



Drug Law, Drug Use and Health in Szczecin and West Pomerania, Poland

Rapid Policy Assessment and Response

Final Report and Recommendations:

Bridging the Gaps Between Needs and Services in the Health and Criminal Justice Systems

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STOWARZYSZENIE NA RZECZ PRZECIWDZIAŁANIA CHOROBOM ZAKAŻNYM NA POMORZU ZACHODNIM

SZYBKA OCENA PRAWA I POLITYKI WOBEC NARKOTYKÓW
ORAZ ODPOWIEDŹ W KRAJACH BYŁEGO ZWIĄZKU RADZIECKIEGO ORAZ W KRAJACH CENTRALNEJ I WSCHODNIEJ EUROPY

RAPORT KOŃCOWY
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Current versions of the tools and training materials are available on the world wide web at <http://www.rpar.org>



Preface

This is a case study of drug policy, public health and HIV in one city and its environs. As such, its findings are not necessarily generalizable to other places in Poland or the region. Yet it is a sobering report, and one that should cause serious concern to anyone interested in preventing and treating HIV, Hepatitis, and drug addiction. A group of dedicated researchers and local citizens took a hard look at how the laws on drug use, and related social and health services, were really being implemented, and what they found was not at all what they expected. Although Poland had supposedly adopted a sort of “tough love” policy in relation to drug users – penalizing possession of even small amounts but promising treatment instead of jail – in fact few drug users go to jail and the criminal justice system is almost never a route to treatment. The team was not surprised to find that the urban harm reduction and treatment services that had been established in the wake of Poland’s first AIDS scare were still working reasonably well. To their great surprise, however, the team found signs of a dangerous epidemic of amphetamine injection in rural areas, where fear of arrest, the stigma of drug use and a total lack of preventive or harm minimization services leaves an open field for the rapid spread of drug-associated disease.

This report has important information for Poland, but it should also be of interest to health and criminal justice policy stakeholders everywhere. It demonstrates that the effects of public policies cannot be deduced from the law on the books or the work plans of ministries. To find the problems, we have to look locally, where life actually happens. While the Szczecin story makes clear that new national policies cannot be effectively implemented without appropriately training staff and funding new services, it also shows that local people, working together in a data-driven process, can come up with practical and effective solutions to their own problems.

We congratulate the Szczecin RPAR team and the CAB for their important work.

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This Report is an adaptation of the original Polish version, written by the Polish RPAR Team. The English version was prepared by Scott Burris and Kristina Arvenitis.

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EXECUTIVE SUMMARY

“...I was terrified when I saw all those kids. At one dealer’s apartment, I saw boys and girls, not older than 16, who injected amphetamine using the same equipment. I told them that they might catch HIV and HCV but they answered that ‘none of us is HIV infected because we don’t use [heroin] and HIV is only in [heroin].’”

-Female amphetamine user, 26

In 2005, a Rapid Policy Assessment and Response [RPAR] intervention was conducted in Szczecin, Poland, to assess the impact of Polish drug policy on the health of drug users in the city and surrounding rural areas. In the RPAR, a team of Polish researchers worked with a Community Action Board comprised of law enforcement, drug treatment providers, medical officers, NGO leaders, lawyers, judges, and others to collect and analyze three kinds of data:

- 1) laws and written policies relevant to health risks in the target populations;
 - 2) existing data on the epidemiological situation and the operation of the criminal justice system;
- and
- 3) qualitative interviews with police, judges, prosecutors, drug users, sex workers and others who describing how the laws are put into practice.

By combining the assessment of law on the books with research on how law is actually being applied on the streets, the RPAR directly addressed the well-known gap between policy intent and implementation. By relying on local research capacity and leadership, the RPAR supported local capacity to produce change. The RPAR emphasized the link between formal policies and actual practices. It highlighted the importance of and aimed enabled bottom-up change at the local level, to create a means of holding states accountable not just for their formal policies but for the real practices that influence people’s daily lives.

The Szczecin RPAR uncovered evidence of dangerous new drug use patterns, and significant gaps in the health and drug treatment services available to prevent HIV and other serious health problems among drug users. The findings indicate that drug policy in practice does not correspond to the strategies embodied in recent Polish drug legislation, and that urgent action is necessary to prevent serious health problems in rural northwest Poland.

Key Findings & Recommendations

CRIMINALIZING DRUG POSSESSION IN POLAND HAS NOT FULFILLED ITS GOALS IN PRACTICE

Over the past decade, Poland's legislators have strenuously debated the approach the country should take towards the problem of individual possession of illegal drugs. By the year 2000, the law had moved from largely ignoring individual possession of small amounts of drugs to penalizing individual users. As an integral part of this move towards greater use of criminal sanctions, however, the legislature also created several means of offering drug treatment instead of, or during, incarceration for drug offenders. On paper, at least, Poland committed itself to arresting more drug users and using the threat or application of prison time to deter drug use and increase uptake of treatment.

That is not how the new laws have worked in practice. The RPAR found that, at least in the Szczecin area, drug use is increasing, drug users are rarely imprisoned for simple possession or small-time dealing, and the criminal justice process is virtually never used to direct drug users into treatment.

- Drug use is common among young people in both urban and rural areas; drug users we interviewed reported no difficulty in obtaining drugs.
- Police officers often use threats against drug user in order to secure arrests of larger drug dealers, but rarely arrest people merely for possessing small amounts of drug for personal use.
- Most people convicted of drug possession are not sent to jail or treatment.
- While Polish drug law provides avenues for drug treatment as an alternative to incarceration, accused drug offenders are not aware of these potential options, legal aid attorneys rarely advocate for treatment options, and prosecutors and judges are loathe to mandate treatment.

Key Recommendations & Actions:

Criminalizing drug possession does little to address the underlying social and psychological factors that produce rising rates of drug use, nor has the current drug policy regime proven sensitive to the risks of disease associated with injection drug use. Polish political leaders may wish to reconsider the wisdom of addressing drug use as a criminal justice problem. Meanwhile, however, there are a number of simple steps that could be taken within the existing legal framework to make sure that drug treatment options are available, effective and actually used in the criminal justice system. These include:

- Training seminars for judges and prosecutors, introducing the drug problem and demonstrating a variety of options under the law for handling drug offense adjudication
- Increasing cooperation and communication between criminal justice and drug treatment staffs
- A user-friendly database of health, social and drug treatment services to facilitate judicial and prosecutorial referrals

A RISE IN RURAL DRUG USE IS CREATING SERIOUS UNMET NEEDS FOR PREVENTION, TREATMENT AND DISEASE SURVEILLANCE.

Poland successfully blunted an urban HIV/AIDS epidemic in the early 1990s by rapidly adopting harm minimization programs such as syringe exchange and opiate replacement therapy. Now the country may be facing an epidemic of injection drug use in rural areas. Young people, lacking after-school activities and employment options, turn to the recreational use of illegal drugs. Misperceptions regarding the methods of HIV transmission are widespread. Our informants indicated that many of these new rural drug users are young, and unaware of the risks of disease associated with drug injection. By the nature of small communities, rural drug users are more of a hidden population than they are in Szczecin.

The Szczecin RPAR has found that HIV testing, syringe exchange and drug treatment services, available in urban Szczecin, are not available in the outlying towns. Rural drug users have no ready access to HIV testing, risk-reduction information, needle exchange or drug treatment programs. Public knowledge of the high incidence of intravenous drug use and the risks involved is very low and local officials were not legally obliged to create educational programs until 2005. The situation poses a risk of a rapid increase in HIV, hepatitis and other blood-borne or sexually transmitted diseases.

Key Recommendations & Actions:

Health officials at all levels of government should quickly investigate the growth of amphetamine and other injecting drug use in rural areas, and act to ensure that necessary treatment and prevention services are put into place. “Just say no” approaches to drug use are ineffective, and alcohol treatment programs are not suited to the needs of amphetamine and opiate users. Real alternatives, and interventions to minimize the harms of drug use, are essential to prevent the spread of serious disease among drug users. Cooperation between law enforcement, health authorities and the NGO sector is essential to make information and services accessible to drug users.

Immediate action steps include

- Convening drug policy officials, clinics, churches and other relevant community members, as well as the National Bureau for Drug Prevention, to discuss the situation in the rural areas
- Educating stake-holders about drug treatment and harm minimization interventions
- Rapid epidemiological and behavior assessments of drug use and disease in rural areas, including surveys for students, educators and psychologists and interviews with drug offenders
- Development of harm reduction interventions including outreach, education, drug treatment and syringe exchange for rural areas

LACK OF THERAPY AND HIV PREVENTION METHODS IN PRISON AND DIFFICULTIES IN THE SOCIAL REINTEGRATION PROCESS

Once in prison, drug users face long waiting periods for therapy. There is a misperception that drug usage does not exist in prison, but in fact prisoners report a high rate of risky activities such as unprotected sexual contact, rape, and intravenous drug use. A lack of social services contributes to the difficulty of reintegrating into society upon release. Released from prison, many former narcotics users have problems with interviewing and other basic skills necessary to gain employment. There is deficient support for continuing abstinence following prison sentences or drug treatment, and low rates of employment amongst rehabilitated drug users, which leads to high rates of relapse and recidivism.

Key Recommendations & Actions:

Without appropriate health and prevention services, prisons can become incubators of bloodborne disease. If imprisonment is to be an effective tool of rehabilitation and social reintegration for drug offenders, prisons must do more than confine convicted drug users. Rather, prisons must combine health services during imprisonment with coordinated pre- and post release social and health services.

- Creation of better employment counseling services
- More linkage between non-governmental organizations and the Regional Unemployment Office
- Better access to drug treatment and harm reduction services inside prison.

LACK OF QUALITY LEGAL SERVICES IN THE CRIMINAL AND CIVIL JUSTICE SYSTEMS

Currently, accused drug offenders are unaware of mechanisms in the law which would allow them to take part in drug addiction treatment as opposed to serving out a prison sentence. While defendants have a right to legal counsel, they are largely ineffective at advocating for their clients. Attorneys and clients sometimes do not even meet until the day of trial, and drug users report that their attorneys have never familiarized themselves with the facts of the case. Drug users also lack services in civil matters.

Key Recommendations & Actions:

If the intention of Poland's drug policy is to use the threat of criminal sanctions and prisons "therapeutically," it is essential that drug defendants have lawyers who are familiar with addiction, addiction treatment and the legally available avenues for diverting addicted clients from prison to treatment. Action steps include:

- More widespread availability and sponsorship of free legal advice for accused drug offenders
- Recruitment of prospective counselors and legal aid representatives amongst law students
- Training in addiction and the law for defense counsel.

NEXT STEPS IN SZCZECIN AND BEYOND

At the conclusion of the Szczecin RPAR, the research team and the CAB developed an action plan to pursue the findings and recommendations for action. It was agreed to seek funding from local, national and European sources to facilitate the cooperative activities outline above. The Action Plan includes

- Add a section on “Drug Counteraction” to the budget of Szczecin for FY2006, earmarking local funds to be used to support recommended projects.
- Provide more support for small towns and communities outside Szczecin, including a conference to assess needs and develop solutions, the establishment of Community Action Boards in rural towns, and provision of needle exchange and health education services in rural areas.
- Offer training seminars for judges and prosecutors on the problems of drug addiction and the available treatment options that may be pursued in lieu of prison sentences for drug offenders.
- Develop a user-friendly mechanism for information about and referral to local health, treatment and social services for drug users.
- Organize free legal advice services for drug users and provide technical assistance to lawyers representing drug suspects.
- Provide employment counseling for drug users in recovery.
- Continue long-term efforts to make Polish drug law more flexible and sensitive to health issues.



The Rebuilt Old Town of Szczecin

Rapid Policy Assessment and Response

I. INTRODUCTION

"Most of my teenage neighbors have already tried drugs; some of them are addicted."

-Male amphetamine user, 49

Drug addiction is a serious health problem that produces unfortunate social side-effects. Drug users are at high risk for serious diseases like HIV and Hepatitis, and not infrequently engage in criminal activity (theft, prostitution, drug dealing) to pay for their drugs. Although addiction has been classified as a disease by the World Health Organization, it remains stigmatized as a character flaw. Injection drug users [IDUs] are considered to be junkies, associated with disease, filth and uselessness, and are cast to the bottom rung of the social ladder. Over many years, the City of Szczecin has developed a reasonably effective network of health and social services for drug users, including methadone treatment, educational outreach and syringe exchange, but overall the city and the region still suffers from a lack of services and the underlying tension between health and criminal justice responses to drug addiction. "Zero tolerance" as a criminal justice policy and a social attitude aims to completely eradicate the use of illegal drugs by providing for prison sentences even for small possession, but it is questionable whether should be in the competence of criminal or health policy. Stringent criminal code regulations for possession or use causes addicted persons to be regarded as offenders, adding to existing social stigma and resulting in the concealment of behaviors. As a result, healthcare and social workers are less able to reach drug users to offer treatment and assistance and restricts harm reduction efforts. On paper, Poland's drug policy uses the criminal justice system as a bridge or spur to treatment for people with addiction, but on the streets the reality is completely different.

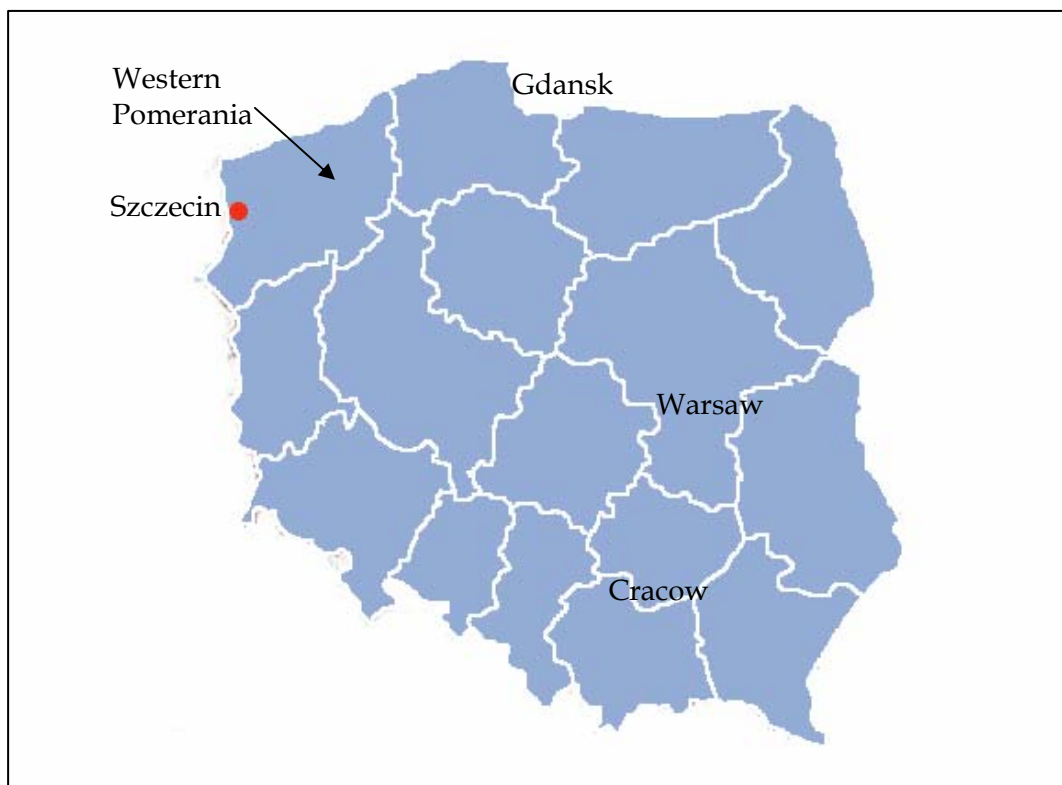
The Szczecin RPAR collected laws, health and criminal justice statistics, and interviews with drug users, health officials, legal personnel, and criminal justice representatives in order to study the intersection of criminal law and public health with respect to intravenous drug use and disease prevention in the region. The project identified a number of serious problems. Poland's zero-tolerance approach to drug possession is coupled with a growing amphetamine problem. The increased rate of HIV infections has also been a concern, with data from Szczecin outpatient clinics indicating that HIV diagnoses in each

of the years 2002-04 has nearly doubled in comparison to that in 1995; worse, nearly half of all new patients admitted to intravenous drug use. All informants in the Rapid Policy Assessment and Response agreed that the use of “kompot” (Polish heroin) is decreasing in the region due to many opiate users entering methadone programs and aggressive arrests of producers and dealers in the region. The imprisonment of dealers and the rehabilitation of users in the city and the subsequent decline in heroin production have led to the decline in popularity of the drug in the Szczecin region.

Unfortunately, the decline in opiate use seems to have been more than matched by a rise in amphetamine production and use. Amphetamines are increasingly popular and widely accessible in the region, particularly amongst young people. Many users believe that the use of amphetamines improves their mental acuity, with one user reporting better facility in speaking foreign languages. Some of those who inject amphetamines reported that they do so because they desire a better and more long-lasting effect from the drug. Access is easy, and the adage, “the smaller the town, the cheaper the drugs,” is the general rule. Rural drug use poses special challenges, as prevention services, medical facilities and drug rehabilitation programs are more or less unavailable in rural communities. While intravenous drug users in the city of Szczecin report being able to purchase clean syringes at pharmacies or rely on needle exchange programs, in the rural areas, it is much more difficult to obtain clean syringes and exchange programs are not available. Incarceration has not led to cessation of amphetamine use, as prisoners continue to use while in prison and a lack of employment and rehabilitation options leads to high rates of relapse upon release. While local drug programs are required by national law to combat drug abuse, they are not required to offer treatment to drug addicts.

The move in Poland to punish individual drug users as criminals was driven by a number of factors, including a purported need to comply with international treaties on drug control. Part of the impetus, however, was the argument that being arrested and threatened with jail would deter new users and spur people suffering from drug addiction to take up treatment. Neither result seems to have taken place in Szczecin and surrounding areas, and it is clear that at least part of the reason is that the new policy was not accompanied by the necessary resources and training for police, prosecutors, defense lawyers and judges.

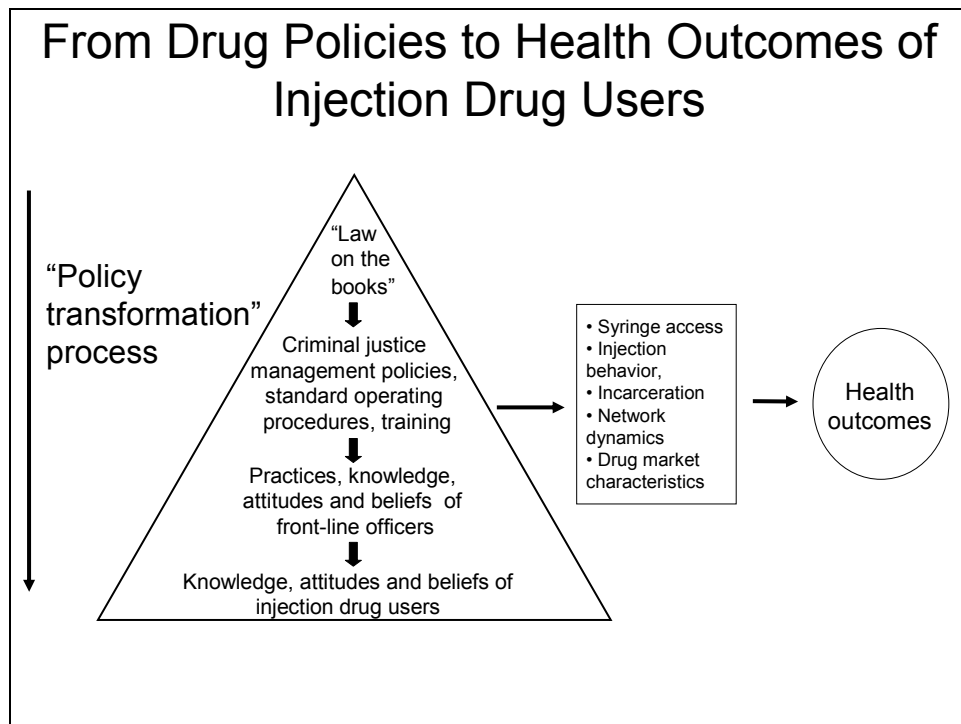
This report explains the RPAR methodology, and then describes key findings and recommendations for action. Appendices include detailed information about RPAR methods and findings.



Szczecin, a city of more than 400,000 people, is a port on the Baltic Sea near the German border in the West Pomeranian region of Poland, the largest industrial and shipping port in the region. West Pomerania is known for having one of the highest unemployment rates in Poland at 25.6%, high above the national mean of 17.6%. The problem of high unemployment is greater in the small cities and is worst in the rural regions.

II. METHODOLOGY

In RPAR, a research team from a site city works with a Community Action Board to collect three kinds of data: 1) laws and written policies relevant to health risks in the target populations; 2) existing data on the epidemiological situation and the operation of the criminal justice system; and 3) qualitative interviews with police, judges, prosecutors, drug users, sex workers and others who can describe how the laws are put into practice. The data collection and interpretation are guided by the CAB, which develops an action plan and final report. RPAR is designed to be used by people who do not have extensive experience in policy or qualitative research. Research and analysis is based on a conceptual model in which laws and law enforcement practices are understood to influence the health of drug users in a range of subtle and not-so-so subtle ways. In this model, the policy transformation process – the ways that officials put the law into practice, and how those practices are perceived by those subject to the law – is just as important as the actual wording and formal intentions of the law.

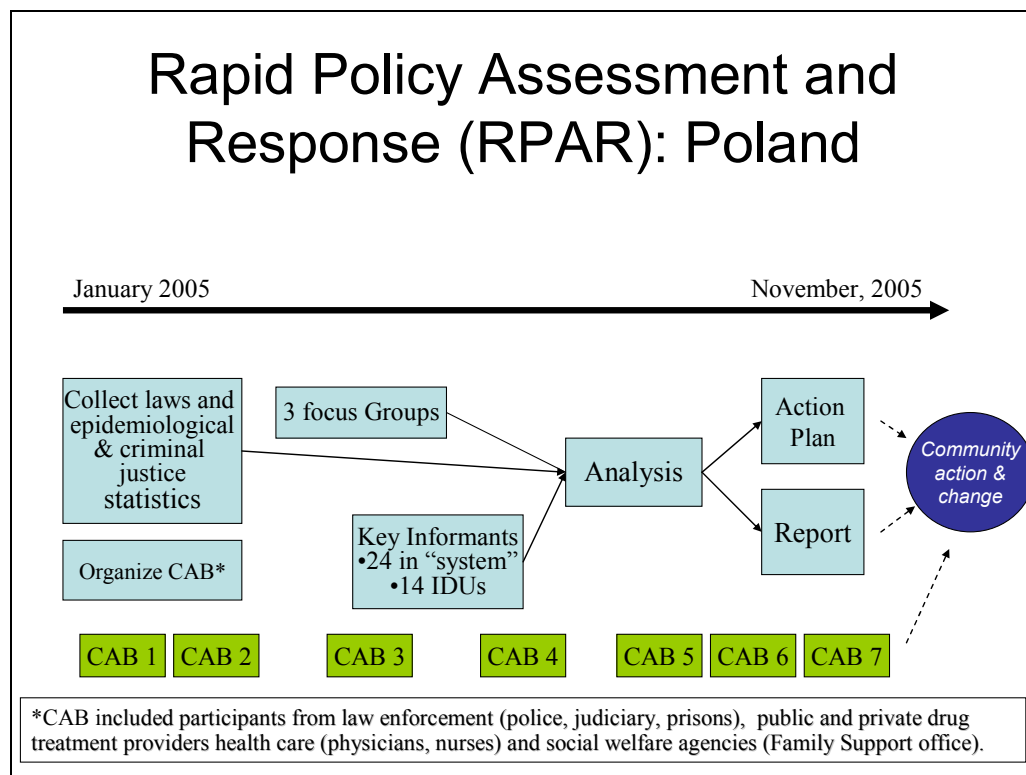


The *Szczecin RPAR* collected data on existing law related to drug law and policy, information as to how such laws are implemented and enforced by lawmakers and law enforcement officials, and epidemiological data. Preliminary work, such as getting approval from responsible ethics committees, team recruitment and training began in March, 2004. The RPAR began in January, 2005 and was completed in November, 2005.

Existing Data

The first three months of the RPAR were devoted to collecting laws in a variety of domains (see Appendix V), as well as existing data on drug-related diseases and the operating of the criminal justice system. At this time, the CAB was recruited and began meeting.

Rapid Policy Assessment and Response (RPAR): Poland



Qualitative Data

The RPAR team conducted three Focus Groups. The first Focus Group included drug treatment providers and clinical health care providers (e.g. medical doctors and therapists representing the healthcare system); the second Focus Group consisted of health interventionists (e.g. those individuals intervening in crises and actively working with narcotic drug addicted individuals on a daily basis, NGO representatives seeking to support addicts and counteracting the social marginalization and stigma that drug addicted individuals face), and the third Focus Group comprised of representatives from law enforcement and criminal justice systems (e.g. police officers, prosecutors, judges, and attorneys).

The team also conducted 24 interviews with individuals in the criminal justice, public health and drug abuse systems, both at the staff and the leadership levels. These detailed interviews, which normally took 1-2 hours, probed the informant's attitudes and experiences in addiction, bloodborne disease, social services and public policy, and the actual operation of the criminal justice and social and health services systems. Similar interviews were conducted with fourteen IDUs. Informants were recruited purposively with the assistance of CAB members and through snow-ball methods.

Analysis of the Data and Action Plan

All data collected were presented to the CAB, which carefully considered the information and selected the most vital aspects to be integrated into the report. At several meetings, the research team led the CAB through analytic exercises aimed at identifying root causes of the problems identified in the

research, and developing and prioritizing feasible solutions. During the final stage, the CAB prepared an Action Plan, which included detailed planning for the implementation of each solution, divided into separate stages.

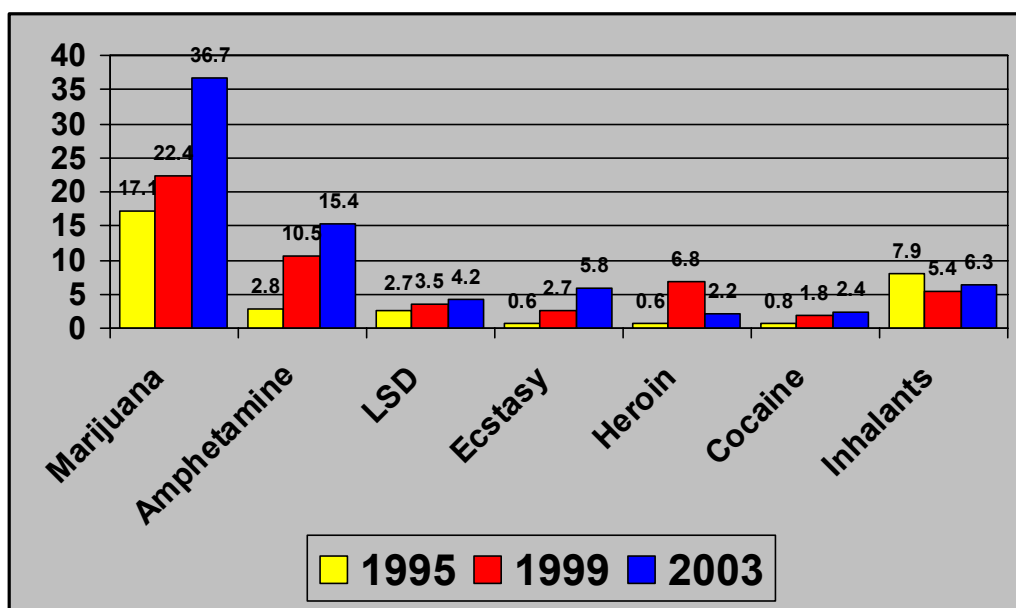


Szczecin Coat of Arms

III. FINDINGS

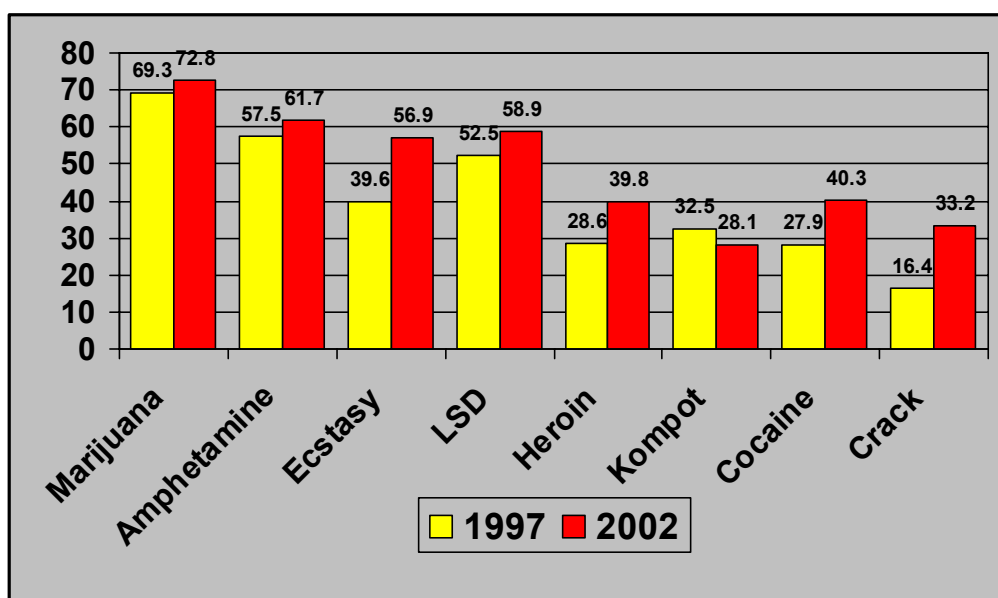
Existing data on drug use and HIV in Poland provide the context for the findings of the RPAR. Poland's HIV epidemic, which emerged in the late 1980s and early 1990s, was worst among injection drug users and appears to have been controlled by rapid introduction of prevention measures including syringe exchange, outreach and drug treatment. Nonetheless, there is a reservoir of HIV in the population, and approximately 600 new cases are diagnosed each year. HIV prevalence in West Pomerania is 0.4/100,000, with 51% of total cases arising from injection drug use. Nearly all West Pomeranian drug users diagnosed with HIV are co-infected with hepatitis C. (Further epidemiological details are provided in Appendix I.)

Drug use, particularly among young people, seems to be increasing.



Drug use among young people aged 17 – 18 (%). Source: *The European School Survey Project on Alcohol and other Drugs: www.espad.org*

Moreover, young people report that drugs have become easier to get.



Percent of respondents 16-24 (18-24 in 2002) reporting that obtaining drugs is "very easy." Source: The European School Survey Project on Alcohol and other Drugs: www.espad.org

With drug use on the rise, drugs easy to obtain, and a live reservoir of HIV and Hepatitis in the population, the conditions in Northwest Poland are cause for serious concern. In this environment, effective harmonization and coordination of health, law enforcement and social development measures are essential.

A. Criminalizing possession has not fulfilled its goals in practice

"Prosecutors have many crimes to pursue and many trials to conduct. Getting a drug user into treatment takes time, we feel pressure [to close cases]...."

