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Drug policy profile: Poland

Abstract: This paper describes the development and main characteristics of drug policy in Poland. It provides readers – from researchers to policymakers – with an insight into how illicit drugs have been controlled and drug-related problems responded to along the course of various historical and social developments.
It starts with the early days of drug control in Poland in the 1920s, describes the changes related to the emergence of Polish heroin – *Kompot* – in the late 1970s, and highlights the role played by NGOs in shaping national responses and developing a public-health-oriented drug policy approach in a Communist country during the 1980s. The specificities of central and eastern European drug policies, both before and after 1989, are analysed and compared with other parts of Europe.
The challenges that new psychoactive substances pose for drug policy and responses are also examined. The paper provides a comprehensive overview of the development of drug-related interventions – including opioid substitution treatment and professionalisation of the non-medical treatment sector in the early 2000s.

Keywords drug policy | drug laws | polish heroin / *Kompot* | new psychoactive substances | Poland | drug treatment | drug problems

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Introduction

The EMCDDA's drug policy profiles aim to describe some of the main characteristics of national drug policies in Europe and beyond. In contrast to other approaches, we do not attempt to assess these policies, but instead to outline their development and main features. Our objective is to help readers — from researchers to policymakers — gain a better understanding of the way in which countries control drugs and respond to drug-related security, social and health problems.

National drug policies are the result of the interaction of multiple factors, such as political and administrative structures, the role and influence of stakeholders, financial resources, the drug situation, other public policies (e.g. health, security) and international agreements. There is no model for how to combine these factors and assess their respective weight and interrelations. However, this should not prevent analysts from exploring the significant changes in these factors that may have shaped drug policy in the short and long term.

The EMCDDA's drug policy profiles use a historical perspective to identify such drug policy changes. While some of these changes may have occurred in parallel in many countries because they were facing the same issues (e.g. the adoption of new UN conventions, HIV/AIDS epidemics, diffusion of new drugs), the policy profiles show that each country has its specific drug policy timeline.

This profile is the first one to examine a central and east European country: Poland. It considers national strategies and action plans, the legal context within which they operate, and the public funds spent, or committed, to resource them. It also describes the political bodies and mechanisms set up to coordinate the response to the multi-faceted problem and the systems of evaluation that may help to improve future policy.

The profile puts this information in context by outlining the size, wealth and economic situation of the country as a whole, as well as the historical development of the current policy. One note of caution for the reader is that the availability of information and analysis in the area of demand reduction is, as with most national and international drug policy studies, much greater than in the area of supply reduction.

What is a drug policy?

Responses to this question range from 'it covers all activities related to illicit drugs' to 'it is a set of principles or an ideology that directs public action in this field (e.g. war on drugs, harm reduction)'.

To prevent both a too broad or too restrictive approach we will use an adaptation of Kilpatrick's definition of public policies (www.musc.edu/vawprevention/policy/definition.shtml): 'A system of laws, regulatory measures, courses of action and funding priorities concerning (illicit) psychoactive drugs and promulgated by a governmental entity or its representatives.'

Poland in figures

		Year	Poland	EU (27 countries)
Population		2012	38 538 447 (p)	503 663 601 (p)
Population by age	15–24	2012	13.2 %	11.7 % (p)
	25–49		36.5 %	35.4 % (p)
	50–64		21.4 %	19.5 % (p)
GDP per capita in PPS (Purchasing Power Standards)(1)		2011	64 (p)	100
Total expenditure on social protection (% of GDP) (2)		2010	18.9 %	29.4 % (p)
Unemployment rate (3)		2012	10.1 %	10.5 %
Unemployment rate of population aged under 25 years		2012	26.5 %	22.8 %
Prison population rate (per 100 000 of national population) (4)		2011	211.2	
At risk of poverty rate rate(5)		2011	17.7 %	16.9 %
Political system		Centralised (6)		

(p) Eurostat provisional value.
(1) Gross domestic product (GDP) is a measure of economic activity. It is defined as the value of all goods and services produced less the value of any goods or services used in their creation. The volume index of GDP per capita in purchasing power standards (PPS) is expressed in relation to the European Union (EU-27) average set to equal 100. If the index of a country is higher than 100, this country's level of GDP per head is higher than the EU average and vice versa.
(2) Expenditure on social protection includes benefits, which consist of transfers in cash or in kind to households and individuals to relieve them of the burden of a defined set of risks or needs.
(3) Unemployment rate represents unemployed persons as a percentage of the labour force. Unemployed persons comprise persons aged 15 to 74 who are: (a) without work during the reference week; (b) currently available for work; (c) actively seeking work.
(4) Situation in penal institutions on 1 September 2011.
(5) Share of persons aged 0+ with an equivalent disposable income below the 'at risk of poverty' threshold, which is set at 60 % of the national median equivalised disposable income (after social transfers).
(6) Poland is a parliamentary republic, with certain competences delegated to local governments and administrations.
Source: EMCDDA country overview — Poland (www.emcdda.europa.eu/publications/country-overviews/pl)

Policy timeline: key dates

International and EU developments		National developments
	1923	Act on Narcotic Substances and Preparations
	1951	Act on Pharmaceutical Products, Narcotic Drugs and Sanitary Articles
UN Single Convention on Narcotic Drugs	1961	
UN Convention on Psychotropic Substances	1971	
	1976	Development of Polish heroin (kompot)
	1978	The first therapeutic community
	1985	Act on Prevention of Drug Addiction
UN Convention Against Illicit Traffick in Narcotic Drugs and Psychotropic Substances	1988	
	1989	The first needle and syringe exchange programme established
European Plan to Combat Drugs	1990	
Report on the European Plan to Combat Drugs	1992	The first substitution treatment programme
	1993	Establishment of the Bureau for Drug Addiction (currently known as the National Bureau for Drug Prevention)
EU Plan to Combat Drugs 1995–97	1995	
	1997	Act on Counteracting Drug Addiction Establishment of the Narcotics Bureau within police headquarters
UN General Assembly Special Session on the World Drug Problem	1998	
	1999	National Programme for Counteracting Drug Addiction 1999–2001
EU Drugs Strategy 2000–04 EU Action Plan on Drugs 2000–04	2000	Amendment to the Act on Counteracting Drug Addiction
	2002	National Programme for Counteracting Drug Addiction 2002–05
	2004	Poland becomes a member of the European Union
EU Drugs Strategy 2005–12 EU Drugs Action Plan 2005–08	2005	New Act on Counteracting Drug Addiction
	2006	National Programme for Counteracting Drug Addiction 2006–10
EU Drugs Action Plan 2009–12	2009	
	2010	Response to the legal highs phenomenon
	2011	National Programme for Counteracting Drug Addiction 2011–16 Amendment to the Act on Counteracting Drug Addiction (introducing principle of opportunity)
EU Drugs Strategy 2013–20 EU Drugs Action Plan 2013–16	2013	

The early days of drug control in Poland (1920s–75)

The first drug-related legislation in Poland was adopted shortly after the country regained its independence after 123 years of occupation ([1]). The Act on Narcotic Substances and Preparations of 22 June 1923 implemented the provisions of the 1912 Opium Convention and allowed Poland to fulfil its international obligations. With drug problems not really perceived as an issue requiring legal regulation, this brief law was primarily adopted to bolster the new Polish state's position in the international arena (Abucewicz, 2006).

Drug use patterns between the two world wars varied across the country and between social groups. Among the reported users were veterans of the First World War using amphetamine, artists and bohemians experimenting with opium and cocaine, and housewives abusing painkillers. Ether drinking was widespread in two regions of Poland due to its low price and wide availability as well as a lack of knowledge about associated harms ([2]). Morphine use and addiction were mainly encountered among medical doctors (Marcinkowski and Jabłoński, 2008).

Psychiatric services first reported drug users entering treatment in 1921. The numbers remained low until 1928, with only 85 admissions over the whole period. In the following five years the numbers increased slightly, and 210 drug users were admitted to treatment (Marcinkowski and Jabłoński, 2008). The issue increasingly caught the attention of medical doctors and psychiatrists in the 1930s as they started to encounter drug users in their daily work. It also marked the beginning of these professionals' involvement in Polish drug policy. In 1931 the first national drug coordination body — the Polish Committee of Drugs Prevention and Addiction — was created. It was mainly composed of doctors and pharmacists, who promoted a medical approach to the phenomenon (Abucewicz, 2006). The Committee's main task was to coordinate the efforts of the state, local and regional governments, as well as care associations, in addressing drug problems. It promoted, for example, the obligatory treatment of drug addicts in prisons (Marcinkowski and Jabłoński, 2008).

([1]) In 1795 the Third Partition of Poland took place and its territory was divided between the Russian Empire, the Kingdom of Prussia and the Austrian Empire. During the occupation all laws were shaped by the occupying powers. An example of drug laws can be found in the EMCDDA's drug policy profile on Austria (Trinklein et al., 2014). Poland regained its independence at the end of the First World War.

([2]) Ether drinking had been popular among Polish peasants in the regions of Silesia and Podkarpacie since the late nineteenth century. It was introduced by migrant workers from the German Empire and was an important competitor to alcoholic beverages before 1918 (Zandberg, 2010). In 1928 a regulation of the Ministry of Health limited the availability of ether (Abucewicz, 2006).

Discussions initiated in the early 1930s on the size of the drug problem and how to tackle the issue were stopped by the outbreak of the Second World War. At the end of the war, the control over Polish territories passed from Nazi Germany to the Red Army and then from the Soviets to Polish Communists. The post-war status of Poland was decided at the peace conferences in Yalta, Teheran and Potsdam, where the Polish independent government-in-exile was ignored. A new communist government was formed and in 1948 the Polish United Workers´ Party gained control over the country for the following 40 years.

A new legal framework for drugs was adopted in the early 1950s by the new government, which was focused on rebuilding the country and on constructing a new social and economic order ([3]). The Act of 8 January 1951 regulating the production, sale and control of pharmaceutical products, narcotic drugs and sanitary articles replaced the 1923 legislation. It contained a more detailed list of controlled substances defined as narcotic drugs, including opium, cannabis, ether, morphine, cocaine and heroin. Unauthorised production, import, export, transportation, storage and selling of these drugs remained a criminal offence punished with imprisonment and a fine. The use of drugs without medical prescription was punished with up to one year's imprisonment and/or a fine when performed in public.

In the 1950s and early 1960s drug use was mostly reported in relation to the misuse of medicines. About 100–150 drug-dependent patients were recorded every year, most of whom had been prescribed painkillers such as morphine over long periods or were health professionals with easy access to such drugs (Świątkiewicz et al., 1998). At the turn of the 1960s and 1970s, drug use changed significantly and the issue was increasingly seen as a social rather than a medical problem (Świątkiewicz et al., 1998). The change was due to a new generation of young people who had been influenced by the hippie movement, and who held protests in Warsaw, Kraków and other cities against the existing political and social order (Sierosławski et al., 1998). Since then, taking drugs was no longer a private matter but more of a public act, and it was part of a new counter-culture (Świątkiewicz et al., 1998).

Contrary to what happened in western Europe, where young people mainly used illicitly produced drugs, young Poles primarily used medicines stolen from pharmaceutical plants, hospitals and drugstores, or obtained through forged prescriptions (Marcinkowski and Jabłoński, 2008) ([4]). The medicines mainly contained opioids (morphine, codeine) and stimulants (e.g. amphetamine, ephedrine). Another popular way to obtain drugs was to extract opioids from medicines provided for stomach ache that did not require a medical prescription (Sierosławski et al., 1998). Other widely available products were also used, such as volatile substances used in chemical cleaning, which were inhaled.

The development of drug use among young people triggered reactions from new actors such as psychologists, teachers and lawyers, who were concerned by the growing problems and harms related to drugs. However, public debates regarding drug use and its consequences remained very limited, with authorities actively censoring information on these issues ([5]). The government made a clear distinction between the misuse of medicines by adults and illicit drug use by young people. The former was an unwanted consequence of positive developments such as medical research, a growing pharmaceutical industry and, more generally, modern civilisation. Its occurrence could therefore be acknowledged. The latter was associated with the capitalist economy and 'western civilisation', poor living conditions and a lack of proper legal regulations, and the Polish authorities therefore denied that it occurred (Abucewicz, 2006). Drug use among young people was also defined as a threat to social and political order, and this definition shaped the limited public debate and the drug policy throughout the 1970s.

Available data suggest that at the beginning of the 1970s about 50 000 people were experimenting with drugs and misusing medicines (Marcinkowski and Jabłoński, 2008) and that the number of drug users receiving treatment was growing rapidly, with a fivefold increase in the number of patients in psychiatric healthcare centres and a threefold increase in the number in psychiatric hospitals recorded between 1969 and 1973 (Godwod-Sikorska et al., 1981). In 1973, at the peak of the first drug wave in Poland, around 3 000 people were treated for drug dependence in psychiatric healthcare centres and an additional 700 in psychiatric hospitals (Godwod-Sikorska et al., 1981). The first specialised treatment centre, the ward for treating polydrug users at the Voivodeship Hospital for the Nervously and Psychologically Ill, was opened in Lubiąż near Wrocław in 1971 and functioned until 1976. Adult drug users have also been admitted for treatment since 1972 in the Sanatorium for Children and Young People in Garwolin, where new approaches for the treatment of drug addiction emerged (Marcinkowski and Jabłoński, 2008).

([3]) A report prepared in 1947 by the Office for War Compensations noted that over 6 million (22 %) of Polish citizens died during the war and over 20 % of agricultural lands, 80 % of transportation facilities and 65 % of Warsaw's infrastructure were destroyed.

([4]) Cannabis was, however, also available in Poland (Lagerspetz and Moskalewicz, 2002).

([5]) Only 23 television programmes related to drugs and drug addiction were broadcasted by the public television during the 1970s and they all presented drug use as a problem of western countries, without reference to Poland (Abucewicz, 2006). In the press, addiction was presented as the outcome of (inappropriate) social relations among hippies in the 'degenerated West' (Sierosławski et al., 1998). Drug problems in capitalist countries served as a powerful propaganda tool.

The government's reaction to the growing drug problems was very limited, not only in the area of treatment but also in the area of prevention. The most significant policy change was the introduction by the Ministry of Health and Social Care in 1973 of new rules for the prescription and sale of some medicines. Special prescription forms were introduced and the number of pharmacies authorised to dispense medicines with psychoactive effects was reduced (Abucewicz, 2006). These restrictions contributed to a temporary stabilisation of drug use as travel restrictions, strict border controls and low currency exchange rates prevented foreign drugs from entering the country (Świątkiewicz et al., 1998). However, this stabilisation did not last and drug users soon turned to new, home-made, drugs.

Polish heroin, NGOs and public health (1976–89)

Despite its ratification of the UN Single Convention on Narcotic Drugs in 1966, the Polish state did not exercise control over the cultivation of poppy, which was used both for the production of medicines and for culinary purposes. Governmental experts claimed that poppy extracts obtained from the Polish species of the plant had no intoxicating effect (Abucewicz, 2006). This was not the case, as users found ways to produce drugs extracted from the plants (*Papaver somniferum* L.), which were cultivated in all areas of the country ([6]). The most popular were the so-called 'poppy milk', taken intravenously, and 'poppy tea', taken orally. Both were also well known in other countries in the region including Lithuania, Ukraine, Russia and Hungary (Sierosławski et al., 1998).

In 1976 a chemistry student from Gdańsk found a simplified technique for extracting opiate alkaloids from poppy straw (Krajewski, 1997). The new user-friendly method no longer required specialised knowledge or sophisticated equipment, and the necessary chemical reagents were easily available in drug stores and other shops. The result was a new drug called 'Polish heroin' or *kompot* (see the box '*Kompot*: production and characteristics'), and its use spread rapidly all over Poland. The substance was mainly injected and almost exclusively produced and distributed among users ([7]). It was associated with a new subculture of dependent opioid users that included many young people who had attended higher education (Moskalewicz and Welbel, 2013).

In the late 1970s the number of dependent opioid users was estimated at 8 500 (Godwod-Sikorska et al., 1981) and an increase of 27 % in the number of clients entering inpatient treatment for the first time was reported between 1978 and 1979 (from 332 to 424). These developments were mostly ignored by the government, which still saw illicit drug use as a purely western problem. This attitude changed with the ascent of the independent trade union Solidarity in 1980 and, more generally, with the move towards greater political freedom in Poland. The destabilisation of the communist system resulted in drug problems being officially recognised and triggered a public debate on the issue (Moskalewicz and Świątkiewicz, 1999). The first mass media reports on drug use occurred in the 1980s, as a result of which Polish citizens became familiar with the phenomenon ([8]). Doctors and other health professionals were now also able to publicly express their views and call for action. The debate continued during and

Kompot: production and characteristics

Kompot is produced from poppy straw and several chemical reagents. It contains heroin, morphine, codeine and other opium alkaloids. The exact content is often unknown and different batches rarely have the same content (Wodowski, 2004). In principle the substance contains opiates in amounts large enough to create effects that are similar to but generally weaker than those of heroin.

Morphine and other opiate alkaloids are crudely extracted during the production process and converted into a substance that contains heroin. Heroin and other acetylene derivatives of morphine that are found in kompot are unstable and gradually hydrolyse back into morphine if moisture is present. The speed of this process depends on temperature and storage conditions (Wodowski, 2004).

The drug has the form of a brownish liquid. It has a bitter taste and often a vinegary odour that results from the addition of anhydrous acetic acid during the last stage of production. Kompot is generally injected but in rare cases it is smoked. As muscles cannot easily absorb the high amount of oily liquids in kompot, injection is almost always done intravenously. Intramuscular injections often cause serious abscesses and infections (Wodowski, 2004).

([6]) The estimated acreage of poppy cultivation in the mid-1970s was over 16,000 ha (Lagerspetz and Moskalewicz, 2002).
([7]) A profit-oriented drug market only appeared in the late 1980s.
([8]) Over 300 articles on drug addiction were published in 1981, compared with only 40 over the whole previous decade (Abucewicz, 2006).

mainly after the imposition of martial law by the Polish government between December 1981 and July 1983 (Krajewski, 2004).

The problems related to the use of *kompot*, a substance that contains highly toxic residues due to its primitive production process, increased rapidly in the early 1980s. Hospital admissions for drug dependence tripled from about 1 000 in 1980 to about 3 000 in 1984 (Świątkiewicz et al., 1998), while the number of registered drug-induced deaths grew from 18 in 1978 to 102 in 1982 (Krajewski, 1997). There was also a change in the socio-demographics of drug users, with most new users coming from working class families rather than from the elite, as had previously been the case. These developments triggered changes in the state treatment system and, for example, the first detoxification and addiction treatment ward opened at the psychiatric hospital in Warsaw in 1980 ([9]). However, the number of beds in specialised facilities remained very low, with only 90 beds reported in 1981 (Godwod-Sikorska et al., 1981) and with most drug users undergoing treatment in generic psychiatric services (Świątkiewicz et al., 1998).

A more in-depth transformation of the Polish drug treatment system had, however, started. Attempts to treat drug users with new methods had already been reported in the early 1970s, notably at the Sanatorium for Children and Young People in Garwolin (Marcinkowski and Jabłoński, 2008). At the end of the decade, the concept of a therapeutic community and long-term rehabilitation was first implemented within the Sanatorium, before becoming an independent institution in Głosków managed by the non-governmental organisation (NGO) ([10]) MONAR ([11]), which was created in 1981. Its charismatic founder, Marek Kotański, was a psychologist whose work was strongly inspired by the Synanon model in the USA ([12]) (Świątkiewicz et al., 1998) (see the box 'NGOs' involvement in drug policy').

The following years saw a rapid increase in the number of NGOs and treatment centres, mainly based on the model of the therapeutic community developed in Głosków (Marcinkowski and Jabłoński, 2008). This resulted in a growing differentiation of drug treatment provision, with a psychiatric approach in the state healthcare system on the one side and more socio-therapeutic oriented centres run by NGOs on the other side (Świątkiewicz et al., 1998). The main players in this new system were psychologists and psychiatrists who had been working within the state system and were now willing to

([9]) The first special wards for drug-addicted prisoners were set up in 1986.
([10]) NGOs were initially called 'social' or 'voluntary' organisations.
([11]) Youth Movement for Prevention of Drug Addiction.
([12]) Synanon was an organisation providing rehabilitation services to drug users. It was founded in California in 1958 and pioneered new approaches in group therapy (Batiste et al. 1971). It was formally dissolved in 1991 after many controversies regarding both its methods and its revenues. There is still an active branch in Germany.

NGOs' involvement in drug policy

The role and activities of NGOs since the early 1980s significantly influenced the present shape of demand reduction interventions in Poland, which is built on cooperation between them and the public sector. NGOs provide the largest share of services and account since the late 1980s for about two-thirds of the institutions working at the national level. Over half of the current institutions run by NGOs began their operation before 1989 and these most experienced organisations with long period of operation in the field of demand reduction are primarily financed by public funds (Sobiech, 2008).

The involvement of NGOs in drug prevention and treatment started in the late 1970s. The first of these, MONAR, is still considered the most influential NGO in this field. Nowadays, it runs about 70 institutions, including 31 treatment and rehabilitation centres (therapeutic communities) and 37 counselling centres for prevention and therapy (MONAR, 2012). The NGO's first institution, a therapeutic community, was designed for approximately 30 people (Marcinkowski and Jabłoński, 2008). It was based on equality among members and full abstinence, and became a model for other residential centres. Therapeutic communities are managed by teams of professionals from various backgrounds, and former drug users who successfully completed therapy and underwent training. The latter represented 40 % of MONAR's staff in 2008 (Koczurowska, 2008). Since the beginning of the 1980s the organisation has also implemented drug prevention activities and in 1985 it developed The Pure Hearts Movement, a project promoting a healthy and drugs-free lifestyle among young people.

Other NGOs providing services in the drugs field in the 1980s and early 1990s (prevention, consultations, help lines, detoxification, etc.) included the Society for Prevention of Drug Abuse (Towarzystwo Zapobiegania Narkomanii, 1983), the Association of Parents and Friends of Addicted Children — Return from D[ependence] (Towarzystwo Rodzin i Przyjaciół Dzieci Uzależnionych — Powrót z U, 1985), the Society for the Prevention of Social Pathologies — Kuźnia (Towarzystwo Zapobiegania Patologiom Społecznym 'Kuźnia', 1987) and the Roman Catholic Anti-drug Movement KARAN (Katolicki Ruch Antynarkotyczny KARAN, 1992).

develop, sometimes with their patients, new alternatives to existing mental health services ([13]). This was echoed within the new public debate on drugs in which MONAR, for example, vociferously demanded the development of specialised care services for dependent drug users ([14]). The government did not oppose such developments, as the major actors in the field did not blame state authorities for the existing drug problem (Moskalewicz and Świątkiewicz, 1999). The drugs issue also diverted public attention away from other issues, such as alcohol problems or lack of basic day-to-day products, even food, in the country. It is within this context that policymakers gradually shifted from an ideological definition of drug problems linked to the crisis of capitalist societies to a more clinical one (Abucewicz, 2006), with an emphasis on inter-generation conflict.

This transformation was reflected in the new Act on Prevention of Drug Addiction adopted in January 1985. Both the expert committee who prepared the draft and the parliamentary committee who adopted it gave it a strong public health orientation. The new law was rather unusual given the generally punitive attitudes of the communist authorities, and by today's standards it would be perceived as quite liberal (Krajewski, 2004). It introduced criminal sanctions for drug supply only, and differentiated between simple supply, i.e. drugs sharing (punished with imprisonment of up to three years) and supply for gain, i.e. dealing (punished with imprisonment of up to 10 years). Drug users were only subject to administrative sanctions (drug confiscation), independently of the amount of substance involved (Krajewski, 2007). The law also laid down the foundations for the health and social care system. Treatment, rehabilitation and social reintegration for drug users were to be performed by public health centres with the support of NGOs and church organisations, a rather unexpected partnership within a communist country. The law also stated that treatment should take place with the voluntary consent of drug users. Compulsory treatment needed to be court-mandated and limited to two years, and was only admissible in two situations ([15]).

The 1985 law also included control measures for poppy cultivation: it now required a licence from the local government and a contract for selling the poppy straw to state agencies (Sierosławski et al., 1998). Growing poppy in violation of these provisions was a criminal offence punished by up to two years imprisonment, community services or a fine. This led to a progressive reduction of the total acreage of poppy cultivation from 20 000 to 4 000 hectares (Moskalewicz and Świątkiewicz, 1999), thereby limiting the availability of the raw material used to produce *kompot*. However, cultivation continued, mainly by farmers who were not aware of the new provisions, and poppy cultivation constituted around 70 % of drug offences for a few years after 1985 (Krajewski, 2001). The use of Polish home-made heroin remained widespread over the next decade ([16]) as users were still able to produce the drug for themselves and for their friends (Moskalewicz and Świątkiewicz, 1999). The control measures also contributed to the emergence of a profit-oriented black market (Krajewski, 1997).

