



European Monitoring Centre  
for Drugs and Drug Addiction



# **2013 NATIONAL REPORT (2012 data) TO THE EMCDDA by the Reitox National Focal Point**

**„LATVIA”**

**New developments, trends and in- depth  
information on selected issues**

**Reitox  
2013**

# FOREWORD

*2013 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 discusses recent developments and research data from 2012 and early 2013. 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. The length of the sections in the report depends on the amount of data available on each subject area.

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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 deputy director of Centre for Disease Prevention and Control of Latvia/ EMCDDA Management Board member Dr. Dzintars Mozgis and the director of Centre Mrs. Inga Šmate.

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## List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral treatment
BST	Buprenorphine Substitution Treatment
CA	Court Administration
CDPC	Centre for Disease Prevention and Control of Latvia
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 (10 <sup>th</sup> revision)
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
PREDATA	Patient REGISTER DATA
RPAC	Riga Psychiatry and Addiction Centre
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

In 2011, several significant regulatory enactments were adopted and came into force — laws and regulations of the Cabinet of Ministers or amendments thereto that directly or indirectly deal with drugs.

On 14 March 2011, the Cabinet of Ministers approved the *Guidelines for the Containment and Control of Narcotic and Psychotropic Substances and the Prevalence thereof for the Period from 2011 to 2017*. The Guidelines aim to reduce the availability of illicit narcotic and psychotropic substances, the acceptability of their use to the society and the harm substance use causes to the population by improving the quality and efficiency of health care services rendered to drug users.

To achieve the goals set in the Guidelines, three main courses of action have been put forward: 1) prevention of drug addiction and drug abuse, 2) health care of addiction patients and drug users, and 3) reduction of drug supply. These courses of action comprise measures for the coordination and monitoring of implementation of which an interdisciplinary course of action has been envisaged, namely, policy coordination and collection and analysis of information.

## Drug use in the general population and specific targeted groups

In the spring of 2013, a methodological study was carried out in Latvia in accordance with ESPAD methodology (a survey project for European schools regarding alcohol and other narcotic substances).

The primary objective of the methodological study was to determine whether and to what extent the answers of students differ depending on whether the fill-in questionnaire form is completed in the conventional manner (as a printed copy) or electronically. However, as the sample group for the study was selected as a representative sample of 14-16 year-olds from Latvia, it provides an insight into the prevalence of alcohol, tobacco and drug use in this target group, and, although the data should be interpreted with caution, it is comparable with the findings of previous ESPAD studies. The methodological nuances of the study and drug use prevalence rates in three age groups ascertained by surveying students have been described in this section.

## Prevention

Course of action “Competence Development” of the Latvian National Development Plan for 2014 to 2020 envisages that by 2020 all children and young people have to be provided with high-quality primary and secondary education, as well as access to activities outside of formal education, while course of action “A Healthy Person who is Able to Work” focuses on premature death and loss of ability to work and the relationship between the causes thereof and various health risks, including smoking and risky drinking. Within the framework of this course of action, one of the tasks to be completed is prevention of addictive substances and processes.

In 2012, many activities were carried out as comprehensive preventative action, and it can be observed that local government involvement is showing a tendency to increase.

Selective prevention activities are carried out not only in Riga, but regionally as well. The indicated prevention is not common in the country. Significant initiatives have been implemented in the field of environmental prevention, especially in limiting alcohol consumption.

It has to be emphasized that in most cases, prevention activities in the country are not based on examples of the best practice; usually only a quantitative evaluation is carried out, and assessment of the effectiveness of preventative intervention is provided in very few cases.

In 2012, three media campaigns were organised at the national level with the following target groups: 1) drivers of vehicles, to reduce the number of vehicle accidents, 2) the adult population, in order to reduce illegal purchasing of alcoholic beverages among the population, 3) people who want to quit smoking or to get more information about smoking-related problems. No drug awareness campaigns were carried out in 2012.

## Problem Drug Use

Improvement in medical data quality that had been achieved in recent years was continued in 2012, which allows identifying the number of treated drug users more precisely, thus providing opportunities to estimate the number of drug users more accurately. The number of drug users in the problem drug user category in Latvia in 2011 was estimated by using the treatment multiplier method.

The number of unique drug users treated in 2011 was identified by using the number of treated drug users in three databases: 1) PREDA, 2) APANS database of the National Health Service (NVD), and 3) the SPANS database of the NVD (National Health Service). In total, the databases identified 2044 unique problem drug users (users of opiates, cocaine and amphetamines) who received out-patient or hospital assistance. The percentage of drug users (14.2%) who have sought drug treatment within the last 12 months that was obtained from the Cohort Study on Drug Users in 2012 was used as a multiplier.

The estimates show that in 2011, there were approximately 12,974 problem drug users in Latvia, or 9.4 per 1000 people aged 15-64.

The main drawback of these estimates to be pointed out is the fact that the method used does not allow estimating credibility intervals in a precise manner, therefore, the reliability of the estimates is subject to a large extent to the quality of treatment data and the findings of the study.

## Drug-related treatment: treatment demand and treatment availability

According to the industry statistics report data, 647 (or 31.8 per 100 thousand people) first time cases were registered, i.e., patients with a drug-related diagnosis<sup>1</sup> for the first time in their lives, of which 199 cases (9.8 per 100 thousand people) with an addiction syndrome or psychosis related diagnosis.

At the end of 2012, the prevalence of psychoactive substances addiction (excluding alcohol and tobacco) recorded in Latvia was 3093 (152.8 per 100 thousand people), whereas the prevalence of intoxication or abuse related diagnoses was 1451 (71.7 per 100 thousand people).

In recent years, polydrug-related diagnosis has been the most common (F19), which was diagnosed in 41.9 per cent of the cases registered for the first time in 2012 (in contrast with 37.3% in 2011). The second, third and fourth most common diagnoses were related to opioids (F11, 12.5% (18.2% in 2011)), stimulants (F15, 16.8% (18.9% in 2011)) and cannabinoids (F12, 25.1% (18.4% in 2011)).

In accordance with the new definition of medical treatment, 2187 drug users received out-patient treatment in 2012, of whom 402 received assistance for the first time in their lives. The collected data shows that, in comparison with 2011, there has been a minor increase in the number of patients treated during the year (the number of patients treated for the first time increased by 16, and the number of patients treated during the year increased by 177).

At the end of 2012, 355 patients underwent treatment on long-term pharmacological opioid addiction treatment programmes, of whom 278 patients were on the methadone treatment programme, and 77 patients were on the buprenorphine programme. In comparison, at the end of 2011, there were 218 patients on the methadone program and 59 patients on the buprenorphine programme.

## Health correlates and consequences

In 2012 there a significant increase in the number of PWID tested for HIV in HPP has been observed: in 2011 there 642 persons were tested while in 2012 the number was 1,147. This increase is due to the fact that in 2012 there two studies have been carried out among PWID.

By the end of December 2012, a total of 5,527 HIV cases were registered in Latvia (including 1,217 persons diagnosed with AIDS). In 2012 there were 339 new HIV cases registered in Latvia (16.7

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<sup>1</sup> Diagnoses F11–F19, except for F17.



per 100,000 population). Compared to the European Union's (EU) average number of HIV cases per 100,000 population, Latvia took the second leading position in 2012.

The situation regarding the spread of acute viral hepatitis B (HBV) has not changed in 2012 compared to previous years. In the reporting year 82 cases of HBV were registered in Latvia (in 2011 – 64, in 2010 – 85). Looking at the number of notified cases of acute viral hepatitis C (HCV) in 2012 (n=49), it can be seen that it is slightly lower comparing to previous years (in 2011 - 67; in 2010 – 61).

According to the data from the Database on Causes of Death, 17 deaths were recorded in 2012 with drug overdose as the cause of death, a number that has increased by six cases in comparison to 2011. Of all the deaths in 2012, four were women and thirteen were men. The average age of the women was 26, whereas the average age of the men was 31. The combined average age of persons who had overdosed was 30. The youngest deceased recorded was 20 years old, while the oldest was 36 years old.

Of all the cases, intentional poisoning (ICD — 10 codes: X61 and X62) was recorded in one case, accidental poisoning (X41 and X42) was recorded in eleven cases, and in five cases the intention of the person is unknown (Y11 and Y12). In one lethal case, death was induced by heroin overdose (T40.1), in six cases by morphine (T40.2), in two cases by methadone (T40.3), in four cases, by amphetamine / methamphetamine (T43.6), and in four cases the substances were not specified.

### **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. Legislative changes in 2011 ensure that the methadone programme now is available also to persons in prison.

In the reporting year the number of HIV prevention points (HPP) in the country has remained the same as in 2011, i.e. 18 prevention points were operating in 15 cities (4 of HPP were providing the services in the capital city Riga). In 3 prevention points the services of mobile units was carried out parallel to other activities and 7 HPP carried out the outreach work. Comparing to the situation in the previous reporting year (2011) it can be concluded that the number of mobile units have remained the same whereas the volume of outreach services has decreased (in 2011 the outreach work was provided by 9 HPP).

According to CDPC data, 311,188 syringes and 81,354 needles were distributed by HPP in 2012 which is less than in previous year (n=338,473 syringes and 81,036 needles) but similarly to the situation in 2010 when 310,774 syringes and 109,842 needles were disseminated. The number of used syringes and needles collected has slightly grown from 322,038 in 2011 to 331,136 in 2012.

### **Social correlates and social reintegration**

Social exclusion and addiction issues are multi-dimensional, they can mutually both reinforce and affect one another. Unfortunately, in Latvia there have not been any studies on social exclusion problems among drug users, therefore, the data used in the present report only partially reflects the actual situation. The two key aspects that were used in the report in relation to the social exclusion of drug users were the rates of employment and education of these persons. The analysis is based on data about the drug-addicted patients treated in out-patient clinics, as well as data about users who participated in the cohort study in 2012.

The issue of social reintegration is by nature as vast and complex as the issue of social exclusion, and in fact it has yet to be acknowledged that the issue of social reintegration in relation to drug users has never been a primary issue at the national level among other socially-excluded groups of people. All in all, social reintegration in Latvia operates on a very low level, and often the term "reintegration" is confused with the term "rehabilitation", which both are two different things.



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

Overall, the number of offenses related to the illicit trade in drugs and drug use recorded in 2012 has increased; namely, the number of administrative violations has increased by 5.4%, while the number of criminal offenses has increased by 24.1%. The substances that were most often involved in violations and criminal offenses were methamphetamine, heroin, and marijuana.

It has been observed that the number of criminal offenses related to drug use and storage for non-marketing purposes increased in 2012, which has been accounted for by the fact that in previous years greater attention was paid to serious crimes.

The proportion of persons convicted for the trade and use of narcotic substances is increasing year on year, and in 2012, 11.2% of all convicts were convicted pursuant to drug-related legislation. Consequently, the proportion of persons convicted for illicit trade in drugs in Latvian prisons is growing year on year (22.4% in 2012). Likewise, the number of persons, who are considered regular or problem drug users and have been registered in prison accounting records, increased.

Starting from 2012 onwards, pharmacotherapy with methadone or buprenorphine can be carried out in prisons. In 2012, the treatment was provided to 14 prisoners.

The prevalence of HIV and AIDS among prisoners remains high, and according to estimates, approximately 8.5% of the persons were infected with HIV in 2012.

Starting from 2012, an individual risk assessment and development of a resocialisation plan is a mandatory requirement. The involvement of prisoners who have been diagnosed with addiction to psychoactive substances in motivational and other programmes is reinforced.

## **Drug Markets**

Overall, the number of narcotic substances seizures by the law enforcement authorities rose by 16.2% in 2012. However, the situation in the narcotic and psychotropic substances and precursors illegal market remains stable, and, as in previous years, methamphetamine (30.4%), heroin (17.4%), and marijuana (17%) were the most frequently seized drugs.

Narcotic substances are mainly imported into Latvia as transit goods, a part of which is sent on to other countries. A share of the imported goods, methamphetamine, heroin and marijuana remain in the domestic market, but in practice hashish and cocaine do not end up on the illegal market and are sent on to the destination countries.

Local narcotic substance production is mainly attributed to the marijuana farms. Several farms, whose output is mainly sold in Latvia, are discovered every year.

Considering the number of seizures, seized quantities, purity and price, this indicates that heroin is making a comeback to the market following its overall shortfall in Europe in recent years. It is also possible that amphetamine and MDMA might be making a comeback to the illegal market, because an increase both in the number of seizures and quantities has been observed.

Continuing the trend of the previous year, the trade in new psychoactive substance kept increasing in 2012. For example, of all the seizures in 2010, in 7% of the cases new psychoactive substances were seized; in 2012, the proportion of new psychoactive substances seized was 12%. Almost 80% of the seized substances were synthetic cannabinoids.

# Part A: New Developments and Trends

## 1. Drug policy: legislation, strategies and economic analysis

### 1.1. Legal framework

In 2012, a number of important legislative enactments were adopted and came into force in Latvia. The key ones deal with establishing a new control system for psychoactive substances, namely, by transitioning from an individual list system to a generic list system and by completely changing Schedule 1 to the Cabinet Regulation No. 847 of 8 November 2005 “Regulations Regarding Narcotic Substances, Psychotropic Substances and Precursors to be Controlled in Latvia”. Accordingly, the Law On the Procedures for the Coming into Force and Application of the Criminal Law was amended in accordance with the principles of the generic system. Apart from these changes, other legal acts were amended as well.

#### Cabinet Regulations and amendments to Regulations issued in 2012

On 1 April 2012, amendments to the Cabinet Regulation No. 628 of 4 November 2003 “Organisational Procedures for Restriction of the Spread of Human Immunodeficiency Virus Infection (HIV) and AIDS and the Treatment of HIV-Infected Persons and AIDS Patients” came into force, with Paragraph 2 in new wording.

The amendment envisages that the Ministry of Education and Science in co-operation with the Centre for Disease Prevention and Control of Latvia also includes questions about the prevention of HIV infection in health education programmes for children and young people. The Centre for Disease Prevention and Control of Latvia in co-operation with all the governmental institutions and non-governmental organisations concerned also carries out informative and educational activities in the field of HIV prevention.

Cabinet Regulation No. 241 “By-laws of the Centre for Disease Prevention and Control” came into force on 6 April 2012, defining the functions, tasks and rights of the Centre for Disease Prevention and Control (hereinafter — *CDPC*), as well as the organisation of its activities. Among other tasks, the By-law also specifies that the CDPC carries out the functions of a Reitox National Focal Point to participate in the European Information Network on Drugs and Drug Addiction (Reitox) maintained by the European Monitoring Centre for Drugs and Drug Addiction in compliance with Regulation (EC) No 1920/2006 of the European Parliament and of the Council of 12 December 2006 on the European Monitoring Centre for Drugs and Drug Addiction, as well as enables information exchange between the national focal point within the European Information Network on Drugs and Drug Addiction (Reitox) and the European Monitoring Centre for Drugs and Drug Addiction regarding the production, illicit trade and use of new psychoactive substances and preparations containing new psychoactive substances in compliance with Council Decision 2005/387/JHA of 10 May 2005 on information exchange, risk assessment and control regarding new psychoactive substances.

Cabinet Regulation No 296 “On Amendments to Cabinet Regulation No. 103 of 2 February 2010 “Procedures for obtaining and renewing driving licences and procedures for the issue, replacement and renewing of driving licences”” were adopted on 24 April and came into force on 2 January 2013, supplementing the provisions by adding Section 9.1, “Procedures for destroying a driving licence”, and, among other provisions, specifying that the license is destroyed if the driving licence had been revoked due to driving a vehicle under the influence of alcoholic beverages, narcotic, psychotropic, toxic or other intoxicating substances, regardless of the driving licence’s removal period.

Amendments to Cabinet Regulation No. 847 of 8 November 2005 “Regulations Regarding the Narcotic Substances, Psychotropic Substances and Precursors to be Controlled in Latvia” were adopted in December and came into force on 23 February 2013, in which Schedule I has been modified according to the basic principles of the generic system. Paragraph 1 defines the

substances and plants that are classified pursuant to the Single Convention on Narcotic Drugs of 30 March 1961:

- 1.1.synthetic opioid analgesics,
- 1.2.morphine derivatives,
- 1.3.phentanyl derivatives,
- 1.4.plant-based products with narcotic effects.

Paragraph 2, however, lists substances and plants classified pursuant to the Convention on Psychotropic Substances of 21 February 1971:

- 2.1. phenylethylamine derivatives,
- 2.2.natural substances and their derivatives,
- 2.3.compounds of other substances,
- 2.4.plant-based products with psychotropic effects, and
- 2.5.psychotropic substances that correspond to the characteristics of (...). Chemical characteristics of 18 groups of substances follow.

These regulations came into force with amendments to Chapter II of Annex 2 to the Law On the Procedures for the Coming into Force and Application of the Criminal Law.

On 21 May 2013, a new substance, carfentanyl, was added to Schedule I to the Cabinet Regulation, in accordance with the generic system framework.

### **Laws and amendments to laws adopted in 2012**

When changes were made to Cabinet Regulation No. 847, the Law On the Procedures for the Coming into Force and Application of the Criminal Law was amended in a corresponding way by structuring substances in accordance with the generic system. The relevant changes came into force together with the changes in Cabinet Regulation on 23 April 2013.

On 1 April 2012, amendments to the Latvian Administrative Violations Code came into force and among other provisions they imposed liability for unauthorised use of narcotic substances (previously it was for use without medical prescription); namely, a person is issued a warning or is fined for up to two hundred lats, and in addition the person is notified in writing and warned about the onset of criminal liability if the person commits the offense repeatedly during that year (unauthorised use, preparation, acquisition, possession in small amounts).

Additional amendments to the Latvian Administrative Violations Code came into force on 1 July 2012, expressing Section 255 in new wording which stipulates that administrative detention period for persons who have been under the influence of alcoholic beverages, narcotic substances or other intoxicating substances shall be counted from the moment the person has become sober.

Amendments to the Criminal Law were adopted on 13 December 2012, but came into force in April 2013, whereby one of the most important changes is the stipulation that various offences related to narcotic substances and psychotropic substances and other offences shall carry a new form of punishment — short-term imprisonment. The term “short-term imprisonment” includes the deprivation of a person’s liberty for a period from 15 days to three months.

Also, changes made to the law should be pointed out that are applicable to liability for giving prescriptions without medical necessity or for prescribing other medical documents for obtaining narcotic or psychotropic substances, as well as for issuing such substances without a prescription or knowing that a prescription is fictitious or has been given illegally if this has been done with large amounts of narcotic substances or psychotropic substances or if this has caused other grave consequences. Previously, the Criminal Law did not stipulate such a provision.

Another important change is that the term or provision regarding the use of substances without a doctor’s prescription has been deleted. Currently, use of narcotic and psychotropic substances is defined as “unauthorized use”, which carries criminal liability (if the person commits an offense repeatedly within a year).

Amendments to the Law On Procedures for the Legal Trade of Narcotic and Psychotropic Substances and Medicinal Products were adopted on 29 November 2012 and came into force on

1 January 2013, adding Sub-section 14.1 and stipulating the responsibilities of the State Agency of Medicines in issuing special permits for activities with psychotropic and narcotic substances and medicines. Procedures have been prescribed for how natural persons arriving from a non-Schengen country or departing for such a country may import/export medicines containing substances on Schedules II and III for personal use without a special permit. Specifically, medicines containing substances included in Schedule II may be imported/exported without a special permit for a personal course of treatment that does not exceed 14 days, but medicines containing substances included in Schedule III — for a course of treatment that does not exceed 30 days. It has also been stipulated that a natural person arriving from a Schengen Agreement country may import medicines for personal use containing substances included in Schedules II and III if the person has obtained a certificate issued by the relevant national authorities attesting to a need to use narcotic or psychotropic substances for treatment purposes.

Amendments to the Law On Procedures for the Legal Trade of Narcotic and Psychotropic Substances and Medicinal Products that were adopted on 31 October 2013 and came into force on 14 November 2013 stipulate for the imposition of a temporary ban on new psychoactive substances that pose a threat to the community and public health. It has been envisaged that the CDPC shall be able to impose a ban on the substance by means of an expert opinion for no longer than 12 months during which an in-depth risk assessment of the substance will be carried out and the substance shall be accordingly subjected or not subject to control.

## 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 an integrated document, which includes a description of the situation and problem formulation, policy and performance objectives and indicators for their achievement, as well as the action plan and the funding needed to implement the policy statement.

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.

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 policy results, 4 performance results, 10 actions;
- 2) health care of drug users and drug addicts – 2 policy results, 7 performance results, 15 actions;
- 3) reduction of drug availability – 2 policy results, 7 performance results, 12 actions.

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 – 16 actions in the action plan.

The authorities stipulated as having responsibility for implementation of tasks set in the 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 Program is funded from the annual State budget without extra financial allocations. If the responsible authorities are unable to complete a task from State budget funding, the issue of

supplementary funding is to be reviewed in 2014 and in subsequent years, together with the budgetary priority submissions from all Ministries. However, financing is foreseen for some activities, namely capacity building of the Forensic Service of the State Police in order to improve identification of psychoactive substances.

### **Implementation and evaluation of national action plan and strategy**

It is anticipated that the results of implementation of tasks set by the Drug Program will be evaluated twice – mid-term and ex-post evaluation. 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. The Ministry of Interior must submit the mid-term evaluation to the Cabinet of Ministers by the 1 July 2014, and final evaluation by the 1 July 2018.

Evaluation of the Drug Program must be carried out with accordance to relevant legislation but design of it will be developed by the responsible institution.

The mid-term evaluation is foreseen as internal process evaluation and the main aim of it is to monitor the effectiveness of the implementation. The main objectives will be to monitor the accomplishment of the action. The results of the evaluation will be used to make relevant changes in the action plan, e.g. improving the actions, removing or adding new actions. The fulfilment of policy and performance indicators will be checked in order to monitor the situation, however no corrections or improvement or indicators is foreseen.

### **Coordination arrangements**

In drug policy coordination the highest authority is the Drug Control and Drug Addiction Restriction Council chaired by the Prime Minister. The members of the Council are ministers and official representatives from State Revenue Service, the National Police and the National Health Service. The main task of the Council is to coordinate governmental agencies, municipalities and non-governmental organizations to ensure implementation of drug policy. The Council is also responsible for national program development, implementation and evaluation. Council meetings are held when necessary.

A responsible body of the coordination of the implementation of the Drug Program is the Council Secretariat. The functions of the Secretariat are performed by the representative from Ministry of Interior, who is also the National drug coordinator. The board has set up three working groups:

- demand reduction group;
- supply reduction group;
- information analysis working group.

Council working group's main objective is to monitor the situation in the country and to initiate new legislation or actions to improve policy implementation.



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

Drug use in the general population is one of the five key EMCDDA epidemiological indicators. It reflects the prevalence of drug use among inhabitants aged 15-64 years. This indicator incorporates the conducting of regular representative population surveys using a range of questions approved by EU experts (EMQ - European Model Questionnaire), which has been extended by the addition of questions of interest to the Member States.

Latest developments in the indicator at both the national and the international level include the necessity of obtaining additional information about intense drug use habits and drug availability. Likewise, the issue of data reliability is becoming increasingly more topical among researchers in recent years due to the rising non-responsiveness levels, so is the need for methodological studies using new ways of collecting data, such as conducting surveys via the Internet and the capability of generalising the surveys.

In the spring of 2013, a methodological survey using ESPAD methodology was carried out in Latvia.

The primary objective of the methodological study was to determine whether and to what extent the answers of students differ depending on whether the fill-in questionnaire form is completed in the conventional manner (as a printed copy) or electronically. However, as the sample group for the study was selected as a representative sample of 14-16 year-olds from Latvia, it provides an insight into the prevalence of alcohol, tobacco and drug use in this target group, and, although the data should be interpreted with caution, it is comparable with the findings of previous ESPAD studies. The methodological nuances of the study and drug use prevalence rates in three age groups ascertained by surveying the students have been described in this section.

### 2.1. Drug use in the general population

In Latvia to date, there have been three large-scale representative studies (Goldmanis et al., 2003; Koroļeva et al., 2008 and Sņikere et al., 2012) which permit the tracking and monitoring of prevalence of drug use among the population. These studies were conducted on inhabitants aged 15-64 years and were conducted in accordance with the EMCDDA recommended methods, thus to a large extent allowing the results obtained from Latvia to be compared with the situation in other EU states. In accordance with these methods, the survey questions on drug use were measured in three time periods - during lifetime, during past year and during past month. In addition to the questions about the prevalence in use of various substances, the range of issues studied also included questions about attitudes and values, availability of drugs, etc. (EMCDDA, 2002).

The first large-scale survey took place in 2003; while the second and the third studies conducted using comparable survey methodology took place in 2007 and 2011 respectively<sup>2</sup>. The target sample size exceeded more than 4500 respondents (4534 in 2003, 4500 in 2007, and 4493 in 2011), also allowing the prevalence of a relatively small phenomenon in the general population to be measured with a sufficiently high degree of accuracy.

Outlined below in this section are the main prevalence indicators for use of any illicit drug,<sup>3</sup> comparing the results of the 2003, 2007 and 2011 studies (Goldmanis et al., 2003; Koroļeva et al., 2008 and Sņikere et al., 2012) by key age and gender groups (see Table 2.1.).

14.3% of Latvian residents aged 15-64 years have tried some form of illicit drug during their lifetime. Relatively many fewer inhabitants had used illicit substances within the past year (recent use) or past month (current use): respectively 4.4% and 1.8%. A reduction in drug use is evident in comparison with 2007. The number of inhabitants experimenting with drugs has decreased by

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<sup>2</sup> See also ST1\_2012\_LV\_01

<sup>3</sup> Marijuana/hashish, ecstasy (MDMA), amphetamines, cocaine, heroin and/or other opioids, LSD and/or other hallucinogens

1.8% (from 16.1% to 14.3%); the number of recent users by 1.7%, and the number of current drug users - by 0.4%. Thus, drug use indicators have returned to approximately the 2003 level.

According to data from the Central Statistical Bureau, currently in Latvia there are approximately 1.4 million (1 384 502) inhabitants of working age. According to the results obtained, it can be generalized that in Latvia 198,000 people have tried drugs. The sampling error in this case is 1%, i.e. it can be argued with a 95% probability that 13.3-15.3%, or 184-212 000 Latvian inhabitants have tried at least one illicit substance

During the past year, approximately 61 000 inhabitants had used drugs (compared with 92 000 in 2007). The sampling error in this case is 0.5%. This means that it can be argued with 95% confidence that 53-69 000 or 3.8 to 5.0% of the population had used drugs during the past month in 2011 compared with 5.4-6.6% of the population in 2007 and 4.0-5.2% of the population in 2003.

Drugs had been used during the past month by 1.8% of 15-64 year olds, or about 25 thousand ( $\pm$  6 thousand) inhabitants. T-test results confirm that the reduction in drug use since 2007 may also be considered statistically significant.

**Table 2.1. Proportion of recent and current users who have tried any drug, 2003, 2007 and 2011 (%)**

	During lifetime (LTP)	During past year (LYP)	During past month (LMP)
15–64 years			
2011	14.3	4.4	1.8
2007	16.1	6.1	2.2
2003	12.3	4.6	2.2
15–34 years			
2011	22.9	8.2	3.2
2007	27.9	11.9	4.2
2003	21.9	9.7	4.7
35–64 years			
2011	7.8	1.5	0.7
2007	6.8	1.6	0.7
2003	5.3	0.9	0.5

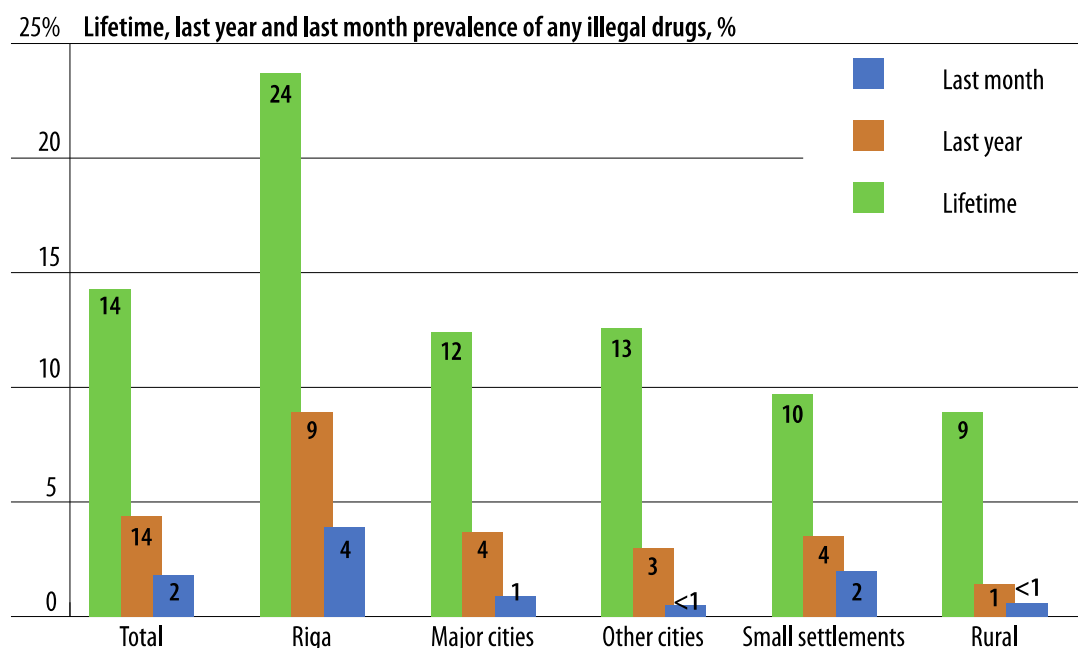
Source: Goldmanis et al., 2003; Koroļeva et al., 2008; Sņikere et al., 2012

Latvia, there is a risk that they may have been replaced by new substances or substances not hitherto listed in the Schedule of Prohibited Substances. As stated in the EMCDDA 2013 European Drug Report, although the drug situation in Europe is stable, qualitative changes do exist. New psychoactive substances are emerging, such as the new synthetic cannabinoids; mephedrone, "Spice" and other intoxicating plant mixtures are becoming more widespread (EMCDDA, 2013).

As in the 2003 and 2007 studies, in 2011 the persons most commonly trying and using drugs are those living in Riga: a total of 23.7% of them had tried drugs, 8.9% used drugs during the past year, and 3.9% of the population aged 15-64 years had done so in the past month, (see Figure 2.1.). In other cities, 12-13% have tried drugs, 3-4% have used them during the past year, which is almost 50% less than found for the general population of Riga. The number trying drugs in the smaller towns is slightly lower (10%), but the number using drugs during the past year is similar to what it is in the major cities. In rural areas the number of drug users is significantly lower: only 9% had tried them, and only 1% of the population aged 15-64 years had used them during the past year. These results confirm the need to pay particular attention to combating the spread of drugs in Riga, where the indicators for drug use among young people are of particular concern. In Riga, drugs have been tried by one in every two (51%) males aged 15-34 years. It must also be noted that since 2007 the numbers trying drugs in various urbanised areas have steadily declined.



**Figure 2.1. Lifetime, last year, last month prevalence rates of any illegal drugs, by level of urbanizations (%)**



Source: *Snijkere et al., 2012*

As in previous years, significant differences are observed between the genders: men have tried drugs nearly three times more frequently (21.1%) than women (8.02%). During the past year, 6.2% of men and 2.7% of women had used drugs. It must however be noted that the differences in rates between the genders have decreased since the previous survey; drug use has significantly decreased within the men's group, while indicators for the women's group are relatively stable.

Drugs were most commonly tried, or used during the past year and past month by young people aged 15-34 years (see Table 2.2.): 23% have tried drugs, 8% have used them during the past year and 3% have used them during the past month. Drug use is rare among those aged 35 and over: although 8% have tried drugs, only 1.5% have used them in the past year and 0.7% during the past month. Importantly, the reduction in trying and using drugs has occurred among the younger age group, in which the number trying drugs decreased by five percentage points and the number recently using drugs by four percentage points (from 12% to 8%).

The largest number trying drugs for the first time is observed among men aged 15-34 years: 31% of men and 15% of women in this age group have tried drugs; 11% of men and 5% of women had used them during the past year.

**Table 2.2. Proportion of recent and current users who have tried any drug, relative to gender and age (%)**

	Lifetime prevalence	Last year prevalence	Last month prevalence
15–64 years			
Men	21.1	6.2	2.7
Women	8.0	2.7	0.9
Total	14.3	4.4	1.8
15–34 years			
Men	31.0	11.1	4.4
Women	14.6	5.2	1.9
Total	22.9	8.2	3.2
35–64 years			
Men	12.9	2.2	1.4
Women	3.4	1.0	0.2
Total	7.8	1.5	0.7

Source: *Snijkere et al., 2012*

As in previous years, the most commonly used illicit drug is marijuana or hashish; 12.5% of the population have tried it. After marijuana the next most popular drug is ecstasy (tried by 2.7%), amphetamines (2.3%), cocaine (1.5%) and various opioids (1.1%). LSD, other hallucinogens, and heroin are rarely encountered substances; they have been tried by less than 1% of the population (see Table 2.3.).

**Table 2.3. Distribution of illicit drugs tried during lifetime, by gender and age in 2011 (%)**

	15–64 years			15–34 years			35–64 years		
	M	F	T	M	F	T	M	F	T
Any drugs	21.1	8.0	14.3	31.0	14.6	22.9	12.9	3.4	7.8
Any drugs except marijuana/hashish	7.8	3.4	5.5	11.4	5.6	8.5	4.7	1.8	3.2
Marijuana or hashish	18.7	6.7	12.5	28.0	12.7	20.4	11.0	2.5	6.5
Ecstasy	3.9	1.6	2.7	6.5	2.4	4.5	1.9	1.1	1.5
Amphetamines	3.6	1.0	2.3	5.4	2.3	3.9	2.1	0.2	1.1
Cocaine	2.0	1.0	1.5	2.6	1.7	2.2	1.5	0.5	1.0
Heroin	1.1	0.1	0.6	1.5	0.1	0.8	0.8	0.0	0.4
Other opiates	1.5	0.6	1.1	2.4	1.0	1.7	0.8	0.4	0.6
LSD	1.1	0.4	0.7	1.9	0.6	1.3	0.4	0.3	0.3
Other hallucinogens	0.9	0.2	0.5	1.4	0.2	0.8	0.4	0.2	0.3
Inhalants	2.7	0.5	1.5	3.9	0.8	2.3	1.7	0.3	1.0
Spice	3.7	1.4	2.5	6.1	2.7	4.4	1.6	0.5	1.0

Source: *Snijkere et al., 2012*

## Cannabis

As elsewhere in Europe and the world, in Latvia marijuana and hashish are the illicit substances most widely used by the general population. According to EMCDDA estimates, more than 78 million, or nearly a quarter (23%) of the working age population of Europe (15-64 years) have tried marijuana or hashish at least once during their lifetime and this is not significantly different from 2007 indicators (EMCDDA, 2011). In Latvia too, the proportion of first time users of marijuana has not changed significantly in comparison with 2007. 12.5% have tried marijuana or hashish; however, the number of recent users has decreased slightly, and is practically back at the 2003 level. In 2007 marijuana had been used in the past year by 4.9%, while only 4.0% had done so in 2011. T-test results confirm that the reduction is statistically significant at the 95% confidence level.

A similar slight decrease is seen in the number who had used marijuana during the past month - from 1.8% to 1.6%. In this case, the number of users is small and does not support the argument that the difference is statistically significant.

**Table 2.4. Proportion of recent and current users who have tried marijuana, 2003, 2007 and 2011 (%)**

	Lifetime prevalence	Last year prevalence	Last month prevalence
15–64 years			
2011	12.5	4.0	1.6
2007	12.1	4.9	1.8
2003	10.6	3.8	1.8
15–34 years			
2011	20.4	7.4	2.9
2007	21.7	9.7	3.7
2003	19.6	8.1	3.7
35–64 years			
2011	6.5	1.4	0.7
2007	4.6	1.1	0.2
2003	4.1	0.7	0.4

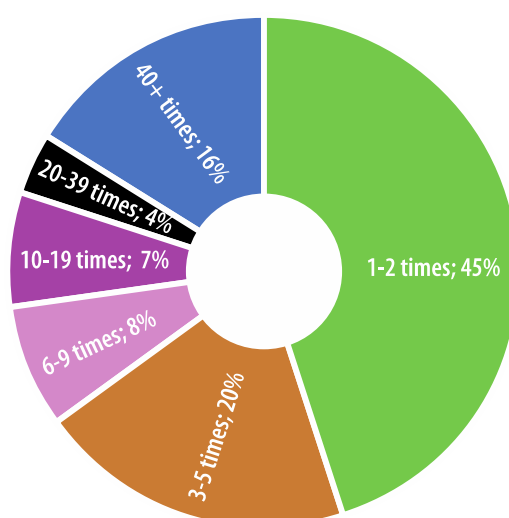
Source: *Snikere et al., 2012*

Almost half (45%) of those who used marijuana or hashish during the past year indicated that they done so once or twice (see Figure 2.2.). However, one in five (20%) had used marijuana 20 or more times during the past year, i.e. more often than once a month. Overall, the number of such regular marijuana smokers comprises 0.8% of the working age population.

Marijuana has been tried more often by men (18.6%) than women (6.7%). It is worth noting that, compared to 2007, marijuana use has declined among men, while among women it has remained practically unchanged. Men had also used cannabis more often during the past year (5.5% compared with 2.5% of the women's group).

Younger respondents aged 15-34 have tried marijuana significantly more often (20.4%) than those aged 35-64 years (6.5%), and they have used it significantly more often during the past year. Overall, 7.4% of the population aged 15-34 years have used marijuana during the past year, and 2.9% have done so within the past month.

**Figure 2.2. Frequency of cannabis use during past 12 months (% of persons reporting last year cannabis use)**



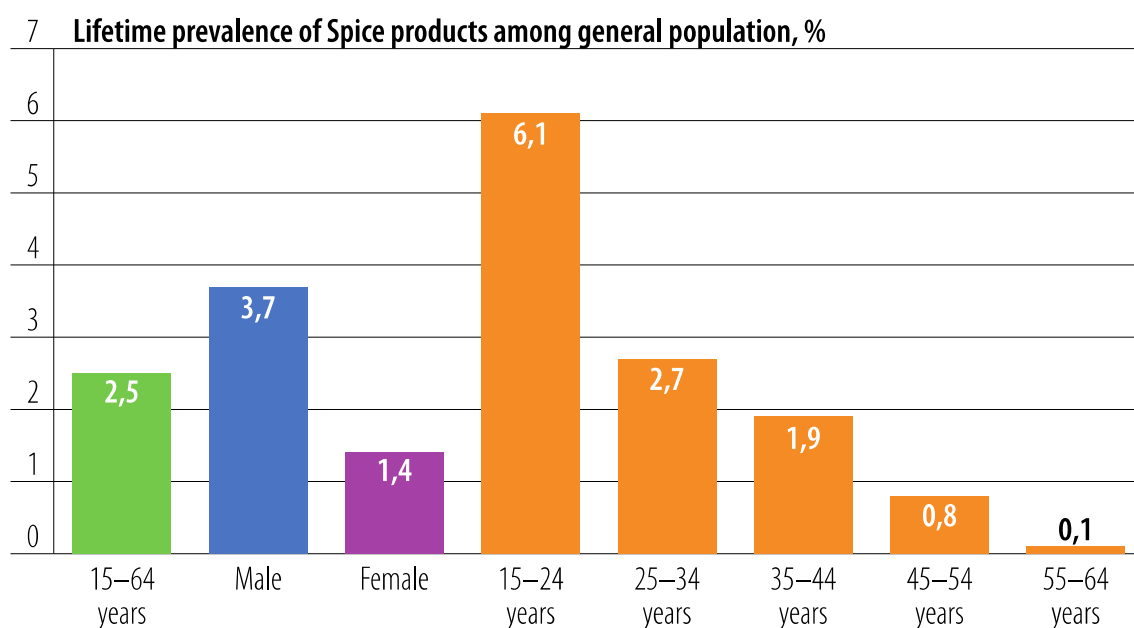
Source: *Snikere et al., 2012*

## Spice and other smoking mixtures

Survey respondents were asked if they had ever tried intoxicating smoking blends/incense (such as the so-called "Spice" group mixes or "Alarama"). The results show that such mixtures have been tried by 2.5% of the population aged 15-64 years, including 3.7% of men and 1.4% of women.

Most often, such mixtures had been tried by young people aged 15-24 (6.1%). With increasing age, the popularity of such substances declines (see Figure 2.3.). Such mixtures were tried most often by those whose income is very low - less than 80 LVL per family member (3.8%), but they are also relatively popular among the highest income groups. As with all drugs, smoking blends/incense are much more common in Riga (tried by 5.5%) than elsewhere in Latvia (tried by less than 2%).

**Figure 2.3. Lifetime prevalence of Spice products, % by various age groups**



Source: *Snijkere et al., 2012*

## Age of trying drugs

The drug which is tried earliest in life is the inhalants. It is not illegal, it is easy to get, and so for children this form of intoxication is the most accessible. 40% (compared with 55% in 2007) had tried inhalants before reaching the age of 16 years. After the age of 18 this type of intoxication is rarely tried (see Table 2.5.). Perhaps this can be explained by the fact that at 18 years of age, other intoxicating substances such as cigarettes become available.

Also tried relatively early on are marijuana, opioids, various hallucinogens, as well as new psychoactive substances not listed in the Schedule of Illicit Substances, the so-called "new drugs": at least 34% of the population had tried them before reaching the age of 18 years. Amphetamines are usually (56%) tried by the 19-25 age group, but before then in only 33% of cases. Cocaine is usually tried even later - usually (44%) by 21-25 year olds.

