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**National Report**

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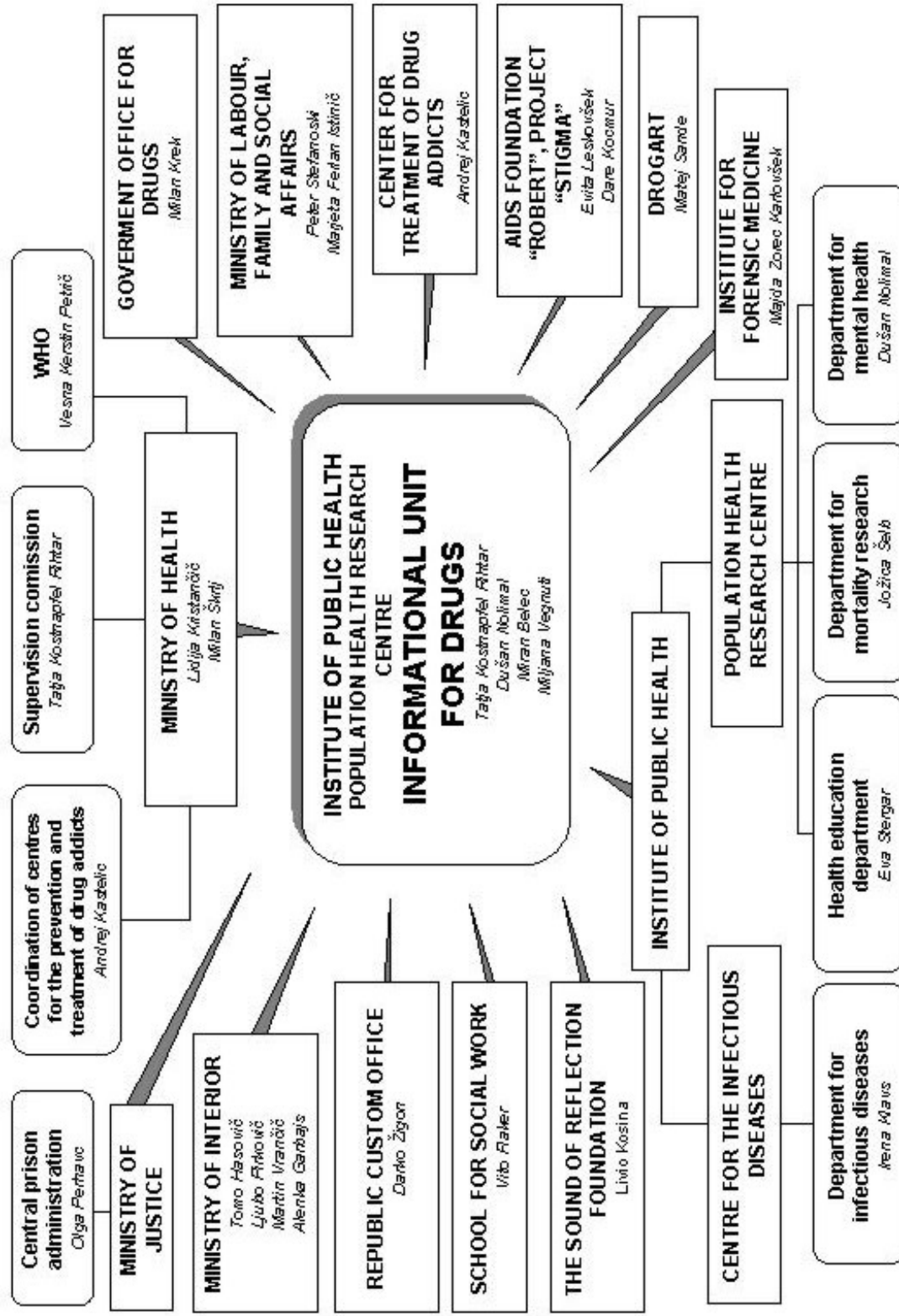
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## **NOTE:**

1. Some of the data stated in this report has not been collected by the regular EMCDDA methodology, but they result from separate researches carried out by individual researchers.
2. For all data are responsible experts who contributed them to the Report.

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# **PART 1**

# **NATIONAL STRATEGIES: INSTITUTIONAL & LEGAL FRAMEWORKS**

## **1. Developments in Drug Policy and Responses**

### **1.1. Political framework in the drug field**

Use and misuse of heroin, cannabis and other illegal drugs have been present in Slovenia since 1960s. Until 1990s it has been believed that illegal drug use is not a considerable problem in Slovenia. Becoming an independent country we have soon recognised drug problem as a topic of high priority. Rising HIV epidemic in some neighbouring countries among intravenous drug users has resulted in reconsideration of existing policies. In 1992 the National Programme was accepted in Parliament and the National Committee for the Implementation of National Programme for the Prevention of Drug Misuse was established.

In 1994 the Government of Slovenia accepted the advisory role of UNDCP for preparation of new legislation and organisational framework for the field of drugs. The new structures were proposed within the Government to create a better co-ordination of national drug policy.

In 1990s an extensive cooperation with international organisations like UNDCP, PHARE Programme, the Pompidou Group/Council of Europe and WHO in particular has outlined the basis of national drug policy. Harm reduction approaches have become more readily accepted through this cooperation.

Cooperation with the Pompidou Group/Council of Europe has contributed to the faster development of drug epidemiology. There were two »Information systems and applied epidemiology of drug misuse« seminars held in Slovenia (Ljubljana 1993, Piran 1994). The primary purpose of these courses was to give the expertise to help us developing a data collection system for planing and evaluating policies and interventions on drug misuse. The goal was to provide an input that would enable our professionals to build on their own experience and identify an appropriate strategy for research and data collection in Slovenia. The second purpose was to be more compatible with the work of the Pompidou Epidemiology Group.

The methadone maintenance treatment was present in Slovenia since 1991. In 1994 the consensus on the implementation of the methadone maintenance programme in Slovenia reached to the national level (The Conference on Methadone, Gozd Martuljek, November 1994). In April 1995 the network of Centres for the Prevention and Treatment of Drug Addiction (CPTDA) has started to establish.

The Coordination of Centres for the Prevention and Treatment of Drug Addiction and the Supervising Committee were formed at the Ministry of Health to guarantee a good realization and supervision.

In 1996 outreach, a method of work with harm reduction activities, was discussed at the meeting at Otočec, cosponsored by the Pompidou Group.

At the beginning the initiative for outreach activities was coming from the governmental structures, but soon Non-governmental organizations (NGO) started to get involved. Nevertheless, outreach has been already presented in Slovenia before the Otočec meeting. NGOs as Piramida in Maribor, Stigma in Ljubljana and Komet in Koper have been executing some outreach activities since 1990. The Republic of Slovenia was included in WHO pilot project **"HIV related harm reduction programme among injecting drug users in Slovenia"**, too.

Prevention, targeting life style and better health are included in the strategy presented in the document Health for all until the year 2000.

In October 1996 the **First Slovenian Conference on Addiction Medicine** was held in Ljubljana. The main issue was to explain the major ideas of addiction medicine and review Alpe-Adria region. First publication on this issue has been published in 1997. The **Second conference on Addiction medicine** was held in 1998.

The **3rd European Methadone Conference** together with the **Regional meeting of Central and Eastern European Countries on Therapeutic Programmes for Drug Addicts and European Conference on Outreach and Open Community Approach** was organised in September 1997 by the Coordination of Centres for the Prevention and Treatment of Drug Addiction at the Ministry of Health and EUROPAD (European Opiate Addiction Treatment Association).

The **First National Conference on Addiction** was organised by the Coordination of Centres for the Prevention and Treatment of Drug Addiction at the Ministry of Health and The Sound of Reflection Foundation in May 1999.

**ISAM** (International Society of Addiction Medicine) **Satellite Symposium** was organised in September 2001 by the The Sound of Reflection Foundation and ISAM, followed by the **WHO Workshop on Pharmacological Treatment of Opioid Dependence**, organised by the same foundation.

Drug Information System in Slovenia has been developing since 1991 in agreement with the Pompidou Group methodology and Phare DIS Programme. The National Public Health Institute has been the chief actor in drug data collection. Nevertheless, we had also done some activities before. FTD data has been collected since 1991 in the Centre for the Prevention and Treatment of Drug Addiction Koper and systematically since 1996 in all CPTDAs.

The decision was made at the ministerial level that the Ministry of Health would act as the Slovenian Focal Point, cooperating with the National Public Health Institute in connection with epidemiology in 1994.

Legal basis is now in the Act on prevention of drug consumption and treatment of drug addicts (Official gazette 98/99).

In Slovenia, according to available estimates, are from 5,000 to 10,000 intravenous drug users (25-50/10.000 population). Sharing equipment for injecting drugs (80%) as well as unsafe sex are common, dangerously increasing the potential for spreading the HIV in this community.

But out of nine gathered reported aids cases in Slovenia in 1999 there was only one with the history of possible intravenous drug use.

Several hundred intravenous drug users have been voluntarily and confidentially tested for HIV in recent years and only three have been found infected. However, the present low prevalence of the HIV infection among intravenous drug users may increase rapidly whenever and if HIV is introduced. Therefore HIV harm reduction interventions related to unsafe intravenous drug use and unsafe sexual behavior among drug users are considered a high priority within the National AIDS Prevention and Care Program.

That is why a network of fifteen regional centers for the Prevention and Treatment of Drug Addictions has been established since 1995 and the professional staff working at the centers has received an additional training. These facts might also contribute to low HIV prevalence in this population, together with introduction of substitutive treatment a few years earlier.

### ***International cooperation***

Slovenia is participating in several international programmes and cooperating with several international organisations dealing with drug issues. International cooperation has played an important role in facilitating certain activities such as implementation of harm reduction approaches. It has also provided knowledge and international experiences to our experts. Although international cooperation has certainly influenced drug policy in Slovenia, all programmes and measurements were adapted to national circumstances.

Since 1993 we have been participating in the **PHARE programme** in several fields:

- Drug Demand Reduction
- Drug Supply Reduction
- Drug Information Systems
- Control on Precursors
- Licit Drug Control
- Money Laundering Project
- Synthetic Drug Project

Phare projects have often been used as an excuse to initiate certain activities on the national level.

One of the most important roles of Phare Projects is in facilitating international cooperation between CEECs and EU countries. Although the cooperation between Slovenia and other CEECs and EU countries concerning drug information systems and data exchange is presently mainly through Phare Projects and some other international projects, it is an excellent starting point for future cooperation on more independent bases.

Phare Project "**Strengthening of the national REITOX Focal Point and strengthening the drug supply reduction and drug demand reduction programmes in Slovenia**" (SI0005/IB/JH-02) is recognised as a facilitating phase of cooperation with the EMCDDA and REITOX.

Due to present international political status, police has not yet been able to establish closer institutional cooperation with the European Union. Drugs, organised crime and money laundering are considered a serious international problem. The efficient prevention will no longer be possible without closer cooperation among prosecuting authorities in all European countries.

Within the Phare Multi-Beneficiary Drugs Programme of the European Commission, oriented towards the transposition of the European Union acquit in the field of drugs, we organized this year (2001) the **Phare Synthetic Drugs Project** in the Republic of Slovenia. It was carried out and coordinated by the Criminal Police. Through the realisation of all envisioned activities (trainings, study visits and a seminar) the basic aims of the project were entirely realised. An important result of the project was the preparation of the National Synthetic Drugs Plan of Activities that will become a component part of evolving national drug strategy. Through establishment of the Europol National Bureau and with the signing of the Agreement on cooperation between the Slovene Police and the Europol, the conditions for active participation in the EU Early Warning System have been created. This system based on the Joint Action on Synthetic Drugs from 1997 and represents an effective tool for early identification of new synthetic drugs. Within the frame of 2001 Phare programme cited above was also concluded the fifth phase of the project "Precursors", already a number of years supervised and directed by our Criminal Police. During the last phase of the project a number of activities had been carried out, oriented especially into final harmonisation of Slovene legislation with EU directives and regulations in the field of precursors control.

To increase the operational abilities of Slovene law enforcement authorities, we established the Central Drug Law Enforcement Commission in 2001. The basic task of this Commission, composed of representatives from Criminal and Uniformed Police and from Customs, is the coordination of all activities in the field of drug supply reduction.

The Republic of Slovenia is actively involved in accession into the European Union in the sense of harmonisation of legislation and other institutional changes in the field of illicit drugs, including the implementation of the Phare

project “**Twinning Project for Prevention and Suppression of Organised Crime**”.

The cooperation with the **Pompidou Group/Council of Europe** has started in 1993 and has been formalised in 1994. It has resulted in several seminars and projects launched in Slovenia. Several Slovenian experts have got a chance to cooperate in different working groups. The cooperation with the Pompidou Group was most beneficial in drug epidemiology. Among numerous programmes Multi city study, ESPAD school survey and DRSTP have given most beneficial results.

The cooperation with **UNDCP** resulted in the preparation of new legislation and reorganisation of governmental structures responsible for drug issues. Within the framework of the UNDCP we are participating in the Sub-regional Programme involving six projects. The countries that are taking part in it are Poland, the Czech Republic, the Slovak Republic, Hungary and Slovenia. The Government of the Republic of Slovenia has verified and signed the Memorandum on Cooperation on these projects, although it has not yet approved the projects or participants. We have not yet received any training from the UNDCP nor have been offered any assistance in equipment.

On the bilateral level of cooperation among **PECO states** we have the most intensive contacts with the Republic of Hungary and signed with it several agreements on cooperation in the police field. With the Slovak Republic we have already signed an agreement on cooperation in the fight against terrorism, illicit drug trafficking and organised crime. The same agreement is just about to be signed with the Czech Republic and Poland. We exchange concrete operational information via the Interpol CNB without any obstacles.

We are founder members of the **Middle European Police Academy (MEPA)**, whose training programme includes drug related issues. Our experts are not only students, but also take a part as lecturers.

Our representatives are actively involved in the work of the committees of the **Central European Initiative (CEI)**.

With two groups of crime investigators we participate at the **ILEA** education and training programmes in Budapest. This is an acquisition of new knowledge and exchange of experiences, a basis of the quality work. Through this programme we can actively cooperate with others in the preparation of training programmes, respectful to our specific needs. ILEA programmes are designed with special attention to drug related problems. Our aim for the future is therefore to continue benefiting from ILEA courses on all fields of police work, especially in the war against drugs.

The Cooperation with **WHO Regional Office** has resulted in Slovenia-Czech Republic Collaborative Project in which Slovenian experience in methadone

maintenance has been exchanged for Czech experiences in outreach work. WHO has also financed several publications about drugs.

**International Labour Organisation (ILO)** has been cooperating with the Ministry of Labour, Family and Social Affairs and The Public Health Institute on the project about drug use at the workplace.

**Open Society Institute** has co financed needle exchange programme at Stigma self help organisation. They established a partnership between Stigma and Lifeline, similar organisation from Manchester in U.K.

Most of the international and national projects launched in Slovenia are coordinated on inter ministerial level and discussed and agreed at the Committee for the implementation of the National Programme for the prevention of drug misuse. National coordinator for PHARE Programme and coordinators for Drug Demand Reduction Project and DIS Project are all members of the Committee.

## **1.2. Policy Implementation, legal framework and prosecution**

### **a) Law and regulations**

Slovenia has signed The Single Convention on Narcotic Drugs from 1961 (Official gazette SFRJ 2/64, 3/78), The Convention on Psychotropic Substances from 1972 (Official gazette SFRJ 40/73) and The United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances from 1988. All of them were adopted in the Act on Succession - (Official gazette RS 9/92).

These and the recommendations of the Legal Advisory Programme at the United Nations International Narcotic Board (Mr. Bernard Leroy, UNDCP Legal Adviser) formed the basis for creating new drug legislation in Slovenia. Three new Acts were adopted.

#### **1. *The Act on production of and trade in narcotic drugs and psychotropic substances (Official gazette RS 108/99, 44/00)***

This Act shall set out the conditions under which the production of and trade in illicit drugs are permitted, and the possession of illicit drugs.

Illicit drugs shall be deemed to be plants and substances of natural or synthetic origin which have psychotropic effects and which can influence a person's physical or mental health or threaten a person's appropriate social status, and which are defined in the list referred to in the third paragraph of this article.

The production of illicit drugs shall be deemed to be all procedures in which substances from article 2 of this Act are obtained, including their cultivation, processing and final preparation.

For the purpose of this Act, trade in illicit drugs shall be deemed to be the import, export, transit and sale of illicit drugs and any other method of releasing illicit drugs into circulation.

The possession of illicit drugs shall be prohibited, except under conditions specified in Articles 7 and 19 of this Act.

The production of illicit drugs may be performed on the basis of a licence obtained from the minister responsible for health.

Opium poppy (*Papaver Somniferum*) and cannabis (*Cannabis Sativa L.*) may be cultivated solely for food or industrial purposes on the basis of a licence issued by the ministry responsible for agriculture.

Illicit drugs may be released into circulation exclusively on the basis of a licence issued by the minister.

Applications for the issuing of a licence for trade in illicit drugs shall be submitted to the ministry responsible for health.

The act is being implemented by regulations to be prepared by the Ministry of Health and other responsible ministries.

The **List of Illicit Drugs Decree** (Official gazette RS 49/00, 8/01, 49/01).

- ***The Regulation on Terms and Proceedings to Issue Permissions for the Export and Import of Drugs*** (Official gazette 8/02).

The Regulation on Evidences and Reports on Drug Production and Trade and Terms of Data Reporting is being prepared by the Ministry of Health and Degree on bookkeeping and health inspection.

In addition, licit drugs are partly regulated by the Medicinal Products Act (Official gazette 101/99).

## **2. *The Act on prevention of drug consumption and treatment of drug addicts* (Official gazette 98/99).**

In this unique act the addiction and the measures for the primary, secondary and tertiary prevention, treatment of drug misuse and rehabilitation and social reintegration are defined. The law also defines the harm reduction measures. Activities and responsibilities of state and establishment of coordinating body at the governmental level are specified.

In this act Inter ministerial Committee is defined and The Governmental Office for Drugs.



The Commission of the Government of the Republic of Slovenia for Drugs shall promote and coordinate the governmental policy and programmes for the prevention of illicit drugs consumption, reduction in illicit drug demand, reduction in harm caused by the use of illicit drugs, treatment and rehabilitation. In addition the Commission of the Government of the Republic of Slovenia for

Drugs shall perform the following tasks:

- monitor the implementation of the provisions of conventions issued by international bodies and international organisations;
- submit to the Government of the Republic of Slovenia the proposed National

Programme and measures for the implementation of the National Programme;

- propose measures to reduce illicit drug supply;
- ensure international cooperation.

The Information System has its legal basis in this law.

Monitoring of the consumption of illicit drugs is carried out in the form of the collection, arrangement, processing and providing of information on illicit drugs, consumers of illicit drugs and consequences of the use of illicit drugs. The purpose is to ensure a national information network, interdepartmentally coordinated collection of data and an informational exchange on the national and international levels.

The activities specified in the preceding paragraph shall be carried out by the competent ministries, public institutions and non-governmental organisations. The competent minister shall set out the method of monitoring in the working areas of individual ministries in more detail.

Monitoring of the consumption of illicit drugs shall be carried out pursuant to the provisions that govern collections of data in the area of health and in accordance with the act that governs the protection of personal data.

For the implementation of the activities specified in the first paragraph of this article, the ministry responsible for health shall organise an illicit drug information unit.

The information unit referred to in the preceding paragraph shall include all competent ministries, public institutions and non-governmental organisations, along with the collections of data in the available area of illicit drugs.

According to this act two degrees were adopted:

- Degree on establishing and performing of Coordination of Centres for the Prevention and Treatment of Drug Addiction (Official gazette 43/00)
- Degree on establishing and performing Supervision Commission (Official gazette 43/00)

### **3. *Precursors for Illicit Drugs Act (Official gazette 22/00)***

The act regulates in details the monitoring of export and import and partially the domestic trade, the list of precursors and its amending in accordance with the amendments of EU and OUN legislation. The Commission on precursors was

established with duties to monitor the application of the act; the conditions for persons dealing with precursors were defined; the procedure for issuing licenses and procedure for export/import precursors scheduled to categories 1, 2 and 3 were arranged; special control measures were applied for export to sensitive; the recording and reporting, inspection and penal measures were regulated.

Degrees are:

Decision on the list of precursors (Official gazette 94/2000)

Decision on the quantities of precursors which may be exported without permission (Official gazette 94/2000)

Decision on the list of precursors and states for applying special measures in exports (Official gazette 94/2000)

## **b) Prosecution policy, priorities and objectives in relation to drug addicts, occasional users, drug related crime**

### **1. Penal Code**

According to the Penal Code of the Republic of Slovenia (Official gazette RS 63/94 - paragraph 196 and 197) illegal production of and trade in narcotic drugs and psychotropic substances and facilitation of illegal drugs use are defined as criminal acts.

The possession of illegal drugs being recognised as for a personal use only is not considered criminal act but an offence according to the Act on Production and Traffic of Narcotics (Official gazette 108/99).

The compulsory treatment for addicted on alcohol and drugs is defined in the paragraph 66 of the Penal Code. A person who committed criminal act owing to his/hers alcohol or drug addiction may be sentenced to compulsory treatment. Treatment may take place in prison or in treatment institution. In a case of conditional sentence, the judge may consider doers readiness for treatment and permits treatment from liberty.

Compulsory treatment for alcohol and drug addicts is discussed in the Penal Code (Official gazette RS 17/78, paragraphs 162,163,164 and 165).

### ***New substances under control in the reporting year directives***

GHB was classified to the list of illicit drugs according to the List of Illicit Drugs Decree in 2002 (Official gazette RS 49/01).

**c) Any other important project of law or other initiative with political relevance to drug related issues**

Since 1999 the Governmental office for Drugs are preparing the National Drug Strategy and National Action Plan among different sectors. They will be launched to the parliament procedure in 2002.

All degrees on the basis of law on drugs are in a phase of preparation.

### **1.3. Developments in public attitudes and debates**

- **National level**

On the basis of the Act on prevention of drug consumption and treatment of drug addicts (Official gazette 98/99) Governmental Office for Drugs was established.

Its predecessor at the governmental level was the National Committee for the Implementation of National Programme for the Prevention of Drug Misuse established in 1992. The Committee was designed as a consultant body of the Government. Lack of executive power has been a main limitation of the Committee. It could only influence through its members' consultations with ministers and other executives of the Government and through the media.

**The Ministry of Health** has several tasks. It is competent for preparing of legislation and responsible for treatment. It is competent for establishment of two legal evidenced bodies: Coordination of Centres for the prevention and treatment of drug addiction and Supervision Commission for monitoring the Centres for Prevention and Treatment of Drug Addiction.

Among other activities the **Ministry of Health** is responsible for issuing import and export authorisations for illicit drugs and precursors, organizing seminars, allocating budgetary resources and preparing list of Illicit Drugs.

**The Ministry of Labour, Family and Social Affairs** is responsible for social rehabilitation and integration. Under its domain is the cooperation with International Labour Organisation regarding prevention at the work place. Supporting outreach work and other harm reduction activities is one of its responsibilities.

**The Ministry of Interior** has the competence for fighting drug related crime. It is also a reliable source on drug related police data.

**The Ministry of Justice - UIKS** deals with addicted prisoners and has been successful in this matter cooperating with health sector.

**The Ministry of Finance** - Custom Office of the Republic of Slovenia is responsible for customs affairs and as such also dealing with drug issues.

**The Ministry of Education and Sport** is responsible for the primary prevention in schools. In this context it cooperates with health sector, mainly with the Institute of Public Health. The school survey ESPAD was a result of such cooperation.

**The Ministry of Defence** is involved in drug demand reduction activities considering the population of young recruits for which is responsible.

**The Institute of Public Health of the Republic of Slovenia (IPH)** deals with drug related data collection and dissemination at national level. Within the scope of its general tasks is responsible for prevention and health promotion at all levels. AIDS and hepatitis prevention and monitoring are part of the Institute's activities. The IPH cooperates with all bodies at local, national and international levels.

- **Regional level**

Several drug related activities are organised at the regional (geographical) level:

#### **Prevention**

**Local Action Groups (LAG)** have been established in several regions (there are 9 regions in Slovenia). Their domain is primary and secondary prevention. The local authorities finance them and there is a significant difference among the involvement of LAT in different regions.

#### **Treatment**

**Centres for the Prevention and Treatment of Drug Addiction (CPTDA)** have been mostly established at the regional level within the health centres or public health institutes. They differ widely in the number of clients. Methadone maintenance programme and counselling are predominant services.

**Center for Treatment of Drug Addicts at Clinical Department for Mental Health** was established in 1995 and additionally financially supported from 1998. Center for Treatment of Drug Addicts should be opened in 2002.

#### **Epidemiology and research**

There is the Institute for Public Health in each region, collecting, analysing and disseminating health data and dealing with health promotion at the regional level. Collecting drug related data is only one of the institute's activities.

### ***Mechanisms of cooperation and coordination***

At the national level the cooperation between all governmental sectors, media and NGOs is assured within the **Governmental Office for Drugs** which guaranties multidisciplinary approach.

**Coordination of CPTDAs at the Ministry of Health** is the coordinating body, established to provide uniform treatment approach in all treatment centres and exchange of treatment experiences. The representatives of therapeutic communities and harm reduction programmes are invited to meetings as non-members of Coordination - representatives from Ministry of Health, Institute of Public Health, Ministry of Labour, Family and Social Affairs, Ministry of Justice and representatives of NGO.

The initiative to create similar coordination of regional Public Health Institute for drug epidemiology issues has already been given. The main reason for this initiative was a need to adopt same methodology of data collection at all levels.

Several networks have been created in the past few years in Slovenia to create common policy and uniform approach and exchange experiences. Among those we should mention **The Network of LAG** who at their second meeting in October 1997 adopted several conclusions concerning LAG preventive activities. Now meetings are performed regularly once a year.

A network of outreach projects has been established to ensure better position of outreach projects in our country.

### **Non-governmental organisations**

***The Act on prevention of drug consumption and treatment of drug addicts (Official gazette 98/99) defines in:***

#### Article 13

“In accordance with this Act, non-governmental organisations shall carry out activities which have been coordinated with the National Programme and which supplement the public service activities in the area of prevention and dealing with addiction to illicit drugs.

The activities of non-governmental organisations may cover schooling and educational activities, preventive activities, harm reduction programmes, programmes of establishing and maintaining abstinence, social rehabilitation and reintegration and other forms of dealing with consumers of illicit drugs and

their relatives pursuant to the second paragraph of Article 2 of this Act and the National Programme referred to in Article 3 of this Act.

The activities under the preceding paragraph may be carried out by non-governmental organisations within resident communities, non-residential programmes and as a part of other forms of work coordinated with the National Programme.

Residential communities shall be deemed to be therapeutic communities which carry out professional therapeutic and rehabilitation programmes, communes via a programme which is mainly based on mutual help, and special-care homes via a programme which is mainly based on life and work in groups.

Non-residential programmes are day centres carrying out programmes of organised help in which consumers of illicit drugs and the people closest to them are included alongside their everyday life. Centres carry out programmes for the reduction of harmful consequences of the use of illicit drugs and their programmes are carried out in the form of fieldwork.

Programmes for harm reduction cover distribution of intravenous injection needles, advice on reducing the harm caused by the use of illicit drugs and other programmes intended for harm reduction.

Programmes in the form of fieldwork shall be programmes of dissemination of informational material, dissemination of medical material and other programmes carried out in the form of fieldwork.

#### Article 14

The non-governmental organisations referred to in the preceding paragraph may voluntarily associate in the Association of Non-Governmental Organisations.

The activities of the Association of Non-Governmental Organisations shall be the following:

- coordination of joint activities;
- mutual linking between member organisations;
- coordination of activities and programmes;
- representation of the Association of Non-Governmental Organisations before public and national bodies, local community bodies and holders of public authorisations;
- promotion of the development of non-governmental forms of work among consumers of illicit drugs;
- acquisition of donations for non-governmental forms of work with consumers of illicit drugs;
- provision of advice for governmental and other services and organisations;
- promotion of professional development and education for members of the organisations.

#### ***Specialised institutions in the field of drugs***

There are a lot of institutions specialised in drug issues.  
List of all of them is included in Annex 6.

## 1.4. Budgets and funding arrangements

### a) Funding (figures) at national level in following fields:

- **Law enforcement (criminal system, police forces, etc.)**

Measures aimed at fighting drugs are funded by the budgets of the responsible Ministries (the Ministry of Internal Affairs, the Ministry of Justice, the Ministry of Finances).

- **Prevention and treatments**

**Preventive activities** are financed from regional and national budgets. Private money is seldom involved.

**Treatment organised within the National Health System** is mainly funded by the health insurance system.

Methadone maintenance in CPTDAs is available to all drug users through compulsory health insurance. Detoxification and treatment in psychiatric hospitals are available to all drug users through additional health insurance.

**Treatment in therapeutic communities** have no legal bases to be financed by health insurance, thus special funds have been established lately within the Ministry of Labour, Family and Social Affairs. Therapeutic communities are financed from various budgets and donations according to their background.

- **Epidemiology, research**

**Drug research** is financed from national budgets, partly as a regular activity of research institutions and partly from special funds at the responsible ministries. At the local level research may be co financed from regional budgets. In some cases research has been supported by international organisations (Open Society Institute, WHO, UNAIDS, Pompidou Group...).

- **Evaluation, quality, training**

**Evaluation, quality, training** is financed from national budgets, partly as a regular activity of research institutions and partly from special funds at the responsible ministries.

**PART 2**

**EPIDEMIOLOGICAL SITUATION**



## **2. Prevalence, Patterns and Developments in Drug Use**

### **2.1. Main developments and emerging trends**

In this part of the report the main developments in drug use, including prevalence and patterns are given. Some main activities and some epidemiological information are discussed.

In Slovenia, as in many other countries, the continuing upward trend in the misuse of illegal drugs has been noticed since 1986.

The illicit drug situation in Slovenia seems to be very much alike to the situation in some other European countries. The drug that causes most problems is heroin, but the most popular drug is cannabis. Since heroin injecting is the predominate route of opiates use, we have been lucky enough not to experience AIDS/ HIV epidemic among the injection drug users. Heroin users in Slovenia administer the drug in various ways. They inject the drug in their veins (intravenously). The latter seems to be the norm among most users. Heroin is also smoked in specially prepared cigarettes. In addition, some people use the drug intranasally (sniffing). Among the users in treatment in 2000, 64.5% injected their heroin and 35.3% admitted sharing at least once in their life. 13.5% of the first treatment demanders admitted sharing in the last month. However, discussions with the fieldwork respondents suggest that among out-of-treatment users the prevalence of sharing may well be much higher. Whether this is really the case should be the object of systematic research, but several observations support this hypothesis.

#### **The use of new synthetic drugs**

The use of synthetic drug is increasing in the Republic of Slovenia. Main activities of the DrogArt - Slovenian Association for Drug related Harm Reduction projects are built around the link of electronic culture and dance drugs.

##### **1. Harm reduction**

From the harm reduction aspect the work includes the distribution of flyers, outreach work (first aid) in rave parties, workshops for young people, lectures for staff and parents in boarding homes, peer education and voluntary work. We are using Internet as a tool for prevention of dance drugs, as a source of information and as a medium of online counselling ([www.drogart.org](http://www.drogart.org)), help and advice for young people. The site has become very popular between club and

partygoers because of the full coverage and reports from events in Slovenia and Croatia, DJ interviews and accurate, up to date drug information.

In the year 2000 we are focused on the new synthetic drugs or revival of some older substances like 2CB and ketamine and on the research of ATS. The increased amphetamine and methamphetamine use between young people in Slovenia and EE is our next challenge for prevention. The relatively easy production of synthetics, transformations in terms of chemical structures and distribution channels over EE countries as well as low street price of these drugs is a current reality and a reason for broadened market for synthetic drugs (and their use between young people) in the near future.

## **2. Research on ATS in Slovenia (1996 to 2001)**

Our knowledge about ATS and dance culture is based from two research projects dated from 1996 to 1998 (Both research projects were directed by B. Dekleva – Faculty of Education). First research was about ecstasy users and the second about drug use in secondary schools in Ljubljana (ESPAD 1998).

The first one was a cross section study using ESPAD-type methodology and representative sample of Ljubljana's 15 years old youngsters. Its main finding is that ecstasy is the drug which use has grown the most in the last three years. In 1998 7% of our 15 years old sample already used it at least once in their life, while among pupils of less academically oriented schools the respective percentage is about 13%. Ecstasy has become the second most frequent illegal drug (on the question - *already used in life*), following cannabis. At the same time - for some percentage of youngsters - it is becoming the first illegal drug that they have used (instead of marihuana).

The second study used snowball sampling and field interviews with ecstasy and other dance drugs users. Its aim was to get to know the (sub)cultures of the users, to estimate their knowledge about dance drugs and the eventual existence of their own spontaneously learned, shared and used harm reduction knowledge, techniques and practices. We were also interested in the drug dealing and using networks, in their relations with other drug using subcultures and similar issues. We found out that users are mostly interested in "objective" information on drugs, that they try to minimize harm and feel that there is an absolute lack of any information on ecstasy and related drugs available for them (except their own experience and information transferred through peers networks).

Our last research project *The use of amphetamine, methamphetamine and other synthetic drugs in Slovenia* (research project was directed by M. Sande – Faculty of Education & DrogArt) was oriented towards the use of ATS in the population of Slovenian partygoers. The goal of the research project was the evaluation of amphetamine, methamphetamine and MDMA use on rave parties and to compare the results with the results gained from general population. The

next goal was to answer the question, whether the use of synthetic drugs in Slovenia is problematic, harmful and chaotic (the link between the quantity of consumed drugs, mixing of different drugs and problems detected by users themselves). The final goal was the evaluation of the connection between the need for sensation seeking and the use of stimulants and the connection between lower self-esteem and the use of stimulants.

The results are pointing on high level (86%) in lifetime prevalence of the MDMA use and relatively high popularity of synthetic drugs (2. MDMA, 3. Cocaine, 4. Amphetamine<sup>1</sup>). Methamphetamine is known, but used by the small percentage of the sample. GHB on the other side is used between 4% of the sample.

The research sample contained 1500 visitors of electronic dance events in Slovenia. One third of the sample replied on the questionnaire over the Internet, and two thirds of the sample answered on the same questionnaire which was distributed on the dance events in Slovenia. We also included a group of students (non users) to evaluate the role of sensation seeking and self esteem on the use of drugs. The final results will be presented in June 2001.

The results are displayed as a comparison between special population of partygoers (Sande, 2000) and ESPAD based School Survey (Stergar, 1999).

*Table 2.1.1. The lifetime prevalence of drug use between partygoers in Slovenia*

<i>Research</i>	<i>Sande 2000</i>	<i>Stergar 1999</i>
	<i>M=20,3 y</i>	<i>M=15 y</i>
	<i>%</i>	<i>%</i>
Marihuana	93,8	32,2
Cocaine	46,7	2,0
Heroin	25,0	2,2
Ecstasy	86,0	5,2
Amphetamine	71,9	1,8
Methamphetamine	9,8	/
LSD	47,1	5,2
Magic Mushrooms	43,1	/
GHB	4,7	/
Sedatives	26,8	/
Ketamine	2,3	/
Crack	3,1	/

*Source: Matej Sande, DrogArt*

<sup>1</sup> On the question "Which is your favourite drug?" the first drug of choice remains cannabis.

Populations using new synthetic drugs seems to be different to the one using heroin and other opiates/opioids. Thus new strategies will have to be established.

Drug policy and response is a result of various initiatives evolving from experts, media, politicians, NGOs, drug users and their relatives. There is a comprehensive national drug plan or strategy accepted that is prepared by Governmental Drug Office and the Slovenian policy is unceasingly dependent on approaches accepted in EU countries. Various international programmes and projects have been imported in recent years, but we always respected the specific needs of our populations and society.

In the last few years, in the light of menacing AIDS/HIV epidemic, harm reduction measures were given priority over approaches aimed to complete abstinence.

Harm reduction and demand reduction programmes principles have been widely accepted among different professionals and at different governmental departments. Increasingly good cooperation has been established between these sectors.

There are many treatment facilities within the national health care system. Long term treatment and rehabilitation is limited to the treatment in few therapeutic communities operating within the country and therapeutic communities abroad. Methadone maintenance programmes, detoxification and treatment in psychiatric hospitals are available to all drug users through compulsory health insurance. Treatment in therapeutic communities have no legal bases to be financed by health insurance, therefore special funds within the Ministry of Labour, Family and Social Affairs have been established lately.

## 2.2. Drug use in the population

### a) Main results of surveys and studies

In comparison with EU countries, Slovenia was staying approximately ten years behind in consumption of illicit drugs among the young. Lev Milčinski with his co-workers, and Dušan Noliml with co-workers studied the extent of drugs in Slovenia at the beginning of the 80s and discovered that it was not large. Research among students in Ljubljana (A. Gosar at all, Medicinski razgledi, 1984) at the beginning of the 80s showed that the widespread of illegal drugs in that period was not as great as in some western countries in the same period. The situation became much worse at the end of the 80s, when younger and younger age groups started to take heroin and certain other prohibited drugs and began to inject their drugs.

Based on scarce literature and observation reports, the following trends can be observed. From the late 1960s to the mid 70s cannabis, LSD, tranquillisers, solvents and minor pain relievers were popular, but there was no epidemic of drug use. After that there was a period of initially increased illicit drug use. In that period there was limited experimentation with opiates. Injection use was rare. In the late 70s, small groups of dropouts started to inject opiates more frequently. Most opiates and opioids were stolen from pharmacies and there was some home grown opium from the farmers. In the late 80s there was the increase of the incidence and prevalence of cannabis, followed by considerable increase in the injection use of heroin.

The police reports also said that at the end of the 80s and at the beginning of the 90s was discovered a visible increase in the illegal production and sale of drugs. That was seen also in much larger quantities of seized drugs, especially heroin; in the increase of criminal offences which the Penal Code defines as illegal production; in the increased sale of drugs and drugs consuming permissions as well as other offences, violent acts and secondary crimes linked with drugs.

The only general survey on the prevalence of drug use among population older than 18 years is from 1994.

Although a small amount of heroin use was noted in the late 1980s. Use of heroin first emerged as a considerable problem in Slovenia during the early 1990s. It started to increase in the mid 1990s and expanded rapidly in the second half of the 1990s.

The quantities of heroin seized in the country have increased dramatically. The proportion of addicts in prisons charged for heroin offences increased sharply.

## **b) General population**

There are presently estimated 5000 -10.000 heroin users in a total population of two million citizens. But this information is not reliable since it is based on key actors' opinion. The majority of heroin users inject. The first demand for heroin addiction treatment, as recorded by the majority of treatment centres, rose rapidly until 1991. Drug injecting is an important risk factor for HIV and hepatitis infection. The fieldwork and ethnography suggest that the level of HIV risk behaviours among injection drug users is unacceptably high. This paper also provides an assessment of the current general drug use situation and status of epidemiological research in Slovenia, with an emphasis on heroin misuse. Trends in demand and market indicators are basis for this report. At present, HIV seroprevalence among treatment populations is low. This merely indicates that HIV has not yet been introduced into the networks of injection drug users in Slovenia. Methadone maintenance began in late 1980s and first syringe exchange started in 1992. Through continuous implementation of harm reduction approaches aimed at injection drug users it may be possible to contain an HIV epidemic in the population of heroin users.

Since early 90s a considerable increase in injection drug taking, heroin in particular, was noticed in Slovenia. More drug-related overdoses were registered for the first time. The rise in hepatitis C and B among drug users in treatment centres was observed.

At present HIV seroprevalence among treatment populations is practically non-existent. This merely indicates that HIV has not been introduced yet into the networks of IDUs. This should not be taken as a reassurance - when introduced, the virus could spread like a wildfire.

The seizure of other drugs has also being increased. The trend in the growth of the amount of confiscated drugs is continuing.

In 1995, the Slovenian police confiscated the first larger quantities of amphetamines (1302 tablets) and ecstasy (7354 tablets). These are new drugs previously hardly found on the Slovenian market. They are mainly used in connection with rave parties and the population of users differs from the one using heroin. No relevant research about ecstasy use has been published yet.

Epidemiological situation of drug use and dependency in Slovenia is subject to dynamic changes. However, the most commonly used drugs are still alcohol and tobacco. On the second place are different medicaments, mainly sedatives, hypnotics, anxiolytics, analgesics. Most frequently prescribed psychoactive drugs are benzodiazepines. Smoking of cannabis has become part of the young people's social behavior. No reliable data on the prevalence of drug consumption in Slovenia is available.

### c) School and youth population

The **ESPAD** survey was carried out by the Institute of Public Health of the Republic of Slovenia in 1995 and in 1999. The data for 1999 and comparisons 1995 –1999 will be presented in this report.

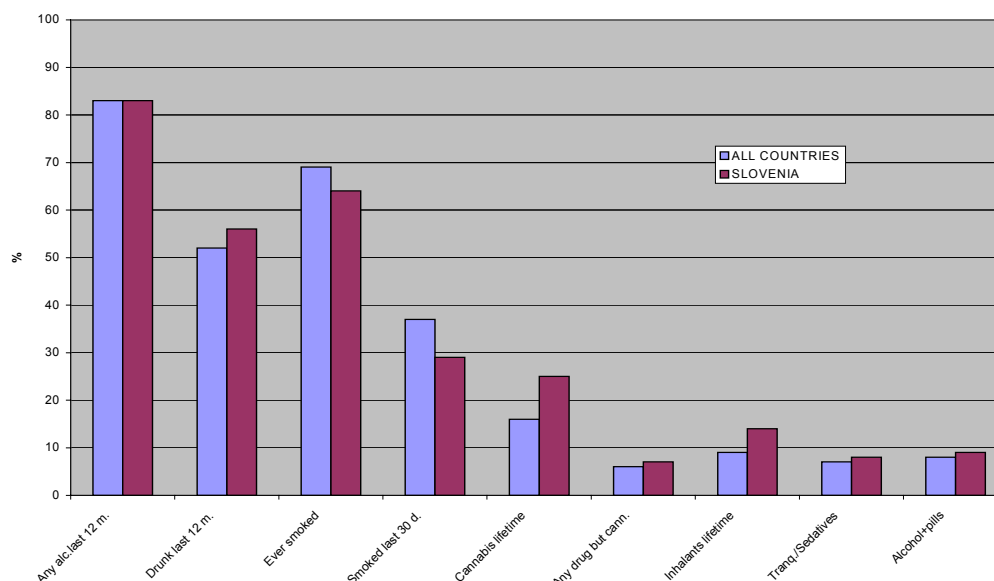
**In 1999** the **target population** consisted of all secondary students in grade 1 born in 1983. It was estimated that about 90% of the age group attended some kind of secondary education in spring 1999. The majority (83%) were found in the first grade. There were 170 secondary schools in Slovenia at the beginning of school year 1998/99. Traditionally, secondary education is offered in four types of schools: grammar schools, 4-year technical schools, 3-year vocational schools and 2,5-year vocational schools.

*Table 2.2.1. School survey data, Slovenia, 1999*

	<i>lifetime prevalence, %</i>	<i>last 12 months prevalence, %</i>	<i>last 30 days prevalence, %</i>
Cannabis	24,9	21,2	12,8
Heroin	2,6		
Cocaine	1,8		
Hallucinogens	3,0		
LSD	2,4		
Other halluc. Magical mushroom	1,5		
Solvents	14,5	7,0	2,7
Hypnotics and sedatives	7,9		
Amphetamines	1,2		
Ecstasy	4,1		
Anabolic steroids or other doping substances	2,3		

*Source: Eva Stergar, Institute for Public Health*

Figure 2.2.2. Key Slovenian results, compared to European average, 1999



Source: Eva Stergar, Institute for Public Health

The proportions of Slovenian students who had been drinking any alcohol and had been drunk during the previous 12 months are both very close to the averages of all ESPAD countries (83% and 56% respectively). The lifetime prevalence of smoking cigarettes is somewhat lower than the average (64 vs. 69%), as is the 30 days prevalence (29 vs. 37%). The proportion of students who have used marijuana or hashish is higher than average (25 vs. 16%), while the use of other illicit drugs is about equal (7%). The use of inhalants is higher (14%) than average (10%), while the use of tranquillizers or sedatives without a doctor's prescription as well as alcohol in combination with pills are both very close to the averages of all countries (8 and 9% respectively).

**d) Specific groups** (e.g. conscripts, minorities, workers, arresters, prisoners, sex workers, etc.)

- **General information about prisoners with drug problems**

Among people who have problems with drugs we include long-time drug users and people who occasionally use drugs. There are also people who started experimenting with drugs in prison.

We obtain information about people who are dependent on drugs or who occasionally use drugs on the basis of the documentation accompanying the person on the path to prison (e.g. court ruling, compulsory treatment measure imposed on a drug addict, report from the Social Work Centres etc.), but generally at the beginning of his sentence a drug addict himself discloses his problem because he is concerned about a withdrawal crisis or because he is on a methadone therapy.



Drug problems are presented among all categories of prisoners – remand prisoners, inmates, people sentenced in a misdemeanour procedure, young offenders. Most often they are men between the ages of 16 and 49.

*Table 2.2.2. Number of prisoners with drug problems compared to a total prison population*

	1995	1996	1997	1998	1999	2000
Total prison population	4046	3767	3882	5113	6348	6703
No. Dependent on drugs	133	156	268	306	471	512
Percentage	3.28	4.14	6.90	5.98	7.40	7.63

*Source: Central Prison Administration*

Other problems connected with drugs are illegally bringing drugs into prisons, dealing in drugs on the black market, taking drugs, a danger of infection from sharing needles and experimenting with drugs.

## 2.3. Problem drug use

### a) National and local estimates, trends in prevalence and incidence, characteristics of users and groups involved, risk factors, possible reasons for trends

Slovenia's social economic and political situation is conducive to further increase of drug use. Increase in drug availability, limited economic perspectives and the loss of traditional values have contributed to the epidemic proportions of drug use among the young population. Of course, speculating about the current extent and future trends of the problem of drug use with deficient reliable sources of information is not easy task. The individuals who had a specialized knowledge of or were involved with drug problems stated that the number of problematic heroin users probably was somewhere between 5000 - 10.000 individuals at risk. These numbers are seemingly still smaller than in the Western Europe, but not negligible compared to the small size of our country and the population of two millions. It seems that they have already reached the level at which the spread of HIV could be facilitated. If HIV would enter the nets of injection drug users, seroprevalence among these populations might quickly reach high levels. Also, increasing drug related mortality among drug injectors heightened the need for more valid information on the level of risk behaviours.

Before 1989 the drug injecting problem in Slovenia - recognized today as the main risk behaviour - seemed quite limited and the country had very little

experience with a response to the drug problems. The problem has become to be regarded as more serious during recent five years, if the size of such a problem is determined by the great attention of the mass media and high level of public concern.

Today the reliable data on the drug use problem are available through the treatment demand data. In the past we did not have the reliable and comparable epidemiological data on drug misuse problem. In the beginning of 1990s, i.e. when a large number of young people in Slovenia became involved in heroin the reporting was non-existent. The reasons for this insufficiency in the past were a lack of treatment and a lack of research of infrastructure, specialized knowledge and experiences in addressing drug problems. All these resulted in the lack of methodological and conceptual clarity of the described estimation approaches.

Though sharing needles and syringes decreased, many patients are still doing it. More concerning is the fact that more than half of the treated users were never tested for HIV infection. These findings require a fast response. Of course, the data also reflects the quality of data collection.

The prevalence of drug use problem's data is still scarce. However, we now have the reliable information on drug treatment demand. The heroin injectors are mostly studied through this approach. The majority of heroin users inject. Most of them are multiple drug users. Some users sniff, smoke the drug in cigarettes or chase it from an aluminium foil. Drug injecting is an important risk factor for HIV infection. There is an urgent need for more ethnographic research to collect necessary information on risk behaviour.

The early attempts in the fieldwork suggest that the level of HIV risk behaviours among injection drug users (IDUs) is unacceptably high. This suggestion is corroborated by the high hepatitis C sero-prevalence level in a small treatment sample.

At present HIV sero-prevalence among treatment populations is practically non-existent. This merely indicates that HIV has not been introduced yet into the networks of IDUs. This should not be taken as a reassurance - when introduced, the virus could spread like a wildfire.

## **b) Risk behaviours (injecting, sharing, sex...) and trends**

A more detailed insight is provided in Part 4, Chapter 11. Infectious diseases.

### **3. Health Consequences**

#### **3.1. Drug treatment demand**

The connection between injection drug use and (imminent) epidemics of infectious diseases among users urges us to reconsider the addiction treatment and drug abuse control policies in the early and middle 90s. It was concluded that even if the risks associated with illegal drug use were not entirely preventable, proper harm-reduction strategies could reduce them considerably. These approaches have gained increasing support over the last decade, while more conventional psychiatric approaches have appeared ineffective, expensive and counterproductive. The drug treatment demands increased considerably in the period from 1991 to 2001. The Methadone maintenance programs are the most common exemplars of harm reduction as an approach to health care of drug users in Slovenia.

The Drug Treatment Demand (DTD) Project and the use of the Pompidou Group Treatment Demand protocol to collect data on drug treatment demand is one of the most important projects in the field of drug reporting systems. It also monitors treatment demand trends. Some additional questions on sexual risk behavior (numbers of partners, condom use and prostitution - trading sex for drugs or money), hepatitis infection and criminal behavior were added to the list of information collected by PG questioner. Also, we collect more detailed information on injecting risk behavior, including "currently and ever shared other injecting equipment".

The DTD Project has worked successfully in the network of the centers for prevention and treatment of illicit drug use for more than six years. Actually we started to collect first data on the pilot base in 1991 in the cities of Ljubljana and Koper. Most of this time we have done our best to improve data quality and comparability of treatment demand data and to provide annually descriptive data reports for the different cities and the country. Starting in 2002, the new PG/EMCDDA questioner on treatment demands has been introduced and the risk behavior list of questions has been revised. The DTD data on drug users entering treatment centers for drug addiction represent the basis for planning activities of these centers. The planners and providers of health care use these data to identify the types of patients opting for specific activities and to formulate incentives for the treatment of individual sub-groups. Furthermore, the data indirectly show the changing patterns of the more problematic drug use among the population. It is therefore necessary to differentiate between the data on the users who seek drug-abuse treatment for the first time and those who have already undergone the treatment. The ratio between first and repeat treatments is an accurate indicator of drug use incidence. The collected data are also a useful basis for the research into the efficacy and cost-effectiveness of drug-abuse treatment.

Also, this project had a strong impact on our training efforts in drug use epidemiology and information systems. Therefore the DTD project allowed to establish a human network that will be maintained with the extension of this project to other drug treatment facilities.

In the period from 1996 to 2000 drug users most commonly sought treatment because of the heroin use (92.4% in the year 2000) and because of other drugs to a considerably lesser extent. Most were male (77.3 %), with a mean age of 24.7 years for male and 22.7 years for female. In recent years the proportion of cases for stimulant (cocaine, amphetamines), ecstasy and cannabis have increased, although at low levels. Combinations of illicit drugs, alcohol and benzodiazepines are common. Injection drug use that prevails among the treated drug users is associated with a high risk of local infections, necrosis, breakdown of the circulatory system, generalized septicemia, overdose and many potentially fatal infectious diseases, such as HIV and hepatitis B and C infection.

The proportion of treated current injectors (injecting last month) who reportedly sharing needles and syringes during the month before the treatment demand has decreased and reached 18.2 % in 1996. After that it has increased up to 30.4 % in 1998 and went back to 25.8 % and 28.1 % in 1999 and 2000 respectively. However, no upward trends in reported HIV incidence rates and HIV prevalence among treated drug users have been observed.

In the period from 1996 to 2000 the prevalence of HIV infection has consistently remained below 1% among the tested drug users. During the same period the prevalence of HBV detected among drug users demanding treatment for the first time ranged from 0 to 3% and the prevalence of HCV was between 9 to 13 % (for data for injecting drug users only see the "information on the prevalence of HIV, HCV and HBV among injection drug users").

The coordinator always checks individually reported data variable by variable. Data check routines and internal consistency checks were developed (together with the PG experts). The comments and reactions about unclear information are exchanged by phone or mail. This process allows better data quality in reporting. It serves as a training opportunity as well.

Of course there is a limitation of this sort of surveillance, regarding validity of self-reported information. There are also missing values on some variables. But during the course of the project the data quality improved remarkably.

Up till now the analyses of drug use, injecting risk behavior and sexual risk behavior trends (e.g. development of heroin use in the reduction of injecting, needle sharing and condom use behaviors, introduction of new drugs on the scene, the prevalence of HIV and hepatitis etc.) were the most challenging outcomes of this project. The trend analyses of TD data, combined with information from qualitative research will be the most important task in the future. Since the questionnaire has been revised in 2002, additional guidelines will be developed.

Figure 3.1.1. Drug treatment demand, Slovenia, 2000 (N=946)

Treatment contact Details	All treatments	First treatments	Socio-demographic information	All treatments	First treatments
No. of cases/demands	946	377	Male	77,3 %	77,4 %
Coverage estimation			Age < 20 years	18,3 %	34,5 %
Double counting controlled	yes	yes	Age 30 years and more	14 %	6,6 %
Never treated	39,9 %	100 %	Mean age	24,3	22
Self referral	91,4 %	91,7 %	Current living status – with parents	70,2 %	78,7 %
Problem drug use			Current living status – with partner	15,1 %	9,3 %
Primary drug heroin	92,4 %	84,6 %	Regular employment	26,7 %	19,4 %
Primary drug cocaine	0,8 %	1,06 %	Never completed primary school	4,8 %	3,7 %
Injecting (heroin, opiates)	75,9 %	64,5 %	Higher level of education	2 %	1,6 %
Smoke (heroin, opiates)	14,2 %	27,5 %	Risk behaviour vedenje		
Primary drug use daily	49,7 %	64,2 %	Currently injecting (last month)	56,4 %	61,3 %
Primary drug use - age <15 years	6,2 %	8,2 %	If injecting, shared past month	11,3 %	13,5 %
Mean age of primary drug use	18,9	18,6	Ever injected	83,8 %	72,1 %
			If ever injected, ever shared	47,5 %	35,3 %
			First injecting age < 20 years	42,9 %	39,8 %
			Mean age of first injecting	20,2	20,1
			HIV tested – positive	0,2 %	-
			Never tested for HIV	42,3 %	74,5 %

Source: Nolimal D., Vegnuti M., Belec M., Institute of Public Health of the Republic of Slovenia in collaboration with 16 outpatient drug treatment centres, April, 2001

### 3.2. Drug-related mortality

**We would like to stress out that there are no uniform national data according to EMCDDA methodology in the Republic of Slovenia. But some data are available, anyway.**

**Accoding to a research of** Majda Zorec Karlovšek PhD, Institute for Forensic Medicine, Medical Faculty, University of Ljubljana, in the year 2000 29 drug related deaths are noticed in Slovenia, all associated with the use of opioides. In 20 cases a drug overdose was detected as a direct drug related death (heroin, methadone, tramadol and their combinations with ethanol and benzodiazepines), in 9 cases as an indirect drug related death. Heroin or the analyte morfine was detected in 15 cases (51,8%).

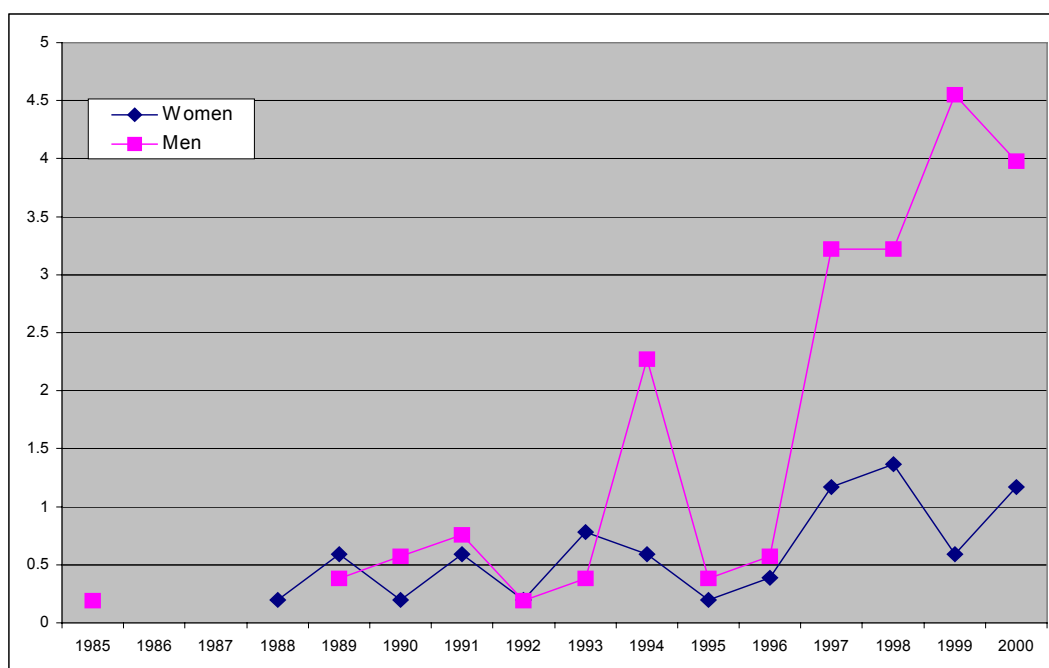
The number of all drug related deaths is higher than in the year 1999 for the ratio 1,2. The ratio for the year 1998 is 1,45. In the year 2000 is also interesting the rise in the number of indirect drug related death (suicides of addicted people) to the year 1999 for the ratio 9:4=2,25.

The Reports from the toxicological department of the Institute of Forensic Medicine are based on the number of requests for toxicological analyses in the cases of drug related deaths.

Data collection on deaths due to illegal drugs use has no uniformly prescribed methodology – direct comparison are difficult. But we started with activities for preparation data base on mortality according to EMCDDA guidelines.

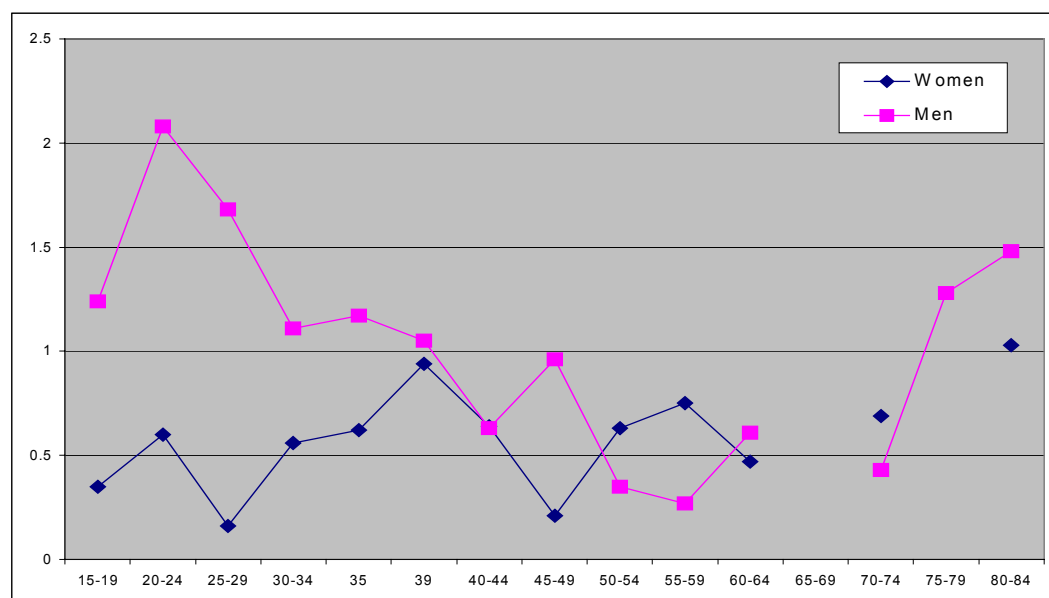
According to a research, done in the Institute of Public Health some data are available:

Figure 3.2.2. Mortality rate per 100.000 population by age groups and gender (Slovenia 1985 -2000)



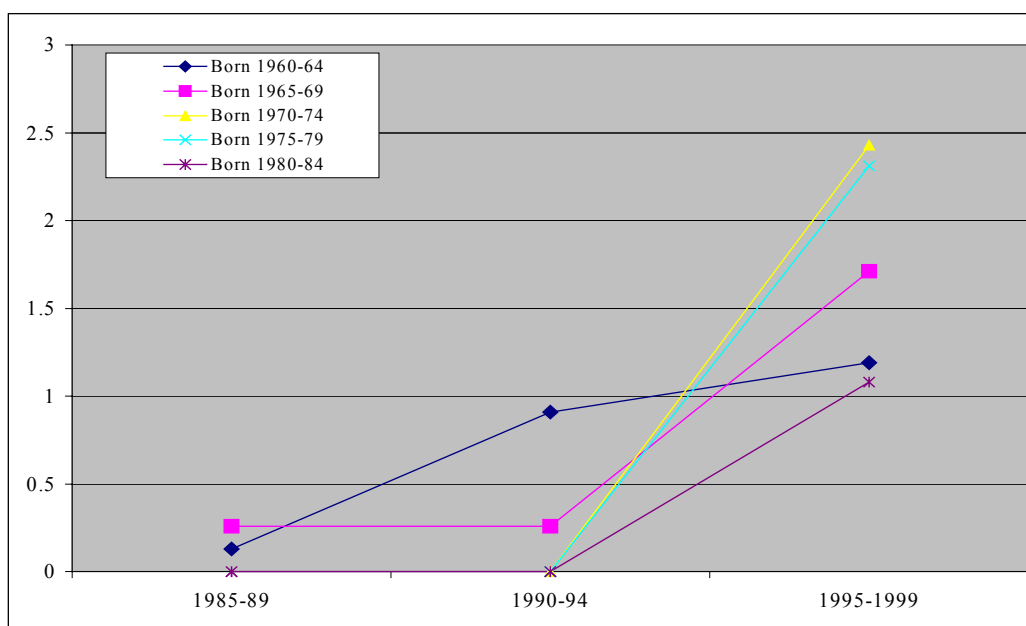
Source: Jožica Šelb, Institute of Public Health

Figure 3.2.3. Mortality rate due to drug use population for population aged 15 to 49 by gender (1985 -2000)



Source: Jožica Šelb, Institute of Public Health

Figure 3.2.4. Mortality rate due to drug use by birth cohort (1985 -1999)



Source: Jožica Šelb, Institute of Public Health



### **3.3. Drug-related infectious diseases**

A more detailed insight is provided in Part 4, Chapter 11. Infectious diseases

#### **HIV and AIDS**

Slovenia has a low level HIV epidemic. In 2001 the reported newly diagnosed HIV incidence rate was 8.0 per million (one case injecting drug user - IDU) and reported aids rate 2.5 per million (no IDU cases). According to all available HIV surveillance information the prevalence of HIV infection among injecting drug users in Slovenia remains below 1%. Regretfully, all HIV prevalence information is limited to treatment data and no information is available from needle exchange, other lower threshold harm reduction programmes or from community based surveys.

#### **HBV**

In 2001 reported acute HBV infection incidence rate in the Slovenian population was 0.9 / 100.000 population, which underestimates the burden of the disease. Since information on transmission route was not available it was impossible to estimate the proportion of injection drug users. During the period from 1996 to 2000 the prevalence of antibodies against hepatitis B virus (HBV) among confidentially tested injection drug users treated in the network of Centres for Prevention and Treatment of Illicit Drug Use ranged between 2.6% to 6.6%. All available HBV prevalence information is limited to treatment data.

#### **HCV**

In 2001 reported acute HCV infection incidence rate in the Slovenian population was 0.5 / 100.000 population, which greatly underestimates the burden of the disease. Information on transmission route was available for six cases of the total of 10 reported cases. Four cases were among injection drug users. During the period from 1996 to 2000 the prevalence of antibodies against hepatitis C virus (HCV) among confidentially tested injection drug users treated in the primary health care network of Centres for Prevention and Treatment of Illicit Drug Use ranged between 20.8% to 30.1%. All HCV prevalence information is limited to treatment data.

### **3.4. Other drug-related morbidity**

#### **a) Non-fatal drug emergencies**

The toxicological laboratory has started with the study of drugs prevalence in fatality.

#### **b) Psychiatric co-morbidity**

According to the study "An eight year naturalistic observational study of heroin-addicted, methadone maintained psychiatric patients" (Lovrečič, Center for Treatment of Drug Addicts Koper and Maremmani, PISA-SIA Group) dually diagnosed patients need a higher stabilization dosage (highest dosage maintained for a minimum of one month), as high as 150 mg/day, than patients with no additional diagnosis who on the average become stabilized on 120 mg/day. This difference is statistically significant. The higher stabilization dosage range (80-120mg/day) needed for dually diagnosed patients suggests that unresponsiveness to standard treatment observed in this category may actually be due to under medication. The need for such high dosages may derive from pharmacocynetic issues, since the psychotropic drug dosages needed to treat this category of patients are also higher than average.

The time needed to reach stabilization is as long as 6 months for patients without dual diagnosis (min max), whereas dually diagnosed patients require as long as 14 months on the average to reach stabilization. On the whole, dually diagnosed patients needed higher stabilization dosage and a longer time to reach it; the latter factor is not exclusively due just to higher dosages. Therefore, greater care is recommended for such subjects during the stabilization phase; dose adjustment may be required even after some years of ongoing treatment.

The PISA-SIA Group is an operational unit of the Department of Psychiatry, University of Pisa, Italy. It comprises a hospital division, a Day Hospital and an Outpatient Unit. The Outpatient Service runs a programme of methadone maintenance designed to meet the needs of two types of patients.

The first type of patients comprises those who fail to respond favourable to standard protocols (methadone dosages are generally in the 60-80 mg/day range, with the maximum of 100 mg/day). In the PISA-MMTP are no dosage limits and patients are encouraged to accept an increase of their dosage if they continue to show addictive behaviour. They are referred to public services that treat addiction and operate on a territorial basis.

The second type of patients comprise of heroin-addicted psychiatric patients who are resistant to standard psycho-pharmacotherapy. These patients do not remain compliant with pharmacological treatment; once they have left the hospital they usually discontinue the treatment and show psychopathological symptoms and addictive behaviours despite the number of admissions to

hospital (at least two in the previous two years). After referral by the hospital division of the Department, they receive methadone maintenance treatment as soon as they leave hospital.

Data emerging from our naturalistic study make it possible to identify another subgroup of heroin addicts who should be started on methadone as a priority. A third or a half of all opiate addicts may suffer from mental disorders. Enrolment in treatment makes a significant positive impact on their psychological well-being.

Methadone maintenance reduces maladaptive behaviors (likelihood of overdose and law-breaking); it is effective on the risk behaviors of pregnant addicts, with worthwhile benefits for both, the mother and the fetus; it is effective on risk-behaviours in HIV-infected addicts. Our data shows that even those mentally ill heroin addicts who have proved to be resistant to treatments, both for addiction and mental illnesses, and are non-compliant with psycho-pharmacotherapy are likely to develop an adaptive behaviour as long as they are maintained on an adequate methadone programme. Thus both, compliance with the treatment of addiction and the possible treatment of the concomitant mental illness, become achievable aims.

Therefore, even in dually diagnosed patients methadone maintenance confirms its power to reverse maladaptive behaviours.

**c) Other important health consequences (e.g. drugs and driving, acute and chronic drug effects...)**

According to the article Drugs and traffic safety – slovenian approach (Majda Zorec Karlovsek, Borut Stefanič)

The Institute of forensic medicine in Ljubljana performs toxicological analysis of blood and urine samples taken from traffic participants apprehended due to suspicion of alcohol and drugs. Retrospective study of requests for toxicological analysis gets the insight in growing problem of drugged driving in Slovenia. The activities of institute in this field are directed also in the law enforcement, education, epidemiological research and prevention issues.

*Table 3.4.1. The number of requests for toxicological analysis in cases of suspicion of drug impaired driving*

<i>Year</i>	<i>Police controls (PC)</i>	<i>Traffic accidents (TA)</i>	<i>All</i>	<i>Ratio PC/TA</i>
1991	3	3	6	1.00
1992	3	9	12	0.33
1993	4	3	7	1.33
1994	13	27	40	0.48
1995	42	23	65	1.82
1996	73	35	108	2.09
1997	155	69	224	2.25
1998	206	99	305	3.08
1999	516	166	682	3.11
2000	667	221	888	3.02

*Source: Majda Zorec Karlovšek, Borut Stefanič, Institute of Forensic Medicine, Faculty of Medicine*

Average age among drivers in the accident group was 27.5 years for males and 29.3 years for females and in the non-accident group 24.9 years for males and 25.3 years for females.

*Table 3.4.2. Frequency at which drugs were encountered*

	<i>Police controls</i>	<i>Traffic accidents</i>	<i>All (n=1307)</i>
Benzodiazepines	14.2%	31.6%	17.5%
Opiates	19.7%	24.0%	28.6%
Cannabinoids	66.2%	38.0%	60.8%
Cocaine	8.7%	5.2%	8.0%
Methadone	26.6%	25.6%	26.4%
Amphetamines	11.5%	8.0%	10.9%
Others	4.0%	18.0%	6.7%

*Source: Majda Zorec Karlovšek, Borut Stefanič, Institute of Forensic Medicine, Faculty of Medicine*

### **Health conditions and driving ability of special groups of drivers**

During the Slovenian symposium on traffic medicine held in may 1998 in Rogaška Slatina several conclusions and recommendations concerning health conditions of traffic participants are given.

It is obvious that a special regulation is necessary for drug rehabilitation programmes, methadone substitution programme and driving ability.

To the problem of drivers attending methadone maintenance programme a special conference was performed in June 2001, organised by the Government Office on Drugs and the Institute of Forensic Medicine.

## 4. Social and Legal Correlates and Consequences

### 4.1. Social problems

#### a) Social problems - social exclusion

The basic starting points for the treatment of difficulties related to illicit drug use in the social care system are defined in the National Social Care Programme until 2005 (Official gazette RS 31/2000).

The goals stated in the proposal of the National Social Care Programme which shall be ensured by the social care system and indirectly by the network of providers of services and programmes for the treatment of social issues related to illicit drug use are as follows:

- Improvement of the quality of living,
- Assurance of active forms of social care,
- Development of expert networks of social assistance,
- Establishment and development of the plurality of the activity,
- Design of new approaches to the management of social hardships.

The drug use in the social care system is treated as one of the many behaviour patterns which may lead to the decreased level of social inclusion of a drug user or persons who are close to him/her. The fact is that the drug use presents the behavioural and relational pattern on the basis of which the variety of responses to everyday-life challenges might be limited. Thus in the very last stage of the social career of a drug user - the stage of addiction - the majority of important vital questions are solved by strategies related to the drug use.

With the intention of preventing and eliminating social exclusion which results from or occurs simultaneously with the use of illicit drugs, the ministry assures conditions for the operation of expert services which function within the framework of public services as well as within the framework of activities which complement the offer of public services and activities of mutual help of drug users, persons who are close to them or other interested persons.

In social care, the professional support to drug users and persons who are close to them is directed to the development of individuals and groups in order to control to the highest possible extent the course of their lives in accordance with their own ideas, visions and strengths. Processes and methods of assistance in social care are intended to stimulate the integration processes, i.e. the processes that enable the social inclusion of individuals and groups into a broader social context. Social care engages in the prevention and elimination of conditions and actions of individuals and groups that cause their social exclusion (excommunication, marginalization, incapacity of exerting influence, etc.).

A part of the social context used by the individual when solving his/her own social hardship also consists of various institutions in various fields. When a

person in hardship, with regard to the nature of the hardship, properly contacts these institutions with the request for help, this is just a one more piece of evidence that this person is "properly" socially integrated. This is another reason why it is so important that a part of the social care system is composed by providers of public service of social care, with an as evident and standardised offer of professional support as possible. Providers of public service are holders of already established and operationalised professional treatments. The network of providers which complements the offer of public services shall try to even more specify the needs of its users and to even more include them into the planning of the activity intended for them. They enable an even higher level of (re)organisation of implemented programmes in accordance with specific problems of users.

Currently, the providers of social care services within the framework of public service are social care institutions - social work centres (altogether 62 of them) which provide social care services for drug users and persons who are close to them, particularly the first social assistance, personal assistance and assistance to the family at home. Public institutions are financed directly from the state budget for the services of the first social assistance and from the municipal budgets for the service of personal assistance.

Providers of programmes which complement the offer of public service are selected by regular annual tenders. Thus in 2000 thirty organisations were co-financed in the total amount of 6,300,000 SIT (28 125 EUR) and in public institutions (social work centres, there are 62 of them in Slovenia) 834 individuals were treated whose fundamental problem was related to the illicit drug use. In the same year 496 of them were treated for the first time.

## 4.2. Drug offences and drug-related crime

### Description of legislation defines misdemeanours and criminal offences

- **Production of and Trade in Illicit Drugs Act:**

**Article 33 defines:**

“Individuals shall be liable to a monetary fine of between SIT 50,000 (EUR 230) and SIT 150,000 (690 EUR) or a prison sentence of up to 30 days for committing the offence of possessing illicit drugs in contravention of the provisions of this Act.

Individuals shall be liable to a monetary fine of between SIT 10,000 (40 EUR) and SIT 50,000 (EUR 230) or a prison sentence of up to 5 days for committing the offence of possessing a smaller quantity of illicit drugs for one-off personal use.

In accordance with the provisions of the Misdemeanours Act, persons who commit the offence specified in the first paragraph of this article and who possess a smaller quantity of illicit drugs for one-off personal use and persons who commit the offence specified in the preceding paragraph may be subject to more lenient punishment if they voluntarily enter the programme of treatment for illicit drug users or social security programmes approved by the Health Council or Council for Drugs.”

**Article 34 defines:**

“Illicit drugs shall be confiscated from the perpetrator of a violation under this Act without any monetary compensation, irrespective of whether the illicit drugs were the property of the perpetrator or whether they were only in the perpetrator’s possession.”

- **Penal Code of the Republic of Slovenia:**

**Article 196: Unlawful Manufacture and Trade of Narcotic Drugs**

“(1) Whoever unlawfully manufactures, processes, sells or offers for sale substances and preparations recognised to be narcotic drugs, or whoever purchases, keeps or transports such substances or preparations with a view to reselling them, or whoever serves as an agent in the sale or purchase of the above shall be sentenced to imprisonment for not less than one and not more than ten years.

(2) If the offence under the preceding paragraph has been committed by at least two persons who colluded with the intention of committing such offences, or if



the perpetrator has established a network of dealers and middlemen, the perpetrator shall be sentenced to imprisonment for not less than three years.

(3) Whoever without authorisation manufactures, purchases, possesses or furnishes other persons with the equipment, material or substances which are, to his knowledge, intended for the manufacture of drugs shall be sentenced to imprisonment for not less than six months and not more than five years.

(4) Narcotics and the means of their manufacture shall be seized.”

### ***Article 197: Rendering Opportunity for Consumption of Narcotic Drugs***

“(1) Whoever solicits another person to use a drug or provides a person with drugs to be used by him or by a third person, or whoever provides a person with a place or other facility for the use of drugs shall be sentenced to imprisonment for not less than three months and not more than five years.

(2) If the offence under the preceding paragraph is committed against a minor, the perpetrator shall be sentenced to imprisonment for not less than one and not more than ten years.

(3) Narcotics and the tools for their consumption shall be seized.”

### **Criminal offences and Misdemeanours**

Similarly as in the previous years also in 2000 an increase was registered in the number of the discovered criminal offences and suspects as well as in the seized quantities of illicit drugs and the discovered offences due to the illegal possession of illicit drugs.

In comparison with 1999, the number of criminal offences increased by 22.2 %.

The increase was also registered in the number of discovered suspects against whom criminal information was provided. The number of discovered offences of illegal possession of illicit drugs also increased by 34 %.

It may also be established that there was an increase in the number of persons who were detained due to the suspicion of having committed a criminal offence in the field of illicit drugs. For this reason in 2000 a 78.9 % increase in the number of detained persons was registered.

The internal structure of the discovered criminal offences shows that there prevail criminal offences pursuant to Article 196 of the Penal Code of the Republic of Slovenia. It is necessary to mention that the increased total number of discovered criminal offences is predominantly a consequence of the increased number of discovered criminal offences pursuant to Article 196 of the Penal Code of the Republic of Slovenia, since the number of such offences increased by 25.9 %, while the number of discovered criminal offences due to enabling the consumption of drugs pursuant to Article 197 only increased by 14.9 % which is less than the average value amounting to 22.2 %.

*Table 4.2.1. Number of Criminal offences and Misdemeanours*

<i>Illicit Drugs</i>	<i>Criminal offences</i>	<i>Misdemeanours</i>	<i>Together</i>
Heroin	148	404	552
Cocain	25	70	95
Ecstasy	31	117	148
Amphetamine	11	47	58
Canabis (plant)	47	379	426
Canabis (marihuana)	309	3.643	3952
Canabis resin (hashish)	6	54	60
Lsd	0	0	0
Methadone	15	43	58
Benzodiazepines	2	17	19
<b>Together</b>	<b>594</b>	<b>4774</b>	<b>5368</b>

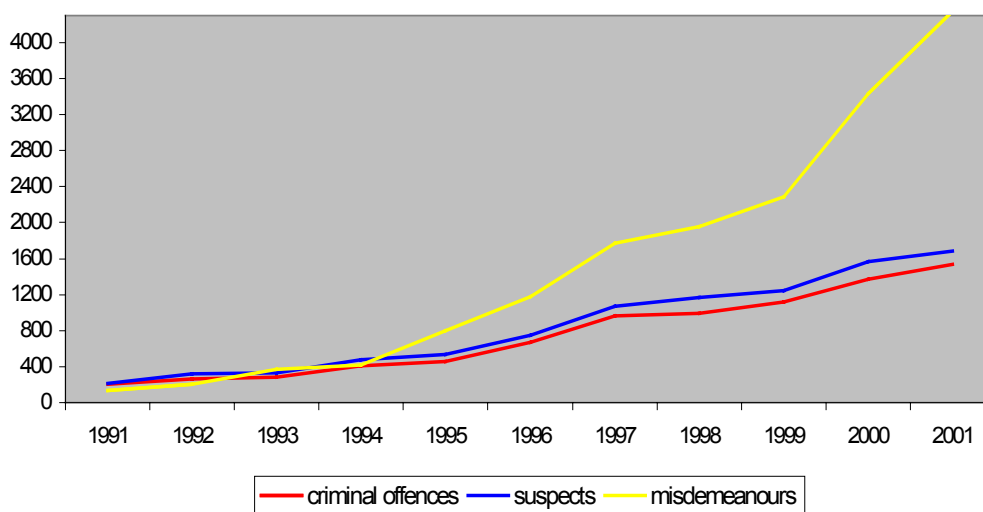
*Source: Ministry of Interior*

*Table 4.2.2. Number of Criminal offences and Misdemeanours from 1991 to 2001*

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Criminal offences	202	264	281	407	453	675	964	988	1121	1370	1537
Suspects	210	325	329	475	539	752	1072	1168	1241	1568	1681
Misdemeanours	135	205	365	418	796	1174	1773	1954	2289	3433	4352
No. of deaths	5	9	9	4	12	16	16	18	19	12	18

*Source: Ministry of Interior*

Figure 4.2.1. Number of Criminal offences and Misdemeanours



Source: Ministry of Interior

### 4.3. Social and economic costs of drug consumption

There are no studies and assessments of social costs caused by the drug use yet. We are also not able to estimate the consumption, demand and resources spent for drugs.

## 5. Drug markets

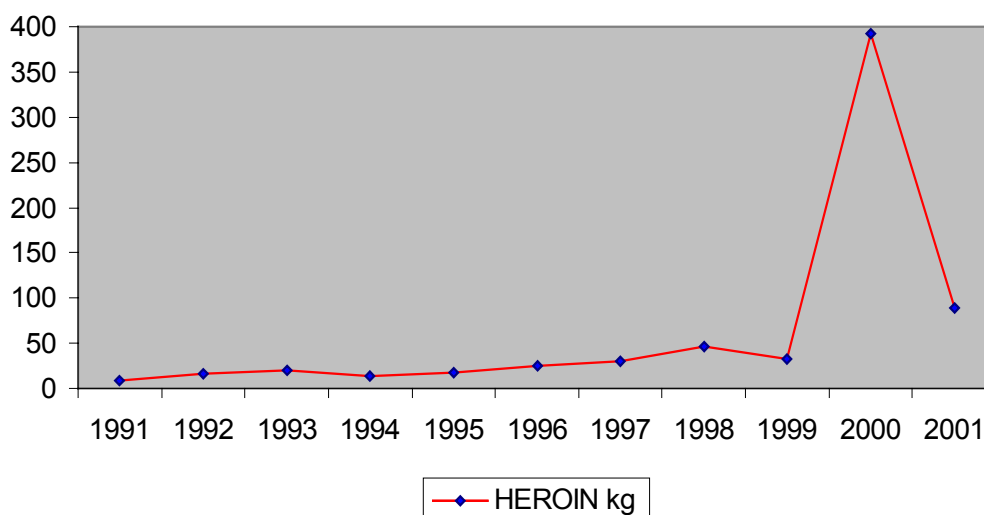
### 5.1. Availability and supply

According to our estimation, Slovenia is one of the countries with a high level of presence and abuse of illicit drugs, of illegal traffic in illicit drugs and of the operation of organized criminal groups. This situation also results from the particular influence by the nearby economically unstable regions after the normalization of the situation in the Balkan area. All this gives a special character to the imperilled situation of our country in the field of safety, which is directly and indirectly related to the issue of illicit drugs.

### 5.2. Seizures

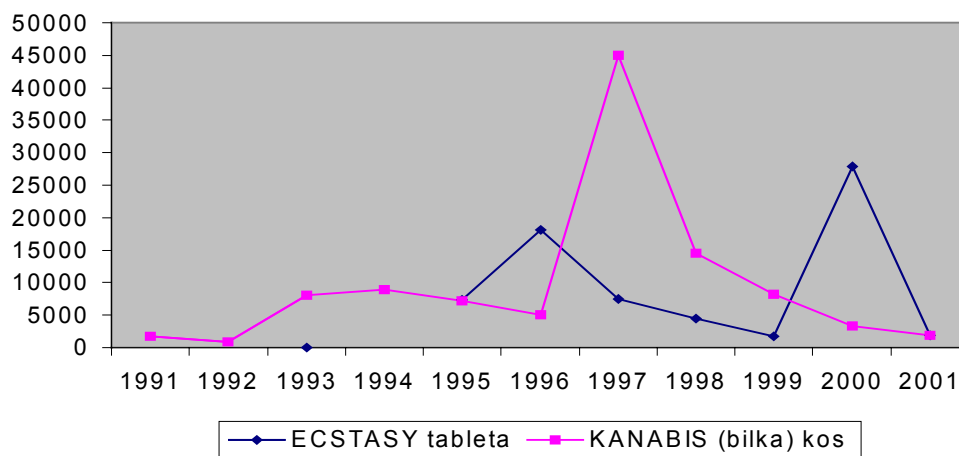
#### Trends in quantities and numbers of seizures

Figure 5.2.1. Numbers of seizures of heroin



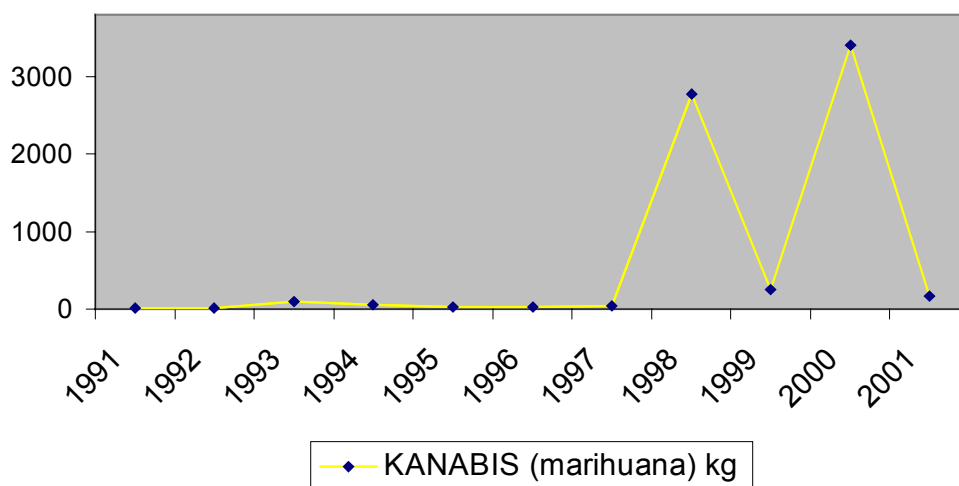
Source: Ministry of Interior

Figure 5.2.2. Numbers of seizures of ecstasy and cannabis unit



Source: Ministry of Interior

Figure 5.2.3. Numbers of seizures of cannabis



Source: Ministry of Interior

Table 5.2.2. Seizures of illicit drugs

ILLICIT DRUG	UNIT	2000	2001	Increase Decrease %
HEROIN	kg	392,65	88,93	-77,4
COCAIN	kg	0,98	1,08	10,2
ECSTASY	tablets	27.928	1.852	-93,4
AMPHETAMIN	kg	0,2	0,06	-70,0
	tablets	309	89	-71,2
CANABIS (plant)	piece	3.354	1.925	-42,6
	kg	6,1	2,78	-54,4
CANABIS (marihuana)	kg	3.413,24	175,1	-94,9
CANABISC RESIN (hashish)	kg	1,22	2,36	93,4
LSD	piece	59	0	-100,0
METHADON	tablets	245	382	55,9
	MI	1,545	3,346	116,6
BENZODIAZEPINE	tablets	735	460	-37,4
Anhydrid Acetic acid	kg	9.900	10.000	1,0

Source: Ministry of Interior

### 5.3. Price/purity

Some data on price are available in standard table 16: "Price at street level of some illegal substances".

Some data on purity are available in standard table 14: "Purity at street level of some illegal substances".

## 6. Trends per Drug

Comparable data on drug use are rare, but according to available researches and collected data in different sectors, we can conclude that in Slovenia we have been observing considerable increase in drug consumption, heroin in particular, since 1990.

New synthetic drugs are becoming more and more popular among young and are related to the techno subculture. School surveys pointed at constantly falling age of drug abusers.

Drug related deaths are increasing.

Risk behaviour among injecting drug users is of special concern according to the rise in hepatitis C and B infection in this population. However, HIV epidemic has not yet been observed in this group.

At the policy level the tendency towards more structuring and networking has been noted, especially in sector and educational social.

Heroin use was reported to be increasing in the 1990s. Surveys estimated that there were some 1500 – 3000 users (75 – 150 per 100 000 population) in the mid-1990s, increasing to 5000 (250/100 000) in 1997. Overall, 2% of school children reported having used heroin in a high school survey performed in 1992 (*WHO Regional Office for Europe, 1997*).

The use of amphetamines, LSD and cocaine has also increase. Multiple drug use (including alcohol) is common. A high school survey in Ljubljana reported that 4.8% had used LSD, 4.5% tranquillisers and other pills, 1.6% glue and 0.8% cocaine (*WHO Regional Office for Europe, 1997*).

According to a **ESPAD-survey** (European School Survey Report on alcohol and other drug use among 15 to 16-year-old) performed in 1995 and 1999, for the use of all illicit drugs in a lifetime, nearly three-fourths of the surveyed students in **1999** (74.4%) said they had never used any of the listed substances i.e. marijuana, amphetamines, LSD or other hallucinogenic drugs, crack, cocaine, ecstasy or heroin. Using any of these illicit drugs once to 5 times was reported by 12.8% of the respondents. Slightly less than 3% had used these substances 6 to 9 times, 10 to 19 times or 20 to 39 times in their lives, and 6.5% acknowledged the use of illicit drugs 40 times or more.

Marijuana use was denied by 76% of the surveyed. Of those who had tried it, 3% had done so at age 12 or earlier, 12% at age 13, 35% at age 14 and as many as 45% at age 15.

There were statistically significant gender differences concerning the age at first use of marijuana. A higher proportion of girls than boys said they had never smoked marijuana.

Overall average annually reported newly diagnosed HIV incidence rate during last five years (1997 to 2001) has been 6.5 per million population (8.0 per million in 2001). Average annually reported aids rate has been 3.5 per million population (2.5 per million in 2001). The prevalence of HIV infection has not reached 5% in any population group, not even in the most affected group of men who have sex with men.

According to all available information the prevalence of HIV infection among injecting drug users in Slovenia remains low.

During last 10 years (1992 to 2001) the reported newly diagnosed acute HBV infection incidence rate in the Slovenian population decreased from 4.5 / 100.000 population in 1992 to 1.0 / 100.000 population in 2001. Due to underreporting, HBV reported incidence rates greatly underestimate the burden of the disease.

Nevertheless, the downward trend should be noted. For the period from 1997 to 2001 information on transmission route is available for a minority of cases. Injecting drug use was implicated in 0% to 25% of those cases.

During the period from 1996 to 2000 the prevalence of antibodies against hepatitis C virus (HCV) among confidentially tested injecting drug users treated in the primary health care network of Centres for Prevention and Treatment of Illicit Drug Use ranged between 20.8% to 30.1% (30.1% in 1996, 21.1% in 1997, 20.1% in 1998, 21.2% in 1999 and 20.8% in 2000).

In the period from 1996 to 2000 drug users most commonly sought treatment because of the heroin use (92.4% in the year 2000) and to a considerably lesser extent, because of other drugs. Most were male ( 77.3 %), with a mean age of 24.7 years for male and 22.7 years for female.

The trend analyses of TD data, combined with information from qualitative research will be the most important task in future.

Drug problems are present among all categories of prisoners – remand prisoners, inmates, people sentenced in a misdemeanour procedure, young offenders.



## **7. Conclusions**

No analysis of the relationship between different indicators, based on the scientific approach, have been published.

For the policy planning to be based on relevant research data more quality research should be introduced. The implementation of the reporting system on treatment and care (FTD and TD in particular) and mortality at the national level should be one of the future priorities as are the analysis of the relationships between different indicators. A prevalence study in general population should also be one of priorities. There is also a need for more qualitative information on the risk behaviour and psychosocial and cultural context of drug use in Slovenia.

The uniform methodology of collecting and analysing the data will provide the basis for the comparison of our data with other European countries and the world, the basis to follow the trends and to evaluate the accepted measures. That will help us in preparation of the proposals for various activities for the prevention and reduction of illicit drug use.

**PART 3**

**DEMAND REDUCTION  
INTERVENTIONS**

## **8. Strategies in Demand Reduction at National Level**

Description of national framework of demand reduction emphasising new trend and developments at organisational level:

In Slovenia we are developing a modern and holistic approach in the field of Drug Demand Reduction. All relevant legal recommendations from international organisations like UN and EU are included in those attempts. As recognition of importance of drug problem in the modern Slovene society, the Government has established an Office with the task to prepare a New Drug Programme and to coordinate different policies led by several ministries with the responsibilities in this area. The highest coordination body in the country is Inter-ministerial Commission on Drugs. In this Commission the members are seven ministries from respective Ministries and seven more experts from different drug fields. The Governmental Office carries all concrete activities on this level. On the local level DDR activities are coordinated by the Local Action Groups. Their location is the most often at the Major Office.

### **8.1. Major strategies and activities**

Synthetic description of major national strategies in demand reduction and new developments:

Slovenia developed the first National Drug Programme in 1992. In the year 2000 activities for the new Drug Programme has started. Based on an integral, balanced, multidisciplinary and a global approach the first draft version of the New Drug Strategy was discussed in the mid February among the junior and senior policy makers. It is planned that the final version is going to be send to the Government by the mid of April. After the discussion in the Government, National Assembly will start with the first reading.

Through an extensive international cooperation with international organisations such as EU - PHARE Programme, UNDCP, WHO, Council of Europe/Pompidou Group, Interpol, DEA etc. Slovenia has gained variety of information and technical assistance that has assisted different actors in field of DDR.

Slovenia has adopted a national drug control policy and consistent demand reduction strategies. DDR infrastructure can be regarded as developed and with the crucial instruments in place if not fully deployed. A great variety of programmes, projects and initiatives have been adapted to our specific needs.

Although core components of a coherent and consistent DDR policy have already been adopted, the Government (as represented by Governmental office for Drugs and ministries at the core of DDR) has expressed concern about the

drug abuse problem and a willingness to further promote DDR programmes. Several attempts are being made to further enhance the DDR instruments.

The current national respect of policy, strategies and component-wise implementation of DDR in general may be viewed as promising if not yet adequate to meet the challenge.

In respect of awareness, treatment, rehabilitation, social re-integration, NGOs and community involvement - though quite a few programmes seem promising - further development and effective strengthening is needed, should the entire DDR sector attain international standards.

Slovenia is able to expand and strengthen its DDR on its own and/or is also capable to acquire any missing skills if desired. Augmented collaboration between major protagonists would further accelerate this process. Provision of limited high-level target-oriented international cooperation would facilitate the process of further developing the DDR sector.

### **Structural framework**

At the national level DDR activities are coordinated by the Governmental Office for Drugs which response to the drug problem. A Phare National Coordinator and a Phare DDR Coordinator have been appointed and are members of the Governmental Office for Drugs.

The local governments (in major cities) are involved in DDR and participate in Local Action Groups, provide premises, staff and budget. Municipalities support specialised institutions and organisations dealing with prevention. The city of Ljubljana is particularly active in this aspect. The Drug prevention Office of the Ljubljana City with its task to coordinate among all subjects dealing with drug problem at the city level is an extremely active body at the local level. Ljubljana faces an advanced drug abuse situation. Correspondingly, most services available in Slovenia are represented in its capital city.

A few major cities have formed a **Local Action Group**, initiating systematic collaboration between various institutions and professionals at the community level. This is a particularly positive development.

The full incorporation of **NGOs** in DDR is not yet achieved. In line with the level of DDR structure, programmes and services available in Slovenia, up to 10 NGOs are involved directly with DDR. The Government via the Ministry of Labour, Family and Social Affairs and the Ministry of Health provides a budget for NGOs, primarily in support of prevention and rehabilitation programmes (encompassing parents support groups). NGOs also work in health promotion, provide positive alternatives, drug education, they offer drug hot lines etc.

There are several NGOs which include drug issues amongst their objectives.

Overall NGOs, in particular those exposed to international contacts, seem to act professionally. Staff seems to be among the professionals who know a lot about DDR. For certain activities NGOs tend to rely on and employ professional staff (medical personnel, psychologists, social workers etc.). Some drug specialised NGOs depend on volunteers (in particular in parents self-help groups).

Among the leading members/advisors of some specialised NGOs are present (or former) GOs officials/professionals. NGOs depend on GOs budget and the GOs do not fully rely yet on NGOs efforts.

The Ministry of Labour, Family and Social Affairs uses parts of its budget for commissioning DDR to NGOs at the national level. Presently, it accepts and supports prevention and rehabilitation programs proposed by some NGOs.

Regular cooperation exists with quite a few international NGOs through which they have acquired considerable know-how and achieved transfer of knowledge and expertise.

In the past year Non Governmental Organisations have established the Association of Drugs NGO with several tasks. The most important one should be to become a relevant, competent and respected partner to the Government in all the relevant matters.

## **8.2. Approaches and new developments**

Since 90s harm reduction approaches have gained acceptance and support among professionals and in public in Slovenia. The first Needle Exchange Programme has started back in 1992, but even before that variety of activities was carried out for a promotion of Harm Reduction. Methadone maintenance and needle exchange programmes are part of national strategy for the prevention of HIV and hepatitis infections. Drug addiction is defined as a disease within a psycho-social context and it is seldom that drug addicts are viewed as criminals in public and in the media. For the last few years harm reduction approaches have been given priority over the abstinence-orientated approaches. Preventive vaccination against Hepatitis B is a part of a treatment for those included in the Methadone Maintenance Programme.

Primary prevention has not been given enough priority and the adjustments of strategies would be required. Primary prevention should be targeted within education and should centre on the general awareness creation and health promotion. At this stage it should be directed at the decision makers and professionals and more broadly extended to the wider civil society. Prevention should also highlight a provision of positive alternatives and interventions appropriate to a young (abuser) generation. Overall, the domination of DDR

from the health sector should give way to a more multi-disciplinary global approach. All above-mentioned has been discussed and endorsed into the new Drug Strategy.

The involvement and support of (specialised and non-specialised) NGOs needs to be enhanced and that of the local communities further promoted.

In general, as a prerequisite to sound and realistic DDR, political and public awareness and the attitude of the decision makers and civil society might require some re-alignment in regard of what constitutes »drugs« and »abuse«. The stigma associated with drug users needs to be further addressed.

Governmental Office for Drugs has organised or participated in several training activities in the field of DDR. Networks in the prison, social welfare and NGO's are supported by this agency. All relevant information are published and available on-line.

Different research activities were financially supported by the Office and findings disseminated to the broadest audience.

## 9. Intervention Areas

### 9.1. Primary prevention

#### 9.1.1. Infancy and Family

##### a) Intervention in different fields:

###### - During pregnancy/for future parents

Pregnant drug users have possibility to be counselled and followed during pregnancy by their physician. There is also a booklet with relevant information for them.

Existing prenatal health education programmes do not offer information regarding drug use and how it affects health of mother and child.

###### - Aiming at young parents

###### - Aiming at the families with adolescent children

There are several efforts and initiatives within local communities (e.g. in Ljubljana) to work with parents of adolescents in different ways and through different channels (e.g. organizing “School for parents” within school, centre for social work or in a church; organizing meetings for parents to discuss different topics with professionals). The contents vary a lot – from parental skills to specific information about drugs.

##### b) Interventions in crèche/kindergarten and other specific interventions in

Health promotion of pre-school children is addressed by “The healthy kindergarten” project in Slovenia. More than 40 out of approximately 300 kindergartens are members of the network. The intersectoral project (the initiative came from the health sector that lives within education sector) addresses education, teaching methods, communication, risk factors (e.g. physical activity, safety, smoking, nutrition, hygiene). The magazine with relevant articles (e.g. Let us listen to children, Children and communication, Recycling, toys for small children, Healthy nutrition in kindergarten) and news (e.g. Quit smoking and win, News from healthy kindergarten) is published. The aim of the project is cooperation of kindergarten teachers, parents and local community with the goal of achieving healthier lifestyle within kindergarten and consequently better health.

##### c) Statistics and evaluation results

Not available.

##### d) Specific training

The service of social prevention shall be provided by social work centres, often in cooperation with the providers of local youth programmes. The service is predominantly intended for the stimulation of social inclusion and is not exclusively focused on the prevention of drug abuse.

### 9.1.2. School programmes

#### a) **Mandatory, recommended or voluntary solutions at different school levels**

##### a1) **Mandatory/recommended solutions for elementary schools**

Over the last decade, the Slovene education system has experienced thorough and all-encompassing modernisation. Principles forming the basis for the renewal were set at the beginning and are as follows:

- Accessibility and transparency of the public education system,
- Legal neutrality,
- Choice at levels,
- Democracy, autonomy and equal opportunities,
- Quality of learning.

The new legislation (1996 – 2000) includes acts on the organisation and funding of education, pre-school education, elementary and grammar school education, vocational and technical education, adult education, higher education, professional and academic titles, school inspectorates, music schools, placement of children with special needs, vocational certification.

Changes have been introduced gradually according to the legislation adopted, in parallel with the gradual provision of facilities and staff. Most curricula were renewed; mechanisms for monitoring the implementation were developed. The new system will be fully adapted in 2003/2004.

Education for health as a cross-curricular field is a novelty within Slovene educational system. The cross-curricular field is a thematic field that has its specific topics and contents (like any other subject). They are carried out within several subjects (foreign language, mathematics, geography etc). In Slovene educational system are 3 CC fields: environmental education, professional orientation and education for health.

The National Curricular Council nominated a special group of professionals who prepared the program for the Education for health. The group tried to take into account and build on achievements, experiences and recommendations for education for health:

- of Slovene teachers;
- of teachers from foreign countries, e.g. Hungary, the Netherlands, Norway, United Kingdom, France;
- of international organisations (e.g. WHO);
- of international projects (e.g. European Network of Health Promoting Schools).

The group prepared **recommendations for holistic approach** to health within school framework – whole school approach to health. Education for health does not begin and end in the classroom. All aspects of school life have to respect their influence and importance for health. It is about supportive school environment (at micro and macro level), hidden curriculum, quality of interpersonal relations, cooperation with local community, school nutrition etc.



Everyday life should offer opportunities for strengthening the knowledge and information passed to children in the context of education for health.

Recommendations on didactics and teaching methods were prepared. Special attention was put on development of action competence. Recommendations in connection with organisational questions were prepared. Two groups of subjects were identified:

- supporting subjects (science, sports, techniques, home economics);
- supplementary subjects (history, geography, Slovene language, mathematics, music, art, foreign languages);
- activities were identified (class meetings, recreation break, days of activities etc).

These are the nine major groups of contents:

- family life,
- psychological aspects of health,
- personal hygiene,
- education for healthy sexual life,
- food and nutrition,
- physical activity and health,
- safety,
- first aid,
- use and abuse of substances.

For every content group the aims and topics were identified. E.g. for use and abuse of substances:

Aims:

- Schoolchildren should realise that all medicines are drugs but all drugs are not medicines.
- There are substances that could be bought without a doctor's prescription and substances that could be bought only on the basis of a doctor's prescription; pupils have to understand their effects on human being.
- To adopt general safekeeping measures for medicines and other substances (diluents, substances for cleaning...).
- Schoolchildren should know the characteristics of the decision making process; they should adopt peer pressure resistance skills.
- Schoolchildren should know that everybody is personally responsible while deciding whether to take drugs or not.
- Schoolchildren should be informed about drugs and their effects.
- Schoolchildren should be informed about drugs related legislation.
- Myths and stereotypes about drugs and drug users should be discussed.
- Schoolchildren should be informed about historical, cultural and social factors/conditions related to production, distribution and use of drugs all over the world.
- Schoolchildren should realise that drug use is present also in Slovenia.

- Schoolchildren should understand the formative role of mass media in values, attitudes towards drug taking, especially tobacco smoking and alcohol consumption.

Topics:

- What are medicines?
- What are drugs?
- Health related decision making process
- The process of becoming addicted – from nonuser to addiction
- Why do people abuse drugs?
- Alcohol
- Tobacco
- Cannabis
- Other illegal drugs
- Important steps in decision making process
- Peer pressure
- How do you say “no”?
- First aid
- Self-concept

Suggested literature for teachers and pupils was cited.

The proposal for the curriculum was published in a booklet. The next step for successful completion of the curriculum is preparation of detailed interrelations of education for health contents with curricula of other subjects.

### **The Slovene Network of Health Promoting Schools (SNHPS)**

The Republic of Slovenia is a member of the ENHPS (European Network of Health Promoting Schools) since March 1993. Three phases were undergone within the past time:

- Pilot phase (1993 – 1996; 12 schools; 1 secondary, 11 elementary)
- Dissemination phase (from January 1997 on; 130 schools; 100 elementary)
- Phase of national strategy building (from March 2000 on, not very efficiently)

The Slovene project developed the whole school approach to health; it strives to follow 12 internationally set goals. The recommendations from Ottawa charter for health promotion were borne in mind while structuring the programme.

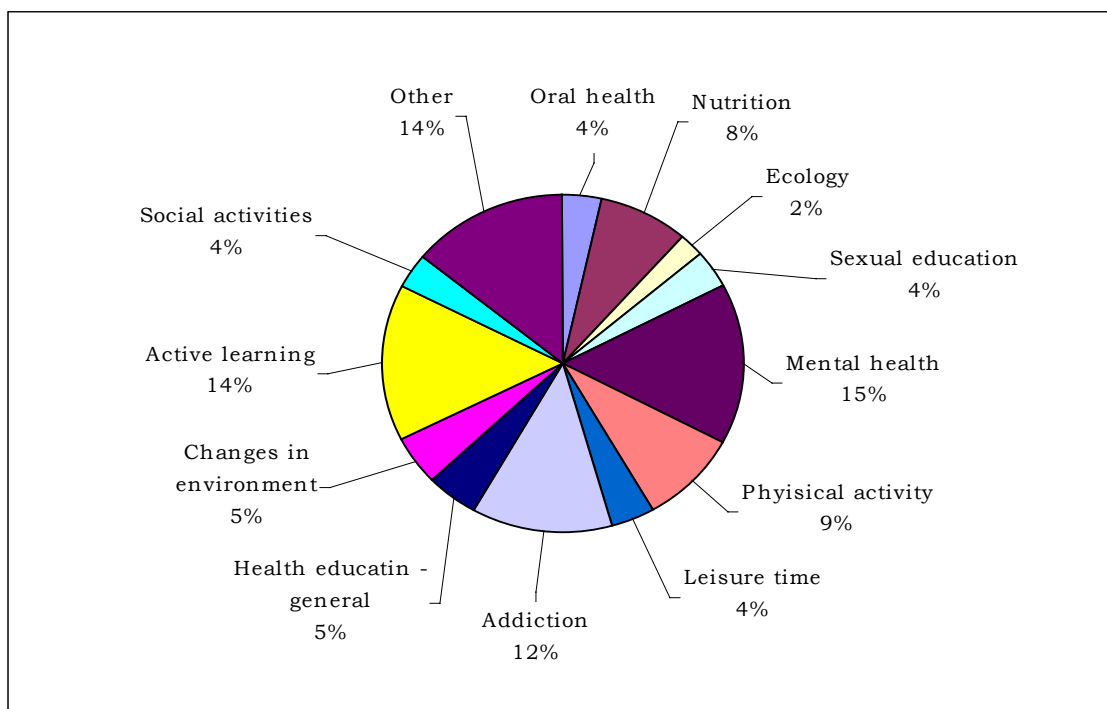
There are three characteristics of Slovene programme:

- Education for health curriculum
- Hidden curriculum
- Co-operation with local community

The project is planned and evaluated on a six months basis. Every member school (school project team) plans activities according to their own problems, needs, interests and consideration. Teachers and other staff are trained in order to be competent to carry on the programme. The in-service training is organised by the National Institute of Public Health (the national support centre for the

project) or by other institutions. NIPH analyses activities within network on a yearly basis.

Figure 9.1.1. The activities of SNHPS by content in the s. y. 2000/01 (all schools)



Source: Eva Stergar, Institute for Public Health

In 2000/2001 the most frequent contents were mental health promotion (15% of all activities; 15% in primary schools, 16% in secondary schools) and drug use prevention (12% of all activities; 19% in secondary schools, 11% in elementary schools). It should be mentioned that during the whole year 2000/2001 a project called “Message in the bottle” was going on as a part of the European initiative at the occasion of Stockholm’s ministerial conference Young people and alcohol.

## a2) Voluntary solutions at school level

According to recent analysis performed by the National Council for Healthy Lifestyle of Schoolchildren many schools carry out various programmes aimed at the drug use prevention. The initiative for programs derives from at least four sources:

- The school feels the need to carry out the programme and seeks for appropriate programme/performer.
- The programme is “offered” by GOs or NGOs.

- The local community offers support for drug use prevention programmes.
- The ministries (of health, of labour, family and social welfare) invite in the framework of public official invitation for tenders to prepare drug use prevention/social skills/spare time activities programmes.

The programmes vary according to duration, performers, topics and methods used. There are no verification mechanisms, with the exception of those programmes that are financed through public official invitations.

**b) General (health promotion, life skills) or specific (directed to high risk groups) programmes**

**b1) General programmes**

The **Mental health promotion** programme was developed within ENHPS. Slovene schools have participated in it from the pilot phase on. The programme consists of in-service training of teachers and the manual written by Gay Gray and Katherine Weare (University of Southampton). The manual was translated to Slovene language and adapted to our conditions. The long-term goal of SNHPS is that all participating schools organise in-service training on mental health promotion for all their teachers and staff. From 1993 till the end of 2001 75 seminars were organised – more than half of member schools and their staff attended the seminar. The programme covers the following topics:

- What is mental health?
- Building self esteem
- How to assess the situation in our school?
- Effective listening and responding effectively
- Managing stress in school
- Managing change in school
- Energisers (ice breakers)
- Group forming

Three more general programmes were developed within SNHPS:

- **Managing stress in primary school**
- **Managing stress in adolescence**
- **Communication and personal relations among students, teachers and parents** (basic, advanced)

All the mentioned programmes are incorporated in the system of permanent training of teachers. They are most effective when implemented with majority of staff of one school. Till 2001 36 seminars on communication were performed, six on stress management in primary school and two on stress management in adolescence.

Besides mentioned seminars there is a wide range of in-service training offered to Slovene teachers within the system of lifelong education every year. Many of them cover mental health, psychological, educational, communication... topics.

Every year schoolchildren have the opportunity to participate in **children's parliament**. The initiative comes from NGO, the programme is implemented within schools that decided to participate. Every year pupils choose the theme for discussion (in 2001 it was spare time, in 2000 personal relations). They discuss it at several levels (school, community, region). The programme culminates with a delegates' discussion in Slovene parliament: delegates expose their views, they suggest solutions and the theme for the next year is chosen. In the preparatory phase teachers follow the seminar. They get written material and guidelines.

## **b2) Specific programmes**

Institute of Public Health of the Republic of Slovenia co-developed three specific programmes:

- a) Non-smoking promotion
- b) Alcohol? Adults may have influence
- c) Quitting smoking

### Non-smoking promotion in schools

The initiative for development of the programme derived from the members of the Slovenian Pulmonary Patients Association. Their members prepared the programme (manual for the teachers and work sheets for pupils) in cooperation with NIPH's professionals. The production was done by NIPH. The programme has been introduced gradually within **SNHPS** (it started with 11 schools in 2000/2001; in 2001/2002 44 more schools entered the program). The programme starts with one-day seminar for teachers from relevant class. The programme is delivered cross-curricularly from 3<sup>rd</sup> to 8<sup>th</sup> class of primary school. The programme is evaluated on a pre-test post-test basis. Feedback from teachers implementing the programme is analysed.

### Alcohol? Adults may have influence

The programme was developed in 2001 within Ljubljana – Healthy city project. The long-term goal is to reduce harmful alcohol consumption among young citizens of Ljubljana. The short-term goals were: to inform parents about alcohol and its effects on human beings and their health in the broadest sense; to inform parents on parental skills; to educate teachers for implementation of the programme. The program consists of training for teachers, manual for teachers, booklet and leaflet for parents, booklet for pupils, Bulletin for all three groups (it was published within the SNHPS at the occasion of the project Message in the bottle). All the materials and books were prepared – this is true for all the programmes prepared within NIPH – on the basis of pre-testing the relevant groups (relevant surveys were done).

Teachers who were trained at NIPH deliver the programme.

The programme was offered to the Ministry of Health for further dissemination in Slovenia. In 2001 two regions disseminated the program.

#### Quitting smoking

There are several programmes to support quitting smoking in Slovenia: Quit & Win competition that takes place every year; a programme supported by the Pharmacists' chamber; the programme to support GPs work with clients who quit smoking (developed by the NIPH); CINDI quit smoking programme; there are several private initiatives.

#### **c) Involvement of: Teacher, parent, community**

As it is probably seen from the previous text all three groups are involved in prevention efforts in Slovenia. Since there was said enough about teachers and parents involvement, a few words should be written about the work of Local Action Groups (LAG) in Slovenia. LAGs have been developed following recommendations of WHO since 1992. LAG consists of professionals, individuals and groups who have common interest. The long-term goals of LAG are: analysing the problem, programme planning, reduction of harm caused by drug use, preventive efforts in local community, healthy lifestyle promotion. The group assures co-ordinated action, holistic approach to the problem in the community. LAG raises awareness and initiates local action. Since 1996 Slovene LAGs organise meetings on a yearly basis. It is estimated the role and influence of LAGs are very important for holistic approach to drug use problem.

#### **d) Guidelines for school policy**

Not yet prepared.

#### **e) Specific research results, statistics and evaluation results**

##### Workshops on mental health promotion

The evaluation showed increased awareness of pupils: after the programme they were able to identify a significantly greater number of elements constituting mental and emotional health and were more aware of their impact on their own mental health. The programme had some impact on pupils' attitudes towards mental health. The learned mental health skills were inadequate to be used effectively in everyday life situations. Both, the students and teachers, were very satisfied with the programme.

##### Non-smoking promotion programme

The programme is evaluated on a pre-test post-test basis. The analysis of the first year of implementation shows there was statistically significant change in attitudes of pupils of 3<sup>rd</sup> grade.

### **9.1.3. Youth programmes outside schools**

#### **a) Types, settings of activities**

There are programmes run by GO (usually based in the Centre for social work) and NGOs (Information centres for young people, Pupils'/students' associations, Interest groups...). Their activities vary a lot – from general to very specific topics. The information centres for young people have their national coordinator. Their role is to inform and advise young people, to plan and implement various programmes. They organise workshops for pupils, support Internet page etc.

#### **b) Peer-to-peer approaches**

There are many initiatives for peer education in the field of drug use prevention. Probably the most active is the association of students of medicine (Slomsic) who have regular workshops in secondary schools (sex, drugs, aids prevention).

A special programme that involves dropouts from schooling should be mentioned. It is called production school and offers opportunity to dropouts to develop functional knowledge and consequently play more active role.

#### **c) Target groups**

Prevention programmes address different target groups. The most frequent are: pupils, teachers and parents.

#### **d) Specific research results, statistics and evaluation results**

Not available.

#### **e) Specific training**

The programmes are usually introduced by training of those who implement the programme.

#### **9.1.4. Community programmes**

The network of services of public service and the network of programmes for solving social problems related to drug use shall be ensured by the following:

1. Services and programmes for the sensitisation of the highest possible number of drug users (first social assistance, programmes of fieldwork and other low-threshold programmes),
2. Services and programmes of short-term interventions (personal assistance, assistance to a family at home, low-threshold programmes and programmes of mutual assistance),
3. Programmes focused on the achievement of permanent abstinence (therapeutic communities, programmes of whole-day treatments),
4. Services and programmes of reintegration (service of personal assistance and assistance to a family at home, reintegration programmes),
5. Forms of self-help and self-organization of drug users or people who are close to them.

The goal of the network of services and programmes is to assure an active participation when solving person's own problems and to assure the possibility of selection between the various ways of solving these problems. Therefore it is necessary to enable the work of various providers of programmes and related development of new approaches for management of social issues. This is also a part of the strategy when implementing a social-care rights. This strategy has been defined by the Ministry of Labour, Family and Social Affairs in its National Social Care Programme until 2005.

Individual programmes also include forwarding of information and a provision of telephone assistance. There are no providers which offer exclusively this form of assistance to drug users and persons who are close to them.

#### **9.1.5. Telephone help lines**

##### **a) Interventions at national/regional/local: their characteristics (type of information, costs)**

There are many help lines that cover various parts of Slovenia; some are nationwide, others are local. Their numbers are advertised in newspapers for free. Some are general (e.g. telephone for children and youth), others offer specific help (e.g. quit smoking line, AAA, aids, battered women line). Some are free of charge – The Sound of Reflection Foundation help line.

##### **b) Statistics and evaluation results**



Help lines analyse their work on a yearly basis (usually the report is needed for those who finance the line/programme). Some of them present the results in public.

**c) Specific training**

Usually help lines train their staff – according to the topic they are dealing with.

**9.1.6. Mass media campaigns**

**a) Types and characteristics of mass media campaigns (TV, radio, posters...)**

There was campaign to promote quitting smoking in December 2001 (TV spot, PR activities) at national level.

Another tobacco related campaign was going on in June at the occasion of World No-tobacco Day (billboards, posters, leaflets, public event).

A lot of PR activities were done in relation to illegal drug use (the news were published mainly in the press and on TV).

**b) Cooperation with mass media (costs and sharing of the costs with media)**

The Slovene mass media are helpful in passing information to their public. The national TV broadcasts advertisements for free, the commercial networks give substantial discounts.

The press conferences are usually well covered by all types of media.

**c) Statistics and evaluation results**

Clipping is gathered but not analysed.

**d) Specific training**

There is no specific training for mass media campaigns in the field of drug use prevention.

### 9.1.7. Internet

#### a) Use of Internet for:

- prevention
- dissemination of prevention know-how among professional

Surfing the Internet shows quite a huge number of Slovene pages dealing with drugs. The interests, goals and consequently contents vary a lot: from prevention (e.g. DrogArt: Prevention of harm caused by party drugs, The Sound of Reflection Foundation – counselling on drug related problems) to information of marijuana growing. Many pages offer conferences, counselling, possibilities for visitors to ask questions and get answers.

According to the research on the use of Internet in Slovenia 21% of Slovene households and nearly all the schools have access to the Internet. On the other hand the Internet and sitting behind one's PC is not the way of prevention we would highly recommend (radiation, sedentary lifestyle, lack of communication...).

Here are some addresses of home pages dealing with drugs:

[www.web.infopeka.mlz.org](http://www.web.infopeka.mlz.org)

[www2.arnes.si/ljmisss1](http://www2.arnes.si/ljmisss1)

[www.drogart.org](http://www.drogart.org)

[www.uradzamladino.org](http://www.uradzamladino.org)

[www.uradzadroge.gov.si](http://www.uradzadroge.gov.si)

[www.ustanova-odsevseslisi.si](http://www.ustanova-odsevseslisi.si)

#### b) Statistics and evaluation results

Not available.

## 9.2. Reduction of drug related harm

Description of news developments in strategies aiming at prevention of drug related harm

### 9.2.1 Outreach work

- a) **Strategies** (youth work approach, family/community approach, “catching clients”, public health model, self help initiatives, etc.)
- *Target group is not defined by age but with “risk behaviour population” related to drug use.*
  - *One of preferable methods is to involve drug users as volunteers to work with the outreach team as s contact people for other IDU population. Later, when we have already established contacts in some areas, our outreach team works independently.*
  - *Outreach work include distribution of sterile equipment for safer drug use, information about safer use, safe sex, information about different services and motivation approach for IDUs for regular use of stationary needle exchange.*
  - *As self-help component of outreach work we have included some drug users as volunteers who work as distributors of sterile equipment (users for users) in some private locations where many drug users gather together.*

### b) Target groups

Our target group related to outreach work are injection drug users (IDUs), who are mostly hidden from established services.

### c) Synthetic description of actors and instrument

Personnel from Aids foundation Robert

- medical doctor, specialised in social medicine (top director)
- professor of health education – counsellor related to STDs
- 6 social workers (two on outreach, three in drop-in centre, one on the counselling help-line)
- social pedagogue (a project leader of Stigma project)
- two men with secondary school (one on needle exchange, one on the counselling service)
- subprojects: needle exchange, distribution of condoms, outreach work, drop-in centre, counselling service related to drugs and STDs (by phone, e-mail or personal by appointment).

**d) Statistics and evaluation results**

**Statistic of outreach work in 2001:**

*Table 9.2.1. Issued and returned syringes*

Issued syringes with needles	51.410
Returned syringes with needles	39.333

*Source: Dare Kocmur, Aids Foundation Robert*

**e) Specific training**

Specific training for outreach workers is connected mostly with outreach work methods. Basically, outreach team has been educated as social workers. Other education contained basic principles of harm reduction, health issues, safer drug use, safe sex and ethnographic approach. The members of our organization participated in many different workshops and conferences on international and national (local) level, they were also included in the internal education and participated on some specialization seminars organized by the High School for Social Work.

**9.2.2. Low threshold services**

**a) Organisational framework:** structures (public service, NGO, cooperation schemes), tasks and special services

Related to the public service we have 15 centres for methadone maintenance treatment. Related to NGOs we have three low-threshold centres dedicated to IDUs. One is an organization Aids foundation Robert / Project Stigma that contains: drop-in center, needle exchange, outreach work, counseling service. Two others known low-threshold services are on probation and unstable, with a small amount of clients and financial support. They are from cities of Koper and Maribor.

The organisation "Drogart" works on harm reduction related to dance drugs, mostly with spreading harm reduction messages from their web site and distributing the information leaflets at rave parties with its voluntary group. Officially there is a network of methadone centers and on the other side a network of NGOs (but in the last case this does not mean only low-threshold organizations). Basic criteria for involvement is NGO status in drug field.

**b) Target groups**

Except “Drogart” which have a target group related to a dance drugs population the other organizations mentioned above are connected mostly with heroin and the other hard drugs users.

**c) Statistics and evaluation results**

We only can offer statistic about needle exchange and outreach programme – from project Stigma:

**Statistic of needle exchange in 2001:**

Visits in 2001:	7718
Issued syringes with needles:	144.693
Returned syringes with needles:	98.815

**d) Specific training**

Education contained basic principles of harm reduction, health issues, safer drug use and safe sex and ethnographic approach. The members of our organization have participated in many different workshops and conferences on international and national (local) level, have been also included in the internal education and participated at some specialization seminars organised by the High School for Social Work.

### **9.2.3. Prevention of infectious diseases**

#### **a) Synthetic outline on organisation, strategies and actors**

- **Aids Foundation Robert**

Methods used:

needle exchange, outreach work, counseling service related to drugs, safe sex, and STDs

- **Centers for the Prevention and Treatment of Drug Addiction**

Methods used:

- vaccination against hepatitis B
- counseling service related to drugs, safe sex and STDs
- education
- informational materials, leaflets: Vaccination against hepatitis B,

- **Center for Treatment of Drug Addicts**

Methods used:

- vaccination against hepatitis B
- counseling service related to drugs, safe sex and STDs
- education
- informational material

The Sound of Reflection Foundation:

- education
- informational material
- training on Overdose

#### **b) Principal interventions:**

- needle and syringe exchange
- safer sex/safer education (in the frame of counselling service)
- testing, vaccination
- organisation of seminars, workshops, education
- preparing informational material – leaflets, manuals

#### **c) Providing equipment**

Sterile insuline syringes with integrate needles, 2 or 5 ml syringes with separate needles, alco swabs, ascorbine acid, esmarch, condoms, information material

#### **d) Statistics and evaluation results**

-

**e) Specific training**

Education has contained basic principles of harm reduction, health issues, safer drug use and safe sex and ethnographic approach. The members of our organization have participated in many different workshops and conferences on international and national (local) level, have been also included in the internal education and participated at some specialization seminars organised by the High School for Social Work.

## **9.3. Treatments**

### **9.3.1. Treatments and Health care at national level**

is performing according to the Health Care and Health Insurance Act (Official gazette 9/92), Prevention of the Use of Illicit Drugs and Dealing with Consumers of Illicit Drugs Act (Official gazette 98/99),

In article 8 is defined that the treatment of consumers of illicit drugs shall be carried out in the form of hospital and outpatient clinic treatment programmes approved by the Health Council at the Ministry of Health of the Republic of Slovenia.

The treatment referred to in the preceding paragraph shall be carried out by natural and legal persons who fulfil the conditions defined for the performance of medical activities in accordance with the act governing medical activity. In accordance with this Act, "treatment shall also be deemed to be maintenance with methadone and with other substitutes approved by the Health Council."

Article 9 defined that for the implementation of hospital and specialist outpatient clinic treatment, the Government of the Republic of Slovenia shall establish a public health institution – the Centre for Treatment of Illicit Drugs Addicts. Hospital treatment shall be deemed to be hospital detoxification, psychosocio-therapeutic treatment, extended treatment and health rehabilitation.

#### **a) Services offered and their characteristics**

##### **1. Outpatient treatment**

- ***Centres for the Prevention and Treatment of Drug Addiction, located at the primary care health system***

Some of the main already reached goals concerning the HIV/aids epidemics in establishing the network of Centres for the Prevention and Treatment of Drug Addiction have been:

- To provide medical care to all persons with health insurance in the Republic of Slovenia.
- To further develop and strengthen the methadone maintenance program and other substitution programs.
- To develop a manual for methadone maintenance program.
- To develop community and outreach harm reduction programs.
- To assess the extent of HIV-risk behavior and HIV infection among injecting drug users.



## 2. *Inpatient treatment and care*

- **Centre for Treatment of Drug Addicts, Clinical Department of Mental Health, Psychiatric Clinic in Ljubljana**

Centre for treatment of drug addicts at the Clinical Department for Mental Health of Psychiatric Clinic in Ljubljana with nine beds is the only specialised hospital unit offering inpatient treatment.

- **Psychiatric Clinics in the Republic of Slovenia**

All Psychiatric Clinics in the Republic of Slovenia offer drug-free treatment.

### b) **Objectives**

- **Centers for the Prevention and Treatment of Drug Addiction** offer drug-free treatment and not drug free treatments.
- *Centre for Treatment of Drug Addicts, Clinical Department of Mental Health, Psychiatric Clinic in Ljubljana* offer drug-free treatment and counselling for users, relatives and professionals.
- *Psychiatric Clinics offer drug-free treatment*

### c) **Criteria of admission**

- Voluntary
- Compulsory treatment order
- Referral from the Centres for the prevention and treatment of drug addiction

### d) **Involvement of public health services and GPs**

#### **General health care**

Since 1995 GPs were included in training programmes organised by Coordination of Centres for the Prevention and Treatment of Drug Addicts of the Ministry of Health. They are cooperating with CPTDAs concerning their clients and information exchange. Every client at CPTDA has to register with chosen GP, who takes care of clients health problems other than addiction in cooperation with the doctor at CPTDA.

In the future GPs, pediatricians, school medicine specialists and family doctors should take more important role in the treatment of drug use and addiction, especially with young users. To do so they would need more training and support from specialised units.

**e) Coordination between public health services and other community drug services**

The minister responsible for health shall appoint the body for the coordination of the centres for the prevention and treatment of addiction to illicit drugs, which shall propose a treatment doctrine, verify the implementation of the addiction treatment doctrine and coordinate professional cooperation between the centres for the prevention and treatment of addiction to illicit drugs.

Coordination of centres for the prevention and treatment of addiction on regularly monthly meetings invite all responsible persons in the field of drugs: health, social, justice sectors, NGOs etc.

**Activities:**

**1. Regular monthly sessions:**

- **the first part, intended for the members of Coordination centres** (people managing the centres, representatives of the Ministry of Health and the Centre for Treatment of Drug Addiction)
- **the second part** usually consists of professional lectures, panel discussions on selected topics etc.

Everyone involved in the concerns and issues of illicit drug abuse in the country is welcome to attend.

**2. Organisation of conferences, seminars and workshops**

In addition to elementary seminars, the Coordination of Centres for the Prevention and Treatment of Drug Addiction organised the following awareness-raising events:

In 1997 (September 17 - 20) a conference was organised in Ljubljana, at Cankarjev dom Congress Centre, in cooperation with EUROPAD (European Opiate Addiction Treatment Association - "**Heroin Addiction in Europe**"): 3rd European Methadone and Other Substitution Treatments Conference together with Regional Meeting of Central and Eastern European Countries on Treatment Programmes with emphasis on Outreach and Open Community Approach.

867 participants from most of the European countries, as well as from the U.S.A., Asia and Australia, attended.

In 1999 (May 20 - 25), the **1<sup>st</sup> Slovenian Conference on Addiction with international participation** was organised in Ljubljana by the Coordination body and by the Sounds of Reflection Foundation.

Participation in the organisation of:

**1<sup>st</sup> Slovenian Conference on Addiction Medicine, Ljubljana, 1996**

## **2<sup>nd</sup> Slovenian Conference on Addiction Medicine, Bled, 1998**

### **3. The most important changes in the doctrine that have emerged through the network:**

- **Enlargement of the network with new centres and expansion of the existing centres and outpatient clinics in the network**

In 1995, nine centres for the prevention and treatment of addictions from the illicit drugs were opened, bringing the total number of centres to fifteen

- **Development of prevention programmes**
- **Developing the doctrine of a treatment of addiction, especially with regard to the drug users' working and driving ability**
- **Fast urine tests for establishing the presence of illicit substances (a guide booklet has been published)**
- **Testing for hepatitis B, C, and HIV**
- **Immunisation against hepatitis B infection**
- **Implementation of treatment for hepatitis C**
- **Treatment of drug dependent pregnant women; cooperation with gynecologists, obstetricians, pediatricians**
- **Cooperation in developing the doctrine of treating drug addiction in penal institutions**
- **Cooperation in developing the doctrine of medical examination of draftees in the Slovenian military service**
- **Implementation of the Pompidou Group questionnaire "First Treatment Demand"**

### **4. Coordination of centres has been also preparing publishing material:**

- Professional poster "Network of Centres" in Slovenian and English
- Registration card for participants in the methadone maintenance programme
- Folded information leaflets :
  - Hepatitis C
  - Instructions for immunisation against hepatitis B
- Manuals:
  - What Should You Know About Methadone
  - Women and Drugs
  - Urine Tests
  - Overdose
- Club drugs
- Marihuana

### **5. Revised Guidelines for Medical Professionals**

### **6. Over thirty research studies were completed in the centres.**

7. **Members of the Coordination body have published their articles in Slovenian and international publications:** Eurometwork, European Addiction Research, Journal of Heroin Addiction
8. Some members of the Coordination body serve on editorial boards of foreign professional journals: **Addiction Research, Journal of Heroin Addiction.**
9. **Coordination body has organised conferences in conjunction with foreign organisations:**
  - EUROPAD (European Opiate Addiction Treatment Association)
  - IHRA (International Harm Reduction Association)
10. **Members of the Coordination body share their insights and knowledge with colleagues at conferences and seminars at home and abroad.**
11. **Some members of the Coordination body have actively participated in the development of the doctrine "Women, Children and Drugs"** together with the organisation *Child and Parenthood* and the *Pompidou Group*.
12. **Members of the Coordination body have actively participated in drafting the European guidelines for the methadone maintenance programmes.**
13. **The Coordination body through the media regularly informs the public on all aspects of its work.**
14. **Publishing magazine: Addiction**
15. **Members of the Coordination body have established a foundation Odsev se sliši - The Sound of Reflection Foundation.**

**f) Special services**

-

**g) Financing**

Program of treatment of drug addiction is covered by Health Insurance Company of the Republic of Slovenia.

## h) Statistics and evaluation results

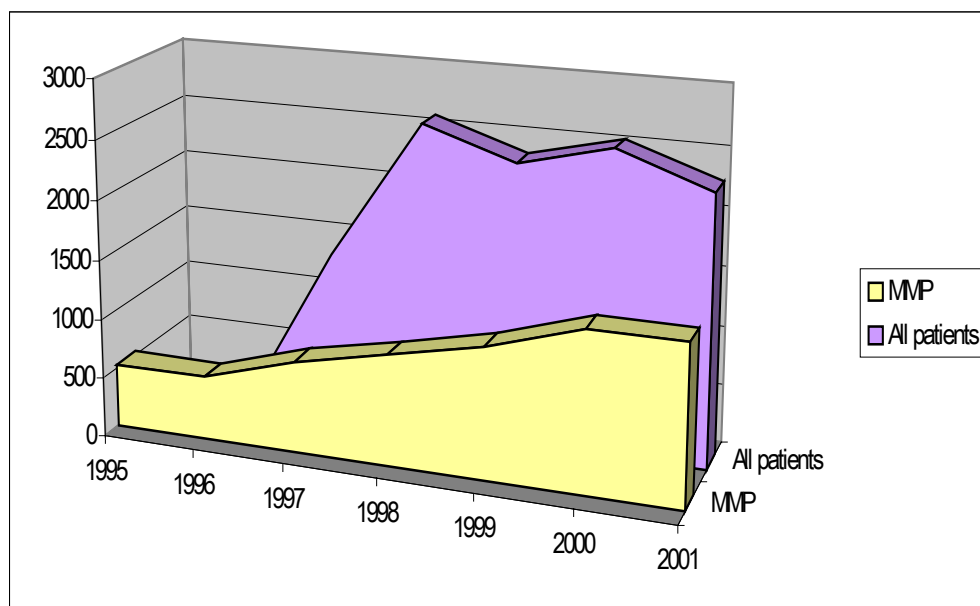
- **Number of treated patients in Centres for the Prevention and Treatment of Drug Addiction**

Table 9.3.1. *Number of patients In Centres for the Prevention and Treatment of Drug Addiction from April 1995 to March 2001*

Year	Methadone maintenance programme	All patients
1995	530	
1996	729	
1997	926	1414
1998	1034	2599
1999	1198	3000
2000	1348	2540
March 31, 2001	1347	2264

Source: Ministry of Health, 2001

Figure 9.3.1. *Number of patients in Centres for the Prevention and Treatment of Drug Addiction from April 1995 to March 2001*



Source: Ministry of Health, 2001

*Table 9.3.2. Number of patients in the Centre for Treatment of Drug Addicts at Psychiatric Clinic Ljubljana - hospital unit*

<i>Year</i>	<i>Women</i>	<i>Men</i>	<i>All</i>
1995	28	52	80
1996	21	56	77
1997	29	54	83
1998	25	68	93
1999	33	68	101
2000	38	71	109
2001	35	79	114
Total	209	448	657

*Source: Centre for Treatment of Drug Addicts at Psychiatric Clinic Ljubljana*

*Table 9.3.3. Number of patients in the Centre for Treatment of Drug Addicts at Psychiatric Clinic Ljubljana - outpatient unit*

<i>Year</i>	<i>No. of clients in outpatient treatment</i>
1995-2001	3250 patients

*Source: Centre for Treatment of Drug Addicts at Psychiatric Clinic Ljubljana*

#### **i) Specific training**

There were organized a lot of elementary and specific trainings for doctors, nurses, social workers, pharmacists, psychologists by the Coordination of Centres for the Prevention and Treatment of Drug Addiction at the Ministry of Health from 1995 to 2000.

#### **j) Other national specifications**

-

### **9.3.2. Substitution and maintenance programmes**

The methadone maintenance program is one of the fundamental harm reduction approaches accepted within current drug policy that aims to protect the users of illegal drugs by increasing the number of users who make contact with the medical service, to diminish the prevalence of HIV and hepatitis B,C among them and to diminish the criminality.

National guidelines for the management of drug addicts including methadone maintenance programme have been adopted by the Health Council at the Ministry of Health of the Republic of Slovenia in 1994. The ministry adopted a set of recommendations for doctors concerning the treatment of drug addicts.

Methadone maintenance programme policies were confirmed at a consensus Symposium on Methadone Maintenance with participants from the Ministry of Health, the Ministry of Internal Affairs, the Ministry of Labour, Family and Social Affairs, and the Ministry of Justice in 1994. Further reviewing of guidelines was done in 2000.

#### **a) Organisation and delivery of substitution drugs**

A network of Centres has been confirmed in the Republic of Slovenia in 1995.

#### **Services provided by CPTDAs**

The drug prevention and rehabilitation centres provide:

- counselling service for addicts, relatives and educators
- individual, group and family therapy
- preparation for hospital treatment
- aid towards rehabilitation and social reintegration
- consultations for health and social services
- determination on the basis of case history, clinical examination, laboratory tests and welfare service reports of indications for the application of the methadone maintenance programme
- supervision of the methadone maintenance programme
- practical implementation of methadone maintenance programme
- community health nursing service
- linkage with therapeutic and self-aid groups
- research work
- epidemiology

### **Staff Requirements of CPTDAs**

In view of the complex nature of drug dependence treatment, the normal operation of a drug prevention and rehabilitation centre requires a multidisciplinary team of specialists including:

- a general medicine or social medicine specialist
- a college-graduate nurse
- a consulting or permanently employed psychiatrist
- a psychologist
- a social worker
- a laboratory technician
- an administrative worker

### **Methadone Maintenance Programme**

After establishing that the criteria for inclusion on the programme have been fulfilled, that all the aforesaid examinations and laboratory tests have been made and contact with the welfare service established, the team meets for joint consultations about the indications for placing the addict on the methadone programme.

The final decision on the placing of the drug user on the methadone programme is made by the programme manager after consultations with the team.

The patient must meet and talk with his counsellor (chief consultant) at least once a week and/or receive one of the forms of psychotherapy once a week.

Methadone dispensing units are outpatient clinics or pharmacies. They do not need to be situated within the Centres for Drug Prevention and the Treatment of Drug Addicts.

Methadone may only prescribe a doctor chosen by the addict, who has received the corresponding licence from a CPTDA and who has gained the basic knowledge at a training course organised by the Ministry of Health and the Clinical Department for Mental Health.

It is recommended that the other doctors prescribe methadone to the addict only in the absence of his/her doctor and in agreement with him/her.

Doctor may authorise a doctor at CPTDA or his colleague in the community health centre to prescribe and dispense methadone to the patient and to apply other necessary therapeutic measures if such arrangement is more expedient for the patient in the programme or for the organisation of the work.

Methadone is administered in the form of a solution mixed with fruit juice and is taken daily in the presence of a nurse, preferably a graduate of nursing college. Patients may take methadone at home only over weekends and during national holidays or on the basis of special therapeutic agreement.



If not abusing heroin, she or he can take methadone home for two days, after three months she/he can take it home for three days and after half a year for a week. Some doctors argue that tablets should be prescribed for a stabilised patients.

**b) Criteria of admission**

Minimum requirements for placing an addict on the methadone maintenance programme (MMP) are:

- opiate addiction in the duration of at least one year and current physical dependence;
- previous detoxification attempts;
- written consent for the inclusion on the MMP;
- minimum age of 18;
- permanent residence in the region where a drug prevention and rehabilitation center is located;
- the addict's own choice of the doctor;
- health insurance.

**c) Mode of prescription**

Methadone is administered in the form of a solution mixed with fruit juice (Heptanon 100 mg/10 ml and 1000 mg/100 ml).

**d) Objective (gradual detoxification, maintenance)**

Treatment is performing according to the EU Methadone Guidelines:

- Short term detoxification: decreasing doses over one month or less;
- Long-term detoxification: decreasing doses over more than one month
- Short-term maintenance: stable prescribing over six month or less
- Long-term maintenance: stable prescribing over more than six month

**e) Substitution drugs, mode of application**

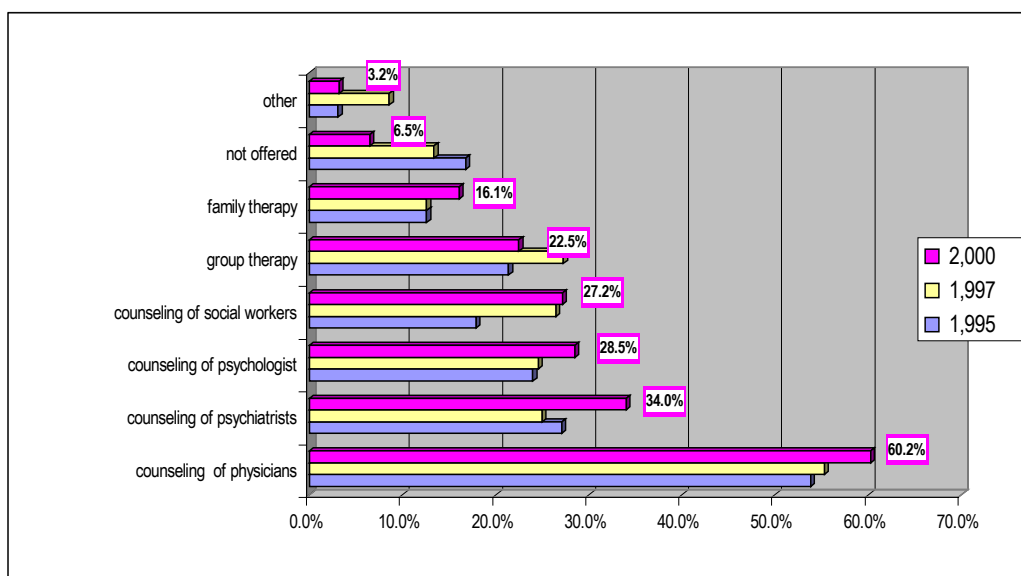
- Methadone
- Buprenorphin and long acting morphine is being introduced

**f) Psycho-social counselling (requirements and practice)**

**Possibilities of participating in psychosocial treatment**

All patients have the possibility to participate in the psychosocial treatment. Only 6.5% have not been offered the psychosocial treatment.

*Figure 9.3.2. The possibilities of participating in psychosocial treatment*

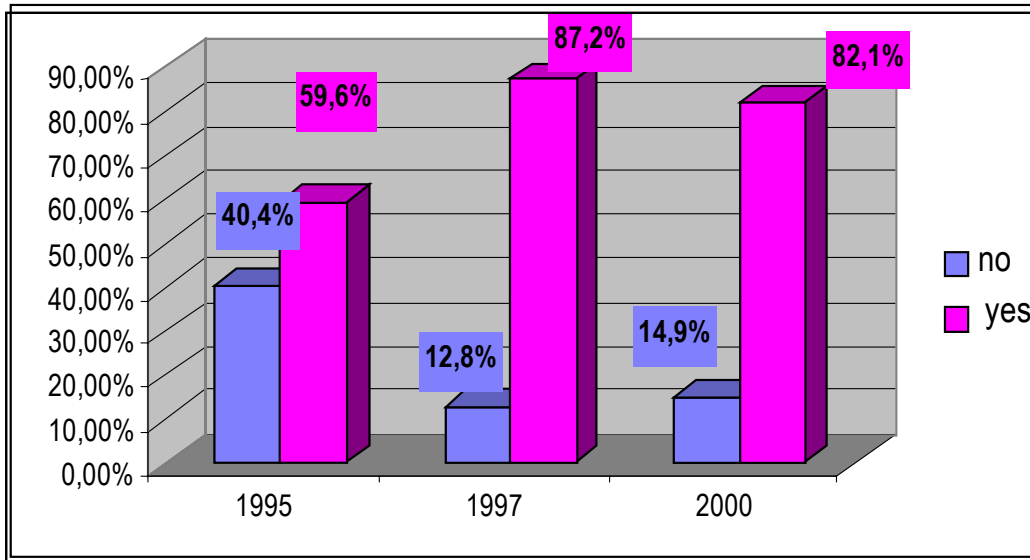


*Source: Kostnapfel Rihtar T., Kastelic A.: Evaluation of methadone maintenance programme in the Centres for the Prevention and Treatment of Drug Addiction in 1995, 1997, 2000. In press.*

### g) Drug testing

#### Urine test

Figure 9.3.3. Testing of urine on drugs



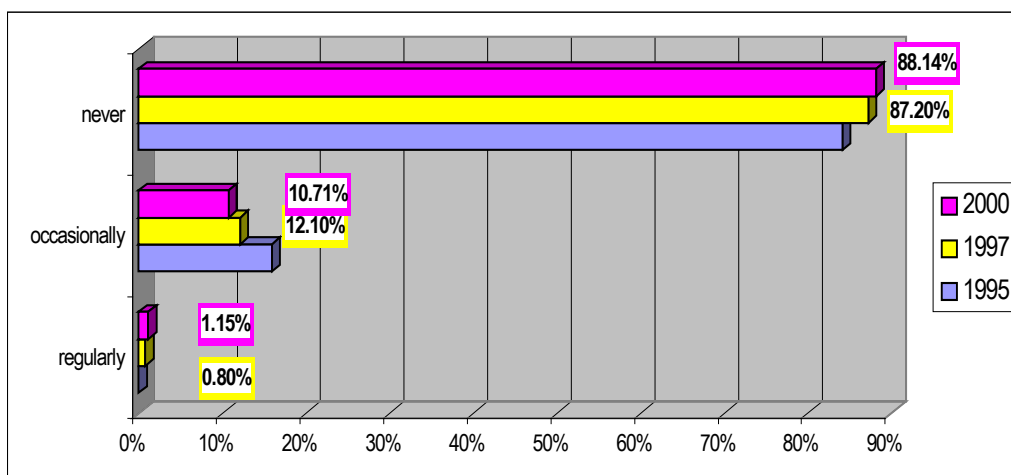
Source: Kostnapfel Rihtar T., Kastelic A.: Evaluation of methadone maintenance programme in the Centres for the Prevention and Treatment of Drug Addiction in 1995, 1997, 2000. In press.

### h) Diversion of substitution drugs

#### Selling methadone

According to a research 88,14% of clients included in the methadone maintenance programme never selling methadone in 2000 and 10,7% occasionally.

Figure 9.3.4. Selling methadone



Source: Kostnapfel Rihtar T., Kastelic A.: Evaluation of methadone maintenance programme in the Centres for the Prevention and Treatment of Drug Addiction in 1995, 1997, 2000. In press.

**i) Statistics (measure point)**

-

**j) Specific research results**

A lot of researches were made in the Centres for the Prevention and Treatment of Drug Addiction.

**k) Evaluation results**

• **Relevance**

Attracting the majority of drug users to contact treatment programs as early as possible is an important goal.

However, the prevalence of HIV infection is among injection drug users, although low at present, possibly because of an early introduction of methadone maintenance. Thus, HIV harm reduction interventions related to unsafe injecting drug use and unsafe sexual behavior among injecting drug users are considered a high priority.

The comprehensive programs of the network of 15 Centres for the Prevention and Treatment of Drug Addiction and the National Centre for Treatment of Drug Addicts have attracted a large number of drug users to participate in treatment.

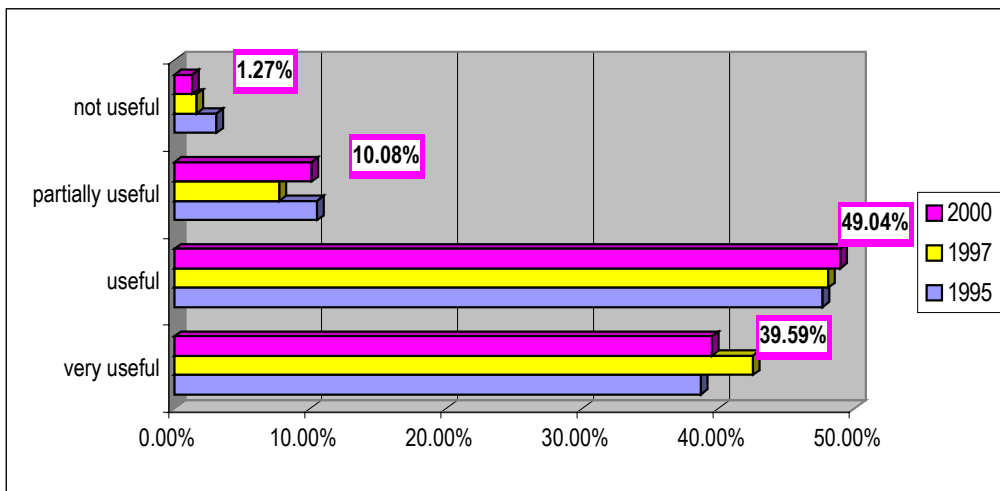
- **Effectiveness and Efficiency**

The inclusion of drug users in the user friendly forms of organized assistance, as that provided by the network of centers, reduces the actual use of illicit drugs and consequently the risks associated with drug use (especially with injecting) such as HIV, hepatitis and other diseases.

A continuous implementation of prevention oriented programs and publication of suitable information reduces the possibility of risk behavior.

The centres' methadone maintenance programs were evaluated in 1995, 1997 and the year 2000. The evaluation data are available and have been partly published in the EUROPAD publication *Heroin Addiction and Related Clinical Problems*. The results show that the methadone maintenance program was considered "useful" to "very useful" for more than 90% of the patients.

Figure 9.3.5. Usefulness of methadone maintenance programme



Source: Kostnapfel Rihtar T., Kastelic A.: *Evaluation of methadone maintenance programme in the Centres for the Prevention and Treatment of Drug Addiction in 1995, 1997, 2000*. In press.

The network of Centres for the Prevention and Treatment of Addiction provides health care and various forms of assistance needed because of addiction. These services are available to all health insured persons in the Republic of Slovenia. The provision of health insurance is a mere formality and can be obtained in a few hours at no cost to all citizens.

The network's cooperation with all addiction programs currently implemented in the Republic of Slovenia, governmental and non-governmental, as well as low threshold and high threshold, is an essential element in providing drug users with integrated assistance.

- **Ethical soundness**

Accessibility and respect for individuality are basic principles of all the programs offered at the centers. All patients included in the programs are fully informed about the operation and requirements of the program as well as their options and sign an informed consent form.

Special programs for adolescents and drug dependent women are provided. The treatment of addiction is the centers' top priority, and there are practically no waiting lists.

Clients are encouraged to participate in the centers' program planning and supervision Consumers' boards are being introduced.

There is a possibility for free legal aid.

The possibility for filing complaints regarding the centers has been incorporated into the system.

- **Sustainability**

Programs for the treatment of addiction are defined by the law regarding the prevention of illicit drug use and the management of drug users. This law defines the forms of treatment and the establishment of centers for the prevention and treatment of drug addiction. The centers' programs are supported by the Slovenian Ministry of Health and funded by the Health Insurance Institute.

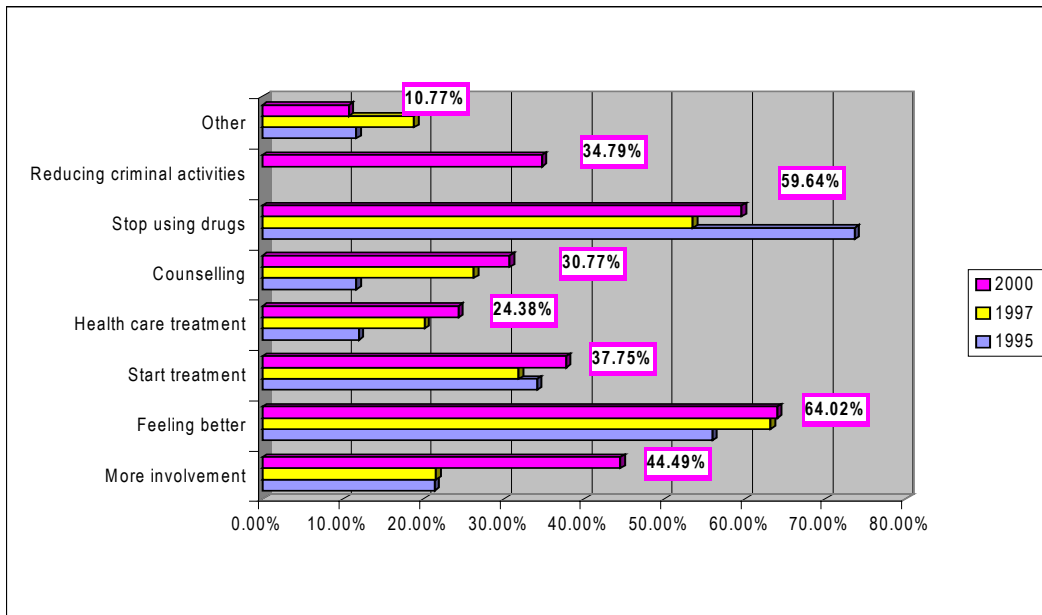
The financing is provided in lump sums and does not entirely cover the cost of full implementation of the programs, primarily because the number of users seeking assistance is increasing.

To a smaller extent, the programs are partly funded by public tenders for prevention projects.

Possibilities to become actively involved in the international projects are being found.

The Sound of Reflection Foundation has been established by the staff in charge of the centers with the hope of improving the funding of the programs.

Figure 9.3.6. Expectations of clients from the methadone maintenance program



Source: Kostnapfel Rihtar T., Kastelic A.: Evaluation of methadone maintenance programme in the Centres for the Prevention and Treatment of Drug Addiction in 1995, 1997, 2000. In press.

## **9.4. Aftercare and reintegration**

Designed implementation of the reintegration activity is assured by three big programmes (Man Project, Hope Society, Centre for the Prevention of Addiction) and some small programmes.

There are no data on the connectedness of unemployment and homelessness with drugs use.

Training programmes for the work with drug addicts and persons who are close to them are stimulated and cofinanced by the Social Chamber of Slovenia.

## **9.5. Interventions in the Criminal Justice System**

### **STRATEGY FOR DEALING WITH PRISONERS WITH DRUG PROBLEMS IN SLOVENIA'S PRISONS**

Drugs, in all aspects, are a modern social phenomenon that has not stopped at the gates of Slovenia's prisons. We do not give medical treatment to people who have problems with drugs, but we do offer them treatment programmes. We develop and adapt the strategy for treating prisoners with drug problems in accordance with the development of programmes by governmental and non-governmental organisations and with the help of experts who contribute at the national level to the development of treatments for dependency illnesses. The main aim of this paper is to present this strategy.

Broadly speaking the strategy for controlling problems in prisons in this area is directed at two levels:

- preventing drugs being brought into the prison and discovering those that have been brought in,
- helping prisoners who have a problem with drugs.

The latter level encompasses several phases and contains several different programmes. The treatment phases relate to the status of the prisoner, from admission at the beginning of the prison sentence or admission on remand to the serving of the sentence and preparation for release.



## a) Interventions

### **ADMISSION PERIOD (on remand or at the start of a prison sentence)**

- **Low-threshold programmes of help**

Individuals on methadone therapy, active drug users and people in crisis arrive at the prison on remand or to start a prison sentence. They are first dealt with by the health service. On a doctor's advice a withdrawal crisis may be alleviated with the use of methadone or other medicines.

Methadone therapy is carried out in prisons on the principle of gradual reduction to withdrawal. Only as an exception and on the advice of a doctor specialising in treating drug dependency can an individual receive methadone maintenance therapy.

The programme of medical help also includes raising the prisoners' awareness of transmissible diseases such as AIDS and hepatitis, encouraging testing and vaccinating against hepatitis B and treatment of individuals with hepatitis C by a specialist in infectious diseases.

Medical assistance in prisons is provided by health workers who are employed full time, by doctors in the public health care system and by psychiatrists from the network of the Centres for Prevention and Treatment of Drug Addiction.

The aim of the medical treatment of prisoners dependent on drugs is to get them to withdraw from the drugs and to strengthen their psychophysical abilities.

### **DURING THE SERVING OF THE SENTENCE**

- **Higher-threshold programmes.**

Higher-threshold programmes are divided into:

- education programmes,
- motivation programmes.

By means of education programmes we raise awareness among the entire prison population about the harmful effects of drugs on health, about development of addictive illnesses, about existing programmes of help for drug-dependent people in society, etc.

In connection with reducing the harm caused by the use of drugs and other hazardous behaviour, and the possibility of HIV or hepatitis infection, a programme of health education is carried out in the form of lectures and discussions with prisoners and prison staff. The aim of the programme is to teach people preventative behaviour, how to overcome fear of these diseases and behaviour against the stigmatising of the infected. For this purpose pamphlets have been produced and distributed among the prisoners, as well as medical advice, such as encouraging prisoners to maintain good personal hygiene, disinfect the living quarters, use the latex gloves whenever a contact with blood is possible, use condoms etc.

Connected to the education programmes, the hardest part of the treatment is to motivate the prisoners who have a problem with drugs to live without drugs, to change their way of life from a passive, unproductive lifestyle into an active one.

The motivation programme proceeds in five phases:

1. recognising the problem,
2. thinking about a change,
3. deciding to make a change,
4. carrying out the change,
5. maintaining the change.

- **High-threshold programmes**

An internal decision by an individual to attempt to live without drugs means a step up to the high-threshold treatment programmes which offer:

- regular health checks and checks to ensure that the individual is "clean" by means of urine tests,
- employment in workshops or employment in work therapy,
- active free-time activities depending on the interests of the individual (sport, music etc.),
- participation in education programmes (within or outside the prison),
- restoring and maintaining contacts with family members,
- free leave from the prison, with a gradual approach being applied,
- familiarisation with the programmes of Center for Treatment of Drug Addicts at the Clinical Department for Mental Health and non-governmental organisations and participating in them while serving the sentence (AIDS Foundation Robert, "Human Project" society, "Meeting" community, "Hope" society, etc.),
- planning for release.

The higher-threshold and high-threshold help programmes are carried out by expert members of the prison staff – social pedagogues, psychologists and social workers specially trained in working with people with dependency problems. Within the working group they acquire new knowledge in the field of dependency illnesses. Through an external expert who regularly participates at the meetings of the working group (generally held once a month) the expert workers can also directly discuss the difficulties encountered in practice. Meetings of the working group are headed by an employee of the Administration. In this way direct cooperation is established between the Administration, the prisons and external experts and institutions in developing and implementing a strategy for dealing with prisoners with drug problems.

The implementation of the programmes includes not only the expert workers but also the prison officers, instructors and the organisers of educational and free time activities.

Prisoners enter into high-threshold programmes after reaching a so-called therapy agreement with the experts. The therapy agreements set out the rules and obligations for both sides participating in the treatment process.

Higher-threshold and high-threshold treatment programmes are carried out in individual and group forms. The basis of both forms of work is a so-called sociotherapeutic method (socio-pedagogical orientation) for dealing with prisoners, the essence of which is to treat the prisoner as an active subject.

The goals of the treatment of prisoners with drug problems are specific and realistically attainable. They include:

- abstinence,
- preventing return to drug use (learning to recognise risk situations),
- learning to resolve difficulties and conflicts.

Based on our experiences so far we find that prisoners only make progress along the road to rehabilitation in an environment free of drugs, so some of the central prisons have put in place the conditions for so-called drug-free units within their capacities.

However, among the prison population there will remain a certain number of people who, for various reasons, cannot or do not wish to undergo treatment of any sort. For this part of the prison population we need to put in place programmes to reduce the harm caused by the continued use of drugs. Needle exchange programmes, for example, pose a challenge to the system of implementing prison sentences, but this is part of our vision for continuing work in this field.

## **b) Drug testing**

### **URINE TESTS**

In 2000, all prisons started carrying out urine tests on the premises of prisons (prior to that these tests were carried out in external laboratories). Before the beginning of implementation, a workshop was organised for all institutional medical workers who are directly engaged in the conduction of these tests. There were also instructions produced about the procedure of taking urine (in our environment carried out by the service of warders), about carrying out the test and about forwarding the results of the test. (Instructions are enclosed.)

**Tests shall be carried out within the framework of the following professional issues:**

- Urine tests for the demonstration of the presence of illicit drugs in the body may only be used in cases where the imprisoned person has signed a therapeutic agreement and is in the treatment process in an institution, or if the imprisoned person gave a written consent to the implementation of the test.
- The goal of the urine test shall be the self-confirmation to the imprisoned person that he/she succeeded in living without drugs.

- Those persons who are making progress in the process of their own rehabilitation shall be tested. Testing with the purpose of achieving the opposite goal, i.e. to prove the "stoned condition", shall be omitted.
- All persons in methadone therapy shall be tested.

The administration shall make an umbrella agreement with the selected supplier and prisons shall order urine tests for their own needs within a certain limit. Costs shall be covered by the prisons. The most of the tests carried out by prisons shall be used to demonstrate the presence of opiates.

**c) Release**

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**d) Statistics and evaluation results**

*Table 9.3.4. Number of Prisoners dependent on Drugs for Individual Years in relations to the Total Number of Prisoners*

YEAR	1995	1996	1997	1998	1999	2000
Number of prisoners	4046	3767	3882	5113	6348	6703
Number of Drug misusing Prisoners	133	156	268	306	471	512
%	3,28	4,14	6,90	5,98	7,40	7,63

Source: Olga Perhac, Central Prison Administration of the Republic of Slovenia, 2000

*Table 9.3.5. Number of Prisoners infected with the Hepatitis Virus*

YEAR	1997	1998	1999	2000
Number of Voluntary Testing	0	214	332	191
Hepatitis A	0	6	4	6
Hepatitis B	0	8	6	19
Hepatitis C	17	36	30	14
Total Summary	17	50	40	39

Source: Olga Perhac, Central Prison Administration of the Republic of Slovenia, 2000

*Table 9.3.6. Number of Prisoners tested and Number testing positive to AIDS*

<i>Year</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>
Number of Voluntary testing	208	161	143
Number of HIV positive	0	0	0

*Source: Olga Perhac, Central Prison Administration of the Republic of Slovenia, 2000*

\*in this field we have close colaboration with the clinic for AIDS in the community which provide support and counselling for HIV positive people. For time being, no one of prisoners need their help.

#### **e) Specific training**

In 1995 an educational program for employees and inmates which improved the understanding of HIV and human rights was started. Seminars, training and discussions for decision-makers, prison authorities, prison staff and prisoners were running in all prisons in Slovenia.

Seminars, training and discussions were provided for all prison staff and prison authorities. Members of staff who would carry out programmes in prisons were selected. Training was organised for the staff, focused on special skills and knowledge.

At the moment, prison administration is intensively cooperating with professionals from health authorities and all activities are going on simultaneously. Prison administration is represented at National Committee through their representative from The Ministry of Justice and at Coordination of CPTDAs through their representatives from prison administrations.

## **EDUCATION OF EMPLOYEES FOR THE WORK WITH DRUG ADDICTS IN PRISONS**

**Basic education events:** Ig - October 1995, Bohinj - December 1995, Ig - June 1996

### **Advanced level:**

- Portorož - Autumn 1997. A three-day seminar in the field of addiction treatment within the organization UNDCP - the Višegrad group (for 20 persons employed in Slovene prisons)
- Dolenjske toplice - June 1998. Education for the work with persons addicted to illicit drug use
- Sicily - October 1998. Seminar: European drug abuse training project (UNDCP)
- Bled - October 1998. 2<sup>nd</sup> Slovene Conference of Addiction Medicine
- Bled - October 1998. National consultation on the treatment of juvenile drug addicts
- Portorož - November 1998, A three-day international seminar: Diminishing the damage caused by the use of drugs in prisons within the framework of the Phare organization.
- Poljče - December 1998. Consultation on the programmes of drug addict treatment in prisons
- Education about urine tests - March 1999
- Ljubljana - 1<sup>st</sup> Slovene Addiction Conference (lectures and workshops on the issue of addiction treatment in prisons)
- Logarska dolina - November 1999. Education for the work with persons addicted to illicit drugs
- Portorož - December 1999. Advanced seminar: European drug abuse training project

There were organized meetings of working groups for the treatment of addiction whose agenda included two parts - the educational and the problem-related one. Lecturers are external experts in the field of addiction treatment. The following topics were presented:

- Burn-out of therapists treating the addiction-related illnesses
- Treatment of recidivism
- Naltrexon in treating alcoholism
- Co-morbidity
- Poisoning with medicines
- Influence of the family on the development of addiction
- Musicotherapy in the process of treatment

**Training and education of workers for the work in the departments without drugs** - April 2001 in the Dob Prison, January 2002 in the Radeče Corrective Establishment, February 2002 in the Dob Prison (expansion of the project).

Supervision established for the teams working in the departments without drugs.

**Starting-up of projects:**

- Records on the drug addict treatment (1999).
- Beginning of cooperation with the non-governmental organization AIDS Foundation Robert with the goal of establishing the pilot project for fieldwork in prisons (March 2000). During that year preparations to the study visit to Bavarian prisons (Munich) were underway. In those prisons the fieldwork is particularly well developed. The study visit was carried out in October 2000.
- The fieldwork pilot project in the Ljubljana Prison (2001).
- Training within the framework of health education for the prevention of infections with the HIV virus, hepatitis and TB for workers and imprisoned persons, carried out cyclically from 1996 onwards. Every year a cycle of lectures and advising is carried out in all prisons.
- Outset of vaccination for workers and imprisoned persons against hepatitis B (April 1999).

## 9.6. Specific targets and settings

### 1. Gender

Management of pregnant drug users is performing according to doctrine which was adopted at Pompidou meetings (Council of Europe) in Strasbourg 1997, Lisboa 1998 and Strasbourg 2000 and was prepared also by the expert from Slovenia.

Women drug users who are in contact with specialised drug services, such as CPTDAs and Centre for Treatment of Drug Addicts, can get support and advice from the staff of these services. They continue their methadone maintenance and try to reduce their methadone. Breast feeding is seen as an important contribution to a good contact between mother and child right from the start and is thus recommended.

Nevertheless, for many pregnant addicts the visits to their gynaecologist represent the only contact with health services. The recognition of the pregnant addict in these cases is difficult, especially when the addiction is denied.

The pregnancy of the addicted woman is considered in Slovenia as a high risk pregnancy. The optimal patient care is given in the antepartum, intrapartum and postpartum periods.

Some data from a research "PREGNANCY IN ADDICTED WOMEN ON THE SLOVENIAN COAST" (Janja Zver, MD, Department of Obstetrics and Gynecology, General Hospital Izola, Slovenia)

While drug abuse has been known since ancient times, nowadays we witness escalation of problems resulting from the vast number of individuals affected. When pregnant women are abusing drugs, they not only affect their own health but also that of their unborn child. In USA, 5,5% of pregnant women use some illicit drug during pregnancy. Although we are aware of rising number of illicit drug users in Slovenia, specially among younger population, the effects of addiction on pregnancy have not been studied on Slovenian population to date.

The aim of study was to identify distinct behaviour patterns and conditions associated with methadone use in pregnant women and to evaluate the pregnancy outcomes.

Cases : 11 pregnant women attending methadone and prenatal programs in our out-patient hospital unit (June 1997 – December 1999).

Controls : 524 women with negative history of drug abuse included in the same prenatal programme (January 1997 – December 1997).

Both groups of women underwent delivery in our maternity hospital unit.



**There were** performed a population- controlled retrospective study. Data were collected from the National Perinatal Information System (NPIS). Significance of analysed data was tested using the Student t-test where  $p \leq 0.05$  was considered significant. Differences between attributive parameters were tested by the Chi-Square and determined by the Fischer's exact test.

Two groups of pregnant women in study were found to be different in age, marital status and smoking habits, while they did not differ in gestation at 1st visit, number of a prenatal visits, parity and hospitalization.

*Table 9.6.1. Mean values with standard deviations or percentages*

	Cases N=11	Controls N=524	P
Age (years)	23,5 ± 3,7	28,1 ± 3,7	0,002
Single (%)	54,5	10,5	<0,001
Smokers (%)	72,7	14,9	<0,001
Gestation week at 1st visit (%)	16,9 ± 6,0	11,4 ± 4,9	NS*
Prenatal visits (N)	7,4 ± 3,7	8,7 ± 2,6	NS
Primigravida (%)	81,8	54,4	NS
At least 1 hospitalization (%)	45,5	27,2	NS

Source: Janja Zver Skomina

\*NS=non- significant

Addicted pregnant women in our study had significantly higher rate of cesarean sections and small for gestational age newborns. No significant differences were observed in the rate of prenatal analgesics use, duration of delivery, breech delivery rate of preterm deliveries.

Table 9.6.2. Mean values with standard deviations or percentages

	Cases N=11	Controls N=524	P
Parenteral analgesics (%)	36,4	14,7	NS*
Duration of delivery (%)	3,6 ± 2,6	4,8 ± 2,9	NS
Breech delivery (%)	9,1	2,5	NS
Cesarean section (%)	27,3	8,5	0,03
Small for gestation (%)	54,5	4,2	<0,001
Preterm delivery (%)	9,1	5,0	NS

Source: Janja Zver Skomina

\*NS=non-significant

Previous studies have confirmed, that babies born to women attending methadone program are small for gestational age. However, beside methadone use, broader spectrum of possible parameters influencing pregnancy should be considered.

In the present preliminary state of the study, a comparatively small group of addicted women was compared with the control group of pregnant women with no history of drug abuse. Nevertheless, several conclusions can be drawn from the analysed sample with high degree of significance. Addicted women tend to conceive at younger age and bulk of them do not give up smoking during pregnancy. More than half of included addicted women were unmarried, which also indicates their strained general living circumstances. The pregnancy outcome results with significantly gestational age newborns compared with the control group indicate that methadone use has an impact on pregnancy. However, considering the mentioned harmful behaviour patterns observed, methadone use itself cannot be exposed as the sole marker which unfavorably affects pregnancy in addicted women. Bearing in mind that the risks to mother and fetus in methadone maintenance are far fewer than those associated with street drugs, as well as the related lifestyle dangers, methadone is the treatment of choice in addict pregnancy. Considerable attention, however, should also be devoted to parenting education, in order to improve the expectant addict lifestyle.

## 2. Parenthood and drug use - children of drug users

Therapeutic interventions include group of relatives in all Centres for the Prevention and Treatment of Drug Addiction, in the Centre for Treatment of Drug Addiction at the Clinical Department of Psychiatric Clinic in Ljubljana, in therapeutic community and NGOs.

### **3. Parents of drug users**

Therapeutic interventions include group of relatives in all Centres for the Prevention and Treatment of Drug Addiction, in the Centre for Treatment of Drug Addiction at the Clinical Department of Psychiatric Clinic in Ljubljana, in therapeutic community and NGOs.

Some NGOs for parents of drug users are organising meetings and can be contacted on three different specially-created parents' hot-lines for information and in crisis.

### **4. Drug use at the workplace**

In 1996 the model programme of drug abuse prevention among workers was launched by the Institute of Public Health of Slovenia together with the Ministry of Work, Family and Social Affairs and as a part of ILO international project. The overall objective of the project was to develop an adaptable, acceptable and feasible model programme for workplaces with the potential for deployment. Data collection on drug problems in workplaces contributed substantially to success of the project planning.

### **5. Drug use in prisons**

Central Prison Administration in 1996 set up a project group which started to collaborate with the Ministry of Health and other experts. At the same time first draft of guidance for treatment for drug misusing prisoners has been written and prepared for discussion at the national level.

#### ***Prevention of infections in prisons***

In 1987 the Ministry of Justice with the assistance of Ministry of Health formulated guidelines for how to approach HIV epidemic in prisons. Prisoners have the same right to adequate health services as the population in the local community, including voluntary, confidential and anonymous HIV testing.

Considering that HIV prevention is an urgent objective among prisoners, especially among those injecting drugs, a prevention strategy for prisons was established. It has been based on recommendations of the Council of Europe and adopted to the local society through cooperation with the authorities responsible for the development of prevention measures in the medical field and collaboration with the national prison administration. This resulted in a booklet

»HIV in prisons«, availability of free condoms and establishment of a monitoring system of condom use.

In the future continuation of prevention activities is planned, collaboration with other authorities and evaluation of the programme.

## 10. Quality Assurance

### 10.1. Quality assurance procedures

As already mentioned, monitoring and evaluation are still in its infancy in Slovenia. The necessity of evaluating drug demand reduction projects and programmes is becoming, however, more and more accepted fact among the professionals. Evidence is often required by policy makers to further support DDR projects. Those who are providing funds more often require planning of evaluation and monitoring as a part of a project.

### 10.2. Treatment and prevention evaluation

#### Prevention evaluation

There are no new data on this topic.

**Model project Drug and Alcohol abuse at a workplace** has implemented evaluation right from the start. The Institute of Public Health of Slovenia has designed guidelines and mechanism for evaluation of drug and alcohol abuse prevention programmes at the workplace in 1998. When the Institute, in co-operation with the employers, decided to take appropriate preventive or remedial actions against alcohol and drug problems in the workplace in six Slovenian enterprises, they did so with the intention that the established programmes would be beneficial.

#### Evaluation of methadone treatment

The comparison study of the **quality of the methadone maintenance programme in 1995, 1997 and 2000** has been done to evaluate methadone maintenance programme as one of the services of CPTDAs.

According to the new directives originating in the Spring of 1995, the methadone maintenance program is operating as one of the services of the 15 Centres for Prevention and Treatment of Drug Addiction in the Republic of Slovenia.

The authors collected data regarding the quality of the program by the use of a questionnaire in the research in 1995, 1997 and in May 2000.

Data regarding the quality of the programme were collected by the use of a questionnaire. In the 1995 questionnaire was completed by 267 clients in the maintenance program (51% of all participants in the program), while in the 1997 questionnaire was completed by 729 clients (71.8% of all participants in the

program). The questionnaire was completed in the 2000 by 845 clients in the maintenance program (63.7% of 1326 participants in the program).

Among those included in the program the number of female participants increased from 22.3% to 23.5%. A slight change in the educational level and employment of the participants was also noted.

The number of participants who were regularly employed increased from 21.8% to 28.6%, while the number of those who worked occasionally decreased from 34.2% to 25.5%.

**Comparison data of clients in the Methadone Maintenance Programme in 1995, 1997, 2000**

Figure 10.2.1. Types of methadone treatment programmes

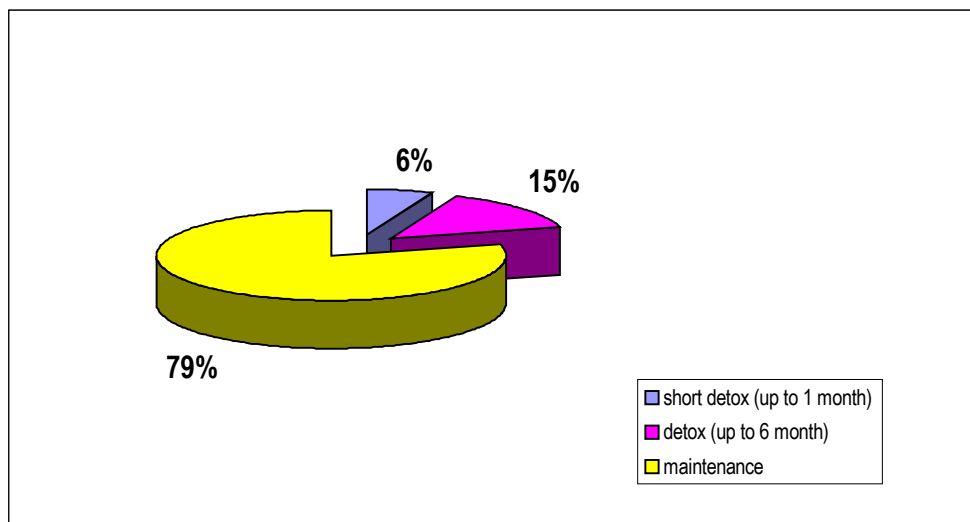


Figure 10.2.2. Gender of clients who participated in the methadone maintenance programme, 1995, 1997 and 2000

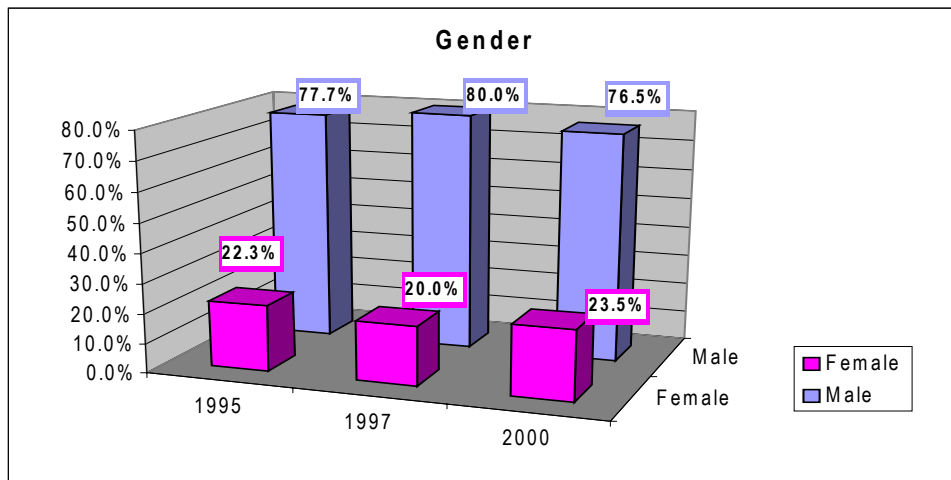


Figure 10.2.3. Average age

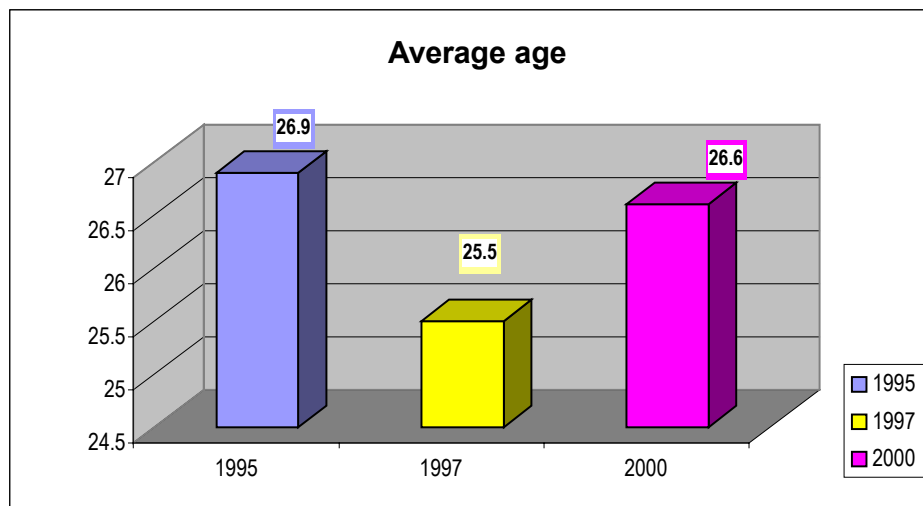


Figure 10.2.4. Level of education

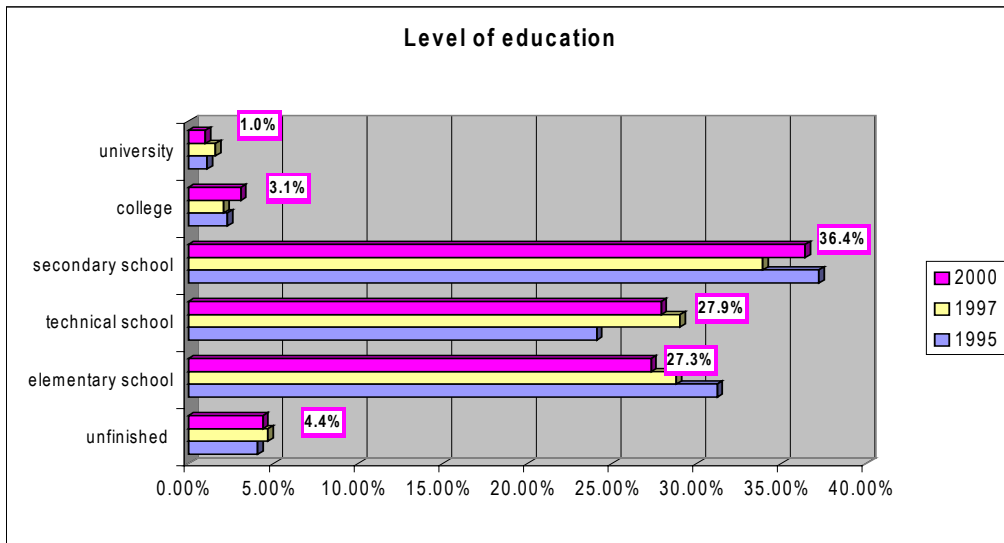


Figure 10.2.5. Employment

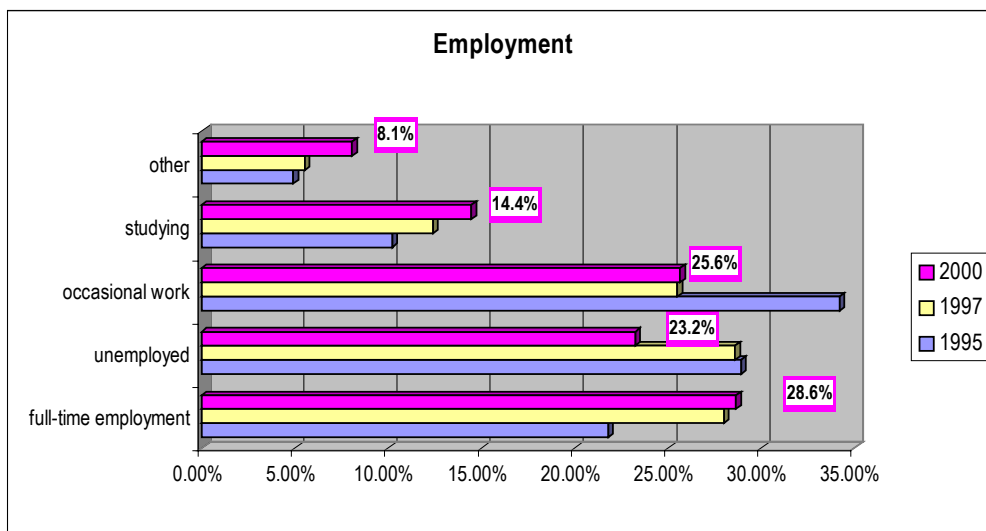


Figure 10.2.6. Testing on HCV

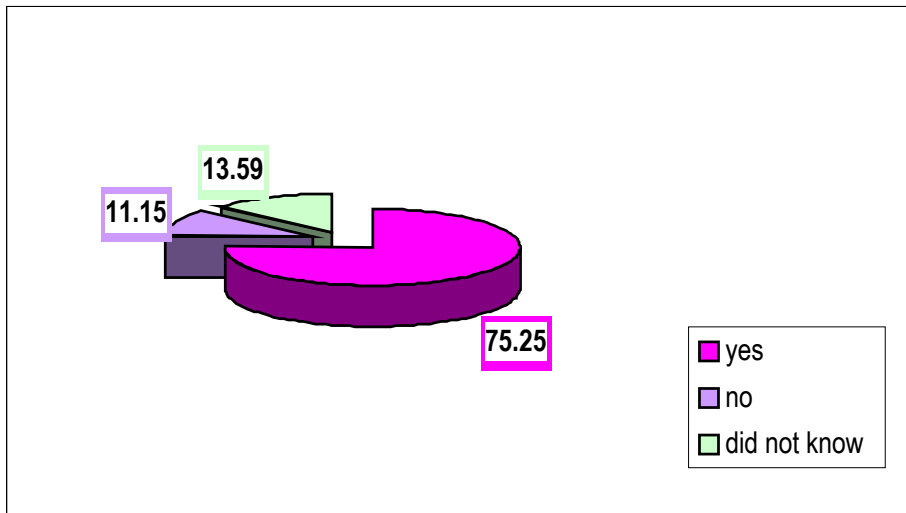
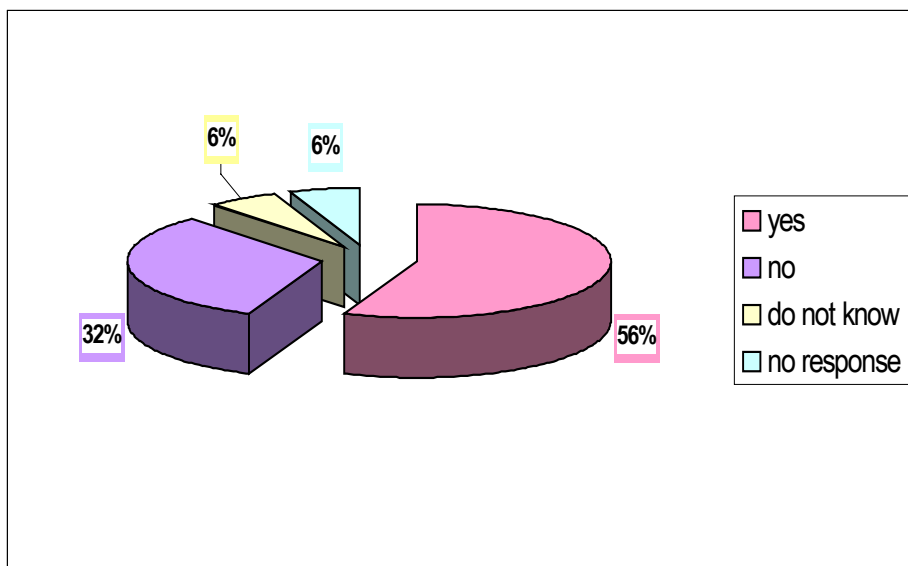


Figure 10.2.7. Vaccination against hepatitis B



Source: Kostnapfel Rihtar T., Kastelic A.: Evaluation of methadone maintenance programme in the Centres for the Prevention and Treatment of Drug Addiction in 1995, 1997, 2000. In press.



### 10.3. Research

#### a) Demand reduction research projects:

Global approach on drugs, Copernicus programme contract no IC 15 CT 98 10 14

*Objectives:* To develop a social approach to the drug phenomenon, although the empirical research has enlightened the decisive social factors of drug development. To build a social diagnosis tool for drugs problems in the field based on the research findings and global approach.

#### b) Relations between research and drug services

- Patrik Kenis, Flip Maas, Robert Sobiech: Institutional Responses to drug demand in central Europe. An analysis of Institutional Developments in the Czech Republic, Hungary, Poland and Slovenia.

*Objective:* Study investigates in detail the institutional response of demand reduction activities in four countries, their strenghts and weaknesses on a country by country basis as well as in the form of cross country comparisons. It thus provides a wealth of information for policy makers, both in terms of availability of services and areas for improvement.

- Vito Flaker, Vera Grebenc, Nino Rode, Janko Belin, Dragica Fojan, Alenka Grošičar, Ilonka Feher, Mateja Šantelj, Andrej Kastelic, Darja Zupančič, Zlato Merdanović: **Landscapes of Heroin Use in Slovenia: Harm Reduction Point of View (Preliminary Research Report)**

This research is a part of the “*TECHNICAL ASSISTANCE TO DRUG DEMAND REDUCTION*” Phare project. Together with the Czech Republic and Macedonia, Slovenia was involved in a regional sub-project of HARM REDUCTION. Our part of the research was based on the *Rapid Assessment and Response (RAR)*, developed by Stimms and Rhodes for the United Nations and the WHO (1998). The concept of our research is based on the same assumptions, and it has the purpose of achieving similar results, i.e. to provide relatively expedient but still accurate ways to create a body of knowledge which can support the development of the responses and services. The research was also linked to the other activities of the mentioned project.

The research draws on the tradition of action and qualitative research, which School for Social Work has developed over the last decades. On the basis of the experience gained from research conducted previously, for example, *Drugs*

*and Violence* (Flaker, 1993), a number of initiatives in harm reduction have been proposed, this methodology being highly appropriate for new insights in the area of drug use, developing organisational experiences, as well as for raising the awareness of both the professional and general public.

Goals of the research were stated as follows:

- to provide a knowledge on drug use in different settings, different styles, cultures; to get to know everyday life circumstances of drug users, their social circumstances, quality of life, hazards as well as strengths of their survival techniques;
- to assess the services available to people with problems related to drug use as well as the effects of other social reactions to drug use;
- to enable the processes which will fill the gaps in present provision as well as promote changes that will enable present structures to offer more adequate services;
- to promote more pragmatic and realistic attitudes in decision making, service providing and general audiences.

*Table 10.3. Risk associated with the sharing of the equipment: factors, rates, points of risk and risk reduction*

<b>Factors</b>	<b>Rate<sup>2</sup></b>	<b>Points of risk</b>	<b>Factors of risk reduction</b>
Awareness	Big	Beginners Withdrawal Fatalism of junkies	Fear of hepatitis Good availability of needles
Availability of equipment	Good	Nights and weekends Deprecatory attitudes in pharmacies Fear of stigmatisation Availability is bad on the deep periphery	Outreach Services of Stigma and AFR
Sharing of needles and syringes	Rare	Beginners Periphery Haphazard use Group use	Rules in group use Extent of individual use
Sharing the spoon and filters	Common	Scrounging filters	Rules in the group use (one who does not have a syringe takes last) Extent of individual use
Backloading and frontloading	Almost non-existent	Exist as a means of transport not dealing Some places (rarely) beginners	Fear of being cheated Users see it as stupidity
Contaminated water	Not often	During group use	

Source: Vito Flaker

<sup>2</sup> Estimate is arbitrary and for orientation purpose.

It appears that the level of awareness among Slovenian intravenous users is quite high, accessibility of needles and equipment is very good, so that in normal circumstances there is not much sharing of needles and syringes. Risk is higher mostly in beginners, which in their careers as users are in a position of not caring at all. Risk is also higher in smaller towns, where accessibility to needles is poorer and the fear of stigmatisation is higher. Other problematic issues involve getting a needle at night and the attitude of pharmacists towards users. The sharing of spoons and filters in group use is widespread and users are mostly not aware of the risk involved. We also identified specific features in the user culture which reduce the risk. In addition to the fact that it is important that needles and syringes are accessible, the work done by non-governmental organisations, field workers, where available, and centres for the treatment of addicts plays an important role. Though group use increases the risk of infection, it reduces the risk of death or severe injuries in the even of an overdose.

### **Preliminary conclusions of the research**

This report has presented the part of the material which was obtained during the research and to some extent also analysed. The research is not finished yet, though. In the next phase they aim to achieve two things.

Vito Flaker etc: "In mapping of drug use we will include data which we have not up to thin point and continue our analysis. Our analysis, as the reader would have probably noticed, stopped on the entirely descriptive and interpretative levels. We made an attempt to summarise and arrange the material in order to tell the story we were told by our respondents. This may perhaps be enough for the sociological research paradigm, but it certainly is insufficient for social work one, where the results of the research must serve the purpose of a more concrete action, interventions and care. Thus, in the following months we are planning to supplement the map and catalogue we created with signposts, itineraries and instructions for use.

In any case, on the basis of impressions and individual ideas which sprang to our mind while processing the data, at this time we can draw some conclusions and possible guidelines aimed at drug-related harm reduction.

The first conclusion which can without hesitation be derived from our research is that the concept of harm reduction is unjustifiably usually limited to the health consequences of heroin use. Social consequences are also present and important in the planning of a harm reduction strategy. The loss or lack of housing, job, friends, contacts with relatives, as these were described, can undoubtedly be destructive effects, which can emerge as a consequence or at the least as an accompanying phenomenon of heroin addiction. We can assume that positive measures which would mitigate the consequences of stigmatisation and social isolation could take the form of positive discrimination, that is, measures which would in principle improve the status of users to provide them with opportunities equal to those available to other people (e.g., facilitated access to employment, housing, etc.). On the other hand, we can assume the

introduction of concrete measures intended for those users who find themselves in material hardship (for example, as users themselves proposed, shelters for homeless users, special public work or workshops, social premises and socialising with normal peers). These measures could have a multifold effect. They would dilute the role of an addicted user because users would be enabled to take on different roles, which diminishes the domination of the role of a user, they would provide a stronger material basis for basic support and also self-confidence which as a result would reduce both health (infections, injuries) and social (impoverishment, crime, prostitution) risks generated by the social consequences of addiction; on the general level, this would contribute to de-stigmatisation and de-ghettoisation of addicted users and drug users as a whole.

The second conclusion that can be drawn on the basis of impressions is that the understanding of heroin use has so far been excessively based on individualist issues. Our data indisputably point at a whole set of phenomena which are explicitly collective (beginning of drug use, rules which govern use, the entire complex of the market and dealing, the knowledge of the effects and risks of drugs, etc.). Furthermore, the group, or to put it better, community aspect of use is much more important in the case of beginners and experimenting users, while the style of "mature users" is more individualised and socialising is more atomised. Habits are formed on the individual level and internalised. The community aspect is also very important in abstainers, particularly those who return from therapeutic communities. We determined that contacts with services are less frequent and the need for concrete professional help is lower or less pressing in beginners, experimenting and controlled regular users. For this reason, they are not accessible as individual clients of these services. This is also the advantage of the group and field approaches over the individual and therapeutic approaches. In this sense, we can envisage the necessity of developing such approaches which will function between groups and user networks, which will influence their culture, strengthen their values and practices, and which reduce risks. Concretely we have in mind projects which would cover a whole neighbourhood, including other important actors in the community rather than just users.

The third general conclusion is that in this type of intervention we cannot merely rely on educational approaches. Teaching and awareness raising, although conducted within a community and among users themselves, are not enough if the measures do not include concrete and actual interventions, which bring about different practices. We can assume that on the basis of finding out that circumstances or situations in which users find themselves are more crucial for a specific activity or practice than personal motivation or interest (e.g., both at the beginning and termination of drug use). For this reason, interventions must be aimed at the concrete and actual contexts of use (e.g., provision of antidote for preventing overdose, provision of premises for social contacts, provision of condoms). In addition to the already-known intervention of harm reduction (e.g., safe injecting, sterile equipment, premises for safe use), attention must be devoted to the withdrawal crisis as one of the key moments in the life of an

addicted user. This calls for the development and furthering of our understanding of the phenomenon of withdrawal, as well as for conducting a dialogue with users, search for ways of lower-risk action and management of withdrawal, and offer them realistic opportunities for alleviating the withdrawal crisis.

Our research arrived at the construction of the concept of fundamental misunderstanding. This concept, which calls for further elaboration, is important, since it can serve as a guideline in the understanding the differences among different types of offer and in the planning of response to the various type of distress of users and to social problems. The essence of the fundamental misunderstanding is that either parents, professionals or other actors want to help when the user does not want help, or that they want to help in an entirely inappropriate manner. At its best, this may result in the fact that all the effort was in vain, while at its worst, it may generate disappointment and distrust on the part of both parties, a family drama, abandonment of help, where the user resorts to the role of a junky and to destructive behaviour. This is why the assessment of the needs and desires of users, as well as of their life context and the “prompt dosage” of help, at the right time and to the appropriate extent, is of vital importance for the construction of services and in the planning of individual measures. In this sense low-threshold and high-threshold services must be looked as at complementary services, as well as continued services, meaning that transition must be possible between them, where we need to accept the necessity and insufficient level of development of low-threshold services in order to develop them with a sensitivity for the concrete reality in a specific environment with respect to both individual and group needs of users. This means that the knowledge derived from research and ethnography is of exceptional importance for the development of these services, and that low-threshold interventions are always also research interventions and vice versa, that they must be derived from the assessment of needs in the community.”

### **c) Training in demand reduction research**

A lot of trainings for professional working with drug users is organized in a form of seminars. Several meetings organized in cooperation with Pompidou Group and Phare Programmes have been used as a training and thus professionals of all specialities working with drug issues have been invited to these meetings.

Since 1995 several trainings and seminars were organized for the professionals working with drug users:

- Fifteen training seminars for the professionals working at CPTDAs and Health Centres from all regions have been organized by The Ministry of Health. Health workers from prisons and psychiatric hospitals, social workers, professionals in Centres for Social Care, psychologists and representatives of the Pharmacy Chamber have also been invited.

- The Ministry of Internal Affairs organized trainings for police professionals, in particular those working with drug users.
- Almost ten training seminars have been organized for professionals in prisons by the Prison Administration in cooperation with the Ministry of Health.

Basic training for professionals of all specialities working with drug users is organised every year by the Ministry of Health in cooperation with Coordination of CPTDAs. Seminars on counseling, motivational interview, woman specific issues, team work, relaps prevention and staff burn-out are planned to be organized.

Addiction prevention is increasingly incorporated into teacher training programmes as an issue of special importance. The institutions for the training of teachers are increasingly seeking cooperation with the addiction prevention experts.

There is a need of more continuous form of training at all levels. The use of distance education was discussed as a form of education for volunteers and outreach workers.

**Seminar about the safety road traffic:** The seminar was interdisciplinary, organised by different institutions. Seminar's objective was to clarify the availability of drivers for driving the car when they are under the influence of different medicines, including methadone as a substitution therapy.

**DRTSP II. :** The aim of the project was developing module of postgraduated educational programme under the supervision of Pompidou Group of the Council of Europe. A number of university professors have prepared a curriculum for postgraduate education for professionals from different fields.

The Governmental Office for Drugs: a yearly conference of the Slovenian LAG :

The conference was held in Celje. Its objective was to find out how to analyze conditions in the local community and how to organize a joint action in the field of drugs on local level. The guest speaker from Great Britain talked about their experience in that matter.

**The Education Office: the National programme Council for the Healthy School Children:** The revision of preventive programmes in Slovenian primary and secondary schools with an aim to prepare evaluation methods and supervision over the programmes.

## 10.4. Training for professionals

### **MASTERS DEGREE PROGRAMME – University of Ljubljana, Slovenia**

Drug demand Reduction in Slovenia and further a field is a subject area that combines findings from the fields of medicine (psychiatry and public health), social work, social science, education, criminology and epidemiology, pharmacy and many more. The rapid and extensive development of this field, its influence on the quality of life and its importance in society demand a high-quality and modern Postgraduate Study Programme for the acquisition of appropriate knowledge in the areas of individual disciplines at the University of Ljubljana.

Drug Demand Reduction is a very broad subject and includes concepts such as prevention, early intervention, treatment, rehabilitation and policy planning. Until now topics for the new Postgraduate Programme have been developed in various different Faculties of the University of Ljubljana; the sensible action to take is therefore to combine existing or supplemented postgraduate teaching, both organisationally and contextually, which would also enable the combining of lecturers and the bringing-together of researchers working within member-bodies of the University of Ljubljana and with external Research Institutes.

The Aims of the Postgraduate Programme include:

- To communicate expertise, scientific knowledge and ‘good practice’ relating to Drug Demand Reduction through training and education at a European level
- To impart information on a range of interventions in the fields of treatment, prevention, policy and research
- To deliver special knowledge germane to the Addictions field

Postgraduate studies in the area of Drug Demand Reduction are predominantly organised and carried out by the:

- Faculty of Medicine
- Faculty of Education
- School of Social Work
- Faculty of Social Science

The Faculty of Medicine, Faculty of Social Science and the Faculty of Education together with the School of Social Work plan to combine all the areas of Drug Demand Reduction that they teach. The Faculties of Law & Criminology, Pharmacy, Sport and Art (Clinical Psychology) will contribute individual classes closely connected with the programme.

Employees at Research Institutes (Anton Trstenjak Institute and the Institute of Public Health) will also take part in the implementation of the individual sections of the programme, through cooperation with specially trained and qualified tutors at the University of Ljubljana.



**PART 4**  
**KEY ISSUES**

## **11. Infectious diseases**

### **11.1. Prevalence of HIV, HCV, and HBV among injecting drug users**

#### **HIV**

Slovenia has a low level HIV epidemic. The prevalence of HIV infection has not reached 5% in any population group. Rapid HIV infection spread seems not to have started yet among injecting drug users. During the period from 1996 to 2000 HIV prevalence consistently remained below 1% among confidentially tested injecting drug users treated in the network of Centres for Prevention and Treatment of Illicit Drug Use. During the same period no HIV infection cases were detected by voluntary confidential testing among injecting drug users demanding treatment for the first time. Similarly, during the period from 1995 to 2001 HIV prevalence among injecting drug users demanding treatment for the first time in two of these Centres (Ljubljana and Koper) and consenting to be tested unlinked anonymously for HIV surveillance purposes consistently remained below 1%. Regrettably, no information on HIV infection prevalence is available from needle exchange or other lower threshold harm reduction programmes nor from community based surveys among injecting drug users.

Average annually reported newly diagnosed HIV incidence rate during last five years (1997 to 2001) has been 6.5 per million population (8.0 per million in 2001) and reported AIDS incidence rate 3.5 per million population (2.5 per million in 2001). During the same period the reported newly diagnosed HIV incidence rate among injecting drug users calculated per total population has remained below 1.0 per million population (one case in 1997, two in 1998, no cases in 1999, and one case in 2000 and 2001) and AIDS incidence rate below 0.5 per million population (no cases in 1997, 2000 and 2001 and one case in 1998 and 1999). In contrast to relatively reliable AIDS reported data the information about reported newly diagnosed HIV infection cases does not reliably reflect HIV incidence.

#### **HBV**

During the period from 1996 to 2000 the prevalence of antibodies against hepatitis B virus (HBV) among confidentially tested injecting drug users treated in the network of Centres for Prevention and Treatment of Illicit Drug Use ranged between 2.6% to 6.6% (2.6% in 1996, 2.7% in 1997, 4.3% in 1998, 6.6% in 1999 and 5.3% in 2000). During the same period the prevalence of antibodies against HBV detected by voluntary confidential testing among injecting drug users demanding treatment for the first time ranged from 0% to 3.8% (0% in 1996, 3.8% in 1997, 1.9% in 1998, 0% in 1999 and 3.3% in 2000).

Unfortunately it is impossible to distinguish between the prevalence of antibodies against HBV and the prevalence of current HBV infection (HBsAg). In 2002 the data collection has been revised. Information on different HBV infection markers will be collected (anti HBc, anti HBs, and HBsAg).

During last 10 years (1992 to 2001) the reported acute HBV infection incidence rate in the Slovenian population decreased from 4.5/100.000 population in 1992 to 1.0/100.000 population in 2001. Due to underreporting, HBV reported incidence rates greatly underestimate the burden of the disease. Nevertheless, the downward trend should be noted. For the period from 1997 to 2001 information on transmission route is available for a minority of cases. Injecting drug use was implicated in 0% to 25% of those cases.

## **HCV**

During the period from 1996 to 2000 the prevalence of antibodies against hepatitis C virus (HCV) among confidentially tested injecting drug users treated in the primary health care network of Centres for Prevention and Treatment of Illicit Drug Use ranged from 20.8% to 30.1% (30.1% in 1996, 21.1% in 1997, 20.1% in 1998, 21.2% in 1999 and 20.8% in 2000). The prevalence among short term injecting drug users (less than 2 years) ranged from 0% to 13.3%. That is clearly lower than among longer-term users (from 21.9% to 38.3%). During the same period the prevalence of antibodies against HCV detected by voluntary confidential testing among injecting drug users demanding treatment for the first time ranged from 8.3% to 32.1% (32.1% in 1996, 12.7% in 1997, 12.5% in 1998, 13.3% in 1999 and 8.3% in 2000). Information on the proportion of chronic HCV infections among these individuals is not available.

During the period from 1994 to 2001 annually reported acute HCV infection incidence rate in the Slovenian population ranged between 0.6/100.000 population in 1994 to 2.6/100.000 population (in 1998 and 2000). Due to underreporting, HCV reported incidence rates greatly underestimate the burden of the disease. For the period from 1997 to 2001 information on transmission route is available for a minority of cases. Injecting drug use was implicated in 40% to 100% of cases (67% in 1997, 1998, and 2001; 40% in 1999; 100% in 2000).

## 11.2. Determinants and consequences

### Injecting risk behaviour

The spread of infections (HIV, HBV and HCV) among injecting drug users is mainly determined by injecting risk behaviour, notably »needle sharing«. Transmission is also possible through sharing other injecting equipment, not just needles and syringes.

In 1996 a behavioural surveillance approach to monitor risk behaviour trends among injecting drug users has been established in Slovenia. We started collecting information about a few injecting risk behavioural indicators within the network of Centres for Prevention and Treatment of Illicit Drug Use. Questions about sharing needles and syringes and other equipment were added to the list of information collected during annual surveys of treated clients and at first treatment demand. Some results for clients demanding treatment for the first time are presented in Table 11.2.1. It is worrying that the proportion of current injectors (injecting last month) reporting sharing needles and syringes during the month prior to treatment demand has not been decreasing recently.

*Table 11.2.1. Injecting risk behaviour among IDU clients demanding treatment for the first time in the network of Centres for Prevention and Treatment of Illicit Drug Users*

	1996	1997	1998	1999	2000
<b>Ever injected illicit drugs (IDU) - bases</b>	<b>238</b>	<b>385</b>	<b>405</b>	<b>298</b>	<b>272</b>
Ever having shared needles & syringes	52.5%	62.3%	60.7%	54.7%	48.9%
Ever having shared other equipment	37.0%	70.9%	74.6%	72.5%	70.6%
<b>Currently (last month) injecting illicit drugs - bases</b>	<b>198</b>	<b>311</b>	<b>322</b>	<b>260</b>	<b>231</b>
Shared needles & syringes last month	18.2%	32.2%	30.4%	25.8%	28.1%
Shared other equipment last month	24.2%	47.9%	43.2%	40.0%	42.0%

*Source: Irena Klavs, Institute of Public Health*

Obvious limitation of such "crude" behavioural surveillance information is the questionable validity of self reported information. However, presumed consistency of data collection methods, relative feasibility of collecting such behavioural surveillance information and appropriateness of such an approach to monitoring trends is convincing.

Regrettably, reliable injecting risk behavioural data from repeated community surveys among injecting drug users is not available.

## **Sexual risk behaviour**

Sexual transmission of HIV and HBV infections among injecting drug users and their sexual partners is also important, while sexual transmission of HCV is thought to be low.

As for higher risk injecting behaviour, a behavioural surveillance approach to monitor sexual risk behaviour trends among injecting drug users has been established in Slovenia in 1996. We started collecting information about a few sexual behavioural indicators within the network of Centres for Prevention and Treatment of Illicit Drug Use. Questions about number of partners, condom use and trading sex for drugs or money were added to the list of information collected during annual surveys of clients and at first treatment demand. Some results for clients demanding treatment for the first time are presented in Table 11.2.2.

Obvious limitation of such “crude” sexual behaviour surveillance information is the questionable validity of self reported data. However, presumed consistency of data collection methods, relative feasibility of collecting such behavioural surveillance information and appropriateness of such an approach for monitoring trends is convincing.

In 2002 the sexual behaviour indicators list has been revised. Unfortunately, the collection of information about ever having received money or drugs for sex has stopped. However, we started collecting important information about the sexual link between injecting drug users and non-injectors by directly asking questions about sexual partners non-injectors during last year.

*Table 11.2.2. Sexual behaviour among IDU using clients demanding treatment for the first time in the network of Centres for Prevention and Treatment of Illicit Drug Users*

	1996	1997	1998	1999	2000
<b>Clients reporting sexual partner(s) last year - basis</b>	<b>124</b>	<b>295</b>	<b>322</b>	<b>261</b>	<b>255</b>
1 partner	70.2%	56.3%	52.5%	51.7%	59.6%
2-4 partners	22.6%	30.9%	33.8%	36.0%	28.0%
5-9 partners	3.2%	7.7%	9.9%	9.3%	9.8%
10+ partners	4.0%	5.0%	3.7%	3.1%	2.7%
Used condom during last sexual intercourse	13.4%	25.4%	25.6%	30.9%	25.3%
Having received money or drugs for sex	3.0%	3.3%	0.9%	1.4%	1.5%

Source: Irena Klavs, Institute for Public Health

Regrettably, reliable sexual risk behavioural data from repeated community surveys among injecting drug users is not available.

### **11.3. New developments and uptake of prevention, harm reduction and care**

#### **1. Prevention**

In the field of prevention, the development of a network of local action groups is foreseen which will accelerate the development of preventive programmes in local communities. At the level of regions, the formation of Regional Action Groups is planned which will connect local groups in a broader area, in accordance with the Regions Act, which is in the parliamentary procedure. There is also foreseen to carry out a more detailed evaluation of preventive programmes in the field of prevention of addiction. The programmes which are currently going on in various environments will be evaluated and the publication "Good Practice" will be prepared. A part of the plan is also to establish a basic information network for educating young people about drugs and here the focus will be predominantly placed on risk groups. The education will embrace not only the youth, but also their parents and pedagogues, and within this framework also programmes for non-school children will be developed. The prevention of drug use will be logically connected with the prevention of alcohol and tobacco consumption, and common activities will be carried out in this field. In the Slovene Army, modern methods of preventive work with soldiers in military service will be introduced. It is also planned to stimulate the creation of

special programmes in work organisations. Special attention will be devoted to children of addicted parents. For every budgetary period an action programme will be adopted for all areas of treatment of drug users.

## **2. Treatment**

The development of the network of Centres for the prevention and treatment of drug addiction will be continued from the aspect of contents. If necessary, the network will be expanded and new, advanced methods of addiction treatment will be introduced, as well as connection with the other governmental and non-governmental programmes of addiction treatment in Slovenia will be continued. The outset of operation of the national Centre for Treatment of Drug Addicts with 35 beds is planned in May 2002. The capacities for the treatment of young people in the form of a hospital treatment as well as in the form of a daily, outpatient treatment, day hospital, prolonged treatment for patients with multiple diagnosis will be assured and detoxification.

Bigger attention will be devoted to risk groups - programmes adjusted to women and their treatment. Special programmes of treatment in prisons will be developed and they will be compatible with the already existing treatment programmes outside prisons. Particular attention will be focused on the prevention and treatment of the infection with the HIV virus, hepatitis C and B, and tuberculosis, as well as to education. A consistent vaccination of drug addicts against hepatitis B will be carried out in all programmes of addiction treatment. Special attention will be paid to the treatment of homeless persons having troubles with addiction.

## **3. Programmes of social assistance**

In the following years we will devote a lot of attention to the prevention of social exclusion and labelling of drug users. With special programmes and through the network of public authorisations, the network of Social Work Centres can substantially contribute to the elimination of social threat of drug users. In this field we will fight for the reduction of social exclusion, further development of services for the assistance to socially endangered drug users, assurance of free entrance to the programmes of social assistance, and establishment of the network of daily centres, therapeutic communities, communes and other forms of social assistance to drug addicts.

## **4. Harm reduction activities**

A lot of attention is being devoted to harm reduction: by stimulating new programmes in the towns where no such programmes exist and by expanding the already existing programmes.

In the following years we predominantly wish to:

- Develop the network of harm reduction programmes (outreach, exchange of needles and counselling);
- Prepare the professional, political, legal and technical basis for the introduction of the pilot project "Safe Injection Rooms";
- Examine the possibility of introducing a test heroin maintenance programme;
- Stimulate pharmacies to implement the drug exchange programme;
- Strengthen the information about a safer drug use between the intravenous users;
- Strengthen the role of drug users as partners in various processes of planning and decision-making.



## 12. Evolution of treatment modalities

### 12.1. Introduction

We will explain the status of treatment services for problem drug users at the beginning of the 1990s, especially from health sector and low threshold sector. Data from social sector are missing.

### 12.2. Legislation/regulations that had an effect on a treatment provision

Health Care and Health Insurance Act (Official gazette 9/92)

Prevention of the Use of Illicit Drugs Act and Dealing with Consumers of Illicit Drugs Act (Official gazette 98/99)

- Article 8 defined that the **treatment of consumers** of illicit drugs shall be carried out in the form of hospital and outpatient clinic treatment programmes approved by the Health Council at the Ministry of Health of the Republic of Slovenia:

“The treatment referred to in the preceding paragraph shall be carried out by natural and legal persons who fulfil the conditions defined for the performance of medical activities in accordance with the act governing medical activity. In accordance with this Act, treatment shall also be deemed to be maintenance with methadone and with other substitutes approved by the Health Council.”

- Article 10 defined **Social security services and programmes for the resolution of social problems related to the consumption of illicit drugs:**

“Social security services intended for the prevention and elimination of social hardship and problems related to the consumption of illicit drugs provided in the form of public services shall in particular comprise social prevention, emergency social assistance, help for individuals and help for the family.

The services specified in the preceding paragraph shall be provided in accordance with the act governing social security and in accordance with norms and standards prescribed by the minister responsible for social affairs.”

#### ► **Developments in outpatient illicit substance abuse treatment (ISAT) over the 1990s and 2000**

In the early nineties, with the expansion of drug use and drug addiction also the prescribing of methadone started, first in the Vojnik Psychiatric Clinic (Dr Novak) and later on in the littoral (Dr Krek).

Due to the increasing number of those who searched for such kind of treatment from the entire Slovenia, the need for structuring a programme and organising at the state level occurred.

The methadone maintenance programme is one of the fundamental treatment - not only harm reduction programme - in current drug policy that aims to protect the users of illegal drugs by increasing the number of users who make contact with the medical service, remain in treatment or join higher threshold programmes.

The **Health Council at the Ministry of Health** has adopted national guidelines for management of drug addicts, including methadone maintenance harm reduction strategy, **in April 1994**. The recommendations concerning treatment of drug addiction were adopted containing instructions for general practitioners, for emergency procedures, the hospital treatment of addicts for diseases connected or unconnected with drug dependence, for psychiatrists, territorial defence doctors and those dealing with prisoners, and for other situations in which medical personnel come across unauthorised drug taking.

The recommendations give instructions about identification of drug use, the diagnostic and therapeutic methods in hospitals and outpatient clinics, and the recommendations for the methadone maintenance programme.

The support is not only provided for opiate addicts, but also for the abusers of sedatives, hypnotics, stimulants, hallucinogens etc., whether they experiment with or are addicted to them.

The recommendations also provide guidance concerning the abstinence syndrome, application of medicaments, stabilisation of opiate addicts, outpatient treatment, detoxification and a detailed description of the methadone maintenance programme.

Methadone maintenance programme policies were confirmed at a **consensus Symposium** on methadone maintenance with participants from the Ministry of Health, the Ministry of Internal Affairs, the Ministry of Labour, Family and Social Affairs and the Ministry of Justice in **November 1994**.

Nine regional Centres for Prevention and Treatment of Drug Addictions were established according to **Degree of Minister of Health in April 1995**.

*Table 12.2.1. Trend of no. of patients and funds for treatment of drug addiction from Health Insurance Company*

<i>Year</i>	<i>Funds (in SIT and EUR)</i>	<i>No. of patients in methadone maintenance programme</i>	<i>No. of all patients</i>
1995	78.962.546 (352.511 EUR)	530	No data
1996	98.000.000 (437.599 EUR)	530	No data
1997	141.243.949 (639.553 EUR)	762	1.414
1998	173.566.015 (774.848 EUR)	926	2.599
1999	206.054.000 (919.884 EUR)	1.097	2.342
2000	214.877.000 (958.692 EUR and 40.000.000 (178.571 EUR)	1.348 (1.11.2000)	2.540 (do 1.11.2000)
2001	287.747.000 (1.284.585 EUR) in 30.000.000 (933.929 EUR)	1.347 (31.3.2001)	2.264 (31.3.2001)

*Source: Ministry of Health*

At the end of the year 2001 there were fourteen Centres for the Prevention and Treatment of Drug Addiction and three outpatient departments in Slovenia.

► **Developments in inpatient treatment over the 1990s and 2000**

Center for Treatment of Drug Addicts at the Clinical Department for Mental Health at the Psychiatric Clinic Ljubljana was opened in January 1995.

*Table 12.2.2. Number of patients in the Centre for Treatment of Drug Addicts at Psychiatric Clinic Ljubljana - hospital unit*

<i>Year</i>	<i>Women</i>	<i>Men</i>	<i>All</i>
1995	28	52	80
1996	21	56	77
1997	29	54	83
1998	25	68	93
1999	33	68	101
2000	38	71	109
2001	35	79	114
Total	209	448	657

*Source: Centre for Treatment of Drug Addicts at Psychiatric Clinic Ljubljana*

Some of the specialist outpatient clinics for drug dependence treatment were not operating very well. The need has arisen to establish a more efficient network of drug prevention and rehabilitation centres in Slovenia which will provide treatment, will be computer-linked and financially supported by the Health Insurance Institute of Slovenia.

The expansion of the programme of the Centre for Treatment of Drug Addicts with a specialist outpatient activity, treatment of youth, prolonged treatment and rehabilitation as well as treatment of critical conditions occurring with drug users, is of national importance and, in accordance with the national programme, is a part of the obligatory health insurance scheme (Health Care and Health Insurance Act, Official Gazette 9/92).

The contents of the programme of the Centre for Treatment of Drug Addicts has been confirmed by the following conclusions:

- Conclusion of the RS Government Committee for the Implementation of the National Programme of Drug Abuse Prevention
- Conclusion of the State Collegiate Body for Psychiatry
- Conclusion of the Health Council

Premises for the expansion of the activity shall be assured in the building of the former Military Hospital in Ljubljana, and these premises were, in accordance with the government decision, allocated already in 1992.

In the Centre for Treatment of Drug Addicts the following activities will be organised: a specialist outpatient activity, detoxification, prolonged treatment and rehabilitation as well as treatment of crisis intervention occurring with drug users.

Establishment of the Centre for Treatment of Drug Addicts presents the supplementation of the existing network of eleven Centres for Prevention and Treatment of Drug Addictions in the Republic of Slovenia. The Centre will be completed until summer 2002.

► **Developments in low-threshold and outreach services over the 1990s and 2000**

In 1991 the group of different health and social professionals, drug users and volunteers founded Stigma Association - the NGO for help, self-help, information and advice on drugs and AIDS. The idea of harm reduction approach in drug field in Slovenia was first developed and practised in Stigma and after that advocated around the state. It was also used in the frame of drug policy issues about pragmatically approaches in connection with more human drug policy.

The first movement (it began after the first methadone substitution program at the Psychiatric Hospital Vojnik in the city of Celje) was prohibited for several months in 1989, when non-formal previous Stigma's members played the crucial role in methadone treatment advocacy. It was the first time that the drug users have made a public stand and engage themselves in a civil action. The work on this topic went on in 1992 when Stigma managed to assemble a number of professionals and drug users around issues of methadone, needle-exchange, counselling about safer drug use, safer sex behaviour, self-help and human rights of the drug users.

In 1995 the Republic of Slovenia was included in the project of WHO for establish of outreach programmes, performing by the Ministry of Health.

In 2000 Stigma has merged with Aids Foundation Robert and remains the project for harm reduction in the frame of new organisation.

The first service established – in low-threshold frame – was Stigma Association in 1991. We start with programme in January 1992. Project contained needle exchange service, help-line related to drugs & Aids, advocacy for methadone maintenance treatment, ethnographic research related to drug use. Basic part of the mentioned project was located only in Ljubljana, some other activities, like »backing up« needle exchange supported by Stigma (user for users on voluntary basis), was taking place in some other areas, mostly in city of Maribor.

Table 12.2.3. Statistic from needle exchange

	<b>Number of visits</b>		<b>Number of visitors</b>		<b>Female visitors</b>	<b>Male visitors</b>
<b>1992</b>	1.612	<b>1992</b>	446	<b>1992</b>	19,80%	80,20%
<b>1993</b>	2.044	<b>1993</b>	418	<b>1993</b>	24,10%	75,90%
<b>1994</b>	1.310	<b>1994</b>	306	<b>1994</b>	24,10%	75,90%
<b>1995</b>	940	<b>1995</b>	225	<b>1995</b>	24,40%	75,60%
<b>1996</b>	1.799	<b>1996</b>	368	<b>1996</b>	25,40%	74,60%
<b>1997</b>	1.324	<b>1997</b>	297	<b>1997</b>	26,60%	73,40%
<b>1998</b>	3.823	<b>1998</b>	630	<b>1998</b>	21,00%	79,00%
<b>1999</b>	3.868	<b>1999</b>	740	<b>1999</b>	16,20%	83,80%
<b>2000</b>	7.892	<b>2000</b>	963	<b>2000</b>	21,70%	78,30%
<b>2001</b>	7.718	<b>2001</b>	1.131	<b>2001</b>	19,40%	80,60%

Source: Dare Kocmur, Stigma

Table 12.2.4. Statistic of issued and returned

	<b>Issued</b>	<b>Returned</b>	<b>Portion of returned</b>
<b>1992</b>	9.235	5.191	56,20%
<b>1993</b>	12.924	6.664	51,60%
<b>1994</b>	10.598	4.603	43,40%
<b>1995</b>	9.673	1.488	15,40%
<b>1996</b>	19.468	5.860	30,10%
<b>1997</b>	11.510	4.066	35,30%
<b>1998</b>	39.041	19.190	49,15%
<b>1999</b>	59.196	30.941	52,30%
<b>2000</b>	135.143	75.228	55,67%
<b>2001</b>	144.693	98.815	68,29%

Source: Dare Kocmur, Stigma

Aids Foundation Robert contains three main projects:

- Project Stigma – harm reduction programme (the biggest one)
- Project Aids – mainly to deal with HIV infected persons, publishing
- Project prisons – harm reduction and social care with prisoners

TYPE	Specialised hospital department (also inside psychiatric hospitals) – inpatient treatment		Therapeutic communities				Outpatient services				Low-threshold centres				Street-based programmes													
	number of departments	FTD	number of departments	FTD	number of communities	FTD	number of communities	FTD	number of communities	number of specialised hospital services	FTD	number of day-care centre with structured programme (stationer)	FTD	number of services	FTD	number of centres with needle exchange	FTD	number of centres without	number of programmes	FTD	number of needle exchange	FTD	number of programmes	FTD	number of programmes	FTD	number of mobile substitution treatment	
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## ANEX 1

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## ANEX 2

### Drug Monitoring Systems and source of information

#### 1. Evolution

The development of drug information system has been one of the priorities in Slovenia since 1993. Slovenia participated in several international projects concerning information system and data collection and by this a framework of activities at a national level was established. Through cooperation with international organisations, Phare-DIS/European Union and Pompidou Group/Council of Europe in particular, the basis for the drug information system were established - the network of people and institutions and the technical network for the collection of reliable and comparable drug related data. At the seminars and meetings which were held in Slovenia with the international support in the last years the information needs and demands were clarified.

**The Institute of Public Health of Slovenia (IPH)** is, together with 9 regional Public Health Institutes, the most important data gathering centre on drugs in Slovenia. The IPH is collecting treatment demand data since 1991. This year the data collection started in Ljubljana and Koper.

The epidemiology experts of IPH and its regional branches meet regularly to impart data comparability at national level and to compare and interpret drug use and misuse trends.

The Unit of Mental Health Protection has been responsible for coordination and contact with international organisations until March 2001. This Unit was responsible for national epidemiology and prevention initiatives in the areas of alcohol, drugs, suicides and others. The responsibility for the Pompidou Group treatment demand and multi-city project was also with this Unit. In addition to its responsibility for the national drug monitoring it has also offered support to initiatives at local, regional, national and international levels to help implemented a new epidemiology and prevention knowledge and methods.

Later, the **CPTDAs** became the main source of health data concerning drug use. With non-governmental treatment and harm reduction services they build a network of institutions that gives the opportunity of data collection at national level. The first treatment demand data collection was implemented in June 1996. The existence of Coordination of CPTDAs on national level proved to facilitate the implementation of FTD data collection.

At the Phare Information System Local Training Seminar at Bled in September 1996 epidemiologists from Regional Public Health Institutes realised and accepted that FTD data should be in the first place collected, analysed and



disseminated directly by the Institute of Public Health at national level. Collection of other drug data such as school and general population survey data should remain in the domain of Regional Public Health Institutes.

In the field of drug control, **The Ministry of Interior** is a source of information on police arrests, quantities of illicit drugs seized, prices of illicit drugs and drug-related deaths; some data are available only for Slovenia and not for Ljubljana. Based on the data on drug-related offences provided by the police and customs officials, the annual report on drug delinquency in Slovenia is drawn.

**The Ministry of Justice** is a source of information on drug misuses in prison population.

## 2. Legislation

According to Prevention of the Use of Illicit Drugs and Dealing with Consumers of Illicit Drugs Act Monitoring the consumption of illicit drugs was defined in Article 15:

“Monitoring the consumption of illicit drugs is carried out in the form of collection, arrangement, processing and providing of information on illicit drugs, consumers of illicit drugs and consequences of the use of illicit drugs for the purpose of ensuring a national information network, the inter-departmentally coordinated collection of data and exchange of information on the national and international levels.

The activities specified in the preceding paragraph shall be carried out by the competent ministries, public institutions and non-governmental organisations. The method of monitoring in the working areas of individual ministries shall be set out in more detail by the competent minister.

Monitoring the consumption of illicit drugs shall be carried out pursuant to the provisions that govern collections of data in the area of health and in accordance with the act that governs the protection of personal data.

For the implementation of the activities specified in the first paragraph of this article, the ministry responsible for health shall organise an illicit drug information unit.

The information unit referred to in the preceding paragraph shall include all competent ministries, public institutions and non-governmental organisations, along with the collections of data in the area of illicit drugs which they have available.”

With the Health Minister Order (no. 5809-2/01, dated March 8, 2001) Informational Unit for Drugs was formally established at the Institute of Public Health of the Republic of Slovenia.

It is considered as a Focal Point and a central unit for drug data collection.

### 3. Sources of information

#### 3.1. Epidemiology

The most important sources for epidemiological drug data are:

- **Institute of Public Health of the Republic of Slovenia with its nine Regional Institutes**

Some data are routinely reported by means of health statistics: hospital admissions, viral hepatitis B (but not data on drug related cases), AIDS, causes of death and data on school survey.

Reporting system according to the first treatment demand indicator is not completely established yet. Only data from CPTDAs are available.

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- **The Ministry of Health**

Various data on CPTDAs and Centre for Treatment of Drug Addiction are available at the ministry.

- **The Ministry of Internal Affairs**

Information on police arrests, quantities of illicit drugs seized, prices of illicit drugs and drug related deaths could be drawn from the data.

- **The Ministry of Justice** - prison data

- **The Ministry of Labour, Family and Social Affairs**

Social care treatment data are available on drug users.

- **Aids Foudation Robert and Stigma**

Data on needle exchange and outreach are available.

- **DrogArt** - Slovenian Association for drug related harm reduction

Data on ATS and dance drugs.

- **The Sound of Reflection Foundation**

Data on Conferences, manuals, counselling services...

### **3.2. Demand reduction**

Information about demand reduction is primarily available at the Governmental office for Drugs since the president was also DDRP coordinator. The ministries possess information on DDR relevant to their sector.

At the regional level information on DDR can be found at the local action teams and in regional Public Health Institutes.

In the town of Ljubljana relevant information is gathered at the Drug Prevention Office.

### **3.3. Documentation centres**

There is no separate drug documentation centre in Slovenia. The documentation where most of the relevant drug information can be found is INDOK Centre at the Institute of Public Health.

A lot of information and publications are available also at the Governmental Office for Drugs, where the drug documentation centre is being established.

Slovenia is reporting to several international organisations on regular and occasional basis. UNDCP questioners are completed, reports to international organisations such as Phare and Pompidou Group are prepared. Police is reporting to INTERPOL and EUROPOL. According to international cooperation in specific projects reports are prepared.

There is no common report, covering all structures and activities, that could be used as a national report.

## ANEX 3

### List of Abbreviations

ATS	Amphetamine type stimulants
BKA	Federal Criminal Police Office of Germany (Bundeskriminalamt)
CPTDA	Centres for the Prevention and Treatment of Drug Addiction
CEECs	Convergence of the Central and Eastern European Countries
CEI	Central European Initiative
DDR	Drug Demand Reduction
DIS	Drug Information System
DTD	Drug treatment Demand
EMCDDA	European Monitoring centre for Drugs and Drug Addiction
ESPAD	European School Project on Alcohol and Drugs
EU	European Union
EUROPAD	European Opiate Addiction Treatment Association
FBI	Federal Bureau of Investigations of United States of America
FP	Focal Point
FTD	First Treatment Demand
HPS	Health Promoting Schools
ICD	International Code of Diagnoses
IDU	Injecting Drug Users
ILEA	International Law Enforcement Training Academy (FBI)
ILO	International Labour Organisation
ISAM	International Society of Addiction Medicine
LAT	Local Action Team
MEPA	Middle European Police Academy
MMP	Methadone Maintenance Program
MSM	Man who had Sexual contact with Man
NGO	Non - governmental Organisation
PG	Pompidou Group
PHI	Public Health Institute of Slovenia
REITOX	European Information network on Drugs and Drug Addiction (Réseau Européen d'Information sur les Drogues et les Toxicomanies)
SNHPS	The Slovene Network of Health Promoting Schools
Ur. list	National Gazette
UNDCP	United Nations International Drug Control Programme
WHO	The World Health Organisation

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## ANEX 6

### List of Institutions

<b>AIDS Fondacija Robert</b>	Wolfova ulica 8 1000 Ljubljana
<b>AMOS – Akademsko katoliško združenje</b>	Koroška cesta 1 2000 Maribor
<b>AN-AN Žiga in Cuderman d.n.o.</b>	Celovška cesta 79 1000 Ljubljana
<b>ARS VITAE PTUJ</b>	Trstenjakova ulica 5a 2250 Ptuj
<b>B &amp; Z d.o.o. (inženiring za izobraževanje, svetovanje in raziskave)</b>	Grablovičeva ulica 1 1000 Ljubljana
<b>Center za socialno delo Ilirska Bistrica</b>	Levstikova ulica 3 6250 Ilirska Bistrica
<b>Center za socialno delo Izola</b>	Pittonijeva ulica 2 6310 Izola
<b>Center za socialno delo Kamnik</b>	Ljubljanska cesta 1 1240 Kamnik
<b>Center za socialno delo Kranj</b>	Slovenski trg 1 4000 Kranj
<b>Center za socialno delo Ljubljana Bežigrad</b>	Podmilščakova ulica 20 1000 Ljubljana
<b>Center za socialno delo Ljubljana Moste – Polje</b>	Alternative – Prizadevanja, povezana s težavami zaradi uporabe drog Kersnikova ulica 4 1000 Ljubljana
<b>Center za socialno delo Ljubljana Moste – Polje</b>	Svetovalnica Fužine – projekt Korak Preglov trg 15 1000 Ljubljana
<b>Center za socialno delo Ljubljana Vič – Rudnik</b>	Tržaška cesta 2 1000 Ljubljana
<b>Center za socialno delo Logatec</b>	Tržaška cesta 13 1370 Logatec
<b>Center za socialno delo Murska Sobota</b>	Slovenska ulica 44 9000 Murska Sobota
<b>Center za socialno delo Piran</b>	Župančičeva ulica 24 6330 Piran
<b>Center za socialno delo Sežana</b>	Kosovelova ulica 4b 6210 Sežana

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<b>Center za socialno delo Šmarje pri Jelšah</b>	Celjska cesta 12 3240 Šmarje pri Jelšah
<b>Center za socialno delo Tolmin</b>	Cankarjeva ulica 6 5220 Tolmin
<b>Center za socialno delo Tržič</b>	Predilniška cesta 16 4290 Tržič
<b>Društvo anonimnih alkoholikov (skupnost AA)</b>	Podmilščakova ulica 14 1000 Ljubljana
<b>Društvo "Projekt Človek"</b>	Malenškova ulica 11 1000 Ljubljana
<b>Društvo Smisel življenja Postojna</b>	Tržaška cesta 36 7000 Postojna
<b>Društvo staršev za pomoč mladini</b>	Ulica Savinjske čete 4 3310 Žalec
<b>Društvo za pomoč in samopomoč na področju zasvojenosti "Zdrava pot" Maribor</b>	Rožnodolska ulica 34 2000 Maribor
<b>Društvo za pomoč mladim "Korak naprej"</b>	Zdravstvena postaja Beltinci Cvetno naselje 1 9231 Beltinci
<b>Društvo za pomoč odvisnikom in njihovim družinam "PO MOČ" Sežana</b>	Ulica 1. maja 1 6210 Sežana
<b>Društvo za preventivno delo</b>	Tržaška cesta 2 1000 Ljubljana
<b>Društvo za rehabilitacijo in preventivo Krma</b>	Cesta maršala Tita 65 4270 Jesenice
<b>Društvo za razvoj in izvajanje povezovanja na prijaznejši osnovi Zarja</b>	Meškova ulica 2 2380 Slovenj Gradec
<b>Febris d.o.o.</b>	Ambulanta za preprečevanje in zdravljenje odvisnih od prepovedanih drog Kolodvorska cesta 24 6257 Pivka
<b>Freeart d.n.o. (Techno duhec)</b>	Slovenska cesta 29 1234 Mengeš
<b>Fundacija "Z glavo na zabavo"</b>	Koseška cesta 8 1117 Ljubljana
<b>Gimnazija Piran</b>	Spodbujanje socialnega učenja Bolniška ulica 11 6330 Piran
<b>Inštitut za sodno medicino Medicinske fakultete Univerze v Ljubljani</b>	Korytkova ulica 2/III 1000 Ljubljana
<b>Inštitut za varovanje zdravja RS</b>	Trubarjeva cesta 2 1000 Ljubljana



<b>Izobraževalno društvo za pomoč odvisnikom "Šterna"</b>	Župančičeva ulica 6 6000 Koper
<b>Jona – Društvo mladih kristjanov</b>	Skupnost Canacolo Trg sv. Mavra 4 6310 Izola
<b>Karitas Portorož</b>	Cvetna pot 4 6320 Portorož
<b>Mestna občina Ljubljana, Urad za preprečevanje zasvojenosti</b>	Resljeva ulica 18 1000 Ljubljana
<b>Mestna občina Velenje</b>	Medobčinska lokalna akcijska skupina (LAS) za preprečevanje zasvojenosti z drogami v Mestni občini Velenje, občini Šoštanj in občini Šmartno ob Paki Titov trg 1 3320 Velenje
<b>Mladinski center dravinjske doline (MCDD)</b>	Celjska cesta 16 3210 Slovenske Konjice
<b>Mladinsko informativno svetovalno središče Slovenije – MISSS</b>	Kunaverjeva ulica 2 1000 Ljubljana
<b>Občina Jesenice</b>	Lokalna akcijska skupina (LAS) Ulica maršala Tita 78 4270 Jesenice
<b>Občina Kočevje</b>	Lokalna akcijska skupina (LAS) Ljubljanska cesta 26 1330 Kočevje
<b>Občina Kranjska Gora</b>	Lokalna akcijska skupina (LAS) Kolodvorska ulica 1a 4280 Kranjska Gora
<b>Občina Rogaška Slatina</b>	Mladinske delavnice Izletniška 2 3250 Rogaška Slatina
<b>Občina Slovenske Konjice</b>	Lokalna akcijska skupina (LAS) Stari trg 29 3210 Slovenske Konjice
<b>Osnovna šola Lucija</b>	Uspešnost v šoli in razvoj pozitivne samopodobe in Srečanja s starši Fazan 1 6320 Portorož
<b>Osnovna šola Sečovlje</b>	Svetloba, zdravje, mladost Sečovlje 78 6333 Sečovlje

<b>"Ptica" – Društvo za mlade Zasavje</b>	Novi dom 4 1430 Hrastnik
<b>Preobrazba - zasebna psihiatrična ordinacija</b>	Zasavska cesta 42 1231 Ljubljana-Črnuče
<b>Psihiatrična klinika Ljubljana</b> <b>Klinični oddelek za mentalno zdravje</b>	Center za zdravljenje odvisnih od prepovedanih drog Zaloška cesta 29 1000 Ljubljana
<b>Psihiatrična klinika Ljubljana</b> <b>Klinični oddelek za mentalno zdravje</b>	Enota za zdravljenje odvisnih od alkohola Poljanski nasip 58 1000 Ljubljana
<b>Sana Vita Zavod Ljubljana</b>	Masarykova cesta 23 1000 Ljubljana
<b>Svetovalni center za otroke, mladostnike in starše</b>	Gotska ulica 18 1000 Ljubljana
<b>Svit – Društvo za pomoč odvisnikom in njihovim družinam</b>	Župančičeva ulica 6  6000 Koper
<b>Športna unija Slovenije</b>	Veter v laseh, s športom proti drogi Tabor 14 1000 Ljubljana
<b>Timotej – Ptuj, Društvo za izboljšanje kvalitete življenja</b>	Aškerčeva ulica 4  2250 Ptuj
<b>"Up" – Društvo za pomoč zasvojenecem in njihovim svojcem Slovenije</b>	Miklošičeva cesta 16  1000 Ljubljana
<b>Ustanova "Odsev se sliši"</b>	Svetovalnica Gornji trg 24 1000 Ljubljana
<b>Konoplja.org (www.konoplja.org)</b>	Mariborska ulica 2 3000 Celje
<b>Zavod Janeza Smrekarja, OE Skala</b>	Skala – mladinska ulična vzgoja Rakovniška ulica 6 1000 Ljubljana
<b>Zavod Pelikan – karitas</b>	Litijska cesta 24 1000 Ljubljana
<b>Zavod Vir – Preprečevanje odvisnosti in rehabilitacija uporabnikov drog</b>	Gregorčičeva ulica 6  3000 Celje
<b>Zavod za zdravstveno varstvo Celje</b>	Ipavčeva ulica 18 3000 Celje
<b>Zavod za zdravstveno varstvo Kranj</b>	Gospodsvetska ulica 12 4000 Kranj
<b>Zavod za zdravstveno varstvo Ljubljana</b>	Zaloška cesta 29 1000 Ljubljana

<b>Zavod za zdravstveno varstvo Maribor</b>	Center za preprečevanje odvisnosti Ljubljanska ulica 4 2000 Maribor
<b>Zavod za zdravstveno varstvo Murska Sobota</b>	Ulica arhitekta Novaka 2b 9000 Murska Sobota
<b>Zavod za zdravstveno varstvo Nova Gorica</b>	Kostanjeviška cesta 16 a 5000 Nova Gorica
<b>Zavod za zdravstveno varstvo Ravne na Koroškem</b>	Ob Suhi 11 a 2390 Ravne na Koroškem
<b>Zdravstveni dom Brežice</b>	Center za preprečevanje in zdravljenje odvisnosti od prepovedanih drog Černelčeva cesta 8 8250 Brežice
<b>Zdravstveni dom Celje</b>	Center za preprečevanje in zdravljenje odvisnosti od prepovedanih drog Gledališka ulica 4 3000 Celje
<b>Zdravstveni dom dr. Adolfa Drolca Maribor</b>	Center za preprečevanje in zdravljenje odvisnosti od prepovedanih drog Ulica talcev 9 2000 Maribor
<b>Zdravstveni dom Ilirska Bistrica</b>	Ambulanta za preprečevanje in zdravljenje odvisnosti od prepovedanih drog Gregorčičeva cesta 8 6250 Ilirska Bistrica
<b>Zdravstveni dom Jesenice</b>	Ambulanta za preprečevanje in zdravljenje odvisnosti od prepovedanih drog Cesta maršala Tita 65 4270 Jesenice
<b>Zdravstveni dom Jesenice</b>	Mentalno higienski dispanzer Cesta maršala Tita 78 4270 Jesenice
<b>Zdravstveni dom Koper</b>	Center za preprečevanje in zdravljenje odvisnosti od prepovedanih drog Santorijeva 9 6000 Koper
<b>Zdravstveni dom Kranj</b>	Center za preprečevanje in zdravljenje odvisnosti od prepovedanih drog Gospodsvetska ulica 9 4000 Kranj

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<b>Zdravstveni dom Ljubljana, OZV enota Center</b>	Center za preprečevanje in zdravljenje odvisnosti od prepovedanih drog Metelkova ulica 9 1000 Ljubljana
<b>Zdravstveni dom Logatec</b>	Center za preprečevanje in zdravljenje odvisnosti od prepovedanih drog Notranjska ulica 2 1370 Logatec
<b>Zdravstveni dom Murska Sobota</b>	Center za preprečevanje in zdravljenje odvisnosti od prepovedanih drog Grajska ulica 24 9000 Murska Sobota
<b>Zdravstveni dom Nova Gorica</b>	Center za preprečevanje in zdravljenje odvisnosti od prepovedanih drog Rejčeva ulica 4 5000 Nova Gorica
<b>Zdravstveni dom Novo mesto</b>	Center za preprečevanje in zdravljenje odvisnosti od prepovedanih drog Kandijska cesta 4 8000 Novo mesto
<b>Zdravstveni dom Piran – Lucija</b>	Center za preprečevanje in zdravljenje odvisnosti od prepovedanih drog Cankarjevo nabrežje 9a 6330 Piran
<b>Zdravstveni dom Sežana</b>	Center za preprečevanje in zdravljenje odvisnosti od prepovedanih drog Partizanska cesta 24 6210 Sežana
<b>Zdravstveni dom Trbovlje</b>	Center za preprečevanje in zdravljