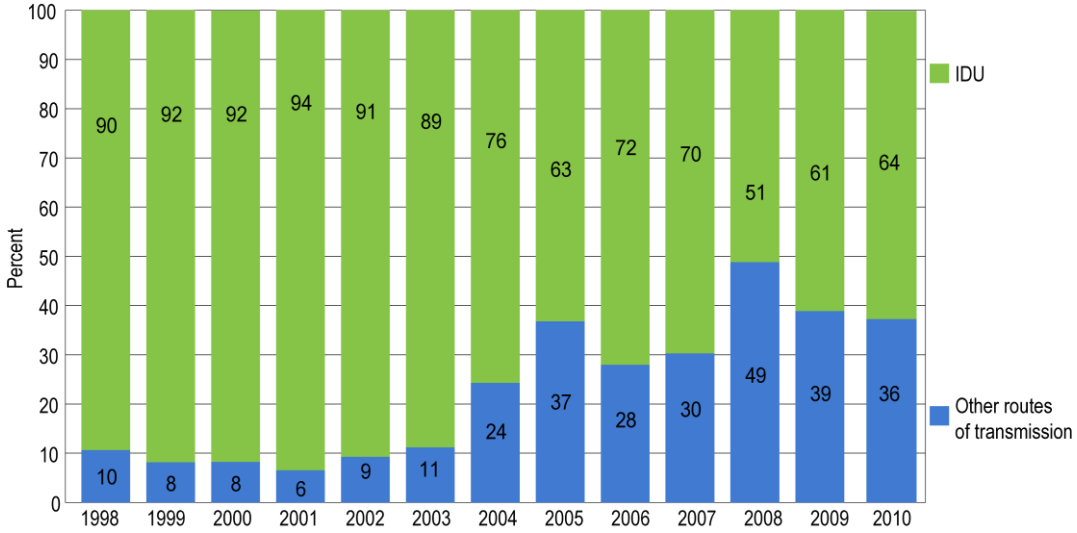


Source: Infectology Center of Latvia 2011

By examining the number of HIV infection cases recorded annually for prisoners, it may be concluded that the situation is similar as in previous years, namely, the transmission of infections by injecting drugs remains predominant. As in the general population, the proportion of cases for sharing injecting paraphernalia has slightly increased from 61.4% (n = 27) of cases in 2009 to 63.8 per cent (n = 30) in 2010. (See Figure 6.4.). However, as in the general population, this difference is not statistically significant (p = 0.8).

As already mentioned in the previous year's Report, the majority of HIV infection cases among prisoners is diagnosed upon their arrival in prison. Testing during time served in prison or at release is carried out only in exceptional cases. Consequently, it is not possible to identify whether these infections have been acquired before imprisonment or during imprisonment, e.g., during an earlier period of detention (Latvian Prison Administration data indicate that more than half of the convicts in prison are repeat offenders, for example, in 2010 only 42.8% had been imprisoned for the first time, the remaining prisoners were repeat prisoners; furthermore most convicted prisoners were there for a protracted period: in 2010 36.2% of prisoners had sentences imposed of 5-10 years, the second most common period (23.2%) was 3-5 years) (Latvian Prison Administration 2011). It would therefore be useful to carry out systematic studies of HIV prevalence among prisoners to estimate the true extent of the infection in Latvian prisons.

Figure 6.4. Proportion of cases acquired by injecting drugs of annual HIV cases recorded for prisoners, 1998–2010



Source: Infectology Center of Latvia 2011

There were 18 HIV prevention points (the so-called "HIV Prevention Network") were operating in Latvia in 2010. As part of this harm reduction programme, in addition to other services clients are also invited to take a HIV express test. In 2010 this test was taken by 1072 persons of whom 68

(6.3%) had a reactive result, which is less than for the previous year (2009) when 1238 HIV tests were conducted, and reactive results showed for 109, or 8.8% (p = 0.03). The reduced proportion of positive results for this test could be explained by intensification in identifying cases in 2009. In 2009 a cross-sectional study was carried out (for ease of selection) in the Ventspils HIV Prevention Point, in which 195 new clients (injecting drug users) were recruited, of whom 70.0% (n = 133) were men. Half (50.0%, n = 97) of the respondents were of Roma ethnicity and 47.2% (n = 91) had incomplete elementary education. During the study a significant number of HIV infection cases were identified; the test was positive for one third of IDUs (29.2%, n = 57) (Public Health Agency 2009).

Table 6.2 shows, by strata, the proportion of reactive results from testing done in the HIV prevention points by gender, age, injecting duration and primary drugs injected. As can be seen, HIV prevalence is higher in older male IDUs, as well as among IDUs with a longer injecting duration and who have indicated heroin or other opioids as the primary drug injected.

Table 6.2. Number of HIV relative express tests and proportions by gender, age, period of injecting and primary drug injected

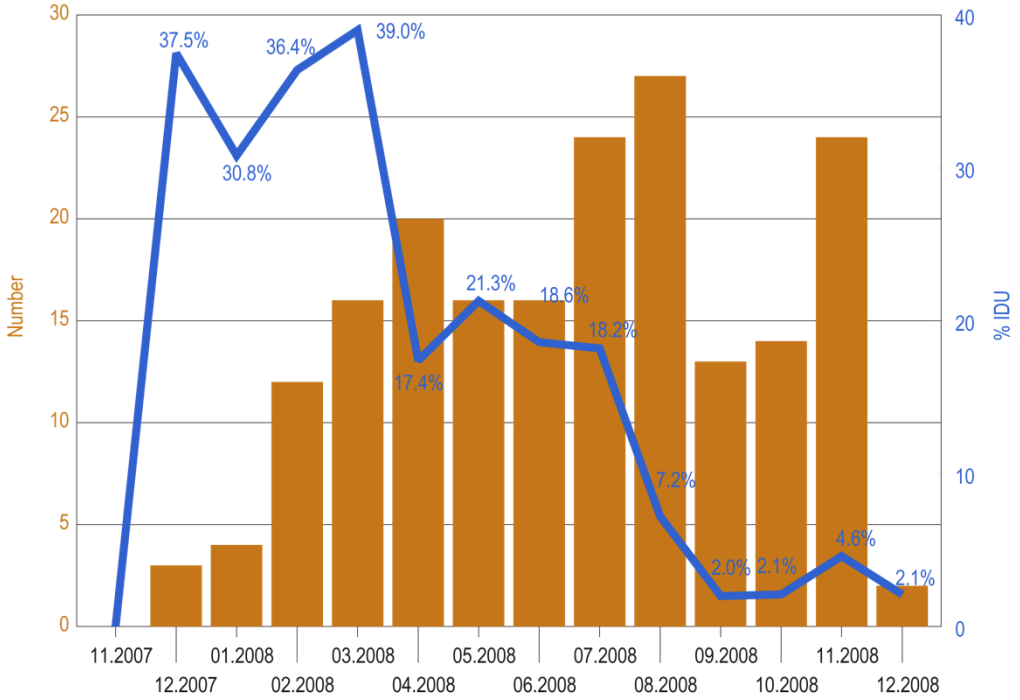
	2009.		2010.	
	n	%	n	%
Gender				
Male	73/618	11,8	26/461	5,6
Female	26/269	9,7	8/159	5,0
Age				
<25 years	22/331	6,6	6/175	3,4
25-34 years	48/393	12,2	16/293	5,5
>34 years	29/162	17,9	12/148	8,1
Period injecting				
<2 years	5/112	4,5	1/36	2,8
2-4 years	10/125	8,0	5/107	4,7
5-9 years	30/211	14,2	4/98	4,1
10 or more years	47/316	14,9	17/201	8,5
Primary drug used				
Opioids	72/497	14,5	18/245	7,3
Other drugs	24/271	8,9	7/225	3,1

Source: Infectology Center of Latvia 2011

Hepatitis A/B/C

According to information provided by ICL, the situation regarding prevalence of viral hepatitis A has stabilised. As is known, there was a sharp increase in the number of hepatitis cases in Latvia between November 2007 - 31 December 2008, with 2817 cases diagnosed in that period. It is thought that the outbreak initially spread among drug users and other risk groups due to non-observance of hygiene standards. Of all cases in the outbreak, 191 (6.8%) were identified among drug users (of whom 90% were injecting drug users). The outbreak was initially observed directly in the country's capital and it is estimated that the incidence of hepatitis A among IDUs living in Riga during that period reached 3216 per 100 000 (Perevoščikovs et al. 2009). The number of cases among IDUs, and the proportion of cases referred to from all cases identified, is shown in Figure 6.5.

Figure 6.5. Number of virus hepatitis A cases among IDUs and proportion of IDUs for all cases recorded in Latvia, November 2007-December 2008



Source: Perevoščikovs et al. 2009

The number of cases of hepatitis A was also high in 2009 (2291), but in 2010 the situation stabilized, with 297 hepatitis cases recorded, of which only three were among IDUs. It should be noted that the number of IDU cases may be significantly larger because in most cases it is unknown whether the illness was diagnosed in any of the socially vulnerable groups (in 294 cases the person's drug use status is unknown).

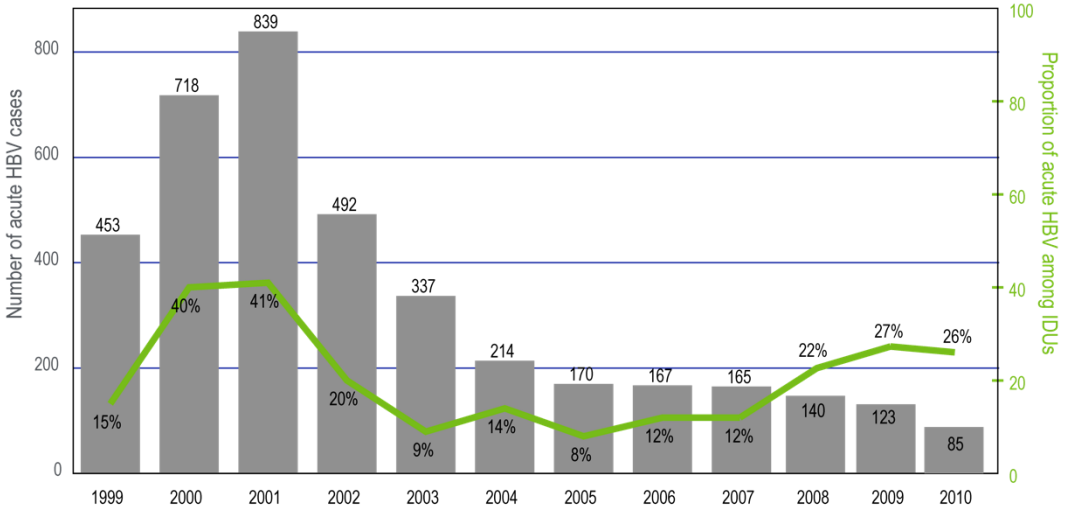
In 2010, 85 cases of acute viral hepatitis B were recorded nationally (123 in 2009); of those, 44 (51.8%) were males. 22 cases (or 25.9%) were acquired via IDU. As shown in Figure 6.6., the incidence of acute hepatitis B, as well as the proportion of IDUs among those cases has remained stable in recent years. However, there is a decreasing trend in the total number of cases diagnosed with hepatitis each year.

In 2010 chronic virus hepatitis B was identified in 43 persons, of which 3 cases (7.0%) were drug injectors. Compared with previous years, it can be concluded that, as in the case of acute hepatitis B, the number of chronic hepatitis B cases identified has decreased (the infection was diagnosed in 73 persons in 2009, and in 70 persons in 2008).

It should be noted that there is still a very high proportion of cases where the transmission route has not been identified; in 2010 it was observed in 16.5% (n = 14) acute and 65.1% (n = 28) chronic hepatitis cases. Thus, it is likely the proportion of IDUs among identified cases is significantly higher.

Experts explain the annual reducing trend in the number of newly diagnosed cases of hepatitis B by the likely impact of vaccination (since 1997 all new-borns in the country have been vaccinated against hepatitis B, and since 2007 children born before 1997 have been vaccinated at the age of 14 (Infectology Center of Latvia 2011)). However, this could be also explained by a reduction in the number of tests for diagnosis of hepatitis, or problems in the reporting of cases.

Figure 6.6. Number of new acute hepatitis B cases diagnosed annually (in absolute numbers) and Proportion of cases acquired by injecting drugs (%), 1999–2010



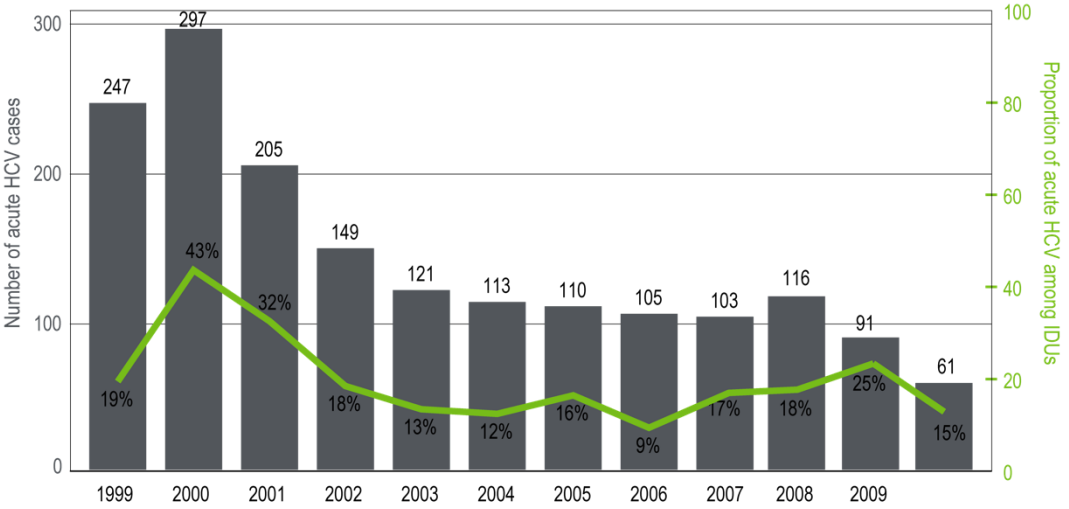
Source: Infectology Center of Latvia 2011

In 2010 61 cases of acute viral hepatitis C were recorded in Latvia, which is less than in previous years (91 in 2009, 116 in 2008). Of the 61 cases, 9 cases (14.8%) were identified among injecting drug users (see Figure 6.7.). It appears that the number of diagnosed hepatitis B cases, as well as diagnosed hepatitis C cases, has reduced in recent years. Since 2006, the proportion of IDUs among reported cases was growing steadily, but in 2010 it has reduced.

The incidence of chronic hepatitis C infections has fallen in 2010 (1052) in comparison with previous years: (1271 in 2009, 1352 in 2008). A tenth of all cases (10.7%, n = 113) was diagnosed among IDUs.

There is still a high proportion of cases with an unidentified infection path: 13.1% (n = 8) acute cases and 63.2% (n = 665) chronic hepatitis C cases. Consequently, the proportion of IDUs among identified cases is most likely to be greater. This might suggest the need to undertake educational and motivation activities for health care professionals in case investigation and the correct filing of urgent reports.

Figure 6.7. Number of new acute hepatitis C cases diagnosed annually (in absolute numbers) and proportion of cases acquired by injecting drugs (%), 1999–2010



Source: Infectology Center of Latvia 2011

According to experts, the reduction of diagnosed hepatitis B and C cases in recent years could also be explained by changes in early 2009 to arrangements for reimbursement of medication for outpatient treatment: where previously the State reimbursed 75% of the cost of medication necessary for hepatitis treatment, then, with the country's financial situation changing, this proportion was reduced to 50% (LR Cabinet of Ministers Regulation No 899, 31.10.2006; with amendments of 01.03.2009). Consequently, it is possible that people's motivation of to be tested

may have dropped, for if diagnosis and starting treatment of infection becomes necessary, they may not be able to afford to contribute to the cost of purchasing medication.

In 2010, 279 express tests for hepatitis C were conducted in 18 HIV Prevention points (syringe exchange points), of which 57.0% (n = 159) indicated a reactive result. It may be concluded that compared with 2009, both the number of tests carried out, and the proportion of the reactive express tests ($p<0.001$) have increased. In 2009, there were 192 tests done, of which 35.9 were reactive. This could be explained by the Peer-driven intervention activity implemented as part of the UNODC project. As part of the activity a significant number of new clients was attracted to the HIV prevention program, who were then trained in harm reduction issues, as well as encouraged to undertake express diagnosis for infection (see the Section on Preventing infections associated with injecting drug use).

In 2010, a study was conducted (from results of the ENCAP study which is described in the 2009 Reitox National Focal Point Report), on HCV-associated factors in the Baltic States. Performing logistic regression analysis (adjusting was done using the conceptual framework approach (Victora et al. 1997), including factors in the adjusting, which proved to be significant (with significance level 0,1) in single factor analysis) revealed that in Latvia the following factors have a statistically significant association with HCV: the source of income for the past 6 months, duration of injecting and injecting frequency, primary drug injected, drug addiction treatment during lifetime that may be attributed to examinations conducted on patients during the treatment, resulting in new cases of infection being identified.

HCV positive status was not statistically significant in relation to factors such as age, gender, nationality, shared syringes in injecting drug use, number of sex partners and use of condoms with casual sex partners, imprisonment during lifetime, and attendance at syringe exchange points during lifetime (see Table 6.3.) (Karnite et al. 2010).

Table 6.3. Factors associated with positive HCV status among IDUs in Latvia

	Unadjusted OR (95% TI)	AdjustedOR* (95% TI)
Age (≥25 vs. <25 years)	**3.0 (1.8-4.9)**	1.2 (0.6-2.5)
Gender (woman vs. man)	**0.5 (0.3-0.8)**	0.6 (0.3-1.2)
Main income source in last 6 months (other vs. full/part time work)	1.4 (0.8-2.5)	**3.5 (1.5-8.0)**
Nationality (other vs. Latvian)	**2.4 (1.5-3.8)**	1.5 (0.8-2.7)
Injecting duration	1.6 (0.8-3.6)	1.1 (0.4-2.8)
(3-5 vs. ≤2; >5 vs. ≤2 years)	**7.3 (3.9-13.7)**	**4.8 (2.1-10.8)**
Injecting frequency (daily vs. less than daily)	**6.2 (2.7-15.3)**	**4.0 (1.6-10.4)**
Primary drug injected during last 4 weeks	**5.3 (3.0-9.4)**	**2.2 (1.1-4.4)**
(opioids vs. amphetamine; other vs. amphetamine)	**7.8 (2.8-23.4)**	**3.7 (1.2-11.4)**
Using shared syringe during last 4 weeks (has used vs. has not used)	**1.7 (1.1-2.8)**	1.6 (0.9-3.1)
Number of sex partners during last 12 months (>2 vs. 0/1)	0.62 (0.4-1.0)	0.6 (0.3-1.2)
Used condom with casual sex partners during last 6 months (ever vs. never)	0.8 (0.3-2.1)	0.9 (0.2-3.2)
Imprisoned during lifetime (has vs. has not been)	**3.5 (2.0-5.9)**	1.6 (0.8-3.3)
Treatment for addiction during lifetime (has been treated vs. has not been treated)	**6.3 (3.4-12.2)**	**3.4 (1.6-7.5)**
Attendance at syringe exchange program during lifetime (has attended vs. has not attended)	**2.6 (1.6-4.5)**	1.5 (0.7-2.9)

** Adjusted by: age, gender, main source of income, nationality, injecting duration, injecting frequency, primary drug, using shared syringe, imprisonment, addiction treatment, attendance at syringe exchange point*

Source: Karnite et al. 2010

According to data from the cohort study of drug users practically all drug users (98%) have at least once in their lifetime been tested for HIV, while 89% had tested for hepatitis B and C. Historically, testing for infectious diseases has never been done in the cohort study (Trapencieris, Sniķere and

Kaupe 2011), but information is available on testing within the last 12 months, which is a significant indicator to evaluate testing programs and the extent to which the target group was reached.

Relatively recently, or during the study year and the previous year[40] 72% of drug users had been tested for HIV, but less than half (41%) drug users had been tested for hepatitis (see Table 6.4.).

According to responses from drug users themselves, 22% were HIV positive.

Table 6.4. Proportion of respondents tested for HIV and hepatitis in four cohort stages, % of respondents

	Ever tested		Recently tested*		Those indicating positive infection status**		
	HIV	Hepatitis B and C	HIV	Hepatitis B and C	HIV	Hepatitis B	Hepatitis C
2007	87	70	67	52	20	22	53
2008	89	74	75	62	18	17	61
2009	96	86	70	46	18	16	66
2010	98	89	72	41	22	11	63

Source:Trapencieris, Sniķere and Kaupe 2011

However, it should be noted that in the cohort study, HIV and viral hepatitis status has been self-reported by respondents, and may not correspond to the actual status. From the 2007/2008 bio behavioural cross-sectional study undertaken within the EC project (ENCAP) (RDS selection method, with 407 IDU respondents) the results were stipulated for the self-reported HIV status diagnostic sensitivity and specificity of the method. It was ascertained that it is a specific (n = 209/211 = 99.1%; 95% TI 96.6-99.7), but not particularly sensitive (n = 42/72 = 58.3%; 95% TI 46.8-69.0) method for the determination of HIV status *(see Table 6.4)*.

Table 6.5. Number of respondents: self-reported or HIV status diagnosed during study

HIV test result (sero-status)	Self-reported HIV status			Not previously tested for HIV	Unknown whether previously tested	Total
	Positive	Negative	Unknown			
Positive	42	30	2	18	0	92
Negative	2	209	7	95	2	315
Total	44	239	9	113	2	407

Source: Karnite et al. 2011

Sexually transmitted diseases and tuberculosis

According to information provided by ICL, first-time cases of tuberculosis (TB), in Latvia have stabilised in recent years (see Figure 6.8), which is regarded as positive, having regard to the financial crisis and the deterioration of socio-economic conditions in the country in the previous year. In 2010, 825 (36.6 per 100 000 population) first-time TB cases were recorded in Latvia; in the previous year the number was almost identical (830; 36.6 per 100 000 population). The indicators continue to be higher for men than women: in 2010 the number of first-time cases per 100 000 men was 52.2 (n = 543) (53.5 in 2009; n = 559) and per 100 000 women it was 23.2 (n = 282): (22.2 in 2009; n = 271). In 2010, there were 109 (4.8 per 100 000 population) TB relapses recorded, which is slightly less than in the previous year (n = 123; 5.4 per 100 000 population).

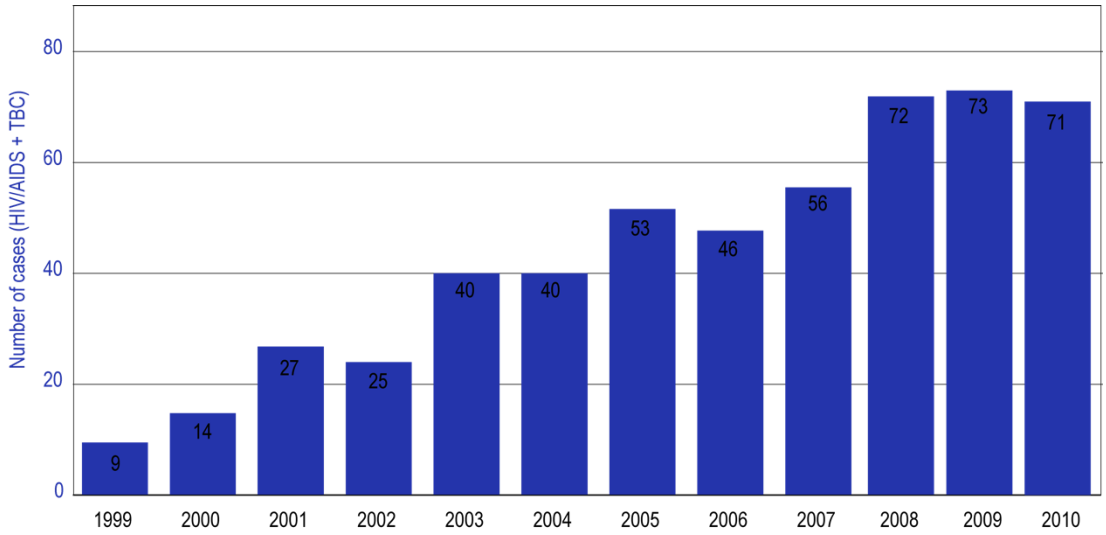
Dual infections for HIV/TB (first-time and relapsed) have also stabilised (see Figure 6.8.): 71 such cases were recorded in 2010 (73 in 2009). As in the previous year, the majority of patients (50 or 72.5%) with dual infection are men (2009: 61.6%, n = 45).

Of all first-time TB cases, 49 persons (5.9%) were drug users (of which 40 were men). It is possible that this proportion of drug users among new TB cases could be estimated higher because drug use status is based on the patient's own statements and if the physician does not specifically ask patients about their risk behaviour factors, this information is not recorded.

[40] This indicator was selected because a significant proportion of drug users are unable to recall the month in which test was taken

Of all HIV/TB dual infection cases the proportion of drug users in 2010 was 50.7% (n = 37; 29 were men).

Figure 6.8. Number of cases of HIV/TB dual infection in Latvia, 2000–2010



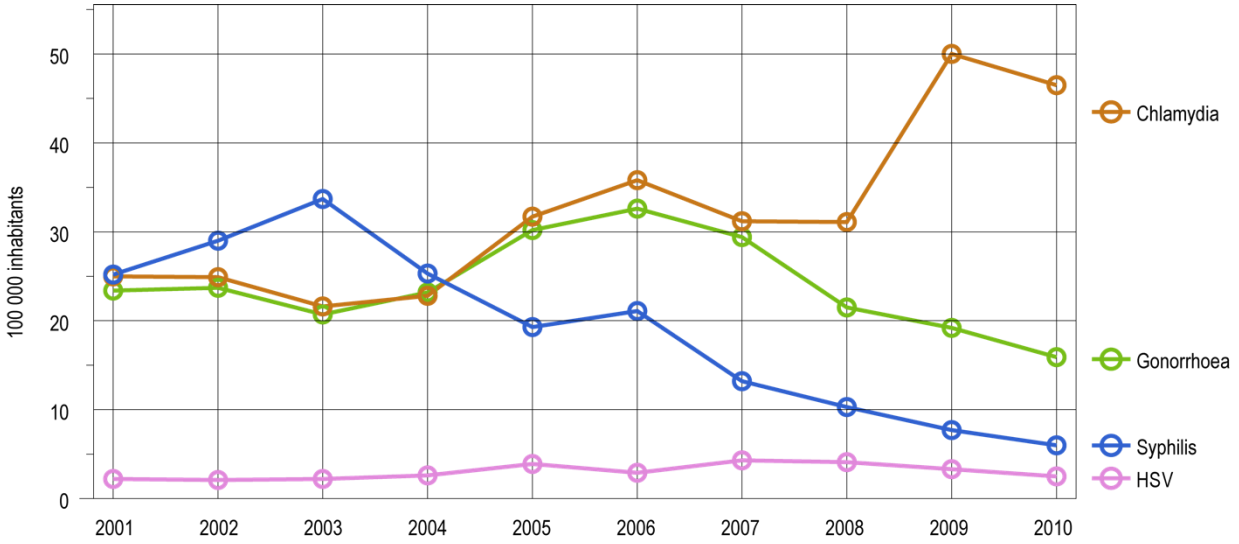
Source: Infectology Center of Latvia 2011

Of all first-time TB cases in 2010, 16.4% (n = 135) were children and juveniles to age 24 (16.8% in 2009, n = 139). Dual HIV/TB infections are identified in older age groups (in 2010 only 2 of 71 cases were juveniles to age 24; in 2009, 7 of 73).

Mortality from TB has also reduced each year: in 2010 74 persons had died (3.3 per 100 000 population). (88 in 2009; 3.9 cases per 100 000 population). Mortality from tuberculosis still remains higher among men than among women: in 2010, 63 men had died (6.1 per 100 000 population) and 11 women had died (0.9 per 100 000 population).

Information provided by ICL shows that compared with 2009, the number of recorded cases of infection with sexually transmitted infections decreased in 2010. There were 2.5 cases recorded of anogenital herpes virus (HSV) infection per 100 000 person-years, 6.0 cases of syphilis and 15.9 gonorrhoea cases per 100 000 person-years. The highest was the number of chlamydia cases recorded: 46.5 per 100 000 person-years (see Figure 6.9.). Unfortunately, information about whether and how many of the infections occurred among drug users is not available.

Figure 6.9. Recorded cases of sexually transmitted infections (per 100 000 person years) during 2001–2010



Source: Infectology Center of Latvia 2011

In considering various issues associated with sexual risk behaviour among IDUs, it must be concluded that this behaviour is very common and the risk of STI transmission among injecting drug users is high. This is evidenced by the results of research conducted in recent years.

For example, as part of the UNODC PDI activities in 2010, a survey of IDUs was undertaken (Dompalma et al. 2010). 1152 respondents participated in the study, with an average age of 28.9 years (17-68), of whom 76.6% (n = 883) were men and 40.6% (n = 465) had been imprisoned during their life time. A total of 11 HIV prevention points in 10 Latvian cities participated in the study. The number of respondents, as well as the proportion of total number of respondents is shown in Table 6.5.

Table 6.6. Number of respondents in cities and proportion of total respondents

City	Number of respondents (n)	*Proportion of total respondents (%)*
Bauska	16	1.4
Cēsis	3	0.3
Daugavpils	299	26.0
Jēkabpils	126	10.8
Jūrmala	20	1.7
Liepāja	26	2.3
Ogre	128	11.1
Olaine	150	13.0
Rīga	382	33.2
Saldus	2	0.2
Total	1152	100

Source: Dompalma et al. 2010

According to the first results of the UNODC study, the majority of respondents (70.7%) had been sexually active in the last month. Only a third (34.5%) of respondents who had more than one sex partner during the last month had always used a condom during the sexual contact. Of those respondents who in last month had had sex with a casual partner, only 29.9% had always used condoms (27.5% responded that they had never used condoms during intercourse with casual partners). It was also found that amphetamine users were more sexually active and with a greater number of sex partners than heroin injectors (Dompalma et al. 2010). An in-depth study is to be presented at the May 2011 European AIDS Conference in Tallinn, Estonia on the relationship between injected drugs and sexual behaviour having an increased risk of infection, and it will be included in the next National Report on the situation regarding the drug addiction problem in Latvia.

As shown by the 2010 comparison of amphetamine and opioid injectors (from ENCAP study data), sexual risk behaviour is more common among amphetamine injectors, but the differences between those drugs are not regarded as statistically significant (for example, 90.8% amphetamine injectors and 90.3% of opioid injectors (p = 0.9)sexually active over the past few months had been; 49.6% amphetamine users and 44.9% of opioid users (p = 0.4) had had 2 or more sex partners during the last 12 months; a condom was not always used during sex with casual partners by 56.1% of amphetamine users and 38.6% of opioid users (p = 0.1) (Karnīte et al. 2010b).

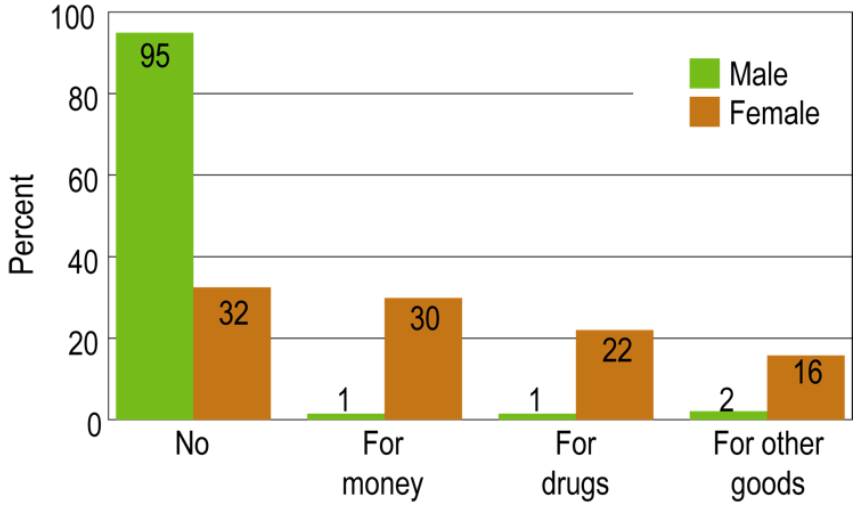
In the 2009 Ventspils study mentioned previously, it was also found that most respondents had been sexually active during the past 4 weeks (94.3%; n = 183). Of those, only 25.2% (n = 46) had used a condom during their previous act of sexual intercourse (Public Health Agency 2009).

Data from the cohort study of drug users (Trapencieris, Sniķere, Kaupe 2011) shows that 87% of drug users had been sexually active within the past 12 months, while about two-thirds (65%) of drug users indicated the existence of a regular sex partner. The majority of drug users were in monogamous sexual relationships: 58% indicated that during the past month they had had one sex partner, 14% had two partners, 23% had three or more sex partners, and 5% noted that they had not had sexual relations during the past month. In comparison with the previous study periods in 2010 there is slightly higher rate of condom use during the last act of sexual intercourse (45% in 2007, 49% in 2008, 46% in 2009, and 55% in 2010).

During their lifetime approximately every fourth respondent (25%; 6% of men and 65% of women) had had sexual intercourse for money, drugs or other material benefits. Sexual services for money during their lifetime had been provided by 20% of drug users; by 17% of drug users to receive drugs, while 13% of respondents indicated receiving other forms of material benefits.

Last year 15% of respondents received money for sexual services, 11% received drugs, and 9% reported other material benefits. There are significant differences by gender *(see Figure 6.10).*

Figure 6.10. Sex for money, drugs or other material benefits during last 12 months by gender, %



Soruce: Trapencieris, Sniķere, Kaupe 2011

6.2. Other drug-related health correlates and consequences

Non-fatal overdoses and drug-related emergencies

The results of the 2010 cohort study (Trapencieris, Sniķere and Kaupe 2011) show that 40% of drug users had overdosed during their lifetime. The proportion of women overdosing is slightly higher than for men (42% to 38% respectively), but these differences are not statistically significant.

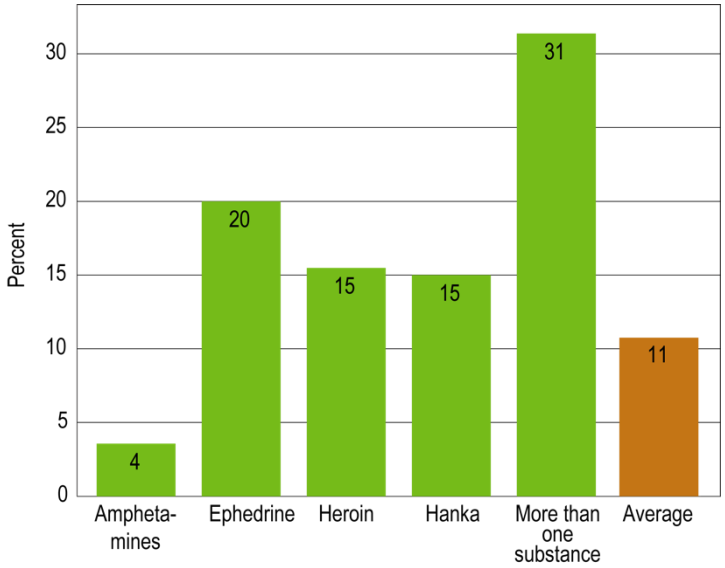
Analysing data on overdosing during lifetime by primary drug used within past 6 months, it is observed that overdosing by amphetamine users is less frequently observed than among heroin users; 25% of amphetamines users and 51% of heroin users respectively had overdosed during

their lifetime. The highest proportion of overdosing (65%) during their lifetime is among drug users who have indicated using multiple substances.

Approximately every fourth drug user who overdosed did so in the past year (28%), while 72% had overdosed over a year ago.

Looking at overdose cases last year, marked differences are observed among users of various substances: amphetamine users overdose significantly less often than users of other drugs. During the past 12 months four per cent of those listing amphetamines as the primary drug overdosed in comparison with 15% of heroin users and 31% of multiple drug users *(see Figure 6.11)*. Overdosing is relatively high among users of ephedrine and hanka, but it is uniquely difficult to draw inferences, because the number using these drugs is small.

Figure 6.11. Overdosing during the past 6 months by primary drug, % of respondents



Source: Trapencieris, Sniķere and Kaupe 2011

In comparison with the previous phases of the cohort study the overdose indicator for the last six months of 2010 (6%) was lower than for 2006-2008 (12-16%), but at the same level (6%) as in the 2009 cohort study.

Sharing injection paraphernalia

According to respondents' answers in the fourth stage of the cohort study (Trapencieris, Sniķere and Kaupe 2011), 16% of drug users had shared a syringe or needle during the past six months, while almost every third (32%) drug user had used other injecting paraphernalia, such as cotton wool, spoon, water etc. that someone had already used.

Compared to observations in the 2009 study, there has been a reduction in the proportion that had shared a syringe or needle during the last six months (when this had been indicated by every fourth or 24% of respondents), while the level remained unchanged for sharing other injecting paraphernalia.

Shared syringes and needles had been used during their lifetime by 28% of respondents, (21% last year, 13% last month), while 7% of respondents had shared syringes or needles more than a year ago.

Of those respondents who had responded regarding sharing of injection paraphernalia in at least two cohort study phases (n = 639), almost every third (29%) drug user had not used shared injecting paraphernalia within the last six months in any phase of the study. A third of drug users (31%) indicated sharing injecting paraphernalia in one phase of the study, 27% in two phases, while 9% and 4% respectively, in three or four study phases.

6.3. Drug related deaths and mortality of drug users

Drug-related death is a complex phenomenon that comprises a significant percentage of all deaths among young people in many European countries. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), in collaboration with national experts, has defined an epidemiological indicator comprised of two components: death directly caused by overdosing on illegal drugs, and death among problematic drug users.

Information on deaths associated with drug use in Latvia is collected and analysed by two institutions: (1) the Centre for Health Economics (CHE) is responsible for maintaining the database on causes of death41 (GMR), and (2) the Latvia State Centre for Forensic Medical Examination (VTMEC) which maintains a special register of data on deceased persons (the Special Mortality Register (SMR)). The CHE-administered General Mortality Register database includes information on the entire country and it is based on death certificates which are initially forwarded from all areas of the country to the Central Statistical Bureau (CSB), and then once a month, to the CHE, which encodes, processes and enters the data collected into the database and performs analysis.

The main operational objective of the Latvia State Centre for Forensic Medical Examination is the conducting of medical inquests.

The two institutions cooperate and during the year compare their databases of deceased persons, as initially the data of both institutions may differ due to the fact that when a person dies, the death certificate and a possible cause of death are written immediately, but if an autopsy is performed on the deceased, the results are received at a later date. If the diagnoses (as originally recorded and as later revealed at autopsy) do not coincide, they are referred for correction. For this reason the databases of both institutions are compared regularly and necessary changes made by the end of the current year.

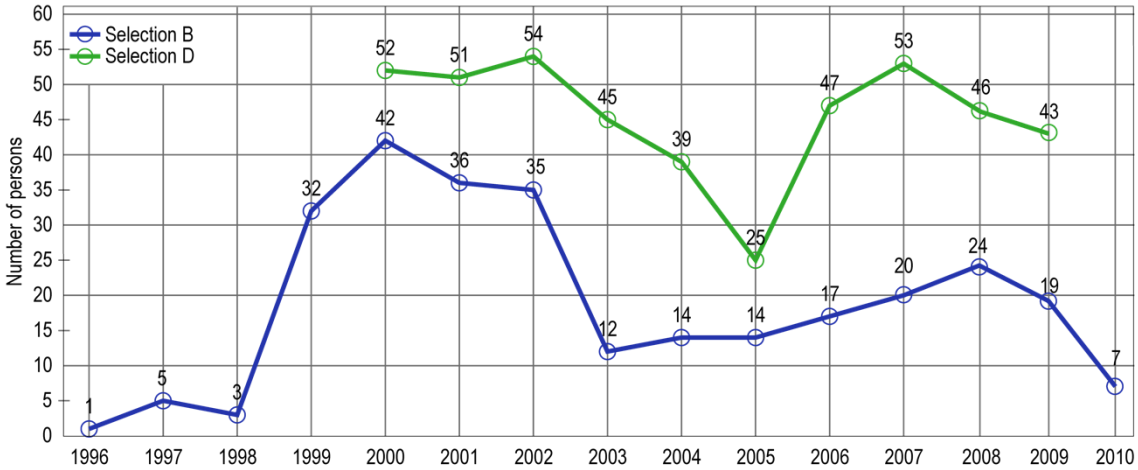
Statistical information

According to GMR data, in 2010 there were 7 deaths recorded directly linked to drug use, or 12 cases less than in 2009. Of the recorded cases, as in previous years, the majority of deceased persons were aged 20-39 years, and were predominantly males (6 men and 1 woman).

The average age of deceased persons was 25.7 years; the youngest was aged 19, and the oldest was aged 30. Of all the cases, intentional poisoning (X61 and X62) was recorded in one case, while in other cases, poisoning (X41 and X42) had been accidental, with various substances (mainly heroin or unspecified opiates).

One death was caused by morphine (T40.2); one death was caused by heroin overdose (T40.1); in two cases, by amphetamine/methamphetamine (T43.6), while in three cases, the substance was not specified.

Figure 6.12. Deaths due to drug use 1996–2010, absolute numbers



Source: Centre of Health Economics 2011

[41] General Mortality Register (GMR)

In addition to the seven deaths mentioned, 12 deaths were caused by the use of psychotropic medications (T42), of which all deaths resulted from the use of benzodiazepines. The average age of those overdosing on benzodiazepines was 43.8 years (25-74 years). Of these, seven were men and five were women.

Cabinet Regulation No. 215 Procedure for determining brain and biological death and release of a deceased person for burial, which came into force on 12 April 2007 stipulates that a person may be declared dead by the family physician, who shall also complete and issue a death certificate in the case of a "normal" death. In a case of violent or unnatural death, the police will refer the person's body for autopsy. In a case of violent or unnatural death, the autopsy is paid for from public funds. The main problem and explanation for the sharp decline in the number of autopsies performed last year, is the previously mentioned Cabinet Regulation. There is concern that a family physician may not always send a person's body for an autopsy and toxicological analysis, but will instead record some other cause of death. This can lead to the fact that the number of dead from drug overdoses in subsequent periods may "inexplicably" reduce. Table 6.12. shows the number of autopsies performed in Latvia and Riga in 2005-2009, and indicates that during this period the autopsy rate has reduced more than two-fold.

Table 6.7. Number of autopsies performed in Latvia and Riga, 2005–2009

	Riga	Total in Latvia
2005	*2828*	*6217*
2006	*2883*	*5984*
2007	*2083*	*4332*
2008	*1521*	*3402*
2009	*1255*	*2841*

Source: Latvia State Centre for Forensic Medical Examination 2010

The fact that drug users often have cause of death declared as unrelated to drug use without an autopsy being performed, is illustrative of the retrospective cohort studies of mortality among drug users in Latvia. These studies and their methodology are presented in detail in the National Reports for 2008 and 2010 (Public Health Agency 2008; Centre of Health Economics 2010).

Continuing to analyse drug user mortality of among the cohort of treated opioid users, it can be inferred that mortality in the target group is significantly higher than in the population of same gender and age. The cohort currently includes 3810 (3047 men and 763 women) opioid users treated during the period 2000-2010 (regardless of whether opioids are shown as the primary drug used, or as an additional drug). By the end of 2010, 401 (10.5%) had died.

The mortality in the cohort of treated opioid users per 1000 person years among drug users aged 15-49 years was 16.0, while directly standardized mortality (by gender and age), was 21.6. Similar indicators were observed by gender (21.4 men and 22.7 women). The fact that the mortality of drug users as a whole significantly exceeds that observed in the general population is indicated by the standardized mortality ratio (SMR). From analysing the data it can be inferred that mortality among drug users is approximately 9 times higher than the same age population (SMR – 9.1; 95% T.I. 8.2-10.1). In addition, the mortality rate for women is significantly higher than that estimated for men (18.8 and 6.0 respectively), due to the fact that women aged 15-49 in the general population die less often than men, while among drug users about equally often. It is also observed that mortality in the youngest age groups exceeds by more than 10 times that observed in the general population, for example, among 15-19 year old opioid users it is 18.9 times higher, while among those aged 20-24 years old it is 10.0 times higher.

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7. Responses to health correlates and consequences

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

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

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

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

7.2. Prevention and treatment of drug-related infectious diseases

Prevention

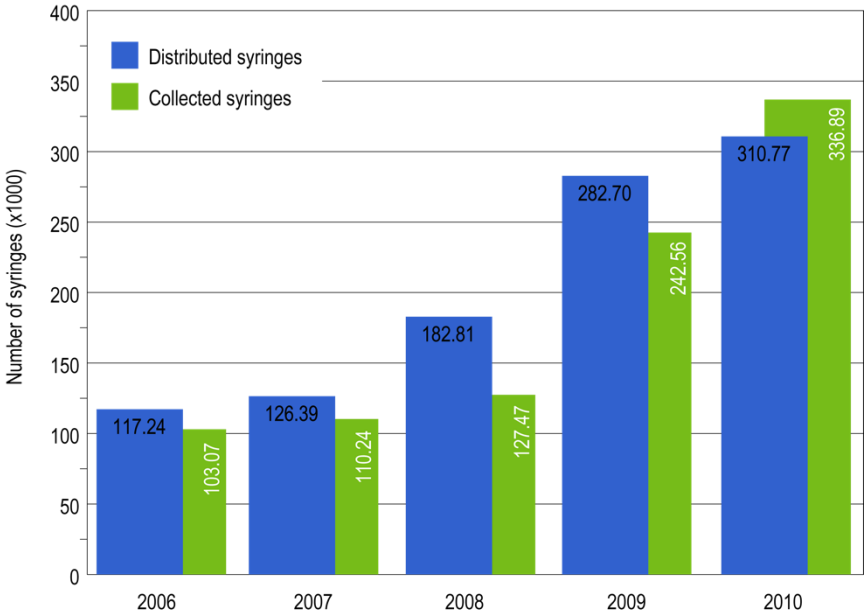
During the reporting year, as in 2009, there were18 HIV prevention points (HPP, HIV prevention network) operating in 16 cities in Latvia. Also identical to the 2009 count is the number of cities in which street work has been carried out (9 cities) and in which mobile units have been active (3 cities).

According to Infectology Center of Latvia (ICL) data the HIV prevention network issued 310 774 syringes in 2010, exceeding the previous year's total of 282 701. Also increased is the number of returned syringes collected (from 242 555 in 2009 to 336 887 in 2010) (See Figure 7.1.), and the number of new clients recorded (4474 in 2009; 4629 in 2010). A similar conclusion may be reached by examining data on contacts with clients: the direct contact count (contact between IDUs and HPP staff) increased from 36 778 in 2009 to 44 487 in the reporting year; the secondary contact count (IDUs exchanged syringes/needles for other IDUs who did not come into direct contact with HPP staff) in 2009 was 21 118; and 32 041 in 2010.

Having regard to the financial crisis in the country, the maintenance and even expansion of the harm reduction program is an important achievement in Latvia.

A major contribution to increasing the scope of the harm reduction program in Latvia has been methodological and financial support provided by the UNODC for the project *HIV/AIDS prevention and care among injecting drug users and prison settings in Estonia, Latvia and Lithuania*, which has been implemented since late 2006, and which ended in early 2011. Thanks to successful cooperation between UNODC and government and municipal authorities, as well as the non-governmental sector, it has been possible to increase the number of syringe exchange points nationally, from 12 in 2007 to 18 in 2010, and to increase the number of syringes issued per IDU from 7 in 2006 to 17 in 2010. It has likewise been possible to increase the availability of methadone substitution therapy: whereas in 2007, it was mostly only available in one location (in Riga), then by late 2010, it was available in 10 locations, including outside the capital. Among those, a *one point care* pilot project was undertaken (more than one disease treated at a single institution); in this case methadone was issued at a location where patients simultaneously received treatment for TB (Laukamm-Josten et al. 1985; UNODC 2011).

Figure 7.1. Number of syringes distributed and collected at HIV prevention points in Latvia, 2006-2010



Source: Laukamm-Josten et al. 2011; Infectology Center of Latvia 2011

Also as part of the UNODC project, an activity for involving injecting drug users in HIV prevention (*Peer-driven intervention,* (*PDI*)) was undertaken in February-July 2010 with the aim of attracting new clients to harm-reduction programs and education about HIV and other drug-related issues. IDUs received a token remuneration (a prepaid mobile phone call card valued at LVL 1) for participating in the activity, involving their companions in the project and "training" them (such "trainers" received a reward if their "pupil" showed a good level of knowledge in a test of drug related harm to health, and its prevention) (Dompalma et al. 2010).

This activity provided an opportunity of reaching new clients mentioned at the beginning of this Section, as well as increasing the number of issued and returned injecting paraphernalia at syringe exchange points. In addition, a study was undertaken within the framework of the activity, attended by 1152 injecting drug users, thus giving an insight into the level of knowledge and health behaviour of IDUs (the results of prevalence sexual risk behaviour are described in the section on drug-related infections).

In addition to the activities mentioned that have contributed to the availability of harm reduction services for non-incarcerated people (a total of 32 projects within the framework of the UNODC grants program), measures have also been implemented in prisons: the teaching material *Reducing Risk among drug users in prisons* was translated and adapted into the Latvian language, and prison staff were trained in the use of this material, the use of interactive teaching methods, and group management, as well as the preparation of project submissions and project management. By late 2010 a total of 13 projects had also been implemented in the penitentiary system within the framework of the grant program, under which interactive and informative educational programs were introduced in seven prisons (of the 12 in Latvia) for various groups of prisoners on drug-related harm and its reduction (UNODC 2011b; Rotberga 2011).

Although, as mentioned previously, the scope of HPP services has increased substantially in recent years, experts nevertheless still consider it inadequate; it is estimated that the number of syringes issued per single IDU in 2010 consists of 17 clean syringes, which is significantly lower than that recommended by the WHO, UNODC and UNAIDS guidelines (namely at least 100-200 syringes, to limit the spread of infections among IDUs). It should also be noted that it has still not been possible to introduce syringe exchange in Latvia's prisons, which is also a major limiting factor for access to this service. Similarly, the proportion of opioid injectors receiving methadone treatment in Latvia is still inadequate, being only 1.7%. As with syringe exchange, methadone is still not available in Latvian prisons.

It is also regarded as critical that vaccination against viral hepatitis B is still not provided nationally for IDUs (Laukamm-Josten et al. 1985).

Research data also evidence the need to continuously broaden and intensify prevention measures for blood-borne infections among IDUs. Namely, the prevalence of risky behaviour among drug users in Latvia is still high. So, for example, the results of a study undertaken in 2010 as part of the PDI activity suggest that 35.3% of IDUs injecting drugs during the past month have used syringes previously used by another person; and 50.0% had given their used syringes to others (Dompalma et al. 2010). A study conducted among Roma people in Ventspils in 2009 indicates that shared injecting paraphernalia were used in the past month by up to 62.6% of IDUs (Public Health Agency 2009).

A study undertaken in 2010 (using ENCAP data) shows that HPP harm reduction services are more widely available for injecting opioid users than for amphetamine users. So, for example, opioid injectors have been tested for HIV twice as often during their lifetime (OR 1.9; 95% TI 1.1-3.4), and three times more often for HCV (OR 2.7; 95% TI 1.6-4.4), and have also attended the syringe exchange program more often during their lifetime (OR 1.7; 95% TI 1.1-2.8) (Karnīte (2) et al. 2010). This might indicate a need to consider the possibility of reaching those who inject stimulants and involving them in a harm reduction program. It should further be noted that injecting of amphetamine has become quite common in Latvia in recent years (e.g. in the PDI study 50.7% IDUs noted that currently their primary drug used is amphetamines, while heroin was the primary drug used by 34.3%) (Dompalma et al. 2010).

