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Czech Drug Policy Developments in the Post-Communist Period

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CHANGING PATTERNS OF DRUG USE IN THE CZECH REPUBLIC DURING THE POST-COMMUNIST ERA: A QUALITATIVE STUDY

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The author carried out a reconstruction of the development of the Czech Republic's drug scene on the basis of the results of key research studies that made use of qualitative methods; he also utilized a multilayer timeline according to target groups and socio-historical perspectives. The last decade of the 20th century was a period in which the Czech drug scene underwent a radical transformation, both in problem drug use (see the definition in the editorial) and recreational use of illicit drugs. The original "hard core" groups were usually comprised of individuals who shared close personal relationships. A system of home production and self-supply dominated the market, and this system was not very organized or hierarchical. The entire drug scene opened up in the course of the 1990s and started to "move" and communicate markedly, both internally and externally. A stabilization of prices, purity, and availability of drugs, as well as the relationships and rules of the black market, was characteristic of the second half of the 1990s. The field of recreational use (of cannabis and the so-called "recreational" drugs in particular) went through a different development during this period, when other changes that deepened the commercial nature of the market took place.

INTRODUCTION

It is relatively difficult to describe the development of the Czech Republic's drug scene in the 1990s on the basis of qualitative studies because the various data sources that existed then were not homogenous, and the opportunities to assess data validity

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were quite limited. Prior to the 1990s, there was almost no qualitative research in the Czech Republic because this type of methodology was not officially taught on the university level and was officially seen as "unscientific and bourgeois." This ideological condemnation imposed severe limitations on qualitative data gathering and analysis and was probably responsible for the poor qualitative data that existed in all scientific disciplines. The idea that drug use was an exceptional phenomenon intimately connected with the licentious lifestyles of the "Capitalist West" and incompatible with the principles of life in a sober socialist society had been widely supported by the ruling communists in the Czech society before the 1990s. Given that there was little social awareness of this phenomenon, widespread condemnation of all drug use was commonplace, and there was a more or less complete absence of adequate scientific research into this phenomenon. The situation in the field of abstinence-oriented treatment of alcoholism was substantially better, however, thanks to the pioneering work of a dedicated group of so-called "alcohologists."

The late 1980s and early 1990s were characterized by a single focus, utilizing quantitative approaches and methods without any efforts being made to link findings from different studies or to improve the validity of the methods then being used to obtain data from targeted populations. These weaknesses were especially apparent in the inadequate generalizations that were drawn from data collected in clinical practices and then applied to nonclinical populations (see e.g. Mečíř, 1989; Netík, Budka, Neumann, & Válková, 1990), as well as in a lack of concern shown for the low validity of many of the surveys that were being used as data sources (Vojtík, 1972; Budka, Vančo, & Vojtík, 1988; Dobiáš, 1984; Šedivý & Válková, 1988).

In order to provide a better understanding of the historical context for the preceding comments, the author has prepared a short retrospective account of the position and role of qualitative research approaches in the Czech Republic. The above-mentioned lack of comparability of data sources and problems associated with data validity relate especially to the period before 1995. During the first half of the 1990s, an open and wide-ranging discussion about research methodology took place. As a result of these discussions, the qualitative approach was rehabilitated along with the first training and teaching in related methods in the universities. This process was relatively slow, however, and its practical impact was first visible in the middle of 1990s only—and then especially during the second half. This is the main reason why we must be very careful in working with and interpreting the data that is available from this period. One additional difficulty was that most professionals believed that several fields of drug use were simply "not researchable" or that simple generalizations taken from clinical observations were sufficient to describe nonclinical populations of drug users as well. One consequence of this situation was

that the professional literature from this early period often provides contradictory and inconsistent statements about the nature of drug use.

Although a review of the Czech professional literature provides sporadic examples of studies that dealt in some way with the topic of qualitative research until the end of the 1980s, there was no scientific research network or other organization in place to deal systematically with qualitative approaches. The impact of the dominant communist ideology on the practice of science was apparent in nearly all academic fields, although humanistic studies suffered the most. Consequently, no university officially taught qualitative approaches under the communist regime, as these methods were regarded as being nonscientific (Miovský, 2003, 2006).

The Czech pathophysiologist Ivo Lát (1958) was one of the first critics of the narrow-mindedness of traditional research methodology in medicine and psychology. Five years later, the journal *Československá psychiatrie* published an article by Jiří Srnec (1962), in which he suggested that research should make use of qualitative methods and approaches when the "...complex development, interactive and dynamic relationships (e.g. research into pathogenic mechanisms, and mechanisms of the origin and persistence of maladaptive reactions of effects of therapy, etc.)..." (Srnec, 1962, pp. 368) are examined. Nevertheless, these first dissident works attracted little if any attention in the mainstream scientific community.

In the field of psychology, Josef Viewegh, whose first studies[1] integrated a qualitative approach, were published as early as the beginning of the 1970s. In particular, his early works on suicidal behavior (Viewegh, 1969) and motivation and imagination (Viewegh 1972, 1975) seem especially important. Břicháček (1981) and Smékal (1983) also published relevant studies in the 1980s; they pointed out that the constant preference for quantification and statistical methods, even in areas they were not especially well suited for, had resulted in a reduction of the explicative power of many research studies. Despite these modest protestations, however, the former regime condemned all of these critical works as unacceptable "alternative" ways of thinking.

A marked improvement in the situation took place after 1989. For instance, sociologists began to publish the journal *Biograf*, a publication specifically dedicated to qualitative approaches and methods. In the field of psychology, successful conferences in 2000 (Čermák & Miovský, 2000) and 2002 (Čermák & Miovský, 2002) helped establish a tradition of regular annual conferences, which in turn helped to foster modern qualitative research approaches in both the Czech and Slovak Republics.

With regard to the specialized area of addiction research, qualitative approaches were found to be especially useful adjuncts in epidemiological studies. Consequently, epidemiologists deserve considerable credit for the modern dissemination and

application of qualitative methods in these fields. It seems that they were among the first to appreciate the potential utility and advantages associated with the collection of relevant qualitative data in their epidemiological work with populations of active drug users who, until then, had been regarded as being "inaccessible for research purposes." In addition, once these innovative approaches were being routinely implemented, it became possible to describe the natural processes of various otherwise obscure phenomena (e.g., needle sharing) and led to explanations of the dynamics and ritual dimensions of this behavior. These methods also revealed how these phenomena could potentially be influenced (Miovský, 2001).

In terms of the direct application of qualitative approaches in addiction research in the Czech Republic, the dissemination of the Rapid Assessment and Response (RAR) methodology (see Stimson, Fitch, & Rhodes, 1998), which had been developed some time before (Pearson & Kessler, 1992), proved to be a historical milestone. The working group organized by the National Drug Commission (for more data on the NDC, see Radimecky, 2007, in this issue) prepared several translations of methodological texts related to RAR methodology and prepared several trainings for Czech researchers between 1993 and 1995. As was true elsewhere, in the Czech Republic the development and adoption of these methods was driven particularly by the need to acquire data about patterns of use, the unique characteristics of local drug scenes, cultural and social differences among users, induction methods, and the like for comparison with that emerging from extensive statistical surveys. Rapid changes occurred throughout the drug scene in the Czech Republic during the 1990s. The rapidity and scope of these changes revealed the relative impotence of traditional quantitative methods and approaches that were then being used. The innovative RAR methods proved especially attractive because many experts found them promising for the collection of information about groups of users who had not previously been studied, the so-called hidden populations. Cernea (1992) pointed out that the closed nature of these groups and limited accessibility to these hidden populations of drug users made it impossible to identify different local trends in a timely manner and then respond to them with adequate intervention measures.

Methods and Data Sources

For this study, the author completed a content analysis of published research reports and the so-called "grey literature" (master's theses, dissertations, and unpublished research reports) dealing with qualitative approaches to research. Analytical work with these qualitative data was mainly based on three techniques developed by Miles and Huberman (1994). These involve the techniques of capturing patterns, themes, or "gestalts" in the direct utterances of participants (derived from transcriptions of interviews), linking subelements to general categories, and marking

and interpreting relationships between qualitative variables. The diversity and lack of homogeneity among the various sources consulted necessitated the consistent enforcement of data validity checking techniques (Čermák & Štěpaníková, 1997). Various types of triangulation were used, as well as the technique of contradictions[2] (Čermák & Štěpaníková, 1998; Miovský, 2006).

THE CZECH DRUG SCENE BEFORE 1989

Urban (1973) was responsible for the first documented attempt to describe illicit drug use in the Czech Republic. He actually avoided directly describing the drug scene and the behavior of drug users in his work—no doubt, due to political considerations. Instead, he reflected upon a phenomenon that became characteristic for the core of the drug scene during the 1970s and 1980s (Drtil, 1978; Netík et al., 1990; Nožina, 1997): high rates of medicament abuse. This trend had become apparent by the end of the 1950s; for instance, the consumption of medicaments with a stimulant effect had increased nearly tenfold between 1959 and 1960 (Urban, 1973). Analgesics and antipyretics also became increasingly popular. Janik and Dusek (1990) also mentioned that the consumption of all types of medicaments producing psychoactive effects increased in the 1970s and 1980s. The most commonly used opiates were so-called "braun" (i.e., a homemade mixture of hydrocodeine, dicodeine, and hydrocodone); medical codeine; Valoron (i.e., a drug with a tilidine hydrochloride content), which was mainly used in the first half of the 1970s; and seasonally produced decoctions of unripe poppy. In addition to these drugs, stimulants, namely Pervitin (i.e., methamphetamine), began to gain popularity among the "hard core" of drug users in the course of the 1980s, and eventually the latter drug practically became a symbol for this group (Nožina, 1997; Zábranský, 2004). Also the raw materials used for the manufacture of Pervitin, e.g. Solutan® with an ephedrine content or pure ephedrine, started to be ab/used without further processing by drug users in the 1970s. The appearance of the so-called "classic drugs" (i.e., cocaine, heroin, and amphetamine) was very rare during this period in the Czechoslovak Socialist Republic (Drtil, 1978)—at least no valid evidence exists that these drugs were even available. A self-supply system, in which individual groups acquired raw materials, fabricated drugs, and then shared them, predominated among the population of drug users. This market did not have a commercial element, and no classic pyramidal sales system developed. Among these friendship groups, production and sales were not typically organized in large units or chains. Therefore, the early communist-era Czech drug scene can be characterized as having been very insular, one based on close personal knowledge and contacts, which also characterized the system of production and distribution (Miovský, Zábranský, Gajdošíková, & Mravčík, 2001).

The author of another significant monograph (Mečíř, 1989) attempted to describe the drug scene before 1989 without having adequate data and studies available. In this case, the researcher relied on the results of clinical studies and data provided by the police—both sources having little credibility. However, he did successfully describe another significant feature of drug use before 1989—the fact that a noteworthy share of poly-drug use and very high consumption of alcohol and medicaments existed among the population of users of illegal drugs who were receiving medical treatment. In other words, there was an extraordinarily high rate of consumption of alcohol among the treated users of nonalcohol drugs; free conversion from one substance (usually different medicaments) to another according to current need and availability was characteristic for this population. Similarly, Mečíř described the phenomenon of inhalant use, especially of pure toluene, the "Čikuli" cleaning agent containing trichloroethylene, and later tetrachlorethylene ("Vulkán" glue), which had a toluene content. As is true elsewhere, the use of inhalants in this period typically involved young children and the socially disadvantaged.

Several Czech authors highlighted continually increasing problems with inhalant use—especially among young people—as early as the beginning of the 1970s (e.g. Drtil, 1978; Vojtík, 1972). However, inhalants only became recognized as a widespread problem in the course of the 1970s and 1980s (Mečíř, 1989). Throughout this early period, the drug scene as a whole showed signs of being tightly encapsulated and impermeable to outsiders. In many cases, individuals were closely linked to a particular community or group of friends with whom they established an internal system that ensured drug supplies, most frequently due to their own ingenuity. Raw materials were relatively easily available and inexpensive, and problems with law enforcement in regard to the use of addictive substances were rather infrequent as a result of the poor equipment and lack of specialized drug knowledge that existed among the police.

Hardly any qualitative information about drug use in prisons is available for the period before 1989, apart from several rather superficial works whose validity is difficult to assess (see, for instance, Sochůrek, 1983). Nožina´s publication (1997) contains a list of basic anecdotal data (the dominance of medicaments, homemade alcohol, various decoctions and teas, etc.); however, no specific research studies were carried out, and it was not possible to verify the reported data. At that time, drug-related topics could only be published unofficially, i.e., in the form of "forbidden fiction" (Škutina, 1969), where authors could take the liberty of writing about topics that were not allowed in the scientific literature.

Nearly all of the early scientific publications shared a very interesting common attribute, the inability of authors to utilize the concept of the so-called recreational use of drugs and alcohol and describe these phenomena. Those interested in a

medical perspective focused on the central theme of "addiction" and paid insufficient attention to other aspects of drug use, such as work with hidden populations of users. The professional publications of that period commonly generalized from the characteristics of treated or imprisoned drug users and erroneously applied them to the entire group of users (e.g., Mečíř, 1989; Netík et al., 1990). In that literature, there is a largely unclarified terminology that consolidates the terms "drug use" and "drug addiction" (e.g., Nožina, 1997). An example can be seen in a claim that the Czech drug scene in the 1970s and 1980s transitioned from one of "innocent drug addicts" of the 1950s and 1960s to an asocial toxicomanic subculture (Janík & Dušek, 1990, p. 138).

The Czech Drug Scene After 1989

The years 1989 and 1990 were milestones for the development of local drug scenes. The economic transformation and market liberalization that commenced then were associated with society-wide phenomena such as a general liberalization of society and a reduction in levels of social control. Understandably, drug use went through a radical metamorphosis in this more relaxed environment.

According to Beisswanger (1993), 6,500 drug users were registered—i.e., had records in official health documentation[3]—in the Czech Republic in 1989, 3,500 of them lived in Prague. The vast majority (80%) of those registered were injecting drug users. Codeine derivatives, sedatives, hypnotics, stimulants, and cannabis were reported to be the most commonly used substances. Beisswanger also mentions a rough "guesstimate" made by the drop-in low-threshold facility workers, who believed that there were 18 to 20 thousand drug users in Prague at that time. Without referring to his source, Beisswanger also reported 35 to 45 drug-related deaths per year (Beisswanger, 1993). The first Czech National Drug Strategy for the period of 1993 to 1994 suggested there had been a reduction in the number of registered drug users; in particular, their number in 1991 was nearly the same as it had been in 1983 (Kalina, 1993, p. 10). Health care facilities (especially psychiatric hospitals and clinics) only reported 3,035 drug users in 1991. We believe that it is possible to explain this low figure as a byproduct of the establishment of treatment programs that did not correspond to the needs of target groups and therefore failed to attract many and by a failure of professionals to recognize and accommodate these changing needs. All of the state health care facilities in existence in 1989 continued to offer and operate the same programs as they had before, in spite of the very rapid changes and developments that had taken place in the local drug scenes. Psychiatric hospitals usually lacked staff with adequate experience related to new and hitherto rather unusual drugs, new drug use patterns, and the rapidly changing behaviors of clients.

At the same time, internal shortcomings in the actual data collection system that existed at the time must also be considered, as these also reduced data validity.

As mentioned above, small insular groups that relied on their own supplies of raw materials and the home production of drugs were typical of the "hard core" of the drug scene in the large cities of the Czech Republic. The insularity and relatively unchanging use patterns were typical until the beginning of the 1990s. Data obtained from older key informants in the PAD study (Miovský et al., 2001) suggest that the conditions typical of the prerevolutionary era, when the police often had relatively good knowledge of these groups, still held true at the beginning of the 1990s—that is, police detectives had good knowledge of these groups based on their personal relationships with "older users." Thus, according to those users, policemen could use their knowledge to arrest the "older drug users" whenever they considered it useful, although they only occasionally exploited this advantage. Instead, there was an established laissez faire relationship that existed between law enforcement and drug users; even though there were some sporadic arrests and subsequent sentences to prison or compulsory treatment, the two worlds coexisted, and neither the public nor the media paid too much attention to them.

From a more general perspective, it is possible to identify two stages in the development of the 1990s drug scene. All parties mention the years 1992 and 1993 as exhibiting the first significant change; however, the causes that fostered these changes actually occurred in 1990 and 1991 (Kalina, 1993; Miovský et al., 2001). Taking some license, this period can be labeled as the "golden age" of drug use in the Czech Republic. Several factors contributed to the drug scene opening up to a significant degree and to its members becoming more "visible" on the streets. These included a low level of coordination of police activities, market liberalization, the relaxation of border controls on goods and persons, and the fact that modern customs systems that focus on the smuggling of illicit addictive substances were then only in an embryonic state. Imported drugs that had neither been very accessible nor widespread earlier began to appear frequently on the black market. It is believed that a massive increase in heroin use only occurred during the second half of the 1990s, although surveys (Miovský et al., 2001) have made mention of several users who had experiences with regular heroin use as early as 1990. At that time, heroin was very difficult to find in Prague, and users had to have both the initiative and special "contacts" in order to get it. Ten years later, drug users and dealers who had experienced this period nostalgically recalled it as a time when they had minimal problems with the police, when "good personal relationships" prevailed in the market, when "not so much money was turning over" in the scene, and when most of those in the market worked on the basis of very personal relationships. They also idealize the past, now believing that relationships "on the street" were not as

economically focused as they later became—to the impersonal, harsh situation of an unregulated, competitive black market. However, it is not possible to corroborate these interpretations of the circumstances with other data sources, except for a comparison with the prices of medicaments that served as essential materials for the fabrication of illicit drugs (Miovský et al., 2001).

Based on the available evidence, it now seems likely that the drug scene went through a complex transformation in 1991 and 1992. The consequences of these actions began to be felt in 1992, when, for instance, the number of registered users (i.e., users recorded in registries maintained by the Health Information and Statistics Institute) increased by 3,326 persons, and a substantial expansion of the spectrum of available drugs used was recorded. At the same time, young users with short drug histories and no criminal careers began to appear more frequently in the central health registry. In developing profiles of the most common use patterns, it is necessary to differentiate between the so-called hard core of the drug scene and the much larger and progressively transforming recreational drug scene. It is also necessary to emphasize the fact that (ethyl) alcohol and tobacco were also very significant commodities used by all groups.

Within the hard core drug scene, codeine derivatives, sedatives, hypnotics, and stimulants (pure ephedrine, pervitin/methamphetamine etc.) were the most commonly used substances. The medicaments Rohypnol® (flunitrazepame), Diazepam® (diazepame), and the analgesic Baforal® (butorphanole) were also very popular, as were Tramal® (tramadole), and Dolsin® (pethidine). Triphenidyl® (trihexyphenidyle) and similar medications with a combined euphoric and hallucinogenic effect also gained great popularity. Solutan®, which has an ephedrine content, and pure ephedrine represent a special category because they were used principally for the fabrication of pervitin which, with no reservations, can be regarded as the dominant symbol and preferred substance of the Czech drug scene in the 1980s and the first half of the 1990s. Both of these "raw materials" were also used in their original form, frequently being combined with cannabis and alcohol.

A very poor knowledge of harm reduction principles existed among "hard core" users from 1990 to 1992. Needle sharing, poor hygiene, and a limited availability of sterile needles and syringes were altogether common. It has been hypothesized that the then relatively low seroprevalence of infectious diseases was probably a fortuitous result of the unique self-contained nature of the scene, although it is not possible to verify this retrospectively.

However, over time the appearance of a massive influx of new and inexperienced users who acted recklessly began to catalyze the change process. It is interesting to note that among older and more experienced users, many made this same observation (Miovský et al., 2001): in their opinion, new, younger users arriving from the

recreational scene and their careless and excessive behaviors in needle sharing and combining different substances "in one shot" were among the sources contributing to an increase in health problems and conflicts with the police. Interestingly, this was the very first generation of Czech drug users for whom the start of a career with cannabis, often combined or alternated with alcohol, was typical (Miovský et al., 2001). At the same time, various decoctions, e.g., from various types of hallucinogenic mushrooms, especially magic mushrooms, *Psilocybe semilanceata,* and, less commonly, fly agaric, *Amanta muscaria,* or combinations with medicaments began to appear. Synthetic drugs, especially LSD "trips" and "crystals," also began to appear on the market in large quantities for the first time.

Very little information is available about the use of inhalants. Knowledge on patterns of inhalant use is limited to reports from those engaged in clinical practice (Kalina, 1996), and almost no research has been carried out on this segment of the drug scene. School and population surveys hardly covered these groups,[4] and neither qualitative nor other surveys carried out in the Czech Republic have paid close attention to inhalants.

The peak and subsequent downturn of the first large wave of changes in the drug scene that had taken place between 1993 and 1995 was captured in the third extensive qualitative RAR-based survey in the Czech Republic. In terms of the broad societal context, this was a period when drug concerns entered the public discussion as an issue that was going to be difficult to solve, and the entire drug field became medicalized and politicized (Zábranský, 2004). Users reported that the first professionally coordinated police antidrug actions took place during this period, which also suggests that more attention was being paid to drugs by the authorities. The same source indicated that police activities became much stricter and more coordinated than they had been before. These aggressive police actions were accompanied by a very pronounced trend of drug market commercialization involving the acquisition of raw materials and drug sales and a gradual vertical differentiation of the scene resulting from the entrenchment of commercially organized dealing. Factors such as the growing number of consumers interested in purchasing ready-made drugs, i.e. "customers," facilitated police and court activities, and an uneven supply of drugs probably fostered a commercialization of these relationships. An interesting transformation of the drug scenes taking place in individual regions commenced during this period as well. While some specifically regional phenomena, i.e., high unemployment, low wages, low educational levels, the development of prostitution, etc. continued to worsen, and especially in highly industrialized areas, black markets began to exhibit many similarities with regard to the spectrum of their available products, drug purity, the price of drugs, dealer chains, customs and traditions, etc. The only exception to these trends was found in

the capital city of Prague—the only place in the Czech Republic where a classical metropolitan drug scene does exist, similar to the ones in other major Western European cities.

The first Czech qualitative study made use of the RAR methodology and built on the experiences of another interesting study (Tyrlík, 1995) that focused on the psychosocial characteristics of long-term drug users in the Czech Republic. The first of these two projects, the 1994-1995 study, was historically the most extensive qualitative study ever carried out in the Czech Republic. That research involved 338 respondents from seven regions of the country. It aimed to describe the psychosocial characteristics of drug users, typical modes of use, and identification of the range of substances being used. It did not contain data about the general drug scene as such because of its focus on the so-called hard core of the drug scene. Unfortunately, it did not utilize standard tools for analysis of the gathered qualitative data and therefore was limited to rather rough "quantification" of those data and the compilation of descriptive statistics. The subsequent study (Tyrlík, Bém, Zuda, & Power, 1996) applied the RAR methodology in a standard manner and used more standard analytical tools. It involved 115 participants who attended low-threshold facilities and/or used streetwork services. This study documented the gradual recession of the traditional, closed, "apartment" scene (Tyrlík, Bém et al., 1996, pp. 33-36), which had survived only because of a certain conservatism on the part of older users. The results show an apparent dichotomization of results, which created a different profile of user psychosocial characteristics, patterns of drug use, and especially their relationships towards the drug market based largely on the ages of the participants in the sample. Older users appeared to be more conservative and resistant to the trend of drug market commercialization and to the increasingly marked disturbance of the original well established rules and bonds they shared.

The year 1997 can be regarded as a period exhibiting a second wave of changes in the development of the Czech drug scene (Miovský et al., 2001). Users associate this period with the biggest changes in the behavior of special police branches in that they started to take a more varied and repressive approach to the street scene. These users also mention that other police branches also focused their activities on drugs, and when they did, this resulted in their capturing the most easily prosecutable cases—e.g., recreational users from high schools or the heaviest users who are also homeless. All users also believe that conflicts with municipal police forces have become more frequent since 1997. They agree, for example, that all of the principal changes that took place in 1999 and 2000 were actually instituted some time between 1997 and 1998. They also believe that the most recent fundamental changes in the drug scene originated during this period, and that the new "drug law" that was put into effect on January 1, 1999, only brought these changes to

fruition. Users believe too that the drug scene has been relatively more stabilized since 1997. In this context, drug users especially point to what they see as a marked trend towards commercialization, i.e., stricter informed rules regulating the drug scene dictated by economic interests as well as a significant increase in the number and professional behaviors of sellers. The entry of new technologies, i.e., especially mobile phones and superior drug production technologies, brought about a marked shift and differentiation between street dealers and those operating at "higher levels" in the dealer pyramid. The users associate these changes with three pronounced phenomena:

1. In some regions, the police began to systematically and relatively consistently identify and arrest the producers of homemade Pervitin. According to drug users, this basically resulted in a significant and long-term disturbance of the balance that had existed among user "gangs" and the breaking of traditional bonds among these groups. These market disruptions created incentives to procure drugs in a different manner and place, e.g., by looking for and contacting new, little known, or completely unknown suppliers of raw materials. As a result, it became increasingly difficult to obtain quality drugs, and the risks were higher. Marked uncertainty came to be associated with the usual distribution chain, which was easily detectable by the police in the case of the relatively self-supplying pervitin scene, narrowly bonded by everyday relationships. This meant that over time, the number of traditional home laboratories decreased. Producers were often sentenced to prison, quit their illegal activities entirely, or started to work for large and well organized, often foreign, groups. In the latter instance, it was probably because the foreign organized groups were able to provide greater security and certainty, inter alia, quality technological equipment, a continuous supply of materials, and outlets for the finished drugs. All of these factors gradually contributed to a complete transformation of the traditional Czech "home" Pervitin scene, whose disintegration was basically completed during this historical period. Ironically, police activities that had focused on these self-supplying groups inadvertently contributed to this takeover process by larger, better organized, impersonal organizations.

2. The entrance of heroin into the market and its gradual domination of the hard drug scene served as a second critical phenomenon in certain regions. The growing popularity of common brown heroin (poor quality heroin with a usual concentration below 30%, and sometimes lower than 10%) in large cities eventually almost caught up with the traditional, previously dominant Pervitin. It also almost edged out the opiates that had been favored by users in the 1970s and 1980s, especially the traditional codeine derivative "braun." The direction of the dissemination of these new trends were predictable, moving from traditional centers around Prague and regions in Northern Bohemia around the main trafficking route in a southeasterly direction to Brno and then to South Moravia. At the same time, an independent center was established around Ostrava in the northeastern part of the country. This center has traditionally escaped being included in national drug trends because it is more closely linked to Poland and Slovakia than to the rest of the Czech Republic. Data from drug users (Miovský et al., 2001) fully confirm the validity of temporal data provided by workers in low-threshold facilities, who reported that white heroin[5] only appeared on a large scale between 1997 and 1998 and then eventually became a common part of the drug supply in several small waves.[6]
3. The commercialization of recreational drug use represents the third and last phenomenon, which seems to have been very significant, especially when it comes to making future prognostications. This process can be observed in the form of changes in sales conditions and prices and even in the quality of drugs, mainly with regard to cannabis. In this instance, there was a marked increase in the volume of sales at the expense of home growing operations. Dealers of other drugs started to appear much more often on the recreational drug scene. Their presence established and then assured a varied supply of hard drugs whose presence used to be exceptional in the "recreational" market, i.e., heroin and pervitin.

Although another RAR study (Minařík & Bém, 1999) implemented in 1998 and 1999 did not focus on the drug scene and drug market as such, its results corroborate the above mentioned description. This earlier study placed the main

emphasis on mapping the characteristics of drug users and documenting changes in their behavior. The same applies to a substudy that was part of an international project implemented in the Czech Republic in 1999 and 2000 (Miovský, 2000). The project involved the reconstruction of the histories of drug users and a subsequent reconstruction of the drug careers of 49 users. The study aim was to identify various combinations of factors that increase the vulnerability of young people to drug use and risky patterns of consumption.

The reconstruction of individual user drug careers was also carried out in a survey of 52 heroin users in Prague (Zuda, 2000).

The adoption of legislative changes in 1998 had an indirect impact on the entire drug scene stabilization process and caused certain acceleration of the merging of "recreational" and "hard core" markets that had remained separated until the late 1990s. Three substudies of the Impact Analysis Project of New Drugs Legislation in the Czech Republic focused on qualitative analyses of the impacts of the newly adopted bill on the drug scene (Zábranský, Miovský, Mravčík, & Gajdošíková, 2002). Regular cannabis users associate the period after the adoption of the amendment with an increased presence of hashish and more potent varieties of marijuana on the black market. They also report that there was a general reduction in the practice of outdoor marijuana growing for personal use and an increase in less risky, though more costly, indoor growing in small "gardens," for instance in "grow boxes" or cabinets in apartments. This was accompanied by a continuing commercialization of the market, which correlated with a permanent increase in demand and a diminution of home growing. It was also significant that the "soft" and "hard" drug markets became intermingled; i.e., it became possible to buy a whole spectrum of illicit drugs in one place or from one dealer. Many older cannabis users continued to support home growing or remain members of self-sufficient groups, while younger users commonly accept standard commercial mechanisms and thereby contribute to the expansion of the commercial cannabis market.

No available data suggest that there has been any reduction in demand. In fact, data from an evaluation of 165 of 250 interviews suggest that the "hard drug" scene has experienced a massive influx of young users aged 18 to 20 years who routinely refuse offers of treatment services and other forms of care. There is also a clear trend involving the withdrawal of recreational, i.e., nonaddicted, nonproblem users from contact with facilities that they used to visit, a trend that is particularly apparent in small towns. In these interviews, the users reported that this was due to growing fears of making unwanted contact with the police (who are thought to be watching these centers) and the subsequent social stigmatization that would follow such a confrontation.

Pervitin users mentioned there has been a gradual reduction in the availability of raw materials for the production of this amphetamine-type drug. This situation was resolved when they began converting other types of medicaments from which it is possible to extract ephedrine or, more accurately, pseudoephedrine. In particular, Modafen®, a composite preparation containing ibuprophene and pseudoephedrine, replaced Solutan®. The reduction in the availability of these products has been associated with improved national controls of medicaments and the prescription of such medicaments, and it has also promoted the actual fabrication of ephedrine.[7]

Increasing pressure from dealers for consumers to purchase larger quantities of a drug at one time represents a basic change in the market: the more drugs a user buys, the better the price and purity of the substance purchased. In these larger transactions, the actual weight of the product is markedly close to that verbally agreed on, which is not true in the purchases of small quantities. Recently, quantity discounts have increased, and some dealers even refuse to sell small quantities at all. Users have responded to these demands by the logical step of amalgamating financial resources from several users, buying a larger quantity, and then dividing and redistributing the purchase. In this instance, we see that the dealers developed pressure for the insertion of another link in the distribution chain between them and the street, i.e., in the place where they are the most vulnerable, and so they basically established another layer of "retail dealers" to lay off some of the increased risk.