The 1985 law also provided for the funding of drug-related research and for the creation of a central drug coordination body — the Commission for Drug Addiction Prevention — to be composed of state officials, representatives of NGOs and church organisations and researchers. The Commission's main task was to draft annual drug prevention programmes and to coordinate their implementation. Resources for the programmes were to come from a special fund within the budget administered by the Minister of Health and Social Care. However, due to a conflict of interests between ministries the Commission was never created and no programme was drafted until 1993 (Osiecka, 1995). The lack of central coordination in the late 1980s also impeded the implementation of tasks for which local authorities were responsible, such as co-financing of medical treatment or prevention and education in public schools. This resulted in an increase in NGOs activity in the late 1980s.

Available indicators suggest that drug use stabilised or even declined after 1985 (Moskalewicz and Welbel, 2013). Meanwhile, the availability of drug treatment increased to 55 outpatient facilities, including 30 treatment units run within the national health system and 25 counselling centres run by NGOs. Inpatient services included over 100 beds for detoxification provided in separate units within mental health services and more than 30 rehabilitation centres, totalling over 900 beds, which were partly run by the State and partly by NGOs, with MONAR as the main provider (Świątkiewicz et al., 1998).

The first case of human immunodeficiency virus (HIV) infection among drug users was detected in Warsaw in August 1987 ([17]) (Marcinkowski and Jabłoński, 2008). Within around 18 months the number of newly diagnosed cases increased to more than 500 (Moskalewicz and Świątkiewicz, 1999). The

([13]) In under 3 years MONAR had developed 14 residential rehabilitation centres, mostly in rural areas (Świątkiewicz et al., 1998).

([14]) MONAR's activities inspired wider groups of society. In 1981 a group of 1 570 pupils from Warsaw signed an open letter (Apel Młodzieży) to the national authorities that was published by major newspapers. It demanded the creation of a wider treatment network for drug users based on MONAR's therapeutic community model.

([15]) For minors (person under 18 years old) sent by a family court following the request of parents or educators and for adult drug users with a prison sentence. If the sentence is not suspended, the court may decide to place the offender in a closed treatment institution before serving the sentence. Both provisions were slightly modified but still exist today.

([16]) In 1996, more than 70 % of patients in residential drug treatment were dependent on opioids (Sierosławski, 2002), with the majority using home-made Polish heroin . The substance is still produced and consumed in Poland.

([17]) Some articles report that this first case was diagnosed in August 1988.

idea of developing syringe exchange programmes to prevent the spread of HIV/AIDS had already been discussed in 1986–87 but was not implemented for a variety of reasons, including a lack of disposable syringes. The situation changed when the first case of infection was reported and in 1988–89 syringe exchange programmes started (Moskalewicz and Świątkiewicz, 1999), first in MONAR counselling centres and then in public outpatient clinics (Moskalewicz and Welbel, 2013) ([18]). MONAR also started to provide syringes in public places where drug users were gathering. Earlier, the NGO had established a special centre only for HIV-infected drug users in Zbicko, near Opole, but starting from 1988, this group of users was admitted to all of MONAR's facilities and to most of those run by other NGOs (Marcinkowski and Jabłoński, 2008).

A time of transition (1989–99)

The fall of the Iron Curtain in 1989 had a significant impact on Poland's drug situation. Like some other post-communist countries, Poland became a new transit zone for smuggling drugs to western Europe (Krajewski, 1997). The range of illicit substances available in the country also widened, with amphetamine and cannabis rapidly becoming popular drugs, while others, such as LSD and ecstasy, were mainly used in the largest cities, including Warsaw, Poznań and Gdańsk (Lagerspetz and Moskalewicz, 2002). The availability of cocaine and heroin was initially more restricted because of their relatively high price.

Increasingly differentiated drug use patterns developed in Polish society. Those who had started drug use earlier and those who were among the most affected and marginalised by the economic and social changes of the early 1990s ([19]) tended to follow the 'old' patterns of use by injecting home-made Polish heroin (Sierosławski et al., 1998). Meanwhile, young people with access to international youth culture used the newly available substances. According to ESPAD data, 9 % of school students aged 15–16 had used drugs, mostly cannabis, at least once in 1995 and twice as many (18 %) four years later (Lagerspetz and Moskalewicz, 2002). And while in 1995 synthetic drugs such as amphetamine and ecstasy were practically unknown, four years later 7 % of school students reported having used amphetamine (Moskalewicz and Świątkiewicz, 1999).

This was also due to the fact that Poland became a major producer of illicit amphetamine. The phenomenon had already been reported in the late 1980s but grew significantly in the early 1990s. In 1992 an estimated 200 laboratories produced the drug within the country (Lagerspetz and Moskalewicz, 2002) and by the mid-1990s it was estimated that 10–25 % of amphetamine sold in Europe had originated in Poland (Krajewski, 2001). Short smuggling routes to western Europe, police forces with a lack of experience in combating drug production and trafficking, no legal control over precursors such as BMK and highly qualified but often underpaid chemists were among the main contributors to this development (Krajewski, 2001).

The increased availability and use of drugs in Poland was associated with rising drug problems ([20]). In 1990 and 1991 hospital admissions due to drug dependence increased for the first time since the mid-1980s, by 14 % and 26 % respectively (Moskalewicz and Świątkiewicz, 1999), while the number of drug-induced deaths reached 167 in 1992 (Krajewski, 1997). Over the next decade the total number of drug users entering inpatient treatment tripled from 2 803 in 1990 to 8 590 in 2000 (Sierosławski, 2002), with increasing proportions of drug users entering such treatment for the very first time, from 45 % (1 260) in 1990 to almost 60 % (5 075) in 2000 (Sierosławski, 2002).

The social perception of problem drug users also changed with the spread of HIV/AIDS (acquired immune deficiency syndrome). About 70 % of all diagnosed HIV cases were among injecting drug users, who represented by far the largest risk group (Szata, 1996). This caused significant tensions within Polish society ([21]), partly because little was known about the transmission of the disease (Sierosławski et al., 1998). A range of educational campaigns and preventive actions were subsequently launched, while new centres for people living with HIV/AIDS were opened in 1991 in Konstancin and Piastów (Marcinkowski and Jabłoński, 2008). Education and harm reduction measures also contributed to the reduction in the number of new HIV infections among injecting drug users from about 600 in 1990 to 300 in 1992 and fewer than 200 in 1993.

Poland was the first among the former communist countries to introduce a methadone prescription programme in 1992 (Marcinkowski and Jabłoński, 2008). Sixty patients dependent on Polish heroin received this type of treatment as part of a research project at the Institute of Psychiatry and Neurology in Warsaw (Karakiewicz et al., 2004; Moskalewicz and Welbel, 2013). In 1997 methadone maintenance treatment was recognised as a legitimate treatment to be financed by public

([18]) There were still problems with the availability of syringes and MONAR used donations from pharmacies and foreign organisations for its programmes. It is estimated that around 10 000 injection kits were distributed annually in the early years of the syringe exchange programmes in Poland (Kulka and Moskalewicz, 1998).

([19]) Unemployment in Poland, which was very low during communist times, grew to 6.6 % at the end of 1990 and to almost 17 % in 1994 (Moskalewicz and Świątkiewicz, 1999).

([20]) Alcohol consumption and related problems increased even more rapidly after 1989 (Moskalewicz and Świątkiewicz, 1999).

([21]) For example, a protest was held in a rural community at Głosków to demand the closure of MONAR's very first rehabilitation centre.

funds ([22]). The new law defined the eligibility criteria for participation in the programme, and provided that substitution programmes could only be run by public healthcare institutions under a special permit issued by the Minister of Health and Social Care. This limitation was heavily criticised as an obstacle to the expansion of methadone programmes in the following years, particularly because of the context of a notoriously underfinanced national healthcare system (Krajewski, 2004). Furthermore, the thresholds to access and remain within this type of treatment were very high. All of this contributed to the slow development of substitution treatment in Poland, with only eight registered programmes and 550 patients in 1999. That year, the adoption of a restrictive directive on opioid substitution treatment (OST) further discouraged the development of new programmes (Moskalewicz and Welbel, 2013) (see the box 'Opioid substitution treatment in Poland').