**Table 2.5. Age at which drugs tried (%)**

	Cannabis	Ecstasy	Amphetamines	Cocaine	Opioids	LSD or other hallucinogens	Inhalants	Other psychoactive substances
Less than 16 years	8	6	3	5	6	8	40	12
16 years	12	9	5	<0.1	11	19	21	14
17 years	14	9	16	12	21	6	17	12
18 years	14	22	9	5	7	10	4	5
19 years	12	14	14	12	19	7	4	10
20 years	10	14	20	6	20	1	7	11
21–25 years	21	21	22	44	4	36	2	20
26–30 years	5	5	6	14	11	9	<0.1	7
Over 30 years	4	1	4	3	2	5	4	10
<i>Number of respondents</i>	<i>467</i>	<i>107</i>	<i>84</i>	<i>61</i>	<i>37</i>	<i>44</i>	<i>61</i>	<i>94</i>

Source: Snikere et al., 2012

## 2.2. Drug Use in the school and youth population

### ESPAD Methodological Study

In the spring of 2013 (April to May), a methodological study<sup>4</sup> was conducted in Latvia using the ESPAD (European School Survey Project on Alcohol and Other Drugs) methodology.

The primary objective of the methodological study was to determine whether and to what extent the answers of students differ depending on whether the fill-in questionnaire form is completed in the conventional manner (as a printed copy) or electronically. However, as the sample group for the study was selected as a representative sample of 14-16 year-olds from Latvia, it provides an insight into the prevalence of alcohol, tobacco and drug use in this target group, and, although the data should be interpreted with caution, it is comparable with the findings of previous ESPAD studies. The methodological nuances of the study and drug use prevalence rates in three age groups ascertained by surveying the students have been described in this section.

In addition to the survey of students, a school management survey was also carried out, within the framework of which principals of Latvian schools or their representatives were asked to evaluate their experience with computerised questionnaires or assessment of academic achievement, and questions were asked about research among students, addiction prevention and the needs of the school. A detailed report on the findings obtained in the school management survey is available on the website of the Centre for Disease Prevention and Control of Latvia (Pētersons et al. 2013).

### Methodology

The sampling frame of studies included a number of young people who were born in a specific year (1997). Within the framework of the 2013 study, the data is also representative of students one year younger (born in 1998) and one year older (born in 1996). The sample of the study was designed as a single-stage stratified cluster probabilistic sample with the school class designated as the sample unit, a principle that was applied successfully in the ESPAD studies carried out in Latvia in 2003, 2007, and 2011.

The sampling frame was designed in accordance with the data at the disposal of the Ministry of Education as of the beginning of academic year 2012/2013 when a total of 46,111 students enrolled in 2828 classes at the level of Form 8 to Form 10. As in the studies carried out in Latvia in

<sup>4</sup> See also ST2\_2013\_LV\_01

the previous years, the sampling frame did not include special education classes and / or schools for children with severe mental and / or physical disabilities, for whom completing a standard questionnaire could be problematic. In total, the sampling frame consisted of 2411 classes in 666 schools, and, according to the Ministry of Education statistics, 42,634 students were studying in those schools.

The sampling frame was stratified according to the form (grade) level (Forms 8, 9, and 10), teaching language (Latvian and non-Latvian) and the urbanisation level (Riga and each of the nine major cities constituted separate strata, while the rest of the country's territory was stratified according to the status of the area (urban or rural) in each of the five regions and the three ranks of the development indices). A total of 114 strata were established and their sizes were calculated in accordance with the Ministry of Education statistics on students in academic year 2012/2013.

In accordance with the estimated number of classes that need to be included in the sample, such classes were selected at random from the entire list of classes the inclusion probability of which is proportional to the number of students in the class. A total of 231 classes were selected.

The fieldwork of the study was carried out from April to May 2013. Overall 161 comprehensive schools agreed to participate in the study, with a total of 178 classes of students surveyed. Refusals were received from 42 secondary education establishment principals (53 classes); however, the sampling method used did not envisage for a replacement of those classes. Considering the number of school refusals and the imprecise information regarding class size and student absenteeism, the sample size was in practice 3071, of which 1060 studied in Form 8, 1126 — in Form 9, and 871 — in Form 10.

On the day of the survey, of the schools / classes that had agreed to participate in the survey, 241 students (164 boys and 127 girls) were absent from school for various reasons and they were not interviewed.

The estimated non-response rate at schools and in classes that had agreed to participate in the survey is 7.8% of all the students, while the estimated non-response rate at class level is 23% (due to school refusal to participate in the study, mainly due to the heavy academic workload). Nine students refused to participate in the survey in a total of six form levels.

Students in a class were divided into two groups in alphabetical order according to the class register: one group was instructed to complete the questionnaire electronically in the school's computer room, while the other group completed printed out questionnaires as in other *LaSPAD* studies (Survey Project on Students in Latvia regarding Alcohol and Other Narcotic Substances).

Probability of inclusion in the sample was calculated for each sampling unit (class), and these were used when weighting the data. Given the uneven level of non-response by gender and regional dimension, the data from the study was weighted according to division by gender within the strata, as well as according to the inverse probability of a student being included in the sample. Data from the additional survey was weighted in a class dimension by gender and the manner of how the questionnaire was completed.

For data analysis, responses provided by 14-16 year-olds (born from 1996 to 1998) were used ( $n = 2896$ ; unweighted data), of which 925 were born in 1998 (14 years old), 1062 were born in 1997 (15 years old) and 909 were born in 1996 (16 years old).

Within the framework of the 2013 study, survey questionnaires were completed by 3071 students, of which 1551 completed them in paper format and 1506 completed them using a computer. For data analysis such questionnaires were used in which gender and the appropriate age were indicated (students born in 1996, 1997, and 1998), namely, 2896 questionnaires.

Table 2.6 shows specific characteristics of students. The data shows that there were no significant differences between the students who completed the questionnaire in the printed format and those who completed them using a computer.

**Table 2.6. “Objective” indicators characterising students, %, by format of how the questionnaire was completed**

	P&P (%)	CASQ (%)
<i>Average marks (p=0.5774)</i>		
8>	10.0	11.3
5-8	79.2	77.7
<5	10.8	11.1
<i>Financial position (p=0.0245)</i>		
Better than that of others	56.7	61.4
Approximately the same as that of others	33.7	31.2
Worse than that of others	9.6	7.4
<i>Family type (p=0.2373)</i>		
Both parents	57.6	61.1
Father+stepmother, mother+stepfather	13.7	11.8
Single parent	21.6	20.6
Other	7.2	6.5
<i>Activities in free time (% every/almost every day)</i>		
Plays computer games	29.7	31.2
Is active in sports	48.2	48.4
Reads books for own enjoyment	8.9	10.7
Goes out in the evening	4.5	5.5
Other hobbies	29.0	28.6
Kills time aimlessly	23.8	25.5
Surfs on the Internet to use up free time	63.9	64.9
Parents always know, where the student spends Friday nights	57.3	57.0

Source: Trapencieris et al., 2013

The main indicators characterising the prevalence rates of substance use in comparison to the previous ESPAD studies are outlined in this section. However, the indicators must be interpreted very carefully, as the sample sizes in each of the age groups achieved in the 2013 study is about two times smaller than those in the studies conducted in 2003, 2007, and 2011; moreover, half of the students filled in the questionnaires using a computer, while the other half filled in questionnaires in paper format, which theoretically could affect the findings.

Unlike for legal addictive substances (tobacco, alcohol)<sup>5</sup>, whose prevalence rates seem to have dropped considerably since 2011, the prevalence of the most commonly used illegal substance, marijuana / hashish, has slightly decreased or has remained at the same level (see Table 2.7).

**Table 2.7. Lifetime prevalence of trying marijuana / hashish in the ESPAD cohort of students by gender, 1995–2013, %**

	Boys	Girls	Total
<i>Lifetime prevalence of marijuana/hashish</i>			
1995	8	3	
1999	22	12	17
2003	21	13	16
2007	24	13	18
2011	29	19	24
2013	24	19	21

Source: Trapencieris et al., 2013

<sup>5</sup> See the technical report on the study in Latvian: Trapencieris M., Pētersons A., Sņikere S., (2013). *Atkarību izraisīgo vielu lietošanas paradumi un tendences skolēnu vidū*. (Addictive Substance Use Habits and Tendencies Among Students.) LASPAD 2013. Technical Report. Riga: Socioloģisko pētījumu institūts (the Sociological Research Institute)



The data from 2013 shows that over the past 12 months, marijuana / hashish has been used by 18% of the 15-year-old boys and 12% of the 15-year-old girls (14% total). These figures, just as those that show the rate of trying the substance, have slightly decreased compared to 2011, but care must be taken when interpreting the data due to the different sampling error values and the methods used. The proportion of current marijuana / hashish users, namely, those who have used this substance within the last 30 days, has not changed substantially compared to the proportion in 2011, when 6% of the young people admitted to marijuana use in the last 30 days, while in 2013 the figure was 7% of the 15 year olds.

Data from the 2013 study shows that the second most frequently used substance (after marijuana / hashish) is the so-called *Spice* Group products, which 15% of the 15 year olds have tried in their lifetime (in comparison, in 2011, the figure was 11%). What is interesting is that, unlike the 2011 study data, the data from the 2013 study do not point at statistically significant differences by gender (it has been used by 16% of the boys and 13% of the girls).

Relatively few school-age young people have used various synthetic stimulants (amphetamines, ecstasy) in their lifetime (2–4%), as has been found in other ESPAD studies.

Although the proportion of young people using various inhalants has declined in comparison to 2011, the figure still remains high — 18% of the young people in the ESPAD cohort have tried inhalants in their lifetime (equally many boys and girls).

### 3. Prevention

In its course of action "Competence Development", the Latvian National Development Plan for 2014-2020<sup>6</sup> envisages that by 2020, all children and young people must be provided with high-quality primary and secondary education, as well as access to activities outside of formal education, while the course of action "A Healthy Person Who is Able to Work" highlights premature death and loss of the ability to work and the relationship between the causes thereof and various health risks, including smoking and risky drinking. One of the tasks to be performed within the framework of this course of action is the prevention of addictive substances and processes.

The Action Plan for the Reduction of Consumption of Alcoholic Beverages and for the Mitigation of Alcoholism for 2012 to 2014<sup>7</sup>, which was drawn up in accordance with the task set in Sub-clause 2.1, Course of Action 2 of the Public Health Guidelines for 2011-2017, envisages that measures shall be taken to reduce the demand for alcoholic beverages, including alcohol use prevention activities.

Section 15 of the Law "On Local Governments"<sup>8</sup> stipulates that it is a function of the local government to provide access to health care, as well as to promote a healthy lifestyle and sports among the population.

In order to expand the role of local governments in promoting the health of the population, in 2012, the Ministry of Health continued its collaboration with the contact persons responsible for promoting health delegated by local authorities.

In 2012, many activities were carried out as comprehensive preventative action, and it can be observed that local government involvement is showing a tendency to increase.

Selective prevention activities are carried out not only in Riga, but regionally as well. The indicated prevention is not common in the country. Significant initiatives have been implemented in the field of environmental prevention, especially in mitigating alcohol consumption.

It has to be emphasised that in most cases, prevention activities in the country are not based on examples of best practice; usually only a quantitative evaluation is carried out, and assessment of the effectiveness of preventative intervention is provided in very few cases.

In 2012, three media campaigns were organised at the national level with the following target groups: 1) drivers of vehicles, to reduce the number of vehicle accidents, 2) the adult population, in order to reduce illegal purchasing of alcoholic beverages among the population, 3) people who want to quit smoking or to get more information about smoking-related problems. No drug awareness campaigns were carried out in 2012.

#### Data collection methods

Information on specific prevention activities is derived, first, from the data provided by the state institutions that are directly or indirectly involved in prevention, second, from the information on the operation of non-governmental organisations (hereinafter referred to as NGOs), local government (municipality) and state institutions published by the media.

In order to clarify the situation in addictive substances prevention and also to promote mental health and suicide prevention activities in municipalities in 2012, at the beginning of 2013, professionals of the CDPC (Centre for Disease Prevention and Control of Latvia) sent questionnaires to 109 municipalities and 9 city municipalities asking to provide answers and to send out a set of questions about the prevention activities for school environment carried out at schools in the municipality.

Until 2011, the questionnaire included questions regarding addiction prevention; in 2012, the set of questions was expanded to also include questions regarding the promotion of mental health and

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<sup>6</sup> Approved with Decision of the Parliament (*Saeima*) of 20 December 2012

[http://www.pkc.gov.lv/images/NAP2020%20dokumenti/20121220\\_NAP2020\\_Saeim%C4%81\\_apstiprin%C4%81ts.pdf](http://www.pkc.gov.lv/images/NAP2020%20dokumenti/20121220_NAP2020_Saeim%C4%81_apstiprin%C4%81ts.pdf)

<sup>7</sup> Approved with Decree No. 614 of the Cabinet of Ministers of 19 December 2012 <http://www.polsis.mk.gov.lv/LoadAtt/file16287.doc>

<sup>8</sup> Available on <http://www.likumi.lv/doc.php?id=57255/>

suicide prevention. The set of questions regarding the prevention of addictive substances in municipalities consisted of ten questions which enabled the respondents both to select corresponding answers and to express their comments replying to the open questions. By using questions in which the respondent has to specify prevention activities for addictive substance use in target groups, we tried to find out whether the municipalities are implementing universal, selective and indicated prevention of addiction. The last three survey questions that addiction and mental health promotion have in common were asked to find out the vision of municipalities about their strengths, weaknesses, opportunities and solutions when implementing the above mentioned prevention activities, as well as potential threats in the future. A separate set of questions was added to the questionnaire for schools. Schools, however, were asked a question regarding an action plan that envisages actions if the school found out that there were addictive substances or suspected that students used, stored or distributed addictive substances. Schools were asked about issues integrated into curriculum subjects that are directly or indirectly related to addictive substance prevention (with an option to select one of the choices offered or to report on other activities), informative events organised by the schools dealing with various issues related to addictive substance problems (with an option to select one of the choices offered or to report on other measures), as well as about parent meetings / evenings held at the school, guest lecturers invited to participate in the activities, etc.

All the questions were analysed both quantitatively by calculating the proportion (%) of the municipalities and schools that had responded and qualitatively by summarising the opinions sent in by the municipalities. As a delimitation of the scope of interpretation of the findings of the survey, the first point to be discussed is the potentially different understanding of the respondents about the concept of prevention of addictive substance use. The respondents were also offered specific examples of addictive substance use prevention activities; however, also in this case, the activities can be interpreted in different ways, which could cause a bias in the gradation by proportion of the municipalities that responded in which such activities were carried out. Second, it should be taken into consideration that 28% of the municipalities did not provide answers to the Centre for Disease Prevention and Control of Latvia for various reasons, which suggests that the findings show the situation in most, but not all municipalities. Third, when interpreting the findings in terms of how they concern schools, it must be taken into consideration that responses were received from only 40% of the schools.

At the end of the survey, 86 replies were received (72%, n=118). The section of the questionnaire addressed to schools was completed by 332 schools (40%, n=822).

### 3.1. Environmental prevention

#### Tobacco policy

Environmental prevention aims to transform the physical, cultural, social and economic environment in which people make their choices. These strategies include measures such as bans on smoking, alcohol price regulation or improvement of health in schools (EMCDDA, 2011). Complementing the information on environmental prevention to restrict the use of alcohol and tobacco provided in the 2011 National Report (CDPC, 2012), it should be pointed out that new policy initiatives were initiated in 2013 by amending the Handling of Alcoholic Beverages Law<sup>9</sup>:

- bans have been imposed on retail sale of alcoholic beverages in dormitories of educational institutions and on the premises of state and local government institutions, premises and the grounds of social care institutions;
- placement of alcoholic beverages other than beer whose absolute alcohol content does not exceed 5.8 per cent of volume in retail outlets in separated shopping halls in the self-service zone. In separated shopping halls, the self-service zone or individual buyer service zone shall be equipped with CCTV cameras;

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<sup>9</sup> <http://likumi.lv/doc.php?id=88009>

- the obligation to produce an identity card to the retailer in all cases, regardless of whether the retailer has requested it, has been imposed on persons aged 18 to 25 when they are purchasing alcoholic beverages. Retailers are prohibited from selling alcoholic beverages to persons whose age is in reasonable doubt and who do not produce identity documents;
- a new provision has been added to the Law, which stipulates for a mandatory requirement that advertisements of alcoholic beverages shall include information that warns about the negative effects of alcohol consumption, as well as informs people about the ban on sale, acquisition and transfer of alcoholic beverages to minors;
- a new provision has been added to the Law stipulating that outdoor advertising of alcoholic beverages shall be banned.<sup>10</sup>

At the end of 2012, the Cabinet of Ministers supported the further advancement of amendments to the Law “On Restrictions regarding Sale, Advertising and Use of Tobacco Products” which stipulate that local government councils shall be delegated the right to impose additional smoking bans or restrictions in order to protect the citizens from exposure to tobacco smoke. In addition to that, it also stipulates for a ban on smoking in apartment houses and on the balconies and loggias of public buildings as well as on smoking closer than 10 meters from apartment house entrances, outside stairs or porches (CDPC, 2013b).

### 3.2. Universal prevention

In basic education, health education matters for students in Forms 1 to 9 have been included in the curriculum of the subject “Social Sciences”<sup>11</sup>.

Health education issues have also been included in the curricula of other subjects of basic education, namely, “Natural Sciences”, “Biology”, “Domestic Science and Technologies”, “Physical Education”.

Schools that participated in the CDPC survey on municipalities have pointed out that in 97% of the schools (that were survey respondents), issues related to the use of addictive substances (tobacco, alcohol) have been integrated in the subjects, while issues related to the problems of narcotic substance use have been integrated in the subjects in 88% of the schools. The Ministry of Education and Science believes that the results of the tests prepared by the National Centre for Education in 2013 show that the knowledge of students about various health education issues in Form 5 is very good, but the everyday habits are not as good. The conclusions of the assessment on the diagnostic test on health education developed by the National Centre for Education (the knowledge of 9551 Form 5 students was assessed) state that overall, the awareness of students about healthy habits can be assessed as positive. Parents and teachers should pay even more attention to the issues of addiction prevention. Through mutual collaboration between parents, teachers and other parties involved, solutions should be sought as to how knowledge could become the basis for students to make personally responsible and healthy decisions and habits in everyday life<sup>12</sup>. At the beginning of 2013, the National Centre for Education carried out a diagnostic assessment on health education issues in Form 9 as well. The conclusions stated that in general the health education knowledge of 6904 Form 9 students is good. Although the knowledge of students, for example, about addictive substances, is good, unfortunately, the responses show a reality where adolescents can freely buy cigarettes, a fraction of students are allowed by their parents to use alcoholic beverages, and adults often go unpunished if they buy an intoxicating substance for adolescents.<sup>13</sup>

<sup>10</sup> <http://likumi.lv/doc.php?id=258036>

<sup>11</sup> Cabinet Regulation No. 530 of 6 August 2013 “Regulations On the State Basic Education Standard, Basic Education Subject Standards and Basic Education Program Samples”

<sup>12</sup> Information available on [http://visc.gov.lv/visc/dokumenti/petijumi/2013\\_diaagnostika\\_5klase\\_veseliba.pdf](http://visc.gov.lv/visc/dokumenti/petijumi/2013_diaagnostika_5klase_veseliba.pdf)

<sup>13</sup> Information available on [http://visc.gov.lv/visc/dokumenti/petijumi/2013\\_diaagnostika\\_9klase\\_veseliba.pdf](http://visc.gov.lv/visc/dokumenti/petijumi/2013_diaagnostika_9klase_veseliba.pdf)

In comprehensive secondary education, the subject “Health Studies” has been established as one of the optional subjects for students in Forms 10 to 12 within the mandatory curriculum of comprehensive secondary education programmes<sup>14</sup>.

Municipal (community based) prevention is based on plans for limiting the prevalence of addictive substances developed by the local governments. Some municipalities have noted that regular coordination group meetings are organised regularly, in which representatives of municipal administration, educational establishments, social service, medical establishments, law enforcement authorities, and NGOs participate.

Findings of the CDPC survey on municipalities show that most of the regional and city municipalities, namely, 93% (80 municipalities) that responded to the questionnaire, are implementing prevention and health promotion activities; in 79% (67 municipalities), implementation of preventive and health promotion activities was included or was going to be included in the municipal development plan or other binding documents; while 17 major city and regional municipalities (20%) had designed programmes (plans) that focus on limiting and preventing addictive substance use.

More than half of the municipalities or 76% (65 municipalities) answered in the affirmative to the question “Are any activities being carried out in your municipality that focus directly on limiting the prevalence of addictive substances and / or processes?”

**Table 3.1. Number of municipalities that have reported on activities carried out in 2012 for the prevention of addictive substance use**

Activities carried out in 2012	Number of municipalities	%
Alternative activities outside of school (sports events, hobby groups, arts school music school, etc.)	61	71%
Organised training for various social groups or professionals	46	53%
Youth centres, support groups established in the municipality	43	50%
Support measures for families	42	49%
Publishing publications and informative materials	25	29%
Other activities ( <i>public events, campaigns, etc.</i> )	24	28%

Source: CDPC survey on municipal activities for the prevention of addictive substances and promotion of mental health in 2012

The data of the survey on municipalities shows that in 71% of the municipalities that responded, free time extra-curricular activities for children and young people are very common (sports schools, arts schools, music schools, etc.) (see Table 3.1).

Hobby groups in interest education establishments<sup>15</sup> are attended by seven times more students than those at school, concludes the study “Interest Education in Latvia and the Role of Interest Education Establishments”. Students attend on average 1.8 hobby groups per week, almost all the respondents attended one or two hobby groups and merely a few attended more than two hobby groups per week. The study was carried out by interviewing 38 interest education establishments, 2199 interest education establishment students, and 1226 parents of interest education establishment students. Data from other studies was also used in the study, and opinions of municipalities, interest education establishment graduates, partner organisations, and other persons and public statistics data (Kalniņa et al., 2012).

56% of the municipalities that answered the CDPC survey questions on activities for the prevention of substance use and for promotion of mental health in the municipalities in 2012, organise training seminars for police officers, representatives of NGOs, health promoters, as well as deal with the training of professionals (teachers, social workers, etc.) (see Table 3.1). Specialists of the Health Promotion and Prevention Division of the Department of Welfare of the Riga City Council carried out regular structured training on addiction prevention in twelve programmes for teachers, medical

<sup>14</sup>Cabinet Regulation No. 281 of 21 May 2013 “Regulations On the State Secondary Education Standard and Subject Standards and Education Programme Samples” <http://likumi.lv/doc.php?id=257229>

<sup>15</sup> An interest education establishment is a multifunctional establishment in which interest education, substantial ways of spending free time, camps during the school holidays, further education courses for teachers, laboratories and cultural events are offered.

personnel, police officers, etc. specialists in accordance with a developed and approved education programme. The training ranges from 8 to 24 academic hours.

CDPC survey results show that youth centres in which addiction prevention measures are being implemented operate in 50% of the municipalities who answered the survey questions, and some municipalities have set up support groups (see Table 3.1.).

Support measures for families are popular with municipalities, 49% note that they provide these measures in the municipality.

It is possible that the involvement of so many municipalities in addictive substance prevention targeting families (family-based prevention) is due to an extended understanding of the issue — support measures for families that are not directly aimed at addiction prevention are perceived as specific measures of addiction prevention. In a more detailed presentation of information only a few of them specify that parents' evenings and informative events are organised by offering lectures to attend.

For example, addiction prevention specialists of the Health Promotion and Prevention Division of the Health Administration of the Department of Welfare of the Riga City Council, offer lectures for parents on the following topics:

- the use of plant mixtures (SPICE) for the purposes of intoxication among teenagers;
- addiction and its formation during adolescence;
- consumption of alcoholic beverages and smoking as a way of socializing among adolescents. What should parents do?
- experimentation with drugs among adolescents. Addiction risk. Support options for parents;
- excessive preoccupation with the latest technologies. What should parents do?
- The role of the family in addiction prevention<sup>16</sup>.

Publications about the use and prevention of addictive substances in the local media (municipal media, NGO websites, regional newspapers, radio, television) are prepared in 29% of the municipalities, and informative materials are also published.

28% of the municipalities have organised other activities (public events, campaigns, etc.) (see Table 3.1).

The findings of the municipality survey show that the municipalities are critical of what has been achieved in prevention of addictive substance use and in promotion of mental health.

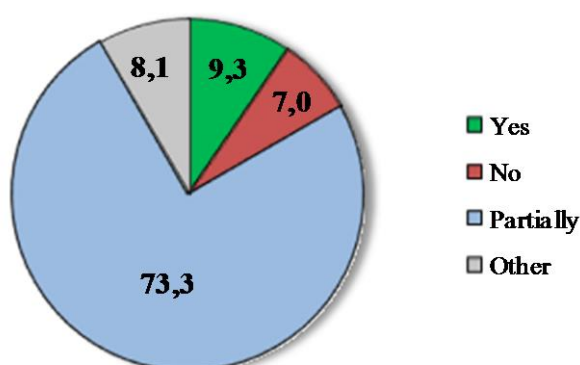
The answers to the question "Do you think that the activities carried out in your municipality for addiction prevention, promotion of mental health, prevention of mental disorders and suicides attain the desired outcome?" attest to that. Only 9.3% of the municipalities answered in the affirmative, the majority (73.3%) of the municipalities indicated that the result was only partially achieved, while 7% believe that the result has not been achieved (see Figure 3.1).

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<sup>16</sup> <http://www.narcomania.lv/pub/index.php?id=119>



**Figure 3.1. Breakdown of the answers given by the municipalities (% of the ones that responded) to the question “Do you believe that the activities carried out in the municipality for the prevention of addictive substance use and for promotion of mental health achieve results?”**



*Source: CDPC Survey on Municipal Activities for Addiction Prevention and Promotion of Mental Health in 2012*

When answering the survey question about the “strengths” of municipalities in the prevention of addictive substance use and promotion of mental health, the majority of the municipalities pointed out, first of all, that there exists an approved long-term planning document stipulating for measures for the prevention of addictive substance use, second, health promotion specialists work for the municipality and competent trained professionals work for local government authorities, and third, that NGOs that can implement the planned activities are actively involved in the municipality. Some of the municipalities believe that “active involvement of the population in free-of-charge sports and cultural events plays an important role in addiction prevention, thus filling their free time with healthy alternative activities that are provided by music and arts schools, sports and youth centres and by municipalities regularly organising sports days, cycling tours, running contests, skiing treks, etc. events, developing an appropriate infrastructure, such as cycling lanes, football fields, skate parks, etc.

When answering the survey question about the “weaknesses” of municipalities in the prevention of addictive substance use and promotion of mental health, most municipalities point out, first, a lack of specialists, especially in health promotion, or insufficient capacity of specialists, second, lack of a regulatory framework (programmes, plans), third, the limited availability of financial resources for carrying out public health promotion activities, and fourth, limited intersector collaboration. Some of the municipalities note that NGOs operate little in the region, public health and health promotion are not a municipal priority, co-operation with medical professionals is insufficient, for example, general practitioners do not have sufficient specialist expertise, there is a lack of methodology for assessing measure effectiveness.

The question “What new opportunities or solutions could promote the implementation of measures for prevention of addictive substance use?” was posed in the survey. Recommendations given by the municipalities have been summarised, taking into consideration the data of the survey (see Table 3.2).



**Table 3.2. Municipality recommendations for promoting the implementation of measures for addiction prevention and promotion of mental health.**

Activities of public authorities	Developing and implementing a detailed plan for health promotion and prevention with adequate funding
	Publishing informative materials in a centralised manner
	Developing and providing a methodology for assessing prevention activities
	Organising national-scale media campaigns
Funding and capacity building	Allocation of national funding for implementing prevention programmes in the regions
	Implementation of interregional projects by attracting funding from EU Structural Funds
	Creating municipal positions for health promotion specialists
	Setting up prevention offices in municipalities
	Organising business trips to municipal centres and educational establishments out of Riga for qualified prevention specialists who will have been trained to work with specific target groups
National and international co-operation	Regular training of specialists
	Engaging in the national and international co-operation networks, for example, the National Healthy Municipalities' Network to promote intermunicipal exchange of the best practices, experience and ideas, to receive methodological assistance when solving various public health and health promotion issues at the local level, and to raise the level of education municipal employees
Best practices	Experience exchange with other municipalities, methodological assistance
	Popularising the best practices in the media
Engaging NGOs in the implementation of prevention projects	Engaging NGOs in prevention activities. Creating funds for funding for which NGOs can qualify for to implement prevention activities.
	Developing youth initiatives and engaging young people more extensively in prevention activities
	Implementation of projects in schools and youth centres

Source: CDPC Survey on Municipal Activities for Addiction Prevention and Promotion of Mental Health in 2012

In 2012, training for municipality employees was organised with support from the European Social Fund to provide instruction to representatives of municipalities on health promotion and public health issues (including reduction of alcohol consumption). The programme was 30 hours long and included lectures and practical classes, as well as training on how to develop projects for health promotion measures. Municipality employees were trained within the framework of the courses.<sup>17</sup>

In universal prevention at school (school-based drug prevention), in most cases, prevention activities were based on an informative approach by improving the knowledge of students about the harmful effects of the substances on health and social risks of substance use. Also, one of the sub-objectives defined in the Public Health Guidelines for 2011 to 2017<sup>18</sup> was to reduce morbidity and mortality from non-communicable diseases by reducing the adverse health effects of the risk factors; it envisages measures aimed at reducing addictive substance use (alcohol, tobacco, narcotic substances) in the general population by improving the knowledge of people about the harmful effects of these substances on health.

The questionnaire set sent to the schools within the framework of the CDPC survey on municipality activities in 2012 for the prevention of addictive substance use and for promotion of mental health

<sup>17</sup> Materials of Conference "Narcotic Substance Use Tendencies in Europe and in Latvia: topical issues and solutions 2012": presentation given by the Head of the Public Health Department of the Ministry of Health [www.spkc.gov.lv](http://phoebe.vsm.gov.lv/misc_db/web.nsf/626e6035eadbb4cd85256499006b15a6/8a03f52e8e639356c225792e00364f3b/$FILE/sasprade.pdf)  
[http://phoebe.vsm.gov.lv/misc\\_db/web.nsf/626e6035eadbb4cd85256499006b15a6/8a03f52e8e639356c225792e00364f3b/\\$FILE/sasprade.pdf](http://phoebe.vsm.gov.lv/misc_db/web.nsf/626e6035eadbb4cd85256499006b15a6/8a03f52e8e639356c225792e00364f3b/$FILE/sasprade.pdf)

<sup>18</sup> Approved with Decree No. 504 of 05.10.2011 <http://polsis.mk.gov.lv/view.do?id=3768>

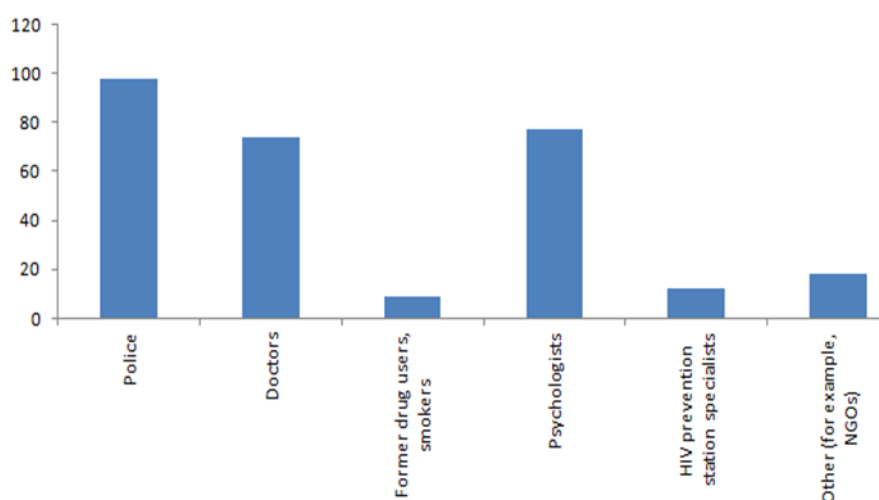
asked the recipients to specify the two main priorities that the school wants to achieve by implementing prevention activities: 67% of the schools responded that they want to create a safe school environment for the students, 64% highlighted the wish to raise student awareness of health / social risks, while 40% of the schools indicated that they want to develop the life skills of students.

Within the framework of the CDPC survey on municipality activities in 2012 for the prevention of addictive substance use and for promotion of mental health, schools were asked the following question: “Is there a school action plan that envisages action to be taken if it has been found or suspected that students use, store or distribute addictive substances pursuant to Cabinet Regulation No. 277 of 23 March 2010 “Procedures for Providing Preventive Health Care and Emergency Medical Assistance in Educational Institutions?”<sup>19</sup>

78% of the schools that responded during the survey gave an affirmative answer with the explanation that the action plan is included in the internal regulations of the school or, in other words, it has been designed as an internal normative act.

In terms of universal prevention, inviting various specialists — doctors, police officers, representatives of NGOs — to organise discussions and lectures during class tutoring lessons still remains a popular activity in Latvia (see Figure 3.2).

**Figure 3.2. Schools (% of the schools that responded) that invite the indicated guest lecturers to implement prevention activities**



Source: CDPC Survey on Municipal Activities for Addiction Prevention and Promotion of Mental Health in 2012

In some schools, lectures are supplemented with discussions in which the role of the manufacturers of legal and illicit addictive substances in the community is discussed (sponsorship, lobbies, etc.), as well as the effect of mass media on the prevalence of substance abuse (advertising, myths and reality), etc. other types of preventive work that can be classified as normative education.

Within the framework of the CDPC survey on municipality activities in 2012 for the prevention of addictive substance use and for promotion of mental health, schools were asked the following question: “Does the school organise information days (project weeks, contests, exhibitions, etc.)?”

<sup>19</sup> <http://www.likumi.lv/doc.php?id=207125&from=off.>

**Table 3.3. Schools (% of the schools that responded) that have indicated that within the framework of information days addiction prevention related issues were discussed**

Topic	Information days are organised in the school (project weeks, contests, exhibitions) (% of the schools that responded)
About narcotic substance use related problems	70
About problems related to other addictive substance use (tobacco, alcohol)	81

Source: CDPC Survey on Municipal Activities for Addiction Prevention and Promotion of Mental Health in 2012

Within the framework of school-based drug prevention, informative lectures for parents are organised regularly about ways of identifying psychoactive substance use and about strengthening familial relationships.

55% of the schools that responded to the CDPC survey questions organise parents' meetings / evenings about the harmful effects of using other addictive substances (tobacco, alcohol), while in 40% of the schools discussions with parents are held about the effects of narcotic substance use (see Table 3.4).

**Table 3.4. Schools (% of the schools that responded) that indicated that they organise parents' meetings / evenings about the topics specified**

Topic	Parents meetings/evenings are organized in the school (% of the schools that responded)
About the effects of narcotic substance use	44
About the effects of using other addictive substances (tobacco, alcohol)	55

Source: CDPC Survey on Municipal Activities for Addiction Prevention and Promotion of Mental Health in 2012

The schools that answered the questions in the school-related section of the CDPC survey indicated that in 94% of the schools, extra-curricular activities are organised for the students (hobby groups, sports schools, interest groups, art, photography, theatre, etc. activities).

### 3.3. Selective prevention in at-risks groups and settings

In order to find out whether selective prevention activities were carried out in the municipalities in 2012, the CDPC survey questionnaire posed the following question: "Are activities for reducing and preventing addictive substance use organised for the following social groups?"

Summarising the findings of the survey, the two target groups for prevention work that are mentioned most often are as follows: students with social or learning problems, in 58% of municipalities, and children and young people from socially disadvantaged families, in 51%, including children whose parents have addictive substance use problems (see Table 3.5). It is possible that the high rate of municipality involvement in selective prevention could be accounted for by a broadened understanding of the concept of selective prevention in the context of this survey, including elements of universal prevention into the concept, such as distribution of informative materials to visitors of entertainment venues, law enforcement raids at entertainment venues, as well as social work with, for example, the homeless, disadvantaged families, etc., rather than understanding it to mean as individual work with young people at risk. It should also be noted in the context of this issue that the role of such school support staff as psychologists, social workers, etc., keeps increasing in working with students with social or learning problems.

**Table 3.5. Municipalities (% of the municipalities that responded to the survey questions) that implement addiction prevention activities for specific target groups**

Target audience of the prevention activities	Number of municipalities	%
Students with social or learning problems	50	58
Children and young people from socially disadvantaged families, including children whose parents have addictive substance use related problems	44	51
Offenders	21	24
Children and young people in social care homes and children's homes	20	23
Young people who leave school without graduating	18	21
People who frequent entertainment venues	13	15
Other target groups	11	13
The homeless	10	12
Ethnic groups (for example, Roma)	8	9

Source: CDPC Survey on Municipal Activities for Addiction Prevention and Promotion of Mental Health in 2012

For example, a school social worker makes sure to help solve the difficult situation in which a child has ended up if bad behaviour, conflicts with schoolmates or teachers, absenteeism, vagrancy, bullying from schoolmates, secluding oneself from other people, loss of activity or other negative changes in a student's behaviour point at such a situation. According to the data at the disposal of the Ministry of Education for 2011, the country had 1131 social workers with social worker qualification. Social workers work mainly in educational establishments or municipal social services, as well as in social correction institutions and classes, social care and rehabilitation facilities for orphans and children without parental custody, group homes (apartments), crisis centres, and in the field of law enforcement and domestic affairs. According to the Ministry of Education statistics data, 285 social workers were employed in general education day schools in the academic year of 2010-2011. Most of them work in Riga schools and city schools, while many small rural schools have no social workers.<sup>20</sup>

Best practice examples of structured individual work aimed at a specific young person at risk or best practice examples of selective prevention aimed at parents were discussed in the National Report 2011 and notable changes have not been observed within the last year..

### 3.4. Indicated prevention

The target of indicated prevention is those children who are prone to experimentation by smoking, drinking alcohol, using illicit narcotic and psychotropic substances, including those who have occasionally used these substances, but have not yet been diagnosed with addiction. Indicated prevention methods include individual work with people who have behavioural or psychological problems that could indicate that these persons might start using psychoactive substances in the future. This type of prevention has rarely been used in Latvia for a couple of years, because it requires consistent input of work and providing a stable flow of funds every year, and professional experts are required who could implement these programmes. To some extent, programme development is hindered by the separated funding models for treatment and prevention, namely,

<sup>20</sup> <http://www.lvportals.lv/skaidrojumi.php?id=243032>

treatment is paid by the state, but funding for prevention is mostly sourced from municipality and foreign projects. This is one of the reasons why all early intervention programmes in Latvia are identified as treatment. Features of indicated prevention are present in children's support group programmes that are being implemented in some addiction treatment facilities, but in this case, the diagnoses in accordance with the ICD-10 classifier are coded as mental and behavioural disorders due to psychoactive substance use (F10-F19) or habit disorders and drives (F63.0).

### 3.5. National and local media campaigns

Informative campaigns are used as a form of universal prevention to reach a wide target audience. To reduce the number of those drivers who tend to drive a vehicle under the influence of alcohol or narcotic substances and, consequently, the number of traffic accidents, the Road Traffic Safety Directorate of the Republic of Latvia (CSDD) in co-operation with the National Police organised the campaign "*No vadītāja līdz izvadītājam ir viena glāze. Nebrauc dzēris!*" ("There is one glassful's worth of difference between a driver and a funeral director. Do not drink and drive!") in 2012. The materials demonstrated during the campaign imitated the consequences of a real dramatic car crash that was caused by a driver who drove under the influence of alcohol. The advertisements were placed on television, on the Internet and the radio, as well as extra care was taken when informing people on the Internet and on social networks. Wrecked cars were placed near shopping centres and in the centre of Riga, and passers-by could listen to a story about each car crash based on real events by calling a free of charge telephone number that was displayed in the installation stand. More Road Police raids were organised during the campaign during which conscientious drivers who had not used alcoholic beverages were given a bottle of mineral water. During the campaign, the website [www.otraiespeja.lv](http://www.otraiespeja.lv) that was designed with support from an insurance company had a considerable number of visitors. On the website, everybody could experience a simulation of what a drunk driver feels like and experience a traffic accident caused by such a driver, as well as face the consequences of driving under the influence of intoxicating substances.<sup>21</sup>

To raise awareness among the general population of the harmful effects that acquisition, trade and use of alcoholic beverages of untested origin can have on human life, social campaign "*Aizkulīs*" ("Behind the Scenes"), which was organised by the Latvian Alcoholic Beverage Producers and Distributors Association (LADRIA) in co-operation with advertising agency "Leo Burnett Riga", media agency "Starcom Latvia", Environmental Advertising Association and financial support from the European Forum for Responsible Drinking (EFRD), was carried out at the end of 2012. Appealing environmental posters were placed in the streets of Riga, Liepāja and Daugavpils, inviting people to think about the untested and life-threatening content of alcohol mixtures of unknown origin that are sometimes sold as "produce of a drinks factory". Campaign messages and myths about the origins of alcoholic beverages of illegal origins were also exposed on the portal [www.atbildigi.lv](http://www.atbildigi.lv).<sup>22</sup>

To raise awareness among the general population of the prevalence of smoking in Latvia, anti-smoking campaign "*Nepūt miglu!*" ("Do not blow smoke!") was organised in 2012. During the campaign, two videos were made with the slogan "How many smokers have YOU brought up?" and were shown on six television channels with support from Modern Times Group<sup>23</sup>. A "*Nepūt miglu!*" application was placed on various social portals, such as [www.draugiem.lv](http://www.draugiem.lv) and [www.facebook.com](http://www.facebook.com), in which interested persons could learn various smoking-related facts. To attract visitors to the application, the Internet portal [delfi.lv](http://delfi.lv) sponsored the placement of advertisement slots. The campaign also made use of environmental advertisements that were placed in 300 places in Riga and the biggest cities. The authors of the campaign made a separate website on the opening webpage of the social network draugiem.lv, and then relevant target audience was attracted in co-operation with draugiem.lv. As of now, over 25,000 people "follow" the website. Information about smoking-related issues was / is placed on the website and exciting content that

<sup>21</sup> Additional information on the website of CSDD [http://www.csdd.lv/lat/noderiga\\_informacija/sabiedriskas\\_aktivitates/socialas\\_kampanas/?doc=1371](http://www.csdd.lv/lat/noderiga_informacija/sabiedriskas_aktivitates/socialas_kampanas/?doc=1371)

<sup>22</sup> Information available on [http://m.la.lv/index.php?option=com\\_content&view=article&id=369693:bezakczes-alkoholu-gatavi-iegdties-26-latvijas-iedzivotju&Itemid=105](http://m.la.lv/index.php?option=com_content&view=article&id=369693:bezakczes-alkoholu-gatavi-iegdties-26-latvijas-iedzivotju&Itemid=105)

<sup>23</sup> The following TV and radio channels are part of MTG: TV3, 3+ and Star FM

promotes active lifestyles is added. The main objective that the organisers of the campaign want to reach is to create a social support system for people who want to quit smoking or to obtain more information, because, as members of the focus group (young people who smoke) who took part in creating the campaign have admitted, the biggest problem when quitting smoking is inability to resist peer pressure. A virtual support group is being formed with assistance from the portal.<sup>24</sup>

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<sup>24</sup> Additional information <http://www.draugiem.lv/neputmigu/>



## 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 data mining methods used in the indicator 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. Prevalence and incidence estimates of PDU

#### Indirect estimates of problem drug users

Taking into consideration the specific features of the data available, indirect estimates of problem drug users in Latvia are mainly performed according to treatment, police and mortality rate methods, which are among the methods recommended by the EMCDDA for estimating the number of drug users. To apply the multiplier methods, two types of data are required:

- 1) number of drug users captured in a data source, for example, drug users treated within a year or “caught” by the police;
- 2) the percentage of the drug users that have indicated that they have sought assistance (or have been caught) within a specific time period, for example, a year, in one of the data sources about which information has been obtained. Such information can mainly be obtained by surveys among problem drug users.