The availability of illicit drugs in prisons is considerably lower than it is outside; however, participants describe the presence of drugs as a common phenomenon, which no one is taken aback by. These claims have been confirmed in recent published studies that were based on originally unpublished data of the Prison Service of the Czech Republic and surveys that were carried out directly in remand prisons and prisons (Miovský, Spirig, & Havlíčková, 2003). Alcohol that had been smuggled in or made inside the prison and psychotropic medicaments were the most commonly used psychoactive products; however, the participants mentioned that pervitin was not exceptional at all, although it costs five to 10 times more than it does on the street.

The original hard core of the drug scene had definitively transformed by the end of the 1990s, and a variety of data sources suggests that there is a trend toward stabilization among these users. The most recent quantitative data (Zábranský, this issue) indicates that there has been a reduction in the number of young users entering the hard core scene. At the same time, the hard core itself is gradually diminishing, while its remaining members have been increasing their consumption amounts. The contemporary drug market has probably reconciled itself to the social, political, and economic changes that have taken place in the Czech Republic. The situation in the field of low-threshold services suggests the original rival relationship between

the "pervitin scene" and the emerging "heroin scene," which was typical in the mid-1990s, has now ended. However, this truce probably only occurred after the transformation of the pervitin (methamphetamine) market, where pervitin production and distribution became fully professionalized. A system similar to that found in the heroin market was developed for pervitin too, and the markets have more or less commingled. Between 1999 and 2002, the spectrum of preferred substances and patterns of use began to stabilize, a trend that was accompanied by a more settled market that was controlled by organized groups to a much greater extent than had ever been the case in the previous decade.

Recent Drug Scene Changes (2002 to 2006)

In recent years (2003-2005), several Czech drug studies have been carried out utilizing qualitative methods. These efforts focused on changes in the needs of illicit drug users in the field. In doing so, they no longer concentrated primarily on drug scene research, but rather emphasized the needs of users with regard to drug services. Nevertheless, these studies supplied new information about the phenomenon of the use of substitution preparations and their widespread dissemination on the black market. This phenomenon has added a new dimension to the previous development of the drug scene. The first of these projects was the *Needs Analysis of Ethnic Minorities Members Who Use Drugs on the Territory of the Capital City, Prague* (Vacek, Gabrhelík, Miovská, & Miovský, 2005). It involved 27 drug using participants and 14 workers at low-threshold services, including several key informants. The results contributed to the discovery of a new phenomenon in the Czech Republic's drug scene that has emerged during the last four to six years: the black market appearance of a medical drug containing buprenorphine, a medicament that is typically used as a substitution treatment for opiate addiction.

At the time of data collection, 11 of the 27 respondents were buying Subutex® (buprenorphine) on the black market and mentioned that it is relatively easy to get it, although price and availability vary. According to the interviews, the street price of a 2 mg Subutex® tablet is CZK 100–200, i.e. approximately 9 USD[8] and 8 mg tablets always sell for CZK 400, i.e., 18 USD.[9] When a user has a "friend" among the dealers, he/she can also get it "on the cuff": (Protocol 11) "...human relationships work on the street; when I just don't have money at the moment, I come there and say, 'Hey, look, I'm flat broke, give me a two and I'll bring it back to you tomorrow. You know, this works among friends. But there are tough dealers, too.'"

Four participants were getting their substitution medication legally. One of the ways in which this preparation gets onto the black market is that a substitution treatment client shares the costs of procuring the medicament in a pharmacy with another user (Protocol 14): "...I buy...a prescription for a share ... I split it."

> (Protocol 1): There certainly aren't enough of those substitution programs to cover the entire Prague scene. And so there are many people who get prescriptions for more Subutex® in their name and then they sell it ... even when a client is entitled to get it legally, he doesn't have enough money for the whole pack of Subutex®, and so more people club together to buy it. The client then doesn't have enough Subutex® for the entire month but only for, let's say, a week, and then he has to hang on for the rest of the month because the doctor won't prescribe any more of it to him in the same month ... there are many black agreements between some pharmacists and dealers. I mean, it works both ways.

The described results were checked against those of a concurrent survey of the Prague drug scene regarding the changes in the needs of the majority clientele of low-threshold services (Miovská, Miovský, Gabrhelík, & Vacek, 2005). In this study, 30 interviews with clients of low-threshold facilities in Prague and two focus groups with providers of low-threshold services were carried out during the second half of 2003. Twenty-four of the users were males, and their average age was 29 years. Eleven participants reported lifetime prevalence of heroin use, 16 respondents used Subutex®, and two respondents used methadone. One respondent only uses methadone to handle withdrawal symptoms: (Protocol 22) "...when I have methadone, I don't feel sick, and I don't have a reason, I don't take those opiates to get high, I just take them so that I wouldn't feel sick."

The participants mentioned the low quality of street heroin in Prague:

> (Protocol 12) ...no, no heroin at all—it is either bad or I don't like it, and that's why I prefer Subutex®....

> (Protocol 7) ...I take heroin when I have a good source, somewhere where it is worth it and I get the agreed weight. But there's hardly any good heroin anywhere in Prague....

> (Protocol 19) ...I do not take heroin; I mean, the quality is pretty bad....

> (Protocol 18) ...no one has good heroin now, it gets cut terribly, and it is really dangerous.

The users in this study mentioned that they used from 1 mg of Subutex® once or twice a week to 4 mg daily. However, respondents most frequently report using 2 mg per day, usually by injection. One of them compared the advantages of Subutex® to those of heroin (Protocol 19):

> I am active when I use it, I don't feel cold, I have no scruples. The euphoria is the only thing I miss. Otherwise it is just like smack, it works for a long time—when I shoot it, I know that I don't have to worry about a thing for twelve hours.... It's cheaper and I know that I don't have to worry about what it actually contains.[10]

Some only use Subutex® after they have been expelled from a methadone program.[11] All of the respondents in this survey who currently use Subutex® buy it on the black market. Some try to get a prescription from a physician, and when they cannot get it, they buy it on the black market. They mentioned that it is easier to get Subutex® on the black market than from a physician: (Protocol 7) "Almost everyone here takes 'subies,' and so it's sometimes better to 'make'[12] those two hundred crowns and buy it here than to run somewhere and beg on my knees."
Some of them used to visit several psychiatrists and had them prescribe Subutex®, which they then sold:

> (Protocol 5) I had, say, five psychiatrists whom I was alternating—I went to the first one, he gave me a prescription, then I went to the second one and got another prescription, and then I was selling it.... Then the "blue stripes" were introduced and no one gave me that prescription any longer.

They also supplied more accurate data about the price of Subutex® than those discussed in the above-mentioned survey. A 2 mg tablet costs CZK 150–250 on the black market and CZK 200 in a pharmacy: (Protocol 5) "One 2 mg tablet costs two hundred, while it used to cost a hundred, but now the availability is restricted, a blue-stripe prescription is required, and so much less of it is available and the price has doubled since then". Half of an 8 mg tablet costs CZK 250 to 400. An 8 mg tablet costs CZK 500-600. Considering an average consumption of 2 mg (CZK 200) per day, a user needs approximately CZK 5,600 (approximately 220 USD) per month to pay for it:

> (Protocol 27) I only get social benefits, and so I can only afford to go and pick it up in a pharmacy once a month. But then I don't have

> anything left for the rent, food, and clothes. And now imagine what happens—not only to me, it also happened to my friends—they pick it up in a pharmacy, then the cops stop them and take it away from them ... even though they have a receipt from the pharmacy, it still happens.

The sample included only one respondent who was in a methadone substitution program: (Protocol 2) "Methadone will simply solve the fact that when I go to get a drink in the morning and I do not abstain, that I will be able to sort out my social benefits and other things, I can simply get myself together and have my clothes washed." This participant aimed to rid himself of his opiate addiction and wanted to use pervitin exclusively.

Two users described negative experiences with methadone: in their opinion, it is the strongest opiate of all, and it does not solve the craving for heroin—unlike buprenorphine. Furthermore, serious withdrawal symptoms occur when they try to abstain from methadone:

> (Protocol 19) I tried it, and I must say it was awful, it is the strongest opiate, I didn't know who I was the first month, the craving didn't go away at all. On the other hand, that Subutex® suppresses the craving for other opiates, and so those who are on Subutex® don't give a fuck about heroin.

The interesting thing is that the above-mentioned trend of the increasing popularity of substitution preparations, which was captured in both of the Prague surveys, also corresponds to trends in regions lying well outside of Prague. It was, for instance, described in a field survey that focused on the clientele of low-threshold services in the Central Bohemia region (Charvát & Gabrhelík, 2004). Among other things, the study pointed out the reasons for differences between methadone and buprenorphine programs. Earlier,[13] a user addicted to opioids did not have to meet the strict requirements for methadone treatment in order to become a Subutex® program client. Therefore, on the one hand, Subutex® makes it possible for a client to get treatment without having to meet strict criteria—for instance at least two failures in an abstinence-oriented treatment before filing an application for methadone treatment—and long waiting times for treatment do not exist. It also enables the client to have to visit a doctor only once a week:

> (Protocol 12) ...you have to meet some of those conditions they have for it, and I did not meet them, for instance, I never went

> for any treatment. They require you to have a treatment history, otherwise they do not care that you take three grams every day and that you have been on it for 15 years. You were never treated, and so you don't meet their regulations and charts, and so they won't accept you. And then you have to wait half a year, they have some waiting times.

On the other hand, being benevolent toward a client by accepting them into a program increases the risk that Subutex® will not serve the purpose for which a physician originally prescribed it. Subutex® is often redistributed to other users for higher prices:

> (Protocol 7) I also know... even those who have it prescribed and then they sell it... ... people misuse it for their own profit, and that's why I am afraid it will be cancelled.

> (Protocol 29) ...many people simply misuse it, don't they? I mean, I guess many people abuse it, they simply enroll in a program, and at the same time, they ... simply, junkies who don't want to quit. Who simply only need money.

Based on existing research, it is very difficult to verify the degree to which substitution programs are being misused by clients (Zábranský, this issue). Therefore, it is only possible to make the general statement that risk minimization, and consequently public health protection, is being achieved, even in the cases of the misuse of this type of treatment. This is because a substance that contains none of the dangerous admixtures that are commonly found in street heroin is the drug that is being abused. The drug is also being used in a less risky manner because it is cheaper than heroin, users are able to procure more of it at one time, and there is less pressure to inject it. This typically occurs when there is a shortage of the substance: (Protocol 3) "... the good thing about it is that you know what you are taking. The horse you get is all crap or it is really good by coincidence and then that's a slip-up, too, isn't it?"

As one of the participants mentioned, another factor that influences the attractiveness of Subutex® is its ready availability, especially for those who know a Subutex® program client. One of the participants said that the availability of Subutex® deteriorated after its mandatory prescription on "blue" forms was introduced as a control measure: (Protocol 17) "Interviewer: So, what about the availability of that Subutex?" Client: "Well, it is quite bad now, you know.... It is

a bit worse now, one has to try harder now...." This suggests that the new control measures have had the desired effect. On the other hand, the fact that Subutex® can only be issued on a "blue prescription" places yet another administrative burden on psychiatrists, which they try to avoid by limiting or even refusing to prescribe the medication:

> (Protocol 7) So I asked him for Subutex pills. But the doctor found out that he would have to use a blue prescription form and that it requires a lot of writing, and said that he wouldn't write the prescription for me.

> (Protocol 5) Well, I mean I kept trying, but nobody will write the prescription for me.... I don't see any way, I can't seem to find anyone who would ... do it for me.

In some localities, Subutex® dealing serves as another reason why it is difficult to find a physician who will prescribe it to users who show a genuine interest in treatment. In the above mentioned survey, 14 out of 29 participants who attend low-threshold programs use (or have recently used) Subutex® intravenously or intramuscularly. A lack of knowledge of the risks associated with the intravenous use of these tablets plays an important role, as does a desire to achieve the same effect as produced by heroin:

> (Protocol 22) Certainly, that's how it should be used—under the tongue, but ... I mean, lust is lust, you know, and when you shoot it, you get the same as with heroin. And so it is ... you know.

Users also frequently mention the so-called "needle addiction":

> (Protocol 23) Well, I know it, you know. I keep thinking about it a lot. I mean, I know it. I take it twice or three times a week... (...) ... it's about that needle, you know....

Only a single client (Participant No. 25) was aware of the risks associated with the injection use of Subutex® (i.e. inevitable vein injuries) and, as a consequence, he uses it in the prescribed manner, i.e., sublingually.