Outpatient treatment and counselling services for drug users developed throughout the 1990s, with the number of counselling services reaching 34 in 1998. A reform of residential treatment was planned within the 1993 National Programme for Prevention of Drug Addiction, which anticipated that only 40 % of existing long-term rehabilitation centres (with two-year programmes) would be maintained and that the remainder would provide shorter treatment (up to one year). However, by 1997 two-thirds of rehabilitation centres retained the two-year approach (Świątkiewicz et al., 1998). In 1999 the estimated number of beds offered in this sector was 1 600 (Marcinkowski and Jabłoński, 2008). New types of services were also developed, such as intermediary treatment centres, including day-care facilities. Regular harm reduction programmes, mostly run by NGOs, have also been conducted in large cities since 1996 (Reitox National Focal Point, 2011).

The transformation of the drug market and increasing drug-related problems prompted discussions about drug policy in post-communist Poland. The development of a profit-oriented and sometimes violent black market dominated by criminal organisations contributed to a gradual shift in the public debate from viewing drug policy as a health issue, to perceiving it as a law and order issue (Moskalewicz and Świątkiewicz, 1999). The legal provisions regarding the possession of drugs for personal use were increasingly criticised in public debates and various stakeholders called for making it a criminal offence: the police advocated that it would help to solve drug supply problems, politicians stressed its educational effects and some NGOs argued that it would reduce drug use (Krajewski, 2004). The provisions of the 1985 law were also associated with the previous regime and therefore subject to rejection (Moskalewicz and Świątkiewicz, 1999). In contrast to debates in the 1980s, discussions were also influenced by international issues and notably by Poland's ratification, in 1994, of the 1988 UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. Proponents of the criminalisation of possession of drugs for personal use stressed that Art. 3(2) of that convention required states to do so, an argument that played an important role during the development of a new drug law (Krajewski, 2004).

The new Act on Countering Drug Addiction of 24 April 1997 was passed in the parliament by a large majority of votes with cross-party support. It criminalised any possession of drugs but introduced provisions allowing that possession of small amounts for personal use could not be subject to punishment other than the confiscation of the drug (Krajewski, 2004). Exemption from punishment was mandatory and did not fall under the discretion of the prosecutor or the court ([23]). The intended objective was to allow the prosecution of drug dealers found with small amounts but not to further marginalise problem drug users. It was later presented as a 'common sense approach', with a balance between punitive and compassionate attitudes, and which allowed law enforcement efforts to be directed primarily to the supply side of the drug problem (Krajewski, 2004).

The new law also further strengthened the public health approach to drugs issues. The scope of alternatives to punishment for dependent offenders was broadened and the prosecutor could suspend the proceedings during the pre-trial phase, including the investigation, if the offender underwent treatment ([24]). Criminal sanctions were thereby used as a tool to motivate drug users to undergo treatment rather than as an instrument of repression (Krajewski, 2008). The new law also facilitated the expansion of needle and syringe exchange programmes that had been run mostly by NGOs for the previous eight years. The legal basis for these programmes was further strengthened in 2001 with an explicit mention of harm reduction activities among the tasks to be performed in the field of drug prevention (Krajewski, 2004).

The number of drug-law offences increased rapidly during the 1990s from 1 105 cases in 1990 to 15 628 in 1999, with a very significant increase following the adoption of the new law in 1997 (Reitox National Focal Point, 2002). The number of drug dealing offences rose from just 121 cases in 1990 to 10 305 in 1999. A threefold increase in dealing offences was reported immediately after the adoption of the new law, with 3 507 cases in 1997 and 10 762 in 1998 (Reitox National Focal Point, 2002; Krajewski, 2004), suggesting that the new

([22]) Until 1997, all programmes had a research status.

([23]) The term 'small amount' was, however, undefined. This was intended to provide some flexibility, but in practice the police and prosecutors saw it as a problem, which contributed to its deletion three years later (Krajewski, 2004).

([24]) In the case of a crime sanctioned by a penalty not exceeding five years of imprisonment, the prosecutor can suspend the investigation if the accused agrees to enter treatment. If treatment is completed successfully, the offender benefits from the so-called conditional discontinuance of proceedings. This mechanism is applied by the court upon an application of the prosecutor and leads to the imposition of a probation period of one to two years. Once this is completed, the person has no criminal record relating to the events.

legislation seemed to achieve its objectives in this area. The overall increase in registered drug-law offences was, however, largely due to improvements in policing (Krajewski, 2004) as modern techniques of crime investigation were introduced, including exceptional measures such as 'invasive' investigation techniques (e.g. electronic surveillance, controlled purchases and supplies) or witness protection measures (anonymous witness and 'crown witness' ([26]). Special drug squads were created within the police forces of some major Polish cities in the second half of the 1990s, and a newly established Narcotics Bureau began operating at the national level ([27]). Law enforcement bodies also became more proactive towards street dealing.

Drug policy coordination in Poland

The first drug policy coordination body in post-communist Poland — the Bureau for Drug Addiction — was established in 1993 by the Minister of Health and Social Care. It coordinated the activities of state institutions and NGOs active in demand reduction. One of its main tasks was to develop a national drug strategy — the National Programme for Preventing Drug Addiction of 1993.

The first comprehensive National Programme for Counteracting Drug Addiction, also covering supply reduction, was adopted in 1999. Following this, the Bureau for Drug Addiction was renamed the National Bureau for Drug Prevention and its mandate was extended to the coordination, implementation and monitoring of the National Programmes that, since 2006, have a legal status. The current programme for 2011–16 is divided into five areas: prevention; treatment, rehabilitation, harm reduction and social reintegration; supply reduction; international cooperation; and research and monitoring ([25]).

Since 2001 the high-level strategic coordination of drug policy in Poland has been performed by the Council for Counteracting Drug Addiction. It includes Undersecretaries of State from the Ministries of Health, Internal Affairs, Justice, Education, National Defence, Agriculture, Social Care, Public Finances, Foreign Affairs, and Science. The Undersecretary of State of the Ministry of Health is the Chair of the Council and the Director of the National Bureau for Drug Prevention is its Secretary. The Council has four working groups: precursors; international cooperation; implementation of the National Programme; new psychoactive substances.

Local and regional authorities have been involved in the implementation of drug policy since 1999, after a major reform of the State established 16 provinces (voivodeships), 314 counties and 2 417 municipalities. The reform, which moved some competences from the central to the local level, only became effective in the drugs area in 2005, when the new Act on Counteracting Drug Addiction indicated the funding sources of decentralised activities and clarified the responsibilities of local and regional authorities. These are mainly related to the funding of prevention activities and, to a lesser extent, treatment and rehabilitation programmes. Local and regional authorities are also responsible for the implementation of regional strategies, which by law are in line with the National Programme. The provincial governments appoint drug coordinators and information experts on drugs and drug addiction who collect and exchange information in this area.

([25]) An expected spending of nearly EUR 70 million (PLN 294 million) for the implementation of the programme was presented by the authorities.

([26]) The Crown Witness Act was adopted on 25 June 1997, and provides the possibility for perpetrators to act as witnesses in organised crime cases. Perpetrators who testify against accomplices receive a special protection programme for a crown witness, including evading criminal responsibility.

([27]) The Narcotics Bureau had functioned since 1997 as a specialised unit within the national police headquarters. In April 2000 it was combined with the Organised Crime Bureau (operating since 1994) and became part of the newly established Central Bureau of Investigations.

Alcohol and tobacco policies

Policies on illicit drugs, alcohol and tobacco have developed separately in Poland, although there is a link between drug and alcohol policies at the local level. According to the main drug law, municipalities are encouraged to use alcohol licensing funds to develop prevention activities targeting both alcohol and drug use. In addition, there is a recent trend of cannabis clients being treated in the health and counselling centres for alcohol. Behavioural dependencies, including pathological gambling, addiction to the Internet and to shopping have since 2010 fallen under the National Bureau for Drug Addiction, which has been granted a special fund for this area.

The Act on upbringing in sobriety and counteracting alcoholism of 1982 is the main legislation governing the supply of alcohol. The minimum age at which alcohol (beer/wine/spirits) can be purchased is 18. There are no restrictions on hours or days of sales, but it is prohibited to consume alcoholic beverages in public places enumerated in the Act, including streets, squares, parks and public transports. Poland's recorded per capita alcohol consumption for adults (aged 15 and over) is 9.6 l of pure alcohol per year, with beer and spirits being the main beverages (World Health Organization, 2011), which places the country as the tenth highest among the EU-28 (OECD, 2012). The State Agency for the Prevention of Alcohol-Related Problems was established in 1993 and is responsible for the coordination of alcohol policy at the central, voivodeship and municipal levels. The main activities in this field are in the National Programme for Preventing and Solving Alcohol-Related Problems 2011–15.