The main drawback of the multipliers method is the fact that this method does not allow identification of the limits of the credibility interval errors that can arise both by not including data on individuals in the data source to be researched, or if the percentage of drug users that have approached the provider of the relevant services that was identified within the framework of the study is imprecise, etc. Elsewhere in Europe, the *capture-recapture* method is used, which provides limits of error in the estimated number of drug users. This method envisages that several types of data with the same identifier should be combined, for example, data consisting of gender, initials and date of birth information, thus looking for overlaps among three or more data sources and, by using log-linear regression methods, the most credible mathematical model showing the data is identified. There have been several attempts in Latvia to use this method, but in most cases it was not possible to estimate the number of problem drug users.

Previous estimates of drug user numbers performed in Latvia and the methods used therein have been described in the national reports for 2010 and 2011 (Health Economics Centre, 2010).

Improving the treatment data quality carried out in previous years was continued in 2012, which allows identifying the number of drug users treated within the year more precisely, thus providing an opportunity to estimate the numbers of drug users more precisely. By using the treatment method, the number of drug users in the problem drug user category in Latvia in 2011 was estimated<sup>25</sup>.

The number of unique drug users treated in 2011 was identified by using the number of treated drug users in three databases: 1) PREDA, 2) APANS database of the National Health Service (NVD), and 3) the SPANS database of the NVD (National Health Service). In total, the databases identified 2044 unique problem drug users (users of opiates, cocaine and amphetamines) who received out-patient or hospital assistance. The percentage of drug users (14.2%) who sought drug treatment within the last 12 months that was obtained from the Cohort Study on Drug Users in 2012 was used as a multiplier.

The estimates show that in 2011, there were approximately **12,974** problem drug users in Latvia, or **9.4 per 1000** people aged 15-64.

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<sup>25</sup>See also ST7\_2013\_LV\_01



The main drawback of these estimates to be pointed out is the fact that the method used does not allow estimating credibility intervals in a precise manner, therefore, the reliability of the estimates is subject to a large extent to the quality of treatment data and the findings of the study.

Regardless of the delimitations mentioned above and assuming that the drug users interviewed in the cohort study were selected randomly, it was estimated that the lowest estimated value of the problem drug users who received treatment within the last 12 months is 11.1%, whereas the highest estimated value is 17.2%. Using these indicators as multipliers when identifying the lowest and the highest estimated value of error, it can be concluded that there were between 10,638 and 16,499 problem drug users in Latvia in 2011.

Likewise, as the number of problem drug users of various substances was identified using the cohort study data of 2010, the number of problem amphetamine users and the number of problem opioid users were estimated in 2012 as well. According to the estimates, it can be concluded that there were 8965 problem opioid users and 5482 problem amphetamine (and/or methamphetamine) users in Latvia in 2011. The numbers of drug users identified in the 2012 estimates can be found in Table 4.1.

**Table 4.1. Estimated number of drug users in Latvia in 2011, according to the treatment multiplier method, %**

	Average estimate (per 1000 15–64 year-olds)	Lowest estimated value (per 1000 15–64 year-olds)	Highest estimated value (per 1000 15–64 year-olds)
<b>Total</b>	12,974 (9.4)	10,638 (7.7)	16,499* (11.9)
<i>Gender</i>			
Males	9763* (10.4)		
Females	3212 (2.9)		
<i>Age</i>			
Up to 24 years	2448 (7.9)		
25–34 years	6686 (20.3)		
35 and older	3840 (4.3)		
<i>Substances</i>			
Opioids	8965 (6.5)		
Amphetamines	5482 (4.0)		

## 4.2. Data on PDUs from non-treatment sources

### Cohort study of drug users in Riga

Cohort study on drug users in Latvia was initiated in 2006, and in 2012 it was carried out for the sixth time. The methodology of the study envisages interviewing one and the same drug users, so that it is possible to assess changes that can be observed in Latvia, for example, in terms of substances used, employment, risk behaviour, etc. In total, in the six stages of the study 1368 drug users have been recruited and interviewed, of whom 122 were interviewed in six stages of the study, 318 in five stages, 229 in four stages, 176 in three stages, 140 in two stages, and 383 drug users were interviewed merely in one stage of the study.

### Socialdemographics

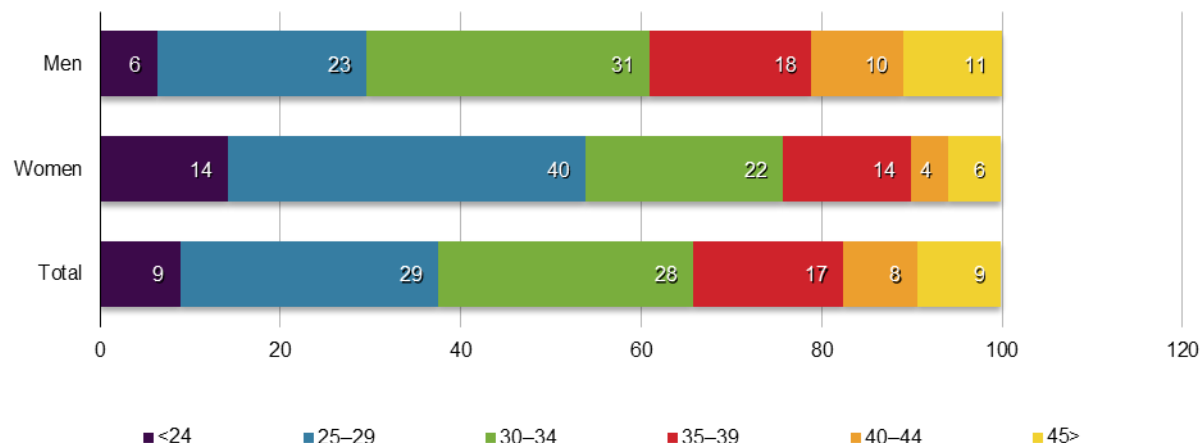
The data of the study indicate that the percentage of women among everyday drug users is approximately 30–33 per cent.

The average age of drug users is 33 and, as interviews with one and the same drug users are conducted year on year, the average age is increasing.

The average age of the interviewed drug users is 33.0 (median 32 years, mode 27 years, standard deviation 7.5).

In the sixth stage of the cohort study, 9% of the interviewed drug users were 15-24 years old, 29% were 25-29 years old, 28% were 30-34 years old, 16% were 35-39 years old, 8% were 40-44 years old, and 9% were over 45 years old (see Figure 4.1).

**Figure 4.1. Age of the cohort study participants, %**



Therefore, the study does not include (with few exceptions when extra respondents are recruited, for example, in 2012 in Liepāja and Jūrmala, in 2010 in Ventspils, in 2008 and 2009 in Riga and its vicinity) drug users with a short drug use record. Consequently, it is possible that problems or substance use habits are not being identified among those drug users who started their drug use relatively recently.

When looking at the nationality of the respondents, it can be observed since the first stage of the cohort study that the percentage of Latvians has been consistently decreasing: in 2007, one in four respondents (27%) indicated that his or her nationality is Latvian, whereas in 2008-2012 a mere 22-23% did that.

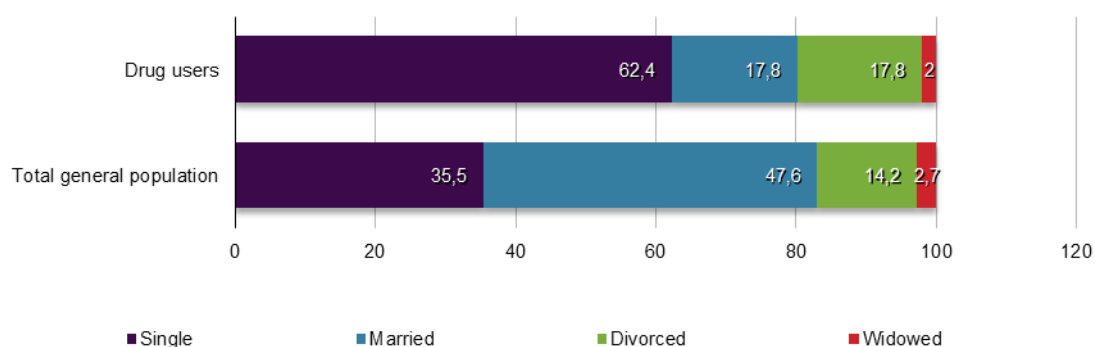
**Table 4.2. Nationality of the respondents, %**

	2006	2007	2008	2009	2010	2012	2011
Latvians	33.0	25.8	21.5	21.5	22.7	22.0	62.1
Russians	55.5	63.5	68.5	67.9	67.1	69.0	26.9
Other nationalities	11.5	10.7	10.0	10.6	10.2	9.0	11.0

Of other minority nationalities, the number of Roma respondents is the highest among drug users, which notably exceeds the number of drug users in this ethnic group in comparison with other minority nationalities.

Likewise as in the previous stages of the cohort study, the respondents interviewed in 2012 are also single according to the marital status they indicated. Approximately two thirds (62%) of the respondents indicated this, and 30% indicated that they live together with a partner. 18% of the drug users are divorced; 12% are married (of which 2% have married repeatedly); 5% are married, but live separately; and 2% of the respondents reported being widowed.

**Figure 4.2. Marital status among drug users in comparison with 20–59 year-olds in the general population, %**



According to the breakdown of the household, approximately a half (51%) of the respondents indicated that they live with a partner, 30% with parents, 20% with children, 12% with friends or acquaintances, and 10% indicated that there are other family members in the household. 22% of the drug users indicated that they live alone, and a mere 11% of the respondents indicated that they live with friends or acquaintances only.

Approximately a half (52%) of the drug users live with somebody who either uses alcohol excessively or takes drugs, therefore breaking away from the drug use environment can be very difficult. 23% of the respondents indicated that they live with somebody who uses alcohol excessively, and 40% live with somebody who takes drugs. For the women, more often than for the men, somebody in the household uses alcohol or drugs excessively: 66% and 46%, respectively ( $\chi^2=18.26$ ,  $df(1)$ ,  $p<0.0001$ ). In Latvian households, in comparison with non-Latvian households, there are fewer people who, in addition to the respondent, use alcohol or drugs excessively: 44% and 54%, respectively ( $\chi^2=3.98$ ,  $df(1)$ ,  $p=0.046$ ). Statistically significant differences have not been observed based on age.

As it had been analysed in the previous stages of the study, statistically significant differences based on respondents' gender could be observed among those drug users who live with a spouse / partner, children and parents: the women more frequently indicated that they currently live with a partner and / or children, while the men more frequently indicated that they live with a partner and / or parents (see Table 4.3).

**Table 4.3. Marital status of drug users (who they live with) by gender, %**

	Total	Males	Females
Lives alone	22.0	24.6	16.6
Spouse, partner	51.2	45.2	63.3
Children	20.4	16.2	29.0
Parents	30.4	34.5	21.9
Brothers, sisters	8.6	9.6	6.5
Other family members	10.1	10.1	10.1
Friends, acquaintances	11.5	11.3	11.8

Drug users who live together with friends or acquaintances only indicated more often that somebody in the household uses drugs than users living in other types of family or household, whereas those who live in a family with parents indicated this least often.

In the 2012 survey questionnaire, questions regarding drug users' children were included. The survey data shows that two in five (40%) of the interviewed drug users have minor children, while every second user (50%) lives together with his or her child (one or several). The women, more often than men, indicated that they have children, 48% and 36%, respectively. Likewise, the women, more often than men, indicated that they live together with their child or children, 65% and 41%, respectively.

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

### 5.1. Strategy and policy

On 20 December 2012, the Saeima of the Republic of Latvia has adopted the National Development Plan of Latvia for the years 2014–2020<sup>26</sup>. The National Development Plan 2020 (NDP 2020) is the hierarchically highest medium-term planning document in Latvia at the national level. The NDP 2020 is closely related to the “Sustainable Development Strategy of Latvia until 2030” and to the “National Reform Programme of Latvia for the Implementation of the “Europe 2020” Strategy”.

It has been pointed out in the strategic objective “Healthy and Fit for Work” of the National Development Plan that the major manageable health risks in Europe resulting in considerable healthcare and social costs include smoking, alcohol abuse, a lack of physical activity, and unhealthy nutrition.

Among the tasks for this strategic objective the following issues are emphasized — preventive measures and elimination of addictive substances and processes: (a) universal and selective preventive measures; (b) treatment of alcohol addicted people in all national development centres to ensure integration of these people into labour market; (c) elimination of the offer of addictive substances<sup>27</sup>.

From 1 January 2012, new legislative rules, which have been intended to bring prisoners’ health care more in line with the existing order for all population, have been included in the Cabinet Regulation No. 1046 “Health Care Organization and Financing Procedure”<sup>28</sup> of 19 December 2006 (hereinafter referred to as the Regulation No. 1046). Until 1 January 2012, it was prescribed by the Regulation No. 1046, that a person can receive out-patient and in-patient healthcare services covered by the State budget provided that this person has a referral prescribed by a family practitioner or by a specialist who has contractual relationship with the National Health Service (hereinafter referred to as the Service). However, it was not specified that the mentioned services could be received upon a referral prescribed by a prison doctor. The Regulation No. 1046 were complemented with a legislative rule, which provides that prisoners can receive the abovementioned out-patient and in-patient health care services upon a referral prescribed by a prison doctor. The Ministry of Justice pays for healthcare services provided by medical specialists working in places of detention, as well as covers patient’s payments and co-payments for those prisoners who receive health care services outside of places of detention. It also ensures covering of patient’s co-payments for medical preparations and medical devices, for which the compensation of purchase expenses is determined in legislative acts concerning compensation of purchase expenses for medical preparations and medical devices prescribed for out-patient treatment.

In Latvia treatment of drug users is determined by the Medical Treatment Law, as well as by the Cabinet Regulation No. 70 “Procedure for the treatment of patients addicted to alcohol, drugs, psychotropic, or toxic substances, gambling or computer games” of 24 January 2012 (hereinafter referred to as the Regulation No. 70)<sup>29</sup>. The Regulation No. 70 provides for several significant changes in the drug-related treatment system, especially for ensuring of long-term pharmacotherapy. The most important of these changes: drug-related treatment is ensured for patients in accordance with their will by those healthcare institutions, where a narcologist is available and where drug-related treatment can be ensured (previously it was possible only in narcological treatment institutions). Long-term therapy with the use of methadone can be ensured not only by a narcologist, but also by other certified medical specialists, who have learned this treatment method and obtained the required certificate in relation to these methods of treatment

<sup>26</sup> Available at [http://www.pkc.gov.lv/images/NDP2020%20dokumenti/20121220\\_NDP2020\\_Saeim%C4%81\\_apstiprin%C4%81ts.pdf](http://www.pkc.gov.lv/images/NDP2020%20dokumenti/20121220_NDP2020_Saeim%C4%81_apstiprin%C4%81ts.pdf)

<sup>28</sup> Available at <http://www.likumi.lv/doc.php?id=150766>

<sup>29</sup> Available at <http://www.likumi.lv/doc.php?id=243233>

and diagnostics. Long-term pharmacotherapy with methadone for the patients, who were receiving this preparation before they are admitted to places of detention, is also ensured in places of detention and the long-term pharmacotherapy with methadone and buprenorphine can be prescribed by a council of physicians consisting of at least two narcologists in any healthcare institution.

## 5.2. Treatment systems

In 2012 State-funded out-patient services were ensured by a narcologist, who is a directly accessible specialist and who provides healthcare services to patients (diagnoses ciphered as mental and behavioural disorders due to psychoactive substance use (F10-F19) or habit and impulse disorders (F63.0)) in accordance with the International classification of Diseases ICD-10.

In our country treatment of addiction patients is also provided by private institutions and private narcologist's practices. If a patient has recourse to a private doctor, all expenses related to the treatment must be paid at a patient's own expense.

State-funded in-patient narcological treatment is provided with the use of beds of narcological profile<sup>30</sup>, located in specialized psychiatry centres, regional multi-profile hospitals, as well as in other medical institutions.

It must be emphasized, that drug users, to whom emergency medical aid is provided, for example, in case of drug overdose (ICD-10 diagnosis groups, basically T40–T43, as well as sometimes F10–F19), in most cases are hospitalized in university hospitals, regional multi-profile hospitals and local multi-profile hospitals, where specialized beds of narcological profile may not be available.

### Out-patient psychosocial intervention

Out-patient psychosocial interventions in our country are ensured by narcologists in cooperation with assistant nurses. Particular institutions have also created multi-discipline teams including also psychologists in addition to the mentioned specialists.

In 2011 out-patient and in-patient aid was provided by 67 narcologists (natural persons) working in contractual relationship with the National Health Service. In 2012 such aid was provided by 69 narcologists working in 42 out-patient and in-patient healthcare institutions. A part of these specialists also provided long-term pharmacotherapy with methadone and buprenorphine.

Specialists in private narcological institutions, which do not have contractual relationships with the National Health Service, also provide out-patient narcological aid in our country.

In accordance with data of the Heath Inspectorate Register of healthcare institutions and medical professionals, in 2011 out-patient and in-patient narcological aid was provided by 111 narcologists. In 2012 such aid was provided by 106 narcologists working in 97 state-owned, municipal, or private healthcare institutions.

**Table 5.1. Narcologists working in contractual relationship with NHS in the years 2007–2012**

	2007	2008	2009	2010	2011	2012
Narcologists (natural persons)	65	77	75	72	68	69

Source: National Health Service, 2013

In accordance with the National Health Service data, the total number of out-patient narcological visits (diagnoses ciphered as mental and behavioural disorders due to psychoactive substance use F10–19 in accordance with ICD-10) in 2012 was 49,959 visits (in 2011 — 38,437, and in 2010 — 36,522 visits), while the number of unique patients was 11,853 (in 2011 — 12781). The average number of out-patient visits per one unique patient in 2012 was 4.2 visits (in 2011 — 3.0 visits and in 2010 — 2,94 visits).

<sup>30</sup> Including detoxification beds, Minnesota programmes, the motivation program, medical rehabilitation. Diagnoses ICD-10: F10-F19

Health problems related to alcohol addiction, abuse or to intoxication were diagnosed for 79.3% of all unique patients (F10 diagnosis group in accordance with ICD-10), while diseases related to narcotic or psychotropic substance intoxication, abuse and addictions (diagnosis groups F11–19 according to ICD-10) were diagnosed for 20.7% of such patients. Unique patients by gender: 77.9% of patients are men and 22.1% of patients are women.

Motivating intervention, cognitive behavioural therapy, supporting therapy for solving of social issues etc. are applied in the course of out-patient psychosocial intervention.

In accordance with the Cabinet Regulation No. 899 “Procedures for the reimbursement of expenditures for the acquisition of medicinal products and medicinal devices intended for out-patient medical treatment” of 31 October 2006, the list of medicinal products to be compensated from the State budget includes medicinal products that are used for treatment of children with mental and behavioural disorders due to use of psychoactive substances provided that particular preparations (with 100% compensation) are prescribed for these children. In accordance with the National Health Service data, the number of unique patients-children, who received compensated medicinal products for the particular diagnoses (diagnosis groups F11; F12.; F13; F14; F15; F18; F19 according to ICD-10) was 28 in 2012 (in 2011 — 30), while a little amount of financial resources compensated from the State budget was used for treatment of children — LVL 300 (in 2011 — LVL 290)<sup>31</sup>.

### **In-patient psychosocial intervention and detoxication**

In case of acute emergency situations related to use of addictive substances (basically, T40–T43 diagnosis groups, and sometimes F10–F19 according to ICD-10), medical aid is provided by hospitalising such patients not only in medical centres where beds of narcological profile are available, but also in university hospitals, regional multi-profile hospitals, as well as local multi-profile hospitals, where specialized beds of narcological profile are not available.

The Database of Hospital Bed Utilisation of the Centre for Disease Prevention and Control of Latvia (CDPC) provides information regarding utilisation of hospital beds only in relation to healthcare institutions, which are identified as institutions that provide medical services of narcological profile (State-funded services as well as private services for diagnosis groups F10–F19 according to ICD-10)<sup>32</sup>.

In 2012 the average number of beds of narcological profile was 249 (261 — in 2011), including beds designated for detoxication, Minnesota programme, motivation and medical rehabilitation. Within the last five years, the number of narcological profile beds decreased from 387 beds in 2008 to 249 beds in 2012. These services were provided by 9 healthcare institutions.

220 beds were funded from the State budget, while other beds were located in private healthcare institutions.

In our state, due to circumstances of limited financing, generally detoxication is provided with the use of narcological profile beds.

In-patient psychosocial intervention includes treatment of patients in medical institutions of in-patient type, starting with short-term in-patient programs (Minnesota and motivation programmes) up to therapeutic communities.

In accordance with data provided by the National Health Service information system (as of 10.10.2013), the number of hospitalizations for drug-addicted patients (diagnosis group F10–F19 according to ICD-10) in all hospitals, which have contractual relationships with the National Health Service, was 11,638 hospitalization cases in 2012, of which 11,036 hospitalization cases or 94.8% were based on diagnoses related to alcohol use (diagnosis group F10 according to ICD-10), and 602 hospitalization cases were based on diagnoses related to use of narcotic and psychotropic substances (diagnosis group F11–19 according to ICD-10) or 5.2%.

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<sup>31</sup> <http://www.vmnvd.gov.lv/lv/503-ligumpartneriem/operativa-budzeta-informacija/arhivs>

<sup>32</sup> All patients with diagnosis codes F10–F19 according to ICD-10 are treated in the specialized narcological treatment profile.



Analysing the National Health Service data concerning patients with mental and behavioural disorders, the number of unique patients treated within the framework of Minnesota and motivation programmes is relatively small: in 2012 there were 395 unique patients treated within the Minnesota programme, while 23 unique patients were treated within the Motivation programme. The mentioned facts show evidence of possible limited accessibility of this service.

Social rehabilitation for children and adults with mental and behavioural disorders due to use of psychoactive substances is financed by the Ministry of Welfare on the basis of regulations prescribed by the Social Services and Social Assistance Law, in accordance with the procedure specified by the Cabinet Regulation No. 914 "Procedures, by which persons addicted to psychoactive substances receive social rehabilitation services, and requirements for social rehabilitation service providers" of 6 November 2006.

In accordance with data provided by the Ministry of Welfare, in 2012 resources in the amount of LVL 57,072 were used for social rehabilitation of adult persons addicted to psychoactive substances, while LVL 53,856 were used in 2011 and LVL 44,080 — in 2010. In 2012 social rehabilitation services were received by 10 adult persons (in 2011 — by 14 persons and in 2010 — by 15 persons).

In 2012 resources in the amount of LVL 141,011 were used for rehabilitation of children addicted to psychoactive substances, while resources in the amount of LVL 297,450 were used in 2011 and resources in the amount of Ls 257,157 were used in 2010. Social rehabilitation services were received by 52 children in 2012 (by 56 children — in 2011).

### 5.3. Access to treatment

This section describes data reported by the indicator of demand for treatment and by narcological support providers, in the same way as it was described in national reports of previous years. The following subsections describe:

- Historically collected information, which covers a period of time starting from 1980, according to information collected in the national statistical report concerning diagnoses F11–F19, excluding F17 (tobacco),
- Information regarding treated drug users collected by the VIS APANS (Management information system for out-patient service payments) and SPANS (Management information system for in-patient service payments) systems of the National Health Service.
- Data collected with the use of more accurate definitions in accordance with EMCDDA and obtained after bringing together the information contained by PREDA (Register of patients suffering from certain diseases) and APANS systems, so these data can reflect situation in the narcological treatment field more precisely in comparison with previous years.

In 2011 it is planned to launch purposeful preparation for making amendments to the data collection form or register card and structure, which is used for treatment indicator. In 2012, many work group meetings were organized, during which the new data collection card was developed in collaboration with competent experts and approved by the Cabinet of Ministers. The new data collection card will be valid from 1 January 2013.

Data obtained with the new data collection form will allow more accurate monitoring of this field, as well as will extend the possibilities of analysis. Moreover, the planned card amendments and corrected definitions will provide more information to this policy makers and planners, as well as to specialists working in this field for evaluation of the treatment process results, in order to provide argumentation for the necessity to implement certain activities based on knowledge and evidence.

Detailed data concerning each registered drug-addicted patient in Latvia have been collected since 1997, when this register was created. The register card includes socio-demographic information concerning patients (gender, age, nationality, employment, education, place of residence, family structure, characteristic of living conditions), information on diagnosis and on use of substances (used drugs, frequency of use, period of use, type of use), as well as the way of diagnosis determination and the results of treatment. Largely, this information corresponds with the



Treatment Demand Indicator (TDI), which is used in EMCDDA member countries. The obtained data are used annually for international comparison, e.g., for EMCDDA annual reports and for UNODC reports. Several variable data, which are included in the register card, do not coincide with TDI definitions; however, continuous works are performed in order to improve quality of the register data in relation to the number of medical institutions, as well as to the provision of more complete information on patients, etc.

The information on diagnoses, which is included in the PREDA system, is annually reflected by the Centre for Disease Prevention and Control of Latvia (CDPC) in its annual statistical reports and then submitted to the Central Statistical Bureau.

In the national report for 2010 the most significant differences and the required system improvements are described (The Centre of Health Economics, 2010). In 2011–2012, the main part of these non-conformities was solved within the framework of TDI revision and the quality of data will be potentially improved.

### **Characteristics of treated clients (TDI data included)**

In accordance with the statistical report data for this field, in 2012 there were 647 (or 31.8 per 100 thousands of people) primary registration events, i.e., registered patients with diagnoses related to drug abuse<sup>33</sup> for the first time in life. In 199 of these events (9.8 per 100 thousands of people) a diagnosis related to the addiction syndrome or to psychosis was stated (the Centre for Disease Prevention and Control of Latvia, 2013).

In the end of 2012 the registered expansion of psychoactive substances addiction (except for alcohol and tobacco) in Latvia amounted to 3093 events (152.8 per 100 thousands of people), while the expansion of diagnoses related to intoxication or to excessive use of drugs amounted to 1451 events (71.7 per 100 thousands of people).

Within the last years, the most frequently stated diagnosis was related to use of multiple substances (F19) and was registered in 41.9% of primarily registered events in 2012 (in comparison with 37.3% in 2011). The next frequently stated diagnoses are related to use of opiates (F11 — 12.5% (18.2% in 2011), stimulants (F15 — 16.8% (18.9% in 2011)) and cannabinoids F12 — 25.1% (18.4% in 2011). The diagnoses related to use of sedatives (F13) are mentioned in relation to 4.9% (2.2% in 2011) of patients, diagnoses related to use of inhalants (F18) are mentioned in 1.1% of events (2.1% in 2011), while diagnosis related to use of cocaine (F14) is mentioned in relation to two patients.

### **Outpatient treatment (definition used in previous years)**

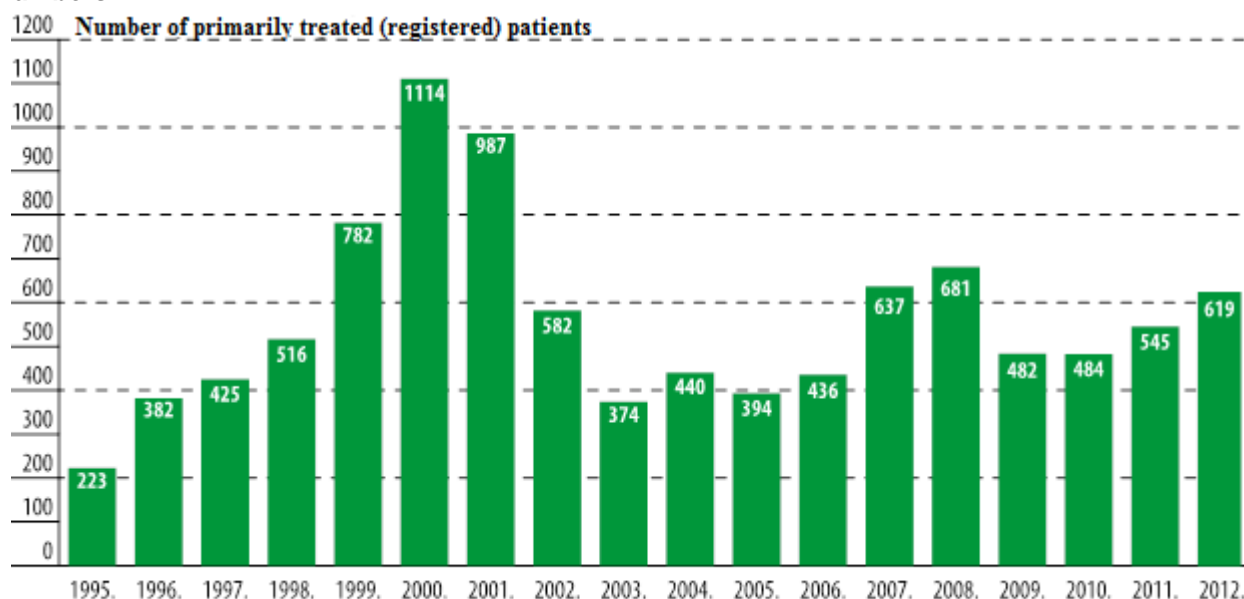
Since the first patient registration in 1976 and up to 31 December 2012 in Latvia 10842 patients are registered with a diagnosis related to intoxication, abuse, and/or addiction of psychoactive substances.

Since 1993/1994, the number of primarily registered patients with diagnoses related to use of psychoactive substances (except for alcohol and tobacco) started to grow significantly. The number of primarily registered patients had achieved its maximum in 2000 and has significantly decreased until 2003, while within the period from 2005 until 2008 the number of these patients increased during each year. The number of primarily registered patients in 2009 decreased significantly in comparison with 2008, while in 2010 it remained constant at the level of 2009. The data obtained for the year 2012 showed evidence of significant increase of the number of primarily treated/registered patients<sup>34</sup>, who had health problems caused by drug use, as the number of such patients increased by 74 persons (or 13.6%) (see Figure 5.1.).

<sup>33</sup> Diagnoses F11–F19, except for F17.

<sup>34</sup> In accordance with the Treatment Demand Indicator. A patient is considered as primarily treated in those cases, when a patient is included in the Register of patients suffering from certain diseases for the first time with one of F11–F19 diagnoses according to ICD-10 (except for F17 — tobacco), with indication of a particular substance. In accordance with the used definition, in the event a patient has been previously treated due to health problems caused by alcohol use and later — due to drug abuse problems, the registration related to drug abuse shall be considered as primary in this context. In accordance with the data obtained from the National Health Service for the years 2007–2011, significant number of patients are registered based on hospital discharge summaries and “signal tickets” obtained

**Figure 5.1. Number of primarily treated (registered) out-patients in the years 1995–2012, in absolute numbers**



Source: Centre for Disease Prevention and Control of Latvia, 2013

From 619 primarily registered patients with health problems related to drug abuse, dynamic and preventive attendance has been provided for 126 persons on the basis of a signal card of expert appraisal, while attendance has been provided for 157 patients based on the information provided in hospital discharge summaries registered in the card. A part of these patients (in accordance with the data included in the VIS APANS system — 159 of primarily registered patients) did not visited a narcologist in an out-patient clinic during 2012.

### Outpatient treatment (new clarified treatment definition)

Considering the fact that the information collected in the PREDA system in Latvia did not exactly correspond with the treatment definition given by EMCDDA and used over the world, as well as the fact that the information concerning drug users treated within a year has not been collected, purposeful work is being performed for many years in order to gather this information in two databases (PREDA and VIS APANS) to ensure more precise definition of a treated patient. In 2012, when the information gathered in these databases was combined, the number of drug users, who were treated during 2007–2012, has been established for the first time. Characteristic features of these patients, in accordance with TDI definition, have also been established. This approach can also be used for analysis of the prospective situation with treated drug users. After the TDI revision process is completely implemented, there are only few changes to be made in data collection schemes in relation to patients treated in 2013. In comparison with the data included in this subsection, the changes performed in the course of revision process will not significantly affect the trends.

A patient shall be considered as a treated person or to be included in the Treatment Demand Indicator data in the event a PREDA card is filled-in for this person AND if an out-patient ticket for this person is registered in the VIS APANS system by an attending narcologist during a calendar year. But in case if only a PREDA card OR a ticket in the VIS APANS system is registered for a patient, this person shall not be considered as treated in an out-patient clinic during this year. In 2012 after performing PREDA data quality control it was discovered, that the data concerning 785 (984 — in 2011) drug users, for whom narcological treatment was funded from the State healthcare budget, was not included in the detailed information contained by the PREDA system. Considering that the mentioned number is significant (approximately, for each third patient), in the

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from expert appraisals — events, when an out-patient visit has not been registered. For representation of out-patient treatment in our country, these cases must not be classified as treatment events. This information has not been considered for comparison of the obtained data with previous years.

future it shall be necessary to implement various mechanisms, which can ensure obtaining of more complete information in the PREDA system, because this system is used for planning of policies and services, as well as for monitoring of the situation.

In accordance with the new treatment definition, in 2012 there were 2187 drug users treated in out-patient clinics, of whom 402 persons received assistance for the first time in life. The collected data show that, in comparison with the year 2011, little increase in the number of annually treated patients is observed (the number of primarily treated patients increased by 16 persons, while the number of annually treated patients increased by 177 persons).<sup>35</sup> The trends observed during five years, concerning annually and primarily treated patients, are reflected in the Table 5.1.

**Table 5.2. Number of out-patients treated within one year and primarily treated in the years 2007–2012, in absolute numbers**

	2007	2008	2009	2010	2011	2012
Treated within one year	1594	1952	1816	1962	2010	2187
Primarily treated	331	386	290	311	386	402

Source: Centre for Disease Prevention and Control of Latvia, 2013

Among patients, who were treated in 2012, **95** people, or at least each forth person (23.6%), were women. Since 2007 the annual trends concerning percentage of primarily treated women remain constant within the range of 23–24%, except for 2008, when only 18.7% among primarily treated patients were women (see Table 5.3.). The percentage of women among annually treated patients is a little lower — in 2012 there were **457** women or 20.9% of patients treated by a narcologist. These indices do not significantly differ from average indices for six years period.

**Table 5.3. Percentage of women among out-patients treated within one year and among primarily treated patients in the years 2007–2012, %**

	2007	2008	2009	2010	2011	2012
Treated within one year	22.3	19.4	20.3	20.5	20.7	20.9
Primarily treated	23.3	18.7	23.1	24.4	23.1	23.6

Source: Centre for Disease Prevention and Control of Latvia, 2013

The average age of primarily treated patients in 2012 is 26.4 years; Significant differences in relation to gender are not observed, the respective age is 26.4 and 26.5 years (see Table 5.4.). The average age of annually treated patients exceeds the average age of primarily treated patients by three years, while the age of patients since 2007 shows a trend to increase.

**Table 5.4. Average age of primarily treated patients and patients treated within one year in the years 2007–2012, by gender**

	2007	2008	2009	2010	2011	2012
Treated within one year						
Total	27.7	27.8	28.5	29.2	30.1	30.0
Men	27.6	27.8	28.5	29.1	30.0	30.1
Women	27.8	27.9	28.6	29.4	30.6	30.0
Primarily treated						
Total	25.5	26.1	26.1	28.3	27.7	26.4
Men	25.5	25.9	25.9	27.0	27.9	26.4
Women	25.5	27.2	26.8	32.0	27.1	26.5

Source: Centre for Disease Prevention and Control of Latvia, 2013

7.2% of primarily treated patients were younger than 15; 26.1% of primarily treated patients were 15–19 years old; 16.9% of primarily treated patients were 20–24 years old; 19.2% of primarily treated patients were 25–29 years old; 13.2% of primarily treated patients were 30–34 years old; 8.7% of primarily treated patients were 35–39 years old, while 8.7% of primarily treated patients

<sup>35</sup> According to previous PREDA quality control results, within one year this system will also include data concerning 200 additionally treated patients, who were treated within previous year. Approximately 30 of these patients are primarily treated.

were older than 40 (see *Table 5.5.*). The data obtained within the last two years (in 2010 and in 2011) show significant increase of the number and percentage of primarily treated patients, who are older than 40 years.

**Table 5.5. Primarily treated patients by age groups in the years 2008–2012, %**

	2008		2009		2010		2011		2012	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Jounger than 15	20	5.2	20	6.9	18	5.8	18	4.7	29	7.2
15–19 years	61	15.8	56	19.3	60	19.3	88	22.8	105	26.1
20–24 years	115	29.8	77	26.6	57	18.3	68	17.6	68	16.9
25–29 years	99	25.6	68	23.4	66	21.2	80	20.7	77	19.2
30–34 years	46	11.9	35	12.1	44	14.1	62	16.1	53	13.2
35–39 years	21	5.4	15	5.2	29	9.3	29	7.5	35	8.7
40 years and older	24	6.2	19	6.6	37	11.9	41	10.6	35	8.7
<b>Total</b>	<b>386</b>	<b>100</b>	<b>290</b>	<b>100</b>	<b>311</b>	<b>100</b>	<b>386</b>	<b>100</b>	<b>386</b>	<b>100</b>

Source: Centre for Disease Prevention and Control of Latvia, 2013

2.0% of treated patients in 2012 were younger than 15 years; 16.0% of treated patients were 15–19 years old; 12.2% of treated patients were 20–24 years old; 22.9% of treated patients were 25–29 years old; 22.5% of treated patients were 30–34 years old; 11.5% of treated patients were 35–39 years old, while 12.8% of treated patients were older than 40 years (see *Table 5.6.*).

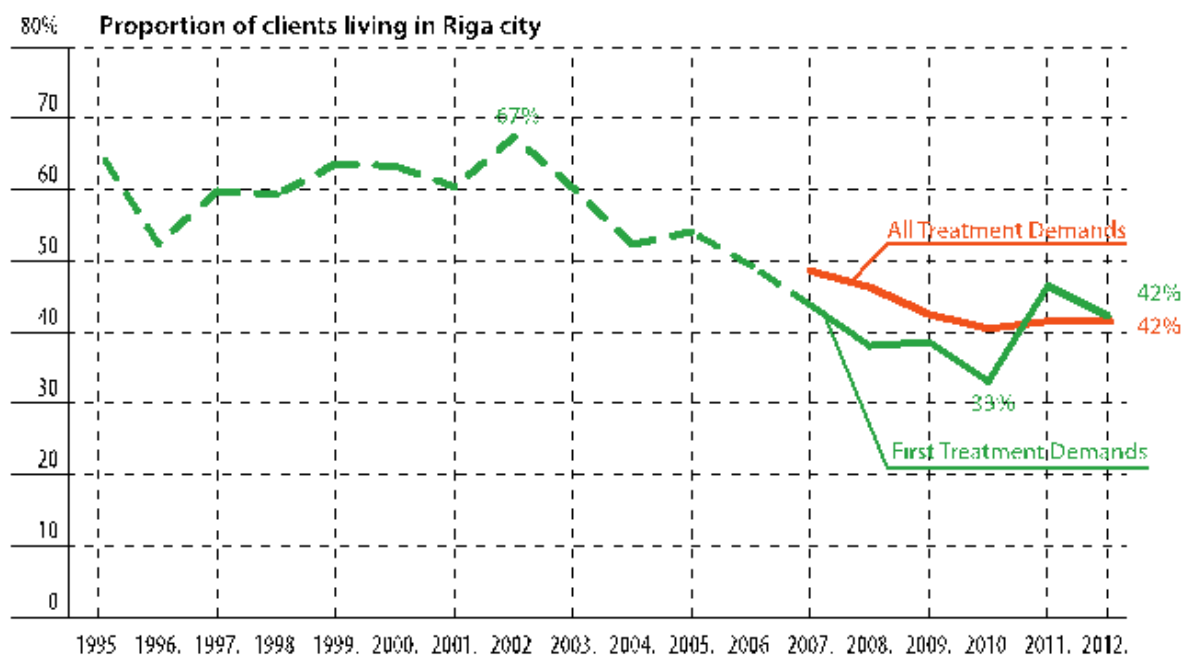
**Table 5.6. Patients treated within one year by age groups in the years 2008–2012, %**

	2008		2009		2010		2011		2012	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Jounger than 15	44	2.3	33	1.8	28	1.4	27	1.3	44	2.0
15–19 years	275	14.1	275	15.1	320	16.3	287	14.3	351	16.0
20–24 years	461	23.6	353	19.4	306	15.6	262	13.0	266	12.2
25–29 years	563	28.8	503	27.7	546	27.8	541	26.9	501	22.9
30–34 years	289	14.8	325	17.9	345	17.6	428	21.3	493	22.5
35–39 years	143	7.3	147	8.1	187	9.5	209	10.4	251	11.5
40 years and older	177	9.1	180	9.9	230	11.7	256	12.7	281	12.8
<b>Total</b>	<b>1952</b>	<b>100</b>	<b>1816</b>	<b>100</b>	<b>1962</b>	<b>100</b>	<b>2010</b>	<b>100</b>	<b>2010</b>	<b>100</b>

Source: Centre for Disease Prevention and Control of Latvia, 2013

In 2012 the percentage of patients, who were primarily treated in out-patient clinics outside of Riga, showed a little increase in comparison with the results of 2011. 46% of primarily treated patients lived in Riga in 2011, while 42% of such patients lived in Riga in the 2012. The highest percentage of treated patients living in Riga was observed in 2002, while since that time significant increase of primarily treated patients living outside of Riga was observed. In accordance with the analysed data concerning annually treated patients, it was observed for the last three years that the percentage of patients living in Riga remains constant (within the range of 41–43%). However, the percentage is significantly lower than in 2007 (49%) (see *Figure 5.2.*).

**Figure 5.2. Percentage of primarily treated patients and patients treated within one year, in Riga (%), in the years 1995–2012**

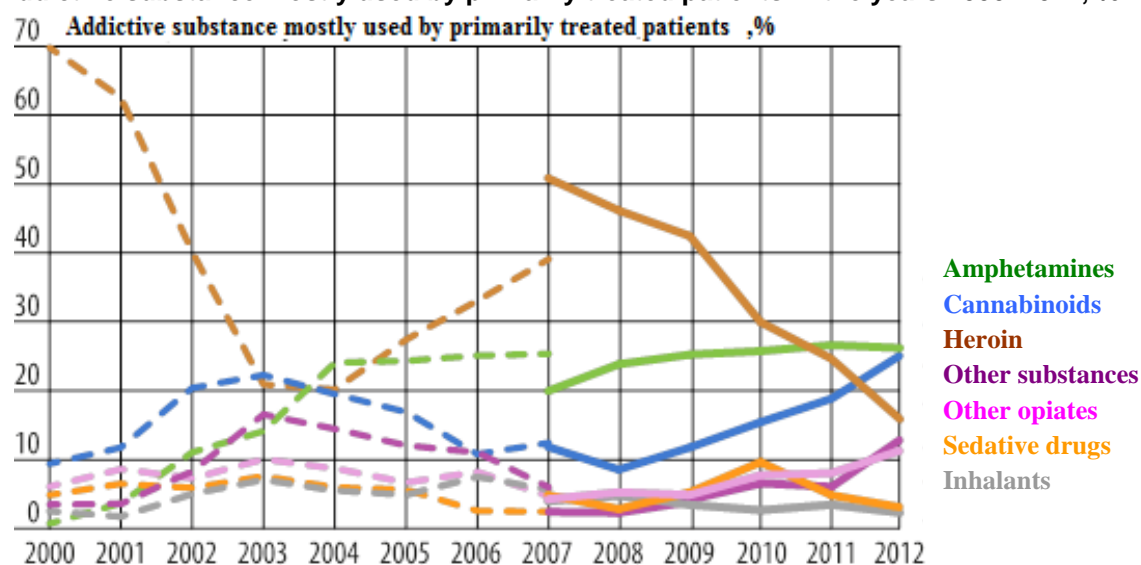


Source: Centre for Disease Prevention and Control of Latvia, 2013

The data obtained in the year 2012, concerning mainly used drugs among primarily treated patients, show that amphetamine is the most frequently used substance (in 107 patients, or 26.6%). Cannabinoids are indicated as the mainly used drugs similarly (in 106 patients, or 26.4%), while heroin as the mainly used drug is indicated for 61 patient (or 15.2%). Other substances have been mentioned less frequently than for each tenth patient.

41 patients (or 10.2%) have primarily used other opioids (mainly — *khanka*<sup>36</sup>), 14 patients (or 3.5%) have used sedative or somnifacient drugs, 13 patients have used inhalants, 5 patients have used other stimulants (except for amphetamine, 3 patients have used LSD or other hallucinogens, 2 patients have used methadone, 2 patients have used cocaine and 1 patient has used ecstasy (or MDMA). The primarily used substance has not been clarified in 39 patients (or 9.7%), while the used drug was not indicated in 7 patients. The percentage of primarily treated users of various substances is represented in the Figure 5.3.

**Figure 5.3. Addictive substance mostly used by primarily treated patients in the years 2000–2012, %**



Source: Centre for Disease Prevention and Control of Latvia, 2013

<sup>36</sup> An opiate prepared from poppy in domiciliary conditions.

According to the data obtained in 2012 concerning primarily used drugs among annually treated patients<sup>37</sup>, heroin is the most frequently mentioned drug (in 789 patients or 36.1%), alternatively to the information concerning primarily treated patients, while amphetamines are indicated as the primarily used drugs in 426 patients (or 19.5%). Various cannabinoids are indicated as the primarily used drugs in 314 patients (or 14.4%), while other opioids are indicated in 250 patients (or 11.4%). Other substances have been mentioned less frequently than for each tenth patient.

109 patients (or 5.0%) have primarily used sedative or somnifacient drugs, 73 patients have used inhalants, 14 patients have used LSD or other hallucinogens, 32 patients have used methadone, 6 have used cocaine, 50 patients have used other stimulants (except for amphetamine). The primarily used substance has not been precisely indicated in 85 patients (or 3.9%), while the used drug was not indicated in 39 patients. The percentage of annually treated users of various substances is represented in the Table 5.7.

**Table 5.7. Addictive substance mostly used by patients treated within one year in 2007–2012, %**

	2007	2008	2009	2010	2011	2012
Heroin	49.5	46.0	42.8	40.4	39.8	36.1
Amphetamines	12.9	15.2	16.7	18.7	18.9	19.5
Other opiates	13.2	12.5	12.6	12.1	12.2	12.9
Cannabinoids	7.7	8.8	10.5	11.4	11.5	14.4
Other substances	6.1	5.9	6.4	5.8	6.2	7.1
Sedative drugs	4.4	4.4	4.7	5.8	5.4	5.0
Inhalants	4.6	4.4	4.0	4.0	4.1	3.3
Not known	1.6	2.8	2.4	1.9	1.9	1.8

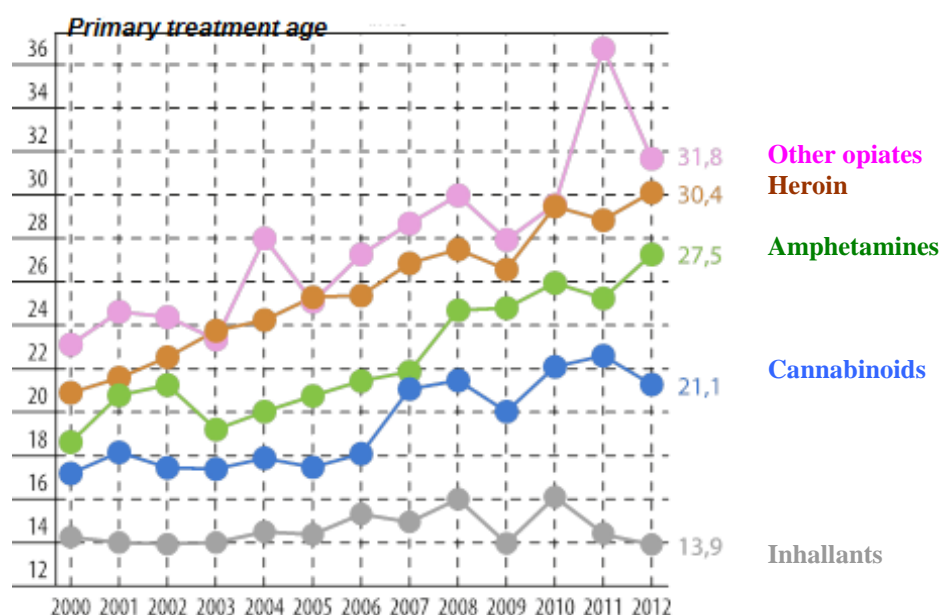
Source: Centre for Disease Prevention and Control of Latvia, 2013

In accordance with treatment data, the primary treatment/registration age is different in users of various drugs. For example, users of inhalants, who have been treated for the first time, were significantly younger (their average age is 13.9 years) in comparison with users of other substances (in accordance with the data obtained in 2012). Users of cannabinoids were primarily treated in significantly older age (21.1 years), they are followed by users of amphetamines (primarily treated in 27.5 years age), then — by heroin users (primarily treated in 30.4 years age), while users of other opioids are the older ones (primarily treated in 31.8 years age).

Practically, in accordance with data observed within the last years, the age of primarily treatment for users of all substances has a tendency to grow (see *Figure 5.4*). This tendency may give evidence for the fact, that drug users seek for help from the healthcare system only in those cases, when they already have relatively serious problems related to drug use. Therefore, the healthcare system is not able to detect drug users of younger age, when it could be relatively easier to treat them.

<sup>37</sup> For interpretation of these results it must be considered, that for several patients the information may be not updated in the PREDA system.

**Figure 5.4. Average age of primarily treated drug users, by mostly used substances in 2000–2012**



Source: Centre for Disease Prevention and Control of Latvia, 2013

## Education

Among patients, who were primarily treated in 2012, incomplete primary education was indicated for 18% (or 71 patients), primary education was indicated for 35% (or 141 patient), 29% (or 116 patients) had obtained secondary education, while only 3% (or 11 patients) had obtained higher education. For 16% (or 63 treated patients) the education level was not specified. Relatively smaller percentage of men has education level lower than primary education, in comparison with educated women (respectively, 26% and 15%). There are no significant differences in relation to education level observed in comparison with the year 2011.

## Family status

43% (or 173) of primarily treated drug users live with their parents, 9% (38) live with a partner without children, 7% (28) live with a partner and with children, 8% (33) live alone, while 2% (8) live in one parent families with one child or with several children. For 13% of patients other kind of family status has been indicated, while for 17% of patients this information has not been specified.

## User profile for different addictive substances

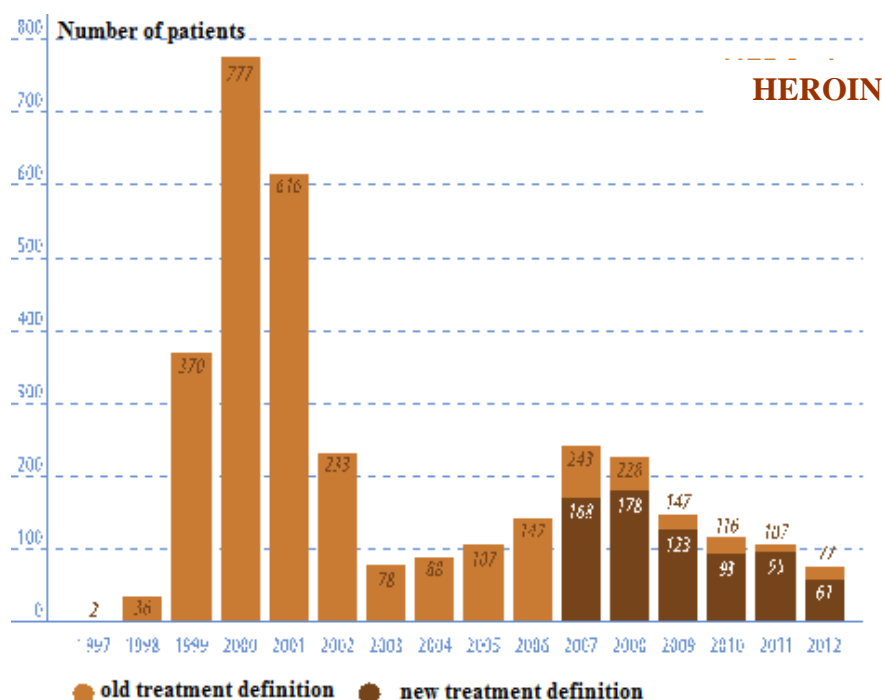
This section includes information concerning the user profile for three most often used substances, such as heroin, amphetamine, and marihuana/hashish (or cannabinoids), in accordance with information obtained by the healthcare data collecting system. Tendencies and changes related to use of these substances since 1997 will also be described in this section.

### Heroin

In accordance with healthcare data (PREDA), since 1997 there have been registered (treated) 3367 primary patients, for whom heroin was indicated as the primary used substance during the first treatment episode. The greatest number of primary heroin users has been registered in the year 2000 (777 patients).



**Figure 5.5. Number of primarily treated (registered) primary heroin users in the years 1997–2012**



Source: Centre for Disease Prevention and Control of Latvia, 2013

In 2012 the average age of primary heroin users was 30.3 years (standard deviation — SD 6.1). The average age of women, who visited a narcologist for a first time, was a little higher than the age of men in similar cases, respectively, 30.8 years (SD 9.9) and 30.2 years (SD 5.0) (see tendencies in the Figure 5.4.). In 2012 the younger primarily treated heroin user was in the age of 17 years, while the older heroin user was in the age of 48 years.

In 2012 among treated primary heroin users 18% were women, while 82% were men. Among registration events the number of primary heroin users accounted for 20.8%. The Table 5.8. represents classification of primarily treated primary heroin users by gender since 2007.

**Table 5.8. Percentage of women among out-patients treated within one year and among primarily treated out-patients — heroin users in 2007–2012, %**

	2007	2008	2009	2010	2011	2012
Treated within one year	22.8	19.5	20.5	20.7	21.1	20.3
Primarily treated	21.4	19.7	25.2	17.2	19.0	18.0

Source: Centre for Disease Prevention and Control of Latvia, 2013

Diagnosis related to use of opiates (ICD-10 F11) was determined in little more cases than for each second (57.4%) primarily treated heroin user, while for other patients (42.6%) diagnosis related to use of multiple substances (ICD-10 F19) was determined. As it is represented in the Table 5.9. below, the most of primarily treated heroin users have an addiction-related diagnosis. However, within the previous years, the percentage of such patients slightly decreased and this fact cannot be definitely explained.

**Table 5.9. Diagnoses groups and percentage of diagnoses related to addiction syndrome among primarily treated out-patients — heroin users in the years 2007–2012, %**

	2007	2008	2009	2010	2011	2012
F11	69.9	71.9	69.9	79.6	56.8	57.4
F19	30.4	28.1	30.1	20.4	43.2	42.6
Total	100	100	100	100	100	100
Of which the percentage of addiction related diagnoses is	98.8	98.9	93.5	93.6	92.6	91.8

Source: Centre for Disease Prevention and Control of Latvia, 2013

In 2012 the absolute majority (93.4%) of treated heroin users use this substance in injection form, while for other treated heroin users the information concerning the form of drug use is not specified. Similar situation concerning forms of heroin use was observed within previous years. During each year, drug use form has been specified for several patients (smoking or sniffing of drugs). However, there are a small number of persons, who indicated such information, e.g., 3 patients in 2012, no one in 2011 and 2 patients in 2010.

In accordance with the PREDA system data for 2012, 72.1% of primarily treated heroin users had used this substance each day, while 6.6% of patients had used this substance 2–6 days a week. 9.8% of patients — once a week, 9.8% did not use this drug within the last 30 days, while for one patient the frequency of heroin use is not specified.

**Table 5.10. Frequency of heroin use in primarily treated out-patients — primary heroin users in 2007–2012, by gender, %**

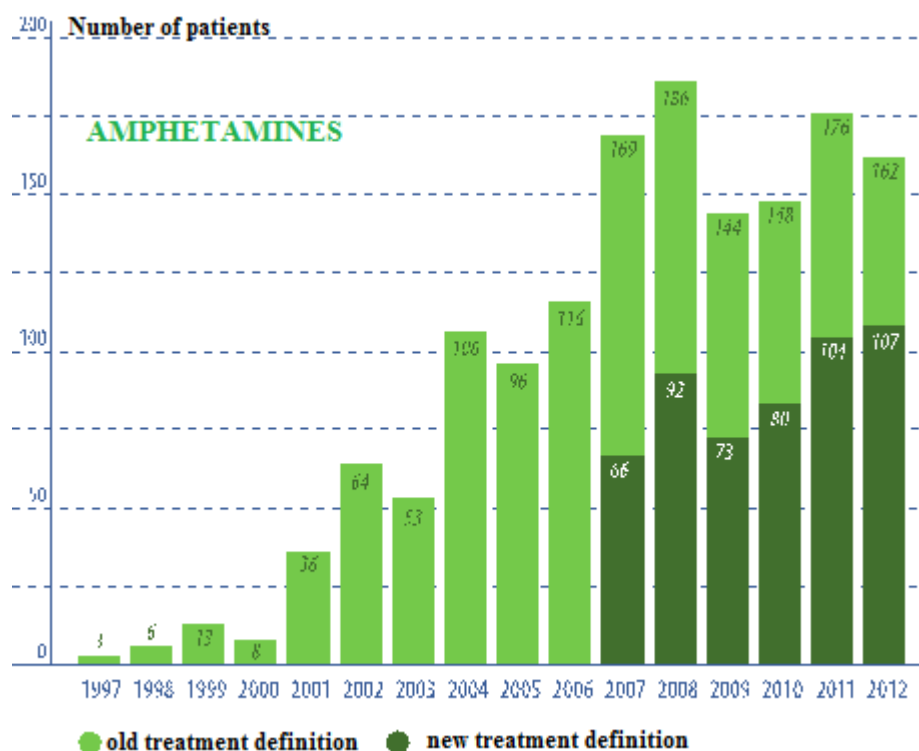
	2007		2008		2009		2010		2011		2012	
	M	W	M	W	M	W	M	W	M	W	M	W
Not used within the last 30 days	0.0	0.0	0.0	0.0	0.0	3.3	5.2	12.5	2.6	0.0	8.0	18.2
Once a week or more rarely	0.8	0.0	0.7	0.0	4.4	6.5	2.6	6.3	5.2	0.0	12.0	0.0
2–6 times a week	7.6	5.6	4.9	5.7	13.0	29.0	20.8	6.3	20.8	16.7	6.0	9.1
Each day	84.9	91.7	90.9	88.6	77.2	61.3	62.3	68.8	71.4	72.2	72.0	72.7
Non specified	6.8	2.8	3.5	5.7	5.4	0.0	9.1	6.3	0.0	11.1	2.0	0.0

Source: Centre for Disease Prevention and Control of Latvia, 2013

### Amphetamines

In accordance with healthcare data (PREDA), since 1997, there have been registered (treated) 1486 primary patients, for whom amphetamines have been indicated as the primary used substance during the first treatment episode. The greatest number of primary amphetamine users has been registered in 2008 (186 patients).

**Figure 5.6. Number of primarily treated (registered) primary amphetamine users in 1997–2012**



Source: Centre for Disease Prevention and Control of Latvia, 2013

In 2012 the average age of **treated** primary amphetamine users was 27.5 years (SD 7.7). The average age of women, who visited a narcologist for the first time, was a little lower than the age of men in similar cases, respectively, 25.5 years (SD 6.5) and 28.3 years (SD 8.0) (see tendencies in the Figure 5.6.). In 2012, the younger primarily treated amphetamine user was in the age of 16 years, while the older heroin user was in the age of 52 years.

In 2012 among **treated** primary amphetamine users 29.9% were women, while 70.1% were men. Among **registration** events the number of primary heroin users accounted for 24.1%. The Table 5.11. shows classification of primarily treated primary amphetamine users, classified by gender since 2007.

**Table 5.11. Percentage of women among out-patients treated within one year and among primarily treated out-patients — amphetamine users in 2007–2012, %**

	2007	2008	2009	2010	2011	2012
Treated within one year	21.8	20.6	22.8	22.3	22.4	24.4
Primarily treated	27.3	20.7	23.3	27.5	29.8	29.9

Source: Centre for Disease Prevention and Control of Latvia, 2012

In 2012 diagnosis related to use of stimulants (ICD–10 F15), was determined for approximately two thirds (63.6%) of primarily treated amphetamine users, while for other patients (36.5%) diagnosis related to use of multiple substances (ICD-10 F19) was determined.

As it is represented in the Table 5.12. below, the addiction diagnosis was determined for approximately each third of primarily treated amphetamine users in 2012. However, percentage of patients with the addiction diagnosis has been very unstable since the year 2007.

**Table 5.12. Diagnoses groups and percentage of diagnoses related to addiction syndrome among primarily treated out-patients — amphetamine users in the years 2007–2012, %**

	2007	2008	2009	2010	2011	2012
F11		1.1			1.9	
F15	60.6	57.6	48.0	60.0	48.1	63.6
F14		2.2				
F19	39.4	39.1	52.0	40.0	50.0	36.5
Total	100	100	100	100	100	100

Source: Centre for Disease Prevention and Control of Latvia, 2013

Approximately a half of amphetamine users (50.5%) use this substance in injection form, 13.1% of patients use it with food or drinks, 26.2% of patients sniff amphetamine, while information concerning the form of use is not specified for 10.3% of primary amphetamine users. In 2011 the percentage of patients, who use amphetamine in injection form, was 46.2%, in 2010 the respective percentage was 47.5%, in 2009 the percentage was 64.4%, in 2008 the percentage was 73.9%, while in 2007 the percentage was 71.2%.

In accordance with the PREDA system data obtained for the year 2012, 9.4% of primarily treated amphetamine users had used this substance each day, 30.8% of patients had used this substance 2–6 days a week, 29.9% of patients — once a week. 15.9% had not use this drug within the last 30 days, while for 15 patients (14.0%) the frequency of amphetamine use is not specified. Among treated amphetamine users, women use the primary substance more often than men do (53% of women in comparison with 44% of men use amphetamines 2–6 times a week or each day). However, in terms of numbers, the number of treated women is small and there differences are not statistically significant.

**Table 5.13. Frequency of amphetamine use in primarily treated out-patients — primary amphetamine users in 2007–2012, by gender, %**

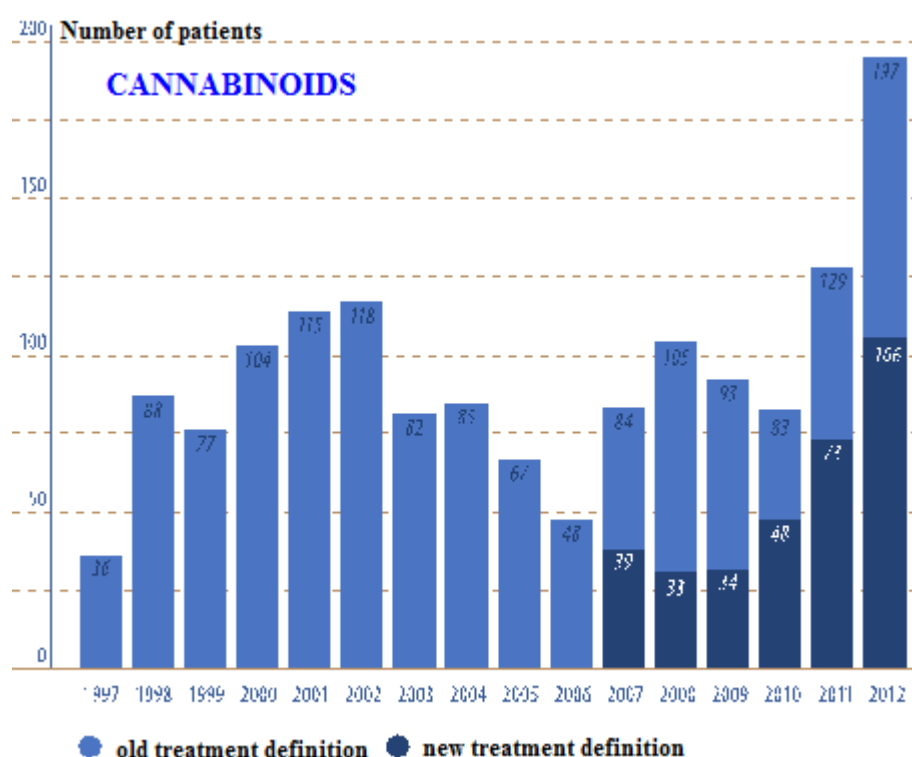
	2007		2008		2009		2010		2011		2012	
	M	W	M	W	M	W	M	W	M	W	M	W
Not used within the last 30 days	0.0	0.0	1.0	0.0	1.8	0.0	3.5	9.1	5.5	6.5	17.3	12.5
Once a week or more rarely	6.3	27.8	13.7	31.6	26.8	5.9	12.1	9.1	35.6	29.0	29.4	31.3
2–6 times a week	25.0	16.7	16.4	10.5	30.4	11.8	31.0	27.3	35.6	29.0	28.0	37.5
Each day	33.3	33.3	35.6	31.6	16.1	47.1	22.4	40.9	6.9	19.4	8.0	12.5
Not specified	35.4	22.2	32.9	26.3	25.0	35.3	31.0	13.6	16.4	16.1	17.3	6.3

Source: Centre for Disease Prevention and Control of Latvia, 2013

### Cannabinoids

In accordance with healthcare data (PREDA), since 1997 there have been registered (treated) 1511 primary patients, for whom cannabinoids were indicated as the primary used substance during the first treatment episode. The greatest number of primary marihuana/hashish users has been registered in 2012 (197 patients).

**Figure 5.7. Number of primarily treated (registered) primary cannabinoids users in 1997–2012**



Source: Centre for Disease Prevention and Control of Latvia, 2013

In 2012 the average age of **treated** primary marihuana/hashish users was 21.1 years (SD 6.8). The average age of women, who visited a narcologist for the first time, was lower than the age of men in similar cases, respectively, 17.9 years (SD 5.2) and 21.4 years (SD 6.9) (see *tendencies in the Figure 5.4*). In 2012, the younger primarily treated user of cannabinoids was in the age of 12 years, while the older heroin user was in the age 44 years.

In 2012 among the **treated** primary marihuana/hashish users 10.4% were women, while 89.6% were men. Among **registration** events the number of primary marihuana/hashish users accounted for 11.7%. The Table 5.14. represents classification or primarily treated primary cannabinoids users by gender since 2007.

**Table 5.14. Percentage of women among out-patients treated within one year and among primarily treated out-patients — marihuana/hashish users in 2007–2012, %**

	2007	2008	2009	2010	2011	2012
Treated within one year	10.7	11.6	14.2	9.9	7.3	9.2
Primarily treated	10.3	6.1	9.1	10.4	6.9	10.4

Source: Centre for Disease Prevention and Control of Latvia, 2013

In 2012 a diagnosis related to use of cannabinoids (ICD–10 F12), was determined for approximately two thirds (70.8%) of primarily treated marihuana/hashish users, while for other patients (29.2%) a diagnosis related to use of multiple substances (ICD-10 F19) was determined. As it can be viewed in the Table 5.15. below, the addiction diagnosis was determined for approximately each sixth (17.0%) of primarily treated users of cannabinoids in 2012. However, percentage of patients with the addiction diagnosis has been very unstable since the year 2007.

**Table 5.15. Diagnoses groups and percentage of diagnoses related to addiction syndrome among primarily treated out-patients — cannabinoids users in the years 2007–2012, %**

	2007	2008	2009	2010	2011	2012
F12	64.1	78.8	64.7	66.7	72.6	70.8
F11					1.4	
F15				2.1		
F19	35.9	21.2	35.3	31.2	26.0	29.2
Total	100	100	100	100	100	100
Of which the percentage of addiction related diagnoses is	20.5	48.9	38.2	29.2	19.2	17.0

Source: Centre for Disease Prevention and Control of Latvia, 2013

In 2012 the absolute majority (86.8%) of treated marihuana users had used this substance in smoking form, while for other treated marihuana users the information concerning the form of drug use is not specified.

### Clients in long-term pharmacotherapy using methadone

As a positive tendency observed in 2012 and within the previous years, increase of the number of patients involved in the methadone programme must be mentioned. However, in terms of geographical coverage no changes have been observed. The amendments to normative acts, which were made in 2011, prescribe that the methadone programme shall be continued also for patients in places of detention. In spite of the changes performed during the previous years, the number of patients, who are treated in the methadone (and buprenorphine) programme, is still the lowest among the EU member states when expressed in absolute figures, as well as when viewed as a proportion to the number of inhabitants or to the number of opioids users.

In the end of 2012 within the long-term pharmacological programme for treatment of opioids addiction 355 patients were treated, of whom 278 patients were treated in methadone programme, while 77 patients were treated in the buprenorphine programme. For comparison, 218 patients were treated in the methadone programme in the end of 2011, while 59 patients were treated in the buprenorphine programme.

In the end of 2012 methadone cabinets were working in 9 treatment places, while buprenorphine programmes were working in 8 treatment places.

In Latvia the methadone programme was launched in 1996, while the buprenorphine programme was launched in 2005. In spite of the fact, that the methadone programme was launched practically in-parallel with similar activities in various Western- and Eastern European countries (e.g., in

France the methadone programme was launched in 1995, in Norway it was launched in 1998, in Belgium — in 1994), development of this programme was limited. In accordance with the information gathered by EMCDDA, currently the highest percentage of opioids users, who are treated within pharmacological treatment programmes, (approximately 70% of users) has been observed in Norway, while in Latvia the lowest percentage of such patients has been observed (approximately 2–3%) (according to EMCDDA, 2013). In those countries, where a significant number of opioids users are treated, there are various strategies designated for lowering of social expenses, which may occur as a result of drug use. The strategies are as follows: 1) State-funded buprenorphine programme has been established, 2) pharmacotherapy programmes have been implemented as a part of primary health care, and 3) heroin replacement therapy programmes have been implemented.

In the context of legislation, the drug replacement therapy is regulated by the Sections 61–65 of the Medical Treatment Law, as well as by the Cabinet Regulation No. 70, "Procedure for the treatment of patients addicted to alcohol, drugs, psychotropic, or toxic substances, gambling or computer games" of 24 January 2012, as well as by the Cabinet Regulation No. 175 "Regulations for manufacture and storage of prescription forms, as well as writing out and storage prescriptions" of 8 March 2005. The therapy is also regulated by the Cabinet Regulation No. 441 "Procedures for the purchase, receipt, storage, distribution, dispensation, accounting and destruction of narcotic and psychotropic substances and medicinal products in manufacturing of medicinal products and veterinary medicinal products, at drug and veterinary drug wholesalers and pharmacies" of 17 June 2008. There are also two technological regulations registered in the National Health Service database — "Medical technology for the methadone replacement therapy" and "Medical technology for the use of buprenorphine for treatment of patients addicted to opioids".

The following structures are involved in the implementation of long-term pharmacotherapy with the use of methadone or buprenorphine:

- Narcologists (the methadone programme involves only those narcologists, who have contractual relationships with the National Health Service);
- Certified doctors of other specialties, who are familiar with this method;
- Medicine specialists working in places of detention, in case if treatment of a prisoner (in the methadone programme) had been started outside a place of detention;
- A multi-professional rehabilitation team is working in methadone replacement therapy cabinets: narcologist + medical nurse + psychologist;
- Riga Centre of Psychiatry and Addiction Disorders (RPNC) ensures registration of patients included in the methadone and buprenorphine long-term pharmacotherapy programmes.

In the financial context, the methadone programme is funded by the State (the amount of financing is determined by the Cabinet Regulation No. 1046 "Health care organization and financing procedure" of 19 December 2006). The buprenorphine programme is not funded by the State budget, as buprenorphine is not included in the list of compensable medical preparations. Within the previous years, due to increase of the number of methadone programme patients, it has been observed that queues for involving of patients in the programme are gradually implemented. Currently the waiting period in the queue for joining the programme is relatively small, as it usually does not exceed some weeks. However, considering the low percentage of opiates users in the programme, while this programme has been extended, the implementation of queues may become important and this situation may grow out of control (as it can be noticed from practical experience in other countries), because such queues are developed within many years. Again, this fact may significantly worsen the public health in general.

As it has been mentioned in a presentation included in the ATOME project, there are two kinds of weak points in relation to implementation of replacement therapy programmes — the existing weak points in relation to legislation and financing may encumber significant expansion of the programme (by various thousands of patients):

#### Legislation

- Diagnosis can be determined only by a certified narcologist
- Mandatory council of physicians is required in order to launch treatment programmes

- Patient must visit a council of physicians at least several times within a year
- Treatment with buprenorphine and methadone cannot be started in places of detention
- Buprenorphine card is required for writing-out buprenorphine without a special prescription
- Prescription for buprenorphine can be written-out for a patient no more than twice in a month
- Card and a prescription (passport?) must be represented in a pharmacy in order to receive buprenorphine
- Discrepancies and contradictions in the Section 34 of the Cabinet Regulation No. 70 (councils of physicians not only in Riga), as well as in the Section 4 of the Cabinet Regulation No. 175 (one council of physicians in RPNC is mentioned)

### Financing

- Quotas for financing of the methadone programme, low price for the manipulation No. 60012 (0.69 Ls)
- Buprenorphine is not included in the list of compensable medical preparations (approximate expenses for a patient within 1 month amount to LVL 136)
- Travel costs required for a patient in order to receive methadone (especially in rural regions)

Currently there are various discussions among healthcare professionals in relation to the necessity of significant changes, which are to be performed for expansion of accessibility of the methadone and buprenorphine programmes. These changes would increase the price of methadone manipulation, as well as provide a possibility to include buprenorphine in the list of compensable medical preparations and to expand coverage of the programmes, which are to be implemented in the low threshold (or HIV prevention) points, as well as to involve municipal social services (e.g., for compensation of travel expenses), to ensure closer cooperation and integration of the programmes in ART programmes, etc.

### *Methadone patients in Latvia*

Riga Centre of Psychiatry and Addiction Disorders (RPNC) is responsible for registration of methadone patients in Latvia. This information is not registered in particular details in the electronic database, and for this reason the possibilities of data analysis are quite limited.

This section has been written and the data have been analysed based on information obtained from the National Health Service (NHS) database (VIS APANS) concerning patients treated in out-patient clinics. This database contains general information provided by medical institutions in relation to patients — their identity code, gender, date of birth, diagnosis, manipulation code<sup>38</sup>, in accordance with financing rules. The size of a methadone dose provided to a patient is not specified in the database, however, the registered information allows clarifying the number of days, during which a patient has received this preparation in an out-patient clinic. In order to obtain detailed information concerning patients, the data have been combined with the PREDA system, which includes detailed patient information, e.g., a period of drug use and socially demographical characteristics of patients. However, during interpretation of obtained results it is especially important to consider the fact, that the information contained by the PREDA system is not always updated and the discovered problems are not always reflected in national reports for previous years (The Health Economics Centre, 2010, Pugule et al., 2009).

In accordance with the state statistical report data for 31 December 2012, there have been 278 patients treated within 9 methadone programs. 53 (or 19.1%) of these patients were women (the Centre for Disease Prevention and Control of Latvia 2013). 82 patients were involved in the methadone programme for the first time (65 men and 17 women) during 2012, while 39 patients have interrupted their treatment (see Table 5.16.) The most of patients were registered in the programme administered by RPNC in Riga, where 161 patients were treated in the end of 2012. In other cities, the number of patients treated in methadone programmes was significantly smaller, as it is represented in the Figure 5.8.

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<sup>38</sup> Methadone distribution manipulation code is 60012.

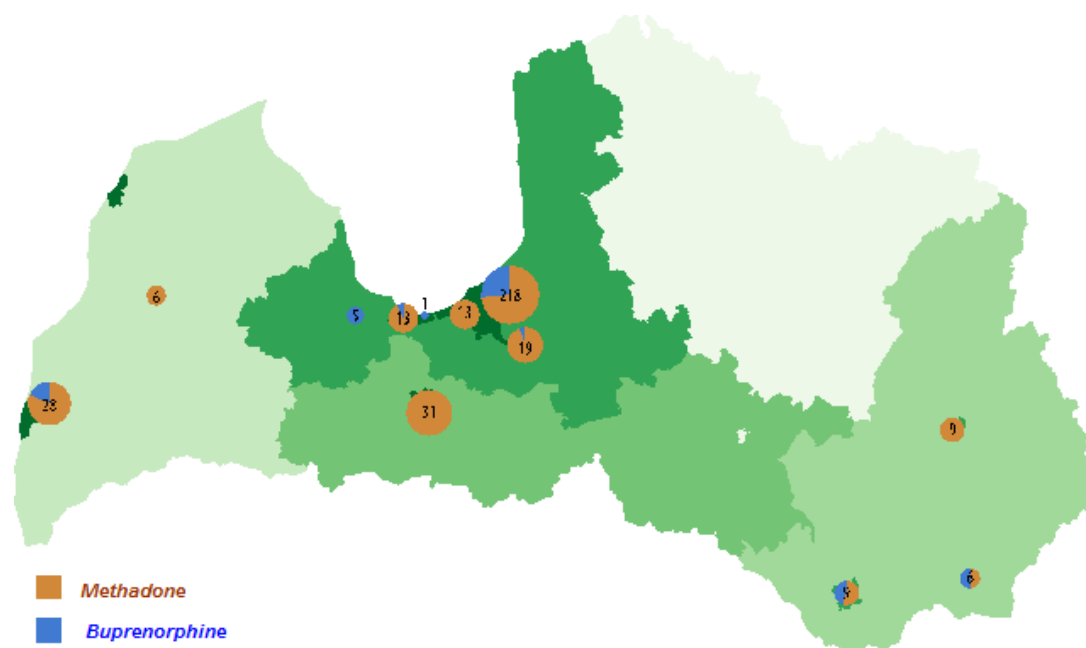


**Table 5.16. Number of patients treated with pharmacologic therapy for opioids addiction in 2007–2012**

		Patients included in the program during one year				Stopped participation during the year			Included in the program during the year			Remained in the program at the end of the year		
		Total	First time in life			T	W	M	T	W	M	T	W	M
Methadone	2012	121	82	17	65	39	7	32	338	68	270	278	53	225
	2011	101	54	11	43	68	15	53	307	58	249	218	43	175
	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	2012	26	23	3	20	12	2	10	n.a	n.a	n.a	77	13	64
	2011	20	17	4	13	7	2	5	n.a	n.a	n.a	59	12	47
	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 <sup>39</sup>	16	55	n.a	n.a	n.a	59	11	48
Total	2012	147	105	20	85	66	17	49	n.a	n.a	n.a	355	66	289
	2011	121	71	15	56	75	17	58	n.a	n.a	n.a	277	55	222
	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 for Disease Prevention and Control of Latvia, 2013; calculation in accordance with VNC APANS data

**Figure 5.8. Location of methadone and buprenorphine programmes in Latvia and number of their participants at the end of 2012**



Source: Centre for Disease Prevention and Control of Latvia, 2013

<sup>39</sup> 53 of them are Finnish patients (11 women and 42 men), who were excluded from the program.

In accordance with the National Health Service data (manipulation code 60012), 338 patients have received methadone in 2012. 187 (or 55.6%) of these patients have participated in the programme without interruption, practically during all calendar year (358 and more manipulations). 270 (79.9%) men and 68 (20.1%) women have participated in the programme during one year.

The average age of methadone patients was 34.0 years (SD 7.7). In 2012 the younger methadone treated patient was in the age of 20 years, while the older patient was in the age of 59 years. Among patients included in the methadone programme during 2012, women were a little younger than men, however, these differences are not statistically significant — respectively, their age was 32.9 (SD 7.9) and 34.3 (SD 7.7) years.

**Table 5.17. Age of patients treated in methadone programme within one year in 2008–2012 (%)**

	2008	2009	2010	2011	2012
Younger than 20	0.0	0.0	0.4	0.3	0.0
20–24 years	12.1	8.0	7.1	5.7	4.5
25–29 years	29.5	38.0	36.0	33.0	27.0
30–34 years	18.2	21.5	26.9	30.0	34.6
35–39 years	8.3	6.7	9.1	11.4	15.2
40–44 years	9.8	9.2	7.1	5.5	6.0
45–49 years	11.4	8.0	5.9	7.5	7.2
50–54 years	8.3	6.1	5.1	4.0	3.6
55–59 years	2.3	1.8	2.0	2.5	2.4
60–64 years	0.0	0.6	0.4	0.3	0.0
Average age (standard deviation — SD)	34.6 (9.8)	33.3 (9.3)	33.0 (8.5)	33.5 (8.6)	34.0 (7.7)

Source: Calculation according to the National health Service VIS APANS data, 2013

Of 338 patients, for whom at least one manipulation related to the methadone programme was performed during 2012, 192 (56.9%) patients live in Riga<sup>40</sup>, 4 patients live in Daugavpils, 9 — in Jelgava, 11 — in Jūrmala, 25 — in Liepāja, 31 — in the Riga district, while other patients live in other regions or cities of Latvia. In 2012, approximately 10 patients located in places of detention have been treated within the methadone programme.

In accordance with VNC APANS data, 110,652 doses of methadone were provided and compensated for methadone programme patients during 2012 (for comparison: 74,856 doses in 2011; 62,201 doses in 2010; 39,571 doses in 2009 and 29,903 doses in 2008). In Latvia the size of methadone dose is determined individually for each patient by a treating physician. The dosage size can be changed during the treatment process; however, information concerning dosage sizes is not registered in our country. Several healthcare institutions, for example, RPNC in Riga, have implemented an electronic system for distribution of methadone, so it is possible to perform analysis of dosage sizes.

In 2012 the direct expenses in relation to the methadone programme amounted to 130.1 thousands of lats (185.1 thousands EUR) (for methadone distribution manipulations) and 73.9 thousands of lats (105.2 thousands EUR) (fixed budget for implementation of the programme). In accordance with the National Health Service data, 10 narcologists and 2 psychologists were involved in implementation of methadone programmes in 2012. The budget provided for implementation of the methadone programme has been almost doubled since 2010, as the fixed budget amounted to 35.7 thousands of lats (51 thousands EUR) and the costs of manipulations amounted to 80.0 thousands of lats (113.8 thousands EUR).

<sup>40</sup> According to the registered place of residence (ATVK code).

## 6. Health correlates and consequences

Drug-related infectious diseases and drug-related deaths and mortality of drug users are two most essential indicators presenting extensive information concerning drug-related health correlates and consequences. During the past three years, there have not been observed any major changes in prevalence of HIV. The lack of such changes might be explained by the presence of needle exchange consultative points, which play an important role in reduction of spread of infectious diseases. At the moment one of the greatest issues is the changes of HIV transmission route; previously HIV was mainly acquired through injecting drugs while at present it has changed to heterosexual transmission route.

There is still a large number of the so-called hidden hepatitis B and C cases in the country, and the actual number of infected persons, including drug users, is much bigger. At the moment there are no data on other drug-related sexually transmitted diseases available.

Drug-related mortality is a complex phenomenon, which accounts for a considerable percentage of 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 with two components at present: deaths directly caused by illegal drugs (drug-induced deaths) and mortality rates among problem drug users.

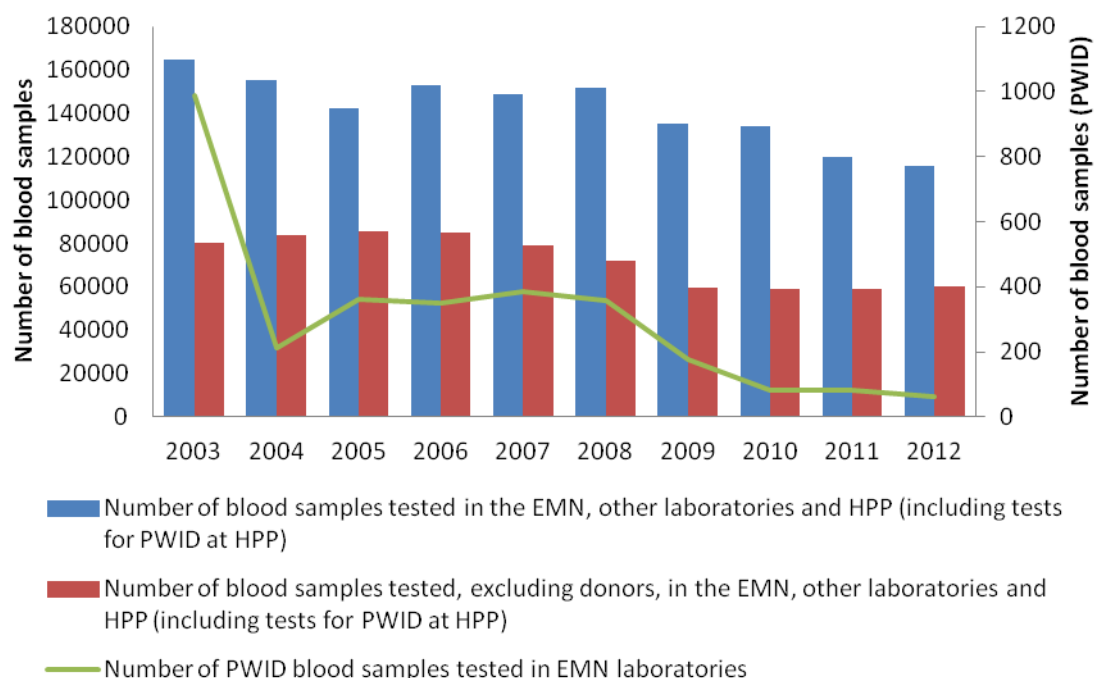
### 6.1. Drug-related infectious diseases

#### Notifications data

##### HIV/AIDS

According to information collected and provided by the Centre for Disease Prevention and Control of Latvia (CDPC) in the Epidemiological Monitoring Network (EMN) and other laboratories, as well as HIV Prevention Points (HPP, called also syringe exchange points), 115,744 blood samples were tested for HIV in 2012. It can be concluded that in 2012 the tendency of previous years has continued, i.e. the number of tests performed in the country is decreasing since 2008. This decrease cannot be explained by any recent changes in testing guidelines or legislation. The only explanation can be the one mentioned in the report of previous year, i.e. in the country a decline in the number of blood donors in Latvia has been observed since 2008 (as basically the number of tests related to blood donors is decreasing while the rest of the number of tests is remaining stable (see Figure 6.1)). Specifically, in 2008 there were 44,619 donors registered, in 2010 – 36,946 and in 2012 – only 33,111 (according to data published by the State Blood Donor Centre, 2013).

**Figure 6.1. Number of blood samples tested for HIV (including tests for PWID) in Latvia, last 10 years (2003-2012)**



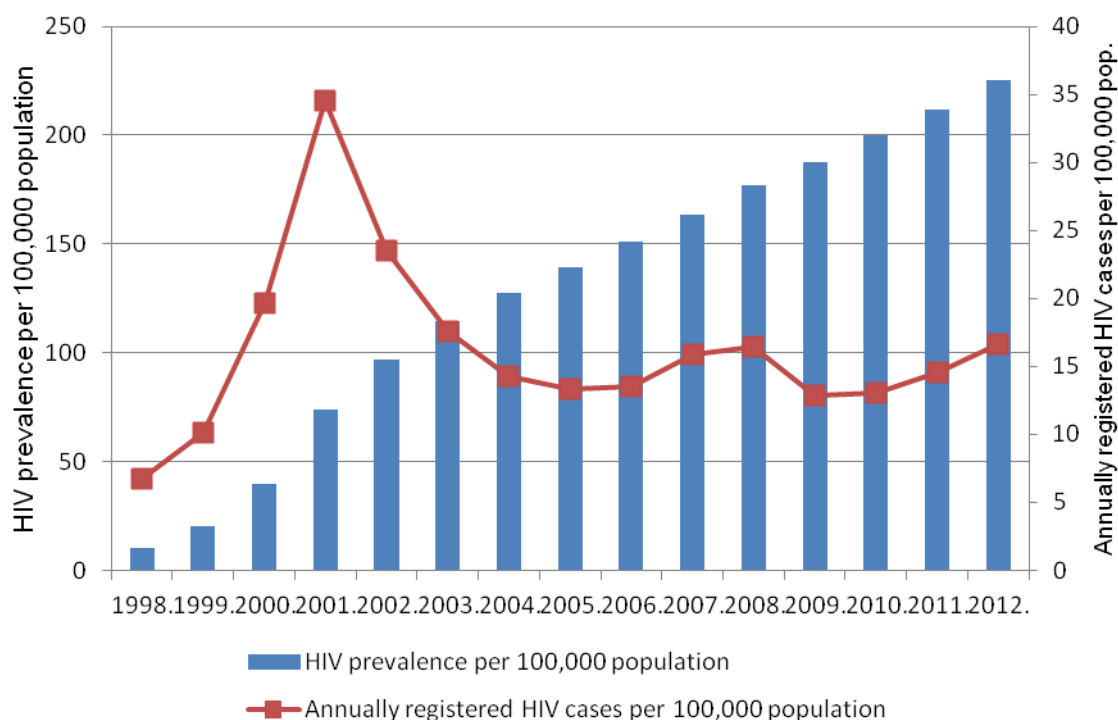
Source: Centre for Disease Prevention and Control of Latvia, 2013

In 2012 there a significant increase in the number of PWID tested for HIV in HPP has been observed: in 2011 there 642 persons were tested while in 2012 the number was 1,147. This increase is due to the fact that in 2012 there two studies have been carried out among PWID. One of them was the biobehavioural study using Respondent Driven Sampling (RDS) methodology within the project TUBIDU (“Empowering public health system and civil society to fight tuberculosis epidemic among vulnerable groups”, led by National Institute for Health Development (Estonia) and co-funded by the Executive Agency for Health and Consumers (EAHC)). The second study was the 6<sup>th</sup> wave of the Drug Users Cohort Study (carried out in Latvia since 2006) where for the first time HIV rapid tests were used instead of self-reporting of HIV status. In frame of the RDS study 300 PWID were tested and within the Cohort Study – 379.

Regarding to the number of persons tested for HIV in penitentiary institutions in 2012, the decrease has been observed: the number of persons tested in 2011 was 3,077 while in 2012 – 2,676. The probable explanation of this fact can be the decline in number of prison inmates: the average number of inmates in 2011 was 6,685 whereas in 2012 – 6,352 (according to data published by the Latvian Prison Administration, 2013).

By the end of December 2012, a total of 5,527 HIV cases were registered in Latvia (including 1,217 persons diagnosed with AIDS). 968 of these people living with HIV (PLHIV) have died. Thus, the HIV prevalence in the country at the end of 2012 was 225 per 100,000 population (in 2011 the prevalence was 212 /100,000 population, and in 2010 – 200 / 100,000 population). Figure 6.2 shows the growing HIV prevalence in Latvia.

**Figure 6.2. HIV prevalence (per 100,000 pop.) and annually registered HIV cases (per 100,000 pop.) in Latvia, last 15 years (1998-2012)**



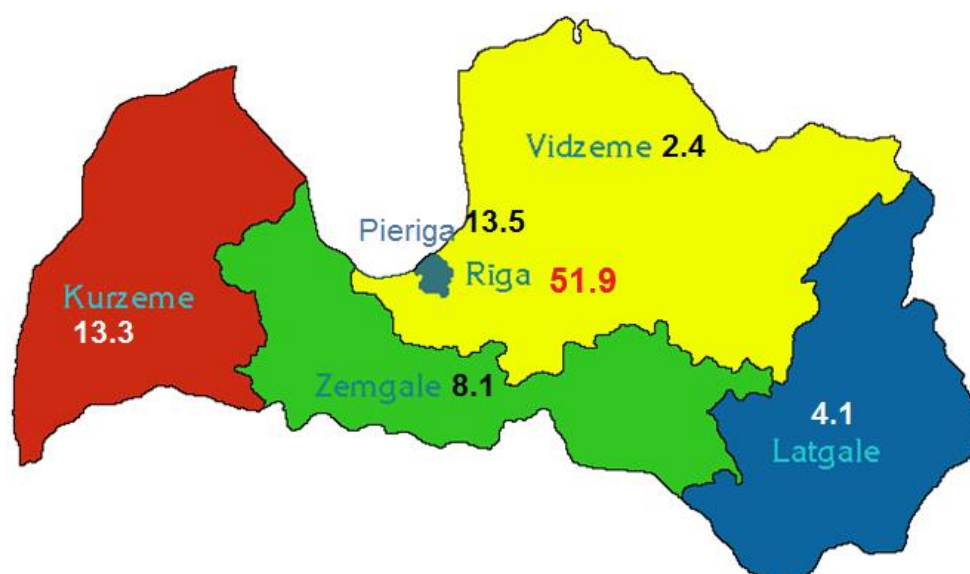
Source: Centre for Disease Prevention and Control of Latvia, 2013; Central Statistical Bureau of Latvia, 2013

In 2012 there were 339 new HIV cases registered in Latvia (16.7 per 100,000 population, see Figure 6.2). It can be concluded that the incidence rate (if annually registered cases are assumed to be incident cases) is increasing annually since 2009 when the rate was 12.8 per 100,000 inhabitants (in 2010 – 13.1; in 2011 – 14.5). Taking into consideration the fact that the number of HIV tests performed in the country is declining year by year it can be speculated that the real incidence rates could be even higher in the country.

Compared to the European Union's (EU) average number of HIV cases per 100,000 population, Latvia took the second leading position in 2012. The first position has been taken by the neighbouring country Estonia - 23.5, while the rate in EU on average was 5.8 per 100,000 population (ECDC, 2013).

Regarding the HIV prevalence there subnational differences can be observed in Latvia. The region with the highest prevalence is Riga (51.9 per 10,000 population). The other regions are less affected – in the western part of Latvia (Kurzeme Region) the prevalence is 13.3 / 10,000 population and in the eastern part (Latgale Region) – 4.1 / 10,000 population. One of the explanations for these peculiarities can be the socioeconomic differences between the regions – Riga, Pieriga and Kurzeme Regions are the ones with lower unemployment rates, higher GDP per capita etc. Thus also the purchasing power of illegal psychoactive substances is higher in these regions. Data of national research show that the drug use is more prevalent in Riga (in general population) comparing to other regions as well as that half of the PDU population is living in Riga (according to National Reports to EMCDDA by the Reitox National Focal Point of Latvia, years 2010 and 2012).

**Figure 6.3. Subnational differences in HIV prevalence by the end of 2012 (per 10,000 population)**



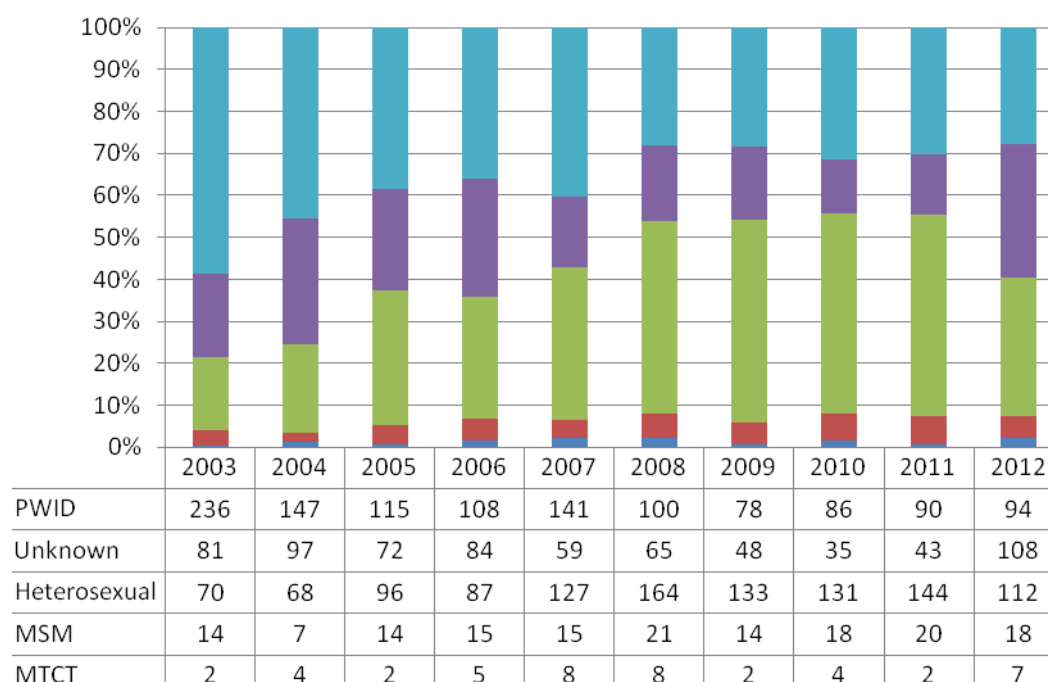
Source: Centre for Disease Prevention and Control of Latvia, 2013; Central Statistical Bureau of Latvia, 2013

In 2012 Latvia still takes the first leading position as regards to AIDS incidence – 6.8 per 100,000 population (while the rate in EU on average was 0.9 / 100,000 pop.) (ECDC, 2013). The fact can serve as an indicator for probable disadvantages in timely HIV diagnostics, treatment and care in the country.

Looking at the mode of HIV transmission in the country, in 2012 the previous tendency can be observed (see Figure 6.4.), i.e. the main mode was heterosexual contacts (33.0%, n=112) followed by cases acquired via drug injection (27.7%, n=94). But it must be underlined that those numbers should be interpreted with caution as the proportion of HIV cases with unknown mode of transmission among annually registered ones is increasing (12.3% in 2010, 14.4% in 2011, 31.9% in 2012). This fact is indicating the necessity of some improvements in the national register-based HIV surveillance system within the coming years.

In 2012 an article has been published in the peer-reviewed journal “AIDS Research and Human Retroviruses” discussing the topic of changes in the modes of HIV transmission in Latvia. Using methods of phylogenetic analysis authors conclude that the “recent increase of heterosexually infected persons did not form a separate subepidemic, but had multiple interactions with injecting drug users epidemic” in late 90ies (Balode et al., 2012). Thus so far it is not relevant to speak about generalization of HIV epidemics in Latvia as the heterosexually infected individuals basically are sex partners of PWID. However, it cannot be excluded that also PWID by themselves are reporting heterosexual mode of transmission because of stigma against drug use in the society / among medical staff.

**Figure 6.4. Distribution of annually registered HIV cases (in absolute numbers and percent) by mode of transmission, last 10 years (2003-2012)**



Source: Centre for Disease Prevention and Control of Latvia, 2013

By the end of 2012 there 2,966 persons were registered in the country (53.7% of all registered cases) who acquired the HIV infection via drug injection. Of them 700 individuals are diagnosed with AIDS and 649 have died.

Examining the cases acquired through drug injection and newly registered in 2012 ( $n = 94$ ), most of them are male (68.1%,  $n=64$ ) and the age at the time of diagnosis is 30-34 years (26.6%,  $n=25$ ) or 35-39 years (22.3%,  $n=21$ ). These tendencies have been observed also in previous years of reporting.

Similarly to the previous years, one fifth of HIV cases registered in 2012 are diagnosed in prisons: of 339 cases registered in the country 59 were among inmates (17.4%) (see Table 6.1.).

**Table 6.1. Proportion (%) of cases diagnosed in prisons among total number of annually registered cases in Latvia, last five years (2008-2012)**

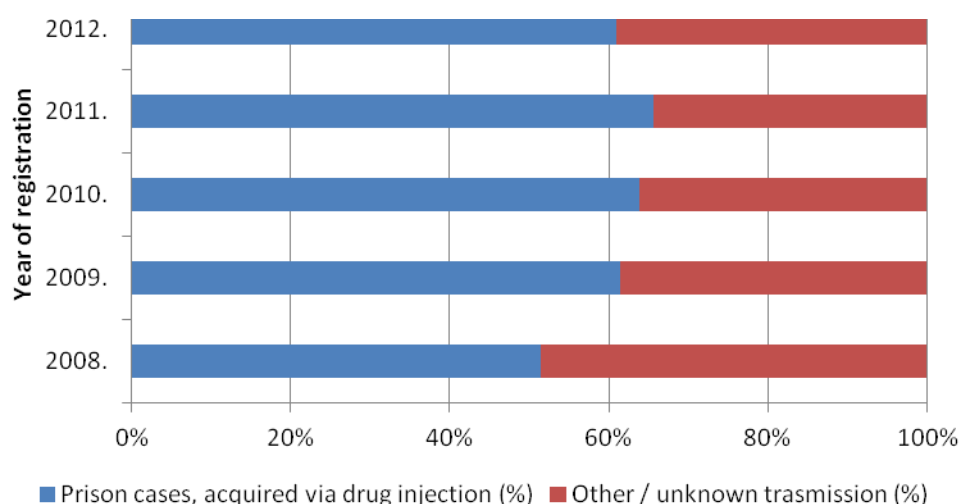
Year	2008	2009	2010	2011	2012
New cases in prisons	70	44	47	67	59
All cases annually registered in the country	358	275	274	299	339
Proportion (%) of cases diagnosed in prisons among all annually registered cases	19.6	16.0	17.2	22.4	17.4

Source: Centre for Disease Prevention and Control of Latvia, 2013

Examining the cases of HIV infection diagnosed in 2012 among prisoners, it appears that still more than a half of the cases (61.0%,  $n=36$ ) are acquired via drug injection (see Figure 6.5.).



**Figure 6.5. Proportion of cases acquired by drug injection from total number of HIV cases annually registered among prisoners, last five years (2008-2012)**

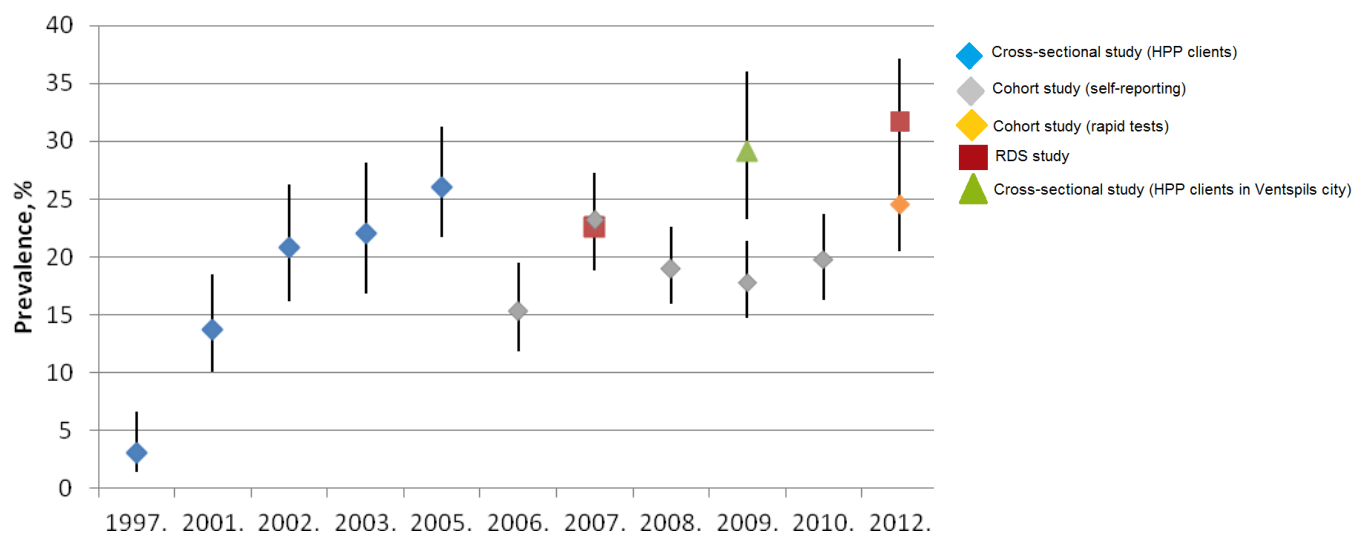


Source: Centre for Disease Prevention and Control of Latvia, 2013

Looking at the studies among PWID in Latvia it can be concluded that the HIV prevalence is growing in this population (see Figure 6.6., the lines indicate 95% confidence interval). Understandably the results of the studies using different sampling methods and different study designs as well as covering different geographical areas of the country should be compared with caution. Nevertheless this comparison can give an insight into the burden of HIV infection in PWID population in Latvia.

A remark should be made about the RDS study result for 2012 shown in Figure 6.6. At the time of development of this report the data are still unpublished. Thus here the preliminary prevalence is shown in the graph.

**Figure 6.6. HIV prevalence among PWID in different studies carried out in Latvia (1997-2012)**



Source: ECDC, 2011

Also an article published in the journal "Epidemics" in 2012 approves the increasing tendencies of HIV among PWID in Latvia. Authors conclude that we can expect a boost in HIV infection in PWID population in the coming years. Authors explain the fact by the increase in the number of susceptibles within the mentioned population due to the social and geographical movement of PWID (Graw et al., 2012).

In Latvia in 2012, as in previous years, 18 HPP were operating national wide (in 15 cities). Within these points, as it was mentioned above, within the reporting year 1,147 persons were tested for HIV (using rapid test systems). A reactive result was found for 20.3% of persons (n=233). Similarly to the previously mentioned prevalence studies among PWID, there also an increase in proportion of reactive test results carried out in HPP can be observed during the last years (see Table 2). It should be mentioned that the comparison of the test results between the years should be done by caution taking into consideration the type of the denominator used (number of tests performed or persons tested). Comparing the data in Table 2 and Figure 6 it can be seen that the proportion of reactive test results among all HPP clients is lower than among research participants. This could be due to the fact that in routine testing in HPP only those PWID are tested who are known being HIV negative un tested so far (known HIV positive persons are not tested repeatedly) whereas in cross-sectional studies all participants are tested not taking into consideration that some of them might be clients of HPP already known being HIV infected.

**Table 6.2. Number and proportion of reactive HIV test results among PWID tested in HPP (2009-2012)**

Year	2009	2010	2011	2012
Number of rapid tests performed* / persons tested	1238*	1114* / 1072	779* / 642	2135* / 1147
Number of reactive test results among tests performed* / persons tested	109*	68* / 68	72* / 72	233* / 233
Proportion (%) of reactive results among tests performed* / persons tested	8.8*	6.4* / 6.3	10.1* / 11.2	10.9* / 20.3

Source: Centre for Disease Prevention and Control of Latvia, 2013

Table 6.3. shows the gender and age stratified reactive results of rapid tests performed in HPP for the last two years. It can be seen that the proportion of reactive results in 2012 is higher among females than males and the proportion has grown since 2011 for both genders. The proportion of reactive results for young PWID (aged under 25 years) has also grown since 2011 (see Table 6.3.). But it should be underlined once again than the number of persons tested in HPP in 2012 (n=1,147) contains the respondents of RDS and cohort studies carried out with the help of HPP services in the reporting year.

**Table 6.3. Number and proportion of reactive HIV test results among PWID tested in HPP according to gender and age (2011-2012)**

		2011		2012	
		n	%	n	%
Gender	Male	46/437	10.5	145/788	18.4
	Female	26/204	12.7	88/359	24.5
Age	<25 years	10/172	5.8	13/144	9.0
	25-34 years	-	-	125/575	21.7
	>34 years	-	-	94/424	22.2

Source: Centre for Disease Prevention and Control of Latvia, 2013

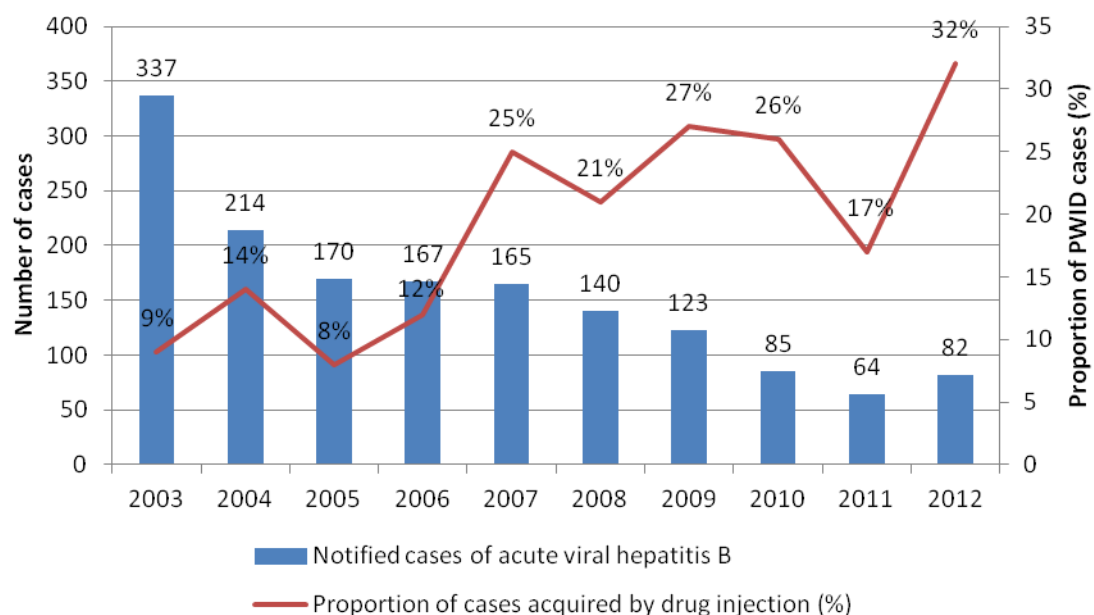
## Hepatitis A/B/C

As it was mentioned in previous report, situation regarding the viral hepatitis A (HAV) spread in the country has stabilized since the outbreak during 2008-2009. According to data collected and provided by Centre for Disease Prevention and Control of Latvia, in 2012 there only 11 cases of HAV were registered in the country (compared to 51 in 2011 and 297 in 2010). There is no information that any of the HAV cases notified in the reporting year is diagnosed among PWID.

The situation regarding the spread of acute viral hepatitis B (HBV) has not changed in 2012 compared to previous years (see Figure 7). In the reporting year 82 cases of HBV were registered in Latvia (in 2011 – 64, in 2010 – 85). Of the 82 cases notified in 2012 61.0% (n=50) were male. Of all the cases registered in the country 31.7% (n=26) were acquired via drug injection. Thus the continuation of annual decline in the proportion of PWID cases cannot be observed anymore in the reporting year (see Figure 6.7.). Nevertheless the observed increase (if compared with the year 2011) is not statistically significant (p=0.05).

It should also be underlined that in 14.6% (n=12) of cases notified, the mode of transmission is unknown.

**Figure 6.7. Number of annually notified cases of acute viral hepatitis B (absolute numbers), and proportion of cases acquired by drug injection (%), last 10 years (2003-2012)**



Source: Centre for Disease Prevention and Control of Latvia, 2013

Of 26 cases acquired through drug injection, 73.0% (n=19) were male. The majority of cases, similarly to the situation in previous year, were diagnosed in PWID between the ages of 25-34 years (50.0%, n=13) followed by the age group under 25 years (30.8%, n=8) (see Table 6.4.). Although the proportion difference between the mentioned age groups is not statistically significant (the 95% confidence intervals overlap – 16.5%-49.9% and 32.1%-67.9% accordingly).

**Table 6.4. Proportion of annually notified cases of acute hepatitis B acquired via drug injection by age, last 5 years (2008-2012) (%)**

	Age group			Total number of cases
	<25 years (%)	25-34 years (%)	>35 years (%)	
2008	56.7	40.0	3.3	30
2009	57.6	33.3	9.1	33
2010	68.2	31.8	0	22
2011	45.5	54.5	0	11
2012	30.8	50.0	19.2	26

Source: Centre for Disease Prevention and Control of Latvia, 2013

Chronic HBV was identified in 73 persons in 2012, of whom only 3 were PWID. But it must be taken into consideration that still in more than half of the cases (65.8%, n=48), the mode of transmission was unknown thus the data interpretation is very limited. Comparing the situation in 2012 with previous years, it can be concluded that the number of cases remain stable (in 2011 – 61 cases; 2010 - 43; 2009 - 73, in 2008 - 70).

In 2012 for the first time the HBV prevalence data from the routine testing in HPP network is available. HPP have used HBsAg rapid test systems and from all 985 persons (PWID) tested the reactive test result was observed for 16 individuals giving the prevalence of 1.6%. Table 6.5. shows the stratified prevalence of HBV among HPP clients tested. It can be observed that the prevalence is higher among males, PWID of older age and longer injecting career and among those injecting drugs other than opioids.

**Table 6.5. Number and proportion of reactive HBsAg test results among PWID tested in HPP according to gender, age, length of injecting career, primary drug injected (2012)<sup>41</sup>**

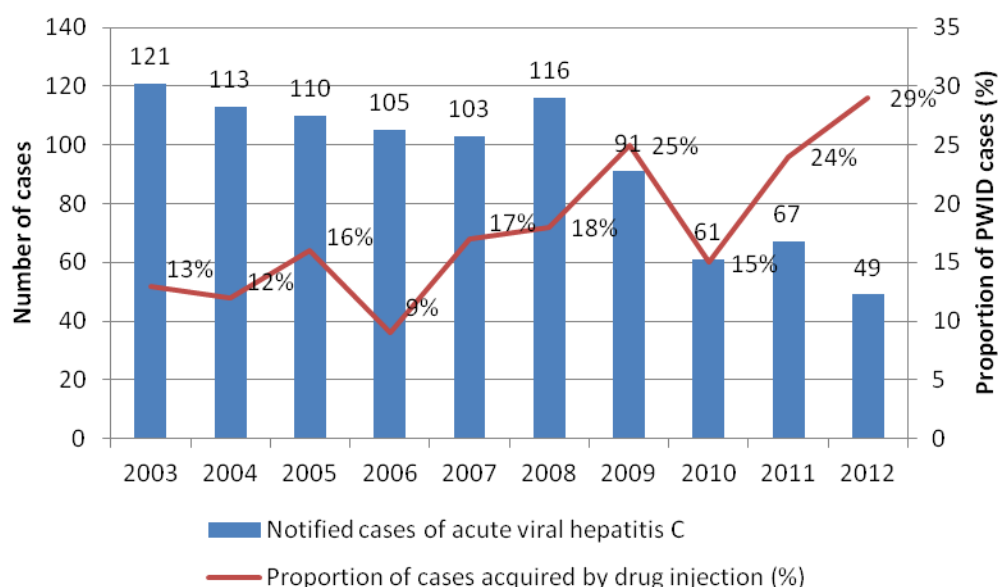
		n	%
Gender	Male	14/686	2.0
	Female	2/299	0.7
Age	<25 years	0/89	-
	25-34 years	8/508	1.6
	>34 years	8/385	2.1
Injecting career	<2 years	0/33	-
	2-4 years	1/69	1.4
	5-9 years	2/173	1.2
	10+ years	11/455	2.4
Primary drug	Opioids	4/383	1.0
	Other than opioids	8/267	3.0

Source: Centre for Disease Prevention and Control of Latvia, 2013

Looking at the number of notified cases of acute viral hepatitis C (HCV) in 2012 (n=49), it can be seen that it is slightly lower comparing to previous years (in 2011 - 67; in 2010 - 61) (see Figure 6.8.). Of the 49 cases mentioned, 14 (28.6%) were acquired via drug injection, which is more than in the previous year (2011 – 23.9%). Nevertheless the observed proportion increase, is not statistically significant (p=0.6), similarly to the case with acute HBV.

It should be mentioned that in 14.3% (n=7) of cases notified, the mode of HCV transmission is unknown.

**Figure 6.8. Number of annually notified cases of acute viral hepatitis C (absolute numbers), and proportion of cases acquired by drug injection (%), last 10 years (2003-2012)**



Source: Centre for Disease Prevention and Control of Latvia, 2013

Of the 14 cases of acute HCV acquired via drug injection 85.7% (n=12) were men. Table 6.6. shows the distribution by age among identified IDU. The majority of cases, similarly to the situation with cases of acute HBV in 2012, were diagnosed in PWID between the ages of 25-34 (50.0%,

<sup>41</sup> The sum of numbers in denominators can differ between characteristics (gender, age, injecting career, primary drug) because of the missing information in some cases

n=7) (see Table 6.6.). Nevertheless the proportion difference between the age groups under 25 years and 25-34 years is not statistically significant (the 95% confidence intervals overlap – 16.3%-61.2% and 26.8%-73.2% accordingly).

**Table 6.6. Proportion of annually notified cases of acute hepatitis C acquired via drug injection by age, last 5 years (2008-2012) (%)**

	Age group			Total number of cases
	<25 years (%)	25-34 years (%)	>35 years (%)	
2008	61.9	28.6	9.5	21
2009	34.8	52.2	13.0	23
2010	44.4	33.3	22.2	9
2011	43.8	43.8	12.5	16
2012	35.7	50.0	14.3	14

Source: Centre for Disease Prevention and Control of Latvia, 2013

The number of chronic hepatitis C infection cases has slightly increased in the reporting year (in 2012 1361 cases are notified, 2011 – 1268, 2010 – 1052, 2009 – 1271, 2008 - 1352). The proportion of chronic HCV cases identified among PWID was 11.4% (n=155) in 2012. However, taking into consideration the fact that still, similarly to the previous years, for more than a half of the cases the route of transmission is unknown (52.4%, n=713), the interpretation of the data is limited.

Within HPP there also HCV testing (using HCV Ab rapid test systems) was provided in 2012. Within the reporting year 1,031 PWID were tested and reactive result was found for 765 persons or 74.2%. In comparison with previous years, it can be concluded that the number of tests has increased (see Table 6.7.) – in 2012 comparing to 2011 the number has doubled. This is due to the fact mentioned already above – in 2012 there two biobehavioural studies were carried out among PWID.

In the proportion of reactive test results (see Table 6.7.) there an increase can be observed during the last years. Nevertheless it should be mentioned once more that the comparison of these results between the years should be done with caution taking into consideration the type of the denominator used (number of tests performed or persons tested).

**Table 6.7. Number and proportion of reactive HCV test results among PWID tested in HPP (2009-2012)**

Year	2009	2010	2011	2012
Number of rapid tests performed* / persons tested	192*	294* / 279	515*	1839* / 1031
Number of reactive test results among tests performed* / persons tested	69*	159* / 159	305*	765* / 765
Proportion (%) of reactive results among tests performed* / persons tested	35.9*	54.1* / 57.0	59.2*	41.6* / 74.2

Source: Centre for Disease Prevention and Control of Latvia, 2013

Table 6.8. shows the stratified prevalence of HCV among HPP clients tested. It can be observed that, similarly to results of HBV rapid testing, the prevalence of reactive results is higher among males, PWID of older age and longer injecting career. But the prevalence is higher among PWID injecting opioids which was not the case speaking about HBV test results.

**Table 6.8. Number and proportion of reactive HCV Ab test results among PWID tested in HPP according to gender, age, length of injecting career, primary drug injected (2012)<sup>41</sup>**

		n	%
Gender	Male	542/713	76.0
	Female	223/318	70.1
Age	<25 years	60/121	49.6
	25-34 years	396/506	78.3
	>34 years	305/400	76.3
Injecting career	<2 years	18/45	40.0
	2-4 years	49/84	58.3
	5-9 years	126/178	70.8
	10+ years	371/445	83.4
Primary drug	Opioids	304/383	79.4
	Other than opioids	190/301	63.1

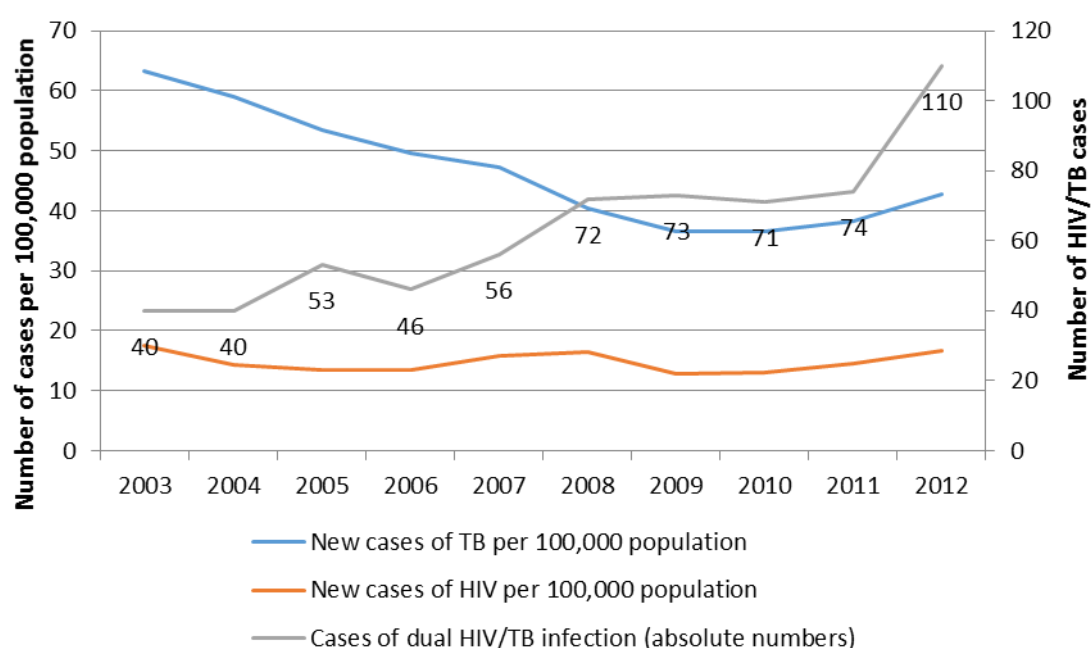
Source: Centre for Disease Prevention and Control of Latvia, 2013

As it is mentioned already before at the time of development of this report the data of RDS study carried out in frame of the TUBIDU project in 2012 are still unpublished. But giving the preliminary HCV prevalence data in comparison with previous RDS study in 2007 (ENCAP project, reported to EMCDDA via Fonte system in 2009) there an increase can be observed: in 2007 the HCV prevalence was 74.4% (n=302/406) whereas in 2012 – 82.0% (n=246/300).

## Tuberculosis

Information provided by the CDPC shows that during the reporting year 880 cases of first-time tuberculosis (TB) were registered in Latvia (42.8 per 100,000 population). Comparing to 2011 the number of cases and the rate have grown (788 cases, 38.3 / 100,000 pop.). Looking at the Figure 6.9. it can be concluded that within last 3 years the TB incidence is slightly increasing.

**Figure 6.9. Number of annually registered first-time TB and HIV cases per 100,000 population and number of cases of dual HIV/TB infection in Latvia, last 10 years (2003-2012)**



Source: Centre for Disease Prevention and Control of Latvia, 2013

As in previous years, in 2012 most commonly TB is diagnosed in persons aged 35-44 years (n=186, 66.0/100,000 pop). And similarly to previous years the infection is diagnosed more often among men than women (63.4 (n=596) and 25.4 (n=284) cases per 100,000 population).

The number of TB relapses remained stable in 2012. During the reporting year 99 cases were identified (4.8 / 100,000 pop.). In 2011 the rate was 4.7 / 100,000 pop. (n=96), in 2010 - 4.8 / 100 000 pop. (n=109) and in 2009 - 5.4 / 100 000 pop. (n=123).

As it can be seen in Figure 9 that in the reporting year an increase of dual HIV/TB cases is observed. In 2010 the number of cases was 71, in 2011 – 74 and in 2012 – already 110.

In 2012 6.5% of all first-time TB cases (n=57) were registered among persons using drugs. The proportion is similar to the previous year (5.8%, n=46). Among the cases registered in persons using drugs 52 were males and only 5 females.

Of all cases of dual HIV/TB infection identified in 2012 (taking into account first-time TB cases and relapses), about half, similarly to the situation in previous years, were drug users (in 2012 – 43.0%, in 2011 - 51.4% and 2010 - 50.7%).

In the reporting year the TB mortality continues the previously observed downward trend: in 2012 the mortality rate was 2.6 / 100,000 pop., in 2011 - 3.2 / 100,000 pop., 2010 - 3.3 / 100 000 population.

Looking at the preliminary data of the TUBIDU study it was found that the typical TB symptoms (blood in sputum and/or cough more than 2 weeks) are present for 27.0% of respondents (n=81/300). More detailed data on the TB related behaviours and knowledge among PWID from the TUBIDU study will be reported next year as at the moment of development of this report the data are still unpublished. Nevertheless it must be admitted that this research covers TB related problematics specifically in PWID population in Latvia for the first time.