-Szczecin prosecutor

In 2000, the Polish government changed its stance on the possession of small amounts of illegal drugs, criminalizing the possession of all drugs in the name of deterrence, tracking down drug dealers and encouraging treatment. The result was an extraordinary increase in registered cases of drug possession. (See Appendix II for detailed statistics.) Despite provisions in the drug laws allowing judges and prosecutors to forgo criminal sanctions against drug offenders in favor of drug treatment or rehabilitation, in reality these methods are rarely invoked. Judges largely feel that it is not their responsibility to send drug offenders to treatment and prosecutors, who take on large numbers of cases, are hesitant to take the extra time to place addicted defendants into treatment programs. Although most people charged with minor drug crimes are not sentenced to prison, many people with addiction problems are sent to prison where there are long waits for drug treatment. Upon release, drug offenders find that

there are weak reintegration programs, and as a result, it is difficult for released prisoners to find a job. Many are victims of addiction relapse and repeated arrest. This section of the report tells the story of Poland's drug policy reform debates and what the RPAR learned about the actual implementation of the policy in the Szczecin region.

1. Legislative history of drug trafficking and possession

In 1985, Poland enacted drug control legislation that allowed the possession of small amounts of illegal drugs. That law was criticized at the time of Poland's consideration of the U.N. Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, which it ratified in 1998. All signatories U.N. Convention agree to criminalize possession of narcotic and psychotropic drugs for "production, manufacture, extraction; preparation, offering, offering for sale, distribution, sale, delivery on any terms whatsoever, brokerage, dispatch, dispatch in transit, transport, importation or exportation."¹ The Convention requires parties to take measures to arrest, initiate judicial proceedings against, and extradite those accused of drug offenses. Following the ratification of the U.N. Convention, members of Poland's legislature debated more stringent criminalization for possession of illegal drugs, arguing that criminalization would deter drug abuse in young people, would increase opportunities to enroll addicted persons in treatment centers, and would increase the ability of law enforcement officers to apprehend drug traffickers and dealers.

In the lead-up to ratification, the legislature passed the Act on Counteracting Drug Addiction [AOCDA] (April 1997).² The AOCDA lists the offenses related to illegal drug distribution. For example, Art. 40 of the AOCDA lists offenses such as the production, synthesis, processing, or reprocessing of psychotropic substances, poppy milk and poppy straw (Art. 53, AOCDA 2005). Offenses listed in Art. 41 include production, processing and reprocessing, storage, acquisition or purchase of production equipment, and adjustment and adaptation of utensils for illegal production (Art. 54, AOCDA 2005). Art. 42 chiefly addresses drug importation crimes, while Art. 43 prohibits purchase and delivery (Art. 56, AOCDA 2005), Art. 44 criminalizes the preparation of illegal substances (Art. 57, AOCDA 2005), and Art. 47 addresses production, processing, and storage of production materials (Art. 61, AOCDA 2005). Art. 49-51 criminalize the cultivation and appropriation of illegal poppy and hemp (Art. 63-65, AOCDA 2005).

Possession

Art. 48 of AOCDA 1997 criminalized the possession of scheduled drugs, creating three categories of offense: 1) Basic possession; 2) Privileged possession (small amounts, i.e. for personal use), and 3) Possession of significant gravity (a considerable amount in possession, i.e., presumptively for

¹ U.N. Convention Against Illicit Traffic in Narcotic Drugs & Psychotropic Substances (1988), art. 3, para. 1.

² In July 2005, the parliament enacted an updated version of the AOCDA, but the data for the RPAR was collected when the 1997 version of the AOCDA was in effect. For the purposes of this study, the general outline of the 1997 AOCDA will be described in detail, with references to the similar provisions of 2005.

distribution). Despite the arguments of those who contended that the Convention required Poland to treat all drug possession as criminal, the 1997 AOCD A included “paragraph 4,” which stipulated that the “possession of small drug quantities or psychotropic substances for personal use [is] not liable for punishment.” After further debate, this was removed with the amendment of the act in 2000. In the most recent debates, the Ministry of Health suggested again decriminalizing possession of small quantities of illegal drugs, but the suggested was not adopted in the AOCD A 2005.

Harm reduction

The 1997 AOCD A threw into some question the legality of harm reduction programs. The criminalization of the facilitation or provision of drugs led some to wonder whether syringe exchange programs [SEPs] distributing syringes to drug users would be regarded as the facilitation of drug use under the AOCD A. In 2001, the legislature acted affirmatively to legally protect harm reduction programs by stating that harm reduction is a valued method of counteracting drug addiction, and the AOCD A of 2005 states that “drug counteraction is implemented by the appropriate shape of the social, economic, educational and health policies, with special emphasis placed on the ...reduction of the social and health harms...” Newer harm reduction measures, such as safe injection rooms, were discussed in debates but were not explicitly mentioned in the most recent amendments to the AOCD A. Nonetheless, it is widely accepted that drug use facilitation laws should not be construed to ban harm reduction programs.

Drug treatment options under the AOCD A

Voluntary rehabilitation treatment and reintegration options for drug users are regulated through the AOCD A, which provides that treatment may be led by a health clinic or by a physician in either group or individual sessions. Rehabilitation may only be conducted by a physician fully specialized in psychiatry or a certified drug therapy specialist. Social reintegration centers also exist in order to expand employment and other options for formerly drug addicted individuals.

Substitution therapy, such as methadone treatments, are authorized by the AOCD A and the 2005 version further simplified the procedures by which substitution treatment centers could be opened. While in 1997, only treatment centers implemented by public health care centers were authorized, today private facilities with appropriate premises and staff may start substitution therapy programs as well. While substitution therapy authorization for outpatients and imprisoned drug users was determined by the Ministry of Health, permission for substitution therapy in penal institutions is now granted by the Head of Penitentiary Services after a favorable recommendation by the National Bureau for Drug Prevention. Specific regulations of substitution therapy, including treatment, principles, manner of exclusion from program, and drug administration regulations are outlined in Ministry of Health regulations.³

Treatment as an alternative to incarceration for drug offenders under the AOCD A

³ Polish Official Journal No. 77, Item 873 (June 2004)

Two routes exist for a drug offender to go into treatment rather than prison. Accused offenders facing a sentence of five years or less who agree to treatment may qualify for “treatment rather than punishment,” is set forth in Art. 57 of the AOCD 1997 (Art. 72, AOCD 2005). The offender must undergo treatment at an authorized treatment center. The prosecutor, after initiating proceedings, may based upon initial treatment results decide to forgo further criminal action in an action called “conditional discontinuation or proceedings.” If the defendant evades treatment, proceedings may be reinitiated. Under Art. 56 (Art. 72, AOCD 2005), a convicted offender whose sentence of imprisonment “shall” order the offender to enter a treatment program, with ultimate execution of the sentence to be decided based on the outcome.

2. Prosecutors and judges rarely apply possible therapeutic actions

Following the enactment of stricter drug possession penalties, arrests and convictions for drug possession began to skyrocket, with a 425% increase between 2000 and 2002. The number of drug convictions in Poland increased every year. Offenders convicted for possession of “normal” quantities are punished less severely, with a smaller percentage of imprisonment penalties in this group. However, members of the drug user focus group noted that they often turned to selling drugs on a small scale in order to finance their drug habit. Statistics on convictions and arrests may be found in Appendix II of this report.

Despite the inclusion of a tool to suspend penalties or criminal proceedings against drug users who agree to undergo rehabilitation treatment, in reality, this happens in remarkably few instances and has been steadily decreasing in recent years. Of 3,761 imprisonment sentences under the AOCD in 2001, only 39 convicts were required to undergo treatment with the conditional suspension of the penalty, only 1.42% of cases. Restricted liberty, or community service is also infrequently used and is adjudged only rarely, with judges and prosecutors opting for conditionally suspended deprivation of liberty or prison sentences.

Prosecutors and judges, trained in the law and adjudication of cases, are not familiar with the medical problems of addiction. Throughout the CAB process, participants from the criminal justice field made quite revealing statements regarding their reasoning for not pursuing treatment options as opposed to criminal sanctions. Judges and prosecutors noted that the criminal justice system is not designed or equipped to handle treatment, but merely to enforce existing law; that mandatory abstinence while in prison was the best treatment for addiction; and that the “reward” of treatment in lieu of punishment showed preferential treatment for drug offenders as opposed to other defendants. “I will never take such a responsibility,” a 29-year-old criminal court judge remarked in her CAB session. “Such a person may commit another crime, and how will it influence my career?”

The CAB was identified several root causes of the problem of judges and prosecutors not referring drug addicted individuals to therapy, which included:

1. **Adherence to professional routine:** Judges and prosecutors are more familiar with the established standards and procedures of offenses where treatment options are not available or applicable. There is the perception that there is no space or time to depart from the set practice.
2. **Pressure to clear the docket:** In the Polish system, the number of concluded cases is important to the performance ratings of personnel. Treatment is not considered a closure outcome, so the case remains officially open to supervise the defendant to determine whether he is undergoing rehabilitation according to the sentence suspension agreement.
3. **Unfamiliarity with addiction:** Prosecutors and judges are not trained in the fields of medicine and psychology and many believe that treatment is not effective or that court personnel are not qualified to assess an offender's need for or ability to succeed in treatment.
4. **Misconception that imprisonment equals abstinence:** There is a sense that prisoners will not be able to obtain illegal drugs while in prison, and that this enforced abstinence will be an immediate solution to the addiction problem. However, drugs are available in Polish prisons and treatment is also difficult to obtain while drug offenders are incarcerated.

CAB members noted that the best strategy to alter the attitudes of judges and prosecutors is trainings – seminars and lectures in the possible application of treatment alternatives stipulated by legal acts – in order to inform criminal justice professionals about the realities of drug addiction, treatment, and incarceration. In order to enhance the willingness to participate and the attendance at such trainings, such training should be framed as an introduction to newly enacted amendments to the AOCD instead of labeling the trainings as strictly about drug addiction. CAB members also identified several organizations, therapists, and other community members that may be useful in conducting training sessions and encouraging prosecutors and judges to take part in training and interdisciplinary meetings.

It was clear that police, prosecutors and judges were largely unaware of the treatment and other services available to addicted people in Szczecin. Thus even those with people disposed to link offenders with treatment or other services were unsure of how to do it. Police officers in the study, for example, reported that they would gladly refer drug users to treatment if they were aware of all of the options. Addressing the root causes of this information deficit, CAB members noted:

1. **Insufficient knowledge of the scale of drug related problems:** Criminal justice professionals are unaware of the epidemiology of drug use, or of support centers for addicted persons and those professionals working to counteract addiction.

2. **Insufficient expert input when dealing with addicted patients:** Criminal justice professionals have no access to experts to aid them in handling cases, and the AOCDA does not contemplate their use.
3. **Limited therapy options:** Although services are available, they are limited. City institutions are under-resourced and there are no NGOs carrying out individual therapy and support in smaller communities outside of Szczecin.
4. **Drug addicted individuals do not seek out help:** The fact that drug addicts do not seek out help – due to fear of targeting and stigmatization – contributes to the lack of information available to be transferred between relevant authorities.
5. **Poor performance from local employees responsible for counteracting drug addiction:** A lack of action from these employees that are entrusted with drug addiction issues at the regional level results in the inability to create an efficient transfer of data and exchange.

CAB members recommended a standardized procedure of information exchange between those organizations encountering addicted individuals, beginning from the first contact (either from outreach activities, health centers, or arrest) and referring to appropriate treatment centers. Also considered crucial was a one-stop-shopping database of institutions (individuals, officials, institutions, NGOs, medical centers) trained to handle drug addicted individuals and relevant information relating the address, extent of duties of each institution, and offered treatments. This database would be offered in electronic format (Web site), as an extensive booklet, as smaller size brochures and would need to be updated periodically. Such a solution was considered feasible by CAB members who identified organizations who would potentially involved in the information transfer for the Action Plan.

Drug treatment instead of incarceration is a formal part of Poland's drug policy, but at least in West Pomerania has not been effectively implemented. Polish citizens have a right to necessary health care, and the State has a responsibility to ensure that its constitutional and legislative promises are carried out through proper training of staff and funding of services.



Szczecin City Hall
(Rafał Konkolewski, 2004
Creative Commons)

B. Rural Areas of the West Pomeranian Region Suffer From Rampant Drug Use, Poor Health Education, and a Lack of Resources

The RPAR, while qualitative in nature and therefore subject to informant bias, uncovered troubling signs of a dangerous drug-use situation in the West Pomeranian region. In the smaller towns, heroin and cocaine are prohibitively expensive, but amphetamines are cheap (with some towns featuring amphetamines at half the going price in Szczecin) and readily available. Amphetamines are thought to be a way of enhancing job performance and one's intellectual abilities and drug users tend to be younger students in primary school and high school who approach the use of amphetamines without any fear. While younger people begin taking amphetamines orally, as they become addicted, they turn to intravenous injection in order to achieve a longer lasting effect – which is crucial for those from poorer communities who want to get a larger “high” for the money. Peer pressure is another reported trigger for injecting behavior, as individuals who are hesitant to inject amphetamines are ridiculed as “weak” if they refuse to use a syringe. According to study informants, users resort to injection within three to six months.

In the face of this problem, the programs for rehabilitation, substitution therapy and syringe exchange are very low or non-existent in rural Poland. While the AOCD purports to counteract drug addiction, it does not mandate or fund local programs to disseminate information about drug addiction and the possibilities of contracting HIV from the use of dirty syringes. A “sobriety law,” a remnant of the Communist law on alcoholism therapy, is the only legal mandate for treatment; it focuses on alcoholism and was deemed ineffective by IDUs interviewed for the RPAR. “[It was] together with the alcoholics. It was stupid,” one IDU remarked, while another IDU informant commented that “There is a therapy in my town but it is useless. I was treated with alcoholics and was individually consulted twice a month.”

Other services are equally problematic. There are still heroin users in rural areas, but those seeking methadone treatment must resort to deception in order to receive substitution therapy that is available to Szczecin residents. “I am glad that I managed to get an address in Szczecin,” one opiate user noted. “It took me three months to do it. Now I will be in the program.” Since communities in the rural regions are very tight-knit, IDUs are hesitant to purchase new clean injection equipment from pharmacies in the fear of recognition and stigmatization and pharmacies are reluctant to sell syringes to young people. As one IDU put it, it is “hard to buy small needles because pharmacy sellers know that we use them to inject drugs. So they say that there aren't any small needles. And, beside that, if someone buys equipment in the pharmacy, everybody in town will know that he takes drugs. No, thanks.”

NGOs do not have the presence in rural Szczecin that they do in the city, and therefore there is no IDU outreach or communications with members of local authorities. Local information exchange amongst institutions and NGOs in Szczecin and in the communities of the greater West Pomeranian region is not satisfactory, according to study informants. With no central information office to provide information about detoxification therapy, prevention methods, social support and reintegration programs, it is difficult for communities to obtain assistance in providing vital public health information to residents.

While drug education is offered in the high school, by that time many young people have already experimented with illegal substances. Similarly, knowledge about HIV infection in rural areas is also quite low, with many IDUs commenting that they are not at risk because they do not share needles with strangers or inject opiates. Interviews with IDUs revealed a lack of knowledge of the relation between blood borne infections like HIV and Hepatitis and injecting drugs, which leads to risky behaviors and needle sharing. The knowledge of methods of HIV infection and dangers of intravenous drug use is significantly lower in the rural communities as opposed to in the city of Szczecin.