Tobacco control is defined in the Act on the Protection of Health Against the Consequences of Tobacco Use of 1995. The main activities in the area of prevention are defined in the Programme to Reduce Health Consequences of Tobacco Use in Poland 2010–13. The implementation and coordination of the programme lies with the General Sanitary Inspector, who performs tasks on the behalf of the Minister of Health. The minimum age for purchasing tobacco is 18. While Poland was one of the first countries in the world to prohibit the advertisement of tobacco products (Zatoński et al., 2011), it ranked 19th out of 30 European countries on the tobacco control scale in 2010 for its combination of tobacco pricing, bans in public places, information campaigns, bans on advertising, health warnings on packaging and the provision of treatment options for dependent smokers (Joossens and Raw, 2011).

In search of the right balance (2000 onward)

The injection of *kompot* was still the main cause of drug-related problems in Poland at the end of the 1990s, but treatment data from Warsaw showed that the use of imported heroin, both smoked and injected, was progressively developing (Lagerspetz and Moskalewicz, 2002). Seizures of the drug also increased at the turn of the century, while the number of reported drug-induced deaths, mostly linked to the use of opioids, increased from 235 in 1998 to 324 in 2002 (Reitox National Focal Point, 2005).

In a survey conducted in 2000 some 21 % of the Polish population claimed that drug abuse was among the three social issues of highest priority, compared to 14 % in 1994 (Lagerspetz and Moskalewicz, 2002). The increase in the number of supply offences was also interpreted by some media and politicians as a sign of a dramatic increase in street-level drug dealing (Krajewski, 2004), while police forces complained that, under the provision of the 1997 Act, dealers found with small amounts of drugs could not be effectively prosecuted without evidence of an actual transaction.

After a government change in 1997, an amendment to the Act on Countering Drug Addiction was drafted by a group of members of Parliament. It included the deleting of Art. 48(4) stating that possession of small amounts of drugs for personal use was not to be subject to criminal punishment. The objective was to discourage drug use, especially among young people, and to improve the detection and prosecution of drug dealers. The amendment was supported by both the government coalition (conservative and liberal) and the social democratic opposition (Krajewski, 2004). The change entered into force in December 2000 and resulted in the penalisation of any possession of drugs, including small amounts for personal use (Krajewski, 2008). Since then, almost every case of drug possession is subject to proactive law enforcement measures (Krajewski, 2013).

Over the following decade, *kompot* and imported heroin co-existed as main problem drugs in Poland, although heroin was mainly smoked and not injected, as had been feared. Data from needle and syringe programmes also suggested a progressive reduction of opioid use, in particular *kompot*, towards the end of the decade (Malczewski, 2013). However, amphetamine use, including intravenously, developed among problem drug users during the 2000s and Poland saw the

emergence in 2000/2001 of a new potent substance, PMMA ([28]), which was associated with several deaths. Mephedrone, another stimulant, became popular after 2008 not only among recreational drug users but also among injectors.

Poland became an EU Member State in May 2004 and took additional steps to develop its drug-monitoring system and to harmonise its drug legislation with existing EU directives and regulations. A new drug law was adopted in July 2005 that clarified the tasks and competences of local and regional governments in the drugs area, enabling local authorities to use funds from alcohol taxes for drug prevention activities. It also fine-tuned other provisions: a new definition and categorisation of drug precursors was introduced ([29]) as well as some new measures strengthening the public health approach to drug use, such as the availability of an alternative to punishment for recreational drug users with high-risk behaviours ([30]).

The new law also extended the range of institutions entitled to provide OST to all healthcare centres possessing a license from a local authority. However, contrary to expectations, private treatment providers were not willing to open new programmes, pointing out the complicated regulations, procedures and funding practices (Moskalewicz and Welbel, 2013). In 2009 the Council for Counteracting Drug Addiction noted that only about 7 % of problem opioid users (1 900) in Poland received OST when the national objective was 20% (Reitox National Focal Point Report, 2010). The Council called for increased funding by the National Health Fund, but expenditures remained stable in 2010 and fell by nearly 23 % in 2011, before slightly increasing in 2012 (5.3 %) ([31]). Meanwhile, thresholds for entering opioid substitution treatment were lowered in 2010, allowing any adult opioid user to enter OST without having tried other forms of treatment beforehand and irrespectively of the duration of drug dependence (previously at least three years). In 2011

The main drug law in Poland

The main drug legislation is the Act of 29 July 2005 on Counteracting Drug Addiction and its amendments. The law does not penalise drug consumption, but any drug possession is a criminal offence. Most drug offences can take a basic, aggravated or less serious form, depending on the gravity of the offence and the quantity of drugs. A basic possession offence is punished by up to three years' imprisonment, and in case of possession of large amounts of drugs by one to 10 years' imprisonment. A less serious form of possession offence is punished by up to one year of imprisonment, community services or a fine. Since 2011 possession of drugs for personal use may remain unpunished, subject to the discretion of the prosecutor and the judge.

As a rule, participation in treatment, rehabilitation and re-adaptation programmes is voluntary. The law only provides for compulsory treatment in specific cases for minors and for addicted drug users with a non-suspended prison sentence, who may be referred to treatment by the court before serving the sentence. The law also allows for breaks in serving the sentence for treatment purposes.

The law distinguishes several types of supply offences depending on the above-mentioned factors, but also whether there is an aim of receiving personal or material gain, and supply to minors. Import, export and transit of drugs are punished by up to five years' imprisonment (up to one year if less serious offence, at least three years if an aggravated offence). Introduction of drugs into circulation (i.e. participating in production on any level, excluding delivery to the final customer) is punished by six months to eight years' imprisonment (up to one year if a less serious offence, two to 12 years if an aggravated offence). Street-level dealing, defined as 'giving drugs in order to receive personal or material gain', is punished by one to 10 years' imprisonment (up to two years if a less serious offence, at least three years if an aggravated offence). It is distinguished from giving drugs, i.e. supply without intent to receive gain, which is punished by up to three years' imprisonment (six to eight months if an aggravated offence).

The list of controlled substances is included in two annexes to the law. The first covers narcotic substances and the second covers psychotropic substances. Each list is divided into four sub-groups. Both lists and groups reflect the international drug control system's classification. In 2004 a list of precursors was removed following Poland's accession to the European Union, and the act refers directly to European regulation in this area (Regulation 273/2004/EC).

([28]) Para-methoxyamphetamine.
([29]) As required by Regulation (EC) No. 273/2004 on drug precursors.
([30]) Until 2005 the suspension of criminal proceedings for treatment purposes was only available to dependent drug users. The suspension of proceedings for recreational users is conditional on participation in an 'educational–prevention' programme.
([31]) Expenditure on substitution treatment by the National Health Fund has increased steadily from 2006 (PLN 3 081 215, or about EUR 734 000) to 2009 (PLN 16 798 181, or about EUR 3 978 000). In 2010 expenditures remained similar to the previous year (PLN 16 536 143, or around EUR 3 937 000), and in 2011 they fell significantly (PLN 12 677 060, or around EUR 3 018 000).

some 32 programmes (including seven in prisons ([32])) provided treatment to 2 200 patients (see the box 'Opioid substitution treatment in Poland').

Drug treatment in Poland is free of charge and financed by the National Healthcare Fund and by the communes and/or counties at the local level. Treatment services, including detoxification units, rehabilitation centres, outpatient clinics and counselling centres, continued to develop during the 2000s. Available data suggest that the number of inpatient rehabilitation centres grew from about 50 in the early 2000s (Reitox National Focal Point, 2005) to more than 80 in 2011 (Reitox National Focal Point, 2012). The number of beds is estimated at about 2 500 and most centres still offer long-term treatment of one to two years based on the therapeutic community model ([33]). Financial constraints and changes in the profiles of drug users, with less opioid users, have apparently contributed to a recent trend towards shortening treatment (Reitox National Focal Point, 2012). The number of detoxification units was 19 in 2011 and they provided about 200 beds (Bukowska, 2013).

A related development during the early 2000s was the professionalisation of the non-medical drug treatment sector via a system of training and certification. The director of the National Bureau for Drug Prevention requested a team of experts to develop guidelines that could serve as the basis for such a certification system, while an amendment to the drug law mentioned the compulsory certification for drug therapists (Bukowska, 2008). Training started in 2002 with two different curricula depending on the level of experience and education and, up to 2013, almost 1 200 professionals had been certified through the system (Bukowska, 2013). The two-year courses are run by independent institutions such as research centres, universities and NGOs.