### **Sexually transmitted infections**

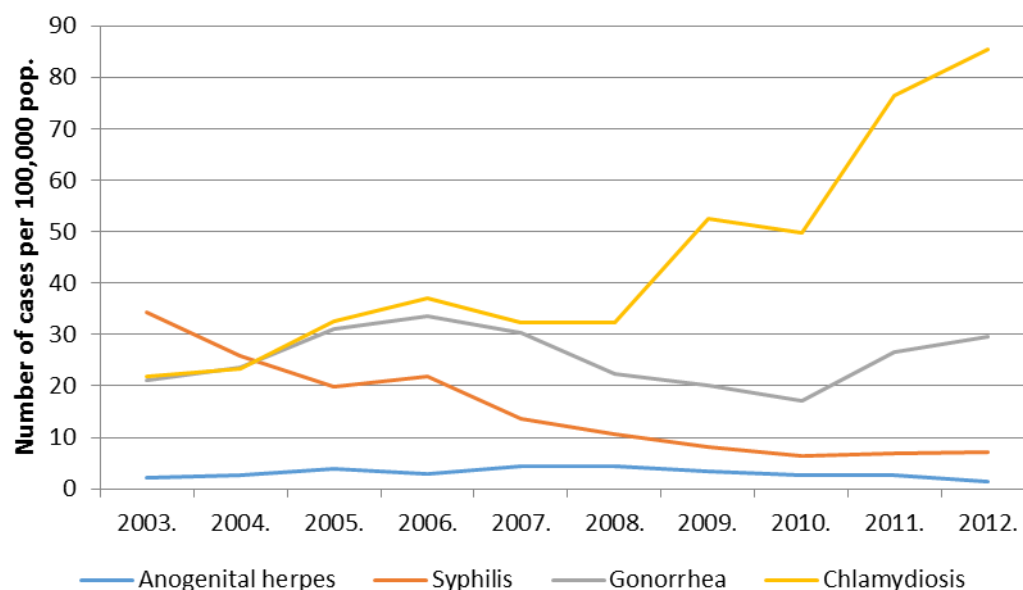
Regarding the cases of sexually transmitted infections (STI) registered in Latvia in 2012 it can be concluded that the tendencies observed in previous year have continued. Some increase in number of cases of gonorrhea and chlamydiosis can be seen. In 2010 there were 17.0 cases of gonorrhoea recorded per 100,000 population, in 2011 - 26.7 / 100,000 and in 2012 – already 29.6 / 100,000 pop. Looking at the data of chlamydiosis - in 2010 49.7 cases per 100,000 population were registered, in 2011 - 76.5 / 100,000 and in 2012 – already 85.5 / 100,000 pop. (see Figure 6.10).

The number of cases of anogenital herpes infection has slightly decreased in 2012 (1.5 / 100,000 pop. whereas in 2011 and 2010 the rate was 2.6 / 100,000 pop.). And the number of syphilis cases has slightly increased from 6.4 / 100,000 pop. in 2010 and 6.9 cases / 100,000 pop. in 2011 to 7.2 / 100,000 pop. in 2012 (see Figure 6.10.).

But as it was said in the report of the previous year, experts mainly associate these increases with improved reporting system rather than changes in the STI epidemics in the country.



**Figure 6.10. Number of annually registered cases of anogenital herpes, syphilis, gonorrhoea and chlamydiosis infection cases in Latvia per 100,000 population, last 10 years (2003-2012)**



Source: Centre for Disease Prevention and Control of Latvia, 2013

In 2012 for the first time the syphilis prevalence data from the routine testing in HPP network is reported to EMCDDA. HPP used syphilis rapid testing (immunochromatographic screening test for the qualitative detection of antibodies of isotypes IgG, IgM, IgA) against *Treponema pallidum*). From all 993 PWID tested the reactive test result was observed for 42 individuals giving the prevalence of 4.2%. Table 6.9. shows the stratified proportions of reactive syphilis test results among drug injectors participating HPP. It can be observed that the proportion of positive test results is higher among males, PWID of older age and among those injecting drugs other than opioids, which is similarly to the routine testing results for HBV described above.

**Table 6.9. Number and proportion of reactive syphilis rapid test results among PWID tested in HPP according to gender, age, length of injecting career, primary drug injected (2012)<sup>42</sup>**

		n	%
Gender	Male	26/317	8.2
	Female	16/676	2.4
Age	<25 years	1/102	1.0
	25-34 years	18/510	3.5
	>34 years	23/378	6.1
Injecting career	<2 years	2/36	5.6
	2-4 years	5/79	6.3
	5-9 years	6/180	3.3
	10+ years	26/463	5.6
Primary drug	Opioids	17/376	4.5
	Other than opioids	20/281	7.1

Source: Centre for Disease Prevention and Control of Latvia, 2013

<sup>42</sup> The sum of numbers in denominators can differ between characteristics (gender, age, injecting career, primary drug) because of the missing information in some cases

## 6.2. Other drug-related health correlates and consequences

### Non-fatal overdoses and drug-related emergencies

Until 2011 there were no data on non-fatal drug-related overdoses compiled for the whole situation of Latvia and there was only an analysis of those overdose cases which required hospitalisation and were treated in the Riga Eastern Hospital (RAKUS) Toxicology and Sepsis Clinic.

On the basis of Amendments (Cabinet Regulation No. 1005 of 27 December 2011, Riga) to Cabinet Regulation No. 746 of 15 September 2008 “Procedures for the Development, Supplementing and Maintenance of Registers of Patients who are Ill with Certain Diseases”, there were changes implemented in the Trauma/injury reporting form. The form was supplemented by part B, which comprises data on poisoning in accordance with ICD-10 code: T36.0–T65.9; The card of trauma, injury and poisoning cases has come into effect on 31 December 2011. In 2012 twenty in-patient facilities provided data for the trauma register (*Table 6.5*).

**Table 6.10. Number of overdose cases by gender, 2005–2012<sup>43</sup>**

	Men	Women	Total
2005	130	39	169
2006	161	60	221
2007	146	40	186
2008	n.a.	n.a.	n.a.
2009	110	33	143
2010	40	6	46
2011	49	12	61
2012 <sup>44</sup>	59	13	72

Source: Data from the register of patients who are ill with certain diseases on patients who have suffered traumas and injuries, 2013; RAKUS Toxicology and Sepsis Clinic, 2012

Similarly to previous years the majority of 72 patients treated in 2012 were males — 59 (81.9%). The average age for overdosing drug users was 26.9 years (in 2011 it was 25.0; in 2010 — 26.2); the youngest was aged 14 years (in 2011 — 15; in 2010 — 14) and the oldest was aged 54 years (in 2011 — 60; in 2010 — 51).

Amphetamines was involved in 17 treated overdose cases, for majority of which the most common overdose substance was amphetamine — 14 cases. Opiates were also involved in the same number of treated overdose cases, for majority of which the most common overdose substance was heroin — 9 cases. The overdose of marijuana and hashish was reported in twelve cases.

The average age of patients overdosing marijuana and hashish was 24.1 years while for overdose of psychostimulants — 27.3 years; the greatest average age of overdosing patients was 32.4 years, which was observed among overdose cases of opiates.

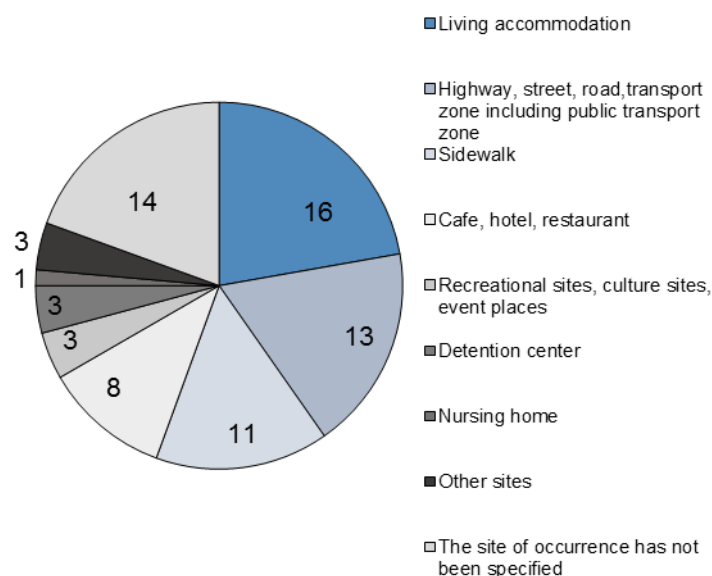
Other specified and unspecified substances were involved in the remaining 26 cases of overdose. In four of these cases the anamnesis suggests smoking “grass/aromatic substances”; in two cases — the use of amphetamine; in two cases — the use of tramadol; in one case — the use of hallucinogens. In 22 drug overdose cases reported in 2012 there was a presence of alcohol in the body.

The most commonly reported place where the overdose occurred was living accommodation (16 cases) while in 13 cases overdose took place in transport area; in 11 cases — on sidewalk. It was also reported that in 2012 three cases of overdose occurred in detention centres.

<sup>43</sup> The 2005–2009 data relate to the number of substances, not the number of patients, i.e. several substances might be indicated for one patient, and data for this period also include cases of poisoning in which only medications are mentioned.

<sup>44</sup> Data from CDPC register of patients who are ill with certain diseases on patients who have suffered traumas and injuries, including data from 20 in-patient facilities.

**Figure 6.11. Distribution of overdose cases by the site of occurrence, 2012**



Source: Data on patients who have suffered traumas and injuries taken from the register of patients who are ill with certain diseases, 2013

A large number of cases were classified as deliberate self-harm — 29 cases; unspecified intention — 10 cases; undeliberate self-harm — 1 case; other and unspecified — 32 cases.

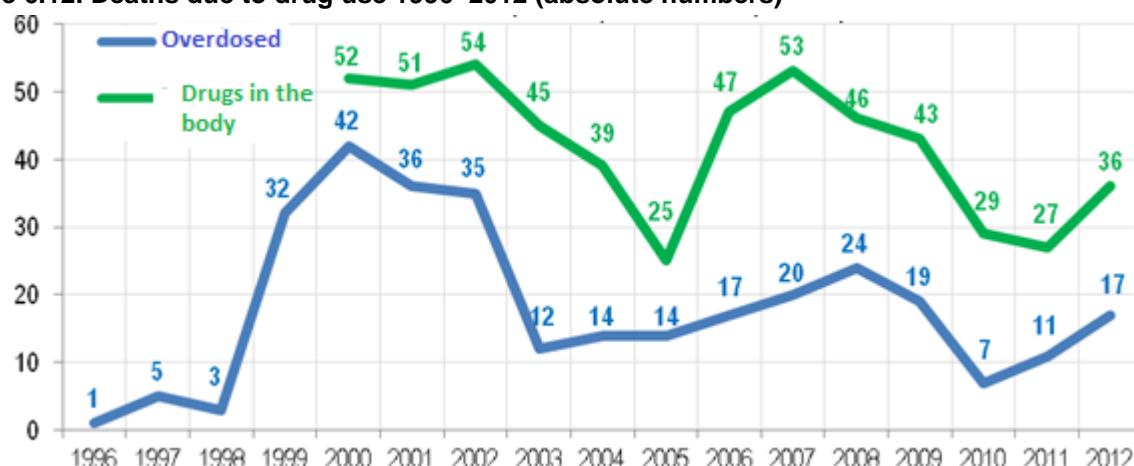
### 6.3. Drug related deaths and mortality of drug users

Information on deaths in Latvia associated with drug use is collected and analysed by two institutions: 1) the Centre for Disease Prevention and Control of Latvia (CDPC) is responsible for maintaining the database on causes of deaths (the General Mortality Register (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 CDPC-administered General Mortality Register database includes information for the entire country and is based on death certificates which are initially forwarded from all registry offices (data is entered into the Mortality Register) to the CDPC, which encodes, processes and enters the data collected into the database and performs analysis. However, the main operational objective of the other centre — 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 are made by the end of the current year.

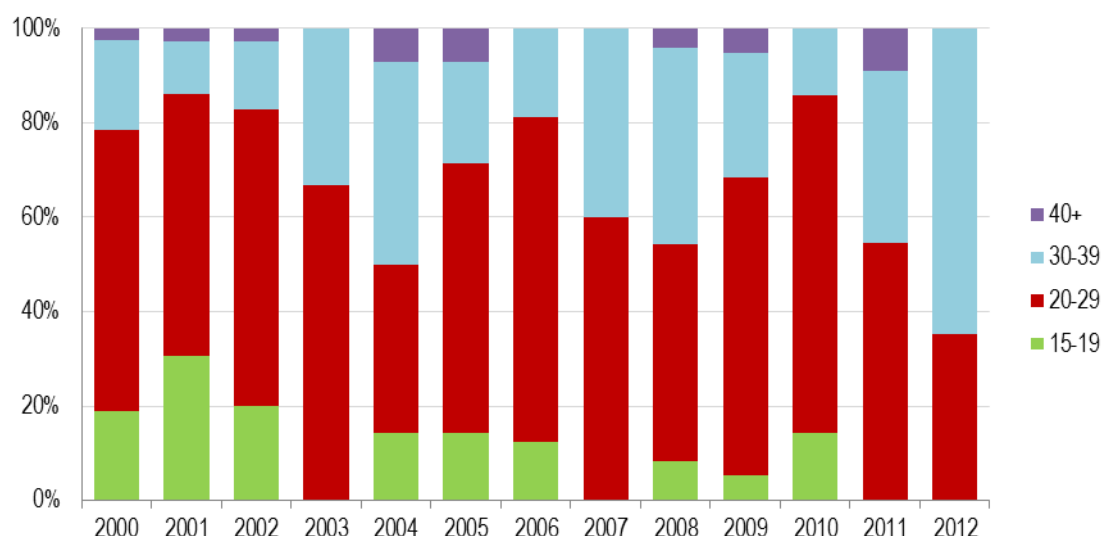
**Figure 6.12. Deaths due to drug use 1996–2012 (absolute numbers)**



Source: The Centre for Disease Prevention and Control of Latvia, 2013; State Centre for Forensic Medical Examination, 2013

According to GMR data there were 17 deaths from drug overdose recorded in 2012, which is six cases more than in 2011. Out of all deaths in 2012, four were women and thirteen were men. The average age of deceased females was 26 years while the average age of deceased males — 31 years. The overall mean age of persons deceased due drug overdose was 30 years. The youngest recorded deceased was aged 20, while the oldest was aged 36.

**Figure 6.13. Distribution of persons who have deceased due to drug overdose by age, 2000–2012, (%)**



Source: The Centre for Disease Prevention and Control of Latvia, 2013

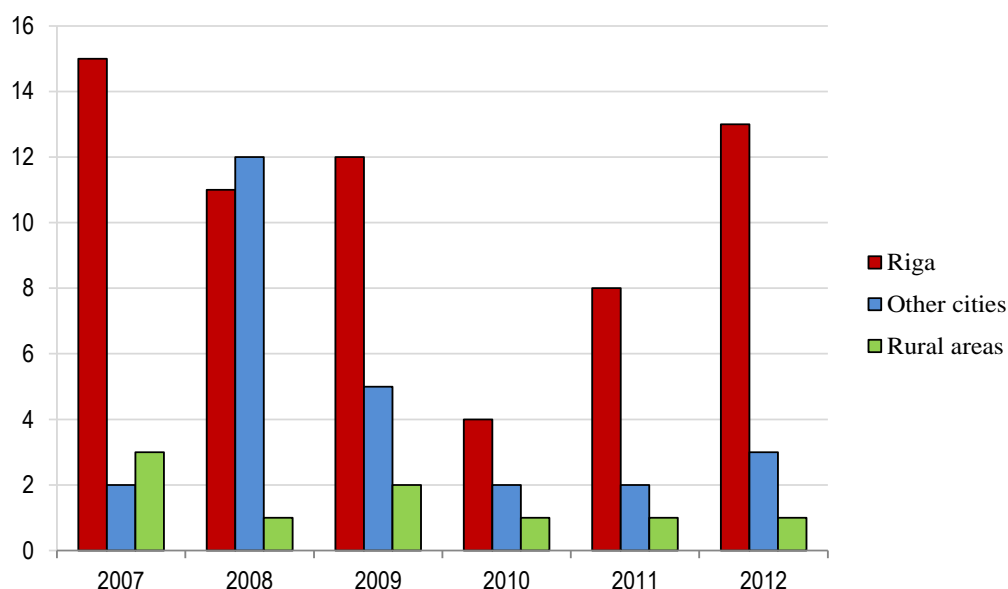
The analysis of age of deceased persons in structural dynamics shows that from 2000 the most of recorded deceased persons are aged 20–29. The years 2004 and 2012 can be mentioned as exceptions since during that time the most of recorded persons deceased due drug overdose were 30–39 years old, which is the second most common age group of the deceased. A positive trend has been noted — a small decrease in number of young persons who have deceased from overdose. A number of deceased who are older than 40 years are relatively small (only 0–9% of all deceased during the past years).

Out of all cases deliberate poisoning (ICD-10 codes: X61 and X62) was recorded in one case, accidental poisoning (X41 and X42) — in eleven cases, while in five cases the intention of the person is unknown (Y11 and Y12). In one case the death was caused by the overdose of heroin (T40.1); in six cases by the overdose of morphine (T40.2); in two cases by the overdose of methadone (T40.3); in four cases by the overdose of amphetamine/methamphetamine, while in four cases the substances were unspecified. It should be pointed out that such large number of

deaths caused by the overdose of amphetamine/methamphetamine was recorded only in 2008. During the previous year there was only one death case of such character.

Often in addition to the overdosed narcotic substance the presence of other drugs is detected in the body of a deceased. In 2012 the following additional narcotic substances were detected in the bodies of deceased: dypirone, bromazepam, fluoxetine, benzodiazepines, codeine, phenobarbital, ephedrine and clonazepam. In five cases there was a presence of alcohol in the body.

**Figure 6.14. Distribution of death cases due to drug overdose by regions, 2007–2012**



Source: The Centre for Disease Prevention and Control of Latvia, 2013

The analysis of overdose cases from geographical perspective (place of residence of a deceased) shows that in 2012 the majority of the death cases were observed in Riga, while the remaining cases — in other cities and rural areas<sup>45</sup>. Such trend has been maintained for several years. One of the exceptions is 2008 since during that year the majority of such death cases were recorded in other cities outside Riga. Another exception was year 2007 when more death cases occurred in rural areas instead of other cities.

According to VTMEC data, 19 deaths from drug overdose were recorded in 2012 (16 men and 3 women), the majority of which is of age 30–34. In 2011, on the other hand, VTMEC reported four death cases less — a total of 15 cases (13 men and two women).

Of the overdose deaths recorded in 2012, 13 were due to poisoning by opiates (mainly by morphine — 9 cases); in four cases poisoning occurred by stimulants, while in two cases the substance was unknown. In most of reported death cases in addition to the overdose narcotic substances there were other drugs detected in the biological environments of the deceased.

According to VTMEC there were cases when the cause of death was not related to overdose, however, the aforesaid drugs were discovered in the biological environments of the deceased. In 2011 in addition to overdose cases there were 11 cases when narcotic substances were found in the biological environments of the deceased; in 2012 there were 17 such cases. Of all the persons deceased in 2012 whose death was related to an overdose, or where drugs/psychotropic substances were found in the biological environments of the deceased, the youngest was aged 22 years, while the oldest deceased was aged 49 years.

In 2012, in addition to drug overdose according to the EMCDDA definition (Selection B), 12 persons died from overdosing of psychotropic benzodiazepines (ICD-10 code T42.4). In seven of these cases the influence of alcohol was also detected in the body of the deceased. Out of all

<sup>45</sup> Distribution in accordance to Classificator of Administrative Territories and Territorial Units, CSB

deaths four were women and eight were men; the youngest recorded deceased was aged 17, while the oldest was aged 84; the overall mean age of persons deceased was 38. Seven of these cases were classified as accidental poisoning, three — deliberate poisoning, but in two cases it the poisoning cause was unknown.

The actual number of deaths from overdose in the country might be much higher compared to the gathered statistical data. In 2012 it was calculated that there were 12,947 problematic drug users in Latvia while this year's statistics show that there were 17 death cases related to drug overdose.

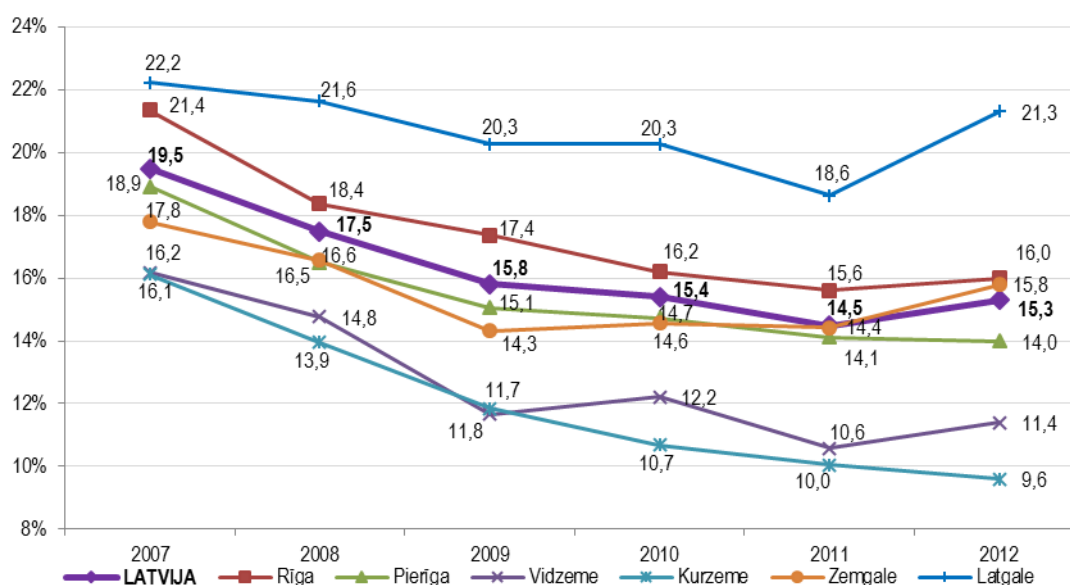
**Table 6.11. The number of deceased due to drug overdose**

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
<b>Estonia</b>	45	86	36	98	57	68	81	67	133	101	123
<b>Latvia</b>	36	35	12	14	14	17	20	24	19	7	11
<b>Lithuania</b>	35	33	40	38	31	62	72	60	68	51	45

Source: The Centre for Disease Prevention and Control of Latvia, 2013

There are several important reasons why the death rate is so low. First, there is the possibility that the presence of certain substances is not disclosed due the specific properties of the substance or due to obsolete technical equipment. Second, the number of autopsies performed in the country has been decreasing. The conclusions also point out the possible solutions for improving the recording of overdose cases — it is necessary to increase the proportion of performed autopsies and prevent the present trend of their decrease.

**Figure 6.14. The proportion of performed autopsies from the total number of the deceased distributed by regions, 2007-2012 (%)**



State Centre for Forensic Medical Examination, 2013

## 7. Responses to health correlates and consequences

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

Although there is evidence that with appropriate measures it is possible to reduce the number of persons overdosing drugs, and the associated mortality (EMCDDA, 2004), in Latvia practically no measures have been taken aimed at reducing the mortality of users, or they have been taken in the form of campaigns.

The human immunodeficiency virus (HIV) infection control programme for 2009–2013 provides for a HIV prevention point (HPP), together with training/informing Prison Administration staff and NGO representatives on the prevention of drug overdose, as well as distribution of informative material. In 2012 CDPC approved training programme “Programmes and Services of Reducing and Preventing Health Threats for Injecting Drug Users and Clients of Other Risk Groups”, which is intended for workers of HIV prevention points, social workers, and health care providers. Topic of prevention of drug overdose is also included in the training. In 2012 (since August when the programme was approved) seven persons (HPP workers) have been trained in accordance with this programme.

The HIV prevention points also operate as needle exchange consultative points, where staff informs users about safe use and what to do in the event of a suspected overdose.

An important role in preventing drug overdose is played by pharmacological opioid treatment programmes for treating dependent patients. At the moment methadone clinics are operating in 10 Latvian cities (Riga, Jelgava, Liepāja, Kuldīga, Jūrmala, Tukums, Olaine, Salaspils, Rēzekne, Daugavpils). By the end of 2012, 355 patients were being treated in long-term pharmacological treatment for opioid dependence programmes, of whom 278 patients were in the methadone programme and 77 patients were in the buprenorphine programme.

### 7.2. Prevention and treatment of drug-related infectious diseases

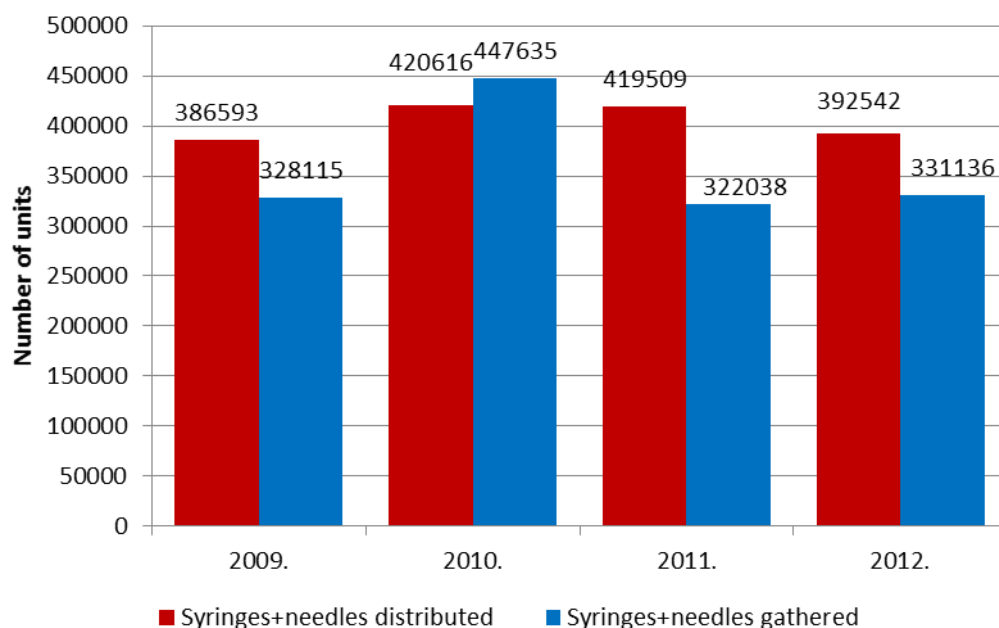
#### Prevention

In the reporting year the number of HIV prevention points (HPP) in the country has remained the same as in 2011, i.e. 18 prevention points were operating in 15 cities (4 of HPP were providing the services in the capital city Riga). In 3 prevention points the services of mobile units was carried out parallel to other activities and 7 HPP carried out the outreach work. Comparing to the situation in the previous reporting year (2011) it can be concluded that the number of mobile units have remained the same whereas the volume of outreach services has decreased (in 2011 the outreach work was provided by 9 HPP).

According to CDPC data, 311,188 syringes and 81,354 needles were distributed by HPP in 2012 which is less than in previous year (n=338,473 syringes and 81,036 needles) but similarly to the situation in 2010 when 310,774 syringes and 109,842 needles were disseminated. The number of used syringes and needles collected has slightly grown from 322,038 in 2011 to 331,136 in 2012 (see Figure 7.1). In general it can be said that no significant changes are observed in the amount of injection paraphernalia disseminated and collected in the reporting year. And it can be evaluated as a positive tendency taking into consideration that the year 2012 was the first year when these services must have been implemented without the valuable financial support from UNODC provided in previous years within the program “HIV/AIDS prevention and care among injecting drug users and prison settings in Estonia, Latvia and Lithuania”.



**Figure 7.1. Number of syringes and needles distributed and gathered at HIV prevention points in Latvia, 2009-2012**



Source: Centre for Disease Prevention and Control of Latvia, 2013

Nevertheless the conclusion regarding the coverage of syringe exchange services remains the same as previously, i.e. that the coverage is far too low for prevention or elimination of HIV epidemics. If the number of syringes distributed in 2012 is divided by the number of PDUs in the country (according to the most recent estimates there are 13,141 PDUs in the country (Trapencieris et al., 2012)) we get the number of 23.7 syringes per one PDU.

The number of clients reported to CDPC by HPP in 2012 through the centralized internet-based reporting system indicates a total number of 2,261 clients (PWID) and 34,546 client-contacts. If these numbers are divided by the number of HPP in the country it gives an estimated average number of 130 clients per one HPP and 1,920 client-contacts per one HPP per year (i.e. 160 contacts per month). The total number of primary contacts with clients has decreased in 2012: as described above in the reporting year there 34,546 contacts were registered whereas in 2011 the number was 49,897 and in 2010 – 44,487 which may be explained again with the ending of the UNODC program in Latvia discussed previously.

In 2012 the number of drug users involved in long-term pharmacotherapy continued to increase (in 2010 the number was 237, in 2011 – 277 and in 2012 – 355). Still the coverage of this service remains dissatisfactory – around 2-3% (if divided by the previously mentioned estimated number of PDUs in the country).

## Treatment

According to the information provided by the Riga Eastern Clinical University Hospital (RECUH), by the end of 2012 69.6% (n=3,847) of all HIV infected persons registered in Latvia have sought specialized HIV care at least once since the diagnosis (i.e. are registered at RECUH). Out of those registered at RECUH 56.3% (n=2,165) were drug injectors.

It can be concluded that out of all persons living with HIV in Latvia by the end of 2012 (n=4,559) 15.0% (n=683) are on ART. And out of all persons receiving antiretroviral treatment one half are persons who inject drugs (see Table 7.1).

**Table 7.1. Number of people living with HIV and receiving antiretroviral treatment and the proportion of persons who inject drugs among them, 2010-2012**

Year	2010	2011	2012
Number of PLHIV receiving ART (by the end of the year)	508	560	683
Number of PLHIV / PWID receiving ART (by the end of the year)	235	248	317
Proportion (%) of PLHIV / PWID among all PLHIV receiving ART	46.3	44.3	46.4

Source: Riga Eastern Clinical University Hospital, 2013

Despite the fact that since 2010 the HIV care and treatment is decentralized in the country (i.e. the care can be received not only in the capital city but also in regions), by the end of 2012 only 13 PLHIV were visiting the infectologists outside Riga. This fact can be explained by the lack of information among HIV infected persons about the mentioned recent changes in HIV care or by the unwillingness of patients to change their help seeking behaviour.

The average cost of ART medication per patient per month has not changed significantly during the last three years: in 2010 the cost was 383.3 LVL (545 EUR), in 2011 – 405.2 LVL (577 EUR) and in 2012 – 408.9 LVL (582 EUR).

No significant changes have been introduced in the country regarding the ART guidelines for asymptomatic HIV patients – in 2012 Latvia still the CD4 cells threshold for initiation of the therapy was 200 cells / mm<sup>3</sup>.

Also in relation to the treatment and care of HCV no significant changes were identified in 2012. The medications still weren't fully covered by state - compensation rate payable by the state remained 75%. As it was reported in previous years the co-payment of 25% per month for a patient may total more than 250 EUR, which is a high sum taking into consideration that e.g. the average salary of the employed in Latvia in the reporting year was around 490 EUR (net) (according to the Central Statistical Bureau of Latvia, 2013) and knowing that many of HCV patients (including PWID) are unemployed or lives on disability pension.

As well in relation to tuberculosis care and treatment there have been no specific changes in Latvia observed in 2012. As it was mentioned above in this report in 2012 there a RDS study has been carried out (TUBIDU project) for the first time in Latvia covering the issues on knowledge and barriers related to access to TB care specifically among PWID. At the moment of development of this report the results of the research are still unpublished and thus will be reported next year. Within the mentioned project also training activities for professionals (e.g. on active TB case finding among vulnerable groups) are planned in Latvia for the year 2013. Training results also could be reported in the coming year.

## 8. Social correlates and social reintegration

Social exclusion is a multi-dimensional issue that can affect various population groups and includes dimensions such as employment, educational level, income, access to social and health services, violence, substance abuse, family status and environment, etc. Furthermore, it is one dimension that can serve as the basis for the existence of other negative factors. For example, a drug user can be socially ostracized because of substance abuse as well as the fact that he/she is not working, and vice versa - the person is unemployed because they are a drug user. This is why it is especially important to be aware of the nature of social exclusion as a multi-dimensional problem and its likely dimensions and consequences.

There is a lack of serious study of social exclusion in Latvia. Existing studies were conducted long ago and focused on studying poverty as a risk factor for social exclusion. Unfortunately there have not been conducted any studies on social exclusion among drug users in Latvia, therefore the gathered data represents the actual situation only partially. There are two main aspects described in this chapter in relation to social exclusion among drug users — employment and educational level of these persons. The analysed data has been obtained from drug users treated in in-patient facilities and from drug users who have participated in cohort study of 2012.

According to EMCDDA social reintegration consists of three pillars: housing, education, and employment (EMCDDA, 2004). The issue of social reintegration is as extensive and difficult as the issue of social exclusion and unfortunately it has to be admitted that the issue of social reintegration of drug users has never been prioritized on the national level compared to social reintegration of other groups. The level of social reintegration in Latvia is rather low and in the majority of cases the social reintegration of drug users is associated with social rehabilitation, but substantial differences exist between these concepts.

### 8.1. Social exclusion and drug use

In 2012 there was a total of 104,052 recorded unemployed persons in Latvia, which is 26,244 persons less than in 2011. Of all reported unemployed persons 57% were women and 43% were men. Most of unemployed persons had only elementary education or incomplete elementary education (49.8%), while only 12.5% had acquired higher (tertiary) education. Most of unemployed persons were aged 45–54 — 29.2%; 21.7% were aged 35–44 (*State Employment Agency, 2013*).

In 2012, 195 persons (154 men and 41 women) were treated in in-patient facilities for drug-users, while in 2011 there were 148 such persons (115 men and 33 women). In 2012, 47 out of 195 were unemployed or were not involved in any particular activity; 64 were reported as students or pupils; 48 were reported as employed persons, workers or servants<sup>46</sup>; 24 were involved in other activities. The analysis of education level of those treated in in-patient facilities shows that 30 persons had incomplete elementary education, 86 had elementary education, 58 persons had secondary or professional qualifications, while the highest (tertiary) education was acquired only by 6 persons. The general trend is that persons who have been treated in in-patient facilities during 2012 had low level of education.

One of the most extensive instruments for analysis of social exclusion in Latvia is cohort study which has been conducted since 2006. In 2012 the sixth stage of cohort study was already carried out. During these 6 stages 1368 drug-users have been surveyed, out of which 122 have participated in all stages of the study. The questionnaire of cohort study includes several important topics: spread of drug use, incidence of infectious disease, quality of life of drug-users, severity of addictions, treatment, family status and environment, education and employment, risky behaviour and its consequences, contact with law enforcement agencies.

Of all participants/respondents, who took part in cohort study during 2012, 67% were men and 33% were women. A similar proportion of genders was also seen in previous years. The mean age of drug-users was 33 years. 69% of respondents were Russian-speaking, while 22% — Latvian-

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<sup>46</sup> Worker, servant and employed person, which are the categories included in the register.

speaking. However, it is stressed that there have not been found any essential statistical differences between nationalities in the causes of trying drugs, therefore there might be other factors, due to which the rate of Russian-speaking drug-users is higher — for example, a higher risk for Russian-speaking persons to be socially excluded.

More than a half of respondents (62%) indicated that they were not married, while 30% specified that they were living together with a partner. Half of the surveyed persons share their households with a partner; 30% live together with their parents; 20% live together with children; 12% live together with friends or acquaintances, while 22% noted that they were living alone.

52% of the respondents indicated that they were living with someone who uses drugs or alcohol excessively, which was a difficult obstacle to change environment, decrease exclusion and start or improve the process of reintegration.

As it was already mentioned, two of the most important dimensions of social exclusion are level of education and employment. 20% of respondents indicated that they had elementary education; 5% of respondents — incomplete elementary education; 11.8% — incomplete secondary education or vocational education. More than a half of the respondents or 56.9% noted that they had secondary education or professional qualification, while 6.3% indicated that they had highest (tertiary) education or incomplete highest (tertiary) education. It should be pointed out that from 2007 the number of drug-users who have only elementary education or incomplete elementary education has decreased, while the number of drug-users with secondary education or professional qualification has increased. It is interesting to note that the education level of younger drug-users is lower than of older drug-users; it might be explained by the differences in the system of education before and after the restoration of independence.

35.9% of respondents noted that they were unemployed and were not studying; 30.9% had a contractual employment (worked officially) and paid taxes; 26.6% of respondents had unofficial employment; 1% of respondents stated that they were studying, while 5.7% of the surveyed persons specified other kind of activity. In 2007 the overall number of officially employed drug-users has increased. The average income of respondents surveyed in 2012 was LVL 350 or approximately EUR 495. The most of respondents noted that they acquired their income from work, their partner, family or friends. 14.5% of respondents indicated that they acquired income from selling drugs; 24.2% mentioned theft as the main source of income, while 15.6% of respondents stated that they acquired income from social benefits. 23.8% of surveyed women specified that they engaged in prostitution.

Even though we might assume that drug-users are socially excluded in terms of receiving social help or being informed about such help, the cohort study does not confirm such assumption. 74% of surveyed drug-users indicated that they were informed about places where they can receive social help; 35% have requested such help, while 15% of drug-users are currently receiving help. This indicator has not essentially changed since 2010.

It might also be assumed that drug-users feel socially excluded or are socially excluded due to their social status, however the cohort study of 2009 and 2012 confirm such assumption only partially. The respondents were asked the following question: "On a scale from 1 to 10, where would you put yourself in the society (1 being the bottom of the society, while 10 being the top of the society)". It was discovered that 15.8% of respondents believed they belonged to the top of society and marked 7 or higher; 38.8% marked 5 and 6, while 45.6% of the surveyed drug-users believed they belonged to the bottom of the society marking 1–4. The respondents were also asked to specify the belonging of their family to various classes of society. 50.2% considered their family to belong to the upper class of society; 41.5% — to the middle class, while 8.2% of drug-users specified the lowest class.

Another dimension of social exclusion is health condition of a person. 51.5% of the respondents rated their health condition as "excellent" or "good", 38.7% as "fair", while 9.8% as "poor". Most of respondents (90%) have a family doctor. The surveyed drug-users were also asked to evaluate the severity of their dependence in accordance to SDS (Severity of Dependence Scale). Compared to the users of amphetamine, the users of heroin pointed out drug-related health problems and severe consequences more often.

An important role in reducing of social exclusion among drug-users is played by their treatment, rehabilitation, and social reintegration. According to the responses of drug-users, 14% or every eighth drug-user has received an addiction treatment during the past year. They also stated that in order for social rehabilitation to be successful it should be free, provided by qualified specialists who have a respectful attitude towards their patients and the treatment should not be connected to any religion. The last factor was indicated by 33% of respondents (*Trapencieris et al., 2012*).

## 8.2. Social reintegration

The issues concerning social reintegration are the responsibility of the Ministry of Welfare of the Republic of Latvia, and one of the most essential legal regulations on providing social rehabilitation services is Cabinet Regulation No. 914 “Procedures by Which Persons Addicted to Psychoactive Substances Receive Social Rehabilitation Services”.

The said arrangements provide that drug-dependent children shall be entitled to State-funded rehabilitation services after completion of a full treatment and motivational course at a treatment centre or after completing a course of treatment prescribed by an addiction specialist. The course of social rehabilitation for a child is relevantly of three, six, twelve, or eighteen months' duration. The services can be obtained repeatedly, and may also be received after the child has attained the age of 18 provided no more than six months remains to course completion.

In 2012 only one facility was operating with the right to provide rehabilitation services for dependent children — Straupe Adolescent Addiction Hospital “Saulrīti”, a non-profit national organisation.

With regard to adult persons, the Regulation stipulates that persons addicted to psychoactive substances are entitled to State-funded social rehabilitation services after receiving a full course of treatment. The services may be received repeatedly, but not more frequently than once every two years. Social rehabilitation services may be received by adult persons for up to 12 months.

In 2012 only two state institutions were authorised to provide rehabilitation services to adult persons: the VSIA Hospital “Ģintermuiža” and Riga Centre of Psychiatry and Addiction Disorders (NR, 2012).

It should be noted that the aforementioned children and adult social rehabilitation institutions are State institutions, but besides these, there are also a variety of non-governmental organisations engaged in activities e.g. in the form of an established commune. Overall, information is held regarding nine such non-governmental organisations that deal with addiction treatment, and in fact — social reintegration in its different forms and meanings — Apziņas ekoloģija, Mount Blessing commune, Independence Balt, Family of God, Akrona 12, Reto Cerība, and Lapaiņi.

The study of 2012 on State institutions and non-governmental organisations providing social rehabilitation services for drug-users shows that most of non-governmental organisations can be characterised as organizations carrying out re-socialisation work, providing support for drug-users, and teaching drug-users to live without drugs and to establish relationships with people who are not involved in drug-use. Most of such organisations are connected to religion and use only work therapy. Some of these organisations are directed by former drug-users, and they do not provide help of trained professionals.

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

Information on the registered administrative and criminal offences, and individuals involved therein, used for preparing of the report, has been acquired from the Information Centre of the Ministry of Interior. Data on the punishments have been acquired from the Court Information Systems (see Table 9.1). In turn, to acquire information on drug-related criminal offences, two databases had to be combined (the Register of Criminal Offences, the Examination Registration System LupaPro 2010). This statistics has not been annually summarized in any of the information systems above and is prepared only within the frame of the National Report.

**Table 9.1. Information sources on offences and criminal offences related to illegal circulation and use of narcotic substances**

Institution in charge	Information systems
Information Centre of the Ministry of Interior	Electronic event log; Search of belongings; Persons having committed administrative offence Register of criminal offences Persons having committed a criminal offence
Court Administration	Court Information System
State Police Forensic Service Department	Examination Registration System LupaPro 2010

Source: Information Centre of the Ministry of Interior, 2013

It shall be noted that the data from the Information Centre of the Ministry of Interior on drug-related criminal offences shall not be considered permanent, namely, these data are not summarized annually according to any specific methodology. Institution in need of these data shall request them in accordance to their own specific criteria. Considering that the procedures contained in the statistics are frequently continued, the statistical data, according to the same criteria, if requested at different time points, may vary. Thus, data from the State Police, the Central Statistical Bureau and the Court Administration are different. This report uses statistics from the Information Centre, required annually in accordance with specific methodology, to prepare the National Report.