Reasons for widespread amphetamine use in the smaller towns in the Szczecin region

When informants were questioned about the reasons for such widespread use of amphetamines, three main factors were mentioned: the large scale of unemployment in the region, the lack of alternative after-school activities for youth, and an imbedded feeling of hopelessness regarding the future. It was discovered that in one IDU's neighborhood, only two of the ten families have members who are employed, the rest surviving on unemployment benefits and that sports and other activities are not available or popular.

When asked to find the root causes with respect to the problem of amphetamine drug use in the smaller cities and rural regions surrounding Szczecin, the CAB indicated the following causes:

1. **Lack of NGOs:** There are no NGOs supporting drug users or addressing drug-related issues in small towns and villages in order to increase the familiarity of local people and authorities with addiction and public health issues related to IDU.
2. **No obligation to diagnose and educate regarding drug problems:** Until the July 2005 amendment of the AOCDA, local communities were not required to create programs to counteract drug addiction. Thus, the only opportunity for treatment has been in programs designed for those with the very different problem of alcohol addiction.
3. **Lack of separate drug programs for alcohol and drug addiction has led to lack of experience in the field:** Communities are not experienced in creating programs for the rehabilitation of drug addicts since there has been no national or financial impetus to establish such programs.
4. **Local authorities do not provide financial incentives for NGO involvement:** Therefore, NGOs have less means with which to potentially jumpstart programs related to drug policy and the counteraction of drug use. When the problem is not considered at the local level, it likely means that there is not an acknowledgement that there is a drug problem in the area. This ignorance of widespread amphetamine use and infectious disease transmission in IDUs leads to a lack of program development and support.

5. **No anonymous needle exchanges or purchase points leads to shared needles amongst IDUs:** Drug users, fearing stigmatization in their small communities, tend to conceal their status and are therefore more difficult to reach in order to conduct outreach activities.
6. **Invisibility of the problem at the community level:** Because addicts are a hidden subculture in small towns and rural villages there is often ignorance of an addiction problem and therefore, there is a lack of interest in drug rehabilitation and drug policy.

The urgent need now is to undertake a thorough and extensive diagnosis of drug use patterns in small communities, which will require initial diagnosis, surveys, and interviews with drug users, therapists, health service workers, and other individuals involved in the process. In order to implement needed outreach in rural communities, considerable financial means will be necessary for training staff and providing salaries for outreach personnel. Adequate preparation for the outreach program will be necessary as the drug problem is a difficult and embarrassing subject that evokes strong emotional reactions. The experience of drug rehabilitation centers and NGOs in working with drug addicted and marginalized individuals and for the training of outreach workers. However, the CAB noted that such actions would be feasible given preparation and financial investment.

The CAB also discussed the specific root causes for the widespread lack of information about and interest in rural drug use. Several were identified:

1. **Lack of NGOs:** Lack of NGOs targeting drug related problems means there is little health education given to drug users and potential users.
2. **Educational campaigns are wrongly addressed to older teenagers:** Drug education is solely given to those students in high school, but RPAR interviews indicated that injection drug use is occurring amongst children 12-to-14-years-old. Earlier drug education may be necessary in order to reach potential drug users before they become addicted.
3. **The quality of educational campaigns in schools is poor:** Lecturers do not have sufficient knowledge on the health risks and dangers of injection drug use.
4. **National educational campaigns do not reach towns and villages:** Drug education programs sponsored by the Polish National Bureau for Drug Prevention are not widely implemented in rural Szczecin, probably due to the impossibility of a drug problem in the region.
5. **Drug users do not view the use of certain drugs as problematic:** The concept of a junkie is still identified with the use of “kompot,” or Polish heroin and therefore drug users do not consider the use of drugs such as marijuana, Ecstasy or amphetamines to be anything more than recreational use.

6. **No alternative activities available for youth:** There is a lack of sports, recreational, and other activities during leisure time. Participants noted that in some cases it is cheaper to use drugs than go swimming, as amphetamine prices in rural areas are cheap and access to gyms and swimming pools is limited.
7. **Feeling of hopelessness leads to no personal development:** Pessimism regarding educational and work opportunities is rampant in interviewed drug users and many believe there is little chance of personal and professional development.

In addition CAB members identified the following root causes relating to engaging in risky behaviors during injection drug use:

1. **Little knowledge of the risks posed by injection drug use:** The RPAR analysis revealed that IDUs believe that infection is limited to the injection of opiates and that amphetamine IDUs are convinced of their safety.
2. **Limited access to sterile injection equipment:** Pharmacies are reluctant to sell needles and injection equipment to those who are not buying legal medication at the same time.
3. **Shame:** The stigma of being an IDU in a small community leads to IDU hesitance to buy injection equipment in pharmacies.
4. **Lack of needle exchange programs:** There is no needle exchange program [NEP] available in the outlying areas of Szczecin.

CAB members believed that finding the funding for outreach work and the preparation of local communities to deal with the problem was the necessary first step in handling the problem of lack of knowledge regarding addiction issues and related health risks. Enlisting the help of NGOs such as TADA and MONAR, which have extensively campaigned in Szczecin in the past, and gaining the support of the National Bureau for Drug Prevention, would be crucial.

When addressing the feasibility of possible solutions regarding curtailing the incidence of risky behaviors in IDUs, it was determined that the creation of a needle exchange program was feasible in small cities. The task could be implemented by MONAR, an NGO with experience in establishing NEPs. Other institutions and organizations would also be contacted in order to gain other perspectives on the problem.



C. Prisons: Insufficient Drug Treatment, HIV Prevention and Reintegration Services

Drug Treatment in Prison

Prisons in the region do offer drug treatment, but space is limited. The time from admittance to a penal institution to actual enrollment in therapeutic procedures can be long, with some people not admitted at all before release from prison. Those informants who were in therapy while imprisoned were satisfied, but many resumed drug use following the return to their old environment and lifestyle.

HIV Prevention and Risky Behaviors in Prison

Discussion of HIV is regarded as taboo in prisons. IDU informants told the RPAR team that being identified as HIV positive in prison equals a “social death” and may pose a risk of violence. In prison, junkies are low in the hierarchy and HIV-positive individuals are at the absolute bottom, and therefore IDUs do not disclose their status to fellow prisoners. Yet risky behaviors in prison, such as tattooing, are widespread. Since tattooing in prisons is de facto prohibited, there are no means of procuring sterile equipment. Drugs are traded on a regular basis in prisons, with supplies provided by family and friends during prison visits. Additionally, the prison also becomes a place where drug use is initiated, with data showing that some people become addicted in prison – contrary to the belief of criminal justice professionals that a prison sentence equates mandatory abstinence.

Options upon release from prison

It is a challenge for formerly addicted prisoners and users to reintegrate into society and find worthwhile employment. Unemployment is a large concern in Szczecin and especially in the smaller communities surrounding the city. Many drug offenders released from prison have little or no experience in looking for work or interviewing. Given the stigma of drug addiction, some are reluctant to use the Unemployment Office in order to search for employment. CAB members decided that support from employment counselors should be provided in a friendlier environment where former addicts would not be afraid to visit, perhaps at the site of a drug therapy facility, methadone clinic, or needle exchange. The same services provided by the Unemployment Office would be available, as well as the same staff, but at a more neutral location. CAB members noted that this solution would be feasible if Unemployment Office employees are familiarized with the results of the RPAR project and the reasons why former are reluctant to visit the Unemployment Office. Funding would need to be targeted from relevant governmental groups and organizations.

D. There is a Lack of Legal Services in the Criminal Justice System and Unfamiliarity with the Law Amongst Drug Users

While proper implementation of drug laws is, in the first instance, the job of police officers, prosecutors and judges, defense attorneys also have a role to play. The RPAR found signs that people charged with drug offenses do not have the level of representation they need or to which they are entitled as citizens of a democratic European state.

Quality of representation in Szczecin

"I had an attorney paid by the state. Now I think it would have been better if he hadn't been there. He didn't do anything."

-Male intravenous drug user, 46

In Poland, an accused defendant is given the right to an attorney, a fundamental right in the justice system. Legal defense counsel is mandatory in trials involving minors, those who are handicapped, and if there is a justified doubt as to the defendant's mental capacity. A defendant must be provided with an attorney during the court of first instance if one has been charged with a serious crime or has already been deprived of liberty. A public defense is provided if the defendant can prove poor financial status and the inability to finance a defense without depriving himself or herself and his or her family of the basic support. Professional defense lawyers can not help the accused present his or her best case, but can also help the defendant charged with a drug-related offense to request the court to apply therapeutic alternatives to prison sentences, according to provisions in the aforementioned AOCDA. (Laws with respect to criminal trials are further explained in Appendix III.)

IDU informants were greatly dissatisfied with the quality of legal representation they received. Most noted that their appointed defense counsel were inactive, neutral, or even detrimental to their cases. One prosecutor reported that judges tend to be more sympathetic to defendants who do not have legal counsel, as they become frustrated of the laziness and incompetence of appointed defense counsel. IDUs said that they did not have a chance to review their case with their attorney prior to trial and were not informed by defense counsel that they could be sent to treatment instead of standing trial with the threat of a prison sentence if found guilty of drug crimes.

Lack of free legal clinics in Szczecin

Drug users often have related, non-criminal legal problems involving other branches of the law including labor and administrative law. The lack of free legal advice for addicted individuals is a problem, though many defendants may obtain free legal advice in Szczecin provided by the Department of Law and Administration at the University of Szczecin. However, many drug defendants do not seek such advice as they are reluctant to appear on the university campus.

CAB members noted that legal clinics to provide pro bono, free of charge legal advice to drug users facing legal problems is advisable and such support should be provided onsite at an NGO such as a drug therapy center or syringe exchange. Staff would include law students or young lawyers with regular duty

hours (such as twice a week) supervised by a weekly on-call lawyer experienced in drug-related cases who could handle more difficult casework. The CAB discovered that the only obstacle to the feasibility of this solution would be the funding of such legal services. Funding could be provided by the city of Szczecin, West Pomerania authorities, the National Office for Counteracting Drug Addiction, or European Union funds. The new legal services organization would need to apply for the sponsorship of one of the abovementioned possible financial sources.



RPAR team member and residents, MONAR therapeutic community near Szczecin

IV. ACTION PLAN

Members of the CAB developed an Action Plan and agreed to work with the research team following the conclusion of the RPAR to put elements of the plan into practice. The plan includes the following main elements.

A. Add a section entitled “Drug Counteraction” to the budget of Szczecin for FY2006

This will enable the earmarking of funds for certain projects related to drug counteraction in order to fulfill the goals of the AOCDA and provide financial support to some of the proposed projects in the remaining sections of the Action Plan.

B. More support for small towns and communities outside Szczecin

Initial conference

The first step in addressing more support for small communities outside Szczecin is organizing a conference of target communities in order to discuss problems found during the CAB sessions and illustrated in the RPAR process. First, representatives concerned with drug issues in rural communities were targeted and invited to participate. The presentation of RPAR results with respect to small communities will be highlighted, including IDU behavior, risky behaviors such as needle sharing, the young age of drug use initiation, lack of knowledge of a drug problem and patterns of drug use, and lack of support for substance addicted individuals. The purpose of the conference will be to educate relevant authorities about the discrepancies between treatment options in Szczecin compared to surrounding towns and the strong benefits of drug counteraction programs.

Local Community Action Boards

Research team and CAB members will conduct meetings to discuss some of the strategies outlined in the RPAR report, particularly with respect to the transfer of responsibility of a number of issues. Local Community Action Boards will be created in each of the participating communes, thus transferring authority to local communities and organizations. Initially, surveys will be conducted in order to diagnose drug use patterns in the communities, and will be distributed at schools, health clubs, and health care centers. Outreach workers will be selected and trained according to procedures employed by drug addiction treatment centers in Szczecin and will distribute appropriate educational materials provided by NGOs in Szczecin and the National Bureau for Drug Addiction. The information provided should be comprehensible by the intended user and should only include information that is relevant to the real problems at hand. For example, information regarding cocaine use should not be in any educational materials since it is not used at smaller communities outside Szczecin.

Needle Exchange Program [NEP]

Following initial conferences and meetings and after local community action boards are convened, a needle exchange program like that in Szczecin should be considered by local authorities. Such a program would need to be financed by the budget of the local community, but is feasible because local authorities would be in close communication with members of a local CAB and because the AOCDA requires local communities to provide a quota in the local budget for measures counteracting drug addiction. The type of NEP and procedures to start and operate such a program would be solely the responsibility of the local community.

Information about infectious disease

Educational campaigns regarding the risks of contracting HIV, Hepatitis and other infectious diseases will be initiated, particularly in the small towns and villages of West Pomerania. Such campaigns will be meticulously planned and targeted to those engaging in risky behaviors such as intravenous drug use. The campaigns should be focused on outreach with direct verbal information provided in endangered environments as well as the distribution of educational leaflets. Such programs should be operated with the cooperation of local authorities, treatment providers, and law enforcement personnel.

C. Seminars for judges and prosecutors

A seminar course for criminal justice authorities has been developed and could be tailored to fit the needs of some of the judges and prosecutors who were interviewed for the RPAR project. The seminars must be programmed to meet the real needs of the informants, who seek to better understand the problems of drug addiction and the available treatment options that may be pursued in lieu of prison sentences for drug offenders.

The RPAR research team will conduct a preliminary seminar in Szczecin and based on feedback, new lecturers for the seminars will be chosen, as well as a location. The costs of such a seminar will be calculated and City Hall will be applied to for support. However, a permanent sponsor for the series of seminars will be sought in order to cover a majority of West Pomeranian judges and prosecutors. Potential sponsors include the National Bureau for Drug Prevention and monies from European Union Structural Funds.

D. Information transfer regarding support organizations and centers

Collecting information where drug addicted individuals may turn to for counseling and support was identified as a crucial measure by the CAB. Since many of these groups were represented on the CAB, it should not be difficult to collect information about a wide array of institutions and organizations in Szczecin and surrounding areas offering help to drug addicted individuals.

After collection, the data will be organized in a summarized version and a complete version, to better provide information in a wide variety of forms, including brochures and leaflets. Police officers participating in the RPAR project commented that abbreviated information about institutions providing support to drug offenders would be extremely useful, reliable, and convenient. A larger publication would be available from the Szczecin City Hall.

CAB members will participate in disseminating the brochures, leaflets and pamphlets throughout the area and provide explanations regarding the usefulness of the provided materials.

E. Free of charge legal advice services

Free legal advice will be provided to those accused of drug-related offenses at NGOs in Szczecin where drug addicted individuals are already familiar. The method of legal counselor recruitment must be identified as well as targeting legal academics who might be involve in such a pro bono legal counseling program. Within six months, the costs of a free legal clinic will be calculated and possible financial sources will be targeted in order to provide funding for legal services. Afterwards, an application to local authorities will be made.

F. Employment Counseling

Another large problem that surfaced during RPAR analysis was the lack of reintegration services to rehabilitated drug addicts emerging from treatment centers or prisons. The most vital reintegration service is that of employment counseling, which is necessary in order to prevent former addicts from resorting to the sale of drugs as a means of employment where there are no other options. Cooperation with professional employment counselors will be necessary, particularly those at the Municipal Unemployment Offices, who will be solicited to provide counseling at Szczecin NGOs, which former addicts are familiar and comfortable with. CAB members will meet with employment counselors in order to discuss the organization of such a program and appropriate budget sponsors will be targeted and solicited

G. Other long-term actions

Reevaluating the AOCDA

Other problems identified include the current legislation covering drug offenses, the AOCDA. Concerns were raised whether the zero-tolerance policies with respect to possession are fulfilling the aims of the legislation – counteracting drug addiction. In the future, analysis should be conducted in order to determine whether there should be an adjustment to drug counteraction policy in Poland allowing for precisely targeted policies addressed to specific recipients and differentiated according to local needs. For example, drug policy with respect to recreational drug users of drugs such as marijuana and Ecstasy

should be markedly dissimilar from drug policy with respect to intravenous drug use because of the differences in risk, usage patterns, and clientele.

