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15 years
of the National Bureau for Drug Prevention

Special Issue

15 YEARS OF THE NATIONAL BUREAU FOR DRUG PREVENTION – TIMELINE

Date	Event
1993	Bureau for Drug Addiction established by way of Regulation of the Minister of Health and Social Care
	development of the first National Programme for Preventing Drug Addiction
1994	establishment of the Interdepartmental Team for Controlling Psychoactive and Narcotic Substances: Regulation of the Chairman of the Council of Ministers
1995	first issue of narkomania newsletter
1999	development the first complex National Programme for Counteracting Drug Addiction, including tasks of drug demand and supply reduction
	National Bureau takes over the responsibility for the implementation and financing of ESPAD research in Poland
2000	first national campaign of the National Bureau entitled Find time for your child] further national campaigns were centred on the following subjects: • The best way out is not to go in: 2002–2003 • Drug-free universities : 2004 • Closer to each other – further away from drugs : 2005–2006 • Support for local communities in counteracting drug addiction: 2006–2007 • Watch your drink: 2007 • Do you know what you are carrying: 2008
	National Bureau publishes a guide (in book form and online) on drug clinics (with the following editions in 2002, 2004, and 2007).
2001	establishment of the Information Centre for Drugs and Drug Addiction cooperating with the European Monitoring Centre for Drugs and Drug Addiction
	joining the EU-wide early warning system for detection of emerging trends and new synthetic drugs by the Centre for Information on Drugs and Drug Addiction
2002	establishing a network of 16 Regional Experts for Information on Drugs and Drug Addiction by Marshal Offices
	launching the system of specialist training in drug addiction therapy and rehabilitation
	appointing the Council for Counteracting Drug Addiction
	first general population survey according to EMCDDA standards concerning drug use among adults
2002–2003	implementation of the first contract on international cooperation focused on supporting administrative structures and adjustment of legal regulations to EU requirements connected to Poland's accession to the European Union; the partner of the National Bureau was France (Phare 2000)
2004–2005	implementation of another contract on international cooperation focused on supporting structures of governmental administration and local communities Fight against drugs: continuation; the partner of the National Bureau was the German Ministry of Health and Social Protection (Phare 2003)
	launching works on standards in addiction therapy (establishing the team for developing accreditation)
	first national survey among students on the prevalence of psychoactive substance use
2005	Act of 29 July 2005 on Counteracting Drug Addiction: • introducing the obligation to approve community programmes and indicating sources of its financing • allowing non-public health care units to provide substitution treatment • introducing forms alternative to a punishment for drug users causing harm
2006	Polish Minister of Health assumes presidency of the Pompidou Group for the period of four years
2006–2007	implementation of another contract on international cooperation focused on supporting structures of governmental administration and local communities "Supporting local authorities in counteracting drug addiction at the local level; the partner of the National Bureau was the German Centre for Information on Drugs and Drug Addiction (Transition Facility 2004)
2007	completion of drafting and beginning of the implementation of the Ethical Code of Addiction Therapist
	launch of the pilot project on monitoring admissions to drug treatment, in line with the standards of the European Monitoring Centre for Drugs and Drug Addiction
	Poland joins the "FreD goes net" international project
2008	implementation of an international contract "Supporting local authorities in counteracting drug addiction at the local level – continuation"; the partner of the National Bureau was Spain (Transition Facility 2006)

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COMMUNICATION WITH SOCIETY IS CRUCIAL

Interview with Piotr Jabłoński, Director of the National Bureau for Drug Prevention, president of the Assembly of Permanent Correspondents of the Pompidou Group, by Tomasz Kowalewicz

The year 2008 marks 15 years since the Minister of Health and Social Care established the Bureau on Drugs, which in 2000 was reformed into the National Bureau for Drug Prevention. How was the drugs scene changing in Poland in the meantime?

In the 1990s, the core of the market were opiates, primarily home-made, the so-called Polish heroine. Today, the basic drug is marijuana. The CBOS study from 2008 that diagnosed the use of drugs among young people from the last classes of secondary schools shows that heroin has been altogether eliminated from the area of interest of young people. In the national representative sample for that age group, there is not a single hint at using heroin, be it the "compote", brown sugar, or crystal heroin. It is a big change. When it comes to the dynamics of the phenomenon, we observed until recently the growth – sometimes dramatic – in the numbers of people reaching for psychoactive substances, both illegal and legal, in the successive studies. Since 2005, we have observed a decreasing tendency in this field among the students of lower secondary schools aged 15–16, at the same time we observe a stabilising tendency, and also a decline in the case of some substances, in the older group – students of secondary schools, aged 17 to 18. These regularities were evident also in other studies, for example in SPAD of 2007, in the Mokotów research, in the Social Diagnosis, and the most recent study which CBOS conducted for the National Bureau. Similar results can also be found in the report of the Polish Highest Chamber of Audit (NIK) published in mid-2008 on the state of safety and social problems in schools. It pointed at the fact that the prevalence of drugs is smaller than it used to be, and keeps falling. Today, the drug scene is dominated by two phenomena: the fall in drug use and poly-drug use (i.e. combined use) of various substances, especially marijuana, amphetamine, ecstasy, and also pharmaceuticals with alcohol. Yet it is to be emphasised that the studies estimating the number of all addicted people in Poland show a marked increase in their number (to the level of 100,000–130,000 people), which may be the result of increased consumption of drugs in the 1990s and in the first years of the 21st century.

A new challenges are the so-called legal highs (Polish: dopalacze), that is a group of psychoactive substances, which is distributed legally through a network of online and "traditional" shops.

What have been the changes in institutional anti-drug actions and in the law on drug addiction during the last decade?

Quite revolutionary legislative and organisational changes have taken place in these areas. Maybe not as important as the outbreak of activity of non-governmental organisations early in the 1980s, which initiated dealing with the drug problem in Poland. Earlier, the problem practically neither existed in the public conscience, nor in the institutional activity of the state.

These were the non-governmental organisations that provoked a response to the problem both on behalf of the society and the state. Much has changed in the recent years in the field of increase in the role and responsibility of institutions representing civil society. The turning point was the year 1999 when local and regional authorities embarked on solving social problems: thanks to the decentralisation of the state and shift of some competence from the level of central government to the local levels. From year to year,

we observed increasingly larger involvement of local and regional authorities, especially at the most local communal level, but also at the regional level. Their financial activity, which allows concluding practical projects, is significant. I see that local and regional authorities perceive dealing with the problem of drugs as an investment in public health and safety within their own commune and region.

Do local and regional authorities deal with prevention or care at a more advanced level of drug dependency?

First of all, it must be said that the interest in professional assessment of local situation is increasing. Decision-makers, local and regional authorities realised that the lack of good assessment involves the risk of embarking on ineffective actions. The National Bureau supports the process of shaping conscious anti-drug policy in local and regional authorities. This is done in two ways: first, through legislative changes in the Act on Counteracting Drug Addiction, and secondly through training and providing local and regional authorities with good practices for conducting effective actions.

Therefore, to answer your question directly, I believe that local and regional authorities focus primarily on prevention, which does not mean that they would not co-finance therapy and rehabilitation, yet they deal with these to a far lesser extent, which after all is logical as treatment and rehabilitation are mainly the domain of the National Healthcare Fund.

When the Polish drug stage was developing, the dominant substance was "the Polish heroin", home-made to a great extent for own use, with only small amounts being sold. The beginning of the 1990s is the time when economic processes turned to market economy. Has this process influenced also the area of drug addiction?

Decidedly so. At the time of "compote", the producer, consumer, and also the tradesman was usually the same person or group of people, while the abuse of drug law was frequently of the so-called "crime without victim" type. Beyond doubt, the 1990s brought an absolute change of that pattern. An addict running with a bottle of "compote" all around the "bajzel" (Polish slang for place frequented by users) became a thing of the past. What became dominant is the well-developed market of the criminal world, supplied with heroin for smoking, brown sugar, and especially amphetamine, which was quite unavailable and expensive still in the 1980s, and now has turned into one of the most popular psychostimulants, in Poland second only to marijuana. Prices of drugs were continuously falling. It was caused by their very large supply and lack of barriers in availability. Drugs became an element of economy, the black economy, and followed the same laws as other products. Large supply, general access, low prices. It has only been in the recent years that respondents of the studies began to point at problems in getting drugs. For the first time in many years, we also noted that prices of drugs in the illegal market had begun to grow.

Did Poland's joining the European Union change anything in the approach to the problem of drug addiction in our country?

Like everyone else, we expected that accession to the Union would change much in many dimensions of social life. Even before the accession we – both the Bureau and the entire milieu – began a range of preparations. What I think here about primarily is the establishment of a system for monitoring the phenomenon of drug addiction and drugs, and establishment of the Information Centre for Drugs and Drug Addiction within the structures of the National Bureau. Thus, before becoming a full fledged member of the Union, we already prepared mechanisms that let us enter the European information flow in drug monitoring. I mean here, primarily the so-called five key indicators developed by the EMCDDA , and also the early warning system on new substances. Moreover, while developing the National Programme for Counteracting Drug Addiction, we were trying to account for the main principles, priorities, and strategies of the EU Anti-Drug Strategy and EU Action Plan on Drugs. At the same time we were developing such elements of the national system that have no role model or counterpart in the European Union, and which we found necessary for its efficient operation, mostly within the area of treatment and rehabilitation, and training of the therapeutic staff. Unique features of our treatment system is its strong reliance on non-governmental organisations and the concept of long-term treatment.

Another question characteristic of Poland and absent from most European Union countries is the model of early care for the young people reaching for drugs. We

developed a system for training the staff, certification of specialists and instructors in addiction therapy. These are our strengths. I am not keeping the fact that we also have shortages under wraps, for example there is too little access to substitution treatment. Even though the number of people dependent on heroin is falling, and therefore the target group for substitution therapy is diminishing, the needs still exceed the capacity. Accession to the Union changed hardly anything here. This results generally from the fact that medicine and health care, which include also counteracting drug addiction, is the domain of internal policies of individual member states. The Union has no special prerogatives in these areas. There is naturally the European strategy, there are certain directives (for example, the recent recommendation concerning inclusion of new substances into the list of controlled substances), yet generally the system of treatment, rehabilitation remains a domain of national law and organisation. A great benefit from joining the European Union is the ability to draw from EU funds and access the know-how. The beneficiaries here include both the National Bureau (We made use of the PHARE programme already during the preparatory phase, and later – from the Transition Facility programme.) as well as other institutions, primarily non-governmental, which to a broad extent began to make use of EU funds or the funds available thanks to our accession to the EU (for example the Norway Grants and the Swiss Polish Co-Operation Programme-editor's note).

You mentioned a system for staff training. Can you say something more about that.

For a long time treatment of drug addiction was primarily the domain of people who themselves had problems with psychoactive substances. I cannot say what percentage of the staff they accounted for, but I want to turn your attention to the fact that the concept that a former addict is the best therapist used to be binding not only in the drug but also alcohol treatment. There was a general opinion that one who used to be dependent would be the best to deal with the person who is dependent. The National Bureau has long forsaken that concept. Scientific literature does not corroborate the effectiveness of such solutions either. Just the other way round, plenty of studies prove that it is training and certification of treatment and rehabilitation staff that are the basic factors in increasing the efficiency of therapy, and not personal experience with psychoactive substances. Moreover, only training may improve the quality of the services offered. This is why we undertook steps aimed at developing and implementing a concept of a training system that would cover instructors, and primarily specialists in addiction therapy; one that would also be an answer to the needs of the milieu. We wanted to codify the training system in such a manner that it would become an impulse for professional development. We expected that completion of training would be transformed into a more efficient, more productive work with the patient. At the same time, we – in our capacity of a central institution – did not want to monopolise training activity within drug prevention. We decided to prepare the principles for training staff and their certification, develop core curricula, and then "give this training away" to universities and other institutions ready and eager to train the staff in line with the principles we developed. The National Bureau does not enter the system until its last stage, namely the verification of the effects of training, by conducting examination procedures. As yet, this model has passed the test. The decentralised system of training began to live its own life: while doing what they are obliged by law, some institutions provide additional elements to the training. For example, the Catholic University of Lublin (KUL), which became a part of the system very early on and developed a training team, expanded the offer with subjects concerning the family. The Polish Federation of Therapeutic Communities (PFST) expanded the module devoted to the therapeutic community method. The system is still developing. Some institutions of higher education began to offer training for therapeutic staff as postgraduate studies. Cooperation with six training teams has ensured not only territorial decentralisation of the training system, but also content expansion.

The training you mentioned concerns treatment, re-integration and rehabilitation. What actions are taken in the area of prevention?

From the perspective of the Bureau, we have in fact narrowed down prevention to second-tier prevention, also defined as selective, i.e. actions addressed to individuals or groups whose vulnerability to problems connected to the use of psychoactive substances exceeds the average. With special interest, we support actions related to harm reduction. When it comes to the training of people who deal with general prevention addressed to

the young people, this is the domain of the Minister of National Education, who we cooperate with, yet this is not our main task.

You mentioned that the National Bureau is trying to develop substitution programmes. Is it an alternative to "drug-free" programmes, which aim at bringing patients to total abstinence?

There are no opposite goals of the total abstinence approach and that focused on harm reduction as there is no contradiction between these concepts. Abstinence is a long-term goal that is reached by a minority of people dependent on drugs. Harm reduction follows a variety of particular goals, sometimes very easy, that may seem – especially for an external observer – trivial, as for example, reducing the dose of the drug taken, or switching from intravenous use to smoking. Once it seemed that such changes may not be goals in the therapy. And yet they weaken the strength of the addiction and enhance the patient's motivation to achieve successive therapeutic goals, thus improving his quality of life. No one said that the dynamics of change ends with this first, sometimes very easy objective.

I believe that in the general understanding, substitution is associated rather with transition from one drug to another, narcotic to a smaller or greater degree, yet administered in a regular manner, without actually the possibility of making another step, which is quitting psychoactive substances at all.

It is not so, absolutely! I believe such thinking to be absolutely outmoded. Substitution or harm reduction aims at many objectives. Substitution programmes, moreover, encompass various patients. Some use methadone to extend detoxification, and some will be taking it for many months if not years. There are also people who receive, even though regularly, yet minimum doses of methadone. They are fully integrated socially, and function efficiently in their social roles: they have families, and learn or work. Besides them, in substitution programmes we also have patients who, as we say are "zeroing in", that is decreasing the doses until in one point of time, they will stop taking methadone entirely and reach abstinence – at least opiate abstinence, as they may use other psychoactive substances, for example, nicotine or alcohol.

We must remember that only from 20% to 30% of drug addicts enter programmes of the "drug-free" type. 70% of those in need remain beyond the institutional support! This is primarily that group that harm reduction programmes should address. It is necessary to pass the message: OK, we do not want you to take drugs, yet if you already do, try to do it in a safe manner. Give yourself the chance to improve the quality of your life. In the beginning, this can be a small step. You do not have to declare immediately that you will live without drugs. It may be at some later time that you will consider it a realistic goal.

I believe that the efficiency of this approach should be corroborated in systematically conducted research.

That is right. Such research was conducted in many countries, even though not in Poland, and has proved high efficiency in limiting such factors as contraction of illnesses, not only HIV but primarily HCV, hepatitis, and STDs. The number of criminal offences and accidents was reduced too. The research proves also that substitution programmes do not fully match the ideal, which is achieving abstinence, yet they are undeniably efficient when it comes to the measures listed above.

It seems to me that the problem of drug addiction in Poland has become quite common. Once it used to be on the one hand a taboo, while on the other it held an element of sensation, once drug addiction began to be spoken or written about. Now, there is less space devoted to drug addiction in the media, and this is what my question is connected to: are there any changes in public opinion in reacting to the problem?

I find this one of the most important things. It has always been my secret dream to stop perceiving drug addiction as a source of sensation, to stop seeing drugs as only a scandal. Drugs and drug addiction are an element of social life. It has always been so, it is not something that has suddenly happened to us. Only the scale of the phenomenon has changed with time. I always found two attitudes an obstacle. First: that drugs are not our problem: not mine, not my family's, friend's, school's, my military unit's, university's. Then whose problem is it? Of some ruffians, derelicts, bored youth from good families? The other attitude is connected to this one. When it finally turns out that it is my problem, my friend's,

my child's, and most often – my family's, the most frequent reaction is a change in the valuation of our life: considering that it has been lost, questioning the sense of being a parent, brother, somebody close. This denotes bankruptcy and experiencing a total defeat at a time when one should rally and act to prevent a certain situation and provide efficient help.

A change in the attitudes is necessary. Drugs must be considered only one of many unfavourable elements permanently present in our lives. Once we have become used to this problem, and at the same time we stop ignoring it – claiming that it may concern everyone but not us, we will be able – once it has affected us – to rally, and not yield to despair and sense of hopelessness. Such an approach will make it easier for us to deal with the problem efficiently. I believe that our society has begun to follow changes in that direction.

Most of the actions of the National Bureau are in fact focused on making the change deeper. Also the legislative changes had a similar object: reinforcement of local and regional authorities, and civil society as the most important elements of responding to the drug problem.

We began to establish educational campaigns that were no longer focused on the message "see how the child's eyes change under the influence of drugs, look at the veins, look for injection marks". We started to say: talk to your child. Not about drugs, just talk to him or her. We started speaking about social connections: "closer to one another – further away from drugs". This was taken up. Today, they say: "closer to one another – further away from crime"; "closer to one another – further from bulimia". We were trying to make people aware of the subject. It was not about accepting drugs, but about perceiving them as an intrinsic element of our life, and discovering that we are not helpless towards them. We can act efficiently as citizens, parents, friends. And this is a key question in this entire matter. The problem of drugs will not be solved by MONAR or Father Arkadiusz Nowak in for all Poles. We need a change in our thinking. It seems to me that this change is being made. It is supported by an increasing number of epidemiological studies, monitoring and showing the facts: that psychoactive substances are present in social life. We observe the convergence of the world of alcohol and the world of drugs. Today, most of those who enter treatment are poly-dnig users drinking alcohol and mixing it with illegal substances. Ever more often, we are aware of the fact that the mechanisms of addictions are the same for legal and illegal substances. Sometimes it is a question of coincidence whether a young person begins to experiment with alcohol or illegal substances. Plenty of studies show that it is in most cases the alcohol that provides the gateway to addiction and illegal substances.

Closing, I would like to ask you what the National Bureau will be focusing on during the coming year, and what the most important thing to be done is.

The hottest subject is the question of new substances, and primarily the so-called dopalacze (legal highs). Another problem is the use of pharmaceuticals, others than those classically identified with drugs: sedatives, anti-depressants, tranquilizers. I mean here generally available substances that can be abused, used for losing contact with reality, or the ones that may be easily processed, as appropriate technologies are frequently generally available, for example, online. We find it a major problem.

The method based on expanding the list of controlled, i.e. illegal substances, has pushed us in a sense "against the wall". We need to begin searching for new ways: on the one hand to stop the phenomenon, and on the other – to educate the society, develop self-awareness, and implement prevention.

When it comes to legal highs, these are mixtures of different substances, most often featuring a warning that they are not earmarked for consumption. They are sold e.g. as plant fertilisers or collectables. There may be hundreds if not thousands of such mixes. We cannot control all of them. We must make people reflect, provide them with tools to begin to learn to care for their safety. That they do not lend their ear to statements that these substances have been officially examined and considered safe. So far, we have no good solution. We are expanding the list of controlled substances, ones that we may consider psychoactive and capable of negative impact on health.

We are also looking for other solutions, for example, a ban on advertising products through reference to psychoactive properties of forbidden substances, which is the case with legal highs: take this product,

because it is legal and acts as amphetamine. What is in fact most important is the communication with society. We are not capable of saving everyone. On the other hand, we should provide the maximum of credible information for everyone to make a choice and know the risk while making the decision.

Thank you very much for your time.

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• stopień rozpowszechnienia i wzorce używania narkotyków wśród całej populacji;
• stopień rozpowszechnienia i wzorce problemowego używania narkotyków;
• choroby zakaźne związane z narkotykami;
• zgony związane z narkotykami i umieralność wśród narkomanów oraz
• zgłaszalność do leczenia z powodu problemu narkotyków.

European policies towards drugs and drug addiction have for a long time tried to skilfully combine elements of repression, prevention, and therapy. This results from many years of experience teaching that the faith in achieving success only through sanctions and repressions is absolutely misleading. Unfortunately, there are plenty of reasons to believe that this message has not necessarily reached Poland.

POLISH LEGISLATION ON DRUGS AND DRUG ADDICTION: BETWEEN REPRESSION AND THERAPY

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In 1985–1997, the questions of drugs and drug addiction, including the problem of criminal responsibility for actions connected to illegal trading of drugs, was regulated in Poland by the Act of 31st January 1985 on preventing drug addiction. It was the first complex regulation of these questions within a single act of law. Appraisal of that Act, despite its numerous shortcomings and shortages, must be positive. Its authors tried to provide a preventive and therapeutic approach to drug addiction, that is one where priority was given on the one hand to drug prevention, and on the other – to the treatment, rehab, and re-integration of the addicted. Criminal sanctions towards addicts and other users were to be used as an actual ultima ratio.

Criticism of the lack of repressions

When it comes to the scope of penalisation, the provisions of the Act of 1985 focused on repression of actions concerning illegal sales of drugs. Other actions including purchasing of drugs and their possession

were not criminalised. The authors of the act drew an assumption that these behaviours are typical of drug users, and therefore, they are actions connected to the demand for these substances. In this sense, the purchase and possession of drugs are actions "normal" for the users, and are commonly present in the group. If the legislature did not want to use mass criminal repressions against the addicted and preferred to apply towards them an approach based on prevention and treatment, these actions indeed had to remain decriminalised.

The solution approved in the Act of 1985 was based on this very decriminalisation, i.e. total impunity for possession of narcotic or psychoactive substances, which however did not mean that such possession was allowed, least to say that drugs were legal in Poland. Such views expressed frequently in the 1990s in the media were based on an utter misunderstanding. Under the law of 1985, possession of drugs, against the stipulations of the Act, was illegal in the understanding of the administrative law, and the substances owned were forfeit (confiscated). It was not true, therefore, that "one was allowed to possess drugs" in Poland. It is, however, a fact that such possession was not penalised.

After 1990, due to the formation process of the "normal" black drug market, the increase in the scope of use of these substances, and also due to the fact that Poland became a significant European producer of synthetic substances and an important transit country for trafficking drugs, the Act of 1985 became the object of growing criticism as too liberal and paying too much attention to prevention and treatment, and too little to repression. The object of a specially harsh criticism was primarily the fact of lack of criminalisation of drug possession. In the media and in statements of politicians it was unanimously – even though entirely unduly – identified with consent to possess and use drugs. Yet the core of the problem boiled down to the fact that, in line with the Act of 1985, it was not a crime to possess any amount of narcotic or psychoactive substances, which included even large amounts. This was truly a solution rather hard to find. As a consequence, if a perpetrator could not be proved to traffic, trade, or perform other similar actions, he remained in fact beyond punishment and the only thing to be done was to confiscate the substances he possessed. This led to numerous complaints, primarily on behalf of the police who claimed that lack of criminalisation of drug possession makes it difficult if not impossible to fight efficiently against the developing transit of drugs across the Polish territory to the countries of Western Europe, illegal production of amphetamine, and primarily – the illegal trading in drugs. It is true, that proving in practice e.g. trading in drugs is frequently very difficult. Actually the only means of proving this is to catch the perpetrator red-handed, that is while dealing out the substance and collecting the payment. This, however, is not always easy and possible. Possession of drugs, on the other hand, is relatively easy to prove, as it is enough to find substances on the perpetrator, and no specific purpose must be proved. In this sense, criminalisation of drug possession is actually treated in the legislation of many states as a means that makes the fight of police against illegal trading in drugs easier. It is important that such a solution does not trigger excessive negative consequences for drug users, and primarily for the addicted.

The accursed gift of freedom

The Act of 24th April 1997 on Counteracting Drug Addiction approved by the Sejm – Lower House of the Polish Parliament satisfied in many aspects the postulates of moderation in using repression in policies towards drug addiction and emphasised, at least to an equal level, prevention and treatment. The basic novelty was the introduction in the Article 48 of the Act of criminalisation of possession of narcotic or psychoactive substances. Article 48.4 stated that the perpetrator, who possesses insignificant amounts of narcotic or psychoactive substances for personal use is not liable to punishment. This meant that the act did not envisage full decriminalisation of "petty possession", but only its depenalisation. In line with this solution, all the forms of possessing the drug remained a forbidden act under the penalty of punishment, and "petty possession" was a circumstance that excluded only the punishment and not the criminal nature of such an act. In practice, this meant that the cases

related to such forms of ownership should not have been initiated, and once initiated – be dismissed.
The solution presented above, even though generally commanding approval, included a serious problem. Unlike the earlier proposals, the act did not contain any definition of "insignificant amount". The earlier drafts, following those from many other European countries, envisaged a special appendix containing specific weight limits for individual substances. What finally prevailed, however, was the argument that the solution assumed in the act would be more flexible than the rigidly defined thresholds, which will allow law enforcement agencies (and primarily the prosecution) more flexible application of the law. Unfortunately, there are plenty of grounds to believe that for the law enforcement agencies – not necessarily used to making independent decisions – such a formulation became a peculiar "accursed gift of freedom". Police and prosecution had profound problems with assessing what volumes of which substance may be considered "insignificant amount". This resulted in numerous practical difficulties in applying the law and became one of the reasons for its later amendment.

To treat rather than punish

As far as other stipulations are concerned, the Act of 1997 retained many solutions of its predecessor, allowing preventive and curative actions, developing them significantly in many cases. First of all, it did not introduce changes related to the admissibility of forced treatment. Nor did it introduce any changes into the exception from the principle of freedom of decision in the treatment envisaged by Article 17 and concerning acceptability of forced treatment and rehabilitation imposed on addicted minors by the family court. Parallel to the above, the Act introduced a new rule, namely Article 57, being the implementation of postulates to include into Polish legislation provisions that would more clearly carry out the principle of priority of treatment over repression towards the addict. This rule allowed the prosecutor to suspend the preparatory measures against the person who committed a crime, if the person entered appropriate treatment. This rule could be applied fairly flexibly, and pertained to crimes subject to penalties not exceeding five years of imprisonment. In this way, the law encompassed most crimes typically committed by the addicted, both these defined in the Act on Counteracting Drug Addiction and in the criminal code. After the conclusion of the treatment, in case of its negative outcome, the persecutor should bring an accusation, and in the case of the positive outcome – put a motion to the court for conditional discontinuance of legal proceedings. In the latter case, resorting to the conditional discontinuance of legal proceedings was to be a certain bonus for entering treatment and for its positive result. In this way, the Polish legislation acquired an act trying to put to practice the "to treat instead of punishing" principle, in which criminal sanctions are regarded rather as a factor motivating drug users to undergo therapy, and not as an instrument of pure repression. Such an approach may naturally have also its undersides. Yet it goes without saying that it is known in the great majority of European legislations, and is an attempt at moving away from pure repression of drug users and involvement of the law enforcement and systems of justice into actions of preventive and therapeutic nature. Leaving aside the fact that the formulation of the rules of the Act of 1997 was far from ideal in this scope, it is to be emphasised that the use of such laws requires also a change in the approach and attitude of the law enforcement and justice systems. Their representatives should first of all realise that in such cases, they deal with a specific category of perpetrators who require special treatment. Unfortunately, in many cases, it turns out that the resignation from purely repressive attitude towards such perpetrators results in significant difficulties for the police, prosecution, and courts, not only in Poland.
Describing the provisions of the Act of 1997 on Counteracting Drug Addiction, it may not be forgotten that for the first time in Poland, it established unambiguous legal grounds for implementation of certain forms of harm reduction strategy, and primarily – of substitution based on methadone. Its Article 15.1 stated clearly that an addicted person may be treated in line with the programme envisaging the application of substitution treatment. It was a very important achievement, as substitution treatment programmes operating earlier in Poland (since early 1990s) had no clear legal grounds.

The Act of 1997 provided such grounds, settling all and any legal disputes at hand. What raised objections from the beginning, however, was the bylaw which defined in greater detail the conditions and principles for conducting substitution programmes and imposed a range of far-going restrictions in the area. Further amendments of this bylaw introduced a number of postulated changes, first of all broadening the rights of persons conducting the therapy, and abandoning the rigorous rationing in the scope.

Already in June 1998, that is just over six months after the new act entered into force, when the experience connected to its operation was still immaterial, the MPs presented a draft amendment. Its most important element was the proposal of deleting the item 4 from Article 48. The justification of the draft stated that "the police experience proves that dealers trading in psychoactive substances frequently have only small amounts on them. It must be stated unambiguously that the content of Article 48.4 does not make the struggle against traders and dealers easier. For that reason, the proposed change of the Act on Counteracting Drug Addiction aims at tightening the responsibility for participation in drug trading."The above statement is exceptionally characteristic of the way of discussing the subject in Poland, which since the early 1990s has too often been dominated by the point of view of the law enforcement and the justice system, who perceive the entire problem primarily from the point of fighting against the illegal drug sales (which is exactly the opposite of the attitudes dominant the 1980s). All the rest, the health and social aspects of the drug problem remained beyond the scope of their interest, as they are beyond the manner of perceiving the question, nearly solely through repressions. In other words, answering the question whether drug addiction is a problem of criminal or health policy in Poland, the first answer is chosen increasingly often, which results from the approach to the problem of drug addiction (characteristic among others also of the United States) primarily through the question of the drug sales. And yet drugs and drug addiction problems are of criminal and health policies. For this reason, many European countries undertake clear attempts at such placement of emphasis that sales of drugs really become the object of criminal policy, while demand for drugs remains – as far as possible – primarily within the area of instruments of health and social policies.

For this reason, the amendment of the Act on Counteracting Drug Addiction passed in 2000 must be considered a typical case of throwing the baby out with the bath water. Even if its authors really acted of the eagerness to simplify fight against illegal trading in drugs, one may have profound doubts whether they managed to meet this objective in any way. At the same time, the highest price for the new solution was beyond doubt paid by the addicted and other drug users: in procedures against them elements of oppression began to take upper hand over actions from the realm of health and social policy, even though it was frequently stated that it was not the goal behind the proposed solutions. It is true that the problem of treating the "petty" possession of drugs by criminal law is in effect, a peculiar way of squaring the circle, and every attempt at solving the question means awarding primacy to one of the opposing options in the policy towards drugs. The criminalisation of the "petty" possession may in certain situations alleviate the fight against trading somewhat, yet by no means is it a miraculous weapon, and the more so it is not the "mace" – as some politicians called it – to be used against the traders and dealers. The price of this approach is paid in most cases by drug addicts and other users. Lack of such criminalisation or its limitation provides significant benefits in the policy towards users, yet its price may pose certain handicaps for the police, which nevertheless must not be exaggerated. Making the work of the police easier should not be treated as the overarching objective of legislation regulating questions of drug addiction (as well as any other rules of criminal law).