Opioid substitution treatment in Poland

Poland was the first among central and east European countries to introduce OST in 1992 but, as in several other countries of the region, its development has been very slow, with only 2 200 patients undergoing OST in 2011. Present impediments to its expansion include limited availability and inefficient management of public funds, the exclusion of GPs as treatment providers, complicated regulations and procedures, the influence of the Catholic Church (Moskalewicz and Welbel, 2013) and the historical development of drug-free treatment in Poland (Sieniawska and Charmast, 2011).

The initial opposition to the development of OST was linked with the belief that drug treatment requires abstinence and a stay in a closed facility. Health professionals also opposed the replacement of 'one addiction with another', especially when no clear legal basis was available (Beniowski, 2008). The legal recognition of OST in 1997 was followed by a gradual expansion, with at least one new programme opening every year in a different city (1998: Zgorzelec, Szczecin; 1999: Lublin; 2000: Krakow; 2001: Poznan). The biggest expansion happened between 1995 and 2000 (Malczewski, 2007) but the underfinancing of the Polish healthcare system (OST was only allowed in public institutions) slowed the upward trend. This prompted the 2005 legal change allowing new players to run substitution treatment programmes. However, this did not bring the expected expansion, due to complicated procedures and funding provisions (Moskalewicz and Welbel, 2013).

Only high-threshold substitution treatment is available in Poland ([34]). Most clients receive methadone, but Suboxone (a combination of buprenorphine and naloxone) is now also available. In 2010 thresholds to enter substitution treatment were partly lowered and this met the opposition of some of the oldest NGOs, which have created the drug-free treatment system in Poland and continue to play a major role in shaping drug policy (see the box 'NGOs' involvement in drug policy'). Their opposition, although softening over time, is still one of the factors that makes the Polish treatment system difficult to reform (Świątkiewicz et al., 1998).

([32]) The first methadone programme in prison was opened in Kraków in 2003.

([33]) Seventy out of 79 centres, run by the state and by NGOs, report using a therapeutic community model (Reitox National Focal Point, 2012).

([34]) According to a 2013 directive of the Minister of Health, participation in an OST programme is subject to: (1) being opioid dependent, (2) being over 18 years old, (3) express consent to participate in the programme and agree to follow its rules. A decision on the discharge of a patient is left to the discretion of OST managers and may be taken in specific circumstances, such as: at least three consecutive positive results of urine tests for the use of other drugs, refusal to undergo the urine tests, giving a substitution medication to someone else. As a rule, substitution medication is given in daily doses and taken in the presence of medical personnel. In exceptional cases and after six months of successful treatment, a substitution drug may be provided for a full week.

There are now over 200 outpatient clinics and counselling centres for drug users in Poland ([35]). They provide a range of services, including post-rehabilitation through group therapy, social assistance and training (Reitox National Focal Point, 2012). Their offer varies across the country, depending on the provider, the number of personnel, their qualifications and the preferred model of treatment (Bukowska, 2013). New treatment options were also developed, such as 'FreD goes net', an early intervention programme for young drug users that has been implemented since 2007 in 50 cities in Poland. The programme relies on brief interventions and motivational interviewing, and aims to prevent young drug and alcohol users aged 14 to 21 from becoming drug dependent. Another example is CANDIS, an evidence-based treatment programme for cannabis-related disorders, which has been implemented since 2011. These new approaches have responded to changes in the profile of drug users, including an increase in cannabis-related problems among young people.

Twenty-one needle and syringe exchange programmes (NSPs) were operational in 2002 in 23 Polish cities and they distributed an estimated 668 000 needles and syringes, a 10-fold increase compared to 1998 (Reitox National Focal Point, 2012). While the amount of distributed needles and syringes reached its highest level in 2004 with 731 000 units, the number of programmes and host cities has been decreasing since 2002. In 2011 they had fallen to 12 programmes in nine cities, mostly located within drop-in centres, providing about 335 000 needles and syringes to their clients. The number of NSP clients has also fallen since 2005, from 5 000 to about 2 100 in 2011 (Reitox National Focal Point, 2012 ([37])).

Steps have been taken to improve the quality of prevention activities in Poland. In 2010 the National Bureau for Drug Prevention, in cooperation with key institutions in this field, introduced a system of recommendations for drug prevention

Responding to new psychoactive substances and the increasing number of smart shops

Three consecutive amendments to the drug law were introduced as a response to the rapidly growing number of smart shops. The first two amendments, in March 2009 and June 2010, enlarged the list of controlled drugs by 18 and 10 new substances respectively. These were, however, rapidly replaced and the number of smart shops continued to grow. Surveys among students aged 18 and 19 also found a significant increase in the use of 'boosters', from a lifetime prevalence of 3.5 % in 2008 to 11.4 % in 2010. The number of reported poisonings also increased rapidly in 2010, with 70 cases reported in August and 123 in September.

On 2 October 2010 the General Sanitary Inspector issued a decision to close all 1 378 existing smart shops for a period of 30 days. A few days later, over one weekend, several hundred sanitary inspectors and about 3 000 policemen inspected almost 1 000 retail shops and wholesale companies, of which 900 were immediately closed (Centrum Informacji o Narkotykach i Narkomanii, 2011). In parallel, an amendment of the drug law modified the definition of a substitute drug ([36]) and imposed a ban on such substances, with fines for producers and retailers ranging from EUR 5 000 to EUR 250 000. Additional changes were introduced in the consumer product safety regulations contained in the Act on State Sanitary Inspection. Under reasonable suspicion, a competent sanitary inspector was now allowed to withdraw a product for up to 18 months in order to examine its potential harms. In addition, specific prevention measures were implemented especially for adolescents. This included a new helpline, a website (www.dopalaczeinfo.pl) and new information materials (Reitox National Focal Point, 2012).

The legal changes benefited from broad support but also faced some criticism, particularly because of the very broad definition of a substitute drug and the lack of specific procedures and prerequisites for assessing a new product (Kapka-Skrzypczak et al., 2011). Despite these concerns, the amendments entered into force and their implementation was associated with a rapid reduction of the number of poisonings, from 258 cases in October 2010 to 60 cases the following month. However, new psychoactive substances continue to be advertised on the Internet and in 2013 there were some media reports about their availability in video rental shops, pawnshops and grocery stores.

([35]) Data on the distribution of outpatient clinics and counselling centres are difficult to find but it is likely that their numbers are relatively similar.

([36]) 'Any substance of natural or synthetic origin in any physical state or a product, plant, mushroom or part thereof, containing such a substance, used instead of a narcotic drug or a psychotropic substance or for the same purposes as a narcotic drug or a psychotropic substance, whose manufacture or introduction to trade is not regulated by separate provisions.'

([37]) Part of the decrease might be due to external factors, including a reduction in drug injection and the provision of cheap syringes in pharmacies.

programmes that aims to increase their quality and promote best practices. However, an internal implementation review after the first year of the National Programme for Counteracting Drug Addiction 2011–16 showed strong disparities in the implementation of prevention activities between urban and rural municipalities and a strong focus on universal rather than selective and indicated prevention.

A significant change in Poland's drug market occurred in August 2008 when the first 'smart shop' selling 'boosters' (the name commonly used in public debate for new psychoactive substances/legal highs) opened in the city of Łódź. By the end of 2008 the number of these shops had already reached 40. Many of them were functioning through franchising agreements with the owner of the first shop. Opening a new shop required only limited investments and had a high potential of profits, and this explains the very rapid increase in the number shops — in 2010, at the peak of the phenomenon, there were almost 1 400 smart shops all over the country (Centrum Informacji o Narkotykach i Narkomanii, 2011). This development triggered growing public health concerns and a public debate on drug policy. As a response, the government prepared a series of amendments to the drug law (see the box 'Responding to new psychoactive substances and the increasing number of smart shops').

As has been mentioned, a significant increase in the number of registered drug-law offences followed the 2000 amendment that made possession of drugs for personal use subject to criminal punishment. The number of offences grew from 19 649 cases in 2000 to 57 382 in 2008, with most offenders being users in possession of small quantities of drugs (Kuźmicz, 2011). This led to criticism of the legal provisions criminalising and penalising possession of drugs for personal use, with independent and governmental experts highlighting the negative side-effects and lack of results of this approach. Instead of preventing drug abuse it had created a new category of criminals (i.e. drug users), kept police forces busy with minor instead of serious drug offences, and was associated with additional public expenditures estimated at about EUR 20 million every year (Kuźmicz et al., 2009).