Outlining strategies for defense counsel

CAB members suggested that a strategy based upon the findings of the RPAR project could be drafted and published in order to provide defense counsel with the most effective ways of representing accused drug offenders during a criminal trial. Since defense counsel rarely apply for therapeutic measures available under the AOCD, such options would be outlined and their effectiveness highlighted in such a paper. The publication of such a “manual” for defense counsel would hopefully inspire defense attorneys to formulate a strategy that is best for their clients.

In the course of the next year, the RPAR team and CAB members are committed to seeking funding and other necessary support for the implementation of the Action Plan, and to continuing to disseminate information about how national policy on the books is actually working on the streets of Szczecin and Western Pomerania.



Drug Law, Drug Use and Health in Szczecin and West Pomerania, Poland

Rapid Policy Assessment and Response

APPENDICES

Appendix I: Epidemiological Data

HIV infection – Poland

Between 1985 and 2005, 9,342 citizens of Poland were confirmed to be infected with HIV-1. Twenty-six percent of those infected were female. According to the official data, among infected individuals, 14.2% acquired the infection by homosexual contact; 17.4% by risky heterosexual behavior; 55.6% during injection drug use; 3.2% via vertical contacts; and 0.2% through iatrogenic means. In 9.6% of cases, the route of infection remains unknown. Some 1590 cases of AIDS were diagnosed during this period with 746 deaths. Each year approximately 600 new infections are diagnosed, with overall HIV infection prevalence at 0.38 per 100,000 inhabitants of the country.

Since 1992, when HIV testing of the Polish population began, the number of the newly discovered infections has steadily decreased. This public health success may be linked to the control of the disease among IDUs, where harm reduction and drug treatment measures have helped drive down infections despite the fact that drug use is increasing. On the other hand, the number of the newly diagnosed infections due to other routes of transmission is continually growing, forming the rising curve for heterosexual contacts and vertical infections, with slight decreases in percentage of infections by homosexual contacts.

Figures 1 and 2: HIV infection in Poland – route of infection

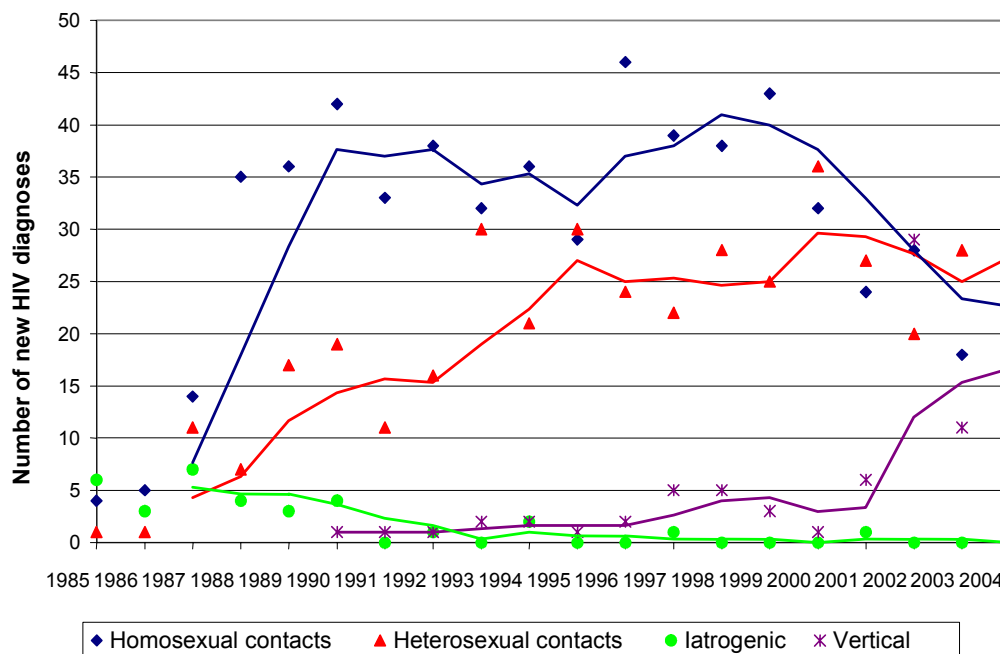
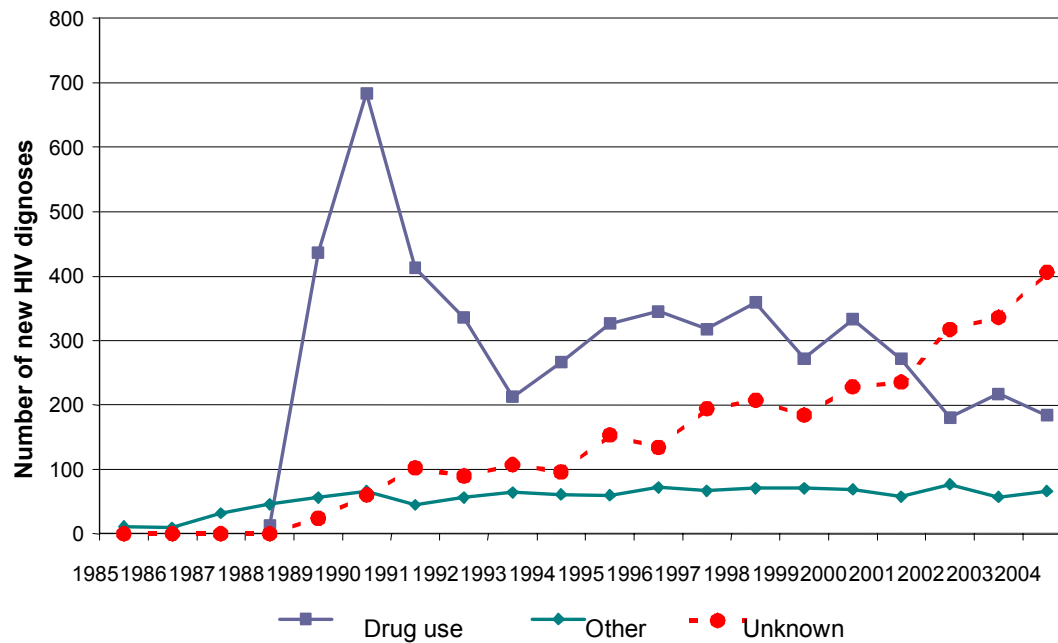


Figure 3 illustrates AIDS morbidity in 1986-2003, which has not altered significantly within the last ten years. Prevalence fluctuated from 108 to 135 of cases with no predictable tendency indicating decrease or increase.

Figure 3. AIDS prevalence

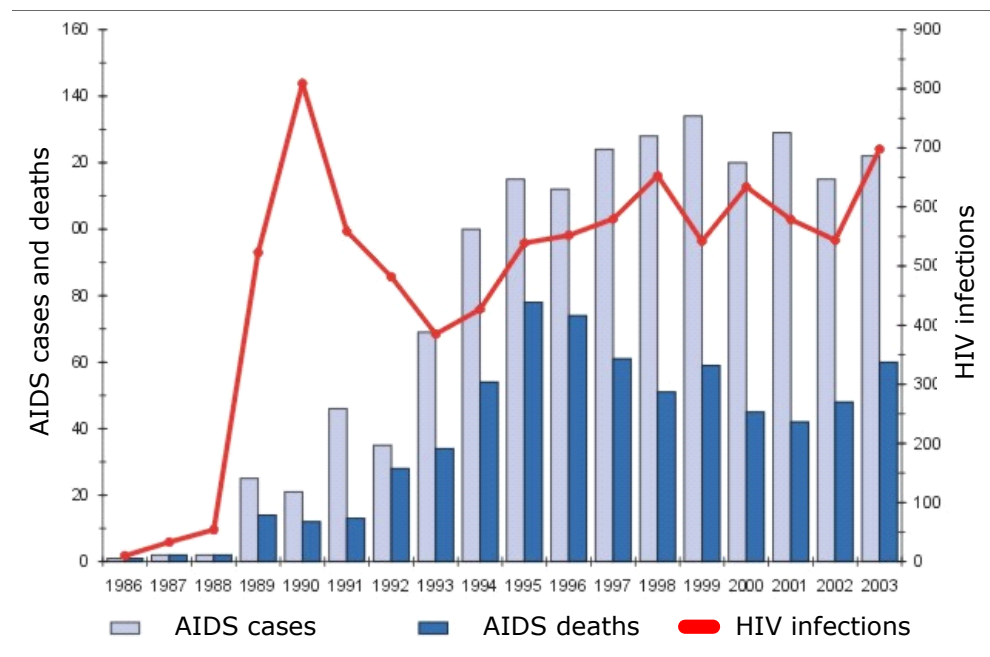
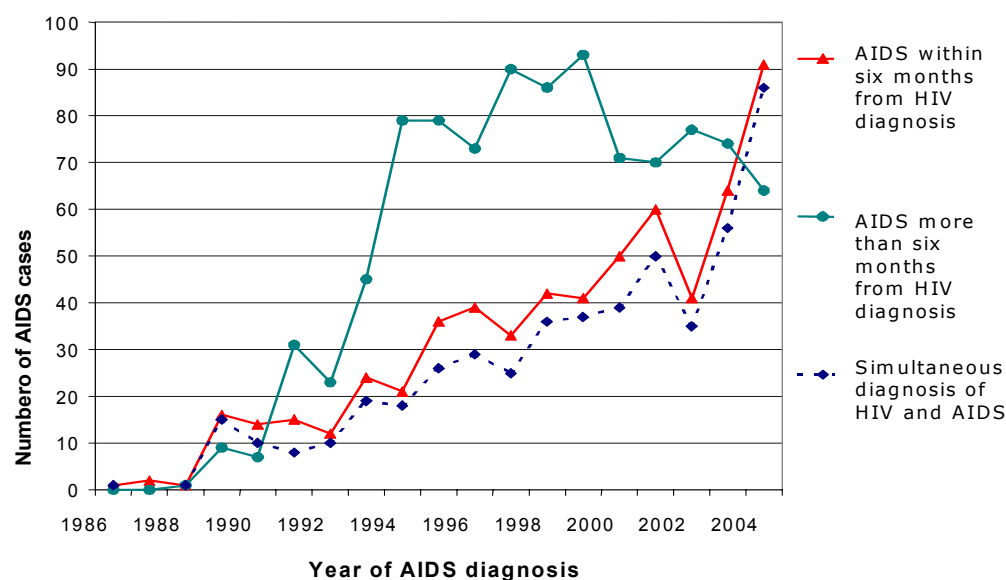


Figure 4 shows the relationship between HIV and AIDS diagnoses, a measure of the availability of health care services to people at risk of HIV. It must be emphasized that, sadly, there is a notable tendency to discover the fact of HIV infection in the late stages of AIDS. Moreover, the collected data and personal experience of the research team members indicate the possibility of underestimation in the number of AIDS cases.

Figure 4. AIDS cases versus confirmation of HIV diagnosis



HIV infections in the Westpomeranian Voyvodeship

HIV morbidity in the region is 0.4 per 100,000 inhabitants (sixth place among fifteen Polish regions) and has remained stable since 2000. From 1985 to 2005, 600 HIV infections were diagnosed in the region (594 of Polish citizens aged 19-64, with 31% of women and 69 % of men) and 51% were individuals infected due to injection drug use. Specialist care is also provided for six HIV positive children. For comparison, in the Zachodniopomorskie Voyvodeship, 91 AIDS cases and 59 AIDS deaths were noted during this period.

Antiretroviral drugs resistance - Poland

In Poland, the number of resistant strains of HIV before initiation of antiretroviral therapy is proven to be higher, reaching 14.1%. Among patients treated with antiretroviral drugs, resistance to at least one class of drugs exceeds 70%. Tendencies observed in Poland such as the increase in number of heterosexual transmissions, late diagnosis of HIV infection, and failure of the antiretroviral treatment in certain groups of patients will favor spread of the resistant HIV-1 strains.

Resistance to the antiretroviral treatment – West Pomerania

Data regarding the HIV resistance among patients treated in Szczecin are not complete. 80 individuals have been genotyped for HIV-1 resistance in the center. In 25 patients, randomly selected, analysis was performed before the initiation of the antiretroviral treatment, with only one person being infected with a resistant HIV-1 strain (one class of drugs only). However, among patients receiving

combined antiretroviral treatment, the resistance in two classes of drugs has been found among approximately 50% of patients.

Tuberculosis and data on TBC drug resistance in Poland.

Tuberculosis has been steadily declining from 16,000 cases per year in 1996 to 10,124 cases in 2003. Multi-drug resistant tuberculosis is diagnosed in fewer than 5% of patients. On the national scale, tuberculosis remains the most common AIDS-defining diagnosis among HIV infected individuals in the last ten years.

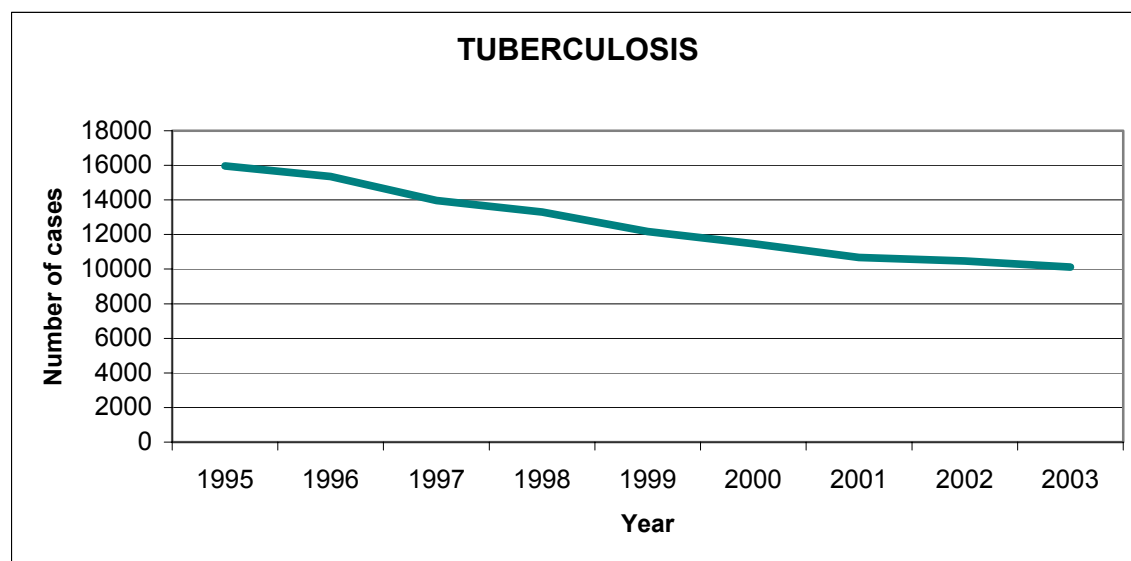


Figure 5. Prevalence of tuberculosis in Poland

Tuberculosis and data on TBC drug resistance in West Pomerania

Among HIV infected individuals treated in Szczecin through the end of 2004, tuberculosis (both pulmonary and extrapulmonary) was diagnosed in 31 patients, 15 of whom acquired the infection by injection drug use. Thus, 30% of CDC category C defining cases were due to tuberculosis. Among patients with AIDS, only one case of MDR tuberculosis was confirmed, in an Armenian citizen, residing in Poland for the last 16 years.

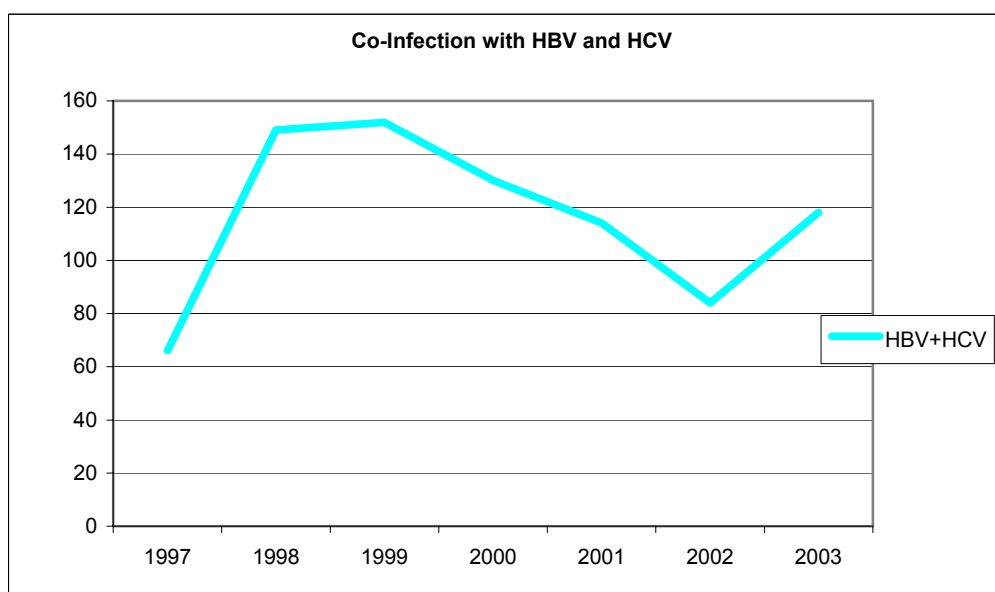
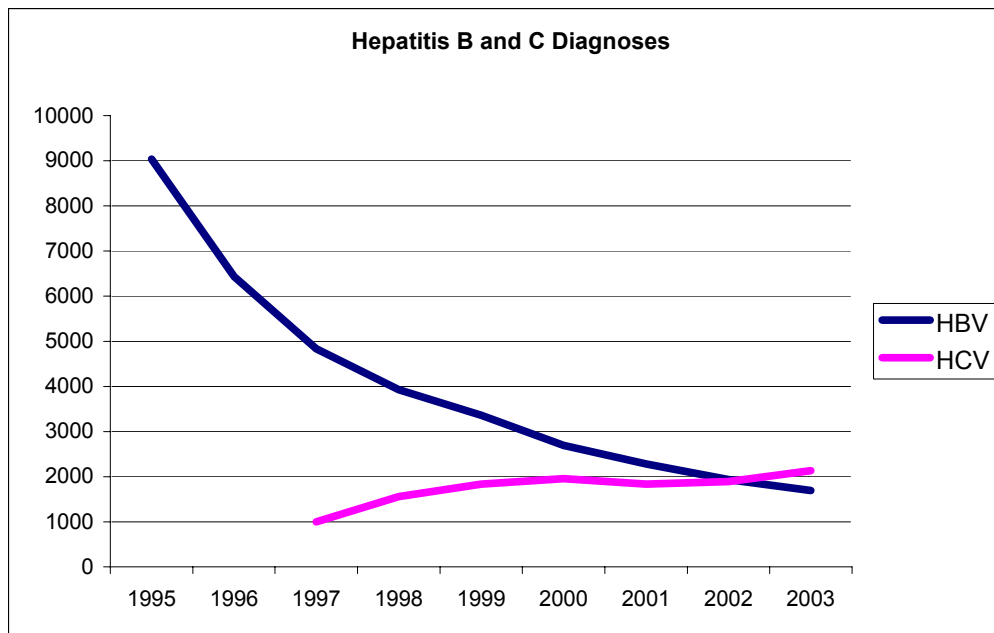
Hepatitis B and C

Data on Hepatitis B and C infection in Poland

Prevalence of Hepatitis B cases declined substantially between 1995 and 2003. This tendency may be mostly due to widespread vaccination. Hepatitis C infection has increased from 998 cases in 1997 to 2,136 cases in 2003. It must be noted that the diagnosis of the hepatitis C in blood donation stations began in 1992, thus blood borne products were not screened for the virus before. Many iatrogenic infections were caused by the transfusion of blood and blood products before screening was

implemented. It is widely known that hepatitis C infections in the general population are heavily under-diagnosed, with certain further increase in new HCV diagnoses.

The number of Hepatitis B and C co-infections has changed from 66 cases in 1997 to 118 in 2003. In 1998-99 the prevalence increased to 150 cases per year with a subsequent drop until 2002. The number of diagnoses rose again in 2003.



Data on Hepatitis B and C and HIV infection in West Pomerania

In 52% of HIV positive individuals there is co-infection with the Hepatitis C virus. In virtually all patients who acquired HIV due to intravenous drug use, anti-HCV antibodies were present. However, in the remaining HIV-positive subjects, HCV co-infection is uncommon (HCV is concomitant to HIV only in 5 of 284 patients). In 8% of HIV infected individuals treated in Szczecin, HbsAg were present, but serological markers of the HBV infection in the past (anti-HBc total) were present in 68% of patients.

Estimates concerning number of drug users who are clients of local NGO and therapeutic institutions in Szczecin.

Associations supporting injection drug addicts in rehabilitation and maintenance of abstinence

The number of psychoactive drug addicted individuals who seek help at local branch of MONAR in Szczecin has decreased lately, but more patients participate in therapeutic programs offered by the association. In 2003, 518 people were supported, of whom 407 participated in the therapy, while 111 refused; 319 families received services. In 2004, the number of patients fell to 418 individuals (and 343 families), but 574 individuals agreed to undertake either individual or group therapy and only 58 refused.

Associations supporting people living with HIV/AIDS

An association aimed at supporting HIV seropositive people served approximately 100 people taking part in permanent or temporary meetings, integration trips and holidays, and trainings and conferences. However, the number of injection drug users participating in this support group does not exceed 10%.

Drug detoxification wards

In 2004, 242 patients were admitted for drug detox therapy. The number of individuals in out-patient care in 2004 was 702, with 32 patients obligatorily treated on the appointment of the court.

Methadone therapy

The therapy was initiated in 1998, and through 2003 a total of 169 patients were admitted. In 2003, 65 patients were treated with substitution therapy, including 15 females. Eleven individuals awaited admittance for treatment. People with HIV comprised 41.4% of the treatment population, with 51.4% being carriers of the hepatitis B and/or C virus. In 2000 and 2001, the greatest number of patients was admitted – 99 patients. Currently a constant decrease is noted – approximately eight or nine individuals per year. The number of new clients is limited as most of the treated are long term, “experienced” injection drug users, addicted mostly to Polish heroin or “kompot.”

Appendix II: Police and Law Enforcement Data

Table 1: Drug related offences detected in 1997-2003. National data for Poland. Source: Chief Police Headquarters, Warsaw

Year	Number of offences	Legal regulation in force
1997	7915	AOCDA 1985 / AOCDA 1997
1998	16432	AOCDA 1997
1999	15628	AOCDA 1997
2000	19649	AOCDA 1997
2001	29230	AOCDA 1997 with amendments from October 2000
2002	36178	AOCDA 1997 with amendments from October 2000
2003	47605	AOCDA 1997 with amendments from October 2000

Above data show the number of detected drug offences in 1997-2003, noting the major changes in the law over this period. More information on the Act on Counteracting Drug Addiction [AOCDA] may be found in the body of this report. From its passage in 1985 until 1997, drug possession was not criminalized by this act. In 1997, a revised Act on Counteracting Drug Addiction was enacted, criminalizing drug possession, but excluding small quantities of psychoactive substances for personal use. In October 2000, the AOCDA 1997 was itself amended to remove the exclusion for small amounts and render every instance of drug possession a criminal offense.

The effect of the 1997 revision of the AOCDA was an insubstantial increase of the detected offenses. There was a notable rise after implementation of the AOCDA 1997, and further escalation after the amendment in 2000. The next table distinguishes between drug dealing and drug possession. It shows that between 1997 and 2002, arrests for dealing increased by a factor of 6, the number of possession arrests in 2002 was 374 times greater than the number in 1997.

Table 2: Offences of drug dealing (1) and possession (2) detected in 1997-2002. National data for Poland. Source: Chief Police Headquarters, Warsaw

Year	Drug dealing (1)	Drug possession (2)	Legal regulation in force
1997	3507	32	AOCDA 1985 / AOCDA 1997
1998	10762	1380	AOCDA 1997
1999	10305	1896	AOCDA 1997
2000	13278	2815	AOCDA 1997
2001	18873	6651	AOCDA 1997 amend. October 2000
2002	20482	11960	AOCDA 1997 amend. October 2000

The number of detected offences of the psychoactive substance dealing and offering has been rising constantly. One of the rationales offered for penalization of small drug quantity possession for personal use was the possibility of using arrest or the threat of arrest to obtain information about drug dealers. The

data cannot support or undermine this rationale, but they do indicate continued law enforcement efforts directed against the drug trade. These increases must be interpreted in light of other data reported here and elsewhere suggesting that drug use in Poland, and therefore the market for drugs, is increasing.

Table 3. Detected offences of psychoactive and psychotropic substance trade in 1999-2003.
National data for Poland. Source: Chief Police Headquarters, Warsaw

Year	1999	2000	2001	2002	2003
Number of detected psychoactive and psychotropic substance trade related offences	1714	1417	1809	1931	2 064
Ratio [%] in comparison to 1999	100	83	106	113	120

There is a similar situation related to the number of detected psychoactive and psychotropic substance trade offenses. The number, with the exception of 2000, systematically increases.

Table 4. Detected offences of narcotic drug possession in 1998-2003, National data for Poland,
Source: Chief Police Headquarters, Warsaw

Year	Number of offences	Ratio [%] compared to 1999	Increase [%] from the previous year
1998	1,380	73	N/A
1999	1,896	100	137
2000	2,815	148	148
2001	6,651	351	236
2002	11,960	631	180
2003	18,681	985	156

Table 4 shows a significant increase in detected crimes of drug possession between 1998 and 2003. 1999 is the last full year in which amounts for personal use were excluded from criminalization. If data from 1999 are regarded as baseline in relation to the year 2001, when the amended act was in force the full year, the number of detected offences increased by 351%. Although the pace of increase is slowing, 2003 offenses were 985% of the 1999 levels.

Table 5. Detected drug offenses per 10 000 inhabitants. Data for Western Pomerania. Source: Regional Police Headquarters, Szczecin.

No	NAME OF THE CITY/REGION	TYPE	OFFENSES
1.	SZCZECIN	CITY	17.6
2.	KOSZALIN	CITY	10.3
3.	ŚWINOUJŚCIE	REGION	14.6
4.	BIAŁOGARD	REGION	9.5
5.	CHOSZCZNO	REGION	7.7
6.	GOLENIÓW	REGION	8.8
7.	GRYFICE	REGION	10.3
8.	GRYFINO	REGION	10.1
9.	KAMIEŃ POMORSKI	REGION	7.3
10.	KOŁOBRZEG	REGION	9.0
11.	MYŚLIBÓRZ	REGION	10.1
12.	POLICE	REGION	11.8
13.	PYRZYCE	REGION	8.7
14.	SŁAWNO	REGION	5.4
15.	STARGARD SZCZECIŃSKI	REGION	6.7
16.	SZCZECINEK	REGION	20.3

Data in Table 5 are partially inconsistent with the information we obtained from IDU and system/interactor interviews. Some of the areas where police data indicate low rates of detected drug offending were reported in the RPAR to be suffering high levels of drug use. This may reflect lack of police enforcement action in these areas, or limitations of generalizability for qualitative data.

Table 6. Convictions for drug related offences in 1997-2002 (no data for 1998-1999). National data.

Source: Ministry of Justice, Department of Statistics.

Year	Number of convictions	Legal act in force
1997	1457	AOCDA 1985 / AOCDA 1997
2000	2820	AOCDA 1997
2001	4257	AOCDA 1997 amended October 2000
2002	6384	AOCDA 1997 amended October 2000

The change in the rise of convictions is smaller than arrests dynamics of the detection increase – as indicated by data for 2000-2002.

Table 7. Convictions for making drugs available for personal or financial benefit and making drug available without this aim in 1997-2002 (no data for 1998-1999). National data for Poland.
Source: Ministry of Justice, Department of Statistics.

Year	Number of convictions for drug dealing	Number of convictions for drug sharing	Legal act in force
1997	201	85	AOCDA 1985 / AOCDA 1997
2000	887	310	AOCDA 1997
2001	1428	428	AOCDA amended 10/2000
2002	1846	605	AOCDA amended 10/2000

Drug dealing can be distinguished in Polish law from the less serious crime of sharing as a kind of “friendly favor”. The number of convictions for both types of drug supply has increased since 2000. This tendency of rise seems to contradict pessimistic opinion of law enforcement professionals regarding their helplessness in fighting against drug supply.

Table 8. Convictions for drug possession in 2000-2003. National data for Poland. Source: Ministry of Justice, Department of Statistics.

Year	Art. 48 para. 1	Art. 48 para. 2 (small amounts)	Art. 48 para. 3 (large amounts)
2000	373	127	98
Percentage [%] of total article 48 offenses	62.37	21.23	16.38
2001	959	301	152
Percentage [%] of total article 48 offenses	67.92	21.32	10.76
2002	2047	626	145
Percentage [%] of total article 48 offenses	72.64	22.21	5.14
2003	5663	1533	368
Percentage [%] of total article 48 offenses	74.87	20.27	4.86

Unlike the number of arrests, the number of convictions rose most substantially only in the basic type category, with one year even showing a decrease in the large amount category.

Table 9. Comparison of registered drug possession offences with valid convictions in 2000-2002.

Source: Chief Police Headquarters, Warsaw and Ministry of Justice, Department of Statistics.

Year	Registered drug possession offences	Valid convictions for drug possession	Percentage [%] of convictions
2000	2815	598	21,24
2001	6651	1412	21,23
2002	11960	2818	23,56

Table 9 shows a significant rise in number of detected drug possession offences, and valid convictions for them. In spite of the increasing number of arrests, suggesting a crack-down on drug dealing, the majority of those arrested for possession are not ultimately convicted.

Table 10 Comparison of valid convictions for offences with adjudicated penalties of imprisonment for offences included in article 48.1 of AOCD. National data.

Source: Chief Police Headquarters, Warsaw and Ministry of Justice, Department of Statistics.

Year	Number of convictions	Number of deprivation of liberty penalties	Percentage [%] of deprivation of liberty penalties
2000	373	338	90,62
2001	959	855	89,15
2002	2047	1797	87,79
2003	5663	4887	86,30

Most offenders convicted of basic drug possession are sentenced to a penalty involving deprivation of liberty, though the percentage has declined steadily over time. By contrast, Table 11 shows that most people convicted for minor possession are not sentenced to deprivation of liberty. Most of those convicted of possession of large amounts are sentenced to deprivation of liberty.

Table 11: Comparison of valid convictions for offences with adjudicated penalties of imprisonment for offences included in article 48.2 of AOCDA. National data. Source: Chief Police Headquarters, Warsaw and Ministry of Justice, Department of Statistics.

Year	Number of convictions	Number of deprivation of liberty penalties	Percentage [%] of deprivation of liberty penalties
2000	127	45	35.43
2001	301	120	39.87
2002	626	242	38.66
2003	1533	588	38.36

Table 12: Comparison of valid convictions for offences with adjudicated penalties of imprisonment for offences included in article 48.3 of AOCDA. National data. Source: Chief Police Headquarters, Warsaw and Ministry of Justice, Department of Statistics.