Speaking about negative consequences of the amendment of the Act of 1997, one must primarily point at the fact that the criminalisation of the "petty" possession pushed drug users deeper into the underground and made efforts to conduct a policy of harm reduction – involving actions in health and social realms – towards them harder. The most extreme example of such consequences was beyond doubt the period – luckily a short one, following the coming of the act into force – of questioning the legality of syringe and needle exchange pro-

grammes. At the same time, everything suggests that the goal of police actions were not as much the major dealers but petty users of drugs, as they are potentially the easiest goal. The experience of the countries that in a similar, exception-free way criminalise the possession of drugs has for years proved that such cases of "petty" possession strongly dominate the structure of the disclosed drug crime. In other words, the full criminalisation of the "petty" possession leads to something that is described as "the great hunt for small fish". It is actually insignificant for fighting the illegal demand for drugs, and at the same time results in a range of negative side-effects. Data from police statistics on disclosed drug crimes as well as results of studies into the files of drug possession cases in Kraków courts, presented in the previous issue of the "Newsletter" prove the existence of this phenomenon also in Poland.

Has change arrived?

The new Act on Counteracting Drug Addiction approved by the Sejm on 29th July 2005 did not change in any way the solutions in the scope of criminal responsibility for drug-related crimes, including drug possesion. Unfortunately, the attempt to introduce all the solutions expanding the possibility of using alternative means in the criminal procedures with those of preventive and therapeutic character proposed in the governmental draft failed. And yet there were important proposals trying to combine the legal and criminal repressions with solving problems of drug users. Even though the grounds for applying the institution of suspending the procedure so that the perpetrator might be subjected to appropriate treatment was expanded, as earlier this institution could be applied only towards the addicted who should enter treatment. Many drug users who commit crimes, however, are not addicted, which makes the rules on suspending procedures against them null and void, and leaves the only option of repression. Hence, the new act provides an opportunity to use such a suspension also towards a person who uses psychoactive substances in a harmful manner, if the person participates in a prevention and treatment programme. The option to use this institution was awarded also to the court during the case, and not only to the persecutor in the preparatory proceedings. A positive solution was also provided to the question of allowing substitution treatment programmes in prisons and remand centres (which had raised numerous controversies earlier). Yet, there was no success in introducing a law granting the sentenced a break in doing the sentence to undergo – under certain conditions – treatment outside the prison. Such a law could beyond doubt help to relieve the growing queue to therapeutic wards. Nor was there any waiver from the requirement of absence of convictions in the perpetrator's history, towards whom the institution of conditional discontinuance of legal proceedings after the positive conclusion of the treatment process can be used. The lack of this exclusion is one of the basic grounds for the fact that the rules of an act, which carries out the principle of "treatment instead of punishment", remain practically dead. Policies towards drugs and drug addiction, especially in Europe, have for a long time tried to combine skilfully elements of repression, prevention, and therapy. This results from many years of experience that shows that the belief in achieving success in this scope through prohibitions and repressions is entirely delusive. Unfortunately, there are plenty of reasons to believe that this message might not have reached Poland fully. In both making and applying law, there is still quite a prevalent conviction in Poland that prohibitions and sanctions of criminal law are the remedy against all social problems. This often leads to something akin to the attempts at magic bewitchment of reality by establishing increasingly more developed legal norms, and encompassing increasing number of situations that are – obviously – ever more "perfect". What is forgotten is not only the fact that legal norms are not only to be created, but also that they need an effort to be used properly, so as to allow the achievement of the objectives assumed. It is also forgotten that law itself, even the most perfect one, remains in most cases helpless towards social problems, unless it is strictly connected to the application of appropriate instruments of modern social policy.

Most prevention programmes use elements of several strategies. For example, the educational approach is frequently combined with environmental strategy, and plenty of various activities find their space within the intervention strategy: from sharing information to family therapy. This is why attributing programmes to a single strategy is, to a great extent, an artificial measure, and is of discretionary character.

SELECTED PREVENTION STRATEGIES

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Prevention is one of the basic areas of work of the National Programme for Counteracting Drug Addiction. Its main goal is to slow down the rate of growth of the demand for drugs. A means to achieve this goal is the improvement of the knowledge of psychosocial determinants of drug addiction and efficient preventive strategies. The authors of the National Programme believe that gathering information about preventive measures that bring desired effects shall allow defining the minimum standards of prevention programmes, verification of the ones in existence, and facilitation of their effectiveness evaluation.

Theoretical concepts most frequently used in prevention practice

Among the theories that had a significant influence on the development of prevention in using psychoactive substances, K. Ostaszewski (2003) mentions the social learning theory, theory of justified action, problem behaviour theory, and the concept of phases. It is worthwhile to supplement this list with the theory of reinforcing resistance, and theory of improving reputation (Okulicz-Kozaryn, 2003).

Briefly speaking, the concepts listed above and their use in prevention may be presented in the following manner:

1. Theory of social learning (Bandura, 1977) assumes that using psychoactive substances takes shape and becomes ingrained as the result of modelling, and psychological, social and/or pharmacological reinforcements that are connected already to the first attempts to use the substance. This means that in prevention, children and young people should be given opportunities to observe attitudes and behaviours that are not connected to the use of psychoactive substances, and ones that clearly oppose them. Positive role models, may include parents, teachers, other adults enjoying authority, peers, and celebrities. It is worthwhile to award desired behaviours, that is e.g. to support the development of child's interests, and respect the rules opposing the use of psychoactive substances.
2. Theory of phases is also known as the theory of substances "gateway" (Kandel et al., 1992). As the involvement of young people into the use of psychoactive substances is of phased nature, to prevent efficiently the development of problems connected thereto, preventive actions must take place as early as possible. It is best to embark on those before children begin to try alcohol (that is when they are 10 12 years of age). Besides the above, it is good to counteract drinking alcohol and smoking cigarettes to prevent taking drugs. Also derived from Kandel's concept may be the increasingly popular theory of early intervention which encompasses a variety of actions aimed at the modification of behaviour of the person who has already made first attempts to use drugs.
3. Problem behaviour theory (Jessor, 1987) believes that both problem behaviours (e.g. drinking alcohol, drug use, rebellious behaviours), and the ones in line with social standards (e.g. going to school, participation in religious life) let teenagers carry out developmental tasks and satisfy key psychological needs (e.g. autonomy, independence from parents) and cope in difficult life situations. Preventive actions based on this concept of action are usually defined as training life skills and include developing such skills that make everyday life and entering adulthood easier, for example, establishing and maintaining contacts,

communication, stress management, conflict solving, assertiveness.

4. The theory of justified action (Ajzen and Fishbein, 1980). Of key importance for the use of psychoactive substances among young people is whether they consider such behaviours common and accepted. This is why prevention should account for the so-called normative education, that is – convince that the norm, i.e. the behaviour that is typical of the majority, is abstinence and disapproval of drug use.
5. Theory of improving reputation (Carroll, 1998). Teenagers, who are generally very keen on the opinion of their peers, undertake a variety of actions only to "show off" in an appropriate light. Some style themselves into rebels, forgetting that reputation gained in their youth may influence their later lives. Which is why teenagers should be shown ways of shaping identity and emphasising their individuality without becoming involved in risky behaviours, for example by working for others, charitable activity, and voluntary work.
6. Theory of strengthening resistance (McWhriter et al., 2001). Young people are exposed to various negative influences of the environment, yet impact of some of them may be neutralised by reinforcing the child's emotional strengths and environmental protective factors. Specific actions include developing of social skills such as e.g. empathy, sense of humour, communication, ability to plan, think critically and creatively, and seeking for help. Other actions may be focused on building "supporting" relationships with other people, ensuring opportunities to participate in meaningful actions, and development of a conviction in the child that others (parents, teachers, friends) believe that the child is going to be successful.

Theories most often mentioned among those that have a marked influence on the development of prevention in using psychoactive substances include social learning theory, theory of justified action, problem behaviour theory, and the concept of phases.

Efficient prevention strategies and examples of their application

Prevention strategies are just one of the ways to classify prevention programmes. They refer mostly to the manner of behaviour that has major significance in achieving the programme's objectives. Other potential ways of categorising programmes make reference to their theoretical grounds or the "level" of prevention: primary, secondary, or tertiary.

The categorisation of prevention strategies presented below is based on the classification of the White House Office of National Drug Control Policy (ONDCP). Listing such strategies is useful, as it allows a general orientation in types of actions that may be undertaken for prevention of using psychoactive substances. Yet the association of a general strategy with specific programmes is already somewhat more difficult, as most programmes make use of elements of various strategies. For example, the educational approach is frequently connected to the environmental strategy, and within the intervention strategy, there are plenty of actions: from sharing information to family therapy. This is why attribution of programmes to strategies is to a great extent an artificial measure, and is of discretionary nature.

A single strategy encompasses highly varied programmes, assigned both for the general population, children and young people from risk groups, and families of vulnerable teenagers; programmes with highly varied duration and scope of impact, and also ones earmarked for implementation in different places (schools, homes, local communities), and programmes that bring a variety of effects. This is why it is difficult to speak about the effectiveness of individual strategies. What seems more important are the results of their implementation in specific activities, towards a specific target group, as well as knowledge of which elements of which strategies are worth combining.

Strategy of sharing information

In the group of school programmes, attention is turned to a programme that is strongly based on the strategy of sharing information, quite commonly criticised for its low effectiveness. It is based on spreading knowledge about popularity, use and abuse of drugs, and consequences of such behaviours and individual, family and

social levels, and sharing information about the forms of assistance available.

Educational strategy

Prevention programmes frequently make use of the educational strategy. It is focused on improving life and social skills of programme beneficiaries. They are taught to take decisions, not to yield to pressures, cope with stress, solve problems, communicate, and think critically. This strategy dominates school programmes, but is also used in working with families, and its elements turn up also in programmes for the youth from high risk groups.

Recently, results of the evaluation study of a single programme based on the educational strategy – Program Domowych Detektywów (lit.: "programme of house detectives") – were published in Poland. The programme deals solely with the problem of alcohol, and brings positive, direct effects in this scope. It also results in reduction of the prevalence of cigarettes smoking (Ostaszewski et al., 2000). Of key importance for the success of the programme is the active participation of parents, and also the form of work adjusted to the age of the beneficiaries (10–11-year-olds), resorting to comic strips and games, and conducted to a large extent by youth leaders (Okulicz-Kozaryn et al., 2000).

Strategy of environmental activities

Of fundamental importance for this strategy is modification of social attitudes and behaviour standards facilitating the use of psychoactive substances. This may include, for example, introduction of clear and precise rules in schools, counteracting the use of drugs, limitation of supply of legal and illegal psychoactive substances in the local environment, and changes in the principles governing cigarette and alcohol advertising. Yet most widespread are the activities that would be hard to define and classify explicitly, as they help to build an atmosphere stimulating the proper and many-sided development of children and young people.

In Poland, programmes making reference to the concept of environmental activities are in most cases conducted in schools. The goal is to facilitate correct development through tightening the sense of bond with the school. The "Spójrz inaczej" programme seems to be close to the strategy of environmental changes. Its goal is to shape the correct personality and support the child's development. Achievement of this goal means that the child will not be interested in the reaching for psychoactive substances in future (Kołodziejczyk et al., 1997). Of key importance in carrying out the programme in all age groups (from class 1 of primary school to class 1 of lower secondary school) are two elements: educational activity and personal contact of the teacher with the children. In the preparation of people conducting the programme, special emphasis is placed on the skill of listening to children and open expression of their feelings and expectations.

The authors of the "Trzy Koła" programme believe it to be similar to "Spójrz inaczej", though it is less structured (Wolniewicz-Grzelak, Grzelak, 2001). It aims primarily at the improvement of social climate in classes and the shaping of a sense of bondage between students. Developing a friendly atmosphere in the classroom provides a good base for discussing with students the questions and problems that are important for them, and develop their social skills. This in turn provides grounds for discussing subjects connected to health hazards, including also the use of psychoactive substances. Studies of the programme's effectiveness among pupils of classes 4–6 proved its positive effects in pro-social behaviours (for example, helping or recognizing others), as well as against the "unhealthy" behaviours (for example, extensive watching of TV and consumption of sweets). However, no significant changes in the frequency of drinking alcohol and smoking cigarettes were discovered (Wolniewicz-Grzelak, Grzelak, 2001).

Strategy of alternatives

The strategy of alternatives is frequently used in programmes for the youth from high risk groups of developing drug-related problems. Alternative classes are introduced to provide the beneficiaries of the programme with a possibility of participating in constructive and healthy forms of activity, which exclude reaching for psychoactive substances. The proposed classes are not only attractive, but they frequently ensure satisfaction of such needs that are otherwise realised by the use of drugs. Frequently, alternative

actions are conducted by youth leaders and/or adult volunteers.
The press informs that the programme "Big Brother, Big Sister" operates in Poland, yet that there is lack of credible information concerning its organisation and principles of conducting it. Most probably, no attempts at evaluating its effectiveness have been made. Yet, as the strategy of alternative actions has long been recommended for working with risk groups (Kamiński, 1978), one may expect that such programmes are fairly widespread in local environments. There is, however, no data on their effectiveness, either. Moreover, following the American experience connected to the implementation of the "Across Ages" and "Leadership and Resiliency" programmes, it may be expected that it would be hard to prove the effects of these programmes in the scope of consumption of psychoactive substances.

Strategy of changes in local community

Programmes for the youth from risk groups may also be based on the strategy of changes in the local community. The grounds for actions conducted in this current include reinforcement of the possibility of conducting efficient preventive actions and intervention within the local community through better planning, organisation, cooperation between institutions, and easier use of the service offered.
The network of Schools Promoting Health has operated for 10 years in Poland. The concept is based on the "habitat" approach, which in fact is tantamount to the strategy of changes in the local environment presented here. School, being an important element of local structures, is treated as the place where students, teachers, and parents live, work, play, and meet. The holistic understanding of health promotion (i.e. in line with the WHO concept), is done by establishing a social and physical environment favouring healthy behaviours at school and around it. In the organisation and policy-making of school, this is manifested for example through the modification of school rules and regulations, changes in the organisation of the working time, introduction of greater amount of physical education, and also closer cooperation between parents and teachers, and support from other local institutions. Moreover, changes are also introduced in the manner of managing schools, with an increase of importance of student authorities. Besides the above, also actions aimed at the improvement of the schools' technical background are conducted: playgrounds and sports halls are built. Special emphasis is placed on the improvement of psychological health and well-being of teachers, and promotion of healthy behaviours among the teachers and parents (Woynarowska, Sokołowska, 2000).

Early intervention

It may be said that all programmes for children and youth from high risk groups are based on the strategy defined as early intervention. It assumes the earliest possible identification of persons threatened with the development of problems connected to the use of psychoactive substances, most often ones who have already tried such substances. Actions aiming at the modification of the behaviour vary a lot: from educational activity and transfer of information to formal intervention, for example referral to a specialist centre or therapy.
Chosen for evaluation among Polish intervention programmes was "Szkolna interwencja profilaktyczna" – school preventive intervention. It lies partially within the strategy of introducing changes in local society, with the actions aimed at changing school rules and principles, and the scope of cooperation among teachers, and between parents and teachers. In reference to specific cases – namely of students "caught" using psychoactive substances and their parents – it provides a form of psychological assistance (intervention is primarily to support parents in seeking the best solutions to the problem discovered). The conducted quality analyses pointed at the possibility of reaching major positive changes in the functioning of school as an institution in line with the proposed method of impact (Okulicz-Kozaryn et al., 2003) and providing the student and his parents with efficient assistance (Borucka et al., 2003). Due to the methodology of research applied, the results acquired may not, however, determine the effectiveness of the programme, but provide only some grounds for the formulation of expectations concerning the positive effects. The study should be repeated on a larger

cohort of schools, with acquisition of broad information from persons who the actions are addressed to (students and parents) and should also involve e.g. 1-year follow-up studies.

Summary and conclusions

The question of effectiveness of prevention has been discussed in recent years by representatives of various milieus dealing with the problem of using psychoactive substances. Generally, everyone agrees that the results achieved so far lie below social expectations. Yet, the conclusions for the future formulated in a reference to the above are varied. Some specialists believe that the impact may be improved. What may serve this goal is for example, a greater involvement of representatives of scientific communities in the development of programmes (Deptuła, 2000), intensification of actions in what is broadly understood as health promotion (Woynarowska, 1999), and construction of programmes on the grounds of solid theoretical grounds and promotion of evaluation studies (Ostaszewski, 2003). Others express doubts concerning effectiveness of prevention as such, and believe that for that very reason one should seek other strategies of action (Sierosławski, Zieliński, 2000a, 2000b). The following conclusions result from the above strategies review:

1. It is difficult to compare the effectiveness of individual strategies, as it depends to a great extent on how the strategy is introduced in practice, i.e. from the concept and implementation of the specific programme.
2. The significance attributed to educational and/or information actions seems lesser than the importance of actions of environment-related character.
3. An important aspect of programmes that make use of the strategy of environmental actions and introduction of changes in local communities is the development of conditions that facilitate both appropriate development and satisfaction of emotional needs of children and young people. This pertains both to material conditions and the general social atmosphere, e.g. the climate of school and the sense of bond with the school.
4. Participation of parents is a standard in all preventive actions. They are the addressees of the programmes to the same extent as the children, and participate in some actions, or actively support the work of other people and/or organisations.
5. What seems to be the common element of the programmes that have been successful in limiting the use of psychoactive substances among teenagers is the care for the availability of the services offered and the adequacy to the needs of the individual recipient. Family therapists adjust their work to the time and/or geographic constraints of the family. Specialists from care centres and other programme operators define individual programmes of actions for each beneficiary. Organisers of educational classes for parents ensure care for their children during the sessions.
6. In Poland there are plenty of prevention programmes based on highly varied concepts: found among them are proposals that make reference to each of the strategies discussed. Unfortunately, attempts at assessing the effectiveness of these programmes are made only occasionally, and studies conducted do not meet the standards defined by American achievements.
7. It is necessary to undertake evaluation studies of prevential programmes. Attention must be paid to the highest methodological standards.

In line with expectations of the National Programme for Counteracting Drug Addiction, a review of effective preventive actions should help to improve the preventive actions conducted in Poland. To achieve this, one needs to answer the question: which of the currently conducted actions should be popularised. Generally, it can be said that the actions that involve local communities are worth promoting. The goal of such actions should be to develop a friendly, safe, and interesting environment for children. Implementation of the actions would require efficient coordination, cooperation, and involvement of many people and institutions. It may be beneficial to prepare a local coordinating staff whose primary goal will be to seek actively for people in need of support, promotion, and streamlining of the operation of the local service, as well as encouragement of other people and institutions to join in the preventive actions. Such coordinators and/or the centres they work with, could become an

intermediary link between e.g. the school and the treatment centre for addictions or mental health centre, as those in need frequently avoid contact with such specialist centres in fear of stigmatisation.

Most probably worth considering is also development of activity of volunteers, whose potential has so far been poorly utilized.

Investments in the development of school educational programmes seem relatively least justified. As the Methodological Centre of Psychological and Pedagogic Assistance at the Ministry of National Education (CMPPP MEN) states, over 20 programmes of are carried out nationwide, with numerous local programmes being introduced (Szymańska, 2000). What may, however, be more advisable is the care for improving confidence and psychological health of the teachers conducting these programmes.

Another important question concerns the shortages in the national prevention offer. It seems that the most serious gaps concern the actions towards children and youth from high-risk groups, and especially programmes for their families. It is most probably worthwhile to develop the system of support for families that would provide an alternative towards the traditional forms of work of counselling centres and social. Especially worth streamlining are the system of reaching all those in need with this offer and accessibility of the services.

Worth attention is also the question of evaluation. The needs in the area of evaluation studies are vast. Luckily plenty of promising initiatives are embarked on, for example, the evaluation of Health Promoting Schools (Szkoły Promujące Zdrowie). The programmes based on the strategy of alternatives remain a mystery. Nothing is known about their effectiveness, nor are there any research project on them known. Beyond doubt, it is a form of action that requires verification.

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Despite a drop observed in drug use, the recent research proves the growth in the number of addicted in Poland. The size of the addicts population is estimated at 100,000 to 130,000 people, of whom at 25,000 to 27,000 are people addicted to opiates. These data and the ongoing changes on the drug scene as well as changes in the needs of drug users call for new conceptual and organizational models for the drug treatment system in Poland.

BRIEF HISTORY OF DRUG TREATMENT OF ADDICTION IN POLAND AND THE CONTEMPORARY SYSTEM OF HELPING THE ADDICTED

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Treatment in Poland: historic perspective

The use of psychoactive substances has been present in our history. Alcohol has long been known in Poland and – like in other countries – it was used as a drug. In European culture, tolerance for alcohol has been very high, and Poland was (and still is) no exception in this area. Also the use of tobacco, the most popular addiction-forming substance of our cultural realm, has had a long history in our country. For the first time, tobacco was brought to Poland from Turkey in 1590, and in 1643 a tax on using tobacco was introduced. In 1661, the Polish Parliament considered it harmless for health (Markiewicz, 1996). The folk tradition for centuries has involved conscious use of local psychoactive plants (e.g. sage, poppy, belladonna) for treatment and paramedical reasons. Yet it is difficult to find information closely connected to the use of narcotic drugs in Polish literature until Poland regained independence in 1918. Before the second world war, addiction to drugs was not a major social problem. First drug addicts turned up in psychiatric treatment in 1921. According to the data from the Psychiatric Hospital in Tworki near Warsaw, there had been 85 drug addicts hospitalised in the entire country until 1928, with the number growing to 295 in the five following years. Pre-war Polish addicts used primarily the classical drugs: morphine, heroin, and cocaine (Bielecki, 1988). Drug addiction between the two world wars in Poland in most cases resulted from the quickly changing lifestyle, material instability, and increasing sociopathy present in some artistic and literary communities. First decades between the two world wars were not free from social ailments resulting from growing unemployment, ideological confusion, movements and re-emigration of people inside the state pieced together after the long period of partition, growing inflation, and changing customs (Lewicki, 1987).

The Polish government – even though focused mostly on building the state and the maintenance of its integrity, and striving against social and economic difficulties – undertook the challenge of fighting against the problem of drug addiction. First, through the ratification of international conventions (aiming for example at supervision of trading in narcotic substances and obliging states to fight against drug addiction, as e.g. the Hague Convention of 1912), and later introducing own regulations based on these, for example, the Act of the Polish Parliament of June 1923, which encompassed all the problems related to drug addiction (Lewicki, 1987).

The character of drug addiction in Poland in 1918–1939 varied across Poland and among various social groups.

Morphinism did not develop its drug subculture, and was mostly connected to the medical model of addiction. The group of well-off people choosing drugs in search of new, unknown sensations was dominated by cocaine users and amateurs of opium. Abuse of headache pills was widespread among housewives. Etheromania was a separate question. The use of ether was widespread mostly in Upper Silesia, around Częstochowa, and in Podkarpacie. In some locations, three fourth of locals used the substance (Bielecki, 1988). The drugs market originated in some large cities, the problem of illegal trading developed, dishonest pharmacists and physicians were punished. Suicides among drug addicts received plenty of attention from the press, and became socially alarming. Since 1999, supervision over the distribution of narcotic substances and control of pharmacies was entrusted to the Department of Health Care of the Ministry of the Interior in 1921. The Institute for Social Matters (ISS) was established, which, in its capacity of an organisation supervised by the Minister of Social Care, took to the formulation of the national programme for counteracting drug addiction and the plans for developing a system of treatment. A major role in combating drug addiction was played by care, social and local authority associations, and foundations. The body coordinating the efforts of the state, local and regional governments, and care associations was the Polish Committee for Drugs and Prevention of Drug Addiction (PKNZN). It is to their activity that we owe the introduction of obligatory treatment of drug addicts in prisons and initiation of establishment of the first stage of hospital treatment of drug addiction. Even though this treatment was occasional, operating on the margin of psychiatric treatment, and in most cases brought hardly any results, the fate of drug addicts, who had previously been left to themselves, markedly improved, which changed the physicians' point of view at the addicts' personality deformed by drugs (Lewicki, 1987).

After the second world war, the phenomenon of drug addiction in Poland was present occasionally and was in most cases the result of the so-called iatrogenic dependence, that is developing as a result of taking substances to treat chronic pain in patients e.g. after operations, in states after amputation of limbs, and in other ailments. The number of people admitted to hospitals with the diagnosis "drug addiction" began to rise significantly after 1960 (in 1960, there were 103 cases, in 1965 – 148, and in 1970 – 336; Cekiera, 1985). In 1969–1973, the number of patients treated for drug addiction in psychological health centres grew fivefold, and of those receiving treatment in psychiatric hospitals – more than 3 times. Low level of drug addiction was a cultural phenomenon in that period. The narcotic substance became an element of youth counterculture. The grounds, on which such low-level drug addiction developed were primarily movements of young contestants. It was the period of fascination of certain youth groups with the hippies movement. Taking narcotic substances became elevated to the rank of ideology, among others by the contestants of the then current political system. From the point of view of epidemiology, a characteristic of that phenomenon was a relatively large number of users with a relatively small number of addicts (IPN information, 1985).

Stimulation with the use of chemical substances was gradually becoming a popular pattern of behaviour for many people in Poland. Even though, as studies prove, for the majority of people, narcotic intoxication was only an episode in their lives, and rarely brought about dependency, yet it frequently assumed forms of behaviours lastingly debilitating psychiatric and physical health, and social functions. Even though in Poland of the 1950s and 1960s, the problem of drugs did not exist officially, the situation changed towards the end of the 1960s, when drug addiction began to spread among the young. Perceived until that moment as a socially harmless phenomenon, drug addiction began to change its public image. The processes of medicalisation and politicisation of the phenomenon were deepening. At the same time, new groups of interest became involved in the processes of interpreting drug addiction, including teachers, theorists of education, officers of the department of education, criminologists, lawyers (Abucewicz, 2006).

In the 1970s, the most frequently used drugs were medications stolen from pharmacies, production plants, and health care centres, and those acquired by forging medical prescriptions. These were predominantly medications from the opiates group (morphine, codeine, Dolantin (Demerol)), Inozemcov drops (stomach drops), psychostimulants (amphetamine, pemoline, ephedrine), and pharmaceuticals that – when taken in large amounts – resulted in hallucinations and psychological disorders

(Parkopan, Asthmosan). Besides these, also different chemicals were used, including "tri" solvent, petrol, and washing powders.

Initially, the problem of drug addiction among the young was disregarded as a transitory fashion among the well-to-do youth, walking in the footsteps of the pseudo-culture and decadence of the West. For a long time, that is nearly until the beginning of the 1980s, the problem of drug addiction in Poland was pushed to the margin of social interest. State authorities used information block (through the censorship clause), and falsely presented and interpreted certain facts connected to the phenomenon.

It is estimated that in the first half of the 1970s, there were approximately 50,000 drug users, while from 2000 to 3000 patients were registered in health care centres every year. As statistics recorded a growth in the extent of drug addiction from the late 1960s to mid-1970s, the state took steps to liquidate the problem. The control of the availability of narcotic substances began towards the end of 1960s: besides limitations in sales, measures against forging prescriptions were introduced. Beginning with January 1973, special prescription forms with a copy were introduced as numbered and registered official forms. Radical steps concerning limitation of access to pharmaceuticals and other narcotic substances were undertaken. One of the unwanted side effects of the introduction of restrictions on consumption and access to legal psychoactive substances was the discovery of poppy, generally available in Poland, by people using forbidden drug substances. Used initially was the poppy milk, and poppy tea (commonly known in Poland as "soup" or "szambo"), acquired in the process of brewing poppy straw. In the later years, the technology of acquiring a mixture of opiates known as "Polish heroine" or "compote" from poppy extract, and administered by injection, became widespread. In a short time, homemade opiates became the drug of first choice for the addicted in Poland (Świątkiewicz, Moskalewicz, Sierosławski, 1988). Easy availability of poppy straw in Poland, as well as uncomplicated and cheap procedure of producing the drug resulted in a sudden growth in the number of persons addicted to opiates administered intravenously.

The growth in the involvement of institutions of control and execution of law was not accompanied by any projects in the scope of prevention, treatment, and rehabilitation of the addicted. In fact, no steps aiming at the establishment of an institutional system for counteracting drug addiction and therapy were taken. These were only the 1980s that brought Poland closer to the legal and organisational solutions initiated during the two decades between the world wars, and especially to the appreciation of the role of the representatives of civil society in counteracting drug addiction.

The addicted, if they reached medical centres at all, were treated within the existing system of health-care. Available for the drying-out treatment for drug addicts in the entire country were just 90 beds. At that time, the treatment and rehabilitation of people addicted to substances were solely in the scope of competence of psychiatrists. At that time, one of the first and leading care centres for the addicted was the Oddział Leczenia Toksykomanów przy Wojewódzkim Szpitalu dla Nerwowo i Psychicznie Chorych (Ward for Treating Poly-drug users by the Voivodeship Hospital for the Nervously and Psychologically Ill) operating in Lubiąż near Wrocław in 1971–-1976. Its head doctor was Dr Zbigniew Thielle, co-author of the Polish pioneering work on addiction to psychoactive substances: Toksykomanie, zagadnienia społeczne i kliniczne (literally: Poly-drug users: social and clinical questions). Among health-care professionals, the treatment of drug addiction was considered very difficult, and the results of various dry-out and social rehabilitation treatments conducted in Poland and abroad were considered hardly encouraging and bringing no reasons for optimism (Andrzejewska, 1974). This is why the experience brought from the operation of the Sanatorium dla Dzieci i Młodzieży (Sanatorium for Children and Young People) in Garwolin, operating at the time under the management of Dr Ewa Andrzejewska, became significant for the development of therapies treating addictions to illegal substances that were positive for the addicts and innovative within state healthcare. In 1972, the sanatorium began to admit adult patients addicted to drugs. Many researchers and practitioners of treating addictions, notably Marek Kotański, embarked on their professional career in this centre.

Forms of therapy in psychiatric healthcare centres offered at the time to addicts proved unsuccesful.

Similarly, combining treatment of alcohol and drug addicts in a single ward ended in a great majority of cases in a complete decomposition of work of these units, and discouraged from therapy both operators and patients (Świątkiewicz, Moskalewicz, Sierosławski, 1988). Awareness of inadequacy of the proposed solutions was becoming widespread in the medical world, and discouraged from undertaking therapeutic efforts for the addicted from substances other than alcohol. Thus, for example in the hospital in Tworki, in the ward transformed in 1972 into a centre admitting both groups of patients, treatment of drug addicts in the rehab wards, adjusted to the treatment of alcoholics, was considered pointless and inefficient (Łęczycka, Steffen-Kusz, 1986).

A revolutionary change in the approach to the therapy of drug addiction was initiated in October 1978 by Marek Kotański. The source of the change was not only his eagerness to bring help to the addicted, but also disillusionment in the methods of therapeutic work and its results, which made "all of us live in illusion: them: that they leave the addiction, and us: that we help them in it" (Kotański, 1984). Together with some patients and staff from the sanatorium in Garwolin, Kotański established (initially in the structures and with the acceptance of the management of the sanatorium, and soon – fully independently) the first rehabilitation centre in Głosków, for approximately 30 people, based on the principles of the therapeutic community. The basic principles of the society where of the product of American and European experiences, and specific features of Polish conditions. The binding rules included:

– charismatic leadership
– equality among members of the community
– full abstinence
– limitation of external role models/patterns
– development of own standards (Siczek, 1994).

A significant impulse for the development of medical detoxification and ambulatory forms was the fact of establishment by Dr Zbigniew Thielle of the first detox and addiction treatment ward at the psychiatry hospital in ul. Nowowiejska in Warsaw in 1980. Another initiative of the doctor was the consulting centre for the treatment of addiction at. Dzielna St. in Warsaw, which played the pioneering role in the organisation of various forms of therapeutic support for the addicted (Karpowicz, 2002).

Early in 1981, the information block on drugs was abolished, and a radical discussion about drug addiction, being a dangerous and widespread phenomenon, began in Poland. Helplessness of the state and its institutions, shortcomings of assistance for this group of people in need, and the necessity of building forms of education and prevention of addiction were pointed at. With the advent of 1981, it turned out that Poland had a quickly growing and extremely dangerous social problem: drug addiction. Estimations concerning the number of the addicted ranged from several to several hundred thousand (Abucewicz, 2006).

Stemming from general criticism of lack of appropriate reactions on behalf of the state and its institutions to the problem of drug addiction, which was exemplified by the "open letter concerning drug addiction" by a group of Warsaw secondary students in 1981 (published on Magazyn MONAR, 1985), Marek Kotański called to life the Youth Movement for the Prevention of Drug Addiction (Młodzieżowy Ruch na rzecz Zapobiegania Narkomanii, MONAR). It fairly quickly brought about the establishment of a network of treatment and rehabilitation centres and consultation points, of which some transformed into diagnostics and ambulatory centres. Soon, there was an explosion of nongovernmental organisations tackling the problem of drug addiction in Poland, and the centre in Głosków became "the mother centre" and the role model for successive centres based on the model of therapeutic community. It was the training place for people who wanted to help the addicted and to establish successive centres both within the MONAR Association and also within the structures of other non-governmental organisations of lay and religious character.

A growing differentiation between centres was observed in the system of care for the addicted. Detox based on state healthcare was fully medical, and initially found its main objective in the detoxification of patients. Already the first experiences showed that the very withdrawal of abstinence syndromes thanks to pharmacological treatment should be treated as just the first step towards abstinence (sobriety). Patients in detox wards were provided with the care of psychotherapists. Conducted within this form of care was therapy motivating to enter further treatment in long-term centres.

Residential centres and rehab units were mostly run by non-governmental organisations which – following the standard of MONAR – began to be established all over the country. The proposal of therapeutic centres was based on similar principles, whose most crucial elements, besides therapeutic activity based on the "here and now" principle, was the patient's passing through successive, hierarchic stages of treatment. They are connected to the acquisition of specific rights and duties, which – through work and self-government – helped to change the sense of own value, and in effect – brought about the change in attitudes and behaviours. What became an equally important principle was shifting the responsibility for maintaining abstinence from the centre's staff to the patients themselves. In the centres focused on abstinence and reducing to the minimum the possibility of supporting the progress of therapy with pharmaceuticals (drug-free approach), the method of therapeutic community became the dominant form of operation. The growth of the number and the severity of drug problems began to be recorded in all aspects of social life, from health and education, via economy and social policy, to broadly understood law enforcement. Together with people sentenced for drug crimes, problems of people addicted and requiring care and therapy penetrated into the penitentiary system. Reacting to the problem, the director of the Central Authority of Penitentiary Institutions (CZZK) established two special wards for drug addicts in the Penitentiary Institution Warszawa-Służewiec and in the Penitentiary Institutions Lubliniec, and four special wards in penitentiary centres of Elbląg, Rawicz, and Wronki, and also in the Detention Centre in Kielce in November 1986. In May 1988, the CZZK issued guidelines concerning anti-drug activity in its penitentiary centres, which facilitated e. g. therapeutic activity targeted at the addicted in prisons and detention centres (Wąsik, 1993). All the actions mentioned above helped to develop professional, therapeutic care for people addicted to substances other than alcohol within the system of medical care for prisoners; the system is currently available at 14 sites, including one specialising in the treatment of women. A relatively new offer carried out by units of the penitentiary system is substitution therapy, which ensures great improvement on the continuity of patient care.

HIV/AIDS

A new phenomenon that profoundly changed the social and health perception of Polish drug addicts, and forced the society to find new ways of reacting to the problem was the quick rice of HIV infections among people administering drugs intravenously. The first such case was detected in Warsaw in August 1987. In April 1993, among the total of 2548 registered HIV positive people, drug addicts accounted for over 70%. With a high level of anxiety in society and no adjustment of the existing centres to admit HIV positive patients, Marek Kotański, established a MONAR for the addicted, infected with the HIV virus in Zbicko near Opole. Nevertheless, it quickly turned out that the homogeneous community developed in this way was strongly reinforced by the fact of infection, which rendered the therapeutic efforts and effects unsuccesful. Following this experience, beginning with 1988, addicted people began to be admitted to all the MONAR and majority of other centres, irrespective of their health status. Further experiences proved that the effects of treatment of addiction among people living with HIV in centres with both types of patients, where such an approach prevented stigmatisation of the seropositive people, to be superior. With the intensification of the HIV/AIDS problem among the addicted, new civil and state initiatives were developed. The "Solidarni-Plus" Association began its operation in 1989, running communities for people living with HIV and their families in Wandzin, Darżewo, and Lutynka. Passed in January 1989 was the resolution of MONAR concerning HIV prevention by giving away needles, syringes, and condoms in the hubs gathering the addicted (railway stations, night lodgings, so-called "bajzle" (Polish slang for places frequented by users), and consultation points and consulting centres), considered historic as it broke the fear of the charge of facilitating the use of drugs. Faced with the increase of the problem of HIV positive addicts, and the climate of social intolerance and aggression against people living with HIV/AIDS, the Ministry of Health and Social Care

undertook an important initiative. Under its patronage, Father Arkadiusz Nowak organised two first centres for people living with HIV/AIDS in Konstancin and Piastów (1991), and later the third one in Anielin (1998). Despite carrying out a variety of educational and preventive actions, it quickly became obvious that large groups of the addicted are incapable of changing their risky drug-related, sexual, and social behaviours. Their lifestyles, whose elements included homelessness, prostitution, and continuation of intravenous administration of "compote" resulted in increasing incidence of numerous somatic illnesses: chronic HBV/HCV, STDs, TB. The problem was aggravated by opportunistic infections linked to AIDS. The state of health of this social group began to call for specialist, costly, and frequently supervised treatment.

Contemporary challenges

An attempt at answering the new challenges is the substitution treatment, strongly set in the concept of harm reduction. As a leader among Central and Eastern European states, Poland introduced methadone programmes into clinical practice. The first programme of substitution therapy was introduced for a group of 120 patients in Warsaw in 1992 (Baran-Furga, Chmielewska, 1994). Implementation of the pilot, experimental substitution programme with the use of a synthetic opiate, methadone, being a pharmaceutical substance earmarked for drug addicts dependent on Polish heroine ("compote"), began at the Psychoneurological Institute under the guidance of Dr Karina Chmielewska and Dr Helena Baran. Administered orally, methadone reduces the risk of contracting HIV through blood. Methadone is effective for 24 hours, therefore the medication is administered as a single dose, once a day. It causes neither drowsiness nor euphoria, and allows the patient to function in social life. The significance of substitution for public health, and the broader "philosophy" of harm reduction lies in limiting drug trade and crime, and decreases the expenditure for treatment of drug addicts. Another unchallengeable benefit is the limitation of new HIV infections and AIDS pandemics (Narkomania, 2007).

The growing number of psychiatric disorders among the addicted resulted in the need to work out a new quality of the treatment offer, which could account for the needs of this group. The answer to the problem was the development of the programme adjusted to the needs of patients with dual diagnosis in the "Familia" centre in Gliwice in 1995. The author of the programme, Dr Andrzej Maj-Majewski, and his team supported the standard of therapeutic community with the experience of psychiatric care. Together with the development of treatment and rehabilitation of addicts, new organisational forms developed to support and reinforce the effects of therapy, allowing social reintegration of people in treatment; their number including hostels and half-way houses. The growth of awareness concerning the needs of patients, who increasingly more often ignore the offer extended by long-term therapy, was accompanied by the development of intermediary treatment centres, including day-care centres. The community of therapists, researchers, and patients found an increasing need of improving the quality of ambulatory treatment, and broadening access to substitution.

Falling back on present epidemiological data, the current system of treating addictions is facing new challenges, including increased popularity of substances other than opiates (cannabis and synthetic psychostimulants, mostly amphetamine) that until recently were dominant, and increasing numbers of admissions into treatment of people diagnosed with the use of numerous psychoactive substances, alcohol being today common and widespread. Observed at the same time is the strong territorial differentiation in the use of these substances, which triggers diversification in treatment structure. Currently, in some regions of the country, it is still necessary to develop substitution treatment, while in others – patients addicted to opiates are registered only occasionally in some centres.

The current system of specialist care addressed to the addicted to psychoactive substances was composed into healthcare system, and is a part of the system of care for people with psychological disturbances. Treatment of the addicted in Poland is free of charge, and widely accessible. It is provided by public and non-public healthcare centres, whose operation since 1999 has been financed by National Healthcare Fund (NFZ) and offices of communes and/or counties (marshals). The system of treatment and therapy in the case of addictions

is composed primarily of specialist ambulatory and residential centres, and forms of intermediary care – still few in Poland, even though in a great demand – including day-care centres, hostels, and post-rehab programmes.

Decomposition and transformation of the organisation of the system for treatment of addictions in Poland can be observed for a time. Following the changes on the drugs scene and changes in the health needs of the population of the addicted, new conceptual and organisational models are looked for. A significant feature that triggers the need of adaptation to new conditions are epidemiological data. Despite the observed drop in reaching for drugs, mostly by young people, the latest research proves an increase in the number of the addicted in Poland. It is estimated that this population may lie in the range from 100,000 to 130,000 people, among whom from 25,000 to 27,000 are the people addicted to opiates (Sierosławski, 2007).

Abstinence-oriented therapy

In the case of addictions to illegal substances, the contemporary Polish model of therapy is based on the dominant role of stationary treatment, whose characteristic form is long-term care provided in 24/7 closed wards. The basic form of treatment is the method of therapeutic community. Currently, there are 85 centres operating in Poland that admit people dependent on psychoactive substances, of which 33 admit minors below 18 years of age. Since 1999, the number of beds for patients has increased by approximately 900, so that currently these centres offer care for approximately 2500 patients. Treatment and rehabilitation in residential centres is based most often on the abstinence-oriented approach. Significant role in the therapy is played by microeducation, learning, and work – being elements that provide preparation to undertake positive social roles. The average waiting time for admission into a residential centre has been reduced greatly in the last years, and today (with the exclusion of substitution therapy) exceeds a few days or weeks only occasionally. Recently, majority of patients in residential centres were people addicted to opiates. Today, a marked drop in the number of these people coming for therapy is recorded. This results in a greater number of free beds in the centres and shorter waiting time for admission to treatment. There is, however, no clear information on the degree to which this tendency is stable.

Treatment of people with drug problem is carried out also in the ambulatory form, provided through consulting centres for addicts, psychological consulting centres, rehabilitation clinics, and day-care centres. According to the data collected by the National Bureau for Drug Prevention (Narkomania, 2007), there are approximately 300 ambulatory centres across Poland that provide assistance experimenting and problem drug users, addicts, and friends and relatives of the patients. The main goal behind the ambulatory therapy, much like in the case of residential treatment, is achieving abstinence by the patient. It often happens that such centres define other goals of treatment, including the improvement of quality of life and/or reduction of substance use, as achievable for the majority of patients more realistically than full abstinence. The offer includes activities of group and individual therapy, skills training, and prevention of relapses, as well as consulting and support groups. The duration of the programme ranges from 3 to 12 months. Funds for the programmes come from contracts concluded by the service providers with the National Healthcare Fund, offices of communes, and marshals (offices of the counties).

The post-rehabilitation offer is developed by programmes of specialist aid, provided for people who have completed the process of treatment, and for people in substitution treatment. They are conducted at hostels and/or half houses. Participants of the programmes receive psychological support, supportive therapy (for example, as a part of groups relapse prevention), instruction in becoming independent (professional training, bridging gaps in education, etc). The goal behind the programmes is social reintegration understood as assistance in returning to a non-pathological functioning in society. These programmes are financed from the funds awarded by municipalities, officers of marshals, National Bureau for Drug Prevention and the National Healthcare Fund.

Substitution therapy

At the current stage of development, substitution treatment is available for approximately 1300 patients who receive assistance from 16 programmes situated in 12 Polish cities. Treatment in this scope is provided primarily by public healthcare centres (14 programmes), while two programmes are conducted in non-public settings. Substitution treatment is currently available also for more than 50 detained people. All the operating programmes use methadone for substitution, even though the existing legislation allows use of other substitution substances (Jabłoński, 2008).

Access to substitution treatment is difficult; in some cases the waiting time ranges from a few weeks even to two years. The barriers are also of territorial character, as some regions of Poland lack this form of therapy altogether. The level of substitution services offered at the moment is highly unsatisfactory, as it covers only from 5% to 6% of the population qualifying for this form of therapy. The National Programme for Counteracting Drug Addiction in 2006–2010 (Appendix to the regulation of the Council of Ministers of 27th June 2006, item 1033) assumes changing the situation defined above, as it envisages increase in the availability of the substitution therapy to the level of 20% of the population in need. Assuming the continuation of today's epidemiological rates, this means that in 2011, substitution treatment should be available for from 5000 to 5400 people.

Bibliography for the article is available from the publisher and from the website www.narkomania.org.pl.

Drug use as a means of coping with the weaknesses and failures in adult life, especially in its early period is increasingly popular. This group of people hardly ever receive adequate help. Moreover, there is hardly any knowledge concerning the number of people using drugs recreationally or for stimulation, nor do we know how many of them become addicted, or at any rate they experience personal and social losses. Moreover, it seems that the small number of such people seek assistance, due to the lack of appropriate programmes offering help.

TYPOLOGY OF PATIENTS USING INSTITUTIONAL AID CONNECTED TO DRUG USE

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Problems with drug use in Poland began towards the end of 1960s. In most cases, these were people building small subcultures who reached for drugs. At the time, the dominant substance was the "compote", an opiate administered intravenously in most cases. Taking such drugs leads to quick addiction, and quick physical, psychological and social degradation. For some, the word "drug addict" (Polish: narkoman) meant stigmatisation while for others it meant belonging to the free people, carefree, the flower children. A characteristic trait of people taking drugs at the time was refraining from alcohol use, which in their subjective understanding gave them the conviction about being somebody "better". At the time, the authorities treated drug addicts as criminals rather than sick people. In later years, most of the MONAR centres for treating people addicted to drugs were created for people addicted to opiates.

It was then that the methods of treatment based primarily on the model of therapeutic community were developed. The addicts were treated in special centres for the period of minimum one year.
Since that time, changes occurred in the types of drugs used, motivation of reaching for drugs, as well as people using drugs, and methods of therapy. It is estimated that the number of users has become stable in recent years. There is, however, a growing number of people who enter treatment due to the use of psychoactive substances. Let us quote the following data:

- increase in the number of people receiving treatment in ambulatory centres: 9479 in 1998 compared to 38,445 in 2005
- the proportion of first-time patients is on the rise: in 1998 they accounted for a third of all patients treated, and in 2005 – for nearly 50%; this may mean that ambulatory treatment lasts shorter
- a relatively small number of patients using drugs receive treatment in day care centres: in 2005 there were only 661 of them
- the number of people receiving treatment in residential conditions is increasing; even though in 2004–2005 the number did not change (12,255) yet it marked doubling the data for 1998
- the largest age groups of patients in ambulatory and residential treatments are people aged from 19 to 29, and under 18 years of age.

In 2005, there were 89 preventive, treatment, and rehabilitation centres for people addicted to psychoactive substances. They provided treatment for 38,000 people. A decided majority of the patients were from 19 to 29 and below 18 years of age. Majority of people receiving treatment in consulting centres need support at the level of being threatened with addiction and addiction itself (82%).

Other data concerning especially people abusing drugs and addicted people come only from individual studies that do not meet the standards of population studies. Hence, it is very difficult to describe who the drug users are, and how the patterns of drug use have changed. It is somewhat easier to say who the people embarking on treatment are. It seems that a number of groups may be differentiated among drug users: people experimenting with drugs, people taking drugs recreationally, people taking drugs as a way of supporting their functioning in life roles, and addicts.

Experimenters

Typically, these are young people. In the recent years, the age when drugs are used for the first time went down even to 11. Yet the age of most people reaching for drugs, ranges from 15 to 16.
The studies show that the number of people taking drugs at least once in their lives ranges from 6% to 17%. The largest group among drug users are those who reach for them once or a few times in their lives, yet every year, a large number of those aged under 18 come to treatment. Usually, those seeking institutional assistance enter treatment in ambulatory centres, some of them choose residential treatment, which may mean that they have serious problems resulting from drug use. A one-off drug use incident during adolescence is probably connected to the greater accessibility, habits and customs accompanying group recreation among young people, eagerness to experience something unknown, decreased control on behalf of the adults. A much greater threat for frequent use of drugs and addiction is the fact, confirmed in research, that people taking drugs more frequently engage in problem behaviours. The use of drugs is part of such behaviours as alcohol use, breaking social and legal rules, resorting to violence or being its victim, and also experiencing a variety of forms of psychological distress, including symptoms of fear and depression.
Thus, a large number of drug users are young people going through the period of adolescence. There is high probability that these are the people who find it difficult to embark on developmental tasks of adolescence. Among the tasks most important in the period are the acquisition of knowledge and skills

necessary for professional and family life, building the sense of identity of oneself, learning to cope with new experiences, shaping of the system of values, the establishment of patterns for relationships with peers, including experiencing of dependence and independence, and experiencing emotional relations. From the period of major dependence on adults and the sense of safety connected to it, one reaches increasing responsibility for own behaviours, and partially also for the behaviours of others, with whom one embarks on friendships and emotional relations. Talking responsibility for oneself and others usually follows the method of trial and error, dependence and rebellion, sense of knowing how to influence events interchanging with the sense of lack of control over them. The notion of good and evil, hierarchy of more and less important goals, the general idea of life goals, and self-esteem and evaluation of other people take shape as the result of these experiences. Difficulties in the process of conducting these tasks may result in fear and depression reactions, volatile moods, uncontrolled aggression, and a sense of inferior value. They may also be manifested through anti-social behaviours, overreaching social principles and standards, breaking the law, and aggression towards the environment.

Drug and alcohol use may be a coping strategy for the tensions of adolescence, yet it is also a barrier in the integration of experiences from the period of adolescence, which in this way obstructs development of the sense of own identity, own value, responsibility for oneself and others, and satisfactory patterns of relations with others. Clinical experience and research proved that drug use is more characteristic of those adolescents who find less support in the family, who have more problems with learning, who experienced more deprivations and losses than satisfaction and achievements. Help for such people is primarily supporting them in the fulfilment of life tasks typical for the period of adolescence: alleviating the tensions resulting from unfavourable events in life, coping with school duties, coping with the peer pressure by gaining greater independence, supporting the shaping of the sense of one's own value. The fundamental participant in this process of support is the family of the adolescent. The problem lies in the fact that the family of a child experiencing problems in growing up is frequently bereft of resources necessary for independent support of the son's or daughter's development. Such a family needs assistance, and this becomes the main centre of helping the person growing up. The family system becomes a patient.

The young are the other main group of drug experimenters. Some will become addicted, unless they receive assistance, bringing back the possibility of using own and family resources necessary for conducting developmental tasks.

Recreational users

Growing in the recent years has been the number of people reaching for drugs in recreational contexts. In most cases, these are young adults. We know very little about the popularity of drugs used for recreational purposes. Discos are one of the places, but not the only. It is estimated that recreational users are young adults living away from the family home: most often students or people working in large cities. Most probably, the substances taken most often in this group are cocaine and amphetamine. European data show that cocaine is used most often by people from 15 to 24, with 13% of people coming for treatment being addicted to cocaine.

The tasks of the period of early adulthood include the choice of the profession, partner, and the beginning of living in an own family. This requires the skill of making decisions, planning own objectives, programme for their achievement, the ability and skill of independent solution of problems. Coping with these tasks is a source of satisfaction that provides the grounds for the shaping of the sense of own value. Lack of satisfaction, lack of the skill of self-dependence and cooperating with others may favour seeking for surrogate satisfactions, with drugs being one of their sources. Drug use at that time may be a signal that there are difficulties in acquiring or maintaining a satisfying job (or course of studies), in establishing or maintaining a satisfying relationship, or starting own family.

A substance that has traditionally "supported" social life is alcohol. Reaching for drugs frequently accompanies alcohol drinking. The number of people using

these two substances simultaneously is on the rise. These people are especially vulnerable to the negative impact of these substances on their functioning in early adulthood.
Aiding such people is primarily supporting them in making life choices adjusted to their capacities, circumstances, supporting them in the search for alternative means of meeting life objectives, acquisition of resistance to a diverse life situations, and coping with such hardships.

Supporting own functioning in different life roles

Short- and long-term life failures often help resorting to stimulation in performing life tasks. This may occur at any stage of the mature life. Exhaustion, overworking, eagerness to be efficient and effective enable seeking psychoactive substances removing fatigue and increasing professional efficiency. This standard most often pertains to young adults below the age of 35. There is no data on the spread of drug use for stimulating activity, and providing support for the mind and emotions. Nevertheless, it seems that today people reaching for such stimulation are those with high need for achievement, the need to stand out: the people who find it hard to cope with tension and to cooperate with others.
Another group are people using legal psychoactive substances: tranquillisers, painkillers, and sedatives. Carrying out professional, family, and social tasks may be especially difficult for some due to their own personality resources. These difficulties may turn up at any stage of adult life. In most cases these are people with neurotic disorders in their personality, with elements of dependence or anxious personality, who are emotionally fragile. The basic problem of these people is the inadequate perception of themselves and their surrounding. From the perspective of own fear, lack of trust in themselves and the surrounding, perception of nonexistent threats, they perceive the world as hostile and threatening, and themselves – as helpless and vulnerable to incessant defeats and failures. These people may be aided through psychotherapy, whose goal will be to change the way of perceiving oneself in the environment, through solving of emotional conflicts, change of irrational convictions, habitual behaviours leading to inefficient coping with life problems.

Addicts

Using drugs leads to addiction. This denotes the state when the powerful need of receiving substance dominates other behaviours, is difficult to control, and results in a physiological state of abstinence after discontinuation or decreasing the volume of substance received. As a consequence, addiction leads to neglecting or abandoning the most important life tasks.
Addiction may be present as the effect of long-term use of any drug. Most people coming for treatment due to addiction have problems with opiates (40–70%). The addicted usually come to treatment when "forced" by their physical state (the need to detoxicate), pressure of the surrounding, or the threat of legal consequences. Most people addicted to opiates undergoing treatment return to drug use. This is a reason why they are offered substitution treatment.
The addicted require specialist care, where the first goal is discontinuation of drugs or their replacement with another substance that removes abstinence symptoms and craving for the drug. There is hardly any data that would allow the evolution of psychological characteristics of people addicted to drugs. For this reason, it is difficult to speak about the personality-related features of addiction. These are the social features of such conditions that are more often mentioned. What is more visible are the results of addiction: both for personality traits and for functioning in the society.
Personality traits of the addicted include primarily powerful concentration on one's addiction. These are different goals in life and mode of functioning that are subordinated to abstinence or taking methadone. A high level of tension and a sense of being threatened with a relapse sometimes result in increased activity, frequently chaotic and interrupted with successive failures. Most of the addicted have incurred major social losses: lack of profession, education, ties with the family; lack of own family or failed family relations. Some losses cannot be made up for but must be accepted, and life must begin anew. Sometimes repeatedly. It is most important to begin it on the grounds of realistic recognition of one's

own potential and the potential of the environment, garnering maximum support and assistance, even if it is limited only to curbing the losses.
More and more often found among the addicts are people who have plenty of illness-related problems. Cooccurring with drug use are psychological disorders, alcoholism, and somatic illnesses. New ways of treating these people, which require co-operation of numerous professionals, are being sought for.

Helping

Drug users differ when it comes to the types of drugs used, time of life when drug use begins, its frequency, circumstances in which drugs are used, motivation for use, and finally – the impact of drug use. They all experience negative impacts, even though the most serious affect those who move into the state of addiction.
Everyone needs assistance, yet it must be assistance adjusted to their needs. In most cases this is help in perceiving and understanding the negative impact of a single or few instances of drug use. For many young people experimenting with drugs, availability of information, assistance of parents, teachers, tutors and peers are sufficient arguments not to repeat those experiments. For people experiencing difficulties in coping with the tasks of the period of growing up, which use drugs as an element of complex problem behaviour, such a system means supporting them through educational and family consulting, assistance in learning, establishment of conditions for healthy ways of spending free time, development of a system for personal resistance to experiences and threats to the psychological health during adolescence.
Resorting to drugs as a coping strategy to manage weaknesses and failures in adult life, especially in its early period, becomes increasingly frequent. This group of people only occasionally receives adequate help. The level of knowledge on the number of people using drugs recreationally and for stimulation is low. Nor do we know how many of them become addicted, or at the least – experience personal and social losses for that reason. It also seems that there are few such people who seek assistance, due to the lack of appropriate programmes. Consulting, whose objective is to help in coping with the initial, difficult professional and family experiences, could be useful in the prevention of drug use as substances supporting solution of problems and decreasing the tensions. Consulting for students could play a similar role. A separate problem is the shaping of standards in spending free time. In 2005, there were 89 counselling, treatment, and rehabilitation centres for people addicted to psychoactive substances. They provided treatment for 38,000 people. A decided majority of the patients were from 19 to 29 and below 18 years of age. Majority of people receiving treatment in counselling centres need support at the level of being threatened with addiction and addiction itself (82%). Out of the 440 members of staff of the counselling centres, only 120 were in full-time employment. This number included 82 specialists and instructors in addiction therapy. The 53 centres for drug addicts employ 774 specialists and instructors in addiction therapy, of whom 688 in full-time employment. The number of patients treated was close to 20,000: approximately half the number in ambulatory centres, with the number of specialists nearly 8 times as high as in the former type of centres.
These few numbers disclose how very limited in its quantity is the therapeutic offer for people coming to aid centres with problems resulting from drug use. We do not know the forms of therapy, even though the statistical data state that more than 22,000 patients of the consulting centres participate in individual and group psychotherapy, yet juxtaposing this against the number of staff employed in those centres, it is difficult to imagine what form of psychotherapy is offered, especially when the same personnel provide 237,470 consultations in total a year.
A variety of patients require diverse forms of help. What should its forms be to match various needs of patients and various problems resulting from drug use? How to motivate people without symptoms of addiction to enter therapy? What organisational forms are necessary to provide such a varied assistance? Who is to give such aid? How to prepare specialist to work with so different patients? It seems that without answering these questions, it will be difficult to provide effective help to all people in need.

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An important element in counteracting drug addiction is the division of tasks performed by governmental and non-governmental organisations. Analysis of the public sector of western states confirm the tendency of limiting the number of tasks conducted by public administration for over a decade. Increasingly often, the tasks performed by governmental institutions are entrusted to other organisations, while the role of administration boils down to fulfilment of key functions connected to strategic planning, monitoring, and evaluation of the policies as well as financing activities performed by non-governmental and commercial organisations.

CONTINUITY AND CHANGE. POLISH SYSTEM FOR REDUCING DEMAND FOR DRUGS

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The 15 years that have passed since the establishment of the National Bureau for Drug Prevention raises questions and reflections. Of key importance among those is the question concerning the establishment of a stable system that could react efficiently to the existing forms of drug use, and be prepared for future changes and challenges. An unquestionable achievement of the construction of such a system is the development of a solid expert base providing systematic diagnosis of the problem of drug addiction, making use of methods and indicators allowing both in-depth analyses of Polish conditions and comparisons of our situation with that in other countries. It is to be remembered that the knowledge of the phenomena which should be the object of interventions conducted as part of public policies and programmes is a necessary, yet insufficient, condition for such changes. It is only to a limited scope that it helps to define changes and factors limiting the scope and effectiveness of intervention. Questions about solutions that would allow embarking on effective actions crop up increasingly often. It is not only about the legal solutions and the volume of public funds. The question about effectiveness solving the problem of drug addiction is at the same time a question about the effectiveness of conducted activities, and about the possibility of introducing expected changes based on existing resources and institutional solutions.

In the states that conduct systematic research of public policies, the analysis of the so-called institutional response enjoys great interest. It is conducted for a variety of social problems, and provides information about crucial entities involved in the implementation of national and international strategies, their mutual relations, resources at hand, and opinions expressed.
The first research project concerning the institutional reaction to the problem of drug addiction was conducted towards the end of 1990s in Poland, the Czech Republic, Slovenia, and Hungary. The basic question asked by the authors of the research was the question whether the similarities in an epidemiological situation, which are present in the countries of Central Europe, resulted in similar institutional reactions. It was assumed that the understanding of the relationship between the specific features of the problem of drug addiction and the institutional context of actions conducted will be of key importance in the evaluation of the current strategies and development of future ones. The study conducted in 1999 encompassed, among others, all organisations of national reach that operated in the realm of reducing the demand for drugs. Four years since the completion of the task mentioned, in autumn 2003, another analysis of the Polish system for counteracting drug addiction was conducted to the commission of the National Bureau for Drug Prevention . The knowledge acquired in the two studies allowed performing an in-depth description of the

Polish system of counteracting drug addiction (in the part concerning demand reduction) and comparison of our system with similar ones functioning in other Central European states. The research provided also information on the changes in the Polish system that took place from 1999 to 2003. Even though what is portrayed by the study refers to the situation that is five to ten years old, it nevertheless illustrates not only the successive stages in the development of institutional reaction, but also provides an incentive to ask questions and put forth hypotheses concerning the current situation.

Counteracting drug addiction: public administration and civil society

Compared to Central European states mentioned above, the Polish system for counteracting drug addiction is to a significant degree based on the operation of non-governmental organisations. In Poland, NGOs account for more than two thirds (68% in 1999 and 67% in 2003) of all institutions operating at national level, which deal with reducing demand for drugs. In Hungary and Slovenia, non-governmental organisations accounted for nearly half of all institutions operating at the national level, while in the Czech Republic, two thirds of all organisations were governmental institutions: ministries, customs officers, and specialised agencies.

The models for counteracting drug addictions seemed to be to a great extent a consequence of social and political changes taking place in the countries under study in the last 25 years. Over a half of Polish institutions began its operation before 1989, with the corresponding number in Hungary being 25%, and in the Czech Republic – only 7%. The "discovery" of the problem of drug addiction and development of a system for counteracting the phenomenon took place in Poland much earlier than in other countries of the region.