In the 2010 – 2011 transition the EC project *BORDERNETwork* was implemented in Latvia ("cross-sectoral and transnational cooperation in improvement of HIV/AIDS/STI prevention, diagnosis and treatment for the Central, Eastern European and Southeastern European countries" ("Highly active prevention: scale up HIV/AIDS/STI prevention, Diagnostics and therapy across sectors and borders in CEE and SEE")), within which a second generation epidemiological monitoring study will take place in late 2011: "Identification of HIV infections, other infections and related (associated) risk factors among persons working in one of the groups subject to the risk of HIV infection : persons employed in prostitution (including injecting drug users)", which will also facilitate assessment of the need for drug-related harm reduction measures in this socially excluded group.

Since UNODC project activities in Latvia are scheduled to conclude in 2011, responsible state institutions, as well as the non-governmental sector will face the challenge of maintaining and expanding on-going services and their scope in the future, without UNODC support. During the financial crisis, the country's funding resources are particularly limited and with that, so are many activities in the field of drug harm reduction, for which implementation is proposed in policy planning documents (last year's Report describes the *National Programme for Limiting HIV and AIDS in Latvia 2009-2013*, as well as the *National Drug Program for 2011–2017* developed in 2010 and approved in March 2011 (Cabinet Order No. 98 of 14 March 2011)) These are not being funded.

Limited funding resources, in both the public and non-governmental sectors create an obstacle to the raising of foreign funding for project implementation due to the inability to provide the necessary co-financing (Republic of Latvia Cabinet of Ministers 2011).

Treatment

In March 2011 experts from the WHO and UNODC visited Latvia in order to assess the progress in implementing the HIV prevalence limitation program, including the promotion of access to treatment and care services. The experts concluded that significant improvements have been made nationally in this field. In particular, during the reporting year, antiretroviral medications were included in the National Schedule of reimbursable medications and expenditure in purchasing this medication is fully reimbursable from state budget funds allocated by law for this purpose each year. Consequently, HIV care and treatment has become decentralised: methodological guidelines on health care for HIV/AIDS patients have been developed for infection specialists in Latvia's regional areas, and since 1 January 2010, prescriptions for antiretroviral therapy medications are being written not only in Riga, but also in Liepāja, Ventspils, Jekabpils, Daugavpils and Valmiera, and patients can obtain medication at pharmacies, rather than just in a single medical institution in Riga, as previously (Laukamm-Josten et al. 1985; Ministry of Health 2011; Infectology Center of Latvia 2011).

It has also been possible to achieve significant reductions in the price of ART, compared with the prices of medications in other countries, by communicating with pharmaceutical companies, as well as formulating rational pharmacotherapy recommendations for the treatment of HIV infection. According to Center of Health Economics data the average expenditure on ART per single patient in 2008 was LVL 9 265; in 2009 it was LVL 5205 and in 2010 it was LVL 3949 (Laukamm-Josten et al. 1985; Centre of Health Economics 2009).

But experts admit that there are still significant deficiencies in the provision of ART in Latvia; although prices have dropped, they are still higher than in other countries or internationally. And, as ART will be needed by a growing number of people in the next five years (in 2008, 313 people in Latvia received ART; in 2009 it was 415 people and in 2010 it was received by 508 persons) work on price reduction will continue to be a national priority.

Similarly, although the access to treatment in Latvia's regional areas is commendable, for various reasons (possibly because of lack of information or doubts about confidentiality) people who are living with HIV rarely utilise it.

Likewise, the criteria in treatment guidelines differ from those recommended by the WHO, namely, the CD4 cell threshold for starting ART in Latvia is 200 cells/mm^3, but the WHO guidelines recommend ART to start at a cell count of 350 (Laukamm-Josten et al. 2011). The Center of Health Economics has undertaken a financial analysis of medication consumption to assess the possibility of increasing the number of patients receiving antiretroviral therapy. However, having regard to an expected reduction in reimbursement for medications available from the State budget due to the financial crisis, it is concluded that it is not possible to provide medication to all patients with the WHO-recommended number of cells (Ministry of Health 2011).

The experts also noted that ART is not provided in sufficient amount for the number of HIV-infected IDUs. Of course, it is most likely that ART for IDUs is often not allocated or is terminated as a result of patient non-adherence (in late 2011 it is planned to conduct a study on patient adherence to ART). It is therefore necessary to consider various incentive measures to encourage patient adherence, for example, the introduction of methadone programs where the HIV patient receives outpatient care and ART prescriptions. It is commendable that, for example, space is provided in the Infectology Centre HIV outpatient department for NGO representatives who provide counselling to companions. However, NGOs have insufficient financial resources to provide sufficient support and to achieve significant improvements in patient adherence (counselling for companions currently takes place on just one day a week). According to the experts, the provision of psychosocial support involving the NGO sector, for HIV infected persons (including IDUs) would significantly contribute to therapy adherence and it would be particularly necessary in regional areas where antiretroviral therapy is being prescribed and health care is provided to HIV-infected persons (Laukamm-Josten et al. 1985).

In Latvia restrictions have also been observed in the availability of treatment for hepatitis. As mentioned in the section on hepatitis prevalence nationally, changes were made in 2009 to the arrangements for reimbursement for medicinal products for outpatients. Previously, 75% of the cost of the medicines was reimbursed from State budget funds, however, with the onset of the financial crisis, the rates for reimbursable drugs were revised, and for hepatitis treatment they were reduced to 50% (LR Cabinet of Ministers 2009). This proportion should be increased in future years (Laukamm-Josten et al. 2011)

With regard to the treatment of tuberculosis the situation observed in Latvia is stable. The national DOTS strategy was introduced in 1995, and the number of TB cases is reducing every year. It is concluded that TB is spreading mostly among certain population groups susceptible to infection and illness risks, including drug injectors. In order to intensify the timely detection of TB cases and thus better treatment as well as limiting the prevalence of infection, in 2011 Latvia plans to launch the EC project Empowering civil society and public health system to fight the tuberculosis epidemic among vulnerable groups (TUBIDU) for which the lead partner is the Estonian National Institute for Health Development. As part of the project it is planned to carry out research on access to various health care services among HIV-infected drug users and the drug user population, as well as provide training for low-threshold centre employees and health care professionals in the early detection of TB and patient motivation regarding the undertaking of TB testing and adherence to

therapy. A variety of information and incentive measures is also planned in the mentioned risk groups for increased TB infection and disease development.

The situation in prisons regarding the field of health care in Latvia has remained as previously; it still remains separate from general health care in the country. The experts agree that medical assistance (including in cases of drug addiction and related infections) is rated as critical. Because of the financial crisis, virtually only emergency assistance is provided in prisons. For example, even a TB screening service, so essential in a closed environment, is currently not provided in prisons. TB tests are not performed at least once a year, as would be required, but are only done in the case of serious symptoms. X-ray equipment is available in only half of Latvia's prisons. It is commendable that the Ministry of Health still continues to provide the penitentiary system with ART and TB treatments, but they are insufficient in quantity; and no support is provided for the transition from prison to freedom (i.e. for example, a person who are receiving ART in prison cannot obtain it after release from prison etc.). The experts remain convinced of the need to transfer the health care of prisoners to the supervision of the Ministry of Health (Laukamm-Josten et al. 1985).

At present no political programming document exists in the country to provide for prisoners' rights and obligations with respect to health care, and for measures to improve the situation. However, in the *Drug Program 2011–2017* approved in early 2011, Task No. 22 stipulates that the Ministry of Justice, in cooperation with the Ministry of Health shall by June 2012 develop a concept for the health-care of prisoners, providing *inter alia*, a solution for the provision of pharmacological treatment for drug addicts and the reduction of social and biological consequences resulting from drug use. The State would be obliged to make every effort to finally resolve the issue of prisoner health care after years of discussion between the two ministries and to improve the situation in prisons.

8. Social correlates and social reintegration

The aspect of social exclusion and reintegration is a multidimensional issue for which available data are mostly linked to economic factors. There is almost no research on other indicators regarding the integration of political and social life. In characterising social exclusion, data was used from a cohort study on drug abuse trends and practices in Latvia (Trapencieris, Sniķere, Kaupe 2011), and considered respondents' level of education, employment and income, as well as crime. The results show that average drug users have lower education, a high unemployment rate, are involved in crime and illegal activities, with half of the respondents having been imprisoned at least once during their lifetime.

Social reintegration is closely linked to social rehabilitation, and is mostly available by means of advice in consultations. The issue of housing, training, employment is not regulated at national level; mostly people who are being treated for drug addiction are included in activities for other target groups.

8.1. Social exclusion and drug use

In comparison to the situation nationally, drug users tend to be poorer and with a lower level of education, unemployed, with greater health problems, and are disinterested in events in the community.

Cohort study (Trapencieris, Sniķere, Kaupe 2011) data indicate that 68% of respondents are male; more than half are Russian (See Table 8.1.). The average age is 31.8 years and most respondents (50%) are aged between 25 and 34 years.

Table 8.1. Cohort study respondents, by nationality (%)

	2007	2008	2009	2010
Latvian	26	22	22	23
Russian	64	68	68	67
Other nationalities	10	10	10	10

Source: Trapencieris, Sniķere, Kaupe 2011

Overall, drug users have a lower educational level than society as a whole, i.e. 7% admitted that they had not acquired secondary education, 19% had primary education, and 11% had not acquired secondary education studying at a vocational secondary school after completing primary school. Only 2% of respondents had completed highest (tertiary) education (See Table 8.2.).

Table 8.2. Respondents' education (%)

	2007	2008	2009	2010
Incomplete primary	9	8	7	7
Primary	22	22	22	19
Incomplete secondary/vocational without secondary	13	14	12	11
Secondary, Special/professional	50	52	54	56
Incomplete highest (tertiary)	4	3	4	5
Highest (tertiary)	2	1	1	2

Source: Trapencieris, Sniķere, Kaupe 2011

Employment rates among drug users are low. The number of problem drug users in official work is significantly low (21%), which indicates that the majority acquire funds unofficially. In addition, a considerable number of respondents (20%) have not noted their occupation, which renders the interpretation of obtained data more difficult. Relatively, many more women indicated that they neither worked nor studied, or noted some other option (See Table 8.3).

Table 8.3. Respondents' employment (%)

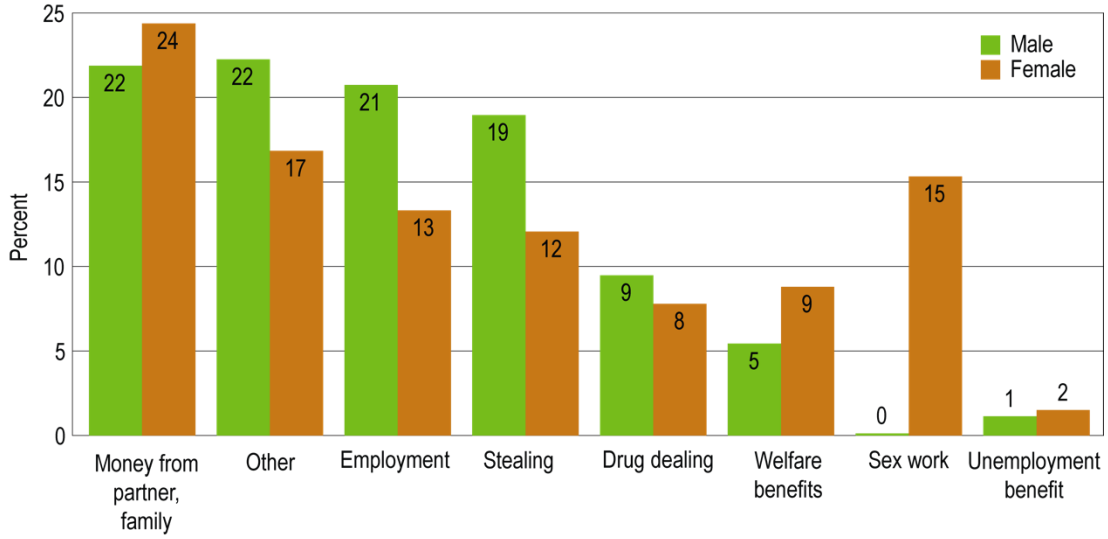
	Men	Women	Total
Official work, paying taxes	31	15	21
Working by verbal agreement	30	24	26
Studying	3	5	2
Not studying, not working	20	34	21
Other	16	22	20

Source: Trapencieris, Sniķere, Kaupe 2011

52% of respondents mentioned their occupation. 24% of respondents noted that they were working in construction, 10% worked in a variety of low-skilled jobs, 7% in various odd jobs, 5% worked as labourers. Other professions mentioned included security personnel, prostitution, IT specialist, and entrepreneur.

Employment is closely associated with sources of income. Respondents noted several income sources, most often indicating that funds were obtained from partner and family (23%). 16% of respondents cited wages as a source of income (See Figure 8.1.).

Figure 8.1. Drug users' income sources, by gender (%)



Source: Trapencieris, Sniķere, Kaupe 2011

Several respondents noted activity that is unlawful or criminal i.e. 15% indicated that they obtained funds by stealing, 8% by drug trafficking, and 15% of women noted that they were engaged in prostitution. A significant association with crime is indicated by answers about being imprisoned, namely 52% of respondents noted that they had been imprisoned (See Table 8.4.). In 2009, of those respondents who had been incarcerated, 57% had been imprisoned once, 25% twice, and 18% on three or more occasions.

Table 8.4. Persons incarcerated during their lifetime (%)

	2006	2007	2008	2009	2010
Persons incarcerated during their lifetime	48	55	47	51	52

Source: Trapencieris, Sniķere, Kaupe 2011

8.2. Social reintegration

The issue of social reintegration of drug users who have undergone a course of treatment has not been developed in Latvia. The issue of reducing social exclusion lies within the competence of the Ministry of Welfare. A strategy designed to mitigate social exclusion has been designed, but it did not include the issue of reducing the risk of social exclusion for people being treated for addictions.

Individual social reintegration issues are included in the treatment program, namely, social rehabilitation, which is within the competence of the Ministry of Health. The program includes motivation, psychological assistance, and the acquisition of life skills. The state has entered

agreements with four institutions that provide this service. In addition, a rehabilitation program is offered by three Christian organizations and one non-governmental organization, but in principle, this program differs from state-funded programs. For example, rehabilitation for adult persons lasts for 12 months, but the programs offered by the Christian organisations may take 2-3 years.

Table 8.5. Number of clients utilising state-reimbursed social rehabilitation services

	Children to age 18	Adults
Number of persons at the end 2009		10
Joined program in 2010	28	29
Discharged in 2010	27	30
Number of persons at the end 2010		9

Source: VSIA Riga Psychiatry and Addiction Centre 2011; VSIA Ģintermuiža 2011; VSIA Saulrīti 2011; VSIA Dzīves Enerģija 2011

Municipal addiction centres mostly provide advice on treatment options and help with arranging the necessary documents; issues regarding housing, educational opportunities and job opportunities are within the competence of the municipal social worker. A reintegration programme has not been developed for people being treated for drug addiction; however, often these people meet other criteria, e.g. needy status, disability, psychiatric disorder - which are the primary groups for receiving services. In accordance with the law, the fact of being treated for drug addiction is not a criterion precluding access to municipal social assistance. Standard rules have been developed for helping with issues of housing, job searching, and social benefits; however, the provision of services to a person receiving treatment for drug addiction lies within the competence of each municipality.

Housing

Eight shelters are available in Riga, and 12 shelters are located in the major regional cities. During winter almost all shelters accept people lightly affected by alcohol. One shelter in Riga is available to people affected by alcohol and drugs. One shelter has opened a day centre, working with people with substance dependencies.

Half-way houses for people being treated for drug addiction are made available by some charitable organisations, but such programs have not been implemented by municipalities. The state partially funds the half-way house for patients of the Riga Psychiatry and Addiction Centre who have undergone a course of social rehabilitation, but have not yet organised their documents and found a place to live. In 2009, 14 persons utilised this service, while 8 did so in 2010 (Riga Psychiatry and Addiction Centre 2011).

Some drug users meet the criteria for using social housing services. Social housing and social apartments is a system established by local government authorities, which mainly target underprivileged families. The allocation of social housing and apartments is assessed individually. Basically it is available to the underprivileged and poor, where a family with dependent children has been evicted from rented accommodation, and also for children, orphans, senior citizens and people with disabilities. The concept of social apartment housing is for payment of 2/3 of the rent payable, as well as 75% of the cost of central heating. Services available in the Social House include medical consultation, advice from a social worker and a caregiver service (Liepaja Social Service 2010).

Employment and educational programs

Programs for drug users have not been developed and implemented. Local municipalities offer in-service programs involving low-qualified physical work, paying a monthly stipend of LVL 100 (Ministry of Welfare 2010). Such in-service work lasts no longer than six months. The state also guarantees courses for improving the qualifications of unemployed persons. However, both programs are available only to those people officially registered as unemployed.

Self-evaluation of Quality of Life for clients in long-term methadone pharmacotherapy

During the 2011 evaluations of MMT in Latvia (Pūgule et al. 2011), program clients were asked to evaluate various living conditions now, and their predictions one year ahead. From the self-evaluation of physical health, social situation, psychological wellbeing, employment, criminality and illegal drugs, employment was specifically evaluated as the worst; namely 60% of respondents felt that the situation had not improved since joining the program, and 49% thought it would be even worse in a year's time. By comparison, 87% noted that physical condition had improved since the start of the programme, 86% noted improvement in their social situation, and 95% indicated improvement in the situation with regard to criminality.

Clients were requested to indicate which extra services apart from those already available they would like to receive at medication dispensing points. 10% of the respondents said they would like to receive services related to finding work.

A study undertaken in 2010 (Trapencieris, Zīle-Veisberga 2011) aimed to evaluate the frequency of alcohol use (AUDIT) and quality of life using the WHOQOL assessment tool. In general, respondents rated all areas very similarly. Physical condition was rated the worst (51 points), while social environment was rated best (56). Psychological condition and the general environment rated respectively at 46 and 54. Differences between the genders were observed with women rating physical condition much worse at 46 points compared to 52 points for men, and surrounding environment, which men rated at 55 points and women at 48 (See Table 8.6.).

Table 8.6. Quality of Life evaluation, by gender and total (WHOQOL-BREF, 0-100 scale)

	Physical Condition	Psychological Condition	Social Environment	General Environment
Total (95% C.I.)	51 (49-53)	55 (53-57)	56 (52-59)	54 (51-57)
Men (95% C.I.)	52 (50-53)	56 (53-58)	55 (51-59)	55 (51-58)
Women (95% C.I.)	46 (41-51)	52 (45-59)	58 (47-69)	48 (39-56)

Source: Trapencieris, Zīle-Veisberga 2011

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

9.1. Drug-related Crime

From the second half of 2008, trends in breaches of the law (including illegal drug trafficking), and the law enforcement response rate (including in the anti-drug field) in Latvia have been to some extent determined by the economic crisis, which is primarily associated with two main factors – a reduction in the standard of living of the population, and a reduction in law enforcement resources (both material and personnel). In 2010, the negative impact mentioned, continued to a large extent. Significant negative effects on the socio-economic situation of the country are evident, for example, by such facts as people turning to cultivation of drug plants and drug production (in 2010, 8 marijuana farms and a methadone manufacturing laboratory were discovered), as well as the population's growing involvement in drug smuggling.

Drug law offences

Penalties for drug use are governed by the *Latvian Administrative Violations Code (*LAVC) and the *Criminal Law* (CL). Pursuant to the LAVC, drug acquisition or storage of small quantities without intent to sell, and drug use without a doctor's prescription, as well as driving a vehicle under the influence of drugs or other substances are penalised. The *Criminal Law* provides penalties for repeated use of drugs within a one year period, as well as the most serious crimes associated with drug trafficking.

Information describing a criminal offence (location, time, motive, level of intoxication or by what drug the offender was affected when the offence was committed) are stored in the integrated information system of the Ministry of the Interior subsystem: the *Criminal Offences Register*, while on the subsystem *Persons who have committed Criminal Offences* information is accumulated on the penalties imposed on persons, and there is no single means by which one can select the people who might have driven a vehicle under the influence of drugs. Therefore, details of persons penalised for driving under the influence of drugs are extracted manually from the subsystem *Persons who have committed Criminal Offences*.

Administrative offences

The unauthorized manufacture of drugs, and their unauthorized acquisition and use without a physician's prescription are each considered an administrative offence.[42] During the year, if a person is punished again for the same violation, criminal liability applies. 2878 administrative protocols were issued for breaches of the relevant sections of the LAVC in 2010, compared to 2668 in 2009 (*See Table 9.1*).

Table 9.1. Protocols issued pursuant LAVC, absolute numbers

LAVC Section	2009	2010
46.1 (Par.2)	2654	2854
46¹ (Par.1)	14	24
Total	2668	2878

Source: The Information Centre of the Ministry of the Interior 2011

[42] **Administrative Violations Code (LAVC) Section 46.1**
Illegal Acquisition or Storage in a Small Amount of Narcotic and Psychotropic Substances and Medicinal Products, as well as Substances, which may be used for the illegal production of narcotic and psychotropic substances (Precursors), or the Use of Narcotic and Psychotropic Substances without Prescription by a Doctor.
LAVC SECTION 46¹.1. Breaches of provisions regarding unlawful preparation, (precursor), manufacture,distribution.

The most frequently imposed penalties for violation of Section 46.1, Paragraph two (storage of small quantity without intent to sell) include a fine (imposed on 2383 occasions), administrative arrest (107 occasions), while in individual cases a warning is given (2 cases). A fine was imposed on 25 occasions and four administrative arrests were made for violations of Section 46.1, Paragraph two in 2010.

Criminal liability

Drug use is referable to the Criminal *Law* Section 253[2] (Paragraph one) and this section is applied if a person re-offends within the period of one year. The preparation, storage, transporting or conveyance without intent to sell (large and small quantities) is referable to the *Criminal Law* Section 253.[43]

The penalty for unauthorised manufacture, acquisition, storage, transportation and conveyance of narcotic and psychotropic substances for the purpose of sale, and their sale, is provided by CL Section 253[1]; unauthorised sowing and cultivating of plants containing narcotic substances by CL Section 256; contraband by CL Section 190; and unauthorised sale of narcotic and psychotropic substances in small amounts: CL Section 253[2] (Par. 2).[44]

Various other offences associated with trafficking in drugs are referable to *Criminal Law* Section 250 on the unauthorised dispensation of drugs; Section 252 on administering a drug against a person's will and Section 309. (Par. 3) for unlawful providing of substances and items to persons who are confined in places of detention and imprisonment and unlawful receiving of substances and items from such persons.[45]

In 2010 a total of 2419 criminal offences were registered, which is 4.7% of all criminal offences registered nationally (total nationally was 51 108 criminal offences). By comparison, in 2010 there were 3% fewer criminal offences registered than in 2009 (2499) (The Information Centre of the Ministry of the Interior 2011).

According to State police data, slightly less than half (42%) of all registered criminal offences related to drug use and possession of a small amount of drugs. 24% were attributable to possession of drugs without intent to sell, while 20% were for possession with intent to sell (See Table 9.2.) According to observations by the State police there was a decrease in the number of criminal offences related to obtaining and possession of small quantities of drugs without intent to sell, as well as repeated use without prescription within one year, but because of increased law enforcement activities in combating serious and particularly serious criminal offences, the number of registered criminal offences associated with drug trafficking and contraband has increased.

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[43] **CL Section 253[2] (Par.1)** - Unauthorised Manufacture, Acquisition, Storage, and Sale of Narcotic and Psychotropic Substances in Small Amounts and Use of Narcotic and Psychotropic Substances without a Physician‟ s Designation, if committed again within the period of one year

CL Section 253. Unauthorised Manufacture, Acquisition, Storage, Transportation and Conveyance of Narcotic and Psychotropic Substances

[44] **CL Section 190.[1]**. Movement of goods and Substances the circulation of which is Prohibited or specially Regulated across the State Border of the Republic of Latvia.

CL Section 253.[1]. Unauthorised Manufacture, Acquisition, Storage, Transportation and Conveyance of Narcotic and Psychotropic Substances for the Purpose of Sale and Unauthorised Sale.

CL Section 253.[2]. (2) Sale of Narcotic and Psychotropic Substances in small quantity.

CL Section 256. Unauthorised Sowing and Growing of Plants Containing Narcotic Substances.

[45] **CL Section 250.** Unauthorised Dispensation of Narcotic and Psychotropic Substances.

CL Section 252. Administering a drug against a person's will

CL Section 309. Unlawful Providing of Substances and Objects to Persons who are Confined in Places of Detention and Imprisonment, and Unlawful Receiving of Substances and Objects from Such Persons.

Table 9.2. Number of criminal offences registered, by *Criminal Law* section, 2010

use and possession		dealing/trafficking/production				Other offences			Total
253	253² (Par.1)	190¹	253¹	253² (Par.2)	256	250	255	309 (Par.3)	
518	1025	158	496	24	1	24	3	155	2419

Source: The Information Centre of the Ministry of the Interior 2011

Most administrative violations and criminal offences are associated with the circulation of cannabis, methamphetamine and heroin (See Table 9.3). In general, since 2007 there has been an increase in violations and criminal offences associated with the illegal movement of cannabis, heroin and methamphetamine, and in crimes associated with the circulation of ecstasy-type substances.[46]

Table 9.3. Administrative violations and criminal offences, by drugs, 2009 and 2010

	use and possession		dealing/trafficking/production	
	2009	2010	2009	2010
Cannabis	111	94	237	252
Amphetamines	30	9	38	12
Methamphetamines	177	271	214	234
Heroin	166	174	161	128
Cocaine	27	4	25	24

Source: The Information Centre of the Ministry of the Interior 2011

Penalties for criminal offences directly associated with drugs

In 2010 there were 1462 persons accused of crimes, of whom 82% were men, and 18% were women. Half the accused (50%) were in the age group 25-34 years, and 25% were in the 18-24 year age group. A total of 17 persons were accused who were less than 18 years of age. A large proportion of the registered criminal offences (42%) were associated with unauthorised preparation of drugs, or their acquisition, storage in small quantities without intent to sell, or using without a doctor's prescription if the offence is repeated within the period of one year. A total of 390 persons (26%) was charged with selling drugs in large or small quantities (*See Table 9.4*).