Summarizing data on violation of drug-related clauses<sup>47</sup>, in accordance with EMCDDA National Report guidelines, the statistics cover the most significant drug-related clauses regulated in the Latvian Administrative Violations Code (hereinafter referred to as LAVC) and Criminal Law (hereinafter referred to as CL), which are divided into three categories (see Table 9.2 and Table 9.3):

1. Use and storage of drugs for personal needs — group “Use and storage”;
2. Illegal circulation of drugs with purpose to sell — group “Illegal circulation”;
3. Various criminal offences, for instance, illegal circulation of prescribed medicines, inducing drug-use, precursor circulation — group “Other”.

In Latvia, both administrative and criminal liability is provided for use and circulation of drugs. Administrative liability is provided for provisions in relation to storage, cultivation and use of narcotic substances for personal use, though, if the individual repeats the offence within one year, criminal liability shall be applied (see Table 9.2).

<sup>47</sup> Clauses of the Latvian law on drugs selected in accordance with — Mežulis D., Judins A. (2009). *Narkotisku un psihotropo vielu noziedzīgas aprites kvalifikācija*. Rīga, Police Academy of Latvia

**Table 9.2. Clauses of LAVC on violation of provisions regarding circulation and use of narcotic substances**

Category	Clause of LAVC	Transcript
Use and storage	<b>Section 46</b>	Illegal acquisition or storage in a small amount of narcotic and psychotropic substances, or the use of narcotic and psychotropic substances without prescription by a doctor
	<b>Section 103<sup>2</sup></b>	Unauthorised sowing and growing of plants containing narcotic substances (in small amounts)
Other	<b>Section 46<sup>1</sup></b>	Violation of provisions regarding manufacturing, production, or dissemination of narcotic and psychotropic medications and precursors

Criminal liability has been provided both for recurrent use and storage and various more severe criminal offences in relation to smuggling, trade, etc. Table 9.3 lists and transcripts clauses of CL on violation of regulations related to circulation of narcotic substances, classifying them in groups — “use and storage”, “illegal circulation”, and “other”.

**Table 9.3. CL clauses on violation of regulations in relation to circulation and use of narcotic substances**

Category	Clause of CL	Transcript
Use and storage	Section 253	Unauthorised manufacture, acquisition, storage, transportation and forwarding of narcotic and psychotropic substances without the purpose of selling such substances
	Section 253 <sup>2</sup> , Part One	Unauthorised acquisition, storage and sale of narcotic and psychotropic substances in small amounts and unauthorised use of narcotic and psychotropic substances without a physician’s designation
Illegal circulation	Section 190 <sup>1</sup>	Smuggling
	Section 253 <sup>1</sup>	Unauthorised manufacture, acquisition, storage, transportation and forwarding of narcotic and psychotropic substances for the purpose of sale and unauthorised sale
	Section 253 <sup>2</sup> , Part Two	Unauthorised sale of narcotic or psychotropic substances in small amounts
	Section 256	Unauthorised sowing and growing of plants containing narcotic substances
Other	Section 249	Violation of provisions regarding the production, acquisition, storage, registration, dispensation, transportation and forwarding of narcotic and psychotropic substances
	Section 250	Issuing of prescriptions where not medically necessary, or illegal issue of other documents for the obtaining of narcotic or psychotropic substances
	Section 251	Inducement to use narcotic and psychotropic substances
	Section 252	Administering of narcotic and psychotropic substances against a person’s will
	Section 255	Manufacture, acquisition, storage, transportation, forwarding and sale of equipment and substances (precursors) intended for unauthorised manufacture of narcotic and psychotropic substances

## 9.1. Drug- related crime

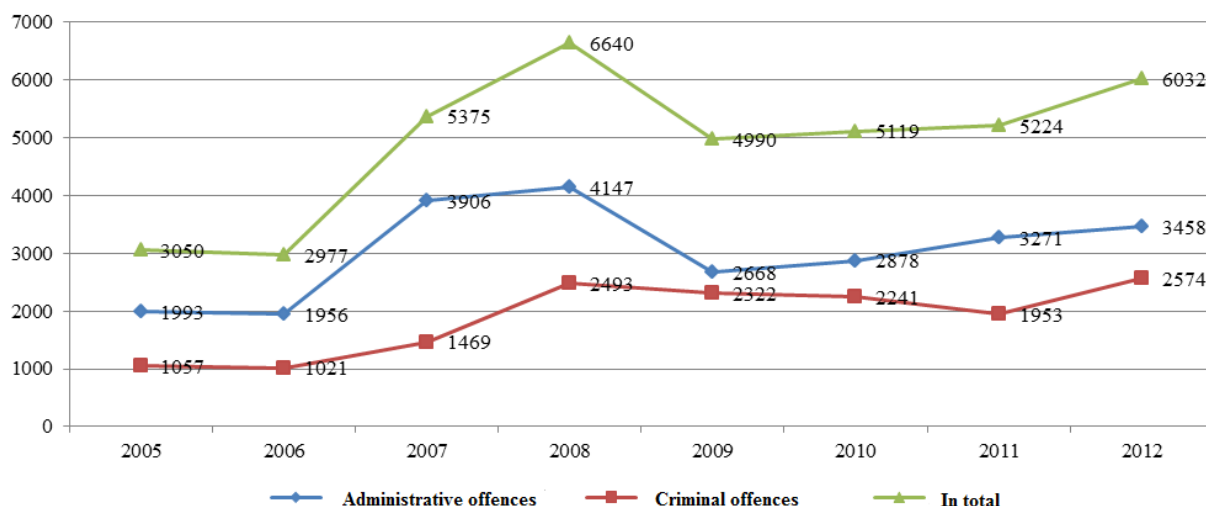
It shall be noted that the summarized statistics allows acquisition of information on violation of the law on narcotic substances only, while, in general, no data have been summarized, which reflect the situation in relation to psychopharmacologic crimes (committed under the influence of narcotic substances), system crimes (committed to ensure smuggling and trade of narcotic substances) and economic offences, committed to acquire money to buy a dose.



## 9.2. Drug law offences

Total number of offences, comparing to 2010, has increased by 13.39%. Number of the registered administrative offences has increased by 5.4%, while the number of registered criminal offences — by 24.12% (see Figure 9.4). Such increase in the number of criminal offences may be due to the fact that total number of registered events in relation to use and storage of narcotic substances has increased. Furthermore, it shall be noted that police expropriated new active substances, part of which was contained in lists of controlled narcotic substances more often, thus increasing the number of charges under CL clauses on storage and trade.

**Figure 9.4. Number of registered administrative offences and criminal offences related to circulation and use of narcotic substances in 2005–2012**



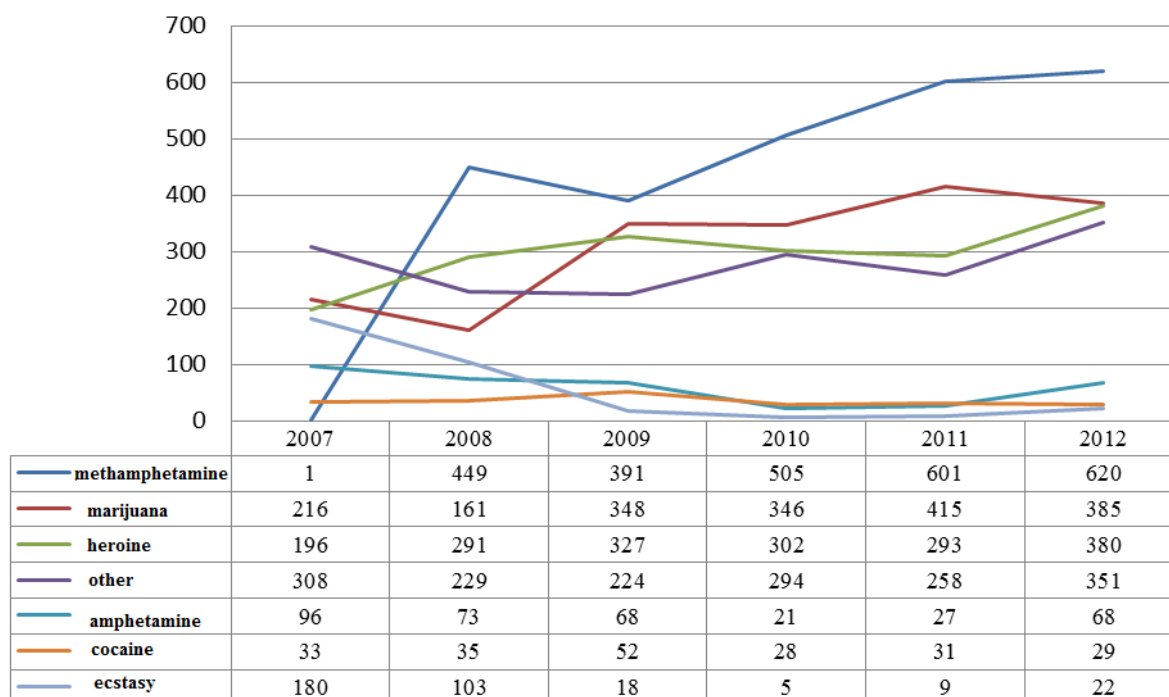
Source: Information Centre of the Ministry of Interior; 2013

When describing registered criminal offences related to narcotic or psychotropic substances, it may be concluded that the three most frequently involved substances are metamphetamine, marijuana, and heroine (see Figure 9.5). According to data from various studies, marijuana is the most frequently used narcotic substance, thus, high level of circulation of the substance may be observed. Metamphetamine and heroine is the most frequently used narcotic substance among problematic users, thus, proportion of these substances on the illegal market is higher and they fall into the view of law enforcement institutions more often<sup>48</sup>.

In general, data on the registered criminal offences correspond with the police data on illegal circulation of narcotic substances and reflect the illegal market in the country. Furthermore, it shall be noted that minor difference may be observed in charges on use and storage and illegal circulation of narcotic substances. For instance, offences in use and storage most frequently involve marijuana, metamphetamine, and heroine, while illegal circulation crimes most frequently involve marijuana, metamphetamine, and other substances.

<sup>48</sup> If, within the frame of one criminal procedure, several substances are expropriated, all of them are included individually by clause and by substance. For instance, if three substances are expropriated under CL as smuggling, the statistics shall include three smuggling events by the substance involved.

**Figure 9.5. Registered administrative and criminal offences by narcotic substance in 2007–2012 (absolute figures)<sup>49</sup>**



Source: Information Centre of the Ministry of Interior, 2007–2012; data from the State Police Forensic Service Department, 2007–2012

### 9.2.1. Administrative Offences

Since 2009, the number of administrative offences in general has remained stable. Comparing to previous year, the number of registered administrative offence protocols has increased by 5.4%. Basically, those are registered protocols under Section 46 of LAVC, consequently, for use and/or storage of narcotic substances in small amounts. Only few events have been registered, which may be referred to unauthorized seeding of plants and cultivating thereof in small volumes, or violation of regulations on circulation of prescribed medicines.

**Table 9.6. Number of registered administrative protocols in relation to circulation and use of narcotic substances in 2005–2012**

	2005	2006	2007	2008	2009	2010	2011	2012
Number of administrative offences	1993	1956	3906	4147	2668	2878	3271	3458

Source: Information Centre of the Ministry of Interior, 2013

In total in 2012, administrative offence protocols were issued to 2621 individuals, which is 8% less than in 2011 (n=2856). From these, 4.2% (n=110) were juveniles, which is more than in 2011, when 79 young people (2.7%) were inflicted a penalty. Majority of penalised persons were males (85.7%).

The most frequent type of punishment for administrative offences shall be considered fine. In 2012, the administrative punishment was inflicted in 88.3% of events. In total, in 3.9% of events, proceeding was terminated; in 2.3% of events, administrative arrest was applied; in 0.3%, warning was pronounced, while measure of constraint of educational nature was applied in two events.

### 9.2.2. Criminal Offences

Comparing to 2011, proportion of the registered crimes in relation to circulation and use of narcotic substances has increased in 2012 and currently is 5.17% of all crimes registered in the country

<sup>49</sup> See ST11\_2013\_LV\_1

(see Table 9.7). According to police observations, such increase is due to both increase in the number of events in circulation and use of narcotic substances and police activities in reduction of illegal circulation. One of the influential factors is also related to distribution of new psychoactive substances and police work to reduce effect thereof.

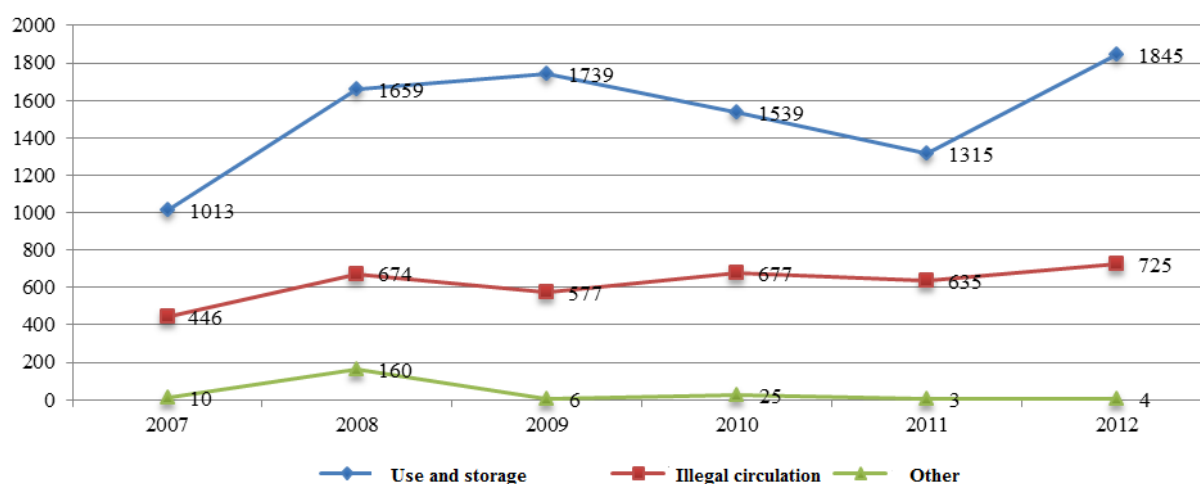
**Table 9.7. Number and proportion of criminal offences in relation to circulation and use of narcotic substances of all offences registered in the country in 2005–2012**

	2005	2006	2007	2008	2009	2010	2011	2012
Number of criminal offences in the country	51435	62328	55620	57475	56748	51108	50469	49758
Criminal offences related to circulation of narcotic substances	1469	2493	1469	2493	2322	2241	1953	2574
Proportion (%) of all reg. crimes in the country	2.06%	1.64%	2.64%	4.33%	4.09%	4.38%	3.86%	5.17%

Source: Information Centre of the Ministry of Interior, 2005–2012

In general in 2012, 71.6% of all registered criminal offences were related to illegal use or storage of narcotic substances without the purpose of trade; in 28.2% events, the crime was related to illegal distribution of narcotic substances, while less than one percent was related to other narcotic substance crimes (see Table 9.8).

**Table 9.8. Registered crimes related to use and storage of narcotic substances for individual use, illegal circulation and other, 2007–2012 (in absolute figures)**



Source: Information Centre of the Ministry of Interior, 2007–2012

Comparing to 2011, number of registered criminal offences related to use and storage of narcotic substances has increased by 28.7%, which, in part, may be explained by the fact that since 2010, the number of administrative offences has increased as well which suggests that more often the volume is found at the individual, for which criminal liability is provided. In general, the number of registered crimes related to illegal circulation of narcotic substances has increased by 12.4%, for instance, number of criminal offences related to illegal circulation of narcotic substances with purpose of trade (CL Section 253<sup>1</sup>) has increased by 17.9%. Other criminal offences remain at a constantly low level, namely, several events have been registered on illegal circulation of precursors, distribution of prescribed medicines, and injecting of narcotic substances against person's will (see Table 9.9).

**Table 9.9. Registered crimes pursuant to CL sections in 2007–2012 (in absolute figures)**

Type	Clause of CL	2007	2008	2009	2010	2011	2012
Use and storage	Section 253	500	514	447	516	500	694
	Section 253 <sup>2</sup> , Part One	513	1145	1292	1023	815	1151
Illegal circulation	Section 190 <sup>1</sup>	33	35	99	158	135	110
	Section 253.1	402	624	451	496	474	578
	Section 253 <sup>2</sup> , Part Two	11	14	27	22	23	33
	Section 256	0	1	0	1	3	4
Other	Section 249	0	0	1	1	2	0
	Section 250	1	153	2	24	0	1
	Section 251	7	7	1	0	1	1
	Section 252	0	0	0	0	0	0
	Section 255	2	0	2	0	0	2
	Total	1469	2493	2322	2241	1953	2574

Source: Information Centre of the Ministry of Interior, 2013

### Acused individuals

In 2012, 1459 persons were charged with various criminal offences related to illegal circulation and use of narcotic substances. Thus, in average, one person is charged with 1.7 criminal offences related to narcotic substances. Majority or 68.6% (n=1000) persons have been charged with use and storage of narcotic substances without purpose of trade. In total, 25.9% (n=351) persons have been charged with illegal circulation crimes, where majority refer to circulation with purpose of trade and with trade (see Table 9.10).

In general, for crimes related to narcotic substances, males were charged more often (85.5%) at the age of 18 to 34 years. In total, 14.5% of persons charged were women. When compared, smuggling and production of narcotic substances basically involves males, while small proportion of women may be observed in charges under CL sections in relation to use, storage and trade of narcotic substances (see Table 9.10).

23 juveniles have been charged with various criminal offences, which makes 1.7% of all charged persons in total. For comparison — total juvenile proportion in administrative offences made 4.2%

**Table 9.10. Persons in 2012 charged pursuant CL sections**

Type	Clause of CL	Males	Females	Adult persons	Under-age persons	Total
Use and storage	Section 253	388	97	448	7	455
	Section 253 <sup>2</sup> , Part One	591	93	668	16	684
Illegal circulation	Section 190 <sup>1</sup>	48	1	49	0	49
	Section 253.1	294	79	373	6	367
	Section 253 <sup>2</sup> , Part Two	19	5	20	4	24
	Section 256	9	0	9	0	9
Other	Section 249	0	0	0	0	0
	Section 250	0	0	0	0	0
	Section 251	1	0	1	0	1
	Section 252	0	0	0	0	0
	Section 255	7	2	9	0	9

Source: Information Centre of the Ministry of Interior, 2013

## Convicted persons and penalties applied

Public statistical reports of the Court Administration contains information on the number of matters received at court of first instance. From all matters, 12%–13% were applicable to illegal circulation and use of narcotic substances each year (Table 9.11).

**Table 9.11. Total number of matters received at all courts of first instance and number and proportion of matters received in relation to illegal circulation and use of narcotic substances in 2009–2012**

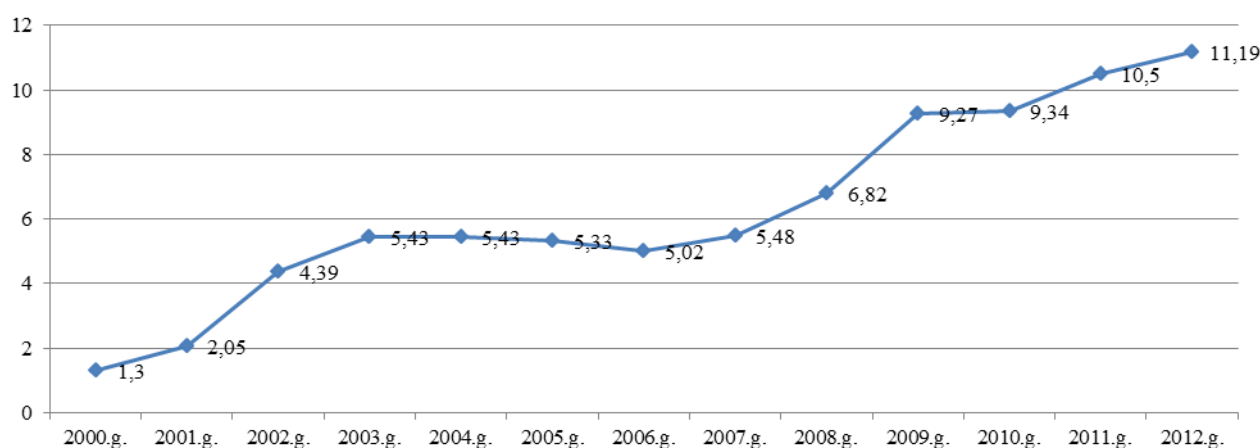
	2009	2010	2011	2012
Number of all matters received at court of first instance	10447	8963	8589	8670
Number of matters received in relation to circulation and use of narcotic substances	1286	1187	1075	1157
Proportion of narcotic matters in all matters (%)	12.3	13.2	12.5	13.3

Source: Court Information Systems, 2009–2012

In addition, the Central Statistical Bureau summarises information on individuals convicted with trade, production or storage of narcotic substances (see Figure 9.12.).

Of all convicts in 2012, 11.9% of persons were convicted with trade, storage and production of narcotic substances (see Figure 9.12). It shall be noted that since 2009, increase in proportion of convicts may be observed, which may be due to the fact that in 2007 and 2008, number of registered crimes increased (see Table 9.4), which were brought to court in several years.

**Figure 9.12. Proportion of individuals convicted with trade, storage and production of narcotic substances to all convicted persons in 2000–2012 (%)**



Source: Central Statistical Bureau, 2000–2013

When analysing the type of applied punishment, it shall be noted that in general the situation during the latest years has remained unchanged, and convicts most frequently are being convicted with imprisonment or imprisonment on probation. Individuals convicted for use of narcotic substances (CL Section 253<sup>2</sup> Part One) most frequently are convicted with community service or their matters are terminated. In turn, to those convicted for smuggling and trade of narcotic substances (CL Section 190<sup>1</sup> and Section 253<sup>1</sup>), imprisonment or imprisonment on probation is usually applied (see Table 9.15). It shall be noted, if a person is charged with more severe criminal offences, the statistics only include punishment for these more severe offences, without separating punishment for circulation of narcotic substances, therefore there might be statistical deviations.

**Table 9.13. Penalties applied pursuant to CL sections in 2012 (in absolute figures)**

Type	Clause of CL	Imprisonment	Imprisonment on probation	Forced labour	Fine	Medical measures of constraint	Terminated or the individual acquitted
Use and storage	Section 253	343	169	6	4	0	45
	Section 253 <sup>2</sup> , Part One	49	56	126	2	0	140
Illegal circulation	Section 190 <sup>1</sup>	14	12	2	1	0	1
	Section 253 <sup>1</sup>	215	105	1	0	0	6
	Section 253 <sup>2</sup> , Part Two	12	9	5	0	0	0
	Section 256	2	0	0	0	0	0
Other	Section 249	0	0	0	0	0	0
	Section 250	0	0	0	0	0	0
	Section 251	0	0	0	0	0	0
	Section 252	1	0	0	0	0	0
	Section 255	0	0	0	0	0	0

Source: Information Centre of the Ministry of Interior, 2013

### 9.3. Other drug- related crime

#### Driving under the influence narcotic substances

Drivers of vehicles suspected of the use of narcotic substances are referred to examination to the Alcohol, narcotic and psychotropic substance examination department of the Narcological Aid Service of Riga Centre of Psychiatry and Addiction Disorders VSIA. Each year, 60% of drivers referred to examination are established to be under the influence of narcotic substances, for instance, in 2012, in 166 (63.35%) of 262 drivers the test has been positive, and in 2011, in 162 (60.9%) of 266 drivers narcotic substances have been established in blood. The number of drivers referred to examination forms 2.6% of all persons referred to examination (State Police, 2013).

In total in 2012, 111 protocols were executed on driving vehicle when under the influence of narcotic, psychotropic, toxic or other similar substances (LAVC Section 149<sup>15</sup> Part Five). Another 79 persons refused to undergo examination, thus, were inflicted penalty automatically pursuant to LAVC Section 149<sup>15</sup> Part Seven, providing the same sanctions as those for driving vehicle under narcotic substances. In total, 108 persons were inflicted fine, 103 — administrative arrests, and 104 individuals were deprived of their driving licence for these offences.

Criminal liability is provided for driving of vehicle with no driver's licence when under the influence narcotic drugs, however, statistics is summarised along with offences committed when under the influence of alcohol, consequently, no summarisation of data has been made, how many of these events are related to driving vehicle when under the influence narcotic substances.

### 9.4. Prevention of drug- related crime

Prevention of crimes related to narcotic substances is integrated into daily activities of police, customs, Latvian Prison Administration, and municipal police. Most often measure in prevention of crimes related to narcotic substances are raids and patrols in the most dangerous places of the city, attendance of festivals and other mass events by police. However, in 2012, several crime prevention projects have been implemented, which both directly and indirectly apply to reduction of number of narcotic substance-related crimes.



### Anonymous reporting on illegal alcohol, cigarette, and narcotic substance trade spots

In June 2012, a project was commenced, when people could anonymously report on illegal alcohol, cigarette, and narcotic substance trade spots, entering the respective address into the specific interactive map of Latvia on the Internet. Until mid of 2013, reports on 1500 illegal trade spots have been received. The highest activity was observed during the first two months, when population had made 1007 marks on illegal alcohol, cigarette and narcotic substance trade spots in the map (mostly, those of the so-called “legal narcotic substances”). Majority of marks in Riga — 606, Latgale — 122, Zemgale — 110 (Ministry of Interior, 2012).

### Juvenile support information system

In 2010 the Information Centre of the Ministry of Interior, with financial support from the EU Crime Prevention and Reduction, established the Juvenile Support Information System, where law enforcement institutions, social institutions, municipalities, educational institutions, and other institutions working with juveniles may report on risk behaviour of a juvenile, for instance, a committed administrative and criminal offence, including in relation to illegal circulation and use of narcotic substances. Thus, within the system, exchange of operative information and cooperation between the involved law enforcement, social, educational institutions is encouraged to prevent early juvenile crime, including in relation to illegal circulation and use of narcotic substances, and victimisation. Although, implementation of the system in the country was provided for 2012, actual implementation occurred in 2013 (*Nepilngadīgo personu informācijas atbalsta sistēmas anotācija*, 2012).

### Study on prevention of children and juvenile delinquency

The study *Children-friendly Legal Environment in Latvia: in Focus — Prevention of Delinquency* was conducted within the frame of cooperation programme between the Swiss Confederation and the Republic of Latvia, sub-project *Support System for Prevention of Juvenile Delinquency*. Cooperation of Latvian municipalities and law enforcement institutions within the pilot project was evaluated in three municipal governments of Latvia. Results of monitoring suggested that municipalities considered use of narcotic substances and alcohol one of crime risks. As a result of the study, recommendations and principal guidelines for prevention of juvenile delinquency were elaborated, including recommendations to improve the Juvenile Information System (Kronberga I., Zamartēns Ž., 2012).

### Prevention of victimisation

Within the project *Prevention of Re-victimisation of the Victim in the State Police*, in 2012, a study on victimisation issues was conducted in Latvia. As a result of the project, training programme for inspectors of the State Police was developed to ensure more effective work with victims and to prevent re-victimisation. Basically, such preventive measure was provided to prevent sexual violation crimes, robbery and theft, however, development thereof may encourage ceasing of victimisation cycle for victims of crimes related to illegal circulation and use of narcotic substances (State Police, 2013).

## 9.5. Interventions in the criminal justice system

### Alternatives to prison

Section 59 Part Four of the CL provides that a court may release a person, who has committed a criminal violation or a less serious crime due to alcoholism, narcotic, psychotropic addiction or toxic substance addiction, from serving a punishment, if this person has agreed to medical treatment for alcoholism, narcotic, psychotropic addiction or toxic substance addiction. The punishment shall be served if the person has not commenced undergoing the medical treatment within the time specified by the court or, after this, has avoided the medical treatment. Treatment costs shall be covered by the convicted person. This practice is almost never applied, and this type of punishment has been applied only in few events during recent years.



## Involving juveniles in forced treatment

In 2012, the Ministry of Health, formed a working group, which updated the issue on involving of juveniles in forced treatment programmes. Namely, legal enactments state that juveniles may be involved in forced treatment, however, experts of the area reported that such practice was very rare and, overall, the system should be enhanced. Within the working group, statistics on juveniles held liable for administrative and criminal offences for use of narcotic substances, and referring thereof to forced treatment programmes was summarized. It has been established that each year several juveniles are involved in forced treatment programmes, though, this is more in relation to alcohol addiction. It has been concluded that there is no system, which would encourage referring of juveniles to narcologist, and fines are usually applied; furthermore, no assessment is carried out if the juvenile shall be referred to an expert (see Table 9.14).

**Table 9.14. Number of drawn-up administrative protocols to juveniles pursuant to LAVC Section 46, and punishment inflicted**

	2010	2011	2012
<b>Number of prepared protocols</b>			
Boys	84	105	129
Girls	15	24	18
<b>Punishment measure inflicted</b>			
Warning	2	2	-
Fine	83	113	132
Educating measure of constraint	1	2	-
Warning	2	2	-

Source: Information Centre of the Ministry of Interior, 2012

## 9.6. Drug use and problem drug use in prisons

To 31 December 2012, in total 6117 prisoners and convicts remained in prisons of Latvia. From all prisoners, 1401 persons (22.9%) were those convicted pursuant CL Sections 253, 253<sup>1</sup> and 253<sup>2</sup> or for crimes related to circulation and use of narcotic substances (see Table 9.15) (Latvian Prison Administration, 2013).

Data on the use of narcotic substances in prisons is provided both by operative registers of prisons and the study conducted in 2010. Operative register accounts individuals, on whom clear indications have been received on regular and problematic use of narcotic substances. Although total number of prisoners decrease, the number of registered narcotic substance users remains stable, and even slight increase in proportion thereof may be observed, namely, in 2010, 862 individuals (12.7%), in 2011 — 904 individuals (13.8%), in 2012 — 910 individuals (14.9%) have been registered. This increase in proportion of narcotic substance users may be explained by the fact that total number of persons convicted for crimes in relation to narcotic substances, including use of narcotic substances, has increased in prisons (Latvian Prison Administration, 2013–2013).

**Table 9.15. Number and proportion of individuals convicted for illegal circulation and use of narcotic substances, and number and proportion of registered users in prisons in 2007–2012**

	Total number of prisoners to 31 December of each year	Individuals convicted pursuant CL Sections 253, 253.1 and 253.2		In operative register as users of narcotic substances	
	number	number	%	number	%
<b>2007</b>	6548	731	11,2	529	8.1
<b>2008</b>	6873	836	12,2	745	11.4
<b>2009</b>	7055	n.a.	n.a.	881	12.5
<b>2010</b>	6780	n.a.	n.a.	862	12.7
<b>2011</b>	6561	n.a.	n.a.	904	13.8
<b>2012</b>	6117	1401	22,9	910	14.9

Source: Latvian Prison Administration, 2007–2012

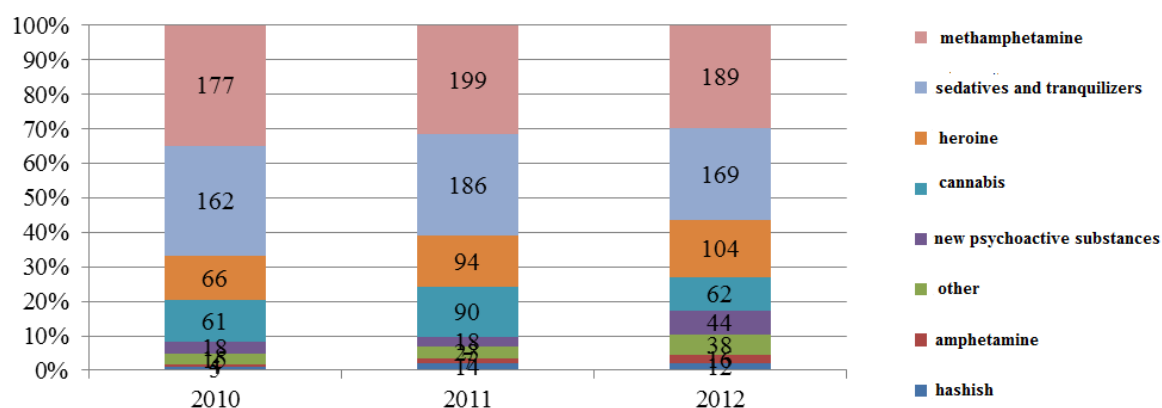
Furthermore, the Latvian Prison Administration summarises information on identified events of use of narcotic substances, as well as on prisoners making injections of narcotic substances. Namely, in 2012, 1849 events of narcotic substance use were established in prisons, of which 1218 were related to intravenous use of narcotic substances. For comparison, in 2011, 1789 events of narcotic substance use were established, of which 1265 were in relation to intravenous use of narcotic substances. It shall be noted that in 2012, 4 death events were registered from overdosing of narcotic substances (Latvian Prison Administration, 2012–2013).

Responses acquired during the study conducted in prisons in 2010 illustrate that approximately each third (31.8%) prisoner has used narcotic substances at least once. Most frequently, prisoners use in prison marijuana and/or hashish (24%), amphetamines (19%), sedatives and tranquilizers (18%). Approximately each tenth (10.1%) has used cocaine, 7.6% — ecstasy, 5.5% — various opiates (Sniķere et. al., 2010)<sup>50</sup>.

### Expropriation of narcotic substances

In total in 2012, in Latvia's prisons, 634 expropriation of narcotic and psychotropic substances have been carried out, that is 3 expropriations more than in 2011 and 126 registered events or 19.8% more than in 2010. Similar to illegal narcotic substance market outside prisons, the most frequently expropriated substance was metamphetamine (30%), followed by heroine (16%) and marijuana (10%). Significant part of the expropriated substances is formed by various sedatives and tranquilizers (27%) (see Table 9.17). In general, it may be concluded that expropriation data for 2010 comply with study data for 2010, reflecting trends in the use of narcotic substances in prisons. Thus, it may be forecasted that data on the use of narcotic substances in prisons for 2012 may be similar to results of the study for 2010.

**Table 9.16. Expropriations of narcotic substances carried out in prisons in 2010–2012 (in absolute figures)**



Source: Data from the State Police Forensic Service Department, 2012–2012

Comparing to previous years, it may be concluded that number of expropriation of metamphetamine, sedatives and tranquilizers and volume thereof has remained stable. Slight increase in the number of expropriations of heroine and volume thereof may be observed, while the number of expropriations of marijuana and volume thereof has decreased (see Table 9.17 and Table 9.18).

<sup>50</sup> See ST12\_2011\_LV\_01

**Table 9.17. Volume of several narcotic substances expropriated in prisons in 2010–2012 (g)**

	2010	2011	2012
metamphetamine	1217.38 g	1056.55 g	1380.16 g
heroin	76.01 g	53.71 g	100.28 g
marijuana	342.26 g	448.80 g	252.49 g
amphetamine	20.18 g	12.34 g	76.21 g
hashish	12.51 g	65.35 g	48.84 g

Source: Data from the State Police Forensic Service Department, 2010–2012

One of the most topical issues in prisons is use of various sedatives and tranquilizers. In total in 2012, 169 expropriations (26.6%) have been carried out, which resulted in expropriation of 1680.75 g and 5172 pills of various sedatives and tranquilizers; for comparison, in 2011, 186 expropriations resulting in 266.89 g and 5300 pills, and in 2010, 162 events resulting in expropriation of 1112.83 g and 4727 pills have been carried out. It shall be noted that approximately half of sedatives and tranquilizers expropriated in the country are from prisons. In general, within this group, benzodiazepines, in particular, clonazepam-containing substances and pills (n=134; 79.29% of entire sub-group) are expropriated, followed by diazepam, phenazepam, oxazepam, and alprozalom. Furthermore, several expropriations of ciclobarbitol, trihexyphenidyl, and zopiclone have been registered.

Number of expropriation of new psychoactive substances and volume thereof has increased from 18 events in 2011 to 44 events in 2012. In two events, cathinone group substances, while in other events — synthetic cannabinoids were expropriated.

In 2012, prisoners committed 16,455 regimen offences and, in total, 367 criminal proceedings were initiated in prisons or investigations in other law enforcement institutions. 237 (64.58%) of them were criminal procedures related with illegal storage and trade of narcotic substances, of which:

- 91 (38.4%) criminal proceeding initiated in relation to search in cells and territory, search of prisoners and thrown-overs;
- 139 (58.6%) criminal proceeding initiated in relation to mailing, correspondence (letters) and parcels;
- 7 (3%) criminal proceeding initiated in relation to use of narcotic substances.

## 9.7. Responses to drug-related health issues in prisons

In general, primary and secondary healthcare is available in prisons, including narcologic aid. However, considering medical technologies of treatment, narcologic treatment opportunities in prisons are limited. Along with the Cabinet Regulation No. 70 “Procedure of medical treatment of alcohol, narcotic, psychotropic, toxic substances, gambling and computer game addict persons” of 24 January 2012, opportunities to provide narcologic aid was extended, namely, opportunity to implement therapy with pharmacological substitutes using methadone and buprenorphin was introduced in prisons.

Currently, pharmacotherapy is offered to those clients only, who have started it before arriving to prison, namely, one cannot involve in the programme when in prison. In total in 2012, the therapy was used by 14 prisoners (Latvian Prison Administration, 2013).

In general, Latvian prisons provide emergency narcological aid, and most often such aid is provided in the medical centre of the prison with further reporting to the administration. However, these data are not summarised. Data on events with F11–F19 diagnoses registered in prisons are available from one prison only. In total in 2012, in this prison, opiate addiction diagnosis (F11.2–9) was registered in 36 patients, while amphetamine addiction (F15.2–9) was registered in 4 patients. Excessive use or intoxication was registered in 33 patients within one year, though, diagnoses were not specified by substances (Data from the Centre for Disease Prevention and Control of Latvia, 2012).

Furthermore, in two prisons — women prison *Iļģuciems* and Cēsis Correctional Facility for Juveniles — Minnesota 12-step programme was implemented. In turn, the Riga Central Prison arranges anonymous meetings for drug addicts.

It shall be noted that thanks to the Norwegian Financial Mechanism a project will be implemented providing for opening of narcology unit in the Latvian prison hospital (located in Olaine) in 2016, where narcologic medical aid will be provided. The project aims to create 200 places in compliance with standards and all necessary equipment to ensure systemic work with addict prisoners. Partners of the project are Oslo prison (Norway), Correctional Service of Norway Staff Academy (Norway), Central Prison Administration of Poland (Poland) and the State Probation Service (Latvia) (Latvian Prison Administration, 2013).

In addition, in 2012 prisoners' possibilities to receive general health care services were improved. Based on amendments to Cabinet Regulation No. 1046 "Procedures for the Organisation and Financing of Health Care" of 19 December 2006, prisoners were provided the possibility to receive consultations, medical examination and treatment with specialists of treatment institutions outside prisons. In 2012 examinations and specialist consultations were organised at medical treatment institutions outside prisons, including 1680 out-patient services and 241 in-patient services. In cooperation with the National Health Service of the Ministry of Health, physicians working at prisons could provide out-patient treatment to prisoners by using compensated medicines and medicinal products. These improvements contribute to prevention and treatment of infectious diseases related to narcotic substances.

### Prevention and treatment of infectious diseases

It may be concluded that in 2012, less than 8.3% of prisoners were HIV-positive, which, in general, is less than in previous year, when 702 HIV-positive events were registered, which was approximately 10.6% of all prisoners. It shall be noted that there are several factors to explain the decrease in the number of registered HIV-positive events: total number of tests carried out has decreased in general (in 2012 — 2767 tests; in 2011 — 3077 tests), number of prisoners has decreased, and number of those prisoners with AIDS has increased.

**Table 9.18. Registered events of HIV, AIDS and tuberculosis in prisons in 2008–2012**

	2008	2009	2010	2011	2012
HIV infection	621	612	657	702	509
AIDS	103	101	120	120	152
Tuberculosis	103	106	81	79	116

Source: Latvian Prison Administration, 2008–2012

Comparing to general data on HIV prevalence in entire population, it shall be noted that HIV prevalence in prisons is significantly higher, furthermore, every fifth newly discovered HIV event in 2011 has been registered in prisons (National Health Service, 2012).

In 2012 in prisons, 30 death occurrences were registered, of which in 19 events were due to health issues (oncologic, cardiovascular disease, AIDS and AIDS with tuberculosis), in 4 events, death resulted from overdosing of narcotic substances, while in 7 events, from suicide.

It shall be noted that at the end of 2010 and beginning of 2011, voluntary consultations and testing for hepatitis C and HIV was introduced, including in prisons. Overall, tests were carried out in 422 prisoners in six prisons. In 235 (55.7%) convicted individuals virus hepatitis C antibodies were discovered. HIV antibodies were discovered in 19 convicted individuals, while HIV/HCV double infected were 15 convicted individuals. Tests were followed by an inquiry among 109 convicted individuals diagnosed with HCV antibodies to establish their level of knowledge in relation to HCV, treatment and maintenance of normal liver function, required VHC preventive measures etc. In general, 67% of respondents admitted that HCV, most probably, was acquired when using intravenous narcotic substances, while 5.5% stated that they might have been infected in prison (Union HIV.LV, 2011).

For the prevention of dissemination of infectious disease, such measures as testing for infectious disease and organisation of information programmes and lectures are taken, but no measures like

syringe exchange or distribution of condoms are applied to reduce risks. Within the project “Education as an instrument in HIV prevention” financed by the USA embassy in Riga, Union HIV.LV paid 22 visits to prisons to educate prisoners on HIV infection and motivate them to take test. In total, 11 prisons were visited, 411 prisoners and 40 staff members took the lectures (Union HIV.LV, 2012). In addition, information on infectious disease was also included in rehabilitation programmes for prisoners.