Disclosure and definition of the problem early in the 1980s, that is at the time of development of civil society, had major impact on the present shape of the Polish model of demand reduction. Demand reduction in Poland before 1989 was the area of operation of six governmental institutions and 14 non-governmental organisations, which accounted for more than half of all the institutions examined. At the same time, similar activities were conducted by only three governmental organisations in Slovenia, and in the Czech Republic—just by one governmental institution. Besides Poland, it was only in Hungary, that – besides governmental agencies –also two non-governmental organisations participated in counteracting drug addiction.

Information concerning the period when Polish organisations indicates four phases of the processes of development of institutional system. The first phase: disclosure of the problem and its initial interpretations were the 1970s and the first half of the 1980s, when both governmental and non-governmental organisations were beginning their operation.

The latter half of the 1980s, and especially 1987–1989, is the period of interest in drug addiction on behalf of successive non-governmental organisations. Undertaking of actions concerning reduction of demand by successive non-governmental organisations was visible also in 1993–1994, while the late 1990s was a time of expanding the system with successive governmental institutions.

Quite a different process leading to the establishment of a different system, took place in Czech Republic, with a reduction of demand was dominated by governmental institutions that began operation in the latter half of the 1990s. A different model was worked out in Hungary. Counteracting addiction began there with non-governmental organisations, beginning with the first half of the 1990s, new programmes for reduction of demand conducted primarily by bodies of public administration.

In the period in question, a characteristic feature of the institutional system for reducing demand was considerable stability. Identified in 1999 were further seven organisations dealing with the reduction of demand for drugs, conducting their operation at the level of entire country. Four years later, activity within the entire country was conducted by 32 organisations. Only one new organisation operating at the national level, turned up in the period in question. Among the six that ceased to operate at the national level, for resigned from conducting their operation due to the lack of sources of financing, and focused on local outreach. The decided majority of organisations that ceased activity where non-governmental ones.

In all the countries analysed, majority of organisations (the so-called inclusive organisations) conducted also other activities besides the actions connected to the reduction of demand. It was only one in four organisations in Poland, the Czech Republic, and Hungary that specialised only in demand reducing programmes (the so-called exclusive organisations). Four years later in Poland, activity focused solely on the reduction of demand was conducted by the same organisations. The continuing domination of NGOs and the presence of the same exclusive organisations prove the stability of institutional solutions, and highly likely professional approach of the system's participants.

Organisations and their resources

A significant presence of non-governmental organisations in the national system for counteracting drug addiction does not automatically translate into their strong position. Frequently encountered are situations where a large number of non-governmental organisations is no more than a façade for implementing the principle of social participation in solving a specific social problem, and finds no translation into the capacity actual. Hence an important part of the studies described was the description of the resources (also financial) that allow efficient reduction of demand.

The data concerning the financial resources prove the position of Polish non-governmental organisations. In 1998, the average budget for demand reduction programmes conducted by Polish associations and foundations amounted to approximately € 250,000, and was five times as high as the budget of corresponding Hungarian or Slovene organisations, and nearly twice as high as in the Czech Republic. In turn, Hungarian and Czech governmental institutions disposed of significantly larger assets than Polish ministries and offices. Considering, however, the differences in the sizes of populations of the countries in question, including differences in the population of the addicted, it may be said that the Polish system for counteracting drug addiction earmarked far more funds to the reduction of demand than the others.

Compared to the period five years earlier, the average budget earmarked for demand reduction actions increased from € 267,000 to € 319,000. The growth in the funds was true nearly exclusively for governmental institutions, which towards the end of 1990s had at their disposal funds that as a rule did not exceed € 10,000 (only 27% of governmental institutions ran projects exceeding € 100,000, while similar assets were owned by 36% of non-governmental organisations). The sector of public administration recorded a near 40% increase in the outlay. The average budget of non-governmental organisations remained generally unchanged.

The Polish system for counteracting drug addiction to a great extent supports organisations with greatest experience. In both studies, largest budgets were characteristic of organisations with the longest period of activity. Among all non-governmental organisations with budget exceeding € 100,000, 78% began their activity in demand reduction before 1989.

The situation of exclusive organisations improved decidedly. In 2003, they had at their disposal budgets that were on average twice as large as in the period encompassed by the previous study. Another characteristic feature of the period in question was the decrease in the volume of funds at the disposal of organisations who had been active for the longest time and ones that began their activity in 1990–1994. The youngest organisations had significantly smaller budgets.

Compared to 1999, their situation deteriorated significantly. The situation portrayed above concerns directly the period preceding Poland's accession to the European Union. It may be expected that these were the exclusive organisations, specialising for quite a long period in counteracting drug addiction, that were capable of efficient application for funds from EU programmes, increasing their potential and options of impact.

Non-governmental organisations are a key element of the Polish system for demand reduction. A powerful position of non-governmental organisations in the system of counteracting drug addiction is to a significant degree the effect of their support from public administration. The financing of Polish non-governmental organisations came primarily from public funds. More than three quarters of all financial assets in the disposal of Polish organisations in 1998 originated from governmental administration or local authorities. The share of public funds in 2003, dropped to 62%, with the parallel increase in revenue received from membership fees and grants.

In 1998, public funds accounted for less than 50% of the budgets of non-governmental organisations in the Czech Republic and Hungary. Another important source of support in these countries was the private sector. In Hungary, nearly 28% of the funds acquired by organisations originated from foreign sources, while in the Czech Republic, this share amounted to 13.5%. In Poland, the corresponding rate did not exceed 6%. In Slovenia, 17% of revenues of non-governmental organisations came from individual donations and membership fees.

In Poland, the foundation of demand reduction programmes on public funds was true primarily for organisations with long period of operation. The share of public funds in the budgets of organisations that began their operation before 1989 amounted to 78% in 1998 and 66% in 2003. A significant change was recorded in the case of organisations that began their operation after 1994. In 1998, the funds transferred by public administration accounted for 71% of their budgets, while in 2003 the corresponding value was 36%, while nearly 27% of the revenue of the youngest organisations was acquired from foundations and associations financing demand reduction. The youngest organisations used foreign funds a few times more often. The decrease in the scope of financing by public administration pertained primarily to inclusive organisations (86% in 1998, and 50% in 2003). For many of these organisations, this meant the necessity of seeking for alternative sources of financing. In the case of the oldest organisations dealing only with the questions of demand reduction, the funds received from public administration accounted for over 80% of their budgets. This proves the stability of the system ensuring the grounds for financing of the most experienced organisations.

In the longer time perspective, dependence on public funds brings the risk of excessive formalisation, and limitation of creativity and modernisation of selected services and actions.

Demand reduction: activities conducted

Characteristic of the Polish system for counteracting drug addiction is a similar structure of actions as the systems operating in other countries of Central Europe. The dominant types of activity conducted by nearly every organisation were prevention programmes. From 70 to 80% of organisations also dealt with the training of professionals. Another equally frequently encountered mode of operation was conducting studies and analyses (especially true about the Czech Republic and Slovenia) and coordination of activity of other organisations, which was true in most cases at the local level. Besides Hungary, most organisations participated in the process of shaping governmental programmes and policies. Polish and Slovene organisations conducted therapeutic actions and rehabilitation programmes more often than those from other countries, while Polish organisations also far more often represented the interests of drug addicts and their families (24% in 1999, and 69% in 2003).

An important element in the system for counteracting drug addiction is the division of tasks performed between governmental institutions and non-governmental organisations. Studies of the public sector in Western states, prove a tendency that has continued for over a decade to limit the amount of tasks conducted by public administration. Increasingly often, the tasks fulfilled by governmental institutions are entrusted to other organisations, while the role of administration boils down to the key functions connected to strategic planning, monitoring and evaluation of the policy conducted, and financing of actions conducted by non-governmental or commercial organisations.

In Poland, the division of tasks between public administration and non-governmental organisations signals the arrival of such tendencies. Thus, for example, the domain of therapeutic and rehabilitation impacts was nearly solely in the area of operation of non-governmental organisations. In 1999, only 18% of governmental institutions conducted programmes in drug addict therapy, while the corresponding rate in 2003 amounted to 30%. In 1999, similar actions were conducted by 56% of non-governmental organisations, and in 2003 by 76%. Public administration Institutions were far more likely to conduct research and analytical work, and coordinate the activity of other organisations. Nearly all governmental institutions participated in the process of developing programmes and strategies. It is worth noticing that participating in these processes was also every other non-government

organisation, which seems to prove the broad social participation in the processes of planning.
Besides the areas where the division of tasks is visible, there are also areas of concerted actions. They include primarily preventive activity undertaken by 96% of non-governmental organisations and 82% of governmental institutions. Maintaining the situation where a decided part of activity of organisations focuses on preventive and therapeutic activity does not seem feasible in the longer run. It may be expected that in the near future we will be dealing with changes based on greater specialisation and focusing on selected types of activity.

Policy towards drug addiction: evaluation of the organisations studied

The studies discussed here provided also information that allows defining specific features of policies towards drug addiction implemented in the analysed countries. Even though the characteristic provided below was based only on the opinions of the leaders of the studied organisations, it presents an interesting portrait of priorities and specific traits of national strategies. For example, a characteristic feature of Slovene policy in 1999 was preference of actions aimed at harm reduction. In Hungary, the element dominant in the national strategy was the institutional control of drug users. In the opinion of Czech leaders, the national strategy was the conjunction of control of demand with harm reduction, with simultaneous strong presence of the remaining actions: health promotion, reduction of demand, and control.
Compared to the countries listed above, Polish policy towards drug addiction, both in 1999 and in 2003, was seen as hardly distinctive, and devoid of specific priorities. This resulted to a great extent from the lower level of information of the leaders of Polish organisations. In 1999, nearly 30% of the respondents were not capable of defining specific features of national policy. What seems to be one of the reasons behind that is the lack of public debate that would show a broader context of projects and programmes conducted by individual organisations. Little wonder that difficulties in performing assessment cropped up far more often among leaders of non-governmental organisations focused, as a rule, on relatively narrow areas of operation.
The diagnosis of Polish policy towards drug addiction, performed by the respondents with crystallised opinions on the national strategy, proves it to be a particular compromise between reduction of demand and control of the supply, with health promotion being mentioned far less frequently. In 1999, only few organisations (17%), identified Polish policy with control and repressive actions towards drug users, which was a significant difference compared to the other countries analysed. Four years later, nearly every other Polish leader considered control and repression the dominant features of the Polish strategy of counteracting drug addiction.
The opinions concerning the assessment of national policy depended on the attitudes towards drug addiction to a great degree. It turned out that people with restrictive views on drug use more often perceived the Polish policy as focused on demand reduction and health promotion. People with progressive views more frequently believed control and repression actions to be its characteristic features. It may be believed that the opinions of the strategy of counteracting drug addiction were to a great extent an effect of accepted views concerning the phenomenon of drug use, rather than a consequence of knowledge about the existing system for counteracting drug addiction.

Conclusion

In the more than two decades that passed from the moment when the problem of drug addiction developed in Poland, a coherent system for counteracting the phenomenon, based on solid grounds, was successfully built in Poland. Against other central European states, the Polish system is unique, both through its broad scope of activity and solid resources. The key element of the Polish strategy is basing the system of demand reduction on the operation of non-governmental organisations. From the perspective of the previous years, it is clearly seen that these organisations played not only a profound role in discovering and defining the problem, but they have also enriched the Polish policies with their experience, know-how, professional qualifications, involvement, and knowledge

of local needs characteristic of the third sector. This solution seems to be a consequence of implementing clear, long-term priorities of national strategy. Unlike other countries, the central institution in Poland that defines the political directions and ensures financial and technical support is the National Bureau for Drug prevention. Entrusting the implementation of governmental policy to non-governmental organisations that are the nearest milieu of the Bureau is a solution that skilfully combines the advantages of the third sector with the long-term strategy of public authorities.

One of the specific features of the Polish system is its stability. A large share of non-governmental organisations have operated for over a decade. Confirmation of this operation in changing political, economic, and social conditions proves the adaptive skills of organisations and the model accepted. The stability of the solutions assumed, allows also institutional development of these organisations, that – compared to those from other countries – have significantly larger resources at their disposal.

Stability of the system and experience of the organisations may, which is a paradox, prove to be its weakness in the situation of violent changes within the area of drug addiction or the institutional milieu. The diagnosis presented in the article proves the danger of formalisation and closing up of organisations within standards and procedures they have tested. This threat is signalled e.g. being dominated by the phenomena of the organisations by psychologists and teachers, and also with the scanty presence of programmes of types other than preventive or therapeutic, traditionally conducted mostly by most non-governmental organisations. Another signal that the old formulas are replicated seems to be the scanty presence of permissive attitudes towards the drug addiction, which is characteristic of Polish organisations against those from other states. One of the consequences of this situation may be closing down on the new ways of managing organisations, blocking further institutional development, cooperation with organisations in other countries, efficient application for EU funds, and participation in international programmes. Another threat, especially significant when faced with a crisis in public finance, seems to be a stronger dependence on governmental grants. Low susceptibility to innovation brings also the risk of inadequacy and inefficiency of the action undertaken in the changing and insufficiently recognised reality. The image of the Polish system for demand reduction presented above is a particular snapshot made in the late 20th and early 21st century. This snapshot shows both the strengths and weaknesses of the system as well as threats to it. The former requires systematic support on behalf of public authorities to ensure stability and continuity of action. The latter, in turn, signals the need for profound reflection and launching corrective mechanisms inspiring searches for new solutions, professionalisation of activity, and expanding the resources necessary to achieve the changes intended. Whether these have brought the expected effects can be proved by another "snapshot", which will show the current image of the system for counteracting drug addiction.

Diagnosis of institutional reactions showing the degree to which the institutional system is capable of meeting current and future threats is just a part of analyses that allow evaluation of impact of national strategies for counteracting drug addiction. A necessary element at such an evaluation is the systematic analysis of drug addiction to portray the changes in the problem, its structure, and conditions. An equally significant element is provided through the analyses of efficiency and effectiveness of the actions conducted that allow evaluation both of individual programmes and the entire policy. As the experience of other countries and international organisations proves, the combination of the types of analyses presented above into a single coherent system of monitoring and evaluation ensures a long-term effictivewess of the strategies.

The article is a copy of the publication in NARKOMANIA Newsletter, No. 4/2008.

Literature

[1] Projekt „Developing Social Research Capacities in Drug Control" objął wszystkie organizacje prowadzące działania dotyczące redukcji popytu, działające na szczeblu krajowym, i wybrane organizacje o zasięgu lokalnym. Badania zostały zrealizowane w ramach projektu European Center for Social Welfare Policy and Research finansowanego przez United Nations International Drug Control Programme. Koordynatorami projektu byli prof. Patrick Kenis i dr Robert Sobiech. Wyniki badań zostały opublikowane w książce *Institutional Responses to Drug Demand in Central Europe. An Analysis of Institutional Developments in the Czech Republic, Hungary, Poland and Slovenia* (Kenis Patrick, Mass Filip, Sobiech Robert (eds.), European Centre Vienna Ashgate, Alderhot 2001.

[2] Sobiech R., *Instytucjonalny system przeciwdziałania narkomanii w 2003 roku*, www.narkomania.gov.pl/raporty2003.htm.

[3] Pierwsze badania przeprowadzono wiosną 1999 roku, stąd też dane na temat budżetów organizacji dotyczą 1998 roku.

Frequently, the helper in therapeutic practice faces the task of explaining either to the patient or to the patient's parents what help actually is and what its forms are. Lack of sufficient information, the stereotypes popular in the so-called "second circulation", and the myths – frequently contradictory on many issues – result in growing apprehensions and great intensity of fear not only in future patients but also in their parents, which strongly debilitates motivation and discourages many people from entering therapy, actually extending the period of drug use and deepening the addiction.

FORMS OF HELP FOR DRUG ADDICTS

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It is not until a dramatic experience or extremely difficult situation occurs that the patient becomes determined to embark on treatment regardless of everything else. Once that has been achieved, treatment consumes far more time, assets, emotions, and involvement in the process of therapy, and does not necessarily end in success and lasting abstinence. All this could, however, begin earlier, if one had a greater awareness of what to expect at each stage of treatment and could become familiar with the assumptions and forms of therapeutic collections. In this article, I would like to present potential patients, their parents, and teachers and tutors what they can expect at respective stages of therapy, and what assistance they may expect in the centres described below.

People reaching for drugs and their families may resort to plenty of forms of aid and therapeutic assistance offered by a variety of centres. Depending on the degree of problem intensity these can be consultation points, ambulatory centres, Drug Addict Anonymous groups, detoxification wards, and wards for the treatment of addictions with various therapeutic programmes.

Consultation point for addictions is in most cases run by associations or foundations, yet recently also by local authorities operating by municipal commissions for addictions. Points usually employ a therapist or a consultant who performs the initial diagnosis of the problem, gathers information concerning the progress of addiction, provides information, supports the decision to enter treatment, and motivates to enter therapy in an ambulatory or residential centre: medium or long-term. If there is no ambulatory centre in a given town, a consultation point is the first place where initial assistance can be obtained. Some points offer also a possibility of diagnosis from a physician (best: a psychiatrist), and psychological consultations.

Ambulatory consulting centre offers, depending on the progress of the illness, varied forms of assistance for drug addicts and of their family members. Centres employ professional therapists, as well as therapist neophytes that is people who have rejected their addiction and help others in coming back to normal functioning, sharing also personal experience and problems from the earliest stages of therapy. In the centre, you can expect medical and psychiatric help, psychological tests, and legal consulting. Thorough diagnosis allows deciding whether the patient may embark on treatment in an ambulatory system, or whether he has reached the stage that already requires treatment in a residential care centre. Ambulatory care centres may be run by associations and foundations not registered with the National Healthcare Fund (NFZ), and ones registered as Independent Healthcare Centres (NZOZ). NZOZ centres are fre-

quently run by natural persons, usually specialists in psychotherapy of addictions: psychologists, teachers, psychiatrists.

Ambulatory consulting centres offer a range of forms of individual and group therapies. They make use of the achievements of numerous currents in psychology. Depending on the therapeutic team, there are programmes whose grounds follow the assumptions of therapeutic communities (MONAR centres) and ones that fall back on the achievements of behavioural and cognitive psychology. I believe that what is most desired is an integral programme making use of all experiences and combining a variety of approaches. To control abstinence, most ambulatory centres perform tests for presence of drugs in urine. As a rule, if the patient is not capable of maintaining abstinence during therapy, he is removed from the programme and proposed returning after a period of "grace" or moving to a residential care centre. The programme in fact confronts the patients with their addiction. Every drug addict believes that he will easily cope with the rejection of the psychoactive substance, and it is only the decision about the therapy and beginning of abstinence that allows finding how deeply the addiction has been rooted in the patient's psyche.

As a rule, programmes conducted by ambulatory centres last from one to two years. Initially, they are very intensive, with the frequency of the meetings being reduced with time. As practice has proved, the patients who do not leave the programmes are those with high motivation and those in the abuse phase. What has proved to be the greatest problem of the ambulatory system is the control of abstinence: parents are not always capable of coping with that, and the potential of the centres is, for obvious reasons, limited. In such cases, an option to have the patient treated in a residential centre (24/7 stays), becomes an option. If, however, abstinence has not been kept longer, most centres require a discharge document from a detox ward prior to enlisting, to prevent the emergence of problems of medical and psychological nature (psychoses, panic attacks, etc.).

The offer of detoxification wards (detoxes) has until recently been extended to patients addicted to opiates (for example, heroin) and their derivatives, and from psychotropics and alcohol. What we observe today it is the need to combine detoxification with psychiatric observation. Such wards offer help to patients abusing amphetamine, ecstasy, and GHB as both the psychological impact and the destruction of organism connected with these substances seem to be far greater than initially believed. It is perfect if the patient goes directly to a therapeutic centre after the detoxification, without returning to his former environment.

Generally speaking, the offer of a detoxification ward covers:

1. Detoxification from the substance received by the addicted.
2. Reduction of the adverse symptoms following quitting drugs: reduction of the craving, pains, seizures, and – in extreme cases – prevention of deaths.
3. Diagnostics of complications including HIV, HBV/HCV, and other related infections diseases.
4. Individual choice of medications for the patient's psychological situation.
5. Prevention of psychological disorders originating when ceasing to take the drug.
6. Motivation to further treatment.

A drug changes the functioning of the body cells, and therefore the task of detoxification is the resetting of the body so that it can function without the drug, as far as possible in a safe and humanitarian way.

Short-term treatment is provided by the addiction treatment wards (OLU). Such wards operate in psychiatric hospitals and psychiatric clinical centres. Their programme is based on the theory of psychological mechanisms of addiction and clinical experience. In the wards, you can count on 24/7 medical care, pharmacotherapy, and psychological help. Initially, nearly all wards in Poland offered assistance for people addicted to alcohol and pharmaceuticals (there are wards for men, women, and coeducational), yet today more than every other of these admits also drug addicts, as it has turned out that an alcohol programme with individual therapy and focus may be effective for some types of patients addicted to drugs. The programme lasts from six to eight weeks. Intensive therapeutic impact (24 hours a day) is a good introduction to continue the therapy. A person finishing this type of programme should continue the therapy either in a consulting centre or in a medium-term care centre. It is worth remembering that no head of a ward says goodbye to the patient

with the words "farewell, you have been healed", but emphasises the need for continuing treatment.

Residential, medium-term treatment offers many programmes of addiction therapy, mostly conducted by health institutions, running therapeutic programmes lasting from six to eight months. They include an intensive therapeutic programme with individual approach. The offers in most cases combine the approach connected to the theory of psychological mechanisms of addiction with the method of therapeutic communities. Each centre is focused also on the development of personal predispositions to persevere in abstinence and on development of individual interests. An important role is also played by teaching a sense of duty, responsibility, care for personal hygiene and physical condition. Some centres for the young make it possible to continue school education, but it is not believed that in their case it is education that is most important. What is most important is the healing.

Residential long-term treatment means therapeutic programmes lasting from 12 to 24 months that are offered by specialised centres of MONAR, Karan, PTZN, ZOZ, and other non-governmental organisations. The staff are therapists, psychologists, and former addicts. Programmes are based mostly on the method of therapeutic community, and encompass a range of both therapeutic and social activities aimed at the reconstruction of such norms and values as honesty, responsibility, frankness, friendship, etc. An important aspect of participation in the system is work, possibility of self-fulfilment in various roles: a cleaner, a cook and a gardener to a security guard and a leader of the community.
Participation in the therapeutic process is divided into a number of stages that include playing certain roles that give privileges defined by the entire community. Every patient beginning the therapy undergoes a trial period and does not receive the first privileges earlier than after a month of staying in the centre. A characteristic feature of the centres are iron norms and principles of operation, whose breaking results in imposing punishments, that is the so-called "dociążenia", or exclusion from the community.
Completion of therapy at a long-term centre is not the final "healing". Addiction is an incurable illness, with characteristic relapses, that is crises that may result in return to the drug.
This is why every graduate should, having left the centre, find a personal therapist or – if he has such a possibility – use the help of support groups for former addicts or Drug Addicts Anonymous groups.

Drug Addicts Anonymous Groups exist already in some Polish cities. Participation in the groups is open to all drug users, independent of the type of substance used, and routes of its administration and combination. When the first groups of drug addicts anonymous adjusted "The first step" from the literature of alcoholic anonymous to their needs, the word "alcohol" was replaced with the word "addiction". The Drug Addicts Anonymous movement has no limitations of social, religious, economic, racial, ethnic, national or sexual nature, there are no entry or membership fees either. Most of the members regularly participate – with small sums – in the payment of the expenditure related to meetings, yet these donations are not obligatory.
In the programme of Drug Addicts Anonymous, members are encouraged to absolute abstinence from all types of substances, including alcohol. The experience of the groups' members proves that continuous and unbroken abstinence provides the best foundation for health and personal growth. The main services available from the groups are group meetings. Each group operates individually, following the principles binding within the entire organisation.
For the weekly meetings, most groups rent rooms in buildings run by public, religious, and civil organisations. One person runs the meeting, while the other members participate in sharing their experience in recovering from drug addiction. Members of the group share among themselves the functions connected to facilitation of the meeting.

The article is a copy of the publication in the Assistance and Education Bulletin PORADNIA. narkomania.org.pl.

When 30 years ago, a group of addicts from a psychiatric hospital near Warsaw decided to leave the hospital and began living together so as to combat drug addiction together, no one expected that this would be the beginning of a method of drug treatment that is absolutely unique in Poland, and the beginning of one of the largest help organisations in Poland and Europe.

MONAR MODEL FOR COUNTERACTING DRUG ADDICTION

Jolanta Koczurowska
Stowarzyszenie MONAR

To Marek, and all of us...

System for helping the addicted and those threatened with addiction

To date, the MONAR Association is a professional, modern, multi-focus system for counteracting drug addiction, from universal prevention, via first contact programmes (street, environment), specialist consulting, therapy and rehabilitation to social and professional rehabilitation.

Currently, MONAR runs six consultation points, 24 consultation centres for addiction prevention and therapy (including 18 non-public healthcare centres), three centres for prevention and early therapy, two detoxification centres, 28 residential rehabilitation centres, and five half-way houses for post-rehabilitation.

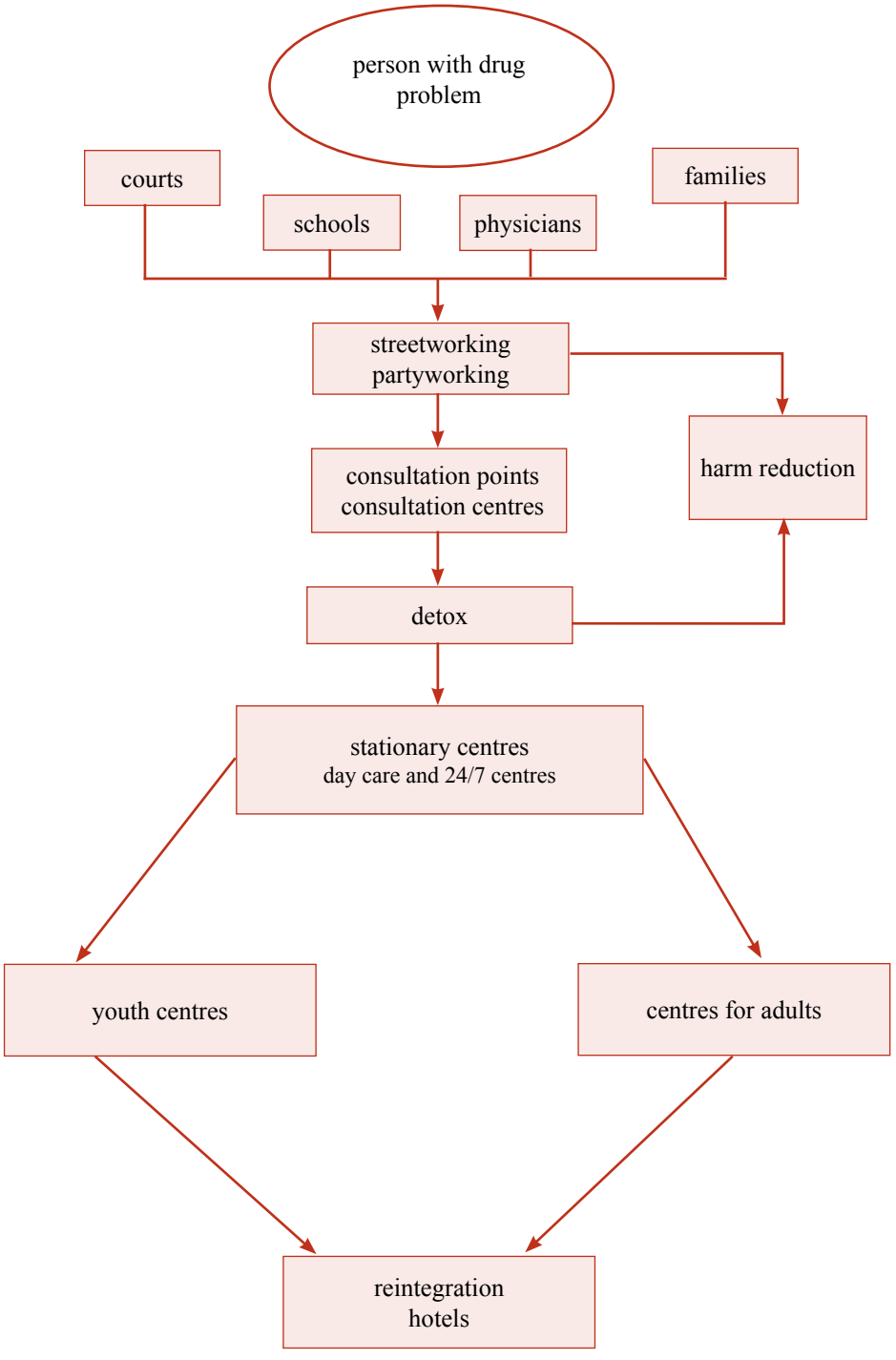
All **MONAR consulting points** have a long tradition of helping the addicted, as they developed early in the 1980s as first institutions of this type in Poland. They offer thorough information about options of treatment, conduct original preventive programmes in the environment, cooperate with families and friends of people with the drug problem, detention centres, and educational establishments. All consultation points feature high standard of accessibility and high competence in directing clients to specific types of therapeutic programmes.

MONAR preventive consulting centres and addiction therapy are professional centres with a rich offer of help services, high standards of availability, and experienced and competent specialist staff. Each consulting centre offers the addicted and those threatened with addiction full medical and psychological diagnosis, possibility of performing drug tests, individual and group consulting, individual and group therapy, and a broad range of assistance for families and friends of people with drug problems: from schools for parents to therapy for families. MONAR consulting centres allow receiving both referrals to detoxification and support during the detox process, provide a variety of psycho-educational classes conducted for a variety of age groups, training sessions and development and integration workshops, and also consultations in legal questions, social assistance, and physical health. The consulting centres offer also support in harm reduction: exchange of needles and syringes, education in cooccurring illnesses, and safe use of drugs. Many consulting centres conduct street therapy and programmes in the places where young people meet.

MONAR consultation points and centres provide on average 120,000 consultations a year. The association runs a **detoxification ward** for people addicted to drugs (in Kraków) and a ward for people addicted to alcohol (in Warsaw).

MONAR rehabilitation centres offer residential therapeutic programmes. Each centre has its own original programme, yet they are all based on the method of therapeutic community accepted throughout MONAR. The programmes are adjusted to the age of the people in need, with centres for children and youth under 19, centres for young adults aged 19 to 25, and for adults. Therapy in the centres lasts from six months (in case of short-term programmes) to 18 months and at times even two years – in medium- and long-term programmes. The stay in the centres is voluntary, yet the centres admit also people with court orders and prison inmates, who have the courts decision

Figure 1. MONAR system system for helping people with the drug problem



exchanging imprisonment for a stay in a rehabilitation centre. The centres of the association provide also help for those addicts who have a history of repeated failed attempts at treatment in residential centres (the GWAN Centre in Kraków). All the residential centres offer also broad help for families and partners of the addicts and those threatened with addiction. In some centres, especially for minors, participation of relatives in the therapy is compulsory.