Year	Number of convictions	Number of deprivation of liberty penalties	Percentage [%] of deprivation of liberty penalties
2000	98	97	98,98
2001	152	152	100
2002	145	139	95,86
2003	368	355	96,47

These data indicate that users are less likely to be sentenced to prison than dealers, but it is probable that many of those “dealers” sentenced to imprisonment for violations of Article 48.1 are people with drug addiction who sell in a small way to pay for their own drugs. These data may also reflect the practice of police using the threat of punishment to convince drug users to cooperate in efforts to arrest and prosecute dealers. Convictions for cases of minor importance comprise of one fifth of all convictions. The punishment stipulated for the basic possession offence is a penalty of liberty deprivation for up to three years. The qualified type (large amounts) is subject to a fine and liberty deprivation up to five years. The privileged type (small amounts) is subject to the alternative penalty of fine, restricted liberty (probation), or liberty deprivation for not more than one year.

Table 13: Comparison of deprivation of liberty penalties (article 48, paragraph 1,2,3) with the suspended and absolute penalties. National data. Source: Ministry of Justice, Department of Statistics.

Legal qualification	Total number of imprisonment penalties	Suspended penalties	Percentage of liberty deprivation penalties suspended [%]
Year 1999			
Art. 48 paragraph 1	178	156	87.6
Art. 48 paragraph 2	23	22	95.7
Art. 48 paragraph 3	47	30	63.8
Year 2000			
Art. 48 paragraph 1	338	295	87.3
Art. 48 paragraph 2	45	40	88.9
Art. 48 paragraph 3	97	76	78.4
Year 2001			
Art. 48 paragraph 1	855	749	87.6
Art. 48 paragraph 2	120	110	91.7
Art. 48 paragraph 3	152	95	62.5

These data are quite noteworthy, as they show that most people sentenced to prison, even for possession of large amounts, are in the end given suspended sentences. It is likely, that narcotic drug or psychoactive substance addicted person, sentenced to conditionally suspended sentence, would sooner or later be apprehended again for drug possession. Moreover, it may be assumed that the probability of consecutive arrest is higher in case of drug addicted user than a dealing person. Therefore, actual imprisonment would be more common among petty drug consumers, including addicted individuals, than people possessing drugs for sale. Drug addiction more is “socially noticeable” and easier to track than drug dealing.

The total increase in the number of offences and then legally valid convictions for them may be interpreted in two ways. Firstly, it may indicate that both law enforcement and justice institutions become more effective against drug related issues implementing tools provided by the criminal law. Conversely, it

may be a result of the general increase in number of committed offences, related to narcotic drugs and psychotropic substances.

Table 14. Legally binding obligation to undergo treatment for adults validly sentenced for suspended liberty deprivation indicted on grounds of Act on Counteracting Drug Addiction, 1997. National data. Source: Ministry of Justice, Department of Statistics

Year	Total number of imprisonment sentences on grounds of AOCD	With suspended execution	Obligation to undergo treatment with the conditional suspension of the imprisonment	Obligation to undergo treatment ruled with conditional suspension of penalty execution in relation to the total number of adjudged conditionally suspended penalties of imprisonment [%]
1999	1 769	1 370	41	2.99 %
2000	2 372	1 815	53	2.92%
2001	3 761	2 741	39	1.42%

Table 14 shows the relationship of suspended prison sentences and mandatory drug treatment. Under article 56, paragraph 1 AOCD 1997, drug treatment is supposed to be obligatory as a condition of a suspended prison sentence, so the number of court appointed treatments should always be equal to the number of conditionally suspended imprisonment penalties. It is significant, that courts do not apply the AOCD, which clearly prescribes the necessity to undergo the treatment in case of suspension of the penalty.

The police's position has been presented in the mass media, and confirmed during the research project: support for penalization of drug possession, which is supposed to allow for efficient persecution of the drug dealers. Certainly, due to penalization of drug possession, police gain effective means for influencing drug addicted people, with easier access to information on the hidden population of drug users and drug business. However, as suggested by the research results, data obtained in this way may not be useful in identifying major dealers.

Appendix III: Laws Related to Criminal Defense

Right to an attorney

For a person charged with a crime, the ability to exercise the right to have an attorney is vital. A professional defense lawyer can help the defendant charged with a drug offence to apply for a therapeutic alternative included in the AOCD. Issues related to the defense in the criminal process are regulated by the Code of Criminal Procedure of 1997.

In some situations having an attorney is mandatory. According to the article 79, paragraph 1 of the Code of Criminal Proceedings, the accused in a criminal trial must have an attorney if he or she is:

1. underage;
2. blind, deaf, or mute, or if
3. there is a justified doubt regarding subject's accountability.

The offender must have a lawyer if the court decides it is necessary due to other circumstances impeding the defense. The regulation included in the article 79, paragraph 4 is important from the perspective of the addicted individual, as it is stated that if, during the proceedings, expert psychiatrists affirm the full accountability of the convict both when committing the offence and during the proceedings, participation of the defense lawyer in further stages of trial is not necessary.

The defendant, according to the article 80 of the Code of Criminal Proceedings, must also be provided with a professional defense during the proceeding in the local court as a court of the first instance, if he or she has been charged with a serious crime or is already deprived of liberty. In such a case, participation of the defense in the first instance hearing is mandatory, and in the appeal and cassation proceedings as decided by the president of court or the judge.

If the case is one in which a defense lawyer is obligatory but the accused cannot afford a lawyer, he or she may move the court to appoint a public defender. The defendant must prove financial need, the president of the appropriate court appoints the public defender. This regulation is important for the drug addicted individuals, whose financial condition may not be adequate to provide for the defense lawyer's fees. However, it is vital for the offender to appropriately document their own financial status

Appeal from an unfavorable verdict

Under the Polish Constitution, judicial proceedings are reviewable in at least one higher court. Article 425 of the Code of Criminal Procedure, lists parties entitled to the appeal from the decision adjudged in the court of first instance. The appeal may be leveled against an entire decision or only a part. The

subject matter of the appeal is limited to orders infringing personal rights or damaging interests of the appealing party. Such a limitation does not apply to the public prosecutor, as according to the paragraph four of the article, he or she may appeal also in favor of the defendant.

Motions for conviction (plea bargains)

Many drug related cases are resolved without a trial. Article 335 of the Code of Criminal Procedure allows the defense and prosecution to agree on a charge and penalty, avoiding the expenses and risks (but also the potential benefits) of a trial. Legal prerequisites include:

1. An individual is charged with a misdemeanor subjected to penalty not exceeding ten years of liberty deprivation.
2. Circumstances of the crime are beyond doubt.
3. Attitude of the offender indicates that aims of the proceeding would be achieved.

If the above stated conditions are fulfilled, the prosecutor negotiates the penalty or penitentiary measures and directs the indictment to court with an application for the verdict of guilt and decision on the previously negotiated penalty or penitentiary measure without trial. Such an application allows for cessation of subsequent evidence investigation in the criminal trial, under a condition that in the light of the collected evidence, suspect's clarifications are beyond doubt.

Appendix IV: Laws Related to Medical Care

Right to medical care

The right to medical care is granted to every citizen by the Constitution of Poland. Article 68, paragraph 2 proclaims that “all citizens, regardless their financial status, are guaranteed equal access to the services of the state financed healthcare by public authorities.” According to the Act on Healthcare Institutions of 1991, patients are entitled to :

- 1) healthcare services based on the requirements of medical knowledge;
- 2) information on their medical condition;
- 3) informed consent to medical care;
- 4) privacy and respect for personal dignity while being provided medical services, and
- 5) die in peace and dignity.

Problems related to the treatment, rehabilitation and reintegration of the psychoactive substance addicted individuals, regulated by the Act on Counteracting Drug Addiction, have been described in the RPAR report, above.

HIV Infection

The situation of HIV infected individuals addicted to psychoactive substances is strongly influenced by the regulations related to the antiretroviral treatment [ARV/HAART]. This treatment, in contrast to substitution treatment, is not regulated by any legal act of the general regulations or law. The basic regulation related to this issue is the Ministry's of Health Program of Health Policy: ARV treatment for people living with AIDS in 2005-2006. (ARV treatment has been governed by such Ministry health policies since 2001.⁴) Responsible institutions include: the Ministry of Health, the National AIDS Centre, National Consultants for HIV/AIDS related issues, the National Health Fund, medical institutions providing ARV treatment, heads of the committees for prevention of nosocomial infections, and units of local authorities.

Reporting HIV and AIDS morbidity is regulated by a specific legal act, the Act on Infectious Diseases and Infections from 2001 (Polish Official Journal No 126, item 1384 with later amendments). Article 20,

⁴ Key document regarding this matter is the third edition of the National Program for HIV Infection Prevention, Care for People Living with HIV and Suffering from AIDS for 2004-2006 (issued by the Ministry of Health and National AIDS Centre, Warsaw 2004, ISBN 83-87068-23-3). The document was accepted by the Cabinet at a sitting on 14th of December 2004. (record of the settlements No 53/2004, point 18). National Program for HIV Infection Prevention Care for People Living with HIV and Suffering from AIDS for 2004-2006 specifies general objectives and detailed planning for future implementation; one of the three key problem areas is “granting wide access to the diagnostics and ARV treatment.”

paragraph 5 specifies that in case of suspicion or diagnosis of AIDS, the physician is obliged to report directly to the appropriate Regional Sanitary Inspector or authorized and indicated by the inspector specialist proper unit for sexually transmitted diseases. By virtue of the paragraph 8 of this article, in cases of AIDS, patient is granted right to reserve their personal data. In such situations, instead of full name and surname, only initials are provided. Similar regulations are to be applied for reporting on HIV infections, as no name and surname is also required if the patient wishes so and reserves the data. Anonymous HIV testing is equivalent to the expression of will for reservation of data.

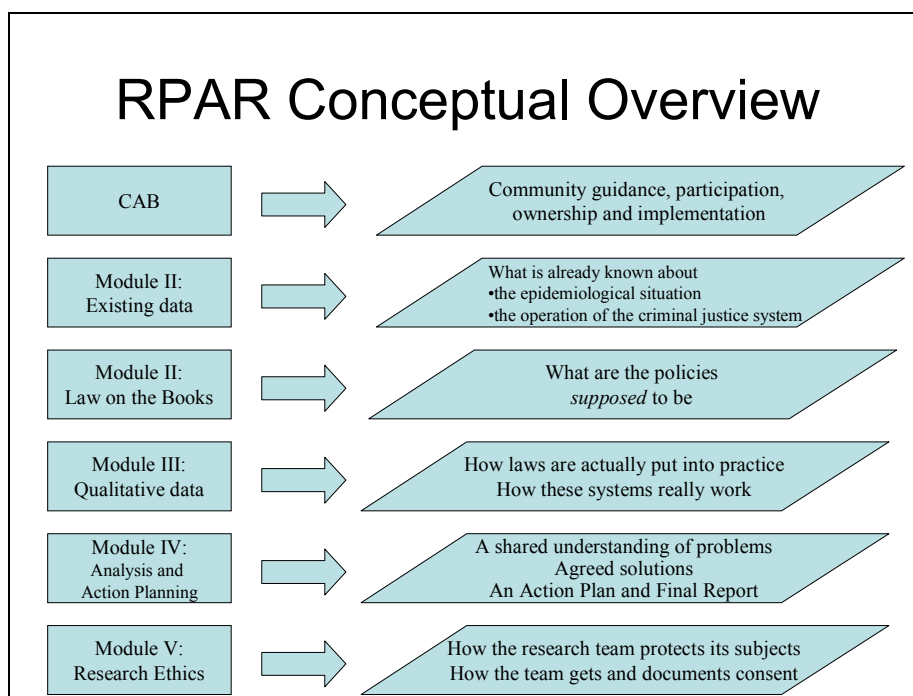
Appendix V: Detailed Information about RPAR Methods and Implementation

Pre-RPAR activities

The Szczecin RPAR was funded by the United States National Institutes of Health, through a grant to the University of Connecticut (Zita Lazzarini, Principal Investigator.) The Szczecin research team was selected from key individuals with expertise in the field of drug policy and drug addiction, from perspectives of health, sociological and law enforcement policy within the target region. In March 2004, assessors applied for a review from the Local Ethical Committee in the Pomeranian Medical University in Szczecin. This was required by U.S. government regulations based on U.S. funding for the RPAR project. In Poland, social research like the RPAR is not required to undergo review, which is limited to medical projects are required by Polish law. The Local Ethical Committee reviewed the research; the research team was required to answer several queries of the Ethical Committee and obtain secondary opinions from the National AIDS Centre and the National Office for Narcotic Drug Counteraction. The approval of the project was eventually granted in October 2004.

In October 2004, a conference dedicated to narcotic drugs and drug addiction was organized at the City Hall in Szczecin, which attracted representatives of relevant organizations and institutions active in regional drug policy from medical, public health, and legal perspectives. It was attended as well by three U.S. investigators (Lazzarini, Patricia Case and Scott Burris). In December 2004, the research team was finalized and members attended initial consultation and training sessions (conducted by the U.S. investigators) on the five modules to be utilized in the research process.

- Module I: The creation and management of CAB meetings
- Module II: RPAR process and quantitative data collection
- Module III: Qualitative data collection (organization of three focus groups and interviewing procedures)
- Module IV: CAB advice regarding an Action Plan
- Module V: Ethical issues such as informed consent



In addition, all research members completed the online course *Human Participants Protection Education for Research Teams*, prepared by the National Institutes of Health (NIH) before beginning RPAR on the project.

Data Collection

Following the completion of training, the research team commenced the quantitative data acquisition stage specified in Module II, gathering information on legal acts, provisions and stipulations influencing the status and situation of drug addicted individuals. In addition, data from police reports and from judicial determinations was located. Alongside quantitative data, epidemiological data on the frequency of HIV infection, incidence of sexually transmitted diseases, other hepatotropic viruses and tuberculosis. At this point, research team members actively began to recruit and select CAB members.

Law on the books

1. **Drug addiction issues:** Polish legislation encompassing use, possession, facilitation of use, production and dealing, treatment alternatives, regulations of addiction treatment such as substitution therapy (methadone), access to treatment, and status of harm reduction programs
2. **Commercial sex work:** Regulations governing commercial sex, solicitation, pimping and human trafficking
3. **Homosexuality:** Laws prohibiting homosexual behavior
4. **HIV-specific criminal exposure:** Criminal law with respect to consciously exposing others to HIV infection and other laws relating to HIV/AIDS

5. **Criminal procedure:** Polish legislation and procedure on arrest, detention, search and seizure, bail release provisions, right to a criminal defense, and appeal measures
6. **Right to healthcare and HIV treatment:** General rules regarding healthcare with special emphasis on HIV/AIDS therapy
7. **HIV testing laws:** Voluntariness of testing, anonymity, number of organizations with access to test results, accessibility of testing and pre- and post-test counseling
8. **Privacy of medical information:** Legislation stipulating the protection of medical data, organizations with access to records, with particular attention given to HIV-status protection
9. **Anti-discrimination provisions:** Anti-discrimination of those with disabilities and HIV-infected individuals
10. **National provisions** related to **international human rights** norms
11. **International drug control agreements** and nationalized control of drug supply

After the data collection phase, the individual provisions were included in a key findings form with the following identifiers: 1) Citation; 2) Type of provision; 3) Text of the law; 4) Narrative summary; 5) Question posed to research team. While collection and analysis of data was completed in April 2005, new legislation was adopted by the Polish Parliament and the appropriate sections were updated in June 2005.

Criminal Justice Data (Arrests & Sentences)

Simultaneously, the research team collected data from police statistics and criminal justice reports. The Chief Headquarters of Police provided the following data:

1. Number of drug-related crimes from 1997 to 2003
2. Number of offenses related to drug distribution and possession from 1997 to 2003
3. Number of offenses related to drug dealing and introduction of drug products into market from 1997 to 2002
4. Number of drug possession offenses from 1997 to 2002

Collection and analysis of the above data was completed at the end of March 2005. The data were also organized into a key findings form, which included the source and the key findings of each topic (listing the data *per se* and conclusions drawn from that data).