### **Preventive measures for the use of narcotic substances and reduction of hazard**

In general, preventive measures for the use of narcotic substances is implemented on a regular basis by carrying out checks in prison cells and parcels. No specific measures are taken to prevent overdosing of narcotic substances in prisons or after release from prisons.

## **9.8. Reintegration of drug users after release from prison**

Re-socialization of prisoners is carried out in accordance with the Sentence Execution Code of Latvia, and since 12 April 2013, in accordance with the Cabinet Regulation No. 191 “Procedure for Re-socialization of the Convicts”. Development of re-socialization has been implemented based upon the Cabinet Decree No. 7 “Concept of Re-socialization of Individuals Convicted with Imprisonment” of 9 January 2009.

In accordance with amendments to the Sentence Execution Code, which become valid from 2012, the convicted individual shall be granted assessment of individual risks and needs and development and implementation of re-socialization plan. Degree of risk of the convicted individual to commit a recidive shall be assessed, and based upon results thereof, re-socialization plan shall be developed. This was not a mandatory requirement before.

Re-socialization of convicted individuals with narcotic, psychotropic or other psychoactive substance addiction is carried out in accordance with the general programme of re-socialization, which is formed of two parts:

- Social behaviour corrective measures including motivation and work with priority groups;
- Rehabilitation of convicted persons, which is basically carried out through general, professional and interest education programmes, employment, arrangements of spare time, and development of household skills.

Re-socialization flow is divided into two parts — individuals with psychoactive substance addiction and individuals with no psychoactive substance addiction. It means that if an individual is established any addiction issues, he/she is involved into the same programmes as all prisoners, but, in addition, he/she is referred to motivation programmes involving issues on disengaging from narcotic substance addiction, as well as, by developing an individual re-socialization plan, opportunity to refer the individual for rehabilitation is assessed. It shall be noted that former prisoners are among clients of several Christian organisations functioning in accordance with principles of therapeutic community.

**Table 9.19. Involvement of prisoners in re-socialization programmes**

	Number of programmes implemented	Number of prisoners involved	Number of individuals having completed the programme
2010	37	2528	2097
2011	31	1205	995
2012	23	714	504

Source: Latvian Prison Administration, 2010–2012

Furthermore, in 2012, 3375 prisoners were involved in educational programmes: general education — 1014 individuals; professional education — 1501; higher education programmes — 12 prisoners. In total, at the end of academic year 2011/2012, 91 prisoners acquired elementary education; 20 prisoners — secondary education; 741 prisoners — professional education. It shall be noted that number of prisoners involved in educational programmes has increased, namely, in

2009, 2278 individuals involved, while in 2012 — 3375 individuals. Since the number of prisoners has decreased, increase in proportion in education area may be observed. Professional education programmes offered prisoners to acquire such crafts like tailor, cook, hair dresser, welder, electrician, and other.

Prisoners are employed in economic services, as well as positions formed by merchants. Prisoners in open-type prisons were employed outside the territory of the prison. As of 31 December 2012, 1224 prisoners were employed. For comparison, in 2010, 1224 prisoners, while in 2010 — 1210 prisoners were employed.

After their release from prison, rehabilitation is continued on individual basis by receiving consultations in line with the re-socialisation plan of the prisoner, or, if the individual is on parole, under supervision of the State Probation Service.



## 10. Drug Markets

The data collected by the Forensic Section of the Department of Criminalistics of the State Police in relation to seizures of narcotic substances, psychotropic substances, precursors and new psychoactive substances in Latvia were used for the analysis of illegal drug market. This institution registers all seizures of narcotic and psychotropic substances, which are performed by the Customs Criminal Board of the State Revenue Service (SRS), as well as by the Prison Administration, by the prosecution service and by other law enforcement institutions.

In addition, the annual report prepared by the Organized Crime Prevention Department of the Main Criminal Police Department of the State Police (the State Police, 2013), as well as the report prepared by the Customs Criminal Board of the State Revenue Service (SRS Customs Criminal Board, 2013) concerning illegal circulation of drugs in Latvia. These reports generally describe the situation and identify the main tendencies of illegal market development. The official press releases provided by law enforcement institutions in relation to performed drug seizures are also used in this section, as well as the information provided by foreign resources (Russia, Belarus, Ukraine) in relation to smuggling of drugs, if it is related to Latvia or its citizens.

In order to characterize availability of narcotic substances for certain groups of inhabitants, information provided in the course of the subsequent stage of cohort investigation of problematic drug users, which was performed in 2012, was used (Trapencieris et.al., 2013).

### 10.1. Availability and Supply

#### Availability of narcotic substances

Various investigations, which provide information concerning availability of narcotic substances among the general population and young people, were performed in 2011 and the results of these investigations have been included in the EMCDDA report for the year 2012 (Pugule I. et. al., 2012). In the year 2012, the subsequent stage of cohort investigation of problematic drug users was performed (Trapencieris M. et.al., 2013). This investigation stage included questions concerning the most frequently used narcotic substances, and therefore identifies the demand for and supply of narcotic substances in this subpopulation. Answers provided by respondents give evidence of the fact, that amphetamines (87%) and heroin (64%), as well as marijuana (42%) and khanka (41%), were the most frequently used drugs within the previous year. Amphetamines (79%), heroin (49%) and khanka (37%) were the most frequently used drugs also within the last month.

#### Origin of narcotic substances

In Latvia narcotic substances are imported basically as a part of in-transit goods, which are forwarded to the Scandinavian countries, to the Russian Federation or to other EU countries. Taking into consideration data on the substances, which are available at the Latvian illegal market, it can be concluded that methamphetamine, heroin and marijuana are imported in Latvia, while a part of these products is forwarded to other countries. The territory of Latvia is used only as a transit country for transportation of hashish and cocaine, because these drugs are available in the illegal Latvian market in small amounts. Although within previous years there were evidence that marijuana which is grown in Latvia is mainly sold in the Scandinavian market, local marijuana, which has been confiscated during this year, was basically designated for the local market. The number of annually discovered marijuana plantations, as well as various small laboratories, which are producing synthetic drugs, can give evidence for local manufacturing of these drugs. Generally, there have been 31 kg of dried marijuana confiscated in marijuana plantations, and this amount comes up to approximately one half of the total amount of marijuana, which has been confiscated in Latvia during 2012. In addition to this, there have been 334,93 kg of non-dried marijuana confiscated. Total weight of this amount of marijuana (in case if it was dried) could exceed the total amount of marijuana that was confiscated in Latvia. There have been 2,4 kg of GHB confiscated in two discovered homemade GHB laboratories. The amount of confiscated substance is equal to a



half of the total amount of confiscated tranquilizers and sedatives in this group (in total, 4,9 kg of this substance and 2914 tablets have been confiscated in 2012).

## Distribution of narcotic substances

In accordance with the data obtained by the State Police in relation to seizures of drugs, these substances are confiscated domestically in 60.3% of all seizure events, while 26% are confiscated in places of detention, and 5.9% are confiscated at the state border, in airports, sea ports or in other international transportation hubs. It must be emphasized, that it was not possible to identify the place of seizure in 7.9% of events. Still, it should be pointed out, that the number of seizure cases related to international trafficking could be much larger, because frequently it is not possible to identify direct relation to trafficking in those cases when drugs are confiscated domestically. Such information also cannot be specified in seizure statistics provided by the police. Among the seizure events, which can be definitely identified as drug trafficking, the greatest part of drugs has been found in postal parcels (34.5%), confiscated in airports (32.4%) and in Latvian sea ports (27.5%). A very little amount of drugs has been confiscated on the inner and outer borders of Latvia (5.6%).

Tendencies of import and transit of drugs in 2012:

Hashish generally is a product in transit, which practically does not come in the Latvian market. The main way for distribution of hashish leads from Spain (Moroccan origin) to Scandinavian countries and to the Russian Federation. For transportation of hashish maritime transport is used, as well as land transport and air transport. In 2012, hashish has been most frequently confiscated in airports and has been found in international postal parcels. Moreover, the most significant trafficking event (in relation to drug amounts) in 2012 was discovered in the Riga Free Port territory, when 116 kg of hashish were found in a car registered in Latvia. These drugs were designated for further transportation for sale in the Russian Federation (relevant information provided by the State Police, 2012).

Cocaine is also basically a product in transit, which is transported from the South American countries to the Scandinavian countries and to the Russian Federation. Nevertheless, the number of seizures related to drug trafficking has decreased in comparison with previous years. The largest drug seizure has been registered at the Riga airport in the beginning of the year, when customs officers apprehended a person from Argentine, who had 61 cocaine capsules in his abdominal cavity. The total weight of these capsules was 772.67 g (SRS Customs Board, 2012).

Marijuana is usually grown on-site, while for the needs of transit and import this product is usually imported from the EU countries (Belgium, Netherlands, Lithuania, and Poland) and from the Russian Federation. It must be pointed out that marijuana was the most frequently confiscated substance by the SRS Customs Service during 2012, and this fact gives evidence of active marijuana trafficking to Latvia, as well as of marijuana transit to other EU countries and to third countries. In 2012, in the Riga airport there was an event, when a Bulgarian citizen, who was travelling from Greece by air transport, had concealed 2.3 kg of marijuana in his personal luggage. The concealed drugs were designated for further transportation to the Scandinavian countries, moreover, this route has been used for various times (SRS Customs Board, 2012).

Heroin is basically imported from Central Asia with the use of overland transportation through Ukraine, Belarus, then Lithuania, as well as through the Russian Federation territory and then through Estonia. It must be pointed out that in the end of 2012 and in the beginning of 2013 citizens of Latvia and Lithuania have been apprehended when carrying heroin from Lithuania to the Daugavpils city, which is located near to the state border. It is also important to mention a particular event in the beginning of 2013, when a citizen of Moldova has been apprehended on the border of Belarus and Lithuania. This person was carrying 85 kg of heroin to be transported to Latvia (apollo.lv, 2012).

Methamphetamine is basically transported from Belgium, Netherlands, and Lithuania. It is considered, that a part of this product is transported further to the Russian Federation. Generally, the number of amphetamines seizures and the confiscated amount have increased in 2012. In accordance with information provided by the State Police, the mentioned increase can be

associated with discovering of an illegal amphetamine production laboratory in Estonia (the State Police, 2013).

Generally, the number of new psychoactive substance seizures performed on the state border and in sea ports, as well as the number of seizures from postal parcels has decreased. A seizure of plant mixture in size of 1.2 kg, which contained AKB84F, as well as two events, when a-PVP was discovered in postal parcels with the total weight of 2.1 kg (SRS, 2013), must be mentioned among the largest seizures.

Distribution of narcotic substances in Latvia is mainly performed by local organised criminal groups, which collaborate with organised criminal groups located in the Russian Federation, Ukraine, Belarus and in the European Union. The use of Russian language facilitates collaboration with organised criminal groups located in former post-soviet states, as well as with Russian-speaking organised criminal groups in other EU countries. Such criminal groups are also involved in money laundering operations, as well as in trafficking of other products and in vehicle robbery.

It has been observed, that criminal groups working in Latvia are multinational, as they usually involve citizens of Latvia, Lithuania, Estonia, Russia, and Germany. There has been various persons convicted of a criminal offence for trafficking of drugs (Section 190<sup>1</sup> of the Criminal Law) in Latvia during 2012, particularly — 20 citizens of Latvia, 10 citizens of Lithuania, 6 citizens of Estonia and 2 citizens of Germany. Citizens of Russia, Bulgaria, Spain, France, the Netherlands, and Kazakhstan were also convicted (one person from each of these countries).

Riga is the central place of drug distribution. From this place drugs are further delivered to other regions of Latvia. It is possible, that several narcotic substances, such as methamphetamine and heroin, are transported directly from neighbouring states to the biggest cities of a particular region, for example, from Lithuania to Daugavpils — the biggest city of South-Eastern Latvia. It must be specified, that investigative institutions have noticed increasing importance of internet communication for organisation of drug transportation and trade.

In comparison with previous years, the Consular Department of the Latvian Ministry of Foreign Affairs has obtained less information concerning those citizens of Latvia, who have been apprehended in 2012 for trafficking and illegal trade of drugs. This information does not reflect all possible events, when citizens of Latvia have been arrested in foreign countries, because such data are received only in those cases, when the arrested person agrees with it (see Table 10.1.).

**Table 10.1. Information received by the Consular Department of the Ministry of Foreign Affairs of Latvia concerning the number of citizens of Latvia, who have been arrested for drug trafficking and for trafficking of illegal of drugs in 2009–2012 (in absolute numbers)**

	2009	2010	2011	2012
Information received by the Consular Department concerning the number of persons	32	55	71	29

Source: The Ministry of Foreign Affairs, 2013

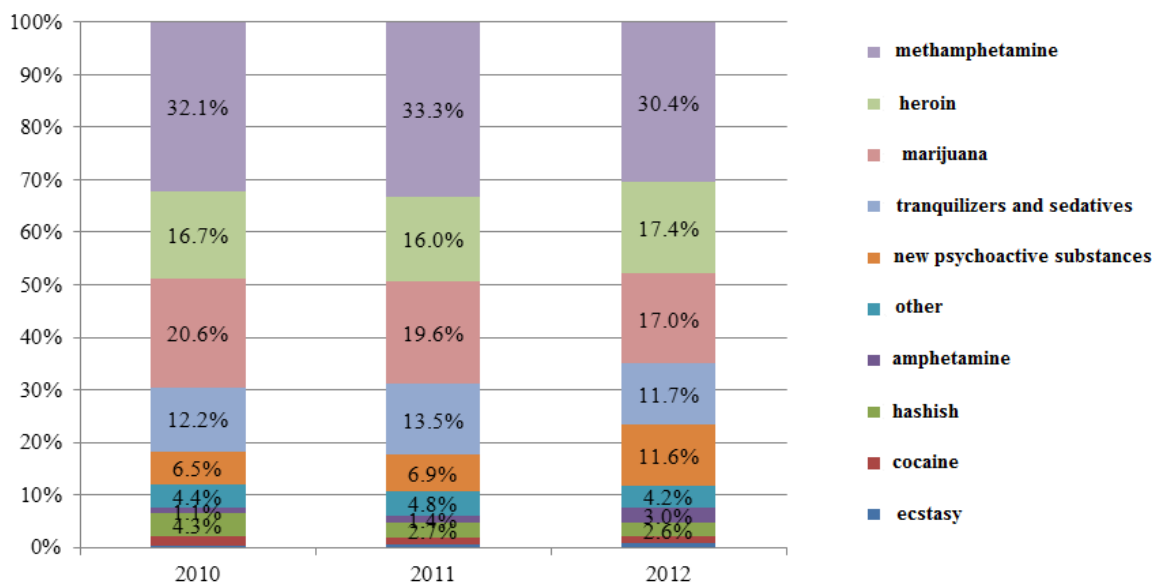
## 10.2. Seizures

### Narcotic and psychotropic substances

In accordance with the data provided by the Forensic Service Department of the State Police, 2438 seizures of narcotic, psychotropic substances, precursors and new psychoactive substances have been performed in Latvia in 2012. The specified number exceeds the number of seizures performed in 2011 (n=2042) by 16.2%, while the number of seizures performed in 2010 is exceeded by 23.8% (n=1859).

The majority of seizures was performed in Riga and Riga region (63%), where the main international transportation activities are also concentrated. Significantly smaller amount of narcotic substances has been confiscated in other cities of Latvia — Daugavpils (4.3%), Jelgava (5.7%), Liepāja (1.9%), and Ventspils (1.3%).

**Figure 10.2. Percentage of performed seizures of narcotic, psychotropic substances, precursors and new psychoactive substances in Latvia in 2010–2012 (%)**

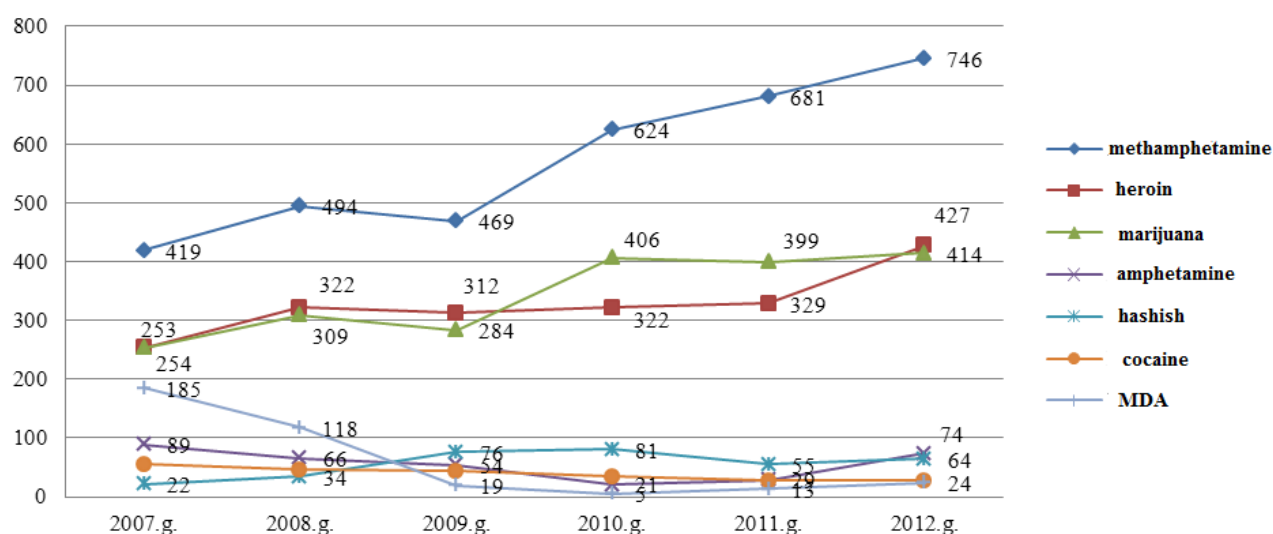


Source: data of the Forensic Service Department of the State Police, 2013

During several years there have been a stable tendency, which indicates that the most frequently confiscated drugs are methamphetamine (30.4%), marijuana (17%), and heroin (17.4%). Other substances basically have been confiscated in small amounts, therefore statistical reports do not describe a particular substance, but only its attribution to a certain classification group. For example, 11.7% of confiscated drug substances were attributed to the group of tranquilizers and sedatives in 2012, while 11.6% of confiscated drugs were attributed to the group of psychoactive substances (see Figure 10.2.).

Methamphetamine (30.4%) has been the most frequently confiscated drug in Latvia during many years. In 2012, in total there have been 746 seizure events for methamphetamine. This amount exceeds the respective amount of seizures performed in 2011 by 8.7% (n=681). In comparison with 2007, the number of methamphetamine seizures has increased by 43.8% (see Figure 10.2.). Considering the fact, that methamphetamine is the most frequently used substance among problem users of narcotic substances, this substance is regularly imported to the local market, while problem users are more frequently observed by the police. In 38.9% of all seizure events the weight of confiscated drugs has not exceeded 1 g, while the large amount seizures (when the confiscated amount exceeded 1 kg) have been registered only in 5 (0.7%) of events. In total, 20.47 kg of this substance have been confiscated and this amount is by one half smaller than in the previous year, when many large seizures were registered (see Table 10.3.).

**Figure 10.3. Number of performed seizures for various narcotic substances in 2007–2012<sup>51</sup>**



Source: data of the Forensic Service Department of the State Police, 2013

In 2012, heroin was in the second place (17.4%) in relation to the number of seizures. It must be pointed out that, in comparison with 2011, the amount of seizures has increased by 22.9%, and the size of seizures has been increased from 0.44 kg in 2011 up to 1.39 kg in 2012, and these results come close to the results obtained in 2007 and 2008 (see Figure 10.2. and Table 10.4.). With regard to seizure data, including purity indices for particular substances, it must be concluded that the market is likely to be recovering from deficiency of heroin that was observed within previous years. In most cases (78.1%) particular drug substances have been confiscated in small amounts up to 1 g, and this fact may be explained with possible storage of drugs for personal needs and with the small turnover of drugs.

**Table 10.4. Amount of some narcotic substances confiscated from 2007 till 2012 (kg)**

	2007	2008	2009	2010	2011	2012
Hashish	0.254	6.88	1.452	23.83	282	117.29
Marihuana (dried)	17.84	42.44	17.88	60.68	34.28	73.85
Marihuana (non-dried)	34.48	157.52	34.28	19.96	496.67	334.93
Heroin	1.75	1.75	2.144	1.12	0.44	1.39
Cocaine	11.9	5.15	0.44	206.06	81.49	1.07
Amphetamine	5.78	4.8	1.297	0.11	0.1	9.43
Methamphetamine	11.83	32.27	7.89	8.26	52.2	20.47
Ecstasy	94753	3945	281	23	3592	847
LSD	146	2	1	9	8	0

Source: data of the Forensic Service Department of the State Police, 2013

In relation to the number of seizures, marijuana currently holds the third position (17%) and, in comparison with previous years, the number of seizures remains stable, while the total amount of confiscated drugs has increased from 34.28 kg in 2011 up to 73.85 kg in 2012. This fact may be associated with various large seizures performed in marijuana plantations in 2012, during which already dried products (designated for further trade) were confiscated. Considering the amount of seizures in relation to the weight of confiscated drugs, it must be concluded that in 34.8% of events the weight of confiscated drugs was below 1 kg, in 45.2% of events the weight was from 1 g up to 10 g, while in 20.1% of events the weight of confiscated substance exceeded 10 g.

<sup>51</sup> See ST13\_2013\_LV\_1

Within the reviewed period, the number of amphetamines seizures has increased from 29 events in 2011 up to 74 events in 2012, while the seizure weight has increased from 0.1 kg up to 9.43 kg. This fact may be associated with discovering of amphetamine laboratories in Estonia.

There is a low number of ecstasy seizure events, although the possible returning of ecstasy is observed in the local market, because there have been 23 seizures registered in 2012, while 13 seizures were registered in 2011 and 5 seizures were registered in 2010. The number of cocaine seizures remains constantly low (28 events in 2012; 28 events in 2011; 34 events in 2010), because amphetamines are the main stimulant drugs.

Within the reviewed period a small plantation of hallucinogen mushrooms was discovered, where 59.8 g of dried mushrooms and 58.4 g of non-dried mushrooms have been confiscated.

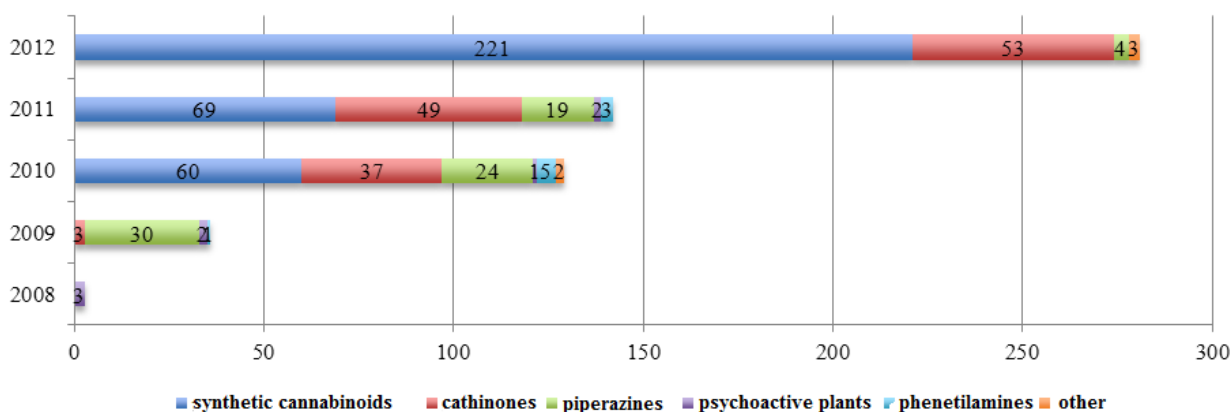
In addition to this, there have been 15 seizures of opiates (dried and non-dried poppy straw, acetylated opium, raw opium) and 52 seizures of synthetic opiates (buprenorphine, codeine, methadone, fentanyl, and carfentanyl) performed in 2012.

In 11.7% (n=289) of these events, the substances belonging to the group of tranquilizers and sedatives have been confiscated. Benzodiazepines (n=270) have been most frequently confiscated substance in this group. Totally, 4.9 kg of drugs and 2914 tablets of substances, which belong to the group of sedatives and tranquilizers, have been confiscated in 2012 (data provided by the Forensic Service Department of the State Police, 2013).

## New psychoactive substances

The number of seizures for new psychoactive substances has increased by one half (n=281) in 2012, in comparison with 2011 (n=142) (see Table 10.5.). Such increase of the number of seizures can be explained with opening of new trade places and with police raids performed more frequently in the places of trade. Totally, 57 new trade places for psychoactive substances have been identified in Riga and in regional cities in the end of 2012 and in the beginning of 2013 (data provided by the State Police).

**Figure 10.5. Number of seizures for new psychoactive substances, in 2008–2012 (in absolute numbers)**



Source: data of the Forensic Service Department of the State Police, 2008–2012

Generally, in 78.6% of events the confiscated substances were synthetic cannabinoids included in plant mixtures, as well as cathinones (18.8%). In addition, there have been three seizures of 5IAI substance and four seizures of piperazines. It must be pointed out that, while in 2010 the substances designated for preparation of end-products were confiscated (such as synthetic cannabinoids in powder form), in 2012 the end-products designated for sale have been basically confiscated (e.g., prepared plant mixtures) (confiscated amounts can be viewed in Table 10.6.).

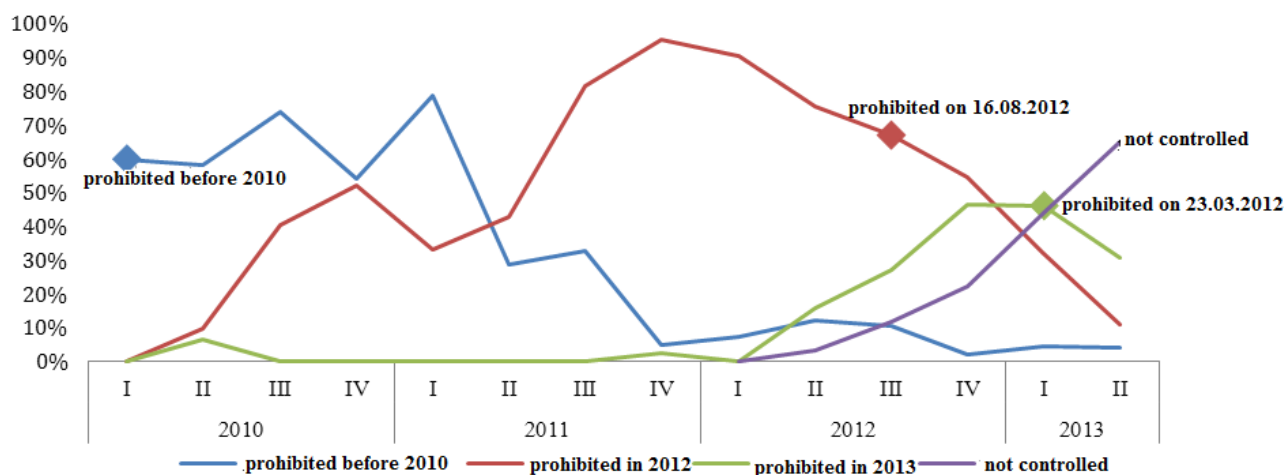
**Table 10.6. Amount of confiscated new psychoactive substances in 2010–2012 (kg/tab.)**

		2010	2011	2012
Synthetic cannabinoids	in powder form	4.8 kg	0.009 kg	0.004 kg
	in plant mixtures	3.07 kg	7.92 kg	2.99 kg
Cathinones	in powder form	24.5 kg	5.92 kg	5.8 kg
	In tablets	6	0	0
Piperazines	in powder form	0.015 kg	0.59 kg	0
	In tablets	627	118	310
phenetilamines	in powder form	0	0.54 kg	0
	In tablets	12	8	0

Source: data of the Forensic Service Department of the State Police, 2010–2012

In 2012, among new psychoactive substances, which were confiscated separately and in mixture with other substances, synthetic cannabinoids AM-2201 (28.8%), JWH-210 (26.3%) and UR-144 (18.5%) have been the most frequently confiscated substances.

It must be pointed out that the national lists of controlled substances were amended in 2012 and 2013, when new substances have been included in the list in 2012 and a generic system has been implemented in 2013. However, the turnover of new psychoactive substances has not decreased due to these actions, because as soon as a new project, which includes recitation of substances to be included in the list, has been published, the respective drug substances are gradually replaced with some new unregulated substances (see Figure 10.7.).

**Figure 10.7. Percentage of simultaneously prohibited new psychoactive substance groups for all new psychoactive substance seizure events in Latvia for the years 2010–2012 (%)**

Source: Zīle-Veisberga, 2013

Generally, it can be concluded that trading of new psychoactive substances can be attractive only in those cases, when trading of the particular substance is not regulated and the trader cannot be punished for these activities. So this is a reason why new psychoactive substances are rarely traded in the illegal market. Totally there have been 8 seizure events identified since 2010, when a new psychoactive substance was identified in a mixture with some “traditional” narcotic substances, e.g., marijuana mixed with JWH group substances, or piperazine mixed with methamphetamine, and cathinone mixed with methamphetamine. In addition to the above mentioned data with regard to trading of substances mixed with drugs, it must be pointed out that among 4544 criminal processes, which were initiated from 2010 till 1 July 2013, new psychoactive substances as well as traditional drugs have been confiscated within 130 (2%) criminal processes. During other seizure events, it was not observed that substances of both categories are confiscated within one criminal process (Zīle-Veisberga, 2013).



## Medical preparations containing narcotic and psychoactive substances

This section describes seizures of substances which are classified as prescription medicines (particularly, benzodiazepines, barbiturates, prescription stimulants, prescription opiates) in accordance to the methodology developed by UNODC<sup>52</sup>. Considering the fact that violations of medicine distribution rules are rarely registered, some medical preparations are illegally imported to Latvia or are produced on-site, as evidenced by some methadone laboratories discovered in 2010, as well as by two small GHB laboratories discovered in 2012.

In total, there have been 2.91 kg, 0.56 litres and 7910 tablets of medical preparations confiscated from illegal trade. In little more than half of seizure events (56.4%), medical preparations have been confiscated in places of detention. Generally, it must be ascertained that the described situation with regard to illegal trading of medical preparations remains the same as within previous years. In 2012, the confiscated substances can be classified as medical preparations involved in illegal trade in 14% (n=345) of seizure events. Benzodiazepines (alprazolame, bromazepam, diazepam, phenazepam, clonazepam, oxazepam) are mainly confiscated (74.4%) in this group of substances. Opiates (buprenorphine, methadone, codeine, and fentanyl) are confiscated less frequently (16%). In addition to this, 15 seizures of trihexyphenidyl (4.4%) and 4 seizures of zopiclone (1.2%) have been registered. Barbiturates have been confiscated only as a mixture with benzodiazepines (n=14; 4.4%). In addition to this, one seizure of ephedrine was registered (53 tablets).

Clonazepam has been the most frequently confiscated substance in this group in 2012 (64.5% of all seizure events), while buprenorphine has been the second frequently confiscated substance (6.4% of all seizures).

## Precursors

Totally there have been 6 seizures of precursors and 2 seizures of acetone (64.22 kg) registered in 2012, as well as 2 seizures of sulphuric acid (21.79 kg), one seizure of chlorohydric acid (27.96 kg) and one seizure of ethylic ether (23 g). Seizures of acetone, sulphuric acid, and chlorohydric acid were associated with discovering of an illegal methadone laboratory, which was performed in 2011.

It must be pointed out that 6.09 kg of GBL (which was used as a precursor for producing of GHB) have been confiscated in 2012 in two GHB laboratories.

The SRS Customs Service provides information concerning particular cases, when pre-precursor (APAAN) had been sent from China to Latvia for forwarding to other EU member states. Similarly, transportation of nitropropene to the European Union through the territory of Latvia was discovered (SRS Customs Criminal Board, 2013).

## Discovered plantations and laboratories for production of synthetic drugs

In 2012, there have been 7 marijuana growing events discovered, while in 2 of these events growing of marijuana was related to personal needs. In three of these events, the plantation was placed in greenhouses, while in four other events it was placed in particular premises. Totally, there have been 3,897 seedlings and 334.93 kg of non-dried marijuana (including the weight of seedlings and the weight of already cut plants), as well as 31 kg of dried marijuana confiscated (the State Police, 2013).

**Table 10.8. Discovered marijuana growing events and confiscated amount of non-dried marijuana from 2007 till 2012**

	2007	2008	2009	2010	2011	2012
<b>Marijuana growing events</b>	3	3	3	8	9	7
<b>Confiscated non-dried marijuana (kg)</b>	34.48	157.52	34.28	19.96	496.67	334.93

Source: The State Police, 2013; data of the Forensic Service Department of the State Police, 2007–2012

<sup>52</sup> UNODC. Annual reports questionnaire Part IV: Extent, patterns and trends in drug cultivation, manufacture and trafficking (unpublished) //



Usually there are two–four men employed in marijuana plantations. The greenhouses are equipped with moisture exhaust devices and heaters, while the plantations, which are located within premises, are equipped with heating lamps, thermometers, spreaders, sprinklers, ventilators, moisture measuring devices, mixers, generators, grease pumps, and energy supply was ensured with use of fuel. Geographically, plantations are discovered within all territory of Latvia. During the reviewed period, the largest plantation was discovered near Gulbene and there were four persons employed in this plantation; it was planned to trade the produced drugs in Riga.

A laboratory producing sedative GHB substance has been discovered in Riga, where 1.9 kg of GHB, 3.1 kg GBL, 230 g of marijuana, as well as large amount of firearms and ammunition have been confiscated during this event. In 2012, there have been a small GHB laboratory discovered in the Riga region; the owner of this laboratory was planning to use it for his personal needs, as well as to sell the produced drugs. Totally, there have been 419.3 g of GHB and 3005.9 g of GBL confiscated, as well as some items, which were used for production of psychotropic substances (funnels produced from polymeric materials, measuring vessel, weighing device (the State Police, 2013).

## 10.3. Prices and Purity

### Prices of illicit drugs at retail level

Prices of drugs in Latvia are observed within the competence of the Organized Crime Prevention Department of the Main Criminal Police Department of the State Police (hereinafter — GKRP ONAP), based on the operative information sources available to GKRP ONAP and to 5 regional departments of the State Police.

In 2012, there have not been any significant changes discovered during the performed analysis of drug prices at the retail level of illegal market.

**Table 10.9. Drug prices for the years 2010–2012 (EUR/g)<sup>53</sup>**

	2011			2012		
	min	max	mode	min	max	mode
Marijuana	7.1	17	11.3	7.1	17	11.3
Hashish	7.1	17	11.3	9.9	17	14.2
Heroin	35.6	99.6	71.4	42.7	99.6	71.1
Cocaine	42.6	85.3	71.1	42.7	99.6	71.1
Amphetamine, methamphetamine	7.1	21.3	14.2	7.1	21.3	14.2
Ecstasy (tab.)	4.2	7.1	7.1	2.8	7.1	4.3

Source: The State Police (GKRP ONAP), 2013

Drug prices are significantly different in Riga (as the capital city) and in the regions of Latvia. For example, the sale price for amphetamines in Riga is 7.1–14.2 EUR/g, while in regions of Latvia these drugs are sold for 7.1–21.3 EUR/g. The sale price for cocaine is 42.7–85.4 EUR/g in Riga, while in regions the price is 71.1–99.6 EUR/g. The sale price for marijuana and hashish is 7.1–14.2 EUR/g in Riga, while in regions the price is 10–17 EUR/g.

Drug prices in 2012 clearly reflect stability of marijuana prices, in comparison with the data obtained for the year 2011. Considering the fact, that the hashish price has increased by 2 EUR, it must be pointed out that the performed situation analysis has not discovered significant changes in the cannabis market. However, this analysis gives evidence to non-essential variation of prices, basically, at the level of regions, depending on the availability of hashish in the market, as hashish is less demanded in comparison with marijuana.

Increase of minimal price for heroine can be explained with the increasing number of drug seizures in 2012 (by 23.1% in comparison with 2011). This fact gives evidence to potential increase of

<sup>53</sup> See ST16\_2013\_LV\_1

heroin percentage in the context of supply and demand of drugs in the illegal market. In addition to the above mentioned, the analysis of drug purity indices for the year 2012 shows that the increase of heroin purity level was observed in 2012. This fact prospectively explains the increase in heroin price. The maximum increase in cocaine price is associated with the increase of purity degree for this substance, as well as with increase of prices. However, it must be pointed out that the sampling scope for this analysis is too small, as it does not allow to perform statistical analysis.

In comparison with 2011, prices of amphetamines have remained unchanged. Decrease in prices for ecstasy may be potentially associated with the fact, that this substance is not popular in the market, and new psychoactive substances have already become popular. It must be pointed out, that the prices for new psychoactive substances are varying between 2.9 and 14.2 EUR/g in Riga and between 7.1 and 42.7 EUR/g in regions.

Statistical data in relation to dosage prices for various drugs are collected by the State Police (see Table 10.10.).

**Table 10.10. Prices for one dose of various drugs in 2012**

	unit	price (Riga)	price (region)
Marijuana, hashish	0.25 g	2.8	2.9–3.6
Amphetamine, methamphetamine	0.25 g	7.1	7.1–11.4
Heroin	cheque (0.1 g)	7.1–14.2	14.2
Ecstasy	tablet	2.9	2.9–7.1

Source: The State Police (GKRP ONAP), 2013

Wholesale prices for narcotic substances remain at the same level as in the previous year. The wholesale price for 1 kg of heroin has varied from EUR 40,000 to EUR 85,000. Prices for 1 kg of amphetamine and methamphetamine have varied from EUR 3,000 to EUR 3,500, while the price for marijuana has varied from EUR 2,500 to EUR 4,000 EUR for 1 kg.

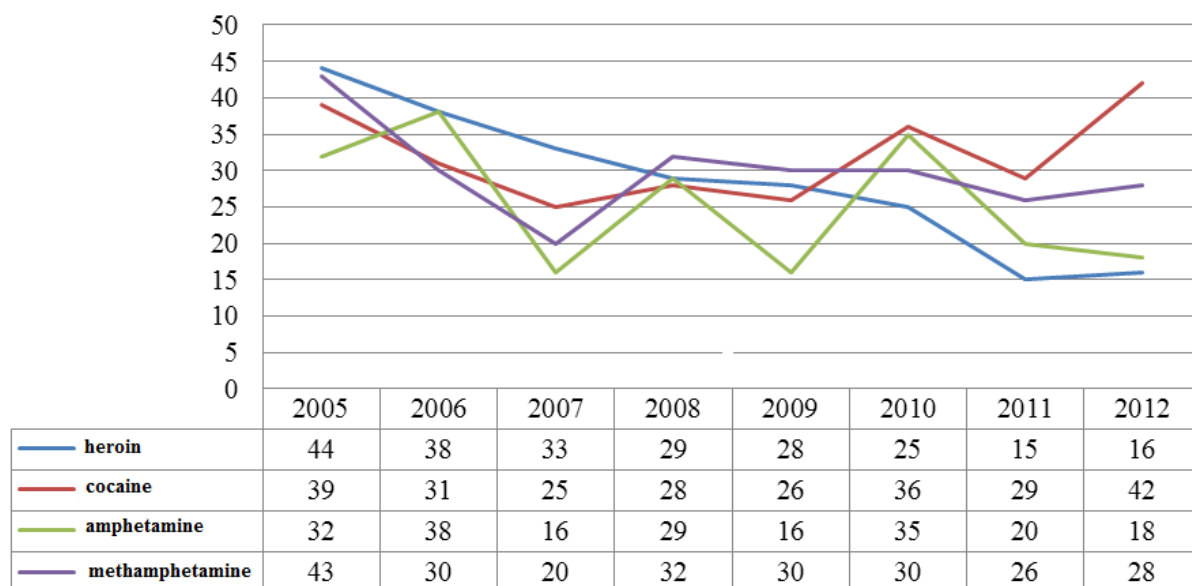
## Purity of illicit drugs

Purity of narcotic substances in Latvia is analysed within the competence of the Forensic Section of the Department of Criminalistics of the State Police. Although the gas chromatography method is applied during expert investigation, it must be pointed out that the THC level is not determined in cannabis products.

Generally, the increase of heroin purity level has been observed in 2012 (63% is the higher index in 2012, while 46% — in 2011). This fact prospectively clarifies the reasons for the above mentioned increase in heroin price. Similar situation has been observed in relation to cocaine purity, respectively, increase of the substance purity level has been observed in 2012, as the higher purity index was 90% in 2012, while it was 65% in 2011. This fact similarly explains the increase in cocaine price (the average purity is 42% in comparison with 29% in 2011) <sup>54</sup>.

<sup>54</sup> See ST14\_2013\_LV\_1

**Figure 10.11. Average purity of various drugs from the year 2005 till 2012 (average purity, %)**



Source: The Forensic Service Department of the State Police, 2005–2012

The purity degree for amphetamine and methamphetamine remained practically unchanged in comparison with the data obtained in 2011, and this fact corresponds with the mentioned information concerning stability of drug prices in the illegal market. Stability was also observed in relation to concentration of MDMA mg per one unit, respectively, in 2011 the average index was 99 mg per one unit, while in 2012 the average index was 102 mg per one unit.

The confiscated narcotic substances were mixed with other active substances, so the value of drugs was decreased, while the total weight was increased due to the presence of additive substances without psychoactive effect. The results of expert appraisals give evidence to the fact, that heroin is most frequently mixed with caffeine, dextromethorphan, and chloroquine, while lactose and glucose are used for increasing of the drug weight. In 2012, the admixture of lidocaine, phenacetin, and caffeine has been mainly identified in confiscated cocaine, while lactose and glucose were used for increasing of the drug weight. Amphetamine is most frequently mixed with caffeine, while methamphetamine is mainly mixed with ibuprofen and the total drug weight is increased with the use of glucose (data provided by the Forensic Service Department of the State Police, 2013).

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