The institutions conducting tasks in the scope of **post-rehabilitation** (mostly programmes for returning to the society and professional re-integration) are hotel programmes that not only provide the sustenance of the graduates of ambulatory and residential therapy in the MONAR centres but also offer support and development programmes including stress management training, relapse prevention training, and workshops in entrepreneurship and negotiation. An important element of the post-rehabilitation programmes are a variety of courses teaching professions.

The MONAR association is Poland's only non-governmental organisation conducting actions in the scope of **harm reduction**. MONAR runs low-threshold programmes for people actively using drugs channelled on the improvement of their health and social condition, and harm reduction programmes related to harm caused by drug use, aimed at counteracting the spread of HIV, HCV and other infections diseases, and criminalisation. The primary offer of MONAR includes health supporting consulting, education and information, exchange of needles and syringes.

As a part of harm reduction programmes, the association runs "drop-in centres" for active drug users, a centre for early rehabilitation, and a re-integration programme for people on methadone.

The method of therapeutic or community

The system of MONAR's professional assistance to addicts and those threatened with addiction, presented above is itself an example of best practice, thanks to the philosophical and theoretical assumptions made, the variety of forms of assistance, and also the adjustment of its actions to a broad milieu of patients. A proof of the above are the effects measured by the number of partly cured people, and the use of the MONAR method for the development of a system of assistance for the addicted and those threatened with addiction not only in Poland, but also throughout the world. Worth special attention among many methods of therapy and rehabilitation of the addicts made known through MONAR is the model of residential help based on the **method of therapeutic community**.

Due to the specific features of addiction, difficulty in unambiguous definition of "healing", and necessity of applying a variety of medical and therapeutic procedures, rehabilitation of an addict requires carefully adjusted external conditions. Good results achieved by therapeutic communities, the "palpable" proofs that a drug addict may be returned to life observed for years reinforced the conviction that the therapeutic community is one of the most effective methods of treating addictions.

The method of therapeutic community, even though it has already made a permanent place in the system of helping the addicted, continues to raise awe as much as doubts. What can be considered the greatest advantage of the method is the fact that it provides a certain social and psychological treatment through the environment, which makes use of the dynamic context of the group living together. Defined structural and organisational frameworks, as well as philosophy and atmosphere prevailing in the communities are used for therapeutic reasons. A community group with the addicted allows all its members the same potential for modification, normalisation, and change of faulty attitudes and behaviours, and solving the individual and group problems. An important benefit from the therapeutic community is also the fact of its reality: concrete, realistic life situations, in which one participates and situations capable of providing significant experience, and serve learning within a society.

The therapeutic community is a peculiar social microcosm – a "small society" with division of roles and tasks, jobs and steps of the career, rights, duties and privileges, organs of executive and legislative power, and parliament and citizens that provides a unique opportunity for a variety of social interactions to turn up, for learning and experiencing social feelings and civil responsibility. Every member of the community has the option to speak out freely and exchange authentic feelings, observations, and thoughts. A definite benefit of the community is the development of optimum potential for learning in a community that is providing members of such communities experiences that allow acquisition of new ways of behaviours necessary in future, realistic life situations. The goal here is not only to regain what a person lost by using drugs, but also to learn to build and maintain proper relations with other people. A therapeutic community makes it possible to acquire coping strategies to manage own difficulties, obtain an insight into the nature of these difficulties, gain greater independence and sense of responsibility for oneself together with an opportunity to garner initiative and energy for further personal development.

Beyond doubt, a positive value of therapeutic communities in working with the patient is the possibility of referring to the patient's authentic experiences, ones that we can participate in and be a witness of at the same time. It can be said that everything in therapeutic communities is therapy, even simple everyday duties are a true mine of knowledge of oneself for members of those communities, while the quality and quantity of interpersonal contacts is the best school of adjustment to the society.

Specific external conditions, namely, the structure and manner of operation of the centre help in the attainment of individual and group goals undertaken by members of the communities.

MONAR therapeutic communities usually have their seats in manor houses or farms far away from city centres. Situated in the cities are only the houses for children and youth communities, as their members need to attend schools. The community of a given centre is a group ranging from 20 to 70 people. All the communities are managed by therapeutic teams composed in most cases from professionals: specialists and instructors in therapy of addictions, physicians, psychologists,

and social workers. In MONAR centres, 40% of the staff are people who were addicted and completed their therapy with positive outcomes. Members of the therapeutic staff are obliged to systematic improvement of the professional qualifications and gaining certificates entitling them to work with addicts. Each of the centres employs a psychiatrist, and some also a general practitioner. MONAR centres employ modest administrative and technical personnel, as most tasks in this scope are performed by members of the community. The model of running the centre follows the leadership style, with the leaders of the therapeutic teams being unmistakable guides for the members of the community.

In all the centres, the basic form of activity of community members (patients) is work: every day housework, renovation, maintenance, garden work, animal husbandry, etc. that allow keeping the centre efficient and comfortable, as well as learning and fun. Besides the above, every member of the community is obliged to participate in therapy (individual and group), community meetings, and active methods of spending free time. Both everyday work and therapeutic procedures are regulated with certain leading principles, the centre's internal regulations, the agenda of the day, and the ethical code binding all the members of the community without any exception.

The therapeutic community follows six basic principles including:

1. Total abstinence from any psychoactive and pharmacological substances (with the exception of those administered by the physician as a result of a somatic illness).
2. No violence towards others.
3. Subordination to the community.
4. Active participation in the life of the centre.
5. Openness and limited trust.
6. Sexual abstinence.

As a rule, these principles are provided in writing in a visible place.

The therapeutic process (stay in the centre) is usually divided into stages, which makes it easier for the members of the community to control the course and effects of own therapy. In most centres, the classical division of therapy into the three basic stages is used: novice, household member, and resident (known here as "monarowiec" – literally "Monar person"). For example, in long-term programmes, the novitiate lasts from three to six months, the household member stage – from seven to nine months, and the stage of the resident – for approximately 9 months. Each of the stages has specific tasks, duties, and privileges assigned. The community decide individually about each shift between the stages in the therapy. In most therapeutic communities, all functions in the centre are performed by members of the community. The council (or board) of the centre, elected in democratic elections, decides about its operation.

A characteristic feature of therapeutic communities is the care for personal development of its members. Which is why the centres run plenty of different creative, artistic, and support classes including music, theatre, dance, eastern martial arts, painting, applied arts, as well as language classes, computer courses, and a variety of educational pursuits around a variety of subjects, and sport groups: aerobics, bodybuilding, team games, and extreme sports groups ranging from rock climbing to parachuting. Some of these are obligatory. The therapeutic communities participate in recreational therapeutic camps at least twice a year. Usually, these take the form of canoeing, cycling, or hiking camps.

A specific characteristic of MONAR communities is the care for developing the custom to observe the tradition and the development of a sense of social and cultural belonging. Serving this end are a variety of centre ceremonies. Usually, the community runs a chronicle of the centre, which includes the so-called family album (i.e. photographs of all who have been members of the community). There are specific "rites" connected to changing the stage of treatment, completion of therapy, and anniversary of establishing the centre. The anniversaries organised once a year are of the reunion character. Celebrated together are Christmas, Easter, All Saints' Day, birthdays, and important life events, for example, graduation from school, moving to another class, getting a job, etc.

The community meet at morning and evening meetings (known as ritual), and intervention meetings: summoned by the bell in difficult, critical situations. Therapeutic meetings are held regularly once or twice a week, there are also the so-called organisational meetings where questions concerning the situation of individual members of the community and the

community as such are decided, and the festive meetings connected to holidays, birthdays, etc. It is at the meetings of the community that decisions about everything taking place in the centre are made, rules for coexistence in the group are set, conditions of the stay are dictated, and progress in therapy is evaluated.

Therapeutic factors

A testimony to the exceptional impact of therapeutic communities on addicts is the quality and quantity of therapeutic aspects present within it. What heals best in MONAR communities:

- Instilling hope, the belief in the improvement of personal situation, solution of the existing problems and better future, consciously maintained by the group and therapists. Most people embarking on the process of rehabilitation do not believe in change, perceiving the world as evil, giving a very negative assessments to their own life opportunities, and primarily feeling no sense of influencing their own lives. In MONAR therapeutic communities, plenty of attention is attached to the reconstruction of lost hopes, proposing plenty of tasks and roles, and encouraging to gathering successes achieved in the mini-society of the centre. This factor results directly from MONAR philosophy: "no one is lost forever".
- Self-help, that is the maximum involvement of members of the community not only into running the household together, but also into mutual assistance. Most addicted people believe that they are not worthy of the positive feelings of others, and that they are of no value for others. In helping others the addicted have an opportunity to reinforce the sense of value, discover that one may be important for someone else. The community is especially keen on mutual assistance. Responsible care and help is one of the elements of the unwritten philosophy of MONAR.
- Socialisation, that is acquisition of new, effective social behaviours helping directly in the more efficient, safe functioning in the society out of the centre, by remaining a fully valued member of the therapeutic community, getting rid of the "junkie" label, playing important social roles in a group, and carrying out socially important tasks defined by the community.
- Universal character of the problems, i.e. conscious discovery and reinforcement of the sense of similarity to other members of the group through the fact of experiencing shared problems, fears, difficulties, and failures. The discovery that other members of the group face similar problems and share the same feelings gives a sense of safety and belonging that makes it possible to disclose oneself and work on oneself. A healing factor is everyday care for understanding of existential truths, conviction that one must approach own limitations and weaknesses with humbleness.
- Interpersonal relations and ties, i.e. the motivation and support from therapists and other members of the community in providing and receiving feedback, active cooperation with others, expression of feelings, constructive work on negative emotions and aggression. Such an attitude during the process of rehabilitation allows the patient to realise the influence of his behaviour on the attitudes and feelings of others. The satisfaction from interpersonal relations is the condition required for weakening the social fears tantamount to the improvement of self-esteem, capability of insight, and increased autonomy and efficiency of own actions. The presence of this factor strengthens the treatment of the centres as homes, and the therapeutic community as a substitute of the family. A family with no unwanted children, one that ensures love and support for all its members, yet one that also poses requirements, defines borders, and demands participation in responsibility for the good of the entire family. During the 30 years of developing the concept of therapeutic community as a method, MONAR developed a conviction among many addicts that MONAR is something more than just an institution, that MONAR are strong, family ties. Many graduates of rehabilitation centres asked about MONAR answer: "... it is my second home".

The efficiency of the method of therapeutic community depends, as has been said before, on the conscious introduction of the healing factors. They are easily identifiable in the MONAR system. Yet, a not-too-optimistic reflection turns up, whether all these factors that have a salutary impact can be saved from the

thickets of administrative red tape and organisational rules that this method is currently subject to.

Therapeutic programmes

MONAR rehabilitation centres, conduct three types of therapeutic programmes:

- short-term, lasting up to six months
- medium term, lasting up to 12 months
- long-term, lasting from 12 to 24 months

The duration of individual programmes depends on the specific features of the clients and the content of the programme.

Short- and medium-term programmes address mostly young people, drug users (not addicts) without cooccurring psychological disorders. Long-term programmes are thus applied towards the adults with long-term history of taking psychoactive substances.

MONAR therapeutic communities have space for the total of 1100 people. The 14 centres with therapeutic communities provide treatment for people with cooccurring psychological disorders. They are included into the regular community programme, as binding in all the MONAR centres is the complex, integrative model of working with people who have drug problems. Staying in the therapeutic communities of MONAR are also people who received court orders and those who had a prison sentence turned into therapy by the court (approximately 20% of patients).

Operating in five centres are post-rehabilitation programmes, while one (GWAN in Kraków) runs a programme for relapse patients.

Residential centres require a referral from specialist consulting centres, family doctors, or courts. A stay in a therapeutic community is preceded, if need be, by detoxification in a hospital. The procedures of admission to a stationary centre include a medical (also psychiatric) and psychological diagnosis, and tests for the presence of psychoactive substances. Defined at the time of introduction to the centre are the needs of the addicted concerning other medical services (e.g. connected to epilepsy, HCV, etc.). At individual stages of participating in the therapeutic community, specific services – every day and regular – are provided, depending on the patient's state of health and capacities, and the potential of the centre and its personnel. The everyday services include individual therapy, group psychotherapy (including meetings of the community and therapeutic groups, known as stage groups), psychotherapy through play, critical interventions, nursing activities, and other forms of therapy e.g. motivational and support therapy. The regular services include medical checkups, psychological tests, evaluation of progress in treatment, and rehabilitation camps.

Philosophical foundations of MONAR

- Human being deserves help, not because he or she is weak, imperfect, addicted or homeless, but because he or she is a human being.
- Every human has an opportunity to stand up, be reborn, changed.
- There are no people lost forever.
- Humanity is the highest dimension of professionalism.
- Drug addiction is an illness of soul and body, and the drug is a paradox sick shelter.
- Helping the neighbour is a manifestation of moral sensitivity and a condition for regaining humanity. (Hence Marek Kotański's famous slogan "give yourself to others.").
- Love of the neighbour is an authentic and unchallengeable source of faith and hope.

The article is a copy of excerpts from Koczurowska J., Monar pomaga 1978–2008, Stowarzyszenie Monar, Warszawa 2008. Title and hadings from the Editor.

METHADONE TREATMENT IN POLAND

BEGINNING OF A SUBSTITUTION PROGRAMME.

Marek Beniowski, MD
Member of the Main Board of the Polish Scientific AIDS Society

Opiate use in Poland began in the 1960s. The first cases were frequently connected to medical personnel, and the substance in use was morphine. Many people used also ether, which was a cheaper substance. Together with the blossoming of the hippies movement came the time for using narcotic substances. Using drugs was connected to the fashion for experiencing altered states of consciousness popular among the flower children. The substances included marijuana, codeine administered orally, benzodiazepines, barbiturates, and "Tri" solvent (trichloroethylene) for sniffing. Early in the 1970s, two students of a secondary chemical school in Gdańsk developed a recipe for home-made heroin. The so-called "compote" became the most popularly used opiate. Drug addicts began to be unwelcome in the society, they were dirty and smelly, could hardly stand on their feet, and the danger of contracting the HIV made people walk round them in a broad circle.

People addicted to heroin systematically increase the amount of injected drug. This is connected to the so-called tolerance, which is the need to receive increasingly larger doses of heroin. In result, the patient reaches the detoxification wards, as otherwise he is threatened with overdose of the drug. Besides consultation points, preventive and consulting centres, centres for therapy, detoxification wards, and the few day-care centres, the Polish system for treatment and rehabilitation of addicts developed most strongly the system of residential care: short and long term, which has thus garnered the richest experience. Residential rehabilitation is conducted by rehabilitation and rehabilitation/re-integration centres that are the main part of the public healthcare and non-governmental organisations including the Society for Preventing Drug Addiction (TZN), "Powrót z U" Association, "Karan" Association, "Familia" Association, and the "Betania" Catholic Association).

The oldest institution offering therapy for adults is the MONAR Association operating since 1978. Despite the structural, formal, and philosophical differences, nearly all the existing centres of residential assistance assumed – more or less consciously – the method of therapeutic community as the main tool for therapeutic influence on the addicted.

It is estimated that the centres mentioned above provide treatment for approximately 2400 people. The efficiency of these centres (understood as the so-called zaleczenie: partial curing), ranges from 5% to 15%, which means that the number of people recovering from addiction ranges from 120 to 360. All the others are threatened with rejection by their family, lack of means of sustenance, homelessness, lack of resources to survive, and also health problems. Many will contract HIV, HBV, and HCV. They are also in danger of contracting syphilis, tuberculosis, toxoplasmosis... They are exposed to the toxic effects of various substances that the "compote" contains, including ammonia compounds and organic solvents, development of the thromboembolic phlebitis, embolic complications in the arteries, infections at the place of drug administration, lethal overdose, and the general deterioration of health due to the extremely unhygienic lifestyle.

For many years, therapeutic programmes were the only way of going out of addiction. Yet as their effectiveness is strongly limited, a concept originated to develop another programme of treatment for drug addicts. The staff of the Institute of Psychiatry and Neurology (IPiN) in Warsaw, made use of medication under the name of methadone. The concept of methadone therapy originated in New York, and had its origin in the works of three psychiatrists Dr Vincent Dole, Dr Marie Nyswander, and Mary Jeanne Kreek. They were looking for a substance that could replace heroin. They chose methadone whose characteristics include good absorption from the alimentary tract,

much longer half-life period than heroin and morphine, and a decidedly slower development of tolerance. The substance was for the first time described in 1941 by Germans: Bockmul and Ehrhart. Methadone may be administered once a day, in the form of tablets and syrup, and the suggested daily dose ranges from 80mg to 150 mg. Until 2004, 225,000 people participated in methadone programmes in the United States, with the number of patients retained for the period of at least one year, ranging from 50% to 80%, while heroin was taken regularly and illegally by anything from 5% to 20% of patients. It was proved that methadone does not cause symptoms of coming off and narcotic craving, blocks the euphoria effects of opiates with short impact, and helps to normalise the disorders of the addict's physiology.

The methadone programme conducted at Warsaw's IPiN under Dr Godwood-Sikorska made it possible to receive the first group of approximately 40 patients and was to finish in their gradual detoxification, yet this was objected to by the patients and their families, which resulted in its continuation. At the time discussion about conducting the programme further – related to the negative attitude to drug addicts, including those who were HIV positive – continued. Medical personnel did not want to issue drug addicts with substances causing addiction, nor was there any support from local communities, nor any legal regulations concerning methadone treatment were in operation. Such a status resulted from the predominant conviction that the only proper way of conducting therapy in case addictions is a stay within a closed centre focused on the achievement of total abstinence. For a number of years, the concept of harm reduction that has been present in many countries remained simply unnoticed: a method supporting all and any activities, whose goal is the minimisation of various threats and dangers connected to the addict's life in contemporary society.

After the initiation of two further programmes in Warsaw, a methadone programme was established in Starachowice (for HIV negative people). In 1995, a new methadone programme was launched in Chorzów. It was possible thanks to obtaining a grant from the Lindesmith Center in New York to organise places for 50 HIV-positive people in the Specialist Hospital in Chorzów. Local authorities conducted a renovation of a section of the hospital and the programme was launched in 1998.

Further methadone programmes were established in Zgorzelec, Szczecin (1998), Lublin (1999), Kraków (2000), Poznań (2001), Łódź (2005), and Wrocław (2007). Two more started in Warsaw, and one in the sub-ward in Siedlce. Methadone treatment continues also in seven detention institutions. National data concerning the number of heroin addicts (from 25,000 to 29,000) show that the current number of methadone programmes is too small to be able to satisfy their needs. This should become food for thought for decision makers, especially that the effectiveness of drug-free programmes is low.

THE MAP OF METHADONE PROGRAMMES IN POLAND

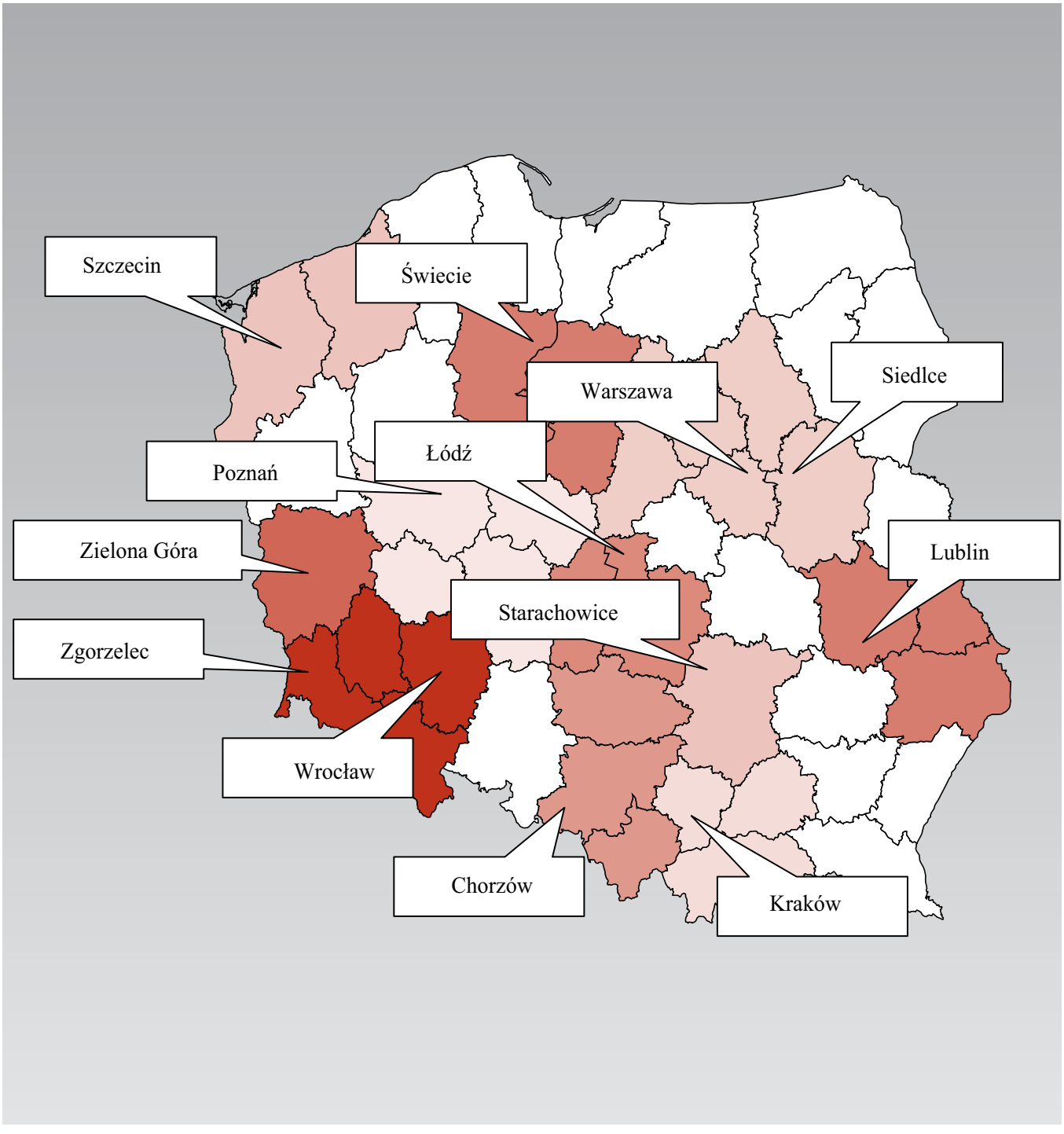
Grzegorz Wodowski
MONAR in Kraków

The change in the stipulations of the law on counteracting drug addiction that allows non-public healthcare units to establish substitution programmes gave hope for major broadening of the access to substitution treatment. Answering these changes, two programmes conducted by non-public health care centres originated in Warsaw. It was in the capital that, despite three substitution programmes that had already existed, the need was the greatest. Today, programmes in Warsaw offer treatment to more than 600 people, so that there is no need to wait for months to join them. The act changed three years ago, yet besides Warsaw's "Eleuteria" and "Mały Rycerz", no other programme conducted by a non-public health care centre emerged. Nobody else even tried. Access to substitution treatment in EU states is at the general level of approximately 40%, which means that more than every third person addicted to heroin is encompassed by this form of therapy. Substitution treatment today in Poland is extended to 1400 people. The number of those addicted to opiates is estimated at from 25,000 to 30,000 people, thus only 4% to 5% of the addicted have an opportunity to resort to this form of treatment. What is the obstacle

for substitution treatment to develop and adjust to the changing conditions, needs, and expectations of opiate addicts? Is there still no demand for substitution treatment? There is, indeed. Still, there are very large areas, large cities, with absolute lack of access to such treatment. The Tri-City, Rzeszów, and the entire north-eastern Poland do not know what substitution treatment is. There has been only one programme operating for years in the Upper Silesia, and offering substitution to 140 people, even though the Silesian conglomeration is one of the largest hubs or opiate users.

When it comes to the number of addicts, Poland is strongly differentiated territorially, with differences being also of qualitative type. There are areas were opiate users are few, and cities where the trend of using heroin is highly dynamic (Warsaw, Wrocław). Due to the low number of

Map 1. Availability of substitution treatment in Poland (full addresses are given in the table on the page 52)



centres proposing substitution treatment (16 programmes), many of them must extend their scope over large areas of the country. For the patients, this means incessant travel. An extreme case is the substitution programme conducted in Świecie nad Wisłą, with no patient of the programme actually living in Świecie, the majority coming from Toruń and Bydgoszcz (approximately 40 km away), and some coming from... the Tri-City 150 km away. In the Lublin programme, residents of Lublin account for only approximately 15% of all patients, while the majority of others arrive from Puławy, and even further from Sanok and Baligród. Of the 60 people treated in Zgorzelec, only 15 live in the town, with others commuting several tens of kilometres from Jelenia Góra, Szklarska Poręba, and even from beyond the region.

Even though the great majority of patients in Warsaw and Kraków are people living in the cities, this to a great extent happens due to the "methadone migration". In Kraków, non-local patients of the substitution programme conducted in the Rydygier Hospital use the hostels and night lodgings to have access to methadone treatment.

The lack of equality in access to substitution treatment means that many addicts that meet the criteria required by the Minister of Health have no opportunity to receive treatment close to their place of residence. These who are determined enough to travel several tens of kilometres every day or every two days, must subordinate their lives absolutely to treatment.

Is that so beacuse the National Healthcare Fund does not want to contract substitution programmes? There are many reasons to believe that it does. Recently, some substitution programmes have been embracing more patients than they have been contracted. The numbers of additional patients in programmes conducted by the "Eleuteria" Association and the Institute of Psychiatry and Neurology count in tens. Their operators do not doubt that the Fund is going to pay for these "excesses" of services.

Some programmes, for example in Lublin, admit patients whether they are insured or not. As it turns out, financing services for the insured is not a problem. The National Bureau for Drug Prevention makes efforts to promote substitution treatment among the National Healthcare Fund officers. Many contracts will be expanded already in 2009. It is to be emphasised that no initiative referring to a methadone programme had its financing rejected by National Healthcare Fund in the recent years.

To what level the dislike of substitution treatment among professionals is the problem? It seems it is high, indeed. Substitution programmes are still a controversial model of approaching the treatment of addicts. The goal of the therapy is not abstinence, but "only" stabilisation of life of the addict, and prevention of escalation of further health problems. For quite a large group of therapists and physicians, abstinence – even if unattainable – is more noble then effective substitution.

The MONAR Association, Poland's largest non-governmental organisation dealing with the addicts, rejects in its very statutory goals the option of substitution treatment. Careful analysts perceived here a certain paradox: allowing implementation of harm reduction programmes with the exception of substitution treatment, the statutes of MONAR allow conducting low-threshold projects, for example syringe exchange, injection rooms, and drug testing: projects that have hardly anything in common with treatment.

Probably, the most serious drawback of Polish substitution programmes is the lack of division into low- and high-threshold. Not all people entering substitution treatment are ready to stop using illegal drugs, even if they believe so before joining the programme. Mixing patient groups with extremely different potential, attitude to therapy, is detrimental both to those who treat methadone as only assistance in avoiding symptoms of coming off, and those who find the therapy helpful in actual stabilisation of life. Little wonder that such status quo frustrates also the personnel running the programme, as it is increasingly difficult to grasp the objectives of substitution treatment. The staff of Warsaw programmes have already begun to notice the phenomenon of patients moving from one programme to another: a patient removed from one of the programmes enlists into another one, from which he will still be removed in a few months due to the repeated breaking of abstinence.

Preparing the requirements and adjustment of programmes to the needs of patients would attract also those addicts who feel disoriented. Differentiation of substitution treatment would, however, require changes in the legislative act regulating this form of treatment. Today, it envisages administering advance doses for the maximum of four days, even to the people who work, and whose working week is five days' long, just like that of most of us! Moreover, the discovery of drugs in the urine quickly liquidated this privilege.

We have already become accustomed to the claim that methadone substitution treatment is attractive and efficient for addicts. It proves also that many addicts do not even think about switching heroin to its surrogate in syrup. There are also ones who have tried methadone treatment and rejected it believing that the substance does not meet their expectations, as it differs too much from the drug they have become used to. A decision to use a greater variety of substitutes would probably mean that treatment could encompass more people, becoming even more efficient. Morphine sulphate, codeine, and heroin are substances that are in an increasingly broader use in substitution treatment in Europe. Polish programmes begin to use buprenorphine. It is a major step forward. The addicts are waiting for the next one.

SUBSTITUTION PROGRAMMES: BENEFITS AND SHORTAGES

Marta Gaszyńska
methadone user for 10 years
President of the JUMP'93 Association of Patients in Substitution

The first substitution programme was established in Poland in 1992. It was an experimental programme, designed for a six-month treatment. It was to encompass the users of "Polish heroine" that is the "compote". At the time, methadone was already successful in the world, yet was it to pass the test in Poland? I was eagerly awaiting this remedy, and so did all the "old guard", because we wanted to live sober lives. I went through the qualification stage, they gave me an appointment, and I finally felt as if I caught the Lord by the feet! For the first weeks, I felt as if I were winged. I went to receive my methadone every day, I did not find it an obstacle. I could meet my friends, have a chat, laugh a bit, cry... I was making up for all with what I lagged behind.

Quite quickly, however, it turned out that we all found that the moments of happiness were lacking, we ceased to enjoy the new life, and problems with the "normal" one began. Alcohol stole in, just to improve the mood. There was more and more of it.

It turned out that we didn't know how to cope with the new reality. How could we know what to use to fill the free time, how to do things in an office, how to fight for our own lives? And yet, these were the drugs that filled our time, now we were left with a void. Despite therapy, a fantastic psychologist, individual and group talks, there was still a void, and it was increasingly difficult to cope when sober. We started the Association under the name "Nowa Droga", i.e. the new road, being a memorial to Zbyszek Thiele, and we were trying to grow up to it, yet we were not able to. We lacked someone among us who would show us what to begin with, what to do. Quarrels cropped up quickly. Problems came in an avalanche; moreover, the six months that we contacted in the programme were at the end, and we were beginning to be "zeroed". We began to take up additional "compote", many of us were on double high – methadone and compote, and some fairly quickly resigned. The management of the programme were fighting for another year, and we had our doses increased again. That year passed away very quickly. I began to take up. My long-time partner, father of my daughter, died, which promoted my falling into a deep binge. I was rejected from the programme for breaking abstinence three times.

I wonder what would have happened if I had stayed... I might have resigned myself, and might have recovered. The assumptions and rules are simple: you break abstinence, and we say farewell – I signed the regulations which clearly defined the principles of participating in the programme. This was the beginning of my methadone road. Now, after 16 years including 10 in another programme, I see that the most important thing is to acquire coping skills for the excess of free time and own limitations.