Discussion

Comparisons of the results of various qualitative studies always reveal pitfalls related to validity concerns. Even though we used a variety of different data validation checking techniques and methods (Čermák & Štěpaníková, 1998), this study suffered from shortcomings related directly to the heterogeneity of the source data. Thus, the various studies we analyzed were produced under very different situations and with different aims. The contexts in which the data were obtained are very difficult to characterize, especially in regard to the pre-1995 sources. In those early studies, it was practically impossible to verify that the investigators adhered to all procedural requirements in the application of a qualitative approach, and therefore it is simply not possible to consistently apply all the basic rules of qualitative analysis to this instead (as suggested by Miles & Huberman, 1994). Another potentially significant source of distortion is the varying degrees of generality associated with the studies' results. For example, low numbers of participants in samples make generalization impossible, yet some of these studies ignore that caveat rather than properly stating that these are mere hypotheses. This is why the author's attention has focused on a description of qualitative indicators and the dynamics of relationships that exist in the local drug scene.

The RAR methodology has certainly caught on and is currently being used in the Czech Republic, even in small regional surveys. For instance, in a study implemented in the Pardubice region (Minařík & Bém, 1999), there is no other available data for developing high quality descriptions of the development of the drug scene.

Conclusion

As we have seen, a system of home production and self-supplies was typical for the Czech drug market during the pre-1989 period. At the time, the market was neither very organized nor hierarchical. For the most part, the market consisted of independent groups of users who were interlaced very little or not interconnected at all. In the 1990s, however, the entire scene opened up and started to "move," with much more communication taking place within and among groups, both internally and externally. Gradually the market was transformed. However, a trend towards homogeneity and stabilization of all aspects (such as dealing rules, quality and availability of drugs etc.) was characteristic of the second half of the 1990s. This relative stabilization affected prices and the purity and availability of "hard drugs," as well as relationships and rules in the black market. A different development took place with regard to recreational drug use, especially cannabis and the so-called "dance drugs," as changes deepened the increasingly commercial nature of the recreational market. New legislation that was instituted in 1999 only had an indirect impact on this drug scene transformation; its main impact was in the acceleration of

the approximation of drug markets of "problem" and "recreational" drugs—which had originally been relatively strictly separated.

This comprehensive overview of the development of the drug scene in the Czech Republic after 1989 from the perspective of qualitative research provides an explanation of the dynamics of relationships between significant phenomena that shaped the scene's transformation. Sociopolitical and economic changes after 1989 brought about the liberalization of social norms and the market as well as establishing the basis for the transformation of the drug scene itself. Although we do not possess adequate research sources with which to document all the basic stages and aspects of this transformation, we have tried to provide a consistent picture of the changes and one that sufficiently captures the richness and dynamics of these events. Ultimately, the transformation brought about very significant changes in the spectrum of substances used and in the patterns of use and rules associated with the drug market. A certain stabilization at the end of the 1990s then provides an ideal opportunity to use the knowledge obtained to rethink the approaches used in the fields of treatment and prevention, which are embedded in the context of the National Drug Policy Strategy of the Government of the Czech Republic (RVKPP, 2000, 2005). Capturing the essence of these changes and describing the main trends with the help of qualitative indicators are a few of the basic research goals. The gradually increasing quality and overall contribution of studies utilizing qualitative methods has resulted in this approach gaining respect and becoming more popular and widely used by both researchers and students.

NOTES

1 An overview of published works by Doc. Josef Viewegh is included in his monograph from 1999: Viewegh, J. [1999]. Psychologie umělecké literatury. Psychologický ústav AV ČR, Nakladatelství Pavel Křepela. Brno.

2 The author reviewed all available qualitative drug use research in the Czech Republic and used triangulation of data sources, methods, and participant accounts, etc. He also utilized the technique of contradictions—a special method that is implemented whenever a research team finds alternative explanations for a phenomenon, especially contrary explanations. Whenever this occurs, special discussions are used to clarify arguments and different aspects of the interpretation (Čermák & Štěpaníková, 1998; Miovský, 2006).

3 A health documentation file was routinely established for each drug user who made contact with a treatment facility upon his/her entry to a treatment program. This fact was registered.

4 The use of inhalants in the Czech Republic and elsewhere in the world has been concentrated in a socially marginalized population; in the Czech Republic, it is mainly the Roma population, a group which lies outside the mainstream of

social research, either because this topic is not attractive to grant agencies or because it is extremely difficult to validate data obtained by standard research methods within this population.

5 The so-called "white heroin" is illegally distributed heroin with a purity that is sometimes several times higher than that of common street heroin. Its purity often exceeds 70% (in one case, a police analysis demonstrated 92% purity in the sample).

6 When interviews were reviewed for any reference to the appearance of brown and white heroin on the Prague scene, the first completely isolated reference to the possibility of getting white heroin occurred in 1993. The first wave of a more massive entrance of white heroin was recorded in 1997 and 1998, and a second one in 1998 and 1999.

7 The factory in a small city Roztoky u Prahy (close to the capital Prague) started production of L-ephedrine-hydrochloride in 1971, using its own patented process. Until late 1990s, the factory (state-owned VUAB, in 1997 privatized as Nystepharm, Inc.) was one of three biggest ephedrine producers in the world. In 1998 it was sold to ICN Pharmaceuticals, Inc., that in 2004 stopped the ephedrine production due to substantially cheaper competition that produced its ephedrine in China, India and other Asian countries.

8 With a prescription, a pack of seven 2 mg tablets costs CZK 263 (approximately 11 USD). The preparation is not covered by any form of health insurance.

9 A pack of seven 8 mg tablets costs CZK 802 (approximately 33 USD) in a drug store.

10 This comment refers to the fact that it is very difficult to anticipate the greatly varying quality of drugs sold "on the street" because they are cut with various admixtures.

11 When a user significantly breaches the rules, he or she is usually expelled from the program for a month and can only come back and receive the substitution preparation after this period of time.

12 In this context, to "make" means to "steal."

13 A tightening in Subutex® prescriptions only came into effect on September 1, 2005. Until then, it was relatively freely prescribed with minimal monitoring and control. "Blue stripe" is the argot expression for the prescription form of opiate-based medicines and other more strictly regulated pharmaceuticals; it has a "blue stripe"—hence the name.

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