The research team also gathered data from Ministry of Justice in Poland regarding sentencing for drug offenses from 1997 to 2002:

1. Sentences for drug distribution and distribution with financial benefit from 1997 to 2002

2. Sentences for drug possession from 2000 to 2003
3. Summary describing registered cases of the drug possession alongside the binding sentences for drug possession
4. Summary comparing the legally binding sentences for drug possession found in Art. 48, para. 1-3 of the Act on Counteracting Drug Addiction [AOCDA] from 1997 with the number of imprisonment sentences
5. Summary comparing the number of deprivation of liberty penalties for drug related offenses related to Art. 48, para. 1-3 of AOCDA from 1997 with suspended and immediate imprisonment penalties
6. Number of legally binding obligations to undergo treatment adjudicated to adults with valid suspended sentences of imprisonment by public prosecution as stipulated by the AOCDA from 1997

The vast majority of data was obtained relatively quickly by February 2005 or week seven of the study. However the time necessary to collect information comparing suspended and immediate imprisonment penalties was significantly longer, and were not available until April 2005 or week fifteen.

In May 2005, with the support of CAB members, data from the Regional Police Headquarters, Szczecin were obtained. The Key Findings form was supplemented with the data on:

1. The number of AOCDA breaches in 2003 and 2004 in the city of Szczecin in comparison to the number of initiated inquiries and investigations in the same place and time frame
2. The number of AOCDA breaches in 2003 and 2004 in the Northwest region of Poland (Zachodniopomorskie Woywodship) in comparison to the number of inquiries and investigations in the same region and timeframe
3. Index of drug related crimes per 10,000 inhabitants in individual communes of the Zachodniopomorskie Woywodship
4. The number of drug-related indictments in courts in 2004 and number of applications for detention in 2004 related to the drug related offenses

Along with the Key Findings form regarding Criminal Justice Data, the research team was expected to complete the Data Evaluation Form, divided into the following sections: 1) source code and citation, 2) disease or topic, 3) limitation on validity, and (4) notes on the access. This evaluation form aimed to assist in the assessment of the credibility of data, to allow for better understanding and to facilitate access to the raw data in future.

Epidemiological data

The research team also collected epidemiological data on infectious diseases and intravenous drug use. Appendices with more specific data may be found at the end of this report.

Infectious diseases

Epidemiology of injection drug use-related diseases provided a basis for the RPAR study, presenting the basic knowledge of health consequences, the scale of the problem, and other tendencies. The collection of this data helped the research team to identify key areas for prospective intervention directly linked to health promotion and prophylaxis.

Statistical data on the following infectious diseases was included in the project:

- HIV/AIDS
- Tuberculosis
- Hepatitis B
- Hepatitis C
- Syphilis
- HIV resistance to antiretroviral treatment in the country and region
- Multi-drug resistance of tuberculosis in the country and the region.

Intravenous drug use

Existing data on psychoactive substance consumption identified the type of administered substance and groups at risk (including identifiers such as gender, age, sexual orientation, and ethnicity). The scale of the problem was assessed in the country, region (Westpomoeranian Voyvodeship) and city (Szczecin), with attention given to prison sentences and arrests.

Description of research team activities

This part of the RPAR project was carried out in three phases according to the principles outlined in the Module II: 1) data acquisition; 2) data evaluation, and 3) identification of key findings based on data analysis and assessment. The research was performed from January 15, 2005 until February 28, 2005.

During Phase 1, data was obtained from official Web sites of national institutions (the National Institute of Hygiene, the Department of Epidemiology in Warsaw, the National Tuberculosis and Lung Diseases Research Institute for the Warsaw District, the National AIDS Center), books, leaflets and official bulletins and as oral and written reports obtained on request of the research team members

(regional medical consultants for tuberculosis, dermatology, venerology, and toxicology from coordinators and the heads of departments and units treating HIV/AIDS infected individuals, and the Chief Sanitary Inspectorate). Additional data sources included medical papers prepared for publication with information granted on personal request from authors regarding HIV resistance to antiretroviral treatment. Collected data were summarized and included into appropriate forms and tables.

During Phase 2, evaluation and assessment were performed using Data Evaluation Forms. Each source was coded with a unique numerical identifier (separate for every data source) and was ascribed to a topic area for which the data was obtained (e.g. disease – HIV, or number of Injection Drug Users in Szczecin) – thus information regarding various topic areas could be collected and analyzed. The validity of the data and their limitations were described for every data source (e.g. whether data were precise numbers or estimates, or whether there were differences in information amongst sources, etc.). Also, information on continued access was noted so that CAB members could refer to the source if necessary (for example, whether the information was permanently available or updated regularly).

Finally, during Phase 3, the most important key findings were extracted from the data. Conclusions of the reports and summaries were analyzed. The tendencies and dynamics of diseases spread and the geographic and demographic characteristics of the analyzed phenomena (e.g. stable number of tuberculosis cases or declining age of drug users) were documented. Each key finding was linked to appropriate data source in the separate Key Findings Form. Key Findings Forms were prepared in order to 1) present conclusions and observed trends and tendencies to the CAB; 2) be used in the analysis, Action Plan, and final report of the project.

Community Action Board (CAB)

The recruitment of the CAB participants begun in the first week of the project. Firstly, the key institutions handling drug-related issues were identified in order to create list of possible individuals committed to and possibly adding to a project. The list included the following organizations:

1. Methadone Treatment Clinic, Szczecin
2. Psychiatric Hospital “Zdroje”, Szczecin
3. Infectious Diseases Department, Pomeranian Medical University, Szczecin
4. Regional Public Prosecution Office, Szczecin
5. Regional Court, Szczecin
6. Regional Police Headquarters, Szczecin
7. “Return form U” (a non-governmental organization working with drug addicted people)
8. Society for Counteracting Drug Addiction
9. College No. 4, Szczecin

10. Penitentiary institution, Nowogad
11. Arrest house (jail), Szczecin

Along with an summary of the most important institutions related to the drug counteracting in the region, the research team members distributed brief information regarding the RPAR project to those invited for participation in the CAB meetings.

Following the identification stage, the next step was to conduct individual meetings with the representatives of the institutions listed above. Interest in the project was high in those individuals representing health and social policy organizations, as every person agreed to participate in the first meeting of the CAB. However, it was more difficult to recruit law enforcement and judiciary system representatives, as these people are extremely reluctant to join any new venture. This difficulty resulted in the need to request patronage from the President of Szczecin City in order to sustain the project's credibility.

CAB meetings

First meeting:

The first CAB meeting was held on the March 9, 2005 in the Szczecin City Hall, with twenty-five participants who had been identified as possessing appropriate knowledge and experience in the drug addiction and policy, were invited. The following agenda was set:

1. Introduction of the participants (Included profession, position, represented organization/institution, experience with drug policy, law, or drug addiction problems)
2. Presentation of the project's objectives and outline (Methods, research aims, and timeframes with special emphasis on the role of the CAB)
3. Presentation of the epidemiological data, law enforcement statistics, and criminal justice data collected by the research team prior to the meeting
4. Power Map Exercise (which included identification of organizations, institutions, or people who influence or may influence the situation of addicted individuals)
5. Identification of the data sources for existing legal, criminal justice, law enforcement, and epidemiological data
6. Distribution of forms of informed consent to participate in the RPAR project, indicating that United States research principles require obtaining formal informed consent and a request for thorough reading of all presented materials
7. Establishment of the next meeting date

After the meeting, the research team organized the newly acquired data sources into the Existing Data Sources form and included internal characteristics for the organizations into the Power Map. The research team members completed the data collection including epidemiological, statistical data from the

law enforcement and judiciary systems, legal provisions, and regulations. This information was included in the appropriate forms and distributed to the CAB participants during the next meeting.

Second meeting

The second CAB meeting was scheduled for April 20, 2005 with the following agenda:

1. Brief presentation of the epidemiological data and data from law enforcement and criminal justice systems
2. Presentation of drug addiction problems identified from the data collection process
3. Repetition of the Power Map exercise
4. Problems and Solutions Exercise concentrating on drug addicted individuals who broke the law
5. Selection of the prospective Focus Group participants in the areas of:
 - Drug treatment providers and clinical healthcare providers
 - Health interventionists
 - Representatives from law enforcement and criminal justice systems
6. Creation of a list of potential system and interactor interview participants who may provide significant insight into drug-related issues
7. Collection of signed formal consent forms

Upon the completion of the second CAB meeting, the research team organized the notes from the meeting with utmost attention given to the notes from the Problems and Solutions Exercise and the Power Map Exercise. Additionally, prospective possible Focus Group participants were included into the Suggested Focus Group Members form and potential system and potential interactor interviewees into the System and Interactor Participants Candidate List form.

Between the second and the third CAB meeting, the first Focus Group comprised of drug treatment providers and clinical health care providers was organized. It was decided, based upon the experience and extensive knowledge of one participant, to include her in future CAB sessions.

Third meeting:

The third CAB meeting took place on May 16, 2005, with the following agenda:

1. Presentation of the key information collected during the first Focus Group meeting
2. Consecutive analysis of the influences and distribution of power during the Power Map Exercise
3. Problems and Solutions Exercise: Discussion of problems identified during the first Focus Group meeting
4. Discussion regarding requests for the selection of additional individuals for participation in the system/interactor interviews
5. Presentation of tasks planned for following weeks, including timeframes, organization of Focus Group meetings, commencement of individual interviews with system and interactor informants

Following the third CAB meeting, the research team members organized the notes from the Problem and Solutions Exercise and included changes into the Power Map. Next, the final recruitment of the Focus Group participants was conducted with attention paid to subsequent recruitment of system and interactor informants.

Two individual interviews were carried out between the third and fourth CAB meeting. May 31, 2005, the Polish research team members participated in training conducted by Professor Scott Burris, which was intended to support current research and to monitor the progress of the project. At this point, it was decided that proceeding to the planned fourth CAB meeting would not be practical given the small number of conducted system and individual interviews and Focus Group meetings. During an interim meeting the research team presented progress of the work, and encouraged CAB members to discuss problems related to injection drug addiction in Szczecin. This discussion provided additional information to CAB members, which was included during the prospective phases of the project. After the interim meeting, the next two Focus Groups comprised of health interventionists and law enforcement and criminal justice system members were organized and individual interviews were conducted with system and interactor informants and injection drug users.

Fourth meeting:

Taking place on July 19, 2005, the detailed agenda for the fourth meeting included:

1. Presentation of the information collected during the second and third Focus Group meetings, data gathered during individual, system and interactor interviews and injection drug user interviews
2. Power Map Exercise: Discussion of the possibility for amendments and extension
3. Problems and Solutions Exercise with newly provided research data
4. Root Cause Exercise to identify reasons underlying existing problems

Before the final analysis of the existing data and beginning work on the Action Plan, the research team members were trained by professor Zita Lazzarini in information analysis and action planning. The qualitative data collection was concluded between the fourth and fifth CAB meetings and the research team members began the preparation of the Final Report, where the Key Findings of the project were described. The description of the Key Findings was attached to the agenda for the fifth CAB meeting.

Fifth meeting:

The fifth CAB meeting was conducted on October 12, 2005. This meeting was designed as a workshop, with the following exercises and discussions on the agenda:

1. Root Causes Exercise for the problems identified during the study
2. Identification of solutions for existing problems
3. Priority Setting Exercise to decide on the feasibility of suggested tasks and solutions

4. Delegation of preliminary responsibility for selected solutions and tasks

During the organization of notes following the conclusion of the meeting, the research team included the root causes and possible solutions into the Analysis and Action Plan Form 1, while the notes from the priority setting exercise outlining an Action Plan and factors determining feasibility were included into Analysis and Action Plan Form 2.

Sixth meeting:

The final report was completed after the sixth meeting. The agenda for the sixth CAB meeting on October 24, 2005 was as follows:

1. Repetition and review of Priority Setting Exercise with respect to feasibility
2. Review of tasks and planned actions: deciding which participants should be responsible for the implementation of solutions, selection of organizations and people to which the Action Plan will be addressed, consideration and planning of necessary strategies for task realization and completion of Power Map Exercise
3. Division of each solution into small, consecutive steps, determination of the timeframe, milestones, and roadmap with indicators of stage completion; completion of the Analysis and Action Plan Form 3

First Focus Group

The first Focus Group was held on May 6, 2005 and consisted of the following professionals:

- Medical rescue physician
- Infectious diseases specialist from the Infectious Diseases Department, Szczecin
- Psychologist from the AIDS Outpatient Clinic, Szczecin
- Psychotherapist representing the substitution therapy in Szczecin
- Psychologist from a substitution treatment facility and general practitioner

The research team conducted the Focus Group using Module III of the project, which includes thematic blocks for discussion. The research team created a series of additional questions, for better moderation of discussion. The meeting provided a scope of information and proved to be a valuable tool of research. However, the necessity to sign the informed consent form as a requirement for participation was widely questioned. It must be emphasized that the clarification of the necessity of informed consent for the participation in this interview was a time consuming endeavor.

After the meeting, the information obtained during the first Focus Group was organized and analyzed. As the discussion was fast-paced and often heated, the digital recording of the session proved to be helpful. The data collected was entered into a form and a PowerPoint presentation was prepared for the appropriate CAB meeting

Second Focus Group

On June 10, 2005, the second Focus Group was convened. Group participants included:

- Representative of NGO, Return from U
- Representative of NGO, TADA
- Social probation officer
- Employee, Municipal Center for Family Support
- Addiction psychotherapist, Zdroje mental hospital (psychoactive substance detox therapy)
- Addiction psychotherapist, Szczecin Catholic organization

Module III thematic questions were also used during this focus group and the information provided by the second Focus Group was similar or identical to that collected during the first Focus Group, confirming the validity of the research data.

Third Focus Group

Participants included the following representatives from law enforcement and judiciary systems:

- Police officer, Regional Headquarters of Police, Szczecin
- Prosecutor, Regional Prosecution Office, Szczecin
- Judge, Family Court
- Judge, Criminal Department of the Regional Court in Szczecin.

This group provided valuable information on the practices and rules functioning in the police department, the prosecution office and the courts in Szczecin, as well as insight into the problems encountered by these institutions related to drug cases against those using psychoactive substances. These data were also appropriately organized, included into forms and presented by means of PowerPoint to CAB participants.

Interviews

System and interactor interviews

Interviews aimed at gaining insights and knowledge in the following areas:

1. Enforcement of drug laws
2. Enforcement of commercial sex work and prostitution laws
3. Enforcement of laws on homosexuality
4. Enforcement of laws on criminal exposure or transmission of HIV
5. Operation of courts and prisons
6. Drug policy politics
7. Harm reduction and public health interventions
8. Advocacy resources
9. Epidemiological data on HIV and drug use
10. Sources of criminal justice data

Interview participants included:

- Prison officials, guards, and therapists
- Judges
- Legal academics
- Policymakers or local authorities
- Police officers
- Prosecutors
- Public health authorities and clinicians
- Probation officers
- Narcotic treatment facility officials and staff
- Emergency and casualty department physicians
- Harm reduction workers
- NGOs working with IDUs and HIV-infected individuals

IDU interviews

At the same time, the research team conducted individual interviews with fourteen injection substance users. Following the methodology, the following informants were included:

- Two men
- Two women
- Two male commercial sex workers
- Two female commercial sex workers
- Two new injectors
- Two men who have sex with men
- Two significant local minorities

The research team conducted fourteen individual IDU interviews, but encountered problems in finding subjects among locally significant minorities. It was also difficult to convince male commercial sex workers to participate in an interview, but eventually, these participants were found and took part in the interviews.