When I entered the programme 10 years ago, we had a day room, where we could have tea or coffee under the watchful eye of the therapists, play bridge, talk – spend holidays together, namedays, birthdays, we all knew one other. When somebody had a problem, he was quickly noticed, as all the time there was a member of staff with us. When the word "courses" was mentioned, on the following day, the therapist brought a list of institutions that organised them. A few people obtained driving licences, graduated from language courses. The fact that we spent a few hours a day together brought us closer to one another and to the staff: we felt interest of the others in our lives, in our matters.

To date, this is lacking very much. The new patients are left to their own resources, the personnel does not

realise who gas what problem, what he or she does not cope with, and what is his of her strength. The contact with the patient is limited to giving out the medication, receiving urine, and that is it. Whoever has family, friends, and something that is capable of dragging him out of the methadone company is lucky. I was successful. Thanks to the family, I began working, and then I started to look for something I'm good at.

Two years later, I changed what I was doing, and found the job that met my expectations. Initially, I had a bad problem: I could not function among people not connected to the subject of drugs. I was afraid of all contacts, I refused on the grounds of lack of time, I kept escaping. I assumed that I would be rejected. I felt horribly alone, I felt highly attracted by people, but the only ones who accepted me were friends from the programme. I did not know that this is easy to cope with. There was no person who would inform me that there are methods that you can use to help yourself.

It is absolutely of highest importance that heads of the programmes employ people who, taking into account all limitations, would be capable of developing the basics of these skills, for example by conducting interpersonal training or classes in self acceptance, the more so that after years of receiving drugs, our skills in this scope are at a zero level.

I do not know what happened that the problems and needs of patients were forgotten in the programmes. I know one thing: Everything depends on people and their good will, on the skill of capturing the essence of addiction, the illness of the soul, the lack of capacity to cope with the world. People reaching for drugs want to deaden the pain, frequently not even realising what pain that is. With time, the pain increases and shifts into other areas of life, which results in an even deeper addiction. To get rid of its cause, methadone is not enough!

What is needed is a long-term therapy with plenty of patience, conducted by a person we trust, and who we will allow to bring out to the light our deepest hidden fears. The programmes focused on distributing the drug, on the serial production of patients. Yes, this is the standard in low-threshold programmes. At the moment, majority of programmes – despite the high requirements towards the patient – contain little of the "high threshold quality". Programmes should change the valuation of the approach to clients, return to the practices from a decade ago, which would bring benefits to the programmes, as they would have lower rotation and more patients will function effectively in their social roles. An alternative is embracing low-threshold requirements.

I do not claim that programmes do not meet their assumptions. Methadone saved many lives, including mine, and still saves the lives of many users. This substance is necessary and irreplaceable in the treatment of addiction from heroin/opiates, yet the current formula ceased to pass the test.

Various solutions have been embraced in the world: low- and medium-level threshold programmes operate side-by-side with those with highest requirements towards the clients. The ones of the highest standard offer a full range of care. Those of lowest – focus on satisfaction of a single need: issuing the medication. Despite that, at every stage they are trying to motivate to enter on treatment. Each of the programmes has found its place and meets its assumptions perfectly well. In 2007, we established the JUMP'93 Association of Patients in Substitution, which gathers people in substitution treatment from all over Poland. They began to listen to us and treat us as specialists in patients. Our remarks are taken into account while designing a new approach to users and substitution, we are present at a variety of training sessions, and have been invited to a debate on rational drug policy.

It is my dream that in future, all the centres for treatment of addiction are adjusted to the actual needs of the clients, so that every addict in every situation and stage of his illness could count on efficient and appropriate help.

CLIENT EXPECTATIONS TOWARDS SUBSTITUTION PROGRAMMES

Marek Zygadło
Specialist in Addiction Therapy, MONAR Kraków

Harm reduction involves drug users in the development of strategy and means of helping these people: this is one of the main principles of this approach. In Poland, it's still quite difficult for the clients to participate in conferences concerning their problems. I succeeded in gathering the opinions of patients – participants of

methadone programmes for the 4th National Methadone Seminar in Zakopane (2008), so that they could be included in the process of developing substitution treatment at least in this manner.

I hope that soon, thanks to non-governmental organisations, the patients themselves will be presenting their problems at a variety of national forums, and maybe also manage their programmes of substitution treatment. In the spring of 2008, we conducted an opinion poll among the patients of methadone programmes. Below is a handful of results. Participating in the poll were 73 respondents from a few Polish cities, in the age groups: 22 to 28 (18%); 29 to 39 (56%); and above 40 (26%), with the oldest respondent being 55. Women accounted for 42% of the respondents, and men for 58%; the time spent in programmes ranged from one to nine years, with most (19%) being their participants for two years; 98% of respondents came from cities with the population of 500,000 or over; 42% believed that access to substitution treatment is difficult, and 41% that it is very difficult; 66% claimed that access to this form of treatment is very difficult in detention centres; 93% expected that there will be other medications to be chosen from, apart from methadone; 36% believed the level of medical care to be insufficient; 16% had such opinion about nursing care, and 18% – about the care received from the therapist; as many as 60% stated that the social care was insufficient; 25% did not feel very safe in the programme; 97% stated that the number of centres is insufficient; and 96% expected the possibility of being given methadone in pharmacies.

Interesting were also answers to the question "What do you believe could be changed for better in substitution treatment programmes?" A handful of them are presented below: interesting therapeutic projects; a day room; a greater number of centres; accessibility of other pharmacological substances; better psychological care; integration meetings; advance doses, so that you did not spend time sitting at the centre; community facilities; changing regulations so that it is methadone that is for people, and not people who are for methadone; access to prescriptions for methadone, according to needs; medical care; physicians knowing something about the problems of the addicted; making the rules on breaking abstinence more rigid; more professional approach of personnel; I feel awkward because of the cameras in the toilets; more understanding for patients; more trust; assistance in the life outside; increasing the number of physicians, and psychologists, and use of support medications; issuing methadone in detention centres; extending the period of receiving methadone (in the afternoon); receiving methadone for seven days to those in employment; greater trust of the personnel to the patients in the programme; easier contact with the manager of the programme; devoting more attention to patients newly brought into the programme; individual treatment of the patient; separating the new people from those who have been in the programme for over one year in therapy; changing the system of awards and punishments for breaking abstinence; better medical care in different healthcare problems; methadone in pharmacies for patients with long history.

A lot of people believe that there should be more centres and "spaces" in the programmes, and those who want methadone to be given for a longer time to the patient's home, for example for seven days to those in employment and with long history of participation in substitution treatment.

There is still a long path of development and improvement before substitution treatment in Poland. We can find consolation in the fact that the situation here is better than in Ukraine, where methadone was made legal in 2008, and where the number of HIV-positive people is 15 times as high as in Poland. We also have a better situation than Russia, where methadone is still illegal, probably due to the narco-mafia, which does not want to lose clients.

My wishes for the patients in need of substitution treatment are variety and large number of programmes, wherever they are needed, professional integration of operators of substitution programmes, a uniform computer database on programmes which would let patients, with their own chip cards, use any programme. Quite a few people from Małopolska would like to go to the seaside, close to Szczecin…

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The article provides an account of activities undertaken on the global scene in relation to the problem of drugs and drug addiction, which the National Bureau for Drug Prevention participates in. Every year, we participate in the sessions of the Commission on Narcotic Drugs, and the Horizontal Working Party on Drugs. In November 2006, Poland began its presidency in the Pompidou Group. Since 2001, the Polish Focal Point (centre for information on drugs and drug addiction) has been cooperating with the European Monitoring Centre for Drugs and Drug Addiction.

INTERNATIONAL COOPERATION IN COUNTERACTING DRUG ADDICTION

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Commission on Narcotic Drugs (CND)

Undertaking the decision to establish the Commission on Narcotic Drugs (CND) in 1946, the UN Economic and Social Council (ECOSOC), made its goal the development of international regulations concerning control of narcotic substances.
In the structure of the United Nations, the Commission is the central organ responsible for the creation of policy connected to all drug-related questions.
The Commission prepares analyses concerning the international situation in reference to problems connected to drugs and drug addiction. To date, 53 states have become its members. The Commission meets usually once a year in the Viennese seat of the United Nations. Since March 2008, the works of the Commission have been chaired by Namibia. Participating in the annual sessions of the Commission on Narcotic Drugs, besides member states of the Commission, are usually also representatives of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), the European Police Office (EUROPOL), the Council of Europe, World Health Organisation, Organization for Security and Cooperation in Europe (OSCE), European Union, and numerous non-governmental organisations.
The principle that all EU states present at the session are represented by the state holding presidency in the European Union allows EU members to speak in one voice. Usually, the Polish delegation to the sessions of the Commission on Narcotic Drugs consists of representatives of the Ministry of Health (National Bureau for Drug Prevention), Ministry of Foreign Affairs, Central Police Headquarters, Office of the National Prosecutor, Chief Sanitary Inspectorate and Main Pharmaceutical Inspectorate, and the Permanent Mission to UN and Permanent Mission to International Organisations in Vienna.
The next session of the Commission to be held between 16th to 20 March 2009 will be of exceptional character. The 52nd session will be devoted primarily to the working out of the final shape of the political declaration concerning the assessment of the UNGASS process

In November 2006, Poland assumed a four-year presidency in the Pompidou Group. One of the achievements of the Polish presidency is the progressive neighbourhood policy, which resulted in embracing Ukraine as a beneficiary of the Group's support activity. Activity of Poland is also focused on establishing dialogue and cooperation with North African states.

initiated in 1998 by the political declaration made during the 20th Special Session of the United Nations General Assembly (UNGASS). The declaration is a 10-year project (1998–2008) emphasising promotion of balanced approach to the question of drugs and drug addiction by the development of national strategies and action plans referring to the reduction of both demand and supply of narcotic substances.

Approved in 2008, during the 51st session of the CND, was the resolution submitted by the European Union, and entitled "Preparations for the high-level segment of the 52nd session of the Commission on Narcotic Drugs, relating to the follow-up to the 20th Special Session of the General Assembly" (CND 51/4 Resolution). Among others, it envisages the establishment of international expert working groups responsible for the assessment of the main themes of the UNGASS project, and including reduction of demand, reduction of supply, control of precursors used for production of narcotic substances, international cooperation between systems of justice, also on the matters of the so-called money-laundering, and international cooperation on the destruction of illegal plantations and promotion of alternative development. The meetings of working groups were held in Vienna from June to September 2008.

Early in October 2008, the President of the Commission on Narcotic Drugs presented a working document summing up the discussion conducted at the Forum of Viennese working groups. It will serve as the grounds for the development of an annex to the political declaration that will be approved during the 52nd session of the CND in 2009. European Union submitted comments to the document prepared. To date, consultations concerning its final version, one that could be accepted by the parties interested, continue.

Horizontal Working Party on Drugs (HDG)

It has been five years since Poland began to participate in the work of the Horizontal Working Party on Drugs, being one of approximately 250 working groups and committees operating within the Council of the European Union[1]. The sessions of the Horizontal Working Party on Drugs are held once a month, and chaired by the state currently holding presidency in the Council of the European Union. The HDG is composed, besides representatives of member states, also of representatives of EMCDDA, EUROPOL, and European Commission. The group deals with:

- coordination of entire drug policies at the level of European Union (coordinating actions related to drugs at the level of other working groups of the Council, in the area of reducing both demand and supply)
- developing drafts of anti-narcotic strategies and action plans of European Union in counteracting drugs and drug addiction
- exchange of information and evaluation of entire drug policies and problems at the level of the Union
- improvement in the coordination of actions undertaken by member states within the Union and beyond.

At the HDG forum, EU states are represented by the representatives of ministries and institutions responsible for national anti-drug policies. Participating in the work of the Group on behalf of Poland are representatives of the National Bureau for Drug Prevention, being representatives of the Ministry of Internal Affairs and Administration, which since March 2007 has coordinated Polish actions undertaken at the HDG forum. (Earlier, the role was played by the Ministry of Health.)

The National Bureau for Drug Prevention together with the Central Police Headquarters has represented Poland at the forum of the Horizontal Working Party since April 2003, that is from the moment of signing the Accession Treaty. Until the accession (May 2004), representatives of Poland were present only in the as observers, without the right to vote. With the moment of accession to the EU, the representatives of Poland gained the right to vote, which let them influence the directions of development of European policy concerning drugs and drug addiction.

During the last six months, that is the period of the French presidency, the most important tasks standing before the presidency and the Horizontal Group include the drafting of a new "Action Plan on Drugs for 2009–2012". Poland participated actively in the preparation of the new plan. It is especially significant

from our point of view, as its scope includes also the time of Polish presidency, namely the latter half of 2011. It is worth turning attention to the fact that the final version of the document includes suggestions and amendments proposed by Poland.

One of the priority areas in Polish foreign policy are the states lying beyond our eastern border that is Belarus, Russia, and Ukraine. Participation in the works of the Horizontal Group gave Poland a realistic opportunity of influencing the shape of EU anti-drug policy across the region. Thanks to the involvement of, among others, representatives of Poland, also the European Union treats this area as one of its priority regions in the context of counteracting drugs and drug addiction.

The Pompidou Group of the Council of Europe

In November 2006, Poland assumed the presidency of the Pompidou Group. The Group was established in 1971 as an initiative of the President of France, Georges Pompidou. Initially, it consisted of only seven states: Belgium, France, Germany, Italy, Luxembourg, the Netherlands, and the United Kingdom; today, it consists of 35 European states.

The main goal behind the establishment of the Group was the development of effective policies concerning the problem of abuse and drug trafficking across Europe. Since 1980, the Pompidou Group has operated within the Council of Europe. Today, its most important tasks include support of multidisciplinary, innovative, and research-supported anti-drug policies in the member states of the Group.

The directions of work of the Pompidou Group and significant political questions connected to the phenomenon of drug addiction are discussed at the meetings of the ministers of the Group's member states. During the meetings organised every three years, priorities of operation for the successive years are defined. Worth turning attention to is the role of the so-called Permanent Correspondents in the work of the organisation. They are representatives of the member states of the Pompidou Group, representing institutions curbing drug demand and supply. They meet every six months to discuss progress in the implementation of the actions defined. During the Polish presidency in the Group, the function of the President of the Permanent Correspondents is played by the director of the National Bureau for Drug Prevention.

Establishing the Group of Experts in the Epidemiology of Drug Problems in 1982 made it possible to initiate development of research and monitoring of drug problems in Europe. Following the decision made in 1982, the Pompidou Group became a key European forum in this field, including Central and Eastern Europe, and gradually involving Russia and the Mediterranean states in the process. The Group's most important achievements include the implementation of long-term projects such as the ESPAD European School Survey Project on Alcohol and Other Drugs and the permanent monitoring of the drug scene in individual cities conducted along standardised methods (Multi-City Study).

The Pompidou Group reaches its goals by:

- faciliatating the development of a universal discussion forum for political decision-makers and professionals solving and researching the problem of drugs and drug addiction
- promotion of complex anti-drug strategies at national, regional, and local levels
- including questions in the scope of prevention and treatment of addiction related to ethics and human rights
- facilitation of the system for gathering information and monitoring the new trends in drugs and drug addiction
- development of courses of action, relevant to the existing needs
- extending cooperation to the European countries that are not members of the European Union.

There are six theme-based platforms that are to favour the attainment of the goals listed above, whose scope of operation encompasses questions lying within the following areas: prevention, treatment, cooperation between systems of justice, research, ethics, airports.

The actions conducted within these fields are defined in the programme of work assumed for three years at the Conference of Ministers. The programme contains justification for undertaking specific actions and information concerning the scope of their

implementation, forms of cooperation, target groups, detailed timetable of work, and financial support.
The European context of the Group's actions has changed since the moment of its establishment. The changes find expression in the increased involvement of European Union in the questions connected to drugs and development of know-how on this phenomenon. This has resulted in redefining the role of the Pompidou Group. Its new mission, approved during the Ministerial Conference in Dublin in October 2003, is the promotion of dialogue and cooperation between EU states and third parties. This refers not only to European countries lying beyond the borders of the Union but also to the countries lying across the border from Europe, that is North Africa and the Caucasus.

The role of Poland in the work of the Group

Poland joined the Pompidou Group in 1991. The main areas of interest of our country include programmes concerning monitoring of phenomena connected to drug addiction. One of them is the ESPAD programme, diagnosing the prevalence of psychoactive substances among school youth, conducted in Poland since 1998. To date, the result of this research provides the main source of knowledge about the scale of the drug and alcohol problem in the population of young people, aged 15 to 16, and 17 to 18. Another research project in which Poland participates actively is the Multi-City Study research. The programme allows monitoring the drug scene in individual cities, according to standardised methods. Polish experts participated also in other projects of the Group, which resulted among others in the development of numerous course books and educational materials concerning drug-related problems.
During the Ministerial Conference in Strasbourg in November 2006, a decision was made to entrust Poland with the presidency of the Pompidou Group for the period of four years. We found that a great honour, yet a great challenge at the same time to stand up to the tasks resulting from the increasing international role of the Pompidou Group.
Assuming the Group's presidency, Poland recognised the following priorities:

- shaping the Group's image and promotion of its actions in the field of international cooperation
- strengthening the bridge functions of the Group, both between experts and politicians, and between countries and regions
- active support of the actions conducted within thematic platforms as the main implementers and creators of the Group's content-related tasks.

The most important initiatives taken by the Polish presidency include the development of a new, non-biding form of cooperation of European institutions and organisations dealing with the reduction of the phenomenon of drug addiction (not only within the EU) – the so-called Inter-Agency Cooperation Group[2]. So far, two meetings of the Cooperation Group have been held: on 28th November 2007 in Warsaw, and on 28th–29th April 2008, also in Warsaw. The next one is planned for 27th January 2009 in Kraków.
The achievements of the Polish presidency in the Pompidou Group include also the progressive neighbourhood policy, thanks to which Ukraine found itself among the beneficiaries of the support activity of the Pompidou Group, and also the success in working towards the extension of cooperation onto the states of North Africa.
November 2008 marked the midway through of the Polish mission in the Group. It was an opportune moment to perform the first summary of our presidency. To achieve that, the first conference was organised in Warsaw on 26th November 2008, gathering approximately 120 experts in anti-drug policy from the 35 member states of the Pompidou Group. Together with the observers from Ukraine and Northern Africa, participating in the conference were also representatives of the European Commission, European Monitoring Centre for Drugs and Drug Addiction in Lisbon (EMCDDA), and the United Nations Office on Drugs and Crime (UNODC).
It is worth noticing that the winners of the European drug prevention prize, awarded every other year, were announced during the conference. The projects awarded in 2008 were:

- "Sweep the weed out of the gate!", a Bulgarian project promoting youth training in life skills aimed

at preventing them from risky behaviours – the danger connected with taking drugs
- "Resist", a Greek project based on a computer game to show young people threats connected to drugs, developing a set of behaviours, and helping to say "no" to drugs
- "Battle of the West", a Dutch project promoting contacts through dance (hip-hop, breakdance, etc) and tasks encouraging to competition among young people.

The goal behind these actions is increasing the awareness of threats connected to drugs and promotion of healthy lifestyle.

It seems that during the last two years, the actions of the Group have become more visible on the international scene, among others thanks to the organisation of meetings of representatives of the leading agencies and institutions – European and world – operating within the area of drug-related issues. The visibility of the Group's actions has also improved by the achievements of the theme-based platforms that are focused on quality (i.e. professionalism and ethics), the development of cooperation between sectors, and coordination of actions.

European Monitoring Centre for Drugs and Drug Addiction

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) was established in 1993 to gather and analyse information about the problem of drugs and drug addiction in Europe. The main goal behind this EU institution is providing the Union and its member states with objective and credible information concerning drug addiction. Thanks to the operation of the EMCDDA, members of the community have access to significant assistance-related data in the creation and evaluation of policy on drug addiction. EMCDDA offers political decision-makers with scientific information necessary to prepare drugs strategies, support scientists and practitioners in the selection of the best actions. Besides the above, it also points at new areas of analysis important for the development of the most complete portraits of the drug scene.

The main objective of the EMCDDA is the reach greater comparability of information on drugs within the EU. The work is conducted primarily in relation to five key indicators:
- the prevalence of drugs in total population
- drug-related deaths and mortality
- number of problem drug users
- prevalence of infectious diseases HIV, HCV, HBV
- treatment demand.

Collected are also other data connected to demand reduction, including confiscation of drugs, and drug prices and purity. To carry out its tasks, EMCDDA makes use of the Reitox network, that is 30 national focal points (monitoring centres) that collect and analyse national data in line with shared standards, and using the same tools for data collection and storage.

The results of the national monitoring are submitted to analysis at the EMCDDA and finally published in the annual report on the state of the drug problem in Europe.

In Poland, the role of the focal point is played by one of the sections of the National Bureau for Drug Prevention, namely the Centre for Information on Drugs and Drug Addiction, established in 2001. The centre works to satisfy both the EU and national needs. It tries to make use of international experience in development of monitoring at regional and local level. The Centre commissions, runs, and initiates research projects aimed at better insight into the problem of drug addiction and follows trends related to it. The results of gathering and analysis of data are prepared every year in a report for the EMCDDA[3]. It is worth noticing that a new scientific committee was established by EMCDDA in 2007, and – following a competition – a representative of Poland became one of its members[4].

Footnotes:

[1] For more information on Horizontal Working Party on Drugs, turn to the Issue No. 1/2007 of the "Serwis Informacyjny Narkomania".
[2] For more information on this, turn to the Issues Nos 4/2007 and 2/2008 of the "Serwis Informacyjny Narkomania".
[3] The annual reports are available from http://www.kbpn.gov.pl/ in the section epidemiology.
[4] Professor Krzysztof Krajewski is one of the committee's 15 scientists.
For those interested in the role of the Committee and the EMCDDA, we recommend an interview with the Director of the EMCDDA, Wolfgang Götz, published in the "Serwis Informacyjny Narkomania" No. 4/2007.

Statistical and poll data concerning drugs and drug addiction show at least a slowdown in the growth trend of the problem in recent years. Will it be of lasting character, or is the recorded change only of momentary nature?

THE PROBLEM OF DRUGS AND DRUG ADDICTION IN POLAND. FIGURES AND TRENDS IN THE PHENOMENON.

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The problem of drug addiction is of interdisciplinary character. It finds itself in the field of interest of various services including healthcare, education, social assistance, law and enforcement agencies, and the media. Each of them has a different interconnection with this phenomenon. For some, a drug addict is somebody addicted to drugs, to others – he is a person who sometimes uses drugs, and yet for others – one who moves within the subculture that accompanies drugs. From among the different perspectives of looking at the phenomenon, let us choose the society-based approach, and treat drug addiction as a problem of the society. In this understanding, a drug addict is someone who regularly uses drugs, and for that reason experiences a variety of serious problems of health, legal, and psychological nature; generally speaking: problems with life. In other words, a drug addict is someone for whom drugs have become a permanent element of lifestyle that interferes with normal functioning in society. Assuming such a definition, we emphasise the harm experienced or caused by the drug user, connected to the use of drugs. This definition is broader than medical, which assumes addiction, and more narrow than the one sometimes accepted by journalists and educators, who see a drug addict in everyone, even those who reach for drugs only incidentally. It is worth noticing that the notion of drug addiction proposed here – and what follows, the notion of a drug addict – integrates the perspectives mentioned above. It provides a convenient starting point for rational preventive and aid actions, leaving aside the question of the moral evaluation of drugs and their use, on whose ground it is easy to stigmatise, thus rendering such actions more difficult. The grounds for these actions should be the assessment of the size and dynamics of the problem.

Following the trends concerning the problem of drugs and drug addiction in the 1990s and in the current decade, and the assessment of the size of the problem is the subject of this work.

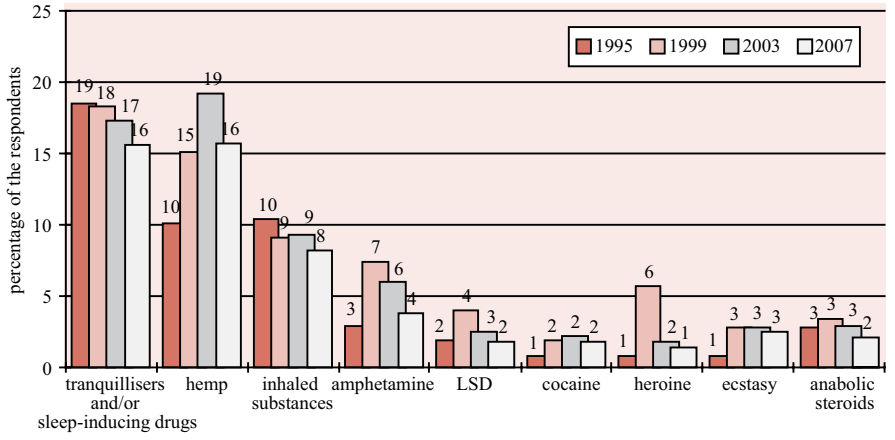
Occasional use of drugs

In 2007, 16% of class three students of lower secondary schools reached for marijuana and/or hashish at least once during their lives. Second most common were inhalants (8%), and third came amphetamine (4%).

Information about the spreading of experimental and occasional use of psychoactive substances comes from the results of opinion polls conducted on a representative sample of general population and some of its segments, for example, school youth.

Such studies were conducted in Poland repeatedly; here we quote the results of school studies conducted in 1995, 1999, 2003, and 2007 by the Institute of Psychiatry and Neurology as a part of the ESPAD European School Survey Project on Alcohol and Other Drugs (Hibell, 2004,

Fig. 1. Percentage of students aged 15 to 16, who used respective substances at least once in their lifetime.



Sierosławski, 2007), and results of studies on the total population conducted in 2002 and 2006 by the National Bureau for Drug Prevention (Sierosławski, 2006).

The school study covered two national representative random samples of students aged 15 to 16 and 17 to 18. The same methodology used in the studies ensures comparability of the data, and what follows, gives the opportunity to follow the trends.

The use of psychoactive substances was studied by presenting the respondents with a list of substances, asking to mark the ones they have ever used. Constructed in this way, the index may be treated at least as a marker of experimenting with substances. Questions were asked also about the use of individual substances during the 12 months prior to the study, which may be treated as the marker of the current use. The results of the studies showed that the decided majority of the respondents had never reached for illegal substances. Among those who have had such experience, majority were people who experimented at most with marijuana and hashish. In 2007, 16% of class three students of lower secondary schools used these substances at least once in their lives (Fig. 1.). Second most popular were inhalants (8%), while amphetamine came third (4%). In recent years, we observe a stabilisation or fall in the spreading of drug experiences. There was a growth in 1999–2003, and it has to be added that in 1995–1999 the problem of drugs followed a very strong rising trend.

At present, occasional use of illegal substances, which is illustrated by their use during the last 12 months, also proves hemp products to be most widespread. In 2007, in classes three of lower secondary schools, more than 11% of students used this substance (Fig. 2.). It was followed in popularity by inhalants (4%) and amphetamine (2%, Sierosławski, 2007).

The fall in the popularity of amphetamine use was larger and began earlier than the fall in the popularity of use of hemp products. This means a greater improvement of the situation connected to the more dangerous substance. In the 1990s, drugs ceased to be the domain of young people only. Already the study conducted in Warsaw in 1999 proved that drugs entered the world of adults, at least when residents of the capital city were taken into account. The study repeated in Warsaw in 2002, together with the national one, proved a small increase of the prevalence of drug use, mostly

Fig. 2. Percentage of students aged 15 to 16, who used respective substances at least once during the 12 months prior to the study.

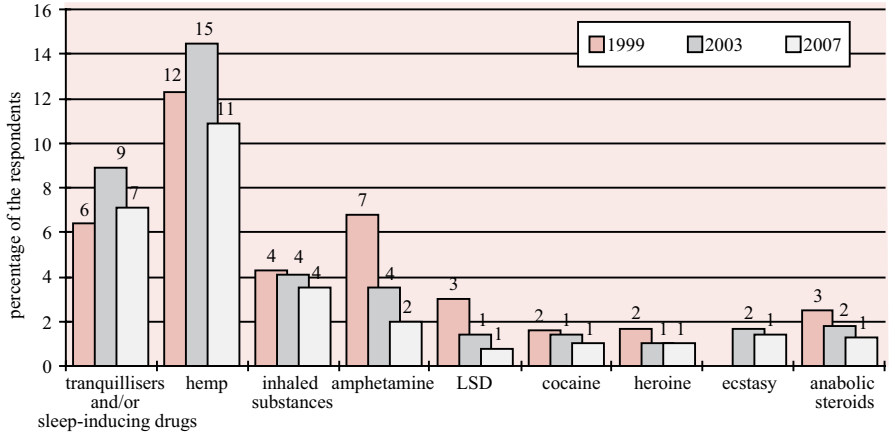
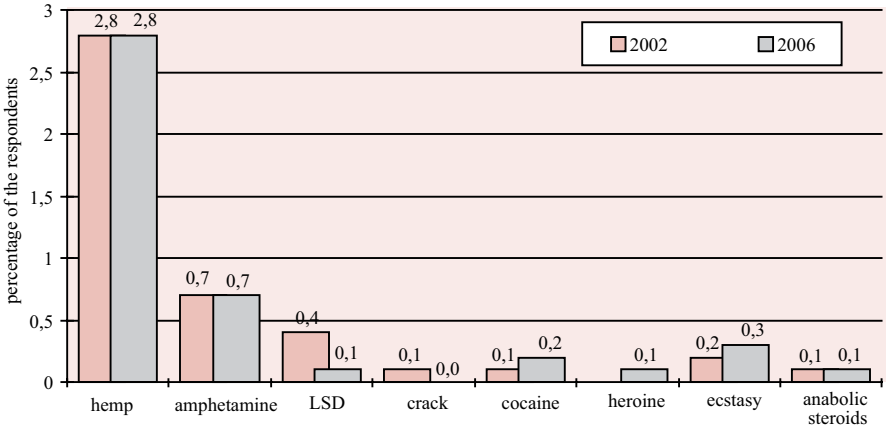


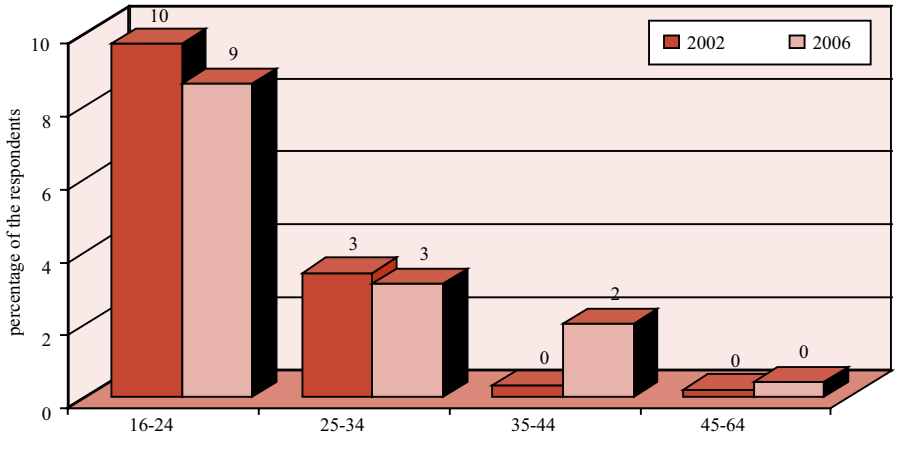
Fig. 3. Use of illegal substances by people aged 16 to 64 during the 12 months prior to the study: results of national opinion polls conducted in 2002 and 2006.



in hemp products. As the national study of 2002 proved, drugs are present in the adult world in a visible manner already at the level of the entire country, even though the prevalence of their use is very low (Fig. 3.). In the light of the results of these studies, hemp products are relatively most visible among the illegal substances. Turning up among the substances used by residents of Poland is also amphetamine, while the popularity of none of the remaining substances exceeds 0.5%.