Under the coordination of the Ministry of Justice, a team of experts prepared a new amendment to the drug law in 2011. It

Poland´s drug situation

Recent population survey data on drug use in Poland show levels that are often above the European average. Some caution must, however, be taken as data shows very significant increases over the period 2006–10 that could also reflect problems with the estimates either at the beginning or at the end of the period. Last year cannabis use among young adults aged 15–34 in Poland was 17.1 % in 2010, above the current European average of 11.7 %. The Polish figure for last year cocaine use among this age group was 1.3 % in 2010 compared to an estimated current European average of 1.9 %. For amphetamines the Polish figure was 3.9 %, three times the European average of 1.3 %. In 2011 almost one in four (23 %) school-aged children aged 15–16 had used cannabis at least once, with an increasing trend compared to the previous survey in 2007 (16 %) (ESPAD, 2012).

The most recent (2009) estimate of the number of problem drug users in Poland had a central value of 79 500, which represents 2.9 cases per thousand population aged 15–64 and is below the estimated European average for problem opioid users only of 4.2 cases. The latest report of the number of drug-induced deaths (overdoses) in Poland was 261 cases in 2010, of which 232 were aged 15–64. The latter represents about 8.4 cases per million population of that age group, with a European average rate of about 18 cases, though the Polish data do not strictly comply with the EMCDDA definition. The number of newly diagnosed HIV cases among drug users (1.2 per million population in 2011) is also below the European average (3.03 cases), but the majority of new infections in Poland have an unknown route of transmission and the figure is therefore likely to be an underestimate.

Every year Polish law enforcement bodies confiscate large quantities of cannabis products. In 2011 some 59 kg of resin, 1 265 kg of herbal cannabis and almost 53 000 plants were seized ([38]). Seizures of cocaine (78 kg) and heroin (51 kg) are relatively low compared to the seizure of amphetamine (395 kg), a drug that is produced within Poland. See the *EMCDDA Statistical Bulletin* for full information.

([38]) An increase in seized cannabis plantations has been recorded in recent years, reaching a total area of 10 593 m2 in 2011 (Reitox National Focal Point, 2012).

introduced Article 62a, which provides the option to discontinue criminal proceedings for individuals caught in possession of a small amount of drugs for personal use ([39]). Contrary to the 1997 law, the new approach relies on the principle of opportunity, which means that the discontinuation of proceedings lies solely in the margin of discretion of the prosecutor or judge. According to the statistics provided by the Ministry of Justice, the new article was applied by the prosecutors in 2 305 cases during the first year. This represents about 12 % of all registered possession cases in 2012 (18 441 cases). The new provision was most often applied in large urban areas, while prosecutors from smaller towns showed significant reluctance. The 2011 amendment also broadened the range of cases where drug offenders could benefit from discontinuation of proceedings for the purpose of treatment ([40]), and introduced the possibility that a prison sentence could be interrupted so that the convicted person is able to attend drug treatment performed outside of the institution ([41]).

Conclusions

This paper examines the drug policy of one of the former communist countries to have joined the European Union in 2004 and 2007. Although it is by far the largest of these countries, Poland cannot be considered to be representative of them all. However, the Polish drug policy profile allows a first insight into some of the specificities of central and east European drug policies both before and after 1989.

One of the first findings of this report is certainly the number of similarities between drug use and drug policy in Poland and in countries located on the other side of the Iron Curtain. This includes an increase in drug use among young people in the late 1960s, with a background of youth protests and new counter-cultures; the spread of opiate use in the second half of the 1970s; the development, in the late 1970s, of therapeutic communities as an alternative to psychiatric care; the definition of a public health-oriented drug policy during the 1980s; and the implementation of needle and syringe exchange programmes in the late 1980s. Europe definitively was not as differentiated as might have been thought, and the Iron Curtain was not as effective as those who erected it had wanted it to be.

However, when looking at the details, differences surface rapidly: Polish hippies used mostly diverted medicines; opiate used in Poland was not heroin imported from Asia but a home-made substance produced by the users themselves; the spread of therapeutic communities was associated with the development of NGOs, something rather unexpected in a communist country; the public health orientation of the drugs policy benefited, among others, from the absence of a drugs market involving criminal organisations; the exchange of needle and syringes was mainly a technical measure. East and west, as they were called until 1989, had therefore more in common than might be expected but their drug problems and responses also had very different flavours due to significant differences in their economies and political systems.

In terms of the specific case of Poland, this report clearly shows that an awareness of developments before 1989 is fundamental to understanding the country's current drug policy. The use of the Polish opiate *kompot*, first developed in 1976, is still an element of the country's drug problem. The NGOs created in the 1980s are still major players in drug policy today and their model of intervention, abstinence-oriented treatment within therapeutic communities, is still recognised as the dominant treatment model (Reitox National Focal Point, 2012) and the recipient of an important part of public funds (Sobiech, 2008). Similarly, the public health approach developed in the 1985 law has, with the exception of the criminalisation of possession of drugs for personal use, been the foundation on which future developments of this approach have been built (Krajewski, 2004).

The post-1989 period has nevertheless added a new set of issues and opportunities for drug policy. The drugs market has changed, with more substances and different players — as illustrated by the rapid expansion in the number of smart shops — and with the country producing and exporting illicit drugs. New legal responses, with a gradual shift to more repressive approaches, were implemented to reduce the spread of drug use and drug supply, not always with the expected results. The development of a new national health system and of new law enforcement bodies, the cooperation with other countries and the adhesion to the EU have also provided opportunities to professionalise and expand existing drug-related responses. All in all, Poland's drug policy is now a combination of old and new, and possibly still in the process of finding its equilibrium (Krajewski, 2004).

One indicator of the progressive but sometimes slow change in Polish drug policy is certainly the implementation of opioid substitution treatment. Poland was the first country in the region to introduce substitution with methadone in 1992.

([39]) It is claimed that non-institution of criminal proceedings by a prosecutor was possible before the 2011 amendment, by reference to the definition of a crime that, according to the Polish Criminal Code, is not committed if a behaviour is not characterised by a significant social danger. However, application of this article remains problematic and prosecutors are not willing to refer to it in drug-possession cases.

([40]) Under Art. 66 of the Penal Code, discontinuation of proceedings was only possible for individuals with no prior criminal record. This made most problem drug users ineligible. This limitation was abolished through a regulation removing the criterion specifically for drug-using offenders.

([41]) Conditions to be met in order to be granted a break in serving the sentence are regulated by the law: the offender must be guaranteed a bed by a treatment centre and the time left until completion of the sentence cannot exceed two years.

Almost twenty years later, the number of patients in OST (2 200) was still below the number of beds in therapeutic communities (2 500), an intervention that is usually recognised as being more expensive and has been much less investigated for its effectiveness than OST. There are certainly many interlinked reasons that explain the difficulties in developing this type of treatment even to the relatively low level set as an objective by the government itself. High thresholds, for both providers and patients, and funding solutions that are not always effective are the most obvious ones. They may, however, also reflect the strengths of some of OST's opponents, notably the main NGOs active in abstinence-oriented treatment, the Catholic Church and conservative politicians, and the weakness of its advocates (Moskalewicz and Welbel, 2013). Perhaps it should also be remembered that the spread of HIV/AIDS in Poland has been dealt with as a sanitary and technical issue and that measures such as needle and syringe exchange programmes were first implemented by NGOs firmly believing in abstinence-oriented treatment. This is rather different from what occurred in some other European countries where the HIV/AIDS epidemic lead to a major overhaul of drug policy. This might also explain the limited development of other harm reduction measures.

Until the early 2000s, Poland could be seen in some ways as an emerging drug market (Krajewski, 2013) requiring responses that had already been tested in other countries. In recent years it has become one of the countries most affected by the spread of new psychoactive substances, often sold as 'legal highs'. As such it has served as an involuntary laboratory for the multiplication of smart shops, the use of new drugs and the related health problems, and for examining the strengths and weaknesses of some legal responses. It has also promoted its own legal approach to the phenomenon at the level of the European Union. The new drugs phenomenon certainly is not over and new issues will appear in the coming years. Poland, as some recent information already suggest, might well continue to be a country at the forefront of trends and policy developments in this area.

Last but not least, it must be noted that Poland has extensively developed drug-monitoring tools and has an elaborate system of follow-up and evaluation of its National Programme for Counteracting Drug Addiction with, every year, an implementation report prepared by the National Bureau for Drug Prevention that is approved by the government and the parliament. These monitoring and evaluation tools are certainly essential for the further development of the Polish drug policy, both at national and at the local level.

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