Table 9.4. Number of accused persons*, distribution by age and gender and *Criminal Law* Section, 2010

	use and possession		dealing/trafficking/production				Other offences			
	253	253² (Par. 1)	190¹	253¹	253² (Par. 2)	256	250	252	309 (Par. 3)	Total
men	**289**	**514**	**53**	**289**	**19**	**0**	**1**	**0**	**24**	**1202**
women	**55**	**105**	**2**	**79**	**3**	**0**	**0**	**1**	**15**	**260**
15-17	3	10	1	1	2	0	0		0	**17**
18-24	104	144	16	84	7	0	0	1	11	**368**
25-34	146	375	26	153	6	0	1	0	20	**736**
35-44	71	79	7	88	4	0	0	0	6	**258**
45-54	18	11	3	35	3	0	0	0	0	**70**
Over 55	2	0	3	7	0	0	0	0	2	**11**
Total:	**344**	**619**	**55**	**368**	**22**	**0**	**1**	**1**	**39**	**1462**

Source: The Information Centre of the Ministry of the Interior 2011

[46] See also ST11_2011_LV_01

* An accused is a person who is held criminally liable, with a decision of a person directing the proceedings, regarding the committing of a criminal offence, and against whom initiated criminal proceedings have not been terminated, and who has not been acquitted or found guilty with a court judgment that has entered into effect. (pursuant to the *Criminal Procedure Law* Section 69, Paragraph one)

Only partial information is available in 2010 regarding persons who have been convicted, punished or acquitted or for finalised cases, because data has not been compiled on penalties imposed for the use or storage of drugs in large or small quantities (CL Section 253² (Par.1)). It must be borne in mind that this group of persons forms the largest proportion. A person is much more frequently convicted for crimes directly associated with the circulation and use of drugs, while a fine or enforced community service is imposed less frequently; one person was acquitted and cases were finalised in respect of 43 persons (*See Tables 9.5 and 9.6*). In addition a bond was imposed on 349 persons.

Table 9.5. Convicted* persons, distribution by Criminal Law section, 2010

***Criminal Law* section**	**Use and possession**		**dealing/trafficking/production**				**Other offences**				**Total**
	253	**253² (Par. 1)**	**190¹**	**253¹**	**253² (Par.2)**	**256**	**250**	**252**	**262****	**309 (Par.3)**	
Deprivation of liberty (Total)	149	N/A	2	59	4	0	0	0	3	9	226
deprivation of liberty suspended for period (Total)	106	N/A	2	47	2	0	0	0	0	3	160
Enforced labour (community service) (Total)	2	N/A	0	0	0	0	0	0	1	0	3
Coercive measures of a medical nature	1	N/A	0	2	0	0	0	0	0	0	3

Source: The Information Centre of the Ministry of the Interior 2011

Table 9.6. Distribution of accused persons by Section of Criminal Law, penalty imposed and decision as to finalising case or acquittal, 2010

	use and possession		**dealing/trafficking/production**				**Other offences**			**Total**
	253	**253² (Par. 1)**	**190¹**	**253¹**	**253² (Par. 2)**	**256**	**250**	**252**	**309 (Par. 3)**	
Fine	0	N/A	17	0	0	0	0	0	0	17
Enforced labour (community service)	0	N/A	10	0	1	0	0	0	0	11
Cases finalised	14	N/A	2	13	4	0	0	0	0	25
Finalised conditionally	17	N/A	1	0	0	0	0	0	0	18
Acquitted	0	N/A	0	1	0	0	0	0	0	1

Source: The Information Centre of the Ministry of the Interior 2011

Operating a vehicle under the influence of drugs, alcohol or other substances

In 2010 a total of 169 protocols were issued pursuant to LAVC Section 149[15].5 and LAVC Section 149[15].7. For operating a vehicle while under the influence of drugs (See Table 9.7).[47] If the same offence is committed again within the period of one year it attracts criminal liability pursuant to Section 262 of the *Criminal Law*. Relevantly, there were 15 such cases registered in 2010.

* Persons against whom the court has imposed a conviction

** Persons who have operated a motor vehicle while under the influence of drugs

[47] **149[15].5.** For operating or instructing operation of a vehicle while being under the influence of a narcotic, psychotropic, toxic or other intoxicating substance.

149[15].7. For consuming an alcoholic beverage, drug or other intoxicating substance after a traffic accident or after a vehicle has been ordered to stop by a police officer, border guard (at or near the State border), until testing to determine the concentration of alcohol in the blood, to determine the influence of narcotic or other intoxicating substance, or release from such testing in accordance with procedure.

106 persons were penalised for administrative violations. Administrative arrest was imposed against 98 persons, 107 were fined, and 97 were disqualified from holding a driver's license (See Table 9.8). Pursuant to Section 262 of the *Criminal Law*, 17 were released on bond, 3 persons were sentenced to deprivation of liberty for 6-18 months and one person was sentenced to enforced labour (community service).

Table 9.7. Persons dealt with in accordance with the Latvian Administrative Violations Code (LAVC), 2010

LAVC section	Number of protocols issued	Fined administratively
149^{15}.5	108	106
149^{15}.7	61	61
Total	3047	2644

Source: The Information Centre of the Ministry of the Interior 2011

Table 9.8. Details of administrative penalties for operating a vehicle while affected by drugs, 2010

LAVC Section	149^{15}.5	149^{15}.7
Administrative arrest	98	55
Warning		
Fine	107	60
Prohibited from obtaining licence to operate recreational vessel	10	1
Prohibited from obtaining driver's license	5	9
Disqualified from holding a licence to operate recreational vessel	7	
Disqualified from holding driver's license	97	47

Source: The Information Centre of the Ministry of the Interior 2011

Other drug related crime

Juvenile offenders

Statistical data indicate a significant reduction in the number of criminal offences committed by juveniles and this can be explained by various factors:

- a significant reduction (more than 11.3% compared with 2009) in the number of juveniles (including those aged 14-17) (*Central Statistical Bureau* 2011);
- juveniles for the most part commit theft and robbery (for example, the proportion of thefts from the total number of criminal offences committed by juveniles in 2010 is around 65%) while the attention of law enforcement agencies (particularly during the economic crisis) is focused on solving major crimes (The Information Centre of the Ministry of the Interior 2011). There tend to be cases where members of the public who have been robbed by juveniles do not even turn to the police, being of the opinion that the property stolen was not sufficiently valuable;
- deficiencies in data registration, for example, it is not obligatory to enter notations on the information system regarding whether crimes had been committed while intoxicated, and for this reason such a notation is often not entered.

It must be noted that disproportions between the total number of criminal offences committed and the total number of those attributable to juveniles may for the most part be explained by the fact that juveniles frequently commit crimes in groups.

Table 9.7. Crimes committed by juveniles 2007-2010

	2007	2008	2009	2010
Total number of crimes committed	**1350**	**1397**	**1038**	**785**
Under the influence of drugs [48]	10	18	6	8
Thefts under the influence of drugs	3	2	0	0
Robberies under the influence of drugs	0	0	0	1
Under the influence of alcohol	354	318	225	127
Under the influence of psychotropic substances	5	5	2	5
Under the influence of toxic substances	0	2	1	0
Number of juveniles who had committed crimes	**2191**	**1812**	**1383**	**988**
Under the influence of drugs (age when crime committed was 14 - 17 years)	0	14	3	3
Thefts committed under the influence of drugs (age when crime committed was 14 - 17 years)	1	5	0	1
Robberies under the influence of drugs (age when crime committed was 14 - 17 years)	0	0	0	1
Juveniles who were not working and not studying	284	344	193	157

Source: The Information Centre of the Ministry of the Interior 2011

Crimes committed under the influence of drugs

The integrated Ministry of Interior information system *Register of Persons Who Have Committed Administrative Violations* subsystem and the subsystem *Register of Criminal Offences* are capable of noting the fact that crimes have been committed by a person while under the influence of drugs, but that indication is not mandatory. The statistical data, regardless of possible deficiencies in data quality, confirm a significant reduction in the number of crimes committed under the influence of drugs and in the number of robberies (See Table 9.8.).

Table 9.8. Crimes committed under the influence of drugs, 2007-2010

	2007	2008	2009	2010
Total number of crimes committed under the influence of drugs[49]	554	756	567	385
Including theft under the influence of drugs	69	66	89	65
Including robberies under the influence of drugs	9	13	12	4

Source: The Information Centre of the Ministry of the Interior 2011

Unauthorised supply of drugs

Altogether in 2010 a total of 24 crimes was recorded[50] associated with the unauthorised supply of psychotropic drugs by one accused person. 1 criminal process was commenced in 2010; 23 registered episodes relate to a criminal process which had commenced in 2009.

In 2010 there was an increase of approximately 71% (from 14 cases in 2009 to 24 cases in 2010) in the number of administrative protocols issued pursuant to the *Latvian Administrative Violations Code* Section 1, Paragraph one.

[48] Offences committed under the influence of psychotropic or toxic substances not taken into account

[49] The inclusion of notations as to the offences being committed under the influence of drugs is not mandatory and so quite frequently such notations are not added

[50] Ministry of Interior Information Centre Integrated Interior Information System *Register of Criminal Offences* Subsystem data

9.2. Interventions in the criminal justice system

Alternatives to imprisonment

The *Criminal Law* Section 59, Paragraph 4 provides that a person who has committed a crime because of addiction to alcohol or drugs may be exempted from penalty by a court if the person has agreed to be treated for alcohol or drug addiction. A penalty shall apply if during the time set by the court for treatment or afterwards, the person has avoided treatment. The cost of treatment shall be borne by the accused person.

This penal practice is almost never applied and has only been imposed on a few occasions in recent years.

9.3. Drug use and problem drug use in prisons

Information in this section is compiled from law enforcement authorities on the problem of drug use in prisons, together with information according to a study undertaken in 2010 (Sniķere et al. 2011) on drug use in prisons. Further information is available from the study report.

Additional information on drug use in prisons is provided in Chapter 11 of this Report, which utilises an analysis of legislation from the above-mentioned report, interviews with experts, information obtained from questionnaires completed by convicted persons and prison staff, supplemented by analyses of existing services for prevention, treatment and harm reduction.

Law enforcement data

The competence of Latvian Prison Administration officials to undertake measures in the anti-drug field is regulated by the Prisons Administration Law.51 According to the Criminal Procedure Law,[52] the Latvian Prison Administration may investigate only those crimes committed in places of imprisonment.[53]

Practical experience indicates that for the most part criminal cases initiated by the Latvian Prison Administration i.e. in prisons, are associated with the illegal circulation of drugs. The Republic of Latvia Ministry of Justice Latvian Prison Administration report of 31 January 2011 notes that the Latvian Prison Administration had initiated 266 criminal cases in 2010 associated with the illegal circulation of drugs, or 83% of the total 320 criminal cases commenced (Latvian Prison Administration 2011). The majority of criminal cases (141) were associated with supplying drugs to incarcerated persons in consignments, parcels, or mail; 95 were associated with drugs being thrown over walls, or drugs discovered and seized in rooms, cells or prison territory during searches; 25 cases were for drugs being found and seized in prison on prisoners; four with the use of drugs without doctor's prescription if that was done repeatedly within a one-year period, and one case was associated with unauthorised supply of a prohibited item and drugs to incarcerated persons where the offender was a prison staff member.

It is not possible to state unequivocally that prisoners commit those or other violations for the purpose of obtaining drugs. Practical experience does not indicate that drug users commit offences (e.g. causing previous bodily harm) more often than prisoners who do not use drugs. It can be accepted that prisoners offend with the intention of obtaining drugs or funds to buy drugs and drug user prisoners who are not employed or do not receive money from relatives or other

[51] e.g. Chapter IV, Section 22, "Rights and Duties of an Official": An official, in performing service tasks, has the following rights and duties: ... 3) to inspect detained and sentenced persons in prisons in accordance with the procedures specified by the Cabinet in order to determine whether such persons have used alcohol, narcotic or psychotropic substances; 4) to perform an inspection of persons, an examination of personal effects and clothing, to remove objects, articles and substances that are prohibited from being brought into, used and kept in a prison in accordance with the procedures specified by law;...

[52] The Republic of Latvia *Criminal Procedure* Law, Section 387, "Institutional Jurisdiction", Paragraph five: Officials authorised by the Latvian Prison Administration shall investigate criminal offences committed by detained or convicted persons, or by employees of the Latvian Prison Administration in places of imprisonment.

[53] e.g. in a case where drugs are thrown over a prison perimeter wall, jurisdiction for investigating the offence shall lie with the State Police as the offence was actually committed outside the place of imprisonment

persons practically have nowhere to obtain money in prison, although the majority of such offences go undetected and criminal cases are not instigated in relation to them (Kairišs 2011).

The most common way by which drugs enter prison is via consignments (in letters or postal consignments) addressed to prisoners. A large number of cases for drugs entering prison is associated with them being thrown over the prison's perimeter walls or handing consignments to prisoners (hiding them in clothes, shoes, domestic items, hygiene items or sewing them into articles of clothing).

For the purpose of fighting the illegal circulation of drugs in prisons the following measures are implemented regularly:

- planned and unplanned cell searches,
- parcel checks,
- checks of postal consignments,
- territory searches,
- visitor checks.

Positive results have been provided by the use of specially trained (drug search) dogs in finding and seizing drugs. The Latvian Prison Administration does not have their own drug search dogs, and therefore, if required, handlers with drug search dogs are requested from other services. For example in 2010 dogs from the Customs Service assisted in the seizure of drugs in the Brasa prison; dogs from the State Border Guard Service and the State police performed the same service at the Valmiera prison, and so forth. The Liepāja prison has an agreement with the Customs Service regarding the use of drug search dogs and as a result the dogs were used on approximately 4 occasions each month in 2010 (Kairišs 2011).

According to information published by the Latvian Prison Administration, approximately 152.69 g (11.3%) and 1401 tablets (86.27%) more drugs were seized in 2010 than in 2009, although no liquid drugs were seized in 2010.

One of the main indicators of operational efficiency for the Latvian Prison Administration is the quantity of drugs seized (in practical terms the quantity of drugs that did not reach prisoners). Analysing the statistical data (See Table 9.9), it is evident that the drugs most often seized in prisons are substances or tablets containing clonazepam, methamphetamines and amphetamines, marijuana, substances and tablets containing trihexyphenidyl, or heroin.

Table 9.9. Drugs seized by Latvian Prison Administration, 2008–2010

	2008		2009		2010	
	grams	tablets	grams	tablets	grams	tablets
Cannabinoids						
Marijuana	182.2		128.1		180.9	
Hashish	27.7		61.1		8.7	
Stimulants						
Amphetamines	36.8		45.1		17.0	
Amphetamines/methamphetamines	10.0		11.5		10.5	
Methamphetamines	762.7		495.1		591.9	
MDMA	29.2	28	1.9			
Preparation containing ephedrone (ml)				19		
Opioids						
Heroin	11.4		29.0		26.1	
Substance containing fentanyl	0.0		0.1		0.1	
Methadone, buprenorphine				2	0.3	2
Substance containing morphine		18				36
Raw opium			0.2			
Poppy straw			1.1			
Poppy straw concentrate (ml)			0.5			
Opium from plant extracts					1.3	
Barbiturates and benzodiazepines	862.2	1320	565.1	1590	627.7	2975
Mephedrone					0.5	
Substances containing JWH					24.1	
Cocaine	0.6		7.7		3.5	
LSD (piece)		1				
Piperazines			5.7	32	10.8	12

Source: Latvian Prison Administration 2011

In comparison with 2009 there is a considerable reduction in the quantity of amphetamine and hashish seized, but there is an increase in the quantity seized for substances and tablets containing methamphetamine, marijuana and trihexyphenidyl. As in 2009, a significant quantity of substances and tablets containing clonazepam was seized.

Results of prison research

This section considers the main prevalence indicators for drug use among convicted persons. As research data indicate that there is less drug use in prison than outside, the survey questionnaire included questions on drug use before and during imprisonment.

The 2010 study (Snikere et al. 2011)[54] was conducted in 11 prisons in Latvia, surveying 1965 convicted persons. In addition to polling convicted persons, 10 expert interviews were conducted with professionals from this field, legislation was analysed and 166 prison staff were surveyed.

The aims of this study were to:

- obtain data on the prevalence of drug use in prisons;

[54] Detailed information on the study and its results is available on the Centre of health Economics website http://vec.gov.lv/uploads/files/4e171e30bf3cb.pdf

- undertake research on the frequency of drug use during imprisonment as well as before imprisonment, and the types of drugs used;
- undertake research on the general health of prisoners and their morbidity with infectious diseases which could be acquired by injecting drugs;
- ascertain prisoners' opinion on measures which could be implemented to limit the prevalence of drug use in prisons;
- undertake analysis of policy and legislation on the problem of drug use in prisons.

The formulation of questions included in the prisoners' survey questionnaire on the most frequently used drugs (or drug groups) is the same as that in the survey undertaken in 2003 (Goldmanis, Koroļeva, Lāce 2003), which permits comparison of results obtained with the previous study and the assessment of changes in drug use prevalence indicators. As in other surveys on drug use, both among the general population and in prisons, three timeframes were also used in this study:

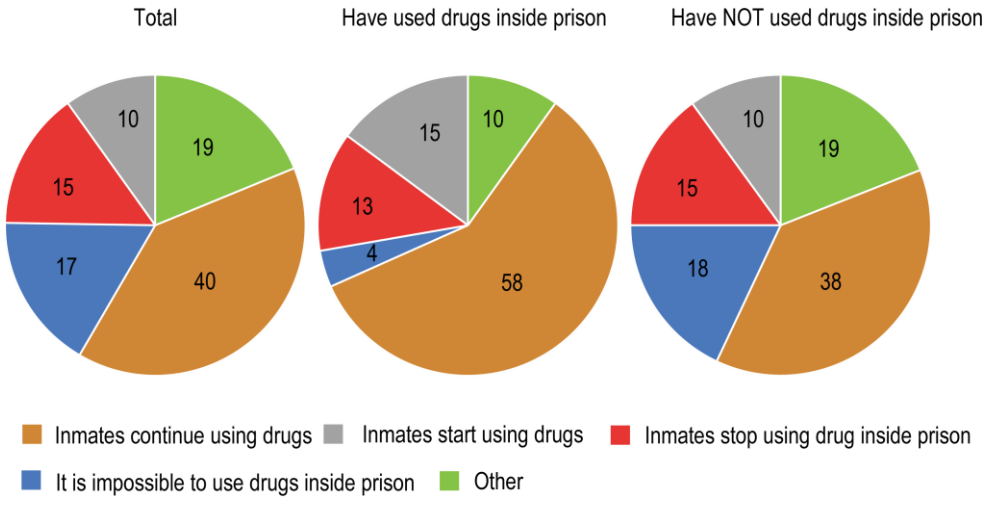
- use in lifetime, which also includes trying drugs on one occasion,
- use during last year or recent drug use,
- use during last month or so-called present drug use.

Evaluation of drug use prevalence

Data from the 2010 survey of prisoners, as in data from previous studies to date, indicate that the majority of convicted persons who have used drugs before imprisonment continue to do so during imprisonment. Regardless of injecting experience, 40% of respondents confirm the previous statement, by agreeing with the view that if drugs have been used prior to imprisonment then their use will continue during imprisonment (See Figure 9.1.). Slightly more respondents thought they would more likely discontinue the use of drugs while in prison (15%), rather than begin using (10%). A large proportion (19%) of respondents expressed yet another opinion formed by three relatively large response groups: "imprisonment does not influence this habit"; "drugs are replaced by medication" and "drug use discontinued for a while".

However the fact that being imprisoned in all respects stimulates rather than deters drug use is confirmed by statistically significant differences, comparing responses from drug users with those of non-users. Thus respondents who had used drugs in prison during the last month, significantly more often confirmed the fact that drug use was continued while in prison (so thought 59% of users and 38% of non-users) or is commenced (15% against 10%) and only 4% of users, regardless of their own experience, stated that it was not possible to use drugs in a specific prison.

Figure 9.1. Effect of prison on drug use, by drug use experience in last month before imprisonment, %



Source: Sniķere et al. 2011

Prevalence of drug use before imprisonment

66.1% of convicted persons had tried using any form of illegal drug[55] during their lifetime before imprisonment (95% T.I. 64.1–68.3%). No significant differences had been observed in the ratio of those trying drugs by gender; 66.1% of men and 67% of women had tried some form of drug. Research data show that younger convicted persons are more likely to have experience of using drugs than older convicted persons *(See Table 9.10.)*.

Table 9.10. Using any illegal drug before imprisonment, by age, %

	15-64 years	15-34 years	35-64 years
In lifetime	66.1	71.8	53.7
In last 12 months	49.1	54.9	36.6
In last 30 days	39.1	43.6	29.2

Source: Sniķere et al. 2011

The highest proportion of those trying drugs is among the 25–34 year age group (74.6%). Trying drugs slightly less often were the 15–24 year and 35–44 year age groups. This was indicated by 67.7% and 63.2% respectively. The proportion of those trying various drugs during their lifetime is significantly smaller among prisoners aged 45–54 years (43.4%) and 55–64 years (16.4%). Using drugs in the last year and the last month before conviction were 49.1% and 39.1% of prisoners. Among prisoners the incidence of trying drugs and using drugs in the last year and the last month before imprisonment is significantly higher than among the general population in the same age group overall: the 2007 study on drug use among the general population indicates that 16% of the Latvian population aged 15–64 years had used drugs during their lifetime, 6% had used drugs during the last year, and 2% had done so during last month (Koroļeva et al. 2007).

Table 9.11. Proportion of prisoners using any illegal drug before imprisonment, and general population in the same age group, %

	Convicted persons	In total population
In lifetime	66.1	16.1
In last 12 months	49.1	6.1
In last 30 days	39.1	2.2

Source: Sniķere et al. 2011

The research data show that the highest proportion (78%) trying drugs before imprisonment is among those prisoners who had lived in Riga before imprisonment. Slightly fewer of those living in the major cities (67%), or in other cities (58%) had tried drugs, while in sparsely inhabited areas only 41% had indicated using an illegal drug during their lifetime. A relatively high proportion of those trying drugs exists among those prisoners who had lived outside Latvia before imprisonment, but in interpreting this indicator the small number of prisoners who had lived outside Latvia before imprisonment must be borne in mind. A similar trend in the prevalence of drug use indicators may also be seen for drug use during the last year and the last month (See Table 9.12.).

Table 9.12. Use of any illegal drug before imprisonment, by place of abode before prison, %

	Total	Riga	Major cities	Other cities	Rural	Other countries
In lifetime	66.1	77.8	67.4	57.9	41.3	78.1
In last 12 months	49.1	61.7	48.6	41.8	23.8	57.1
In last 30 days	39.1	52.4	36.1	31.3	16.4	49.3

Source: Sniķere et al. 2011

The drug most often tried by convicted persons is marijuana or hashish; this had been used at least once in their lifetime before imprisonment by 61% of those convicted. The next most frequently used drugs (or drug groups) in lifetime before imprisonment were amphetamines (41%),

[55] Any form of illegal drug includes marijuana/hashish, ecstasy (MDMA), amphetamines, LSD or other hallucinogens, heroin and other opioids.

sedatives and relaxants (37%), ecstasy (28%), heroin (25%), various opioids (21%) and cocaine (20%).

The number of users of various drugs is lower for the past year than for those using during their lifetime: one in two convicted persons (51%) had used an illegal drug during the last year before imprisonment. The substance most often used in the last year before imprisonment was marijuana/hashish, which had been used by about one in three (37%) convicted persons. The next most often mentioned drugs are amphetamines (30%) and sedatives (26%). Various opioids, including heroin, had been used in the last year before imprisonment by every fifth (20%) person convicted.

Drugs had been used in the last month before imprisonment by approximately 2/5 (39%) of those convicted; marijuana/hashish was the most often used, which had been used by one in four (25%) convicted persons. A similar proportion (22%) had in the last month before imprisonment used amphetamines (22%) and sedatives (26%), while the proportion that had used heroin or other drugs was considerably lower (See Table 9.13.). Similarly to those trying drugs or using within the last year, younger offenders had indicated drug use experience in the last month before imprisonment more often than older offenders.

Table 9.13. Use of various drugs in last month before imprisonment, by age, %

	15-64 years	15-34 years	35-64 years
Any illegal drug*	39.1	43.6	29.2
Any substance**	47.9	50.6	41.9
Marijuana/hashish	25.1	29.4	16.2
Opioids (Total)	15.7	18.6	9.5
Heroin	13.7	16.1	8.6
Other Opioids	8.7	10.4	5.3
Cocaine	4.5	4.7	4.1
Amphetamines	22.4	25.5	15.9
Ecstasy	7.4	9.8	2.6

** marijuana/hashish, heroin, other opioids, cocaine, amphetamines, ecstasy*

*** marijuana/hashish, heroin, other opioids, cocaine, amphetamines, ecstasy, as well as sedatives and relaxants*

Source: Sniķere et al. 2011

The highest proportion of those trying drugs before imprisonment is among those convicted for drug-related crimes.56 79% of those convicted for drug-related crimes had used drugs in the last month before imprisonment, while the lowest proportion (15%) is among those convicted for rape.

The highest proportion of those using drugs daily before imprisonment is among those prisoners who had used heroin or other opioids. This was indicated by approximately 2/3 (67%) of those using heroin during the last month and 45% of those using opioids. Approximately one third of those using amphetamines during the past month had done so daily.

Table 9.14. Regularity of using various drugs in last month before imprisonment, % using specific drug during last month

	Marijuana/ hashish	Ecstasy	Amphetamines	Cocaine	Heroin	Opiates
Every day/several times a day	23.8	16.3	35.3	9.2	66.7	44.6
4-6 times per week	6.2	12.4	10.3	8.1	6.6	8.2
2-3 times per week	13.2	19.7	12.5	14.3	9.0	15.1
At least once per week	19.5	15.7	16.9	15.4	7.5	12.9
Less than once per week	37.3	35.8	25.0	53.0	10.2	18.6

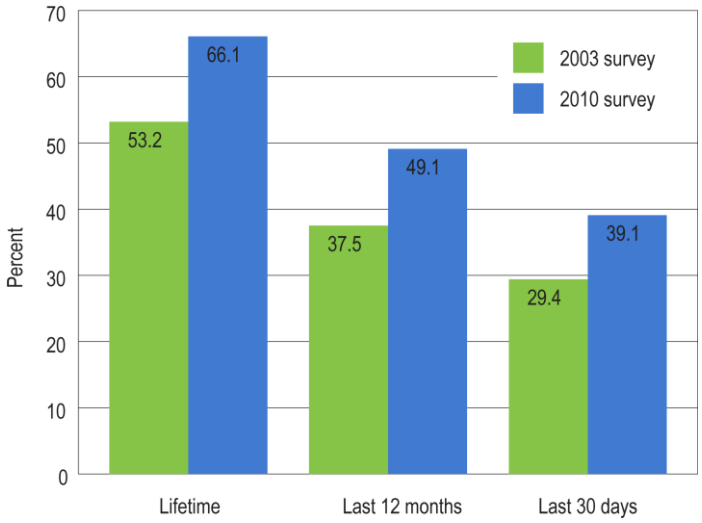
Source: Sniķere et al. 2011

[56] A convicted person may be convicted for several offences. The distribution used in data analysis did not indicate single offences.

Comparing the results of the studies conducted in prisons in 2003 and 2010 it is evident that the proportion of prisoners who had drug use experience before imprisonment has grown significantly. If in 2003 around half (53%) of prisoners had used drugs before imprisonment, then in 2010 approximately 2/3 (66%) had done so. The 2003 survey data show that 38% had used drugs in the last year before imprisonment while 49% had done so in 2010. Similar differences are seen for drug use in the last month before imprisonment See Figure. 9.2).

The greatest increase in the proportion using any drug is among the 25–34 year prisoner age-group, as well as among older respondents; no statistically significant differences for increase in drug use prevalence were observed for the youngest age group (15–24 years).

Figure 9.2. Drug use prevalence before imprisonment, from the 2003 and 2010 studies, %



Source: Sniķere et al. 2011

Respondent replies on drug use experience before imprisonment show that the greatest proportional growth is for the use of amphetamines. If the 2003 survey results show that 22% had tried amphetamines, and 16% in the last year and 10% in the last month, then 2010 survey data show that during their lifetime amphetamines had been tried by slightly less than half the prisoners (41%), while during the last year and the last month before imprisonment they had been used by 30% and 22% respectively. An increase in the proportion of those using other drugs is also observed but these differences are not as significant as the increase in the numbers using amphetamines.

Prevalence of using habit-forming substances during imprisonment

In places of imprisonment alcohol use is likened to drug use from the point of view of the law – both are punishable. According to replies from respondents, approximately one in five (19%) had consumed alcoholic beverages, while during their last year in prison 13 % of prisoners had consumed alcohol. As opposed to drug use in which statistically significant differences are observed both in and out of prison in terms of age, experience with the consumption of alcohol in prisons is not associated with age i.e. both younger and older respondents indicated equally frequently that they had consumed alcoholic beverages during imprisonment.

Among those who had consumed alcoholic beverages during the last year in prison, approximately half (52%) had used alcohol on 1–2 occasions, while 15% had done so daily or almost every day. Approximately one in three prisoners (36%) had used alcohol at least once per month during the past year.

According to replies from respondents approximately one in three (31.8%) prisoners had used drugs on at least one occasion while in prison. A significantly lower level of drug use exists among prisoners aged 45–54 and 55–64 years, whereas there are practically no obvious differences in the other age groups.

About one in five (17.8%) prisoners had used some illegal drug relatively recently (during the last year of imprisonment), while approximately one in 10 (8.5%) prisoners had used drugs during the past month. The proportion of prisoners using drugs in their lifetime, in the last year and last month is shown in the Table below (See Table 9.15.).

Table 9.15. Use of any illegal drug in prison, by age, %

	15-64 years	15-34 years	35-64 years
In lifetime	31.8	34.1	25.9
In last 12 months	17.8	19.5	13.9
In last 30 days	8.5	9.3	6.7

Source: Sniķere et al. 2011

Because the majority of prisoners had replied that they had already used drugs before imprisonment, the number of prisoners who had tried drugs for the first time upon arrival in prison is not large. According to respondent replies 1.4% of prisoners (or 4.6% of those having no drug use experience prior to imprisonment) had tried drugs for the first time while in prison. However, it must be added that of those respondents who had not used drugs in the last year or the last month before imprisonment, 10% and 15% respectively had used drugs on at least one occasion during imprisonment.

The closed environment of the prison also functions as a place in which a number of drug users do not use drugs. Of those using drugs in the past month before imprisonment, 47% indicated that they had not used drugs while in prison. Among those prisoners who, in the last month before imprisonment, had used the so-called "problem drugs",57 a higher proportion than amongst those who had not used these drugs (54% and 48% respectively) indicated using drugs on at least one occasion while in prison.

The most frequently indicated substance used by prisoners while in prison is marijuana/hashish, which had been used during their lifetime, last year or last month by 24%, 12%, and 6% of prisoners respectively. Indicated as the next most frequently used substance is amphetamines, which had been used on at least one occasion by approximately one in five (19.0%) prisoners, while in the last year and the last month they had been used by 10.3% and 3% respectively. Sedatives and relaxants had been used in prison by 18% of prisoners. About one in 10 (10.1%) prisoners had used heroin while in prison; 7.6% had used ecstasy; 5.5% had used various opioids, while 2.9% indicated using cocaine on at least one occasion while in prison. The age structure of those using drugs in prison is similar to that of drug use before imprisonment: younger respondents indicated using some form of drug in prison more often than older prisoners.

In their last year of imprisonment respondents most often indicated that they had used sedatives or relaxants, while the most frequently mentioned of the illegal drugs were marijuana/hashish and amphetamines, the use of which was admitted by 11.7% and 10.3% of prisoners respectively. A notably smaller number of prisoners had used other substances e.g. heroin, cocaine, ecstasy (See Table. 9.16).

Table 9.16. Use of various drugs during last year of imprisonment, by age, %

	15-64 years	15-34 years	35-64 years
Any illegal drug*	17.7	19.5	13.9
Marijuana/hashish	11.7	12.8	9.2
Opioids (Total)	6.7	7.5	5.1
Heroin	5.9	6.4	5.0
Other Opioids	2.8	3.2	1.8
Cocaine	1.0	1.2	0.5
Amphetamines	10.3	11.1	8.7
Ecstasy	2.9	3.3	2.0

Source: Sniķere et al. 2011

[57] 'Problem drug use' is defined by the EMCDDA as 'injecting drug use or long duration or regular use of opioids, cocaine and/or amphetamines'.

8.5% of prisoners had used various drugs during the past month. Respondents most frequently indicated that they had used marijuana (5.9%), while 3% of prisoners noted using amphetamines during the past month. A relatively large number of prisoners (approximately one in eight or 12.1%) admitted using sedatives or relaxants during their last year of imprisonment.

Table 9.17. Use of various drugs in last month of imprisonment, by age, %

	15-64 years	15-34 years	35-64 years
Any illegal drug*	8.5	9.3	6.7
Marijuana/hashish	5.9	6.4	4.9
Opioids (Total)	2.7	3.2	1.5
Heroin	1.7	2.2	0.7
Other Opioids	1.3	1.6	0.8
Cocaine	0.6	0.9	0.0
Amphetamines	3.0	3.1	2.8
Ecstasy	1.4	1.8	0.5

Source: Sniķere et al. 2011

It is possible that data on drug use regularity during the last month is also indicative of a limited availability of drugs. Approximately half of those respondents using a specific drug during the past month had noted using it less than once per week, but there are also those prisoners who had indicated using a drug several times per week. These results should be interpreted with caution, bearing in mind the small number using specific drugs during the past month.

Table 9.18. Regularity of using various substances during last month of imprisonment, % using specific drug during last month

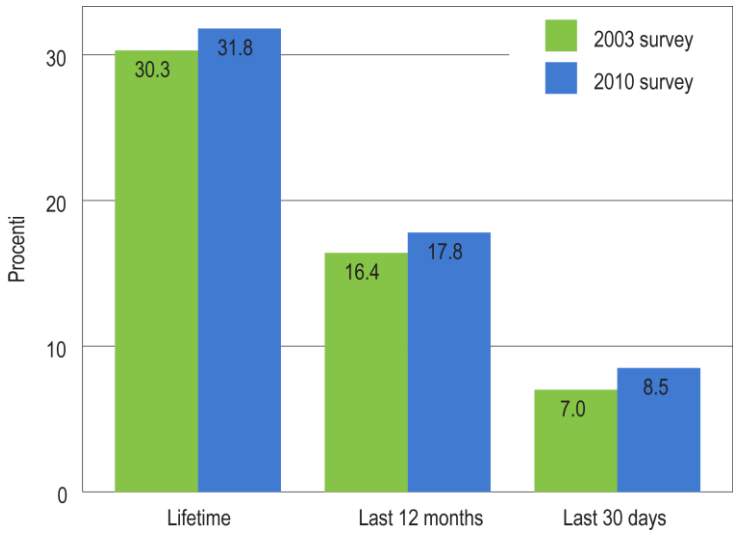
	Marijuana/ hashish	**Amphetamines**	**Heroin**	**Opiates**
Every day/several times a day	23.6	20.2	27.9	16.4
4-6 times a week	7.1	10.3	10.9	16.0
2-3 times a week	5.8	8.9	3.2	3.5
At least once a week	14.3	15.6	3.2	8.5
Less than once a week	49.1	45.1	54.9	55.6
Number of usable responses	120	47	27	23

Source: Sniķere et al. 2011

In comparing results from the 2003 and 2010 studies on the prevalence of drug use in prisons it is evident that prevalence in the use of any drug is slightly higher, although the changes are not statistically significant. In interpreting these results, the closed prison environment must be borne in mind as well as the possible deliberate concealment of drug use experience for fear of sanctions if the information provided in the survey questionnaires was used for other purposes at the individual level.

Data from both prison studies indicate that approximately one third of prisoners had used drugs while in prison: 30.3% in 2003 and 31.8% in 2010. During the last 12 months of imprisonment approximately one in eight prisoners had used drugs: 16.4% in 2003 and 17.8% in 2010, and during the past month: 7.0% and 8.5% respectively (See Figure. 9.4.). Analysis of results obtained from the 2010 study did not indicate any prisoner groups which have significantly more often noted using drugs in prison, than during 2003.

Figure 9.3. Prevalence of drug use in prison in 2003 and 2010 studies, %



Source: Sniķere et al. 2011

Addiction level

According to replies given by respondents on the Leeds Dependence Questionnaire (LDQ), only 39% of prisoners did not have problems associated with dependence. 49% of prisoners possibly had low to moderate dependence (1–10 points on the LDQ scale), 10% had moderate to high dependence (11-20 points), and approximately 2% of prisoners had high dependence problems (21-30 points). Female prisoners more often than male could be classified as having no dependency problems (OR=1.59; 95% T.I. 1.10–2.29; p=0.014), while gender differences are not evident among those having moderate to high dependence problems. Those respondents who had indicated using drugs in the last month before imprisonment may presently be classified as those having moderate to very high dependence problems (OR=5.64; 95% T.I. 3.86–8.23; p<0.001).

As questions on the LDQ scale measured not only drug dependency but also alcohol dependency, analysis of the data considered the extent to which alcohol consumption experience affects dependency indicators. It was concluded that alcohol use frequency before imprisonment does affect the dependency level: those respondents indicating they had used alcohol more than three times per week also scored significantly higher on the LDQ point scale than others (OR=2.97; 95% T.I. 2.04–4.29; p<0.001). As some of those who had used alcohol three or more times per week had also used drugs during the past month, then, controlling alcohol use frequency for drug use experience it was evident that those who had regularly used alcohol but had not used drugs, had a more serious addiction.

9.4. Responses to drug-related health issues in prisons

See also Chapter 11 regarding health care in prisons, limiting drug use (prevention, treatment and harm reduction).

Various preventive measures were taken in 2010 which included lectures and informative campaigns for prisoners, and events of a religious nature. Prisoners were involved in various resocialisation programs (2528 prisoners were involved in the programs, of whom 2097 completed the programs). During 2010, 37 resocialisations were undertaken in prisons (social behaviour corrections (14), social rehabilitations (16) and Christian instructional programs (7)). Of the 37 programs, 14 were implemented by non-governmental, religious and local government organisations. The remainder were implemented by the Latvian Prison Administration and the State Probation Service (See Table 9.19.).

Table 9.19. Description of program participants in programs which directly or indirectly facilitate the prevention of drug use

Total number of participants who completed programs	**1087**
Number of males	**815**
Juvenile males	22
Adult males	793
Number of females	**272**
Juvenile females	35
Adult females	237
Location of program participants (number of persons):	
Closed prison	551
Semi closed prison	514
Open prison	0
Juvenile correctional facility	22
Pre-trial investigation Centre	0

Source: Latvian Prison Administration 2011

In 2010 the drug dependency reduction program Minnesota 12-step program commenced at the Cēsis Juvenile Correctional Facility (10 juvenile prisoners were involved). Programs which indirectly facilitate the prevention of drug use were implemented in several prisons.

Many prisoners are employed at workplaces created by merchants and as domestic servants. 1210 prisoners were employed during 2010; of those 567 were employed in domestic service, while 643 worked in jobs established by merchants. In 2010 the employment level for prisons averaged around 25.05% (approximately 2% more than in 2009) of prisoners fit for work (Latvian Prison Administration 2011).

Preparation of prisoners for release. In 2010 the preparation of prison inmates for release took place in collaboration with the State Probation Service, local governments, the social rehabilitation centre "Ratnieki" and the Evangelical Christian Fellowship "Zilais Krusts". Specific attention was paid to issues relating to family, education and employment, and to the conditions by which means of existence would be provided after release (Latvian Prison Administration 2011).

On 6 August 2010 the Board signed an interdepartmental agreement with the Office of Citizenship and Migration Affairs On cooperation between the Latvian Prison Administration and the Office of Citizenship and Migration Affairs regarding the issuing of passports to persons incarcerated in prisons.

To prepare a prisoner for release, the following documents were completed: documents confirming identity (passport) for 815 prisoners, including documents for the inclusion of the person in the Population Register for three prisoners.

Prison administration staff forwarded requests to state and local government authorities prior to the release of prisoners, and notifications of possible early conditional releases of prisoners: to municipalities for the resolution of issues relating to place of abode: 2007; regarding the need to receive social assistance and social services: 808; to the State police regarding the possibility of declaring place of abode: 1193; to the State police regarding release: 2630 (Latvian Prison Administration 2011).

10. Drug Markets

Based on the number of methamphetamine seizures and quantities seized, its turnover throughout Latvia has increased. The substance is delivered to Latvian territory from neighbouring countries: Lithuania, Poland, Germany, Belgium, and the Netherlands, while the turnover of amphetamine within the country continues to decrease.

The number of marijuana farms detected has increased, as has the number of seizures and the quantity seized. It is thought that part of the output from the largest farm discovered in 2010 was intended for export to the Scandinavian countries.

Turnover in heroin has remained stable, but a decreasing trend in the market share for cocaine has been identified, as well as the gradual disappearance of the ecstasy group of substances from the market. Several major cocaine seizures in 2010 evidence Latvia's increasing role in the transit of cocaine to Russia.

With improvements in identification capabilities, there has been a significant increase in seizure rates and quantities for the "new" synthetic drugs. Substances from the piperazine, cathinone and synthetic cannabinoid groups are the most commonly found.

The average purity of methamphetamine during the past three years has remained stable at around 30%. The purity of heroin has reduced slightly each year, while the average purity of cocaine in recent years has steadily increased.

10.1. Availability and supply

Study results demonstrate that the drugs used (drug availability) are different for different groups. The results of a study on the influence of risk and protective factors on the use of addictive substances among young people in Riga indicate that among students in Years 9 and 10 (15-16 years) the drugs tried most often during their lifetime are marijuana/hashish (22.7%), followed by inhalants (13.9%), tranquillisers and sleeping pills (9.5%). (Koroļeva I. et al. 2010).

Marijuana is the substance most commonly used in places of incarceration (used in prison by 9.2% of respondents last year, and 4.9% last month). The second most popular type of drug was various opioids, which last year had been used in prison by 1.5% of respondents.

In the Eurobarometer study, young people aged between 15 and 24 were asked how easy it is to obtain drugs. The results show that it is easiest to obtain cannabis, while heroin and cocaine are the most difficult to obtain *(see Figure 10.1)*.

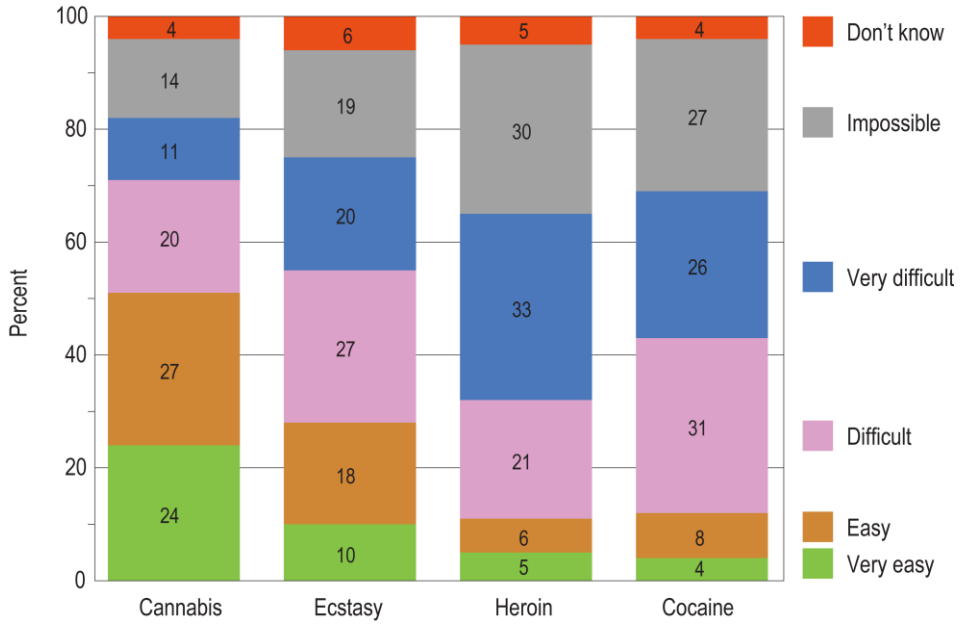
According to available data, 49.89 kg of dried marijuana or 82.2% of the total quantity seized nationally in 2010 was removed from 8 farms in 2010 (State Police 2011).

In October 2010 the State police discovered a methadone manufacturing plant. This is the first drug laboratory discovered since 2005. The illicit laboratory was situated in hidden rooms in the territory of a legal alcohol manufacturing plant. A total of 27.7991 g of methadone was seized, as well as chemicals and essential precursors. Also seized was laboratory equipment: 2 new reactors still in their original packaging, 4 used reactors, a reduction evaporator, dryer, gas cylinder, ventilation system, as well as laboratory equipment showing traces of methadone (State Police, 2011). The involvement of Latvian citizens in the drug industry is also confirmed by the discovery in 2011 of three production facilities for synthetic drugs.

Drug importation routes and means of transport have not fundamentally changed. Land and sea routes, as well as air space are used for importation. Couriers are involved in the carriage of drugs, as well as consignments using the mail. According to information held by the Customs Criminal Board and the State police, citizens of the Republic of Latvia are becoming increasingly involved in international crime by working as couriers. According to official information provided by the Foreign Ministry on the transportation, manufacture, distribution and storage of drugs there were 32 persons detained or convicted abroad in 2009, and 67 persons in 2010 (Gabre 2011). There is a comparative increase in the number of persons detained and convicted for drug smuggling; i.e. in

2007 there were 33 breaches of relevant sections of the *Criminal Law* recorded, 35 in 2008, 99 in 2009, and 158 cases in 2010 (State Police 2011).

Figure 10.1. Perceived availability of several substances, %



Source: Eurobarometer *2011*

Drugs are generally thought of as imported, however, compared with 2009, the number of cannabis farms identified has increased (see Table 10.1.), as a result of which a greater quantity of substance seized was recorded. In 2010, 8 plantation sites were discovered, including the largest marijuana farm discovered to date, from which 3500 plants or 86% of all plants seized in 2010 were removed.58 According to Customs Criminal Board data, output was also intended for export to the Scandinavian countries, as the farm was discovered after the commencement of criminal proceedings following the seizure of 3kg of marijuana on the border of Latvia and Estonia in 2008 (SRS News 23.03.2010). The four largest marijuana farms were discovered in secluded farmyards. Two or three people having Latvian citizenship were employed in the production, preparation and sale of the product. Four farms were discovered in cities - two in Riga, one each in Jurmala and Limbaži; the product was grown and prepared by one man.

Table 10.1. **Marijuana plantations discovered in Latvia in 2006-2010**

	2006	2007	2008	2009	2010
Marijuana farms discovered	1	3	6	3	8

Source: State Police Forensic Service Department 2011

Heroin is imported from the Central Asian region through Russia to Western Europe, Lithuania, Poland and the Scandinavian countries.

Amphetamine/methamphetamine is imported from Lithuania, the Netherlands, Belgium, Germany and Poland. Part of the imported cargo remains in local territory, while part is shipped onwards to Estonia, Russia and the Scandinavian countries.

Several instances related to the transit of cocaine were discovered in 2010. In two cases, large quantities of cocaine were discovered in the port of Riga, which suggests the involvement of the ports in drug transit. In one case, 202.5 kg of cocaine was seized from a ship flying the flag of the Republic of Panama. The cocaine was intended for transit to Russia. In late 2010, 80.1 kg of substances containing cocaine were found in a shipping container brought into Riga Port.[59] Several Latvian citizens were also arrested in 2010 in connection with drug courier activities associated with cocaine smuggling. This included four Latvian citizens arrested in Colombia; four in the UK; two in Spain; and one in Trinidad and Tobago; 4 kg of cocaine were seized (State Police,

[58] Total cannabis plants seized: 4045 units. See ST13_2011_LV_01; ST13_2011_LV_02; ST13_2011_LV_03
[59] Substance seized in late 2010. Seizure recorded by State Police Forensic Service Department in early 2011

2011). In one case recorded at the beginning of 2011, a Latvian citizen who had been traveling from Ecuador to Latvia died after capsules containing approximately 700 g of cocaine had ruptured in his stomach (Newspaper *Neatkarīgā Rīta Avīze* 2011).

Imported marijuana is brought in from the countries of Western Europe (mostly the Netherlands, Belgium, Spain, Britain, and Germany), Lithuania and Poland, as well as Southern Russia (the Astrakhan oblast). It is thought that part of the marijuana produced locally is exported to Scandinavia.

"New synthetic drugs" are imported from China and India via courier consignments. Synthetic cannabinoids in powder form have been found in all the consignments. Most likely the substance eventually enters the domestic market, and is also transported to other member states of the European Union. Mostly these are shipments containing 1 or 2 kg of substances. In some cases recorded, small quantities of substances in the cathinone group were seized from individuals on the land border.

The mechanism for drug distribution at the national level remains the same. Namely, the central site for drug distribution is the capital city of Riga; from there drugs are distributed to the major cities of the Republic. Drugs are basically distributed within a mutually acquainted group of persons. The persons involved in illicit distribution take all possible measures to minimize direct contact between dealer, drugs and buyer; drug marketing schemes are constantly being altered, new people are constantly becoming involved in the unlawful activities, use of prepaid phone cards is widespread, mobile phones are frequently changed, internet social networks are utilised, as are couriers, "stashes" and other methods. There is no evidence of participation by any particular ethnic group in drug distribution. However, there is increasing involvement of people and groups who have previously been involved in economic crimes.

10.2. Seizures

According to data supplied by the State Police, in 2010 there was a total of 1859 drug seizures,[60] which is about 9% more than in 2009 (1694 seizures). The total number of drug seizures resulting from action by the Customs Service has also increased, from 129 seizures in 2009 to 179 in 2010.

The number of seizures of methamphetamine continues to grow, but the number of amphetamine seizures and quantity seized continues to decrease. Compared with the previous year, the number of methamphetamine seizures has increased by 25% and the quantity seized has increased by 5%. In 68% of seizure cases, the quantity of methamphetamine seized was below 5 g.

Seizures of marijuana have increased by 31% compared to 2009, while the quantity seized has increased by 61%, which is attributed to the discovery of several large farms in Latvia in 2010 (State Police Central Criminal Police Department data).

The number of hashish seizures increased from 22 in 2009 to 34 in 2010. A growing trend has been observed each year, with a peak in 2008. 23.34 kg was removed in one seizure in 2010, which dramatically increased the quantity of substance seized (from 1.45 kg in 2009 to 23.83 kg in 2010).

The number of cocaine seizures has fallen from 55 cases in 2007 to 34 cases in 2010; it is thought the economic situation might be causing drug users to turn to other stimulants; the significant quantity of cocaine seized is associated with cocaine transit.

The number of heroin seizures has increased by 3% compared with the previous year, but remains at the same level as in 2008. The quantity of heroin seized was the smallest since 2006. From all heroin seizures, 80% of the quantity seized was less than 1 g.

Among the so-called "new drugs", the seizures recorded most often are for the synthetic cannabinoids and cathinones. In 2010 a total of 24.5 kg of substances from the cathinone group were seized, of which mephedrone and fluoromethcathinone were the most common in terms of seizures and quantity seized. 62 seizures were recorded for the synthetic cannabinoids. There

[60] Individual cases of seizure of a specific drug, nothwithstanding that several seizures might have occurred as part of a single criminal investigation.

were 55 seizures of herbal mixtures (3.07 kg). Powdered synthetic cannabinoids were seized on 7 occasions (4.8 kg), mostly discovered in express courier consignments. Most often seized in 2010 were plant mixes with the addition of JWH-018 (34 cases). In 2010 substances from the piperazine group were seized less frequently i.e. 15.14 g and 672 tablets, compared to 2009, when 122.14 g and 2274 tablets were seized (Early Warning System 2011).

Table 10.2. Number of seizures by law enforcement agencies of substances in the piperazine, cathinone and synthetic cannabinoids groups, and quantity seized (kg) in 2010

		Seizures	Quantity
Piperazines (mcpp, pcpp)	powder	8	15.14 kg
	tablets	16	627 tablets
Cathinones (mephedrone, methcathinone, Fluoromethcathinone, Methylone, MDPV, MDAI)	powder	40	24.5 kg
	tablets	1	6 tablets
Synthetic cannabinoids	plant mixture	55	3.07 kg
(JWH-018, JWH-073, JWH-081, JWH-210, JWH-250, JWH-122)	powder	7	4.8 tablets

Source: Early Warning System 2011

Compared to other years, more narcotic and psyshotropic substances were seized (barbiturates and benzodiazepines) *(see Table 10.3)*.

Table 10.3. Seized medications containing narcotic or psychotropic substances

	2006	2007	2008	2009	2010
Medications containing narcotic or psychotropic substances, in ml, kg.	1.366 kg	0.98kg	5.1 kg 13 ml	3.59 kg 9ml	25.54 kg
Medications containing narcotic or psychotropic substances (tabs.)	37671	4256.5	7858	4881	6518

Source: State Police Central Criminal Police Department 2011

10.3. Price and purity

Substance purity is investigated by the Latvian State Police Forensic Service Chemical Analysis Department. The laboratory does not undertake the determination of THC level for marijuana. For results of testing performed in 2010, see Table 10.4. In examining the trends, it should be noted that only heroin has recorded a steady decline in purity in recent years, i.e. the average purity decreased from 33% in 2007 to 25% in 2010.61 A trend is also observed for methamphetamine, having an average purity of around 30%. The average purity of cocaine has gradually increased in recent years. The average purity of amphetamine varies, probably due to small sample size, e.g. the purity of tablets containing MDMA was determined from only 5 seizures.

Table 10.4. Drug prices, in euros, 2007- 2009

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

Source: State Police 2010

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

Available data for 2005–200962 show that the average drug purity has changed to around 20%. In general, the maximum purity of substances, compared to 2008, has decreased for ecstasy, amphetamines and cocaine.

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

Table 10.5. Mean purity (%)

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

Source: State Police 2010

[62] ST14_2010_LV_01

Part B: Selected Issues

11. Drug-related health policies and services in prison

11.1. Prison system and prison population: contextual information

In accordance with Paragraphs 3 and 4 of Cabinet Regulation No. 827: Prison Board Bylaw of 1 November 2005, (issued in accordance with the State Administration Structure Law Section 16, Paragraph one), the Latvian Prison Administration is a direct administrative authority under the supervision of the Minister of Justice in the exercise of custody as a security measure and the deprivation of liberty as an enforcement measure of criminal penalties, which, along with other tasks, includes the providing of medical care for prison inmates.

In 2010, 12 prisons were operating in Latvia under the auspices of the Latvian Prison Administration, of which six were closed prisons (Brasa, Daugavgrīva, Jelgava, Jēkabpils, Olaine and Valmiera), two were partially-closed (Iļģuciems un Šķirotava), one open prison (Vecumnieki), one correctional institution for minors (Cesis Juvenile Correctional Facility), and two pre-trial investigation centres (Liepaja and Riga Central prison). Women with either arrested or convicted status are located in the same prison (Iļģuciems). In certain prisons, there are the following divisions:

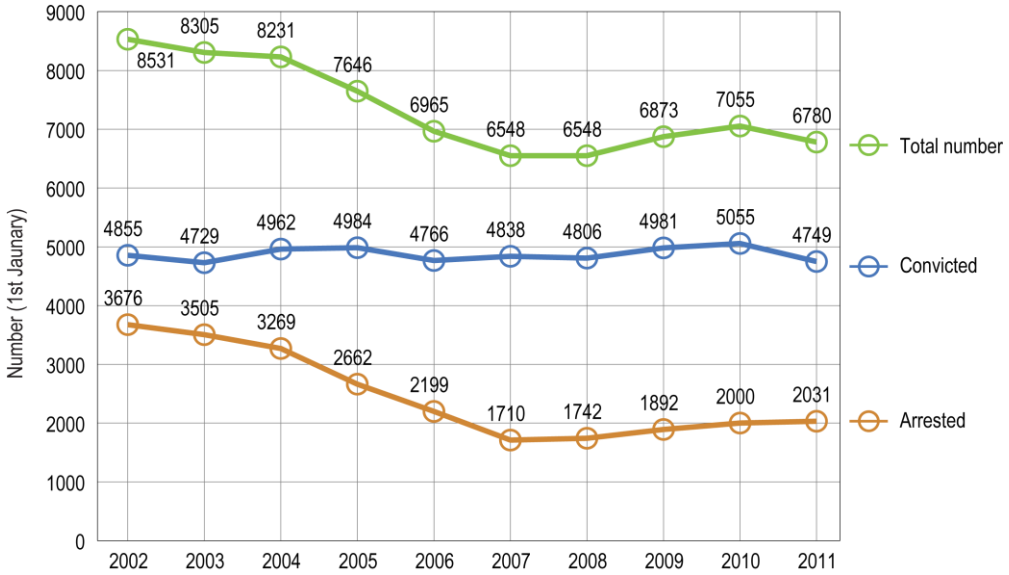
- Liepāja prison and Rīga Central prison: closed prison sections,
- Daugavgrīva, Jēkabpils un Liepāja prisons, and Rīga Central prison: partially closed prison sections,
- Daugavgrīva, Iļģuciems, Jēkabpils and Olaine prisons: open prison sections,
- Daugavgrīva, Iļģuciems, Jelgava and Valmiera prisons, as well as the Cēsis Juvenile Correctional Facility: pre-trial investigation sections,
- Iļģuciems prison: a juvenile correctional facility.

As at 1 January 2011 there were 6780 prisoners in Latvian prisons, of whom 4749 were convicted, and 2031 detainees (see Figure 11.1.). At the beginning of 2011 there were 421 women in prison, 88 juveniles and 93 foreign nationals. According to Prison Administration data, during 2010 there were 5330 convicted persons incarcerated, along with 10258 arrested persons, and 5638 convicted persons, while 10227 detainees left prison for various reasons during the year, for example, due to changes in their security arrangements, completion of criminal proceedings, completion of sentence, etc. (Latvian Prison Administration 2011).

According to Latvian Prison Administration data, the majority of prisoners at the end of 2010 (53.9%) were in closed prisons, 29.9% were in pre-trial investigation centres, 12.7% were in partially closed prisons, 2.8% in open prisons and 0.7% in juvenile correctional facilities.

The most frequently imposed sentence upon conviction is 5-10 years (36.2%). Imposed much less frequently are sentences of 3-5 years (23.2%), 1-3 years (22.0%), 10-20 years (13.1%) and 6 months-1 year (3%). A sentence of life imprisonment is imposed in approximately one case in one hundred (1.1%); a similar proportion of defendants is sentenced to penalties of up to 6 months (1.3%). The relapse rates among prisoners are relatively high: 42.8% in 2010 were serving a sentence for the first time, 22.1% for the second time, 13.7% for the third time, and 21.4%, for the fourth or more times.

Figure 11.1. Prisoner dynamic 2002–2011



Source: Latvian Prison Administration 2011

In late 2010, there were 1322 individuals in prisons who were considered particularly dangerous, and of those the "drug addicts" category was numerically the largest, numbering 862. Other security categories among these include: predisposition to escape (193 inmates), having a propensity to attack prison staff (103) and prone to suicide (149). Comparing changes in the number of "drug addicts" since 2005, it is observed that it has approximately doubled (see Table 11.1.).

Table 11.1. Dynamic of number of 'Drug addicts' in prisons, 2005-2010

	2005	2006	2007	2008	2009	2010
Number of *Drug addicts*	424	479	529	745	881	862
% of all prisoners at end of relevant year	6.1	7.3	8.1	10.8	12.5	12.7

Source: Latvian Prison Administration 2011

According to a data from a study carried out in detention centres in 2010, (Sniķere, Kārkliņa et al. 2010), 66.1% had tried drugs prior to detention, 49.1% of convicted persons had used them relatively recently or in the last year before imprisonment, while 39.1% had used in the last month before detention. 31.8% of convicted persons had used drugs at least once while imprisoned; 17.8% used drugs during the last year in prison, while 8.5% had used drugs used during the last 30 days in prison.

Comparing data from the 2003 study (Sniķere, Trapencieris, Vanaga 2003) of detention centres it can be inferred that among convicts the proportion trying various substances is considerably higher, as is the proportion using drugs in the last year and last month before imprisonment. If 53% had tried drugs before imprisonment in 2003, then 66% had done so in 2010. Trying any drug shortly before imprisonment or in the last month before imprisonment were 29% of convicts in 2003, with 39% doing so in 2010. No statistically significant differences are observed in the number of incarcerated drug users (see also NR Chapter 9).

According to the results of the Riga drug users cohort study (Trapencieris, Sniķere, Kaupe 2011) approximately every second drug user (52%) had been in prison during their lifetime, of whom 16% were there within the last three years. 45% of drug users who had been in prison stated they had used drugs in prison. Virtually all drug users (98%) who had used drugs in prison, admitted to injecting experience in prison, while 87% had used shared injecting paraphernalia.

11.2. Organization of prison health policies and service delivery

Prison health

Health care in prisons must be organized in accordance with Cabinet Regulation No. 199 of 20 March 2007:"Regulations for the health care of detainees and convicted persons in pre-trial investigation centres and custodial institutions" (issued in accordance with the provisions of the Law on the Procedures for Holding Detainees Section 22, Paragraph one and the Sentence Execution Code of Latvia Section 78, Paragraph one.

Paragraph 2 of the Regulation provides that a prisoner shall receive free primary health care, with the exception of elective dental assistance; urgent dental assistance; secondary health care which is to be provided by emergency services, as well as secondary health care which is provided by prison physicians according to their speciality; as well as the most effective and cheapest medications, as prescribed by prison medical staff.

In accordance with information contained in the Regulation, outpatient health care for prisoners shall be provided by the prison's medical unit, and hospital care shall be provided by the Latvian Prison Hospital. On the other hand, if an application is received from a prisoner, which has been harmonised in writing with the prison doctor, the prison administration may make arrangements for the consultation and treatment of the prisoner with the management of a treatment facility located outside the prison. In this case, costs associated with provision of health care service, as well as transport and security costs shall be borne by the prisoner (Paragraph 15).

In a 2010 study of the drug use problem in prisons (Sniķere, Kārkliņa et al. 2010) expert interviews with industry professionals suggest that the real health situation in prisons differs significantly from the requirements stipulated in legislation. This situation has also been brought about for an extended period of time by a variety of other reasons, but, according to the experts, the most important cause has been the complex funding system for prison health care. Having regard to the budget cuts proposed by the Latvian Prison Administration in 2009, there has been a major reduction in projected funding for medical expenditure in prisons, and with that access to primary health care services is very limited and most of the expenditure on essential medication must be met by the prisoner himself.

The Medical Treatment Law of 12 June 1997, Section 4, Paragraph one, provides for the organisation of health care and funding arrangements for the waiting list of applicants for elective health care services, their treatment types and amounts to be paid from the State budget and by the recipient of the services, and that the arrangements for payment are to be determined by the Cabinet of Ministers. In accordance with the procedure laid down in Cabinet Regulation No. 1046 of 19 December 2006: Procedures for Health Care Organisation and Financing (issued in accordance with The Medical Treatment Law Section 4, Paragraph one), Paragraph 17, Sub-paragraph 2, the funding of prison health care shall be administered as follows:

- The payment of costs for health care services to incarcerated persons shall be within the competence of the Ministry of Justice;
- On the other hand, medications for the treatment of tuberculosis and HIV/AIDS and laboratory tests ordered for HIV/AIDS patients shall be met from funds allocated for health care from the State budget.

These provisions are thus indicative of a dual health care funding system, whereby most of the funding must be provided by the Ministry of Justice but treatment of HIV/AIDS patients is funded by the Ministry of Health. The need to make changes to the system of funding has already been mentioned in the previously-mentioned study in interviews with experts as well as an opinion prepared by the Latvian Ombudsman on deficiencies in health care in Latvian prisons.

However, the problems associated with the fact that the most significant proportion of health care is provided in Latvian prisons outside the mainstream health care system have been in existence for a long period of time. This is also evidenced in the Prisoners' health care Concept developed in 2006, at the direction of the Ministry of Justice.

As indicated in the Concept, the fact that the health care of prisoners is separate from the mainstream health care system firstly hampers the flexibility to respond to changes and the latest developmental trends, and secondly, which is particularly emphasized in the Latvian Ombudsman's opinion, raises concerns about the appropriate use of funding and, in general, impedes delivery of health care to prisoners.

To resolve the issues referred to in the Concept, the Ministry of Justice has offered to set up a new model for health care competence distribution and health care for prisoners that will ensure the most effective use of human and financial resources.

It is intended that the Prisoners' health care Concept will be implemented progressively, initially by the Ministry of Justice and the Ministry of Health drawing up a plan for implementation of the Concept and determining the process timelines for necessary amendments to the legislation. The Concept's measures should result in that within a certain timeframe the health care of inmates will transfer to the competence of the Ministry of Health.

Unfortunately, in June 2010 the Cabinet of Ministers adopted a protocol decision which states that the work of the Ministry of Justice and the Ministry of Health to develop a prisoner health care model has lost its relevance. Thus, by the terms of the Cabinet Protocol Decision adopted on 1 June 2010 it may be concluded that the prison health-care concept is no longer being developed in the country. As noted in the Ombudsman's report, with this decision, the issues of prisoners' health are not being addressed despite the fact that the situation in the medical care field has intensified.

Drug-related health policies targeting prisoners

The National Drug Program for 2011–2017 is a document that implements, in accordance with the Development Planning System Law, specific development strategy objectives and tasks set in the hierarchically superior medium-term development planning document, the Latvian National Development Plan 2007-2013 for improving and modernizing the system in the fight against illegal drugs and to engage the public in the fight against addiction diseases, including drug addiction.

The previous policy planning document, the National Drug Programme 2005–2008 ceased its operation on 31 December 2008. As indicated in the evaluation report, many of the activities needed for practical implementation of the program for the development of this policy area have not retained their priority and have not been implemented, and as a result, many problems associated with drug addiction and illicit drug distribution have not been reduced, including in prisons.

Describing the situation of drug patients and drug users' health care in prison, the ex-post report on the previous national program points out that the necessary activities to address drug-addicted prisoners' health care problems have still not been implemented, including the non-development of long-term treatment and rehabilitation programs for prisoners; nor has a program been designed and implemented for preventing social and biological effects of drug use among prisoners, and its continuous operation ensured.

The ex-post evaluation report adopted by the Cabinet of Ministers recommends that, given the close links of the issue to be addressed with the concerns regarding the general administration of prison health care, these issues should be addressed together with the rest of the prison health care conceptual resolutions.

To achieve the Policy objectives and resolution of existing problems in the health care of drug patients and drug users sector, a number of lines of action and tasks have been drawn up within the framework of the Guidelines, including:

- Develop and implement a concept for inmates' health care, including the provision of pharmacological treatment for addicts and implementation of resolutions for the reduction of the social and biological effects of drug use (develop by 30 June 2010; implement by 31 December 2016; responsible authority is the Ministry of Justice, with the involvement of the Ministry of Health);

- Develop amendments to the Criminal Law providing for the removal of the imprisonment penalty sanction for unauthorised use, acquisition and storage of drugs for personal use (responsible authority is the Ministry of Justice);
- Develop and implement a concept for coercive measures in public security to extend for addicted offenders the substitution of administrative and criminal penalties with treatment for addictions by compelling attendance at drug treatment programs and to compel potentially dependent persons to attend addiction treatment programs (to be adopted by the Cabinet of Ministers by 31 December 2010; responsible Ministry is the Ministry of Justice, with the involvement of the Ministry of Health).

As indicated in the Guidelines, as opposed to the EU common anti-drugs policy, deprivation of liberty is still provided as a criminal sanction for repeated drug use, which in the context of the problems in providing treatment for drug addiction in prisons not only fails to achieve the legitimate purpose of such sanctions, i.e. the offender's resocialisation and ceasing of drug use but it is inadequate for the nature of the criminal offence, and also reduces the security situation and facilitates the spread in prisons of consequences associated with drug use (viral hepatitis, (HIV/AIDS, etc.).

The Penal Policy Concept[63], which was approved by Cabinet of Ministers Order No 6 of 9 January 2009, was developed with a view to drawing up conceptual proposals for changes in the penal system, which would be used in developing the necessary amendments to the Criminal Law and other legislation, the adoption of which would promote a more effective application of legal measures to achieve the objectives of the penal policy.

The Concept stipulates that any criminal offence is committed under the influence of a number of factors and circumstances, therefore, criminal penalties must be such as to promote the prevention or mitigation of factors that facilitate criminal offending. The severity of punishment is often not sufficient for a person to knowingly discontinue the committing of new criminal offences. It is therefore important that in practice, additional penalties are imposed together with the principal penalty, which would serve to avert the facilitative factors for offending, and the law should provide broader coercive sentencing options, including medical coercion.

Medical coercive measures are applicable in cases where there is no criminal offence, but, viewed objectively, the act committed corresponds with a criminal offence, with a view to preventing new similar offences being committed (crime prevention). In addition to the application of medical coercive measures, medical assistance and care are also to be provided.

According to information contained in the Concept, as the treatment for alcohol or drug addiction is not actually grounds for exempting a person from punishment, in order to resolve the problem it is important to ensure that a person released from sentence could demonstrate that after completing a full course of treatment they would be eligible to apply for social rehabilitation services, which would be a greater motivator for treatment of those addictions.

In accordance with Section 61 of the Medical Treatment Law, treatment of patients addicted to alcohol, narcotic, psychotropic, toxic substances, gambling or gaming takes place voluntarily at their request in drug treatment institutions in accordance with the procedure laid down by the Cabinet of Ministers. On the other hand, in cases where a patient acts in a manner dangerous to the public, commits systemic administrative offences, or by his actions endangers himself, his immediate relatives or the public, due to abuse of alcohol, narcotic, psychotropic, or toxic substance, they are subject to statutory social and psychosocial rehabilitation by means of coercive measures, but minors face coercive measures of a corrective nature (Sections 62, 63), which include:

[63] 10 March 2010. State Chancellery was presented with the draft amendments to the *Criminal Law* drawn up in accordance with the Criminal Penalty policy Concept. On 20 September 2010 the draft amendments were supported by a Cabinet Committee meeting. After the reconciliation of the Bill with the Prosecutor General's Office and the Ministry of Interior it was submitted to the Cabinet of Ministers for review.

1. Being placed on a police warning list, and a written warning from police that the patient should cease using alcohol, drugs or toxic substances, gaming machines or computer games, and committing related administrative offences, and is required to start treatment;
2. Added to the drug addict list, and motivation developed for the patient to begin voluntary treatment for addiction to alcohol, drugs, toxic substances, gambling or computer games;
3. Judgment of the Court on the obligation of the convicted person to undertake treatment.

According to Section 63 of the said Medical Treatment Law, when sentencing to probation, the Court may impose the requirement for a defendant who has committed a criminal offence while affected by alcohol, drugs or toxic substances or is addicted to gambling or computer games, with his consent, to obtain treatment for addiction to alcohol, drugs, toxic substances, gambling or computer gaming at an institution for social and psychological rehabilitation.

The Concept stipulates the need to amend the Criminal Law Section 59, Paragraph four, stipulating that where a person has committed a less serious crime because of addiction to alcohol, drugs, psychotropic or toxic substances, the Court may dispense with imposing a penalty if the person has received an opinion from an addiction specialist on the need for social rehabilitation for the addiction person. It should be noted that by amending the Section 59 of the Criminal Law, with increases in the numbers seeking treatment and rehabilitation services, there will be a corresponding increase in the funding required to provide them.

At the same time, the Concept envisages that in order to protect public safety, and reduce relapse rates for serious and very serious crimes, the Criminal Law General Section should be supplemented by a new section, providing the public safety application of coercive measures to a person who has committed an offence under the Criminal Law, but after completing his sentence has not reached the goals of resocialisation, or has not been referred to or exempted from prosecution, as well as in the case where medical coercive measures are no longer being applied to the person, and they could still pose a threat to public safety. The law should provide for the possibility of a court ruling to apply public safety measures for persons who have committed, inter alia, a number of serious or particularly serious offences because of alcohol, drugs or other reasons. The Concept particularly emphasises that the aim of public safety measures is not to demean a person, and they must not significantly restrict the person's rights.

Since public safety measures have no punitive function, they may be applied for an indefinite period or for a certain period of time with an option to extend; they must be flexible in terms of monitoring methods and their intensity may vary over time. At the same time, for to public safety measures to be fully effective, it is necessary to provide for criminal liability for evasion of their obligations, and administrative liability for failure to fulfil their obligations.

To create a public safety system with coercive measures and commence its application, work is under way on drafting the Public safety coercive measures concept.

As policy makers indicate, by ignoring criminal punishment policy concerns and without making the necessary amendments to the Criminal Law in accordance with the information contained in the Concept (a) a mechanism will not be created, which will motivate convicted persons to seek treatment for addiction to alcohol or drugs, (b) crime relapse will not reduce among persons who have committed criminal offences, being addicted to alcohol or drugs.

Given the general problems in health care in Latvia's prisons, there are also uncertainties regarding the application of methadone substitution in prisons, which are associated with the requirements of laws as described below.

The law On Procedures for the Legal Trade of Narcotic and Psychotropic Substances and Drugs (9 May 1996) Section 3, Paragraph two stipulates that in Latvia schedules of controlled drugs and precursors are approved by the Cabinet of Ministers at the instigation of the Ministry of Health.

In accordance with this law, Cabinet Regulation No. 847 of 8 November 2005: Regulations regarding Narcotic Substances, Psychotropic Substances and Precursors to be controlled in Latvia, in which, in Annex 2 Schedule II of Controlled Drugs and Precursors, methadone, along with other substances is defined as a highly dangerous drug only permitted for use for medical and scientific purposes.

On the other hand, the fact that opioid drug dependent patients undergoing temporary and maintenance treatments such as the substitution treatment method use medication with the active ingredient as methadone or buprenorphine, is determined by Cabinet Regulation No. 429 of 24 September 2002: Procedures for the Treatment of Patients Addicted to Alcohol, Narcotics, Psychotropic and Toxic Substances, Paragraphs 18 and 19.

It should be noted that long term pharmacological opioid treatment (replacement therapy) using methadone has been operating in Latvia since 1996. In 2008, thanks to amendments made to the said Regulations, access to replacement therapy was extended, eliminating the previous practice which provided implementation of a methadone replacement program at only one medical institution in Riga.

A leading specialist at the Latvian Prison Administration is of the opinion that the provisions referred to in the above Cabinet Regulations needs to include reference to the fact that these drugs can also be used to treat arrested and convicted persons. Admittedly, this suggestion has been opposed by several other experts interviewed in the study, who emphasise that there is no legal impediment to the introduction of the so-called methadone program in prisons, and possibly the only changes required would be to the prison's internal rules.

As is known, the body of various negative factors in prisons such as prevalence of injecting drug use, unsafe sexual contacts, prison subculture of tattooing characteristic among prisoners, sanitary conditions of imprisoned persons, poor health and at the same time, lack of sustainable treatment programs, all increase the risk of the spread of infectious diseases.

Under the National Programme for Limiting HIV and AIDS in Latvia 2009-2013 which was approved by the Cabinet of Ministers Order No. 437 of 30 May 2009, prisoners, injecting drug users, as well as prison staff are defined as a group at high risk of HIV infection.

The Program establishes the main directions for national policy in the next programming period (2009-2013) to further reduce HIV prevalence nationally. Having regard to the European Union's position recommendations by international organisations, within the framework of transnational projects and recommendations developed under the direction of independent experts in the program it is proposed to continue to address issues related to harm reduction measures and provision of long-term pharmacotherapy to injecting drug users, prevention and diagnosis of HIV infection and related diseases, especially in prisons, improvements in health care services, as well as evidence-based planning of measures.

As indicated in the program, taking into account the existing situation and in accordance with the previous independent expert evaluation of the implementation of the programme, the risk of spreading HIV infection and associated diseases in prisons is one of the major problems that the program has been developed to address.

Of a total of 15 action lines aimed at achieving HIV programme results, 6 are focused on activities in prisons: (a) Expanding the availability of long-term pharmacotherapy and improving health care of IDUs; (b) improving the diagnosis of HIV/AIDS in prison; (c) improving the knowledge of preventing HIV and other infectious diseases among prison medical personnel, prison staff and prisoners; (d) providing harm reduction measures, including long-term pharmacological treatment of opioid addiction in prisons; (e) involving national institutions and NGOs in offering an integrated health care service in prisons.

11.3. Provision of drug-related health services in prison

Cooperation between the Latvian Prison Administration and non-governmental organizations in delivering the resocialisation program is usually done on the basis of a cooperation agreement. Cooperation can be initiated by the Latvian Prison Administration (its departments) and non-governmental organizations. Cooperation can be developed and implemented as part of the projects (e.g. through EU co-financing or with funding from international organisations) and outside them. An organization that wishes to deliver a resocialisation program may apply to the Latvian Prison Administration or to its Department. The Latvian Prison Administration will examine the

proposal, coordinate it, and sign a relevant contract by proxy. An exchange of information then takes place (usually by means of formal letters), to ascertain what aid is required by program implementation specialists from the Latvian Prison Administration or the Department, as well as issues relating to the venue for implementation of the program, time period, and implementing personnel. Prior to granting program implementers passes to prison, their details are checked appropriately. The Latvian Prison Administration actually acts as intermediary between the organization implementing the program and the specific prison at which the program will be delivered. The prison provides:

- a briefing to the program implementation organization's representatives on the main prison rules to be observed;
- entry to the prison for implementing organisation representatives by issuing a single-use pass to each representative;
- the presence of prison officials throughout the implementation of project activities;
- program implementation organization representatives with the venues necessary for implementation of required activities;
- attendance by prisoners during implementation of project activities.

One important consideration should be taken into account in the context of health care in prisons is that the funding allocated by the Latvian Prison Administration has a direct impact on the services available, including health care, treatment for drug addiction, prevention or harm reduction. For example, in 2010, the Latvian Prison Administration expenditure was LVL 20.66 million, in 2009 LVL 25.34 million, in 2008 LVL 36.79 million, and in 2007 LVL 32.10 million. It is notable that the Latvian Prison Administration expenditure since 2008 has reduced by more than LVL 16 million, which clearly affects the range and quantity of services available. Mentioned as a positive aid is the UNODC project launched in 2006 HIV prevention and care among IDUs and prisons in Estonia, Latvia and Lithuania in which a myriad of activities have been implemented and which are also described in this Chapter. Information obtained from interviews with experts in a 2010 study undertaken in prisons (Sniķere, Kārkliņa et al. 2010) indicates that a large number of the experts are quite sceptical about the sustainability of project activities, mainly due to the very limited funding.

Prevention, Treatment, Rehabilitation, Harm reduction

Looking at the on-going activities for the reduction of drug use in prisons it may be seen that most of the measures (not taking into account implementation of security measures) are associated with information and education of inmates and prison staff.

The implementation of treatment programs in the classic sense in prisons is minimal. For example, in 2010, only one program (the Minnesota 12-step program) that implemented at the Cēsis Juvenile Correctional Facility may be considered a structured treatment programme, and involved 10 inmates.

In 2008, a program was implemented in the Cēsis Juvenile Correctional facility and for juvenile inmates in the Iļģuciems prison: Incentive programme for young people to completely cease drug use in prison, and after release. The aim of this program is to indirectly affect reduction of crime relapses among drug affected adolescents and young adults to prepare them for integration into society through training on how to overcome the addiction which had been the cause of their criminal activities. The program was intended for inmates without restrictions as to age, gender or social standing, but in practice usually involves minors in prison.

In 2007, the Addiction and aggression management program was implemented in Liepāja Prison.

Individual programs are also implemented in the Iļģuciems prison for women. For example, in 2008, 2009 and 2010 dance movement therapy was conducted in Iļģuciems prison, with the aim of helping adult convicts to achieve internal release from drug or alcohol addiction.

According to reports submitted by the Centre of Health Economics on drug patients, it can be inferred that during 2010 hospital assistance (by means of detoxification) was provided to six inmates with F11-F19 diagnoses and to 2 prisoners in 2009.

In addition to the above mentioned treatment measures, various social rehabilitations, social behaviour corrections, and Christian training programs are undertaken in prisons each year and these include components such as drug treatment, prevention, awareness and education or harm reduction.

For example, from information in the Latvian Prison Administration 2010 Public Report it can be seen that in 2010 in 37 resocialisation programs (16 social rehabilitation programs, 14 social behaviour adjustment programs and 7 Christian training programs), 2528 prisoners were involved; 1492 prisoners were in 32 programs in in 2009; there were 42 prisoners in 1484 programs in 2008; and around 1,000 prisoners in 2007.

Of the programs implemented during 2010, 14 programs were implemented by non-governmental, religious and local government organizations (association "HIV.LV", Society "Agihas", s/o "Karitas", society "Ilģuciems women" and its guest psychotherapists, the Latvian Humanitarian Centre, Riga Lutheran Church, Pentecostal congregations, Liepaja Board of Education, association "Ezer"). Other transition programs were implemented by the Latvian Prison Administration and the State Probation Service. The table below lists the 2008 and 2009 programs implemented in prisons that conditionally include drug components.

Table 11.2. Programs which indirectly facilitate prevention of drug use

Title of resocialisation program	Place of implementation
Limiting prevalence of HIV/AIDS, and drug users and safety and developing understanding of a healthy lifestyle for pre-release prisoners	Brasa prison
Values education and relationship skills program	Šķirotava prison (program in full)
Module 3 *Addiction and prevention*	Jelgava prison
School of life II	Daugavgrīva prison
Module 4 *Health and addiction*	Ilģuciems prison
Protect yourself and others	Cēsis AIN Ilģuciems prison
Dance movement therapy program	Ilģuciems prison
A healthy lifestyle as a deliberate choice	Daugavgrīva prison
Knowledge as the basis of limiting HIV infection	Ilģuciems prison
Listen, learn, improve, and pass your knowledge to others	Šķirotava prison
A healthy mind in a healthy body	Ilģuciems prison
Cooperation and health	Brasa prison Šķirotava prison Valmiera prison Ilģuciems prison Riga Central prison Jelgava prison Liepāja prison Jelgava prison Ilģuciems prison Brasa prison Olaine prison Riga Central prison
Improving the HIV/AIDS situation in and out of prison	Jekabpils prison

Below is a list of programs implemented in prisons which are directly or indirectly related to the objective of prevention, treatment and harm reduction of drug use:

- Program "Limiting the spread of HIV/AIDS, drug users and developing awareness of safety and a healthy lifestyle among prisoners before release". Aim: to limit the spread of HIV/AIDS and drug use, promoting a healthy lifestyle.
- Program EQUIP. Aim: to encourage and prepare young people to think and act responsibly, using the help of their peers, not allowing antisocial behaviour (criminal). One section of the program contributes to the correction of cognitive biases and related issues (including alcohol and drug use).
- Program: Protect yourself and others. Objectives relate mainly to information on risky behaviour and how to correct it. However, some of the objectives of the programme are related to the prevention of substance use, for example, 1) to provide knowledge of drugs and their effects on health, 2) raise awareness of the risks of addiction and becoming addicted, 3) to promote young people's critical thinking skills in relation to alcohol and drug use.
- Minnesota 12-step program. Aim: to acquire the skills for living and resolving problems without using addictive drugs. All four main human functions are affected during the program, namely the physical, psychological, social, and spiritual. Its target audience are adult drug and alcohol addicts.
- Program: A healthy lifestyle as a deliberate choice. Aim: to promote prisoners' knowledge about harm reduction and HIV prevention, facilitating the cultivation of a healthy lifestyle and reducing the risk of spreading HIV.
- Program: School of life II. Aim is to prepare people who are completing or have completed custodial sentences in imprisonment institutions for release and integration into society, helping them to learn and develop basic skills, offering knowledge and influencing attitudes, to facilitate easier communication in everyday life. The *4. program* module "Health and addiction", is intended for program participants to develop an understanding of themselves and their peers of health as a value and learning to understand the impact of addiction on it.
- Dance movement therapy Program. Aim: to help the convicted person to free him/herself internally from drug and alcohol addiction.
- Program Teaching values and contact skills. The 3. program module "Addiction and prevention" is aimed at educating inmates about addiction and its effects, developing skills in addressing addiction problems, enhancing changes in student attitudes and behaviour.
- Motivation program for young people for completely ceasing to use psychoactive substances during imprisonment, and following release from prison. Aim: to indirectly affect reduction in the crime relapse rate among adolescents and young people affected by psychoactive substances; prepare young people for integration into society through training on how to overcome the addiction which has been the cause of their criminal activities.
- Health program. Aim: preventative health for juvenile Prisoners' health: drug abuse, alcoholism, personal hygiene, room hygiene, origins of hepatitis B, C and HIV virus, etc.
- Management of substance abuse. Aim: to provide the client with basic concepts and techniques to help him change personal belief systems, attitudes, and values, so that he will not reoffend.

Precise details for the number of prisoners involved in each program are not known, but the Table below shows the number of participants who completed the program[64] in 2008 and 2009.

[64] In accordance with programs included in Table 11.2.

Table 11.3. Programs which directly or indirectly promote prevention of drug use, participant characteristics

Total number of participants who have completed programs	1087
number of males	815
male juveniles	22
adult men	793
number of females	272
female juveniles	35
adult women	237
Place where detained while attending (number of persons):	
closed prison	551
partly closed prison	514
open prison	0
juvenile correctional facility	22
pre-trial investigation centre	0

Also relative to the problems associated with the use of drugs and other addictive substances is psychological counselling, which takes place at the request of detainees and with their consent, as well as at the initiative of prison officers, according to information provided by the Latvian Prison Administration. For example, during 2010 psychologists completed 3900 consultations in prisons, 1717 unique consultations, 202 crisis interventions, 1725 psychodiagnostic actions and completed 904 psychological assessments (see Table 11.4.).

Table 11.4. Psychologists' work indicators in prisons 2008-2010

	2008	2009	2010
Counselling series	2124	4040	3900
Single consultations	1762	1917	1717
Crisis interventions	187	227	202
Psychodiagnostic measures	2257	2644	1725
Psychological evaluations	800	953	904

Source: Latvian Prison Administration public reports 2008, 2009 and 2010

UNODC project activities

Worth mentioning as one of the most important targeted packages of measures in recent years in Latvian prisons is the UNODC project HIV/AIDS Prevention and Care among injecting drug users and in prison settings in Estonia, Latvia and Lithuania and its activities, in which countless events took place within the conditions of the economic recession [65].

The total project budget for all Baltic States in the period November 2006-June 2011 was USD 5.96 million. An important component of the project was the so-called "small grants program" in which 45 projects in Latvia were supported for a total of USD 914 thousand, some of which were implemented in prisons, and they are reflected in Table 11.5.

In the 2010 study carried out in prisons (Sniķere, Kārkliņa et al. 2010) the interviewed experts generally rated the UNODC project positively, especially in their assessment of the following aspects of the project:

- impact on health areas, including upgrading awareness of the problem of the prevalence of drugs in the prisons, at the political level in Latvia;

[65] More information on project activities and progress reports is available on the website (http://www.unodc.org/balticstates/en/index.html)

- initiating changes in legislation, resulting in commencement of implementation of the so-called methadone programme in Latvia;
- promoting cooperation at various levels: (i) between decision makers and the public service, (ii) policy makers and NGOs, and (iii) between prisons and non-governmental organizations.
- development of information and training material and its adaptation to Latvia;
- syringe exchange points set up in Latvia, and training for syringe exchange points staff;
- support for prison infrastructure, environmental improvement, particularly with regard to the setting up of prevention offices.
- facilitating prison staff training, awareness, communication and exchange of experience, resulting in improved communication skills with the prisoners.

Opinions vary among NGOs regarding activities for the popularisation and implementation of the methadone program. Experts have generally supported implementation of the methadone programme in prisons, but with several conditions: that only people with long-standing experience of opiate use are to be involved in the program; they should be less than 30 years of age, even when group therapy takes place in the course of the programme. Otherwise, methadone is regarded as a "legal drug".

UNODC activities are to continue in Latvia until the end of 2010. In undertaking the project finalisation activities particular thought was given to encouraging the inclusion of educational measures for limiting drug use and the spread of infection in each prison's internal rules.

Admittedly, specialists in Latvia are concerned about the conclusion of the project and on the sustainable development of the activities implemented during its course, due to particularly limited funding.

A very good description of the impact of the UNODC is expressed in the opinion of one expert interviewed: "*A huge thank you to UNODC for what they have done. ... had it not been for the Project, I'm afraid even to think where we would be! Because this project has simply brought to light this problem [of drug use and infectious diseases]. I would say that this project has simply kept the whole system alive. Much has been done within the framework of this project [...] Whereas the United Nations has contributed quite a lot of work and money to enable this program to be developed in this country*" (Sniķere, Kārkliņa 2010).

Table 11.5. Projects implemented in prisons under auspices of the UNODC project and their resultative indicators

Grant recipient	Project title / project duration / UNODC allocated budget	Aim and tasks	Resultative indicators
Association HIV.LV	Be well informed! 01.12.2007-30.11.2008. LVL 4968.00	• Systemic education of prisoners in respect of primary and secondary prevention, treatment of HIV infection, how to live a quality life with HIV/AIDS, and combined therapy schemes. • Implement programs to improve compliance of HIV-infected prisoners with requirements of antiretroviral therapy. • undertake multiplier training of HIV-infected prisoners to spread knowledge within the prison environment.	• 30 lectures/seminars conducted in 12 prisons. • Seminars/lectures involving 951 prisoners. • Answers to letters from 62 prisoners. • 700 booklets distributed to inmates. • Trained 10 prisoners-knowledge multipliers. • Prepared and published 10 informational materials on the website.
Association "Support group for patients infected with HIV and AIDS" (AGIHAS)	United for an informed prisoner! 01.08.2007-30.09.2008. LVL 7820.00	The project aims to reduce the risks of HIV in prisons and among former prisoners.	• Increased level of information and knowledge about HIV prevention and care among prisoners: 15 informative workshops conducted in prisons. 503 prisoners were trained in these seminars. • 62 individual consultations

			conducted with HIV-positive prisoners, assisted by mail. • Informational materials on HIV prevention provided to prisoners. • Selected and motivated 3 peer-prisoner trainers. • Project managers participated in 18 AIDS seminars, conferences and meetings. • Organized 7 project team meetings.
Cēsis juvenile correctional facility	Signpost to a safe life. 10.11.2008 – 15 October 2009 LVL 6539.59	Foster awareness among pre-release inmates from the Cesis Correctional Facility, on safe behaviour in life after prison, with a view to reducing STIs, hepatitis and HIV/AIDS among prisoners and their peers. Promote a healthy lifestyle without addictions and the risk of HIV infection.	• 12 exercise program designed: "Protect yourself"; • 39 prisoners completed the training course; • 21 staff completed training course; • 44 prisoners undertook voluntary testing for HIV; • 26 prisoners participated in the poster competition; • 108 prisoners participated in the event: "A day without drugs"; • 16 prisoners prepared a letter to a friend; • 37 released prisoners received a pack containing information leaflets and condoms.
Association *Understanding ecology*	Motivational program for young people to completely cease using drugs in prison 05.11.2008-31.03.2009. LVL 5497.32	• By undertaking drugs and HIV/AIDS prevention work, achieve the necessary recognition and partial enforcement of the need for risk mitigation measures in two prisons and the Latvian Prison Administration; • Achieve the cooperation of inmates in introducing possible risk mitigation measures, the transmission of information and choosing safer sex by using condoms; • To undertake prevention of drug overdosing and HIV/AIDS through training and to advise on how to live with or to avoid HIV/AIDS and other infections in prison; • To raise young people's life skills and develop their ability to live a healthy lifestyle.	• 37 classes held in 2 prisons; • 23 prisoners participated in classes; • 19 sets of sterilization material distributed; • 200 informative materials distributed
Valmiera prison	Implementation of HIV/AIDS prevention measures in Valmiera prison and awareness of risk level of antisocial behaviour among convicts 01.11.2008-01.11.2010 LVL 8550.00	Educating Valmiera prison staff and prisoners on HIV/AIDS and to carry out a study on the risk levels of antisocial behaviour among convicts.	• Renovations to HIV/AIDS office and purchase of necessary furniture; • Project staff has participated in UNODC-organized seminars and training activities; • "Motivation program" developed for the selection of participants, so that inmates would want to participate in the activities; • Acquired informational materials and brochures on HIV/AIDS, STDs, etc.; • Developed 4 training programmes (3 for prisoners, 1 for prison staff). A total of 268 inmates and 46 prison staff were trained; • Prison staff were informed about project activities; • Distributed 1352 brochures, 1198 informative leaflets and 30 posters put up.
Association HIV.LV	Knowledge as the basis of limiting HIV infection 02.03.2009-31.01.2010	To promote the introduction and strengthening of high-quality advisory services relating to HIV/AIDS in Latvia's penitentiary system, thereby limiting the spread of HIV infection in prisons and society in general.	• Conducted 6 workshops for prison staff, although in 2 prisons the seminar was attended by prisoners instead of staff. A total of 81 prison staff and 19 prisoners attended.

	LVL 3509.78		• 5 prisons held 2 "like-alike" counselling sessions for individual prisoners. Overall, 48 people received advice. • 5 prisons held 2 voluntary counselling and HIV testing sessions for inmates. Where necessary, consultation was also conducted for those prisoners already diagnosed with HIV. A total of 101 prisoners received advice. • 30 lectures for prisoners held in 10 prisons on HIV/AIDS, viral hepatitis B and C, sexually transmitted diseases, tuberculosis. A total of 610 inmates and 40 prison staff attended the lectures and individual consultations were held with 17 inmates
Association "Support group for patients infected with HIV and AIDS" (AGIHAS)	Improving the HIV/AIDS situation inside and outside prisons 01.07.2009-01.07.2010 LVL 8500.,00	To reduce the risk of HIV in prisons, and after release from prison	• 6 workshops conducted for prison staff (11 planned), attended by 103 participants in total (planned 125). • 22 workshops conducted for prisoners (11 planned), attended by 331 convicted prisoners. • 50 individual peer counselling sessions held. • 78 prisoners counselled by written correspondence. • 480 informational materials distributed during the workshops; 98 various information materials sent on HIV-infections, social and other issues, etc. • 20 advocacy initiatives for improving HIV policy and medical care in Latvia. • 24 AIDS meetings, seminars and conferences attended.
Šķirotava prison	Listen, learn, improve, pass your knowledge on to another 01.03.2009-01.08.2010 LVL 8500.00	• Promote the education of prison clients (convicts) on sexually transmitted diseases (STDs), opportunities for reducing hepatitis and HIV/AIDS in detention centres. • transfer and put acquired knowledge into practice in prison work. • To improve the effectiveness of educational programs implemented for prison clients and staff. • Disseminate information compiled on STIs, hepatitis and HIV/AIDS.	• Developed 14 lesson training program "Listen, learn, improve, pass your knowledge on to another"; • 8 prisoner groups trained (102 persons); • Training of 1 prison staff group (9 people); • Training "Like-alike" conducted; • A film produced about project activities; • Project staff participated in training and seminars organized by UNODC; • Project staff shared experiences with colleagues from other prisons; • 3100 Informative materials distributed; • Renovated and equipped training room
Iļģuciems prison	Limiting the spread of HIV/AIDS, safety and healthy lifestyle awareness of inmates in prison before release in Iļģuciems prison" 01.07.2009.-30.09.2010. 10118,50 LVL	Educating pre-release prisoners at the Iļģuciems prison, contribute to limiting the spread of HIV/AIDS and raise awareness about a safe and healthy lifestyle.	• Renovated and equipped training room; • Prepared training program "Protect yourself and others"; • 16 session training program using interactive teaching methods; • 2. prisoners' groups (16 people in each group) completed the training programme; • 100 people received informative materials.
LĢPSVA "Fern	Supporting the	The main aim of the project is to provide	• Organized and presented a one-

Blossom"	prison education programs 01.04.2009-30.10.2010 LVL 5000.00	sustainability for the prison education program and provide support for prison staff in the development of programs and the leading of training sessions.	day training session for 16 staff of both divisions of the Daugavgrīva Prison; • In cooperation with UNODC organized training for 25 staff from various prisons on addiction disease, psychoactive substances and long-term pharmacotherapy with methadone or buprenorphine; • Presented 3 supervision sessions for prison staff who are implementing training programs in their prisons; • Undertake individual counselling sessions for prison staff who are implementing training programmes in their prisons.
Daugavgrīva prison	A healthy lifestyle as a deliberate choice 01.04.2009-30.10.2010 LVL 5000.00	To improve the knowledge of prisoners and prison staff about harm reduction and HIV prevention, to promote a healthy lifestyle without addictions and the risk of HIV infection.	• Developed a training program "Protect yourself and protect others" in Russian: 10 lessons for prisoners and 3 lessons for prison staff; • Renovated and equipped training classroom; • 24 prisoners have undergone training; • 30 prison staff have undergone training; • Training film produced about HIV/AIDS prevention and harm reduction, which was viewed by 30 prisoners; • The project team participated in the training organised by UNODC and other bodies.
Brasa prison	Limiting the spread of HIV/AIDS and, drug use and spread safety and developing awareness of a safe and healthy lifestyle in pre-release prisoners in the Brasa prison 01.04.2009-30.09.2010 LVL 5000.00	Educating pre-release inmates in Brasa prison, to contribute to limiting the spread of HIV/AIDS and raising awareness about a safe and healthy lifestyle	• Cosmetic renovation done, and rooms equipped with necessary furniture; • Project staff developed a 16-session training program; • 2 groups formed (12 inmates in each) and one group of staff (12 employees); • Project staff participated in training and seminars organized by UNODC.

Measures indirectly associated with reducing prevalence of drug use

Prisoner education

In prisons in the 2009/2010 academic year, 2362 or 35% of all prison inmates were involved in educational programs. At the end of the school year 90 prisoners received certificates for primary education, 5 received certificates of attainment for general secondary education and 239 received confirmatory documents for vocational training. In 2010, 31 interest education programmes were implemented in six prisons. 320 inmates were involved in these programs (Latvian Prison Administration 2011).

In the 2010/2011 academic year 1167 prison inmates were involved in different educational events, of which 507 inmates participated in the general education program, and 660 participated in vocational education and training programs.

Employment

During 2010 1210 inmates were employed, of which 567 worked as domestic servants; 643 worked in jobs created by merchants. The employment rate in detention centres in 2010 amounted to an average of 25% of convicted inmates fit for work.

Drug testing

The impact of drug use in prisons is determined by, Cabinet Regulation No 918 of 6 December 2005: Procedure for convicted persons and detainees in detention centres to determine if they have used alcohol or drugs issued in accordance with the Latvian Prison Administration Law, Section 22, Paragraph one, Clause 3. Paragraph 4 of the Regulations provides that in cases where the use of drugs or psychotropic substances is suspected, it shall be tested using tests for rapid detection in biological environments. On the other hand, in accordance with Cabinet Regulation No. 423: Internal Regulations for Prisons (30 May 2006), prisoners convicted on suspicion can be tested to determine drug intoxication, and convicted persons are obliged to submit to testing, to establish whether or not they have used alcohol, drugs or psychotropic substances. Drug use in prisons is criminally punishable. The biological samples obtained are sent to the Riga Centre of Psychiatry and Addiction Disorders, where they are tested using various methods such as GC/MS.

11.4. Service quality

A substantial number of projects in prisons in Latvia supported by the UNODC project 2007-2010 are associated with prison staff training on matters relating to HIV/AIDS, harm reduction and treatment programmes for drug users, etc. (see also the section on UNODC activities for the period 2007-2010).

11.5. Discussion, methodological limitations and information gaps

It is important to mention that in 2010 the approval process continued for the questionnaire Risk and Needs Assessment of the Convicted which in the future will provide valuable information about convicted persons, including drug use. The questionnaire consists of three parts: 1) in relation to the criminal offence, the Court process, attitude of the convicted person to that, etc. (the questionnaire will be completed by a senior officer working with a particular convict), 2) social information, e.g. with regard to education, family, documents etc.; the questionnaire will be completed by a social worker, 3) information of a psychological nature, including in relation to addictions (in relation to drug addiction, data to be coded relating to drug use history, main substances used, frequency of use, offences committed under the influence of drugs or for the purpose of obtaining drugs, drug-related violence, impact of drug use on employment, education, leisure, health, relationships with family, partners, friends, motivation to seek treatment for addiction while in prison, opportunities for starting treatment or participating in relevant programs); a psychologist will complete this questionnaire). The questionnaire originally developed was designed for adult persons, but 2010 an approval process was undertaken to also include non-adult persons. Clarifications and additions to the questionnaire were made as a result of the approval process, and as a result, the questionnaire was launched at the Cesis Juvenile Correctional Facility in late 2010. It is envisaged that the general use of the questionnaire will begin in early 2012 (Kairišs 2011)

A collaborative project was launched 2011 between the Latvian Prison Administration, the Ministry of Interior Information Centre and the Reitox National Focal Point, in which it is planned to 1) create a database of persons who have completed resocialisation programs in 2008 and 2009 2) check those entries in the Penalty Register, to permit evaluation at the individual level of the effectiveness of the program, and how long after release convicted persons commit further violations of the Criminal Law.

12. Drug users with children

12.1. Size of the problem

Families in which the parents are drug users are a relatively "hidden" phenomenon and it is virtually impossible to assess their prevalence and effects. Existing data from the Register of Births suggest that approximately 0.1% of new mothers have used drugs during pregnancy (Centre of Health Economics 2010). A study carried out in 2008 (Trapencieris et al. 2008; unpublished material) found that women with treatment episodes (F10-F19) are more likely to be bear stillborn children and their new-born babies are more likely to die within 24 hours of delivery. It is not known what happens to the mother and child after they leave maternity hospitals. Results from Phase V of the cohort study (Trapencieris et al. 2011) show that approximately 13% of problem drug users live together with their children.

National legislation and regulations are basically created to protect the rights of the child and to ensure favourable conditions for the child's physical and psychological development. If development is impaired (violence, neglect of the child, etc.) the State has the power to isolate the child from the family, although drug use *per se* is insufficient reason to isolate a child from its family. National policy is aimed at eliminating drug use in the family altogether; hence policy planning documents focus more on prevention issues and the reduction of drug abuse among young people in particular. On the other hand, support groups have been formed for young people or families in which a user can be a child, as well as an adult or parent.

Studies on the prevelance and characteristics of drug using pregnant women

Cohort study results indicate that among problem drug users, about one third is women (36% in 2008, 34% in 2009, and 32% in 2010) (Trapencieris, Sniķere, Kaupe 2011). The average age of women for the 2010 survey was 30.72 (SD+/-8.0).

It should be noted that the proportion of women among first-time treated patients fluctuates at around 20% (see Chapter 5), which is less than the percentage reported from the cohort study, and possibly indicates that fewer women are seeking help.

Official statistics on smoking, and using alcohol or drugs during pregnancy, are compiled by the Centre of Health Economics based on data from birth certificates, on which are shown information on the woman's previous pregnancies, diseases that can affect pregnancy, harmful habits, perinatal care, the birth process and the new-born. Information is obtained on the basis of the mother's statements (self-reported), so it is not uncommon for individual fields in the birth certificate, including use of drugs, to be left blank or for the woman to have given false information. Taking into account existing data, 20-30 children are born each year in Latvia to mothers who have used drugs during pregnancy, but the actual number could be much higher.

According to information compiled in 2009, psychoactive drug use was noted for mothers in 0.2% of live births and 0.8% of stillborn children. In addition, harmful practices of the father are also noted and in 2009 drug use by the father was noted in 0.1% of live births and 1.6% stillborn children (see Table 12.1):

Table 12.1 New births, in which harmful habits of the mothers or fathers were noted, 2008 and 2009 (%)

	Mother		Father	
	2008	2009	2008	2009
Live births	0.2	0.2	0.1	0.1
Stillborn	0.7	0.8	1.6	0.7

Source: Centre of Health Economics 2010

Unfortunately, there is relatively little information on the number of children living with parents who use drugs, as well as how that affects their subsequent lives. In Phase IV of the cohort study in 2009 problem drug users were asked whether they lived together with their children (Trapencieris

et al. 2010). 31% of respondents indicated that they had a child, of whom more than half (55%) were living with the child or children. Women more frequently than men indicated living together with children; 68% and 45% respectively.

Of all cohort respondents in 2010, 46% were living together with a partner, 31% with parents, 20% with friends/acquaintances, 12% lived alone, and 13% of respondents were living together with children (11% of men and 18% of women). Similarly, women much more frequently indicated living with a partner and/or children, while men indicated living with partners and/or parents (Trapencieris et al. 2011).

Often drugs are used by several people in the same household. Women more frequently indicated they lived together with someone who uses drugs. It should be noted that all women living with a partner and/or children indicated that someone else in the family used drugs.

Latvia has not carried out studies reflecting the child's development, in cases where parents in a family used drugs. The Orphans' Court compiles statistical information on the reasons for removing a child from the family (violence, conditions of poverty, neglect), but those reasons cannot be directly associated with alcohol or drug use within the family.

Study on the impact of drug use in pregnancy

In order to assess the impact of drug use in pregnancy, and its outcomes, a study was conducted in 2007, which compared data on pregnancy, perinatal and maternity care in three groups of women:

- treated for excessive use, intoxication or addiction;
- had used alcohol and/or drugs during pregnancy;
- no recorded history of using addictive substances.

The study compared two databases (*record-linkage*): data on drug patients and persons who use drugs from the TDI, and the Register of Births.

Selected from the Register were women aged 15 - 49 who also have recorded at least one diagnosis associated with alcohol and/or drug use (F10-F19) during the period 1998 - 2007.

The results showed that during the period 1998-2007, a total of 13 059 women were registered (12 711with full ID) with drug use and addictions, of whom 87% of diagnoses related to the F10 group. The total number of women aged 15-49 years was 7054 (average age of 34 +/-10 years).

Comparing the databases it was concluded that, during 2000-2007, 1202 women with previous treatment episodes (F10-F19) gave birth to 1629 new-borns (1221 births). Every year this is about 1% of all new-borns in the country (see Table 12.2.).

Table 12.2. Number of births and % in study group

Year	National number of births	Number of births and % in study group	
2002	19947	230	1.15%
2003	20877	273	1.31%
2004	20249	273	1.35%
2005	21410	248	1.16%
2006	22196	231	1.04%

Source: Trapencieris et al. 2008

In 71.8% of cases the registered maternal diagnosis was attributable to alcohol addiction, acute alcohol intoxication and harmful excessive alcohol consumption psychoses, in 15.9% to opiate addiction and in 5% of cases, other psychoactive substances had been used (see Table 12.3.)

Table 12.3. Registered maternal diagnosis (SSK-10), 1998-2007 (%)

Alcohol addiction syndrome, acute alcohol intoxication or harmful excessive use, alcohol psychoses (F10)	71.8
Opiates (F11)	15.9
Multiple substances (F19)	5
Amphetamines (F15)	2.3
Sedatives(F13)	2
Marijuana (F12)	1.8
Hallucinogens (F16)	0.8
Inhalants (F18)	0.3
Cocaine (F14)	0.1

Source: Trapencieris et al. 2008

Undertaking analysis for mothers by age groups and diagnoses associated with drugs, the data shows that drug use or addiction are more likely to be found in the age group 15-19 years and 20-24 years, while in the age group over 25, women are more likely to be registered with diagnoses associated with excessive alcohol use or alcohol addiction

The average age of women (treatment episode F10-F19) at childbirth was 27.3 (SD +/-7.9): 19% of women were aged between 15-19, 23% were aged 20-24 years, 23% were aged 25-29 years, 20% were aged 30-34 years and 11% were aged 35-39 years.

For 32.7% of women who had a medical history (F10-F19) it was their first pregnancy, while the total number of abortions in 2000-2007 was 1652 (888 per 1000 live births). By comparison, there were 594 abortions registered per 1000 live births in the country as a whole in 2007.

To prevent various diseases or health disorders in a timely manner, it is necessary to begin pre-natal care for pregnant women as early as possible (before week 12 of pregnancy). Women with a history of drug treatment before week 12 embarked on pre-natal care later. For example, in 2007 nationally 89.6% of all pregnant women registered for pre-natal care before the 12th week of pregnancy. On the other hand, only 69.6% of women of all pregnant women with a previous drug treatment episode had registered before the 12th week.

Most treatment episodes experienced by women had been before or after pregnancy, but for 99 women (6%) a treatment episode was recorded during pregnancy, which is most closely associated with health hazards to both mother and baby. In 40% of all cases, treatment had been more than a year after childbirth, and in 8% less than one year after childbirth. However, the data do not allow determination of marital status and whether the relevant time the child was still in the family. In 34% of cases the treatment episode was more than a year before the childbirth, while in 12% of cases it was less than a year before the childbirth.

The study analysed information on the Birth Certificate on pregnancy and childbirth, which could provide evidence of impact of drug use on the health of mother and child.

Among the most commonly cited problems in pregnancy for the study group were the threatened termination of pregnancy (10.9%), anaemia resulting in problems during childbirth and the post-natal period (3.9%), intrauterine development disorders (3.3%) (Trapencieris 2008). According to Births Register data, the pregnancy complications most often cited nationally were: threatened termination of pregnancy (14.2% in 2007) and uro-genital system disorders (10.8% in 2007). (*Mother and child* 2010).

However, data about living and stillborn babies, and children's weight at birth, are indicative of health disorders which may possibly be caused by harmful habits. As the investigational group is a risk group, often the new-born card is noted that a pregnant woman smokes, uses alcohol and/or drugs.

Smoking, alcohol and use of hazardous substances is most often noted for women who give birth to stillborn children. Drug use is more often noted for stillborn children (5.6%) than for the country as a whole (0.7%). (*See Table 12.4.*):

Table 12.4. Proportion of live births and stillborn children nationally and in the study group (%)

	Nationally		Study group	
	Live births	Stillborn	Live births	Stillborn
Smoking	10.3	23	59.7	45.2
Alcohol	0.4	4.1	26.4	5.5
Drugs	0.1	0.7	19.4	5.6

Source: Trapencieris et al. 2008

Study results show that among children whose mothers had experienced a treatment episode, mortality to the first year of life is higher. In 2007 in the country as a whole, 203 live birth children died in the first year of life, of which 8 (4%) were born to women with a history of drug treatment. Of those, six deaths occurred during the first 24 hours, which is 18% of all registered deaths within 24 hours of birth among new-borns (see Table 12.5.):

Table 12.5. Mortality proportion for live births, nationally and within the study group (%)

	Deceased, nationally		Died – mothers with prior treatment episode (F10-F19)			
Year	First year of life	Within 24 hours	First year of life	First year of life (% of national total)	Within 24 hours	Within 24 hours (% of national total)
2000	210	20	9	4%	4	20%
2001	217	29	7	3%	4	14%
2002	197	20	12	6%	8	40%
2003	198	17	8	4%	6	35%
2004	191	20	10	5%	7	35%
2005	168	17	8	5%	4	24%
2006	170	23	10	6%	6	26%
2007	203	33	8	4%	6	18%

Source: Trapencieris et al. 2008

Analysing the new births cards for mothers from the Register, it is frequently observed that children are born weighing less, i.e. 16.6% were born in the weight group 500 – 2499 g, but 26% were born in the weight category 2500 - 2999 g (*see Table 12.6.*):

Table 12.6. Distribution of live births by weight (%) for mothers with prior treatment episode

Weight / kg	VSMTVA	Mothers with prior treatment episode (F10-F19)
500-2499	4.6	16.6
2500-2999	12.3	26
3000-3499	33.4	35.1
3500-3999	35	18
4000-4499	12.4	3.7
4500-4999	2.1	0.5
5000+	0.2	0.1

Source: Trapencieris et al. 2008

12.2. Policy and legal frameworks

Policy planning documents

Most policy planning documents are associated with relief and prevention, which might occur in families in which the excessive use of alcohol or drugs has been established. Implicit parent-child issues that could relate drug use are referred to in:

- *Public Health Guidelines for 2011-2017*, in which one of the objectives is to reduce morbidity and mortality from infectious diseases, reducing the adverse effects of risk factors on health, while continuing to implement a unified policy for reducing the use of various addictive

substances in society, by improving the population's awareness of the harmful effects on health caused by these substances, and by limiting their advertising and accessibility.

- *Guidelines for Restricting and Controlling the Prevalence of Drugs and Drug Addiction for the period 2011-2017* which focus on preventing drug use, improving the organizations for health care of drug users and drug patients, reducing supply and informing the general public of the dangers of drug use and involving them in the fight against drug addiction.
- The *Latvian National Development Plan 2007-2013*, in which one of the objectives is to build public awareness about healthy lifestyles and nutrition, and to engage the public in the fight against addiction diseases, as well as to improve and modernize the system in the fight against illicit traffic in drugs.
- *National family public policy guidelines for 2011-2017*, which deal with such important issues as, for example, the necessary support in the implementation of parental obligations, reconciling work and family life, a family-friendly environment, support for preservation of family and in difficulties and crises of family and marriage, as well as domestic violence, etc.

In general, in the fight against addiction problems, in all these guidelines related to prevention, treatment, early intervention, informing the public, there are no specific tasks that directly address the problem issues under study, namely, parents who use drugs.

In a 2010 survey of municipalities conducted by the Centre of Health Economics on preventive measures for reducing drug demand in the municipalities, a question was included on whether the municipality offers programs designed for children whose parents used drugs. Individual counselling by a social worker is mostly available in the major cities of the Republic, as are co-dependency groups, which are open to children whose parents are addicted to a drug or use alcohol excessively, as well as parents whose children use drugs. Separate programs designed for only one target group do not exist. Most municipalities indicated that this issue is within the competence of the social services that monitor the situation in families, and provide necessary advice and services.

Legal framework

In Latvian legislation, attention is more focused on the protection of children, defining the competent authority, as well as parents' action in cases detected where the child has become ill with an addiction disease or from using intoxicating substances; but a strategy that would focus on parents who have alcohol or drug dependence, or for whom harmful use has been identified, has not been developed. The issue has been included in the country's national child protection policy which was created on the basis of similar international instruments. Since the parents' abuse of alcohol and use of drugs cannot be considered a reason to remove the child from the family, statistical information on this is not compiled.

According to the Republic of Latvia *Civil Law* it is the responsibility of parents to represent the child in his personal and property relations. Care of the child shall mean his or her maintenance, i.e., ensuring food, clothes, dwelling and health care, tending of the child and his or her education and rearing (ensuring mental and physical development, as far as possible taking into account his or her individuality, abilities and interests and preparing the child for socially useful work). (*Civil Law*, Personal Relations of Parents and Children, Section 177).

The *Protection of the Rights of the Child Law* stipulates that:

(1) A child may be separated from his or her family, if:

1) the life, health or development of the child is seriously threatened by lack of care or due to the circumstances of his or her home (social environment);

2) the child is seriously threatening his or her health or development by using alcohol, narcotic or toxic substances; or

3) the child has committed a criminal offence.

Parental drug use cannot become a basis for removal of a child from the family, if the parents are able to provide for the child's needs. However, drug use and alcohol abuse are often observed in disadvantaged families where parents are unable to provide the child's basic needs such as food and clothing. In such cases, the authorities are empowered to take action to remove the child from the family, on the basis of the *Protection of the Rights of the Child Law* (Paragraph 1 mentioned above). Parental obligations are controlled by social service agencies in each municipality, the Orphans' Court, school social educators, and in emergencies, medical personnel and the police (*Law on Orphans' Courts*, Sections 23 and 24).

Responsible authorities are empowered to remove children by judicial decision or an accelerated (unilateral decision) immediately, for example, in a crisis situation, where a serious conflict, crime, etc. has occurred in the family, Care rights may be restored if the reasons for removing child from the family have been eliminated. Likewise, Orphans' courts decide whether parents can meet with their children.

Cases where the parents have committed a crime and are arrested are dealt with individually. For example, if a crime is committed by one of the parents, and the family situation is favourable, the care rights are not withdrawn. If both parents are in custody, the child is placed in a crisis centre, where decisions are then made regarding guardianship (relatives, adoptive family). After the sentence is complete, it is possible for parents to recover guardianship rights.

12.3. Responses

In 2010, two pregnant women were enrolled in the pharmacological treatment program for opioid dependence. Treatment takes place using medical techniques of the methadone substitution therapy program, which govern the principles to be observed by a physician when dealing with a client during pregnancy.

The method stipulates that it is recommended for pregnant opioid users to begin methadone pharmacotherapy, rather than, for example, buprenorphine-naloxone medications. At the beginning of pregnancy if the woman is still using opiates, it is not recommended that detoxification is undertaken before the twelfth week of pregnancy, or after 32 weeks.

During pregnancy, methadone or buprenorphine may be prescribed only if the potential benefit outweighs the potential risk to the mother and new-born, however, an appropriate dose titration is still necessary, in order to maintain the therapeutic effectiveness of treatment.

Cooperation between addiction specialists and gynaecologists is highly desirable and later also with paediatricians or family physicians to obtain a more complete picture of the woman's and child's health condition, which would permit evaluation of the long-term effectiveness of the pharmacotherapy and a more successful outcome. Unfortunately, such multidisciplinary cooperation in Latvia does not occur sufficiently often. Often, women who use drugs do not record their pregnancy, so it is difficult to keep track of the women's health and that of their children.

Part C: BIBLIOGRAFY

BICEPS (2009). *Budget and social costs of drug abuse in Latvia. Analytical report*. Riga: The Centre of Health Economics.

Centrālā statistikas pārvalde (2010). *Iedzīvotāju veselības apsekojuma rezultāti Latvijā*. Statistisko datu krājums. Rīga: Centrālās statistikas pārvalde

Centrālā statistikas pārvalde (2010). Statistika *par Latvijas vīriešiem un sievietēm*. Rīga: Centrālās statistikas pārvalde

Centre of Health Economics (2010). *2010 National Report (2009 data) to the EMCDDA by the Reitox National Focal Point. Latvia: new developments, trends and in-depth information on selected issues*. Riga: the Centre of Health Economics

Collins, D., Lapsley, H. (2008) *The costs of tobacco, alcohol and illicit drug abuse* to Australian society in 2004/05.

Dompalma E., Stoniene L. Piloting (2010). *A peer-driven intervention model in Latvia and Lithuania: results and information gained*. Presentation in UNODC regional conference "Harm reduction in the Baltic states - the way forward". Available online: http://www.unodc.org/documents/balticstates/EventsPresentations/NSP_25-26Oct10/Dompalma_Stoniene_25102010.pdf

Drug Program for 2011-2017

EACEA (2011). *Grade Retention during Compulsory Education in Europe: Regulations and Statistics*. Brussels: EACEA

ECDC/WHO Regional Office for Europe (2010). *HIV/AIDS surveillance in Europe* 2009. Stockholm: European Centre for Disease Prevention and Control.

EMCDDA (2002). *Handbook for surveys on drug use among the general populatio*n. EMCDDA project CT.99.EP.08 B. Lisbon: EMCDDA

EMCDDA (2010). *Situācija narkomānijas problēmas jomā Eiropā*. 2009. gada ziņojums. Lisabona: EMCDDA

EU Drugs Action Plan for 2009- 2012 (2008/C 326/09)

Ieslodzījuma vietu pārvalde (2011). *2010.gada publiskais pārskats*. Rīga: Ieslodzījumu vietu pārvalde

Kairišs, A. (2011). *Ziņojums par noziedzīgo nodarījumu prevenciju un apkarošanu narkotisko vielu nelegālās aprites jomā Latvijā*. Rīga: Iekšlietu ministrijas Informācijas centrs

Karnite A., Briģis Ģ., Upmace I. (2011). *Vai informētība par savu HIV statusu maina injicējamo narkotiku lietotāju veselības uzvedību?* Rīgas Stradiņa universitātes Zinātniskie raksti 2011 (apstiprināts publicēšanai)

Karnīte A., Trapencieris M., Briģis Ģ., (2010b). *Asins transmisijas infekcijas, asociētā riska un preventīvā uzvedība amfetamīnu un opioīdu injicētāju vidū Latvijā*. 2010.gada Zinātniskās konferences tēzes. Rīga: Rīgas Stradiņa universitāte, 182.lpp.

Karnite A., Uusküla A., Raag M., Rüütel K., Talu A., Abel-Ollo K., Caplinskas S., Caplinskiene I., Upmace I., Ferdats A. (2010). *Prevalence of hepatitis C infection and related factors among*

injecting drug users in Estonia, Latvia and Lithuania. XVIII International AIDS Conference Abstract Book. Volume 2, p. 180

Koroļeva I., Mieriņa I., Sniķere S., Trapencieris M. (2010). *Riska un aizsargājošo faktoru ietekme uz atkarību izraisošo vielu lietošanu jauniešu vidū*. Pētījuma 3. Posms. Rīga: Rīgas Domes Labklājības departaments

Koroļeva I., Trapencieris M. (2003). *ESPAD 2003. Eiropas skolu aptaujas projekta par alkoholu un citām narkotiskajām vielām rezultātu analīze*. Rīga: Narkoloģijas valsts aģentūra

Koroļeva, I. et al. (2003). *Drug abuse prevalence in Latvia*. Survey results. Riga: Narcology Centre, Insitute of Philosophy and Sociology

Koroļeva, I., Goldmanis, M. u.c. (2008). *Atkarību izraisošo vielu lietošanas izplatība iedzīvotāju vidū*. Rīga: Sabiedrības veselības aģentūra

Koroļeva, I., Kārkliņa, I. u.c. (2008). *Narkotiku lietošana izklaides vietās. Pētījuma rezultāti*. Rīga: Sabiedrības veselības aģentūra

Koroļeva, I., Mieriņa, I. u.c. (2007). *ESPAD 2007. Atkarību izraisošo vielu lietošanas paradumi un tendences skolēnu vidū*. Rīga: Sabiedrības veselības aģentūra

Lace I. and Trapencieris M. (2003). *Survey of Drug users. Drug Abuse Prevalance in Latvia*. Population survey report 2003. Riga: Narcology Centre, Insitute of Philosophy and Sociology

Latvijas Infektoloģijas centrs (2011). *2010.gada publiskais pārskats*. Rīga: Latvijas Infektoloģijas centrs.

Latvijas Infektoloģijas centrs. Slimību apraksti. Pieejas elektroniski: http://www.lic.gov.lv/index.php?p=1327&lang=258&pp=10757#B

Laukamm-Josten U., de Colombani P., de Joncheere K., et al. (2009). *WHO/UNODC Mid-term evaluation of the Latvian national HIV programme:2009-2013*

LR MK 2005. gada 17. augusta rīkojums Nr. 559 „Narkotisko un psihotropo vielu atkarības un izplatības ierobežošanas un kontroles valsts programma 2005.- 2008. gadam"

LR MK 2009.gada 30.jūnija rīkojums Nr.437 „Par Cilvēka imūndeficīta vīrusa (HIV) infekcijas izplatības ierobežošanas programmu 2009.–2013.gadam".

LR Tieslietu ministrijas Ieslodzījuma vietu pārvalde (2011). 2010.gada publiskais pārskats.

Perevoscikovs J., Lucenko I., Magone S., et al. (2009). *Community-wide outbreak of hepatitis A in Latvia in 2008 – an update*. Eurosurveillance 14 (3)

Public Health Agency (2008). *2008 National Report (2007 data) to the EMCDDA by the Reitox National Focal Point. Latvia: new developments, trends and in-depth information on selected issues*. Riga: Public Health Agency

Public Health Program for 2011-2017

Pugule I., Sile L., Trapencieris M., et al. (2009). *2009 National Report (2008 data) to the EMCDDA by the Reitox National Focal Point. Latvia: new developments, trends and in-depth information on selected issues*. Riga, Centre of Health Economics

Pūgule I., Sīle L., Zīle A. (2011). *Farmakoloģiskās opioīdu atkarības ārstēšanas novērtēšana Latvijā*. Rīga: UNODC

Rotberga S. (2011). *Results of Project "HIV/AIDS prevention and care among injecting drug users and in prison settings*". Prezentācija projekta noslēguma konferencē "HIV profilakse injicējamo narkotiku lietotāju vidū un ieslodzījuma vietās" 24.03.2011

Sabiedrības veselības aģentūra, UNODC (2009). *Narkotiku injicētāju aptauja un HIV prevalences pētījums Ventspilī.* Pētījuma rezultāti. Rīga: Sabiedrības veselības aģentūra

Sile L., Pugule I. (2008). *Farmakoloģiskās opioīdu atkarības ārstēšanas novērtēšana Latvijā.* Rīga: Sabiedrības veselības aģentūra

Single, E., Collins, D., Easton, B., Harwood, H., Lapsley, H., Kopp, P., and Wilson, E. (2003), *International Guidelines for Estimating the Costs of Substance Abuse*—2001 Edition, World Health Organization.

Sniķere S., Kārkliņa I., Koroļeva I., Trapencieris M., Aleksandrovs A. (2010). *Narkotiku lietošanas izplatība ieslodzījuma vietās Latvijā*. Pētījuma rezultāti. Rīga: Veselības ekonomikas centrs

Trapencieris (2008). *Atkarību izraisošo vielu lietotājas un viņu jaundzimušie bērni*. Rīga: Sabiedrības veselības aģentūra (nepublicēts materiāls)

Trapencieris M., Zīle-Veisberga A. (2011). *Alkohola lietošana ilgtermiņa metadona farmakoterapijas klientu vidū*. AIPAP Nr. 3. Rīga: Veselības ekonomikas centrs

Trapencieris, M., Sniķere, S. u.c. (2009) *Narkotiku lietošanas tendences un paradumi Latvijā: narkotiku lietotāju kohortas pētījuma ceturtā posma (2009. gada) rezultātu pārskats*. Rīga: biedrība „Dialogs"

Trapencieris, M., Sniķere, S., Kaupe R. (2011) *Narkotiku lietošanas tendences un paradumi Latvijā: narkotiku lietotāju kohortas pētījuma piektā posma (2010. gada) rezultātu pārskats*. Rīga: biedrība „Dialogs"

Trautmann F., Rode N. et al. (2007). *Evaluation of substitution maintenance treatment in Slovenia – assessing its quality and efficiency*. Utrecht – Ljubljana: Trimbos Institute of Mental Health and Addiction, Faculty of Social Work, University of Ljubljana

UNAIDS (2011). UNAIDS Terminology Guidelines. Available online: http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/jc1336_unaids_terminology_guide_en.pdf

UNODC preliminary data on project „HIV/AIDS prevention and care among injecting drug users and in prison settings in Estonia, Latvia and Lithuania" final evaluation, 2011 (to be published in 2011/2012)

Upmace I. HIV/AIDS surveillance system in Latvia // Presentation for ECDC in-country mission, 22.09.2011

Valsts asinsdonoru centrs (2011). *Asins donoru un pirmreizējo asins donoru skaits VADC un ASN no 2007. līdz 2010. gadam*. Pieejamas elektroniski: http://www.vadc.gov.lv/images_upl/grafiks1.JPG

Velša Z. (2005). *Veselības izglītības jautājumi pamatizglītības mācību priekšmetu saturā*. Rīga: ISEC

Veselības ekonomikas centrs (2009). *Racionālas farmakoterapijas rekomendācijas no valsts budžeta līdzekļiem apmaksātai antiretrovirālai terapijai HIV/AIDS infekcijas ārstēšanai.* Pieejams elektroniski: http://vec.gov.lv/uploads/files/4d08c0e910688.pdf

Victora C. G., Huttly S. R., Fuchs S. C., A Olinto M. T. (1997). *The Role of Conceptual Frameworks in Epidemiological Analysis: A Hierarchical Approach*. International Journal of Epidemiology 26 (1): 224-227

VM (2011). *Informatīvais ziņojums. Par Cilvēka imūndeficīta vīrusa (HIV) infekcijas izplatības ierobežošanas programmas 2009.-2013.gadam vidusposma izpildi*. Pieejamas elektroniski: http://phoebe.vm.gov.lv/misc_db/web.nsf/626e6035eadbb4cd85256499006b15a6/bda100dbcea27d1dc22576f800338630/$FILE/VMzino_130411_HIVizp.pdf

WHO (2009), *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence*. Switzerland: WHO

Part D: Standard Tables and Questionnaires

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