Comparison of the results achieved in 2006 to the results from 2002 for the population aged 16 to 64 in fact proves stabilisation in the prevalence of the occasional use of drugs (Sierosławski, 2006). The use of individual illegal substances is present, most often in the age category 16 to 24. It occurs very rarely among people over 34, and it is hardly present among people of 45 and more (Fig. 4.). In 2006, as compared to 2002, the percentage of users aged 16 to 24 dropped slightly, while the one in the age group 35 to 44 grew.

Fig. 4. Use of any illegal substance during the last 12 months, by age: results of national opinion polls conducted in 2002 and 2006.



Problem drug use. Estimates.

Estimates of the number of problem drug users in the entire country were created for the first time in 1994. It was then that the number of problem users for the year 1993 was estimated according to the capture – recapture method in two regions: Wrocławskie and Kieleckie. Following upon the adjustment ratios defined on the basis of the data from residential treatment and police, the results from these two regions were extrapolated onto the level of the entire country (Moskalewicz, Sierosławski, 1995). The estimates based on those brought the resultant number of problem users in Poland as in the range from 20,000 to 40,000 (Moskalewicz, Sierosławski, 1995).

The following estimation was conducted for the year 2001 through benchmarking (Tylor, 1997). The sources of data for this estimation were the data from residential and ambulatory treatment, and the data gathered from the total population opinion poll. The last refers to the information about problem users known to the respondents gathered on nomination cards. The results of this estimation shows that the number of problem users in 2001 ranged from 33,000 to 75,000 people. This marked a large increase compared to the first half of the 1990s, which was attested by the dynamics of all the other markers of the

problem of drugs and drug addiction. In 2006, the studies of general population were repeated, and again data on drug users known to the respondents was collected (Sierosławski, 2008). They concerned 2005. The result ranged from 100,000 to 125,000 people. Thus the estimate for 2005 resulted in far greater numbers than the one for 2001.

It is worth noticing that responsible for the increased numbers is primarily the doubling of the adjustment ratio, which is a derivative of the percentage of people in treatment among those nominated. The growth of the adjustment ratio resulted from the drop in the percentage of people in treatment by nearly 50% (from approximately 33%, to approximately 15%). It must be mentioned that the studies of 2002 and 2006 were conducted precisely in the same manner, with special care about ensuring comparativeness of results. The growth in the number of problem users of drugs in 2001–2005 was greater than the dynamics of admission to treatment at the time. It is worth adding that the comparison of the markers of occasional prevalence of drug use, according to studies from 2002 and 2006 suggested stabilisation, while the comparison between the markers of perceived availability of individual drugs showed even a significant drop.

Among health problems connected to drug use, the most dangerous are deaths due to overuse and HIV infections. Their prevalence has remained at least stable for many years.

It remains an open question to what degree we deal with a short growth in the proliferation of the problem, and to what – with greater social sensitivity and greater skill of identification of problem users of drugs by average citizens.

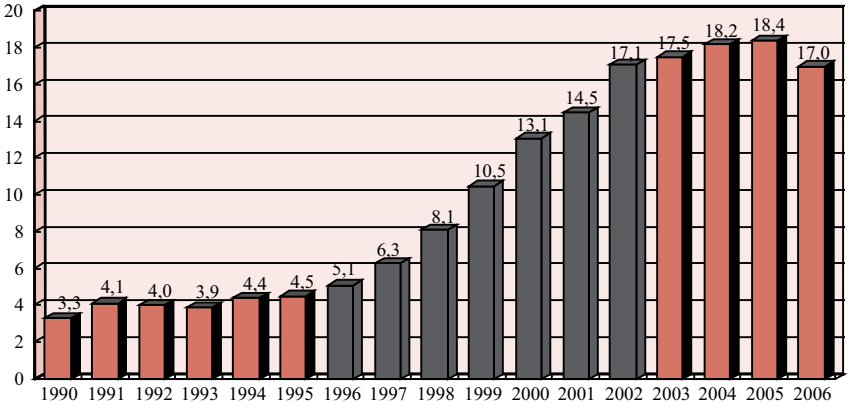
The first years of our century are the time of active educational activity in the field, the time of numerous campaigns organised by the National Bureau for Drug Prevention, and of large involvement of the media. Greater easiness in the identification of problem users of drugs before embarking on treatment makes the proportion of people in treatment among those nominated by the respondents smaller, and consequently the estimation reaches larger values. If this hypothesis were right, this would mean that the prevalence of problem drug use in 2001 could actually have been undervalued.

Some light on this question may be cast by a separate estimation of proliferation of problem use of opiates, traditional in our drugs scene, and the problem use of other substances as amphetamine, ecstasy, cocaine, hemp products, etc. In Poland, the use of numerous different substances has had quite a long tradition, hence the explicit criterion of stratification must be defined for conducting such an estimate. Due to the scope of data gathered, for simplification's sake, we shall divide problem users of drugs into those who reach for the opiates and these who do not use substances from this group. It may be assumed that problem users of opiates are dominated by people whose problem has always been easier to recognise by the environment, and easier to define in the categories of drug addiction. Such hypothesis finds justification both in the longer presence of these substances in our drug scene, and also in their especially high potential for addiction, aiding the relatively quick social degradation.

The estimation of the number of problem opiate users is also significant from the perspective of evaluation of needs in substitution treatment, which may be addressed only to this group of the addicts. In Poland, this type of therapy is very poorly developed, and the availability of such treatment is far from satisfactory; enough to mention that in this aspect we hold one of the last ranks in Europe. The estimation of needs in this scope may thus play the role of a factor stimulating the development of the offer in substitution treatment.

Conducting credible estimations in the proliferation of the problem opiate use encounters problems connected to data availability. Even though we gather information in field studies on the use of opiates by people nominated by the respondents, such data are lacking in the healthcare statistics, treated as the benchmark for conducting the estimates. The healthcare statistics include only information on medical diagnosis, which gives no grounds for unambiguous selection of opiate users. For this reason, we must resort to another estimation, assuming proportions of opiate users among people

Fig. 5. Patients admitted for the first time into residential treatment. In 1990–2006 due to psychological and behaviour disorders caused by the use of psychoactive substances (per population of 100,000).



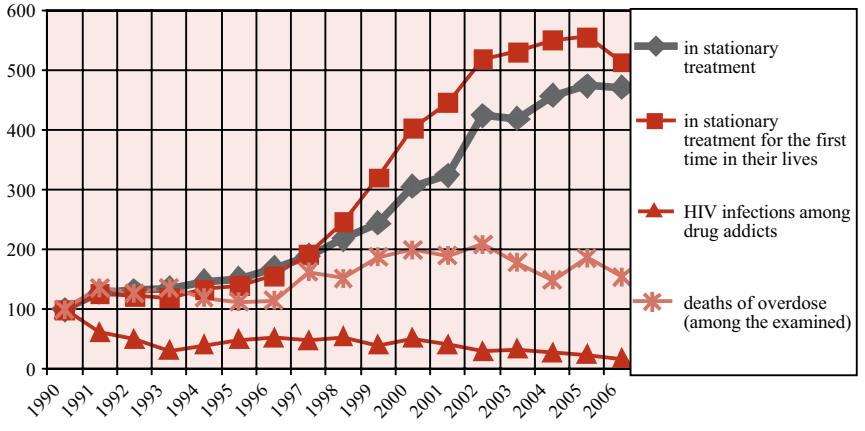
embarking on treatment. On the grounds of data from local monitoring and data from psychiatry diagnoses, we may assume that the share of opiate users among people receiving stationary treatment is at the level of 60%, and among ambulatory patients – at the level of 50%. To simplify, the same share of opiate users was assumed for 2001 and 2005. The percentages quoted above were used to define the number of opiate users and users of other substances.

Following these estimates, the number of problem users of opiates in 2005, was in the range 25,000–29,000. These volumes do not differ strongly from an analogous estimation for 2001 (14,000–28,000).

It is not so in the case of users of other substances. Their number in 2005 was between 71,900 and 98,500, while in 2001, it was between 25,000 and 55,000. Thus it may be assumed that what is responsible for the greater share of the growth in the number of problem use of drugs in 2001–2005 is the increase in the number of problem users of substances other than opiates.

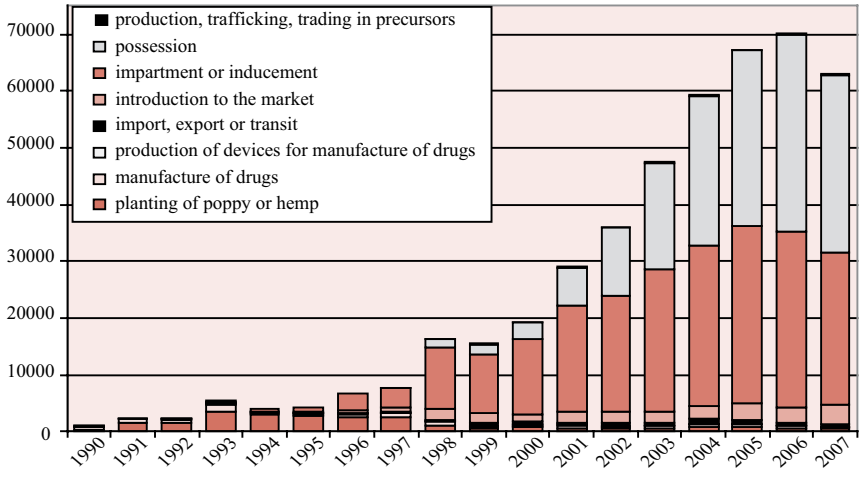
The estimations conducted above must be provided with serious reservations resulting from data availability mentioned earlier. It should also be mentioned that the comparison of estimates from 2001 and 2005 encounters methodological problems that originated among the assumptions of the benchmarking method. These assumptions include the close character of the population estimated, and the competence of respondents in identifying problem users of drugs in their environment. Both these assumptions seem to be met to a smaller degree than in the case of estimating the size of the population of problem users of non-opiate drugs. First of all, this population – as estimates prove – is subject to a greater dynamics, hence its character of a close population is smaller. Secondly, the patterns of using drugs other than opiates seem to be less destructive and provide a relatively new phenomenon, and therefore are socially less distinctive.

Fig. 6. Dynamism of health problems connected to drugs in 1990–2006 (1990=100).



This means that we should approach the estimated numbers of problem users of drugs other than opiates, especially those acquired in 2001, with more limited trust. In this case, the high increase from 2001 to 2005 may be partially the result of residents of Poland "learning" to identify problems of users of drugs other than opiates in their surrounding.

Fig. 7. Crime against the Act on Prevention/Counteracting Drug Addiction in 1990–2007 (instances confirmed by the police).

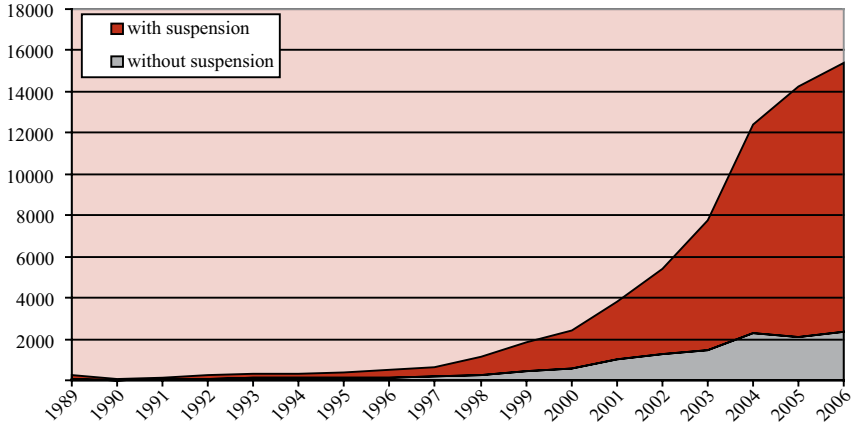


Data from treatment

Information about trends in drug addiction understood as dependence or habitual use of drugs in a way that causes serious problems, is provided also through statistical data from treatment.

Information about the number of patients treated for abuse of psychoactive substances other than alcohol and tobacco comes from residential psychiatric treatment. The data cover also specialist treatment of addictions to pharmaceuticals, which operates as a part of psychiatric health care, i.e. detoxification wards for drug addicts and rehabilitation centres, including ones conducted by non-governmental organisations, if such centres have the status of health care units.

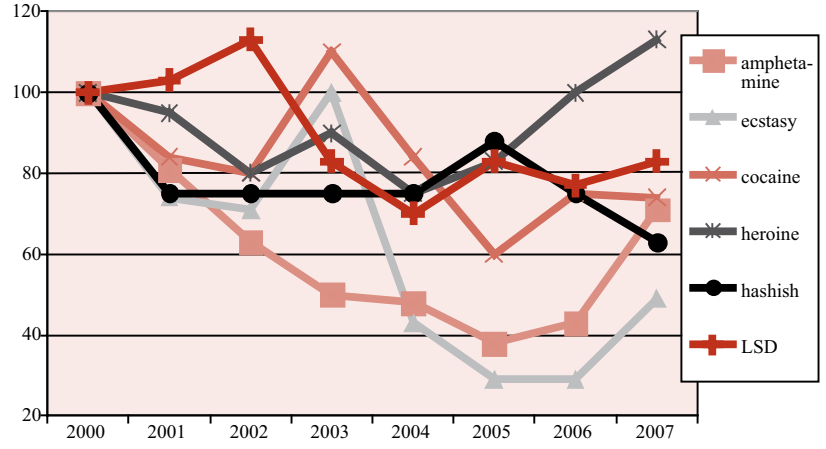
Fig. 8. People sentenced to imprisonment for crimes against the Act on Prevention/ Counteracting Drug Addiction.)



In 2006, 13,198 people with drug problems were admitted into residential treatment. This marks a drop by 122 people, i.e. 0.9% as compared to 2005, when 13,320 patients were admitted. The index of people in treatment per population of 100,000 in 2006 remained at the same level as in 2005, and amounted to 34.9. The stabilisation of the number of patients in 2006 followed a period of a drop in the pace of growth in 2002–2005. It must be remembered that the period was preceded by a major growth trend in 1996–2002. Also a growing tendency, yet of very low intensity, was observed in 1991–1995.

A more useful factor in analyses of epidemiological trends is the number of people admitted to treatment for the first time in their life. This index illustrates the pace with which the appearance of new cases in treatment grows, reflecting, therefore, the rising trend in the phenomenon better than the total number of those coming to treatment. The Figure 5 allows following the indexes of first admissions per 100,000 residents. In the first half of the 1990s, the number of first time admissions grew very slowly, with a very large increase seen in 1996–2002, followed by a very slow growth in the growth rate, and a fall after 2006. It is worth noticing that from 2001 to 2005, the index of first time admissions grew by 27%. These results remain coherent with the estimations quoted earlier. Even though the estimated number of drug addicts grew more than the index discussed here, yet it must be remembered that it illustrates the changes of the phenomenon with a certain delay. The considerations presented here may be complemented with an analysis of the age structure of people coming to treatment. In 1997–2001 the percentage of

Fig. 9. Dynamism of average drug prices in street sales, according to police data (2000–2007).



people aged 16 to 24 was rising persistently, while the share of the age group from 25 to 34 was falling. Still, in 1997, the percentage of patients aged 16 to 24, was at the level of 40%, yet in 2001, it already rose and amounted to 57%. The percentage of the youngest, that is below 15, and oldest, that is above 45, was relatively stable. The first ranged from 3% to 4%, and the latter from 7% to 8%. In 2002, a change in the tendency described here occurred. The percentage of patients aged from 16 to 24 dropped to 55%, i.e. the level from 2000. At the same time, there was a slight growth in the percentage of the oldest patients (that is over 44), and people in the age group 25 to 34. In the successive years, we observed the continuation of this tendency, that is a drop in the percentage of patients aged 16 to 24, and a growth in the groups 25–34 and 35–44. In 2006, the percentage of patients aged 16 to 24, dropped to the level of 41%, while the share of the oldest (i.e. 44 and over) increasing to 16%. It is worth noting that the share of patients aged 16 to 24 reached the level of 1997 in 2006, while the percentage of the oldest, i.e. over 45, nearly doubled in the same time. The changes in the age structure seem to reflect two processes. The first is of a demographic character: the ageing of the population, and the other – of epidemiological character, namely, the slowdown in the growth rate of the phenomenon of drug addiction. The increase in the share of people from younger age groups may have been treated as a signal of a growing wave of the phenomenon. The reverting of the tendency may suggest the beginning of stabilisation of its size.

Drug-related problems

The most dangerous among the health care problems connected to drug use are the deaths due to overuse and HIV infections. Figure 6 shows the indexes of the total dynamics of admissions resulting from drug addiction in residential treatment, of first-time admissions, deaths connected to drugs, and at new HIV infections among people administering drugs intravenously.

To juxtapose these very different rates, the 1990 data for each of them was assumed at the level of 100, and the data from the following years were presented in comparison to the starting year. The data on the graph show that, even though the admission to treatment, considered an index showing

Fig. 10. Percentage of students aged 15 to 16 who considered individual substances easy or very easy to acquire.

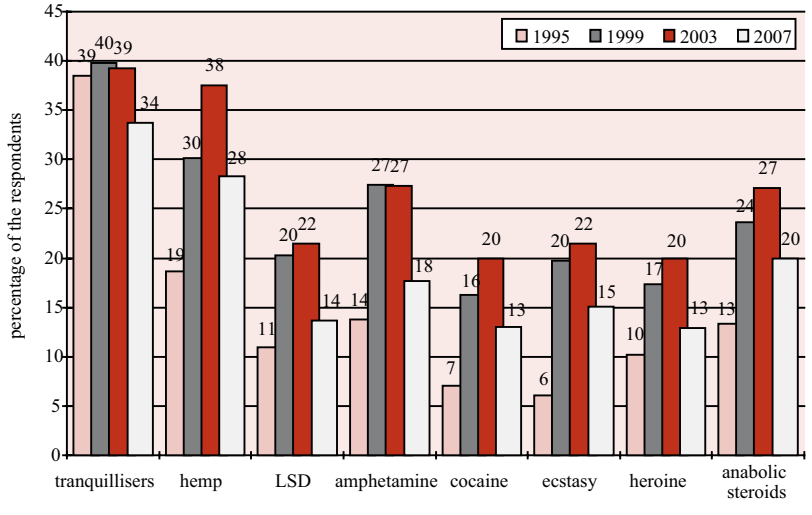
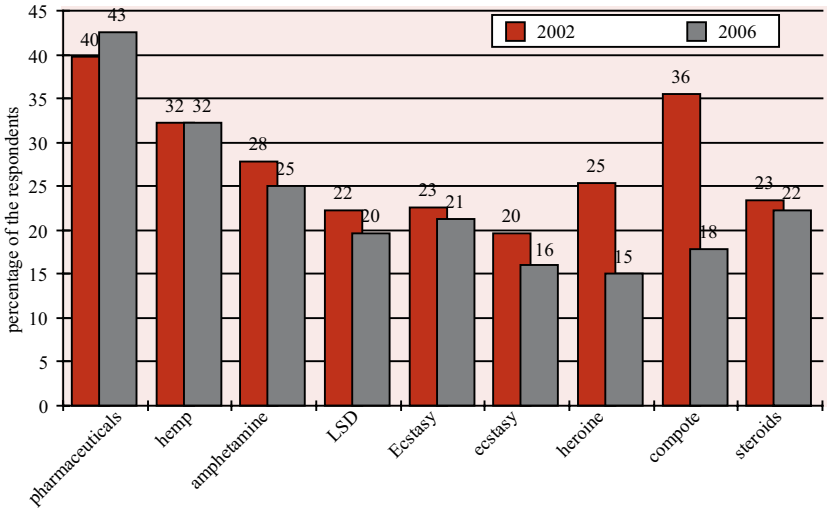


Fig. 11. Percentage of people aged 16 to 64 who considered individual substances easy or very easy to acquire.



the increase in the number of drug addicts, is growing quickly, the numbers of both HIV infections and deaths remain fairly stable. This means that despite a growth in prevalence of drug addiction, the intensity of problems connected to drugs, at least the most dramatic, does not change significantly. Stabilisation in the prevalence of these problems is to a great extent an effect of implementation of harm reduction programmes including exchange of needles and syringes, and education of drug users in increasing safety while using substances.

This interpretation finds additional justification in the trends of HIV infections. The trend of new HIV infections among people using injected drugs follows a different pattern than among the other groups. In the former case, we see stabilisation in recent years, in the latter, a marked increase is visible.

Availability of drugs

Beginning with 1997, after the penalisation of possession of drugs and significant reinforcement of police forces for combating the illegal drug market, the numbers of crimes against the Act on Counteracting Drug Addiction grew many times (Fig. 7.). Of large significance was also the broadening of police rights (controlled supply, controlled purchase, etc.), and international cooperation in persecuting drug-related crime. The growth trend sped up after 2000, when penalisation encompassed also possession of small amounts of drugs, earmarked for personal use. A certain slowdown in the growth rate turned up already in 2006, as the number of crimes discovered dropped for the first time in many years in 2007.

The data in the chart show that instances of drug-related crime prevalent by quantity are impartment of narcotic substances and inducement to their use, and possession of drugs. In the first half of the decade, the number of discovered cases of possession of drugs was growing especially quickly. There was also a major growth in impartment of drugs and impartment to their use. Generally, the image of disclosed crime against the act is dominated by crimes characteristic of drug users.

Following in the footsteps of the growth in the number of crimes disclosed by the police, is also the number of court decisions sentencing to imprisonment (Fig. 8.). The quickly growing number of people sentenced for crimes against the Act on Counteracting Drug Addiction meant a serious burden for the penitentiary system. A large share of the sentenced are drug users, not all of whom are eager to agree that it is necessary to stop the use of substances while doing their sentences, which favours the development of a narcotic underground in penitentiary institutions: a fact that which poses new threats for the penitentiary system.

Observed since 2004 has been a slowing down of the growth rate in the number of the sentenced, including the stabilisation of the number of the sentenced for unqualified imprisonment.

One of the best markers of availability and accessibility of substances is their prices. The data on prices of drugs in the illegal market in our country are collected by the police. The representative nature of these data is difficult to assess, yet taking into account the fact that they have been collected for some time in a similar manner, they may be used to examine the trend. The data presented in the Figure 9 prove a drop in prices of most drugs in 2000−2005.

In the following years, the prices of most drugs began to rise. An analysis in the dynamics of drug prices favours the conclusion that availability of drugs has been falling since 2006.

Changes in drug availability can also be concluded from the opinion polls among the young and adults. Opinions and convictions about the accessibility of drugs, even though they are an indirect marker of their supply, may provide useful information about the dynamics of the illegal drug market through their changes.

The availability of individual psychoactive substances was examined in opinion polls by asking respondents to what extent they would find it difficult to acquire each of them if they wanted to. The scale of answers was defined on the one end by the answer "Impossible.", and on the other by "Very easy.". The respondents were also given the "I don't know." option. The percentage of class three students of lower secondary schools (aged 15 to 16), who declared easy or very easy access to individual substances in ESPAD studies in 1995, 1999, 2003, and 2007 is presented in Figure 10.

As the comparison of results of the 2007 study with the results from the previous years proves, availability of most drugs, as seen by young people, proves a falling tendency in 2007 after a dynamic growth in 1995–2003 (Sierosławski, 2007). Similarly, the results of studies conducted with the use of the same question on random samples of residents of Poland in 2002 and 2006 prove reduced availability of drugs (Fig. 11, Sierosławski, 2006). It seems that the tightening of law in 1997 and again in 2000 as well as the increased activity of the police and its successes finding corroboration in police statistics, did not have a direct impact on the dynamics of the market of illegal substances. If there was such an influence, it was strongly delayed.

Conclusions

Analyses of statistical data and opinion polls concerning drugs and drug addiction prove that the growing trend in recent years at least slowed down. In the light of the data available, we may hope for a drop in the scale of this phenomenon.

What requires an answer first of all is the question about the contribution of the effects of broadly understood social reactions in reverting the growth trend in the problem of drugs and drug addiction. In other words, one needs to know to what extent the drop in the proliferation of the phenomenon results from broad social reactions, including a variety of preventive measures, and to what degree it is a manifestation of the phenomenon's own dynamics.

It may be suggested that the contribution of broadly understood prevention may be significant, as falling tendencies became visible also in the area of substance availability.

Another question suggested by the results of the analyses is the one about the lasting character of the falling tendency recorded at the moment. Will it be lasting, or is it just a momentary break in the trend? The final answer to this question must wait for the gathering of successive data and conclusion of further studies.

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After six years, the system of training in drug addiction prevention has consolidated. Despite nervousness and much anxiety, the idea of selecting training institutions through competition, and resigning from the arbitrary appointment of just one institution authorised to such activity passed the test. The approved solutions encouraged healthy competition between training providers.

REFLECTIONS ON THE TRAINING SYSTEM IN DRUG PREVENTION

Bogusława Bukowska
National Bureau for Drug Prevention

A handful of memories

I suggest a short time travel to begin with. It is November 2002, we are in Popowo, a centre run by the Central Authority of Penitentiary Service. Nearly 50 most experienced addiction therapists, each with at least 18 year-long history of work, arrived here. They came to participate in a special, summary edition of the training designed only for the people with the greatest experience in drug addiction therapy. They come from different parts of Poland, from different centres, and represent primarily the public and non-public health-care institutions. The guest of honour and at the same time lecturer is Martien Kooyman, who established one of the first therapeutic communities in Europe, known as Emiliehoeve, in the Netherlands in 1972. His visit coincided with the publication of Społeczność terapeutyczna dla uzależnionych: the Polish edition of his book. Kooyman's lectures were a good pretext for discussion about the system of helping the addicted, the earliest days of therapeutic communities in Poland were reminded, further possibility for development of this form of assistance was considered, and similarities and differences between Polish and Dutch solutions were analysed.

In the evening, all the participants received from the then Deputy Minister of Health, Andrzej Kosiniak-Kamysz and Anna Ciupa, representing the Polish Psychological Association (PTP) certificates of specialists and instructors in addiction therapy. Among the participants, there was the tragically deceased Marek Kotański, the spiritual father of many of the therapists gathered, who was awarded the symbolical certificate for the specialist in addiction therapy No. 1.

Tales about the beginning of the development of therapeutic communities and Poland had no end. People who created beautiful chapters in the development of the system of aid for those addicted from drugs, as Marek Kotański, Zbigniew Thielle[1], and Ewa Andrzejewska[2] were remembered.

Recalled were patients who had already departed, those who could not be helped, and those who "made it through".

These touches of nostalgia were mixed with satisfaction, thanks to the reception of the well-earned and expected recognition, and the joy from seeing friends for the first time in a long time. The subjects of talks concerned not only the past. It was with curiosity that people looked into the future, considering how a system of training for therapists would be developing, and which way it would go. Care was expressed about the maintenance of high standards of education and lasting character of the solutions approved.

Where are we six years later?

Six years have passed and the training system has consolidated. The solid legal foundations for its functioning were built and took the form of appropriate regulations of the Act on Counteracting Drug Addiction, and regulations of the Minister of Health.

Among others, they regulate such questions as the criteria of evaluating bids submitted to the competition by training institutions, the programme grounds of the training, and principles for cofinancing training participants. Besides the above, also the principles and criteria for the selection of supervisors and institutions

offering internship, recommended by the National Bureau, were worked out.

Despite much anxiety, the idea of selecting training institutions through competition, and resigning from the arbitrary appointment of just one institution authorised to such activity passed the test. The approved solutions encouraged healthy competition between training providers, who – caring for their high level – modify the content and way of their presentation, appropriately adjusting training to the experience and needs of participants. Despite constant changes introduced by the training institutions, the core curriculum defined by the Minister of Health remains the same for all training institutions. It encompasses: The Module 1 – obligatory only for people whose employment in addiction therapy does not exceed two years, in which the participant is obliged to participate in a seminar on psychopathology, workshops focusing on the interpersonal skills necessary for therapeutic work, and an internship in a clinical institution recommended by the National Bureau (altogether 250 hours of tuition); Module 2: obligatory for all participants of the training and encompassing interpersonal and intrapsychological training, theoretical classes, workshops, an internship with a clinical institution, and clinical supervision (altogether 400 hours for instructor in the therapy of addiction, and 440, the specialist in the therapy of addiction).

What lay at the roots of defining the core curriculum was the conviction that there is a certain pool of knowledge and skills necessary in the work of the addiction therapist, irrespective of the philosophical and theoretical assumptions of providing help advocated by the training institution. Moreover, while building the foundations of the training system, the postulate of integrative approach in the therapy of addictions was taken into consideration, and it recommends that the therapist knows a wide array of therapeutic approaches and is skilful in their appropriate use, depending on the client's needs.

The core curriculum makes it possible for training institutions to introduce many additional questions and thematic ranges into the programme of the training, which makes it more specific and varied. Innovative contents introduced by individual providers result primarily from the existing differences in philosophy of bringing help and the manner of defining reasons and mechanisms of the addiction from psychoactive substances. Thus for example, for some the addiction remains mostly a symptom of other disorders in the functioning of the human, while for others it is primarily an illness meeting the ICD 10 medical criteria. The Catholic University of Lublin (KUL) expanded its programme with subjects lying in the scope of addiction anthropology and prevention, Institute of Psychology of Health (IPZ) focuses on behavioural-cognitive approach and the strategic-structural concept of therapy developed by Jerzy Mellibruda. The Polish Federation of Therapeutic Communities (PFST) places main emphasis on the therapeutic community being the basic method of therapeutic influences. The Polish Society for Prevention of Drug Abuse (PTZN) extended the content concerning social reintegration. Following their preferences, a participant may choose the most interesting training. Some of them enjoy the status of postgraduate studies (such an offer is extended e.g. by the KUL).

All the training institutions, irrespectively of the differences between them, should make it possible for the participants to acquire understanding of different models and theories of addiction, understanding of the psychological mechanisms of becoming addicted, establishment of therapeutic relationship, motivation of the client to change behaviour, conducting a diagnostic procedure, adjustment of therapeutic influences to the patient's needs, embarking on group and individual interventions of therapeutic and crisis types. Graduates of the training courses should also be able to recognise their limitations, understand the significance of their work under clinical supervision, and follow the ethical principles of helping.

Since 2002, 695 people have completed training, of wham 511 obtained the title of specialist in the therapy of addictions, and 184 – of the instructor in the therapy of addictions. After six years of carrying out training, the most experienced institutions in the scope are the PTP, PFST, KUL, and the Katowice branch of the PTZN. Most of the participants are graduates of the theory of teaching, social rehabilitation, psychology, sociology. Little wonder that most of them embark on training as specialists in the therapy of addictions.

Caring for the quality of training

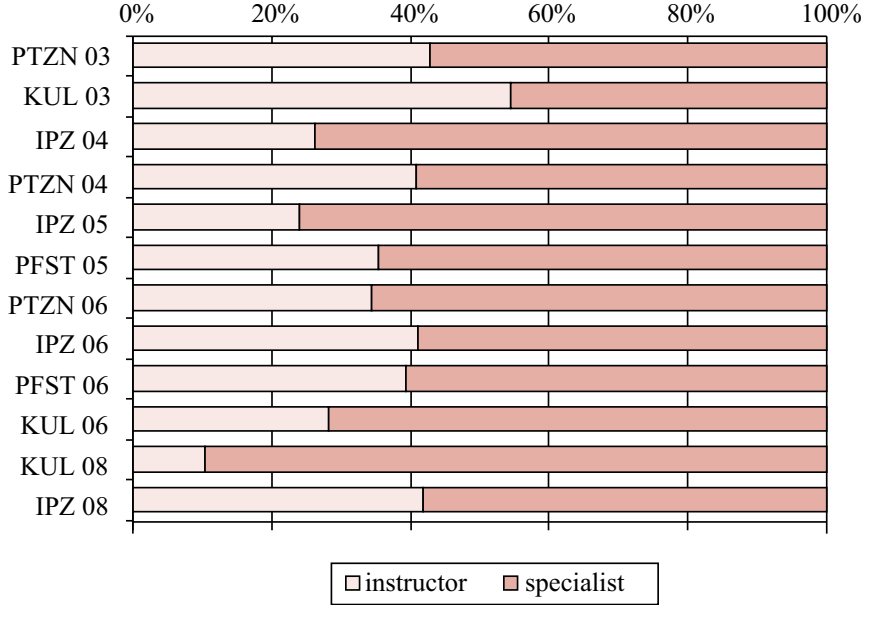
From the beginning of implementation of the system, the National Bureau decided to earmark additional financial resources every year for conducting evaluation studies. The studies began in 2005 and still continue. They encompass all elements of education: the training, the theory and workshop part, the internship, and the clinical supervision. The goal of evaluation studies is to receive answers to the following questions:

1. How does the professional experience of the participants influences reaching the objectives of the training?
2. Are the participants satisfied with the training conducted, and to what extent? What factors influence this?
3. To what degree was the programme of the training completed?

The data from opinion polls, in-depth interviews with participants of training sessions, and interviews with the lecturers are analysed in the following areas:

- effectiveness, from the point of view of the degree of completion of the assumed objectives of the programme
- usefulness, with respect to the needs of the recipients
- applicability, that is the possibility of making use of the best solutions proposed in the programme.

Fig. 1. Scope of education of the participants of certified training sessions conducted by all training institutions in 2003–2008.



The research conducted proves that as a rule, the training completed meets the expectations of the participants. Participants expressed positive opinions and enumerated numerous benefits from participating in the training: ordering and organising their knowledge, acquisition of new skills, improvement of qualifications, exchange of experience.

The elements that are especially highly valued are the clinical supervision and clinical internship, and participants emphasise their practical value. Thanks to them, they can verify the therapeutic skills they have. During the interviews and talks with the participants and lecturers, significant comments and postulates concerning improvement of training quality and increasing the efficiency are given. The introduction of Module 1 for people whose work experience is shorter than two years, reduction of the number of lectures and increasing the number of workshop activities show well how the result of evaluation is used in practice. The analysis of data coming from the evaluation provides also plenty of interesting information concerning the professional experience of people going into training, their education, and motivation.

When analysing the age of participants, we see that people embarking on the courses are increasingly younger (Fig. 2.). This tendency is visible, especially in the last two editions of the training conducted by KUL and IPZ, which began in 2007 and were evaluated in 2008. The illustration above shows that more than 80% of people in training are below 40, and that the number of participants who begin training soon after starting their professional career is on the rise.

Mentioned most frequently among the motives to begin training, is the eagerness to improve qualifications, need of professional training, and acquisition of new skills. What remains an important reason is also the question of obtaining a certificate and meeting formal requirements that are placed before addiction therapists. Other reasons include eagerness to obtain or order knowledge, exchange of experiences, and personal development

Problems with conducting the training

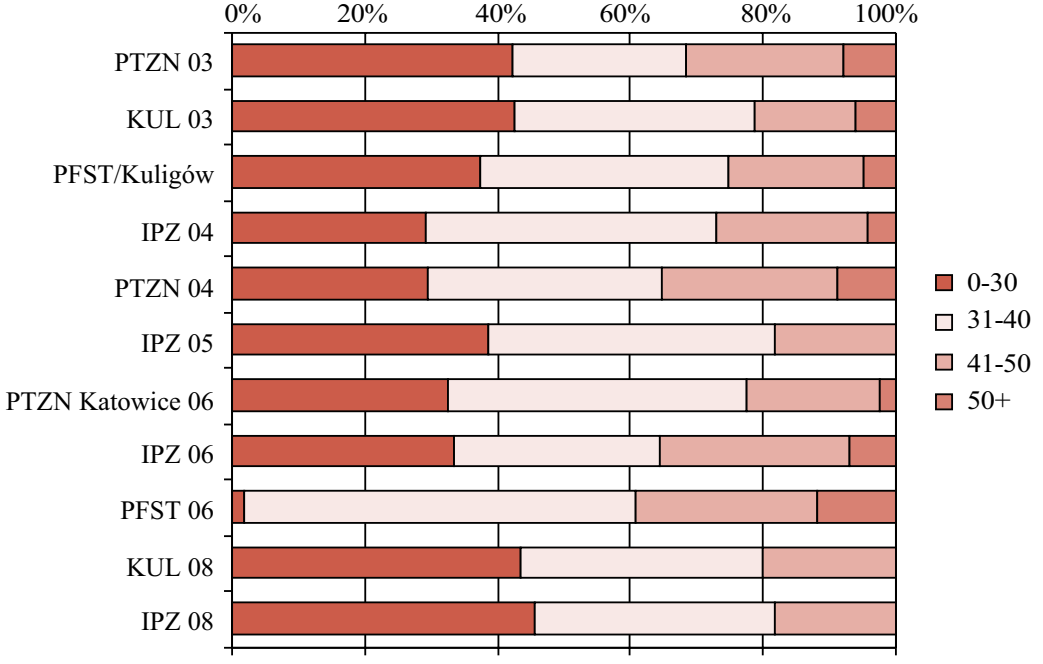
The few-year-long period of introducing the system of training disclosed not only its benefits, but also drawbacks. Some of them require intervention at the level of legal regulations, while others – embarking on material discussion of the content and working out joint recommendations by the training institutions and the National Bureau. The observations and evaluation analysis proved that the role and tasks of the instructor in addiction therapy have not been defined precisely. This has specific consequences at the level of education: the training modules for the specialist and instructor are nearly identical. Most probably, the difficulties in fine-tuning of the specific characteristics of the training for the instructor are a reflection of problems in the unambiguous definition of the instructor's role in the process of therapy of the addicted.

What remains another significant question is the integration of all the parts of the training, and especially the clinical internships including the lectures and workshop part. To date, the institutions providing internships informed that they do not always know what requirements to give the interns, primarily participants of Module 1, whose participants have less than two years of experience at work. The heads of institutions offering internship also expect a better cooperation with the training institutions to define priorities and integrate the internship with the content of the programme so that the intern tutors could refer to the content of lectures and workshops conducted in the educational part. These issues are brought up primarily by the heads over institutions offering internship.

From the point of view of participants of the internship programme, domination of the list of the institutions offering internship by residential institutions is a certain drawback, as it limits the development of therapeutic skills necessary for working in places other than closed centres.

Yet other problems turn up in the case of clinical supervision. There are considerable differences concerning the requirements put up by the supervisors. Some demand presentations of work on electronic carriers, while others accept just a discussion of certain problems that the supervised participants experience in their work as therapists. There are also differences in the scope of supervision. Some supervisors focus on the therapeutic relationship, while others focus also on the process of diagnosis, and preparation of the case study for the exam. All the questions above require more detailed arrangements, which have been planned for 2009.

Fig. 2. Age of the participants of certified training sessions conducted by all training institutions in 2003–2008.



Planned legal changes

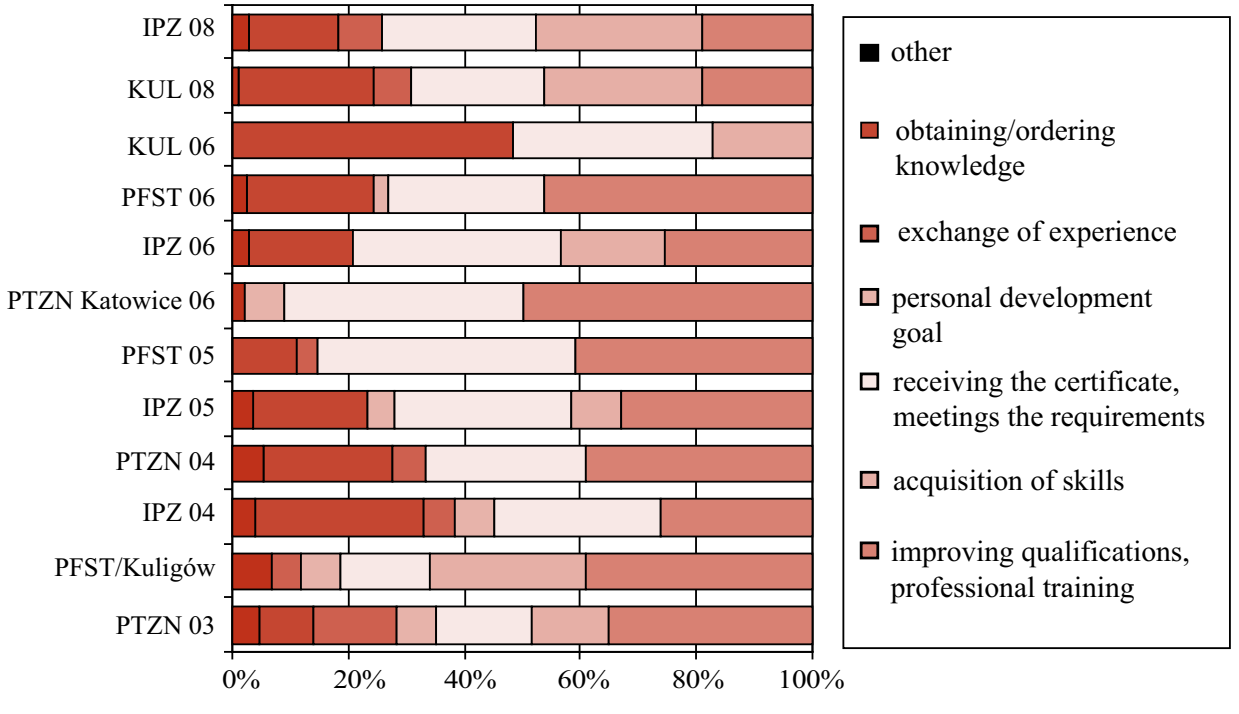
During the successive years of implementing the training system, we observed that there is quite a large group of people who do not take the examination for a number of years after the training. Through an appropriate change in the regulations, we would like to motivate instructors and specialists in the therapy of addictions to take the examination not later than 18 months after completing the training, and not after three or four years, as may be the case today. We also plan to expand the catalogue of study courses, whose graduation entitles to entering training as a specialist in the therapy of addiction, by adding e.g. philosophy.

There is also good news for the graduates of other humanities and social studies. In line with the prepared draft amendment of the act, they too, having received their masters degree and completed postgraduate studies in social rehabilitation, social therapy, and pedagogic, will be able to enlist for training as specialists in the therapy of addiction. Moreover, together with the State Agency for Prevention of Alcohol-Related Problems (PARPA), we decided that the people who have obtained the title of a specialist or instructor in the therapy of drug addiction will not have to go through the entire training cycle if they want to be granted the title of the specialist or instructor in psychotherapy of alcohol addiction. In such cases, it will be enough for them to pass the final examination. The same solutions will apply to the graduates of training conducted under the supervision of PARPA.

Reflections on the exam

Since 2008, the National Bureau has been responsible for conducting final examinations. Until that time, in line with the regulations of the Act on Counteracting Drug Addiction, these were the training institutions that supervised the examinations. Examinations as of the spring and autumn session of 2008 suggest a number of reflections and allow the formulation of significant recommendations. After the analysis of the written part (test) of the exam, it seems that the participants paid too little attention to the compulsory reading, and a large share of questions is based on the content. There are also certain problems connected to the preparation of the case study for the oral exam. In most cases, the mistake made is the presentation of a highly detailed diagnosis, with a parallel superficial description of the therapeutic procedure. Moreover, there are frequently problems in connecting the results of the diagnostic procedure to the therapy plan. Sometimes, one may be made to believe that the diagnosis

Fig. 3. Participants' motivation to embark on training (2003–2008, with all training institutions).



and definition of the plan of therapy or two independent processes, with any connection between the two being hard to notice. In turn, instructors in the therapy of addictions frequently describe the entire therapeutic process, while the examination board is interested in the reflection of the examinee over his role and participation in the therapeutic activities. It is worthwhile for the participants to follow certain guidelines before the examination:

- become familiar with the compulsory reading list (available from the website of the National Bureau www.kbpn.gov.pl in the section "System of training" (Polish: System szkoleń))
- preparing their case study, they should focus equally on the diagnosis and description of therapeutic actions undertaken
- in the study prepared, describe the connection between the diagnosis, actions taken by the therapist, and results of the therapy
- in the case of instructors, describe primarily this part of the therapeutic action for which the examinee was responsible.

Also, encourage participants of the training to become familiar with the website of the National Bureau www.kbpn.gov.pl, which includes up-to-date information about the principles governing internships and clinical supervision, conditions for cofinancing by the National Bureau, internship centres, and proposed internship curricula.

Footnotes

[1] Z. Thielle: in 1971–1976, the Head Doctor of the ward for the treatment of toxicomaniacs by the Regional Hospital for Nervously and Psychologically Ailing in Lubiąż; author of the pioneer work "Toksykomanie, zagadnienia społeczne i kliniczne" Thielle, Zgirski, 1976, PZWL.

[2] E. Andrzejewska: in the 1970s, the Head Doctor of the Sanatorium for Children and Youth Addicted to Pharmaceuticals in Garwolin.

The origin of the system of training and certification in drug addiction

In 2000, the Director of the National Bureau for Drug Prevention, Piotr Jabłoński, in recognition of developing the system of training and one of the priority tasks, established the team to define the framework for the system of training and certification. Its most active members included Piotr Adamiak, Bogusława Bukowska – coordinator, Karina Chmielewska, Piotr Jabłoński, Marek Liciński, Jolanta Łazuga-Koczurowska, Elżbieta Rachowska, Marek Zygadło.

A significant contribution to the final effect of the work of the team was made by Elżbieta Waniewska from the Legal Department of the Ministry of Health, who translated the content assumptions into the language of regulations, and found solutions to many problems of legal nature.

Introduced into the amended Act on Counteracting Drug Addiction of 2000, was the Article 14 item 2a mentioning the possibility of conducting the rehabilitation of patients addicted to drugs by people with at least secondary education, if such people have completed specialist training approved and certified by the minister appropriate for the matters of health.

On the grounds of the Article 14 item 2a of the Act of 24th April 1997 on Counteracting Drug Addiction, a memorandum of understanding between the Minister of Health and the Director of the National Bureau for Drug Prevention concerning entrusting the Director of the National Bureau with the procedure for certification of the programme of specialist training in the field of drug addiction by the Minister of Health was signed on 6th March 2002.

The first institution to provide training in the summary mode was the Polish Psychological Association (PTP), which conducted training for the most experienced therapists in drug addiction with at least 10-year experience in the therapy of drug addiction in 2002. The head of the training was Anna Ciupa, and the members of the Qualifying Committee were Alicja Bukowska, Bogusława Bukowska, Anna Ciupa, Karina Chmielewska, and Paweł Święcki.

The first full-time training was conducted by the PTZN (branch in Zielona Góra) in cooperation with Zielona Góra University. Its head was Professor Dorota Rybczyńska.

Since 2002, the system of training and certification has been supported by Professor Czesław Czabała, who actively joined the process of training supervisors, and presides over numerous teams operating for the benefit of the training system.

Today, the system operates in accordance with the provisions of the Act of 29th of July 2005 on Counteracting Drug Addiction.

With the development of new technologies, the capacity to provide addicts and their families and friends with help is increasing. Poland already has an online service, where specialists provide consultations and support by e-mail.

TO THE INTERNET FOR HELP

Tomasz Kowalewicz
Praesterno Foundation

Www.narkomania.org.pl is the place to find the assistance and education service addressed to all people who get in touch with the problem of drug addiction: young people (also those who take drugs) and parents, teachers and specialists, people dealing with the therapy of addicts and prevention for those in danger.

Since 2004, following a commission from the National Bureau for Drug Prevention, the service has been managed by the Praesterno Foundation, who participate in conducting a programme for counteracting social pathologies among young people in eight cities in Poland since the mid-1990s, cooperating with schools, running prevention classes for students of lower and upper secondary schools, offering training programmes and other forms of professional training for teachers and people active in the area of prevention.

Internet guarantees anonymity

Woman, aged 50: *My 21-year-old son is addicted to drugs. A year ago, he stole a lot of my money. Now he works, yet he is intending to quit the job, because – as he says – he hates it. I'm afraid that if he does, he will begin stealing things and money from home. My husband threatens that if our son doesn't work, he will get rid of him from home. I don't know what to do. Is making our son leave home a good idea in such a situation?*

Beginning to help people who have a drug problem and their families and friends via the Internet was connected to noticing its growing role as a medium used by an increasing part of our society. As far as it was only one household in four that declared access to the Internet in 2004, in 2005, the share was already 30%. In absolute numbers, it marked a growth by over 500,000 households.

The degree of equipping households with ICT devices and technologies, and access to the network varies depending on the income and size of the place of residence. According to data for 2005, Internet access is present at home:

- in 71% of households declaring monthly net income exceeding 7200 zloty (and only 14% of those whose income remains below 1440 zloty a month)
- 40% of households in cities with a population over 100,000 (and only 19% of rural households).

Another significant feature of the Internet, besides the growing general accessibility, is the anonymity of the online contact. Sending an e-mail to no extent violates the privacy of the asker and allows asking any question without the risk of being disclosed.

It seems that these two features of the medium (to reiterate: growing popularity of access and anonymity of the contact) influence significantly the success of the online anti-drug Consulting Centre.

Structure of the service

Girl, aged 17: *I have a friend, she takes drugs, and I want to help her break away from the addiction. How to do it? Help me. She may thank me one day, may she not?*

Consulting Centre and FAQ

The basic feature of the service is the Consulting Centre, where web users may ask questions, using a standard screen.

Besides asking the question, the sender is asked to state his or her sex, age, place of residence, and region. The asker must also define the addressee of the question: the psychologist, the physician, or the lawyer: the data concerning them are personalised so that users know the names of experts providing the answers. Moreover, the

service includes a subsite with most frequently asked questions received by the psychologist and physician together with the answers.

Databases

The clients of the service have a number of databases at their disposal:

a. The national database of help centres providing services to addicts and those threatened with addiction (developed on the ground of the "Gdzie szukać pomocy" [literally: where to seek help] guide, published by the National Bureau for Drug Prevention).
   The database may be queried by two criteria:
   – the region,
   – the type of the centre (ambulatory, detoxification, residential, running HIV tests).
   The database contains the total of 461 centres.
b. Besides the national database of help centres, this section of the service includes national helplines.
c. There is also a database on non-governmental organisations providing assistance in Warsaw for people addicted to alcohol and/or drugs and for their friends and relatives, as well as information about specific centres and assistance programmes.

The Reading Room

Another section offered by the service is the Reading Room with a few tens of articles ordered according to the following subjects:
– studies
– methods of treatment used in Poland
– drug addiction in the world
– assistance
– law
– prevention
– promotion of healthy lifestyle
– upbringing and education.

The articles most frequently read in the service include:
– Maria Moneta-Malewska, "Jak poznać, że ktoś zażywa narkotyki?" [literally: how to recognize that someone takes drugs]
– "Raport o stanie zagrożenia demoralizacją i przestępczością nieletnich oraz patologiami wśród dzieci i młodzieży w województwie wielkopolskim" [literally: report on the status of the threat of demoralisation and juvenile delinquency and pathologies among children and young people in the Wielkopolska Region]
– Mieczysław Wojciechowski, "Od inicjacji do uzależnienia" [literally: from initiation to addiction]
– Robert Rejniak, "Formy pomocy osobom uzależnionym od narkotyków" [literally: forms of help for people addicted to drugs]
– Grażyna Świątkiewicz, "Szybka ocena i reakcja" [literally: quick evaluation and reaction].

Books and Press Review

On a separate subsite, the service offers a review of books devoted to the subject of drug addiction and informs about selected Polish magazines touching problems connected to drug addiction: "Alkoholizm i Narkomania", "KARAN – Narkomanii Nie", "Remedium", "Serwis Informacyjny Narkomania", and "Monar na Bajzlu".

Operation of the Online Consulting Centre

Woman, aged 30: *Can one stop smoking heroin on his own, without therapy, without the help of a psychologist? Precisely a year ago, I learned that my boyfriend had been smoking heroin for eighteen months. Despite many talks, he did not decide to enter therapy, because he said that old people like him (30 years old) received treatment nowhere, and centres were run only for the young. His friend, seemingly, a clean drug addict, convinced me that after a few days' craving, Adam will come back to normal, and with a little bit of strong will, he will leave the addiction without the aid of a centre. I felt that my legs were pulled, but I wanted to believe it.*

In the Online Consulting Centre, everyone may form a question and easily send it to the specialist. (The question is sent straight from the website and does not require opening any e-mail client, as it is enough to click the "send" button.) The centre decides which of the three specialists (physician, lawyer, psychologist) will receive the question. Usually, the users choose the right person, even though it sometimes happens that specialists forward the questions received to one another, for example, the psychologist sends it further to the physician, notifying the asker about the fact.

Answers are usually given within 24 hours from receiving the question, even though – especially on the days when there are many questions and they address difficult problems – it may happen that working on the answer takes longer, and then it reaches the sender later.

Every month, there are approximately 200 questions asked. Nearly two thirds of these (63%) are addressed to the psychologist, one third (34%) to the physician, and 3% to the lawyer.

People writing e-mails are usually those who live closest to people using psychoactive substances more or less intensively (52%). More than every other is a friend, colleague or partner – anxious and helpless in conflicts with their friends and partners taking drugs. The second category within this group are members of the family of drug addicts or users (usually parents or siblings). People abusing psychoactive substances account for 42% of enquiries.

6% of questions are requests for information materials on drugs and theoretical information on drug addiction. Nearly two thirds of questions (63%) are asked by women, and just over one third (37%) – by men. One in five askers is below 18, while 70% are adults (over 18), with 10% failing to state that age.

30% of questions come from towns of less than 50,000 inhabitants, 13% – from towns, whose population ranges from 50,000 to 100,000, and 57% – from cities of over 100,000. Problems mentioned in the e-mails are most frequently connected to marijuana and amphetamine.

Most frequently asked questions and problems

Man, aged 25: *I have smoked marijuana for seven years, since I began to live in Gdańsk, for more than three years I have smoked daily, a few joints a day; plus two beers with that, and some other drugs on top of that at weekends. I have been absolutely clean for the last seven days, I've really had enough of my life in addiction. Yet I have problem with staying clean: every few months for the last year I have regularly stopped taking drugs, yet I can live like that for anything from one to four weeks. I don't have enough strength to deal with my problem. Everyone around me lives like that: my friends, and especially my girlfriend.*

Different categories of people who ask questions turn to us with different problems. Users of psychoactive substances most frequently complain at different somatic and psychoemotional problems, and either want to know whether they result from taking drugs or learn how to cope with them (they frequently mention symptoms they experience having stopped taking drugs). After a description

of incidents with psychoactive substances – the question "Am I addicted to drugs?" may be asked.
Another category of problems belong to the question of what to do to stop taking drugs. A large share of those asking, openly declare reluctance to visit specialists and meet them in person.
The basic problem of the people whose friends and relatives use drugs is the answer to the question how to help them. It happens that the aid they offer has been rejected by the addict. In this situation, the question turns into how to force them into treatment? In this context, the question of declaring legal incapacitation is sometimes raised.
The general strategy followed by those answering the questions is sharing reliable information in answering the question. (Frequently, it is accompanied by indicating online sources where more information on the given subject can be found.)
Specialists provide serious answers, also to the questions that can be suspected of being silly jokes, for example: "My seven-year-old son returned home at midnight, totally stoned. What am I to do?" It is to be emphasised that e-mails that are evidently jokes happen extremely rarely.
Usually, the information given is accompanied by a suggestion not to seek "virtual" advice, but to visit a specialist "in the real world". Such a recommendation is supported by detailed arguments when answering people who declare that "for no treasure of this world" will they go to a Consulting Centre for addicts, or any other institution of the type. The goal is to reduce the fear of personal contact with the specialist, and the fact of addressing a question to the Online Consulting Centre is interpreted as the need for contacting a professional.
Specialists do not run online psychotherapy. In most cases, communication ends after providing a single answer to the question. Only few people become involved in longer correspondence, treating the asking of further questions as a pretext to maintain the contact. A situation that happens more often is sending thanks for the advice. It happens only very rarely that the specialist finds a negative evaluation of his or her answer to the question asked.

The Consulting Centre continues to develop...

Boy, aged 18: *I have such a question... can the weed spoil my psyche? All in all, why do I feel so empty lately? Is it because of the weed? Because I don't smoke, that often... I don't know what's happening to me... I feel that everyone is hiding something away from me... That they are talking about me in secret, that they are running me down behind my back. I feel bad because of that. Please, let someone tell me something, 'cos I don't know what's going on with me...*

The 30 months of running the Online Consulting Centre by the Praesterno Foundation proved the use fulwess of its existence. The space where people experiencing problems with drugs – personal or those of their friends and relatives – may receive help in the form of e-mail information answering their questions, has proved necessary. Beyond any doubt, an advantage of this form of communication is a guarantee of anonymity of the asker and the easiness (if he has access to the Internet) of turning to a specialist with doubts and problems. Naturally, such consultation does not provide an alternative to efficient actions aimed at recovering from drug addiction or giving the coaddicted more serious assistance. Yet this is not the goal of our Consulting Centre.
The database of articles (the Reading Room) that lets people seeking for information expand knowledge of the subjects they find interesting is expanded all the time. Special emphasis is placed on increasing database of handbook-type articles that – as the ranking of most frequently read materials proves – enjoy the greatest interest of service users.
The FAQ section is also expanded with most frequently asked questions together with standard answers to them. Becoming familiar with these frequently provokes people to ask the specialists detailed questions.

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Analysing the operation of the Online Consulting Centre so far, it can be expected that the importance of this form of contact with people afflicted with drug addiction will be on the increase. Virtual assistance will not replace contacts with specialists, yet it may play quite an important role in motivating them to visit appropriate institutions offering professional assistance to addicts, their families and friends.

The article is a copy of the publication in NARKOMANIA Newsletter, No. 2/2006.

NATIONAL EDUCATION CAMPAIGNS

2000–2001 "FIND TIME FOR YOUR CHILD"

The main message of the campaign addressed to parents and guardians was to turn attention to the importance of family as the factor protecting the child from drug use and emphasising the educational role of parents and/or guardians in drug prevention.

2002–2003 "DRUGS – THE BEST WAY OUT IS NOT TO GET IN"

The task behind the campaign was sensitizing young people to the fact that drug use is connected to serious health and social harm. One of its significant elements were actions focused on increasing the safety of young people at the places of recreation, mostly clubs, discos, and concerts.

2004 "DRUG-FREE UNIVERSITIES"

Campaign conducted jointly with the Chancellery of the President of the Republic of Poland to encourage student organisations and university authorities to take preventive actions at universities and students dorms to limit drug use among academic youth. The campaign involved the National Bureau, which commissioned a study into psychoactive substance use among students and the publication of an information and educational brochure.

2005–2006 "CLOSER TO EACH OTHER – FURTHER AWAY FROM DRUGS"

The leading theme of the campaign was the idea that good relations between parents or guardians and children help to develop bonds and intimacy, which to a great extent protect young people from using psychoactive substances, and especially getting addicted. The campaign aimed at sensitising the parents and guardians to problems connected to the phenomenon of drug addiction, increasing the level of relevant knowledge in the society, emphasising at the same time the good communication in the family. In the first year, the message of the campaign (through the slogan "talk with your child more") turned attention to dialogue as one of the most important elements of developing good relations in the family. In the second year, more attention was focused on the quality of these relations and the slogan used was "seek agreement with your child".

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NATIONAL EDUCATION CAMPAIGNS

2006–2007 "SUPPORT FOR LOCAL COMMUNITIES IN COUNTERACTING DRUG ADDICTION"

Campaign addressed to local communities that aimed at supporting local authorities in efficient counteracting drug addiction. The project was addressed to local authorities, the staff of social care and educational institutions, police, local non-governmental organisations, and the entire civil society. The project was conducted as a part of the Transition Facility 2004 programme by the Foundation for Development of Local Democracy (Fundacja Rozwoju Demokracji Lokalnej) in cooperation with the National Bureau. It saw the involvement of 802 communes, and the effect of the project was the development of more than 450 municipal programmes for counteracting drug addiction and publication of a coursebook on designing local drug prevention strategies.

2007–2008 "WATCH YOUR DRINK"

Information campaign concerning safety of young people during musical events in clubs and discos. The goal of the campaign was to turn attention to the threats connected to substances added to drinks to incapacitate the future victim, in most cases with the intent to rape, steal, or commit another crime. A website informing about substances and their dangerous results (www.pilnujdrinka.pl) was launched to offer instruction how to be safe from such crime, and what to do once you have fallen its victim.

2008 "DO YOU KNOW WHAT YOU ARE CARRYING?"

Information campaign on the safety of Polish citizens during foreign travels. The campaign conducted under the patronage of the Minister of Health and the Minister of the Interior and Administration was to protect Polish tourists from inadvertent trafficking. Preventive actions undertaken as part of the campaign were to turn the attention of travellers going abroad to the existing threat posed by criminal drug groups and to encourage the habit of watching luggage at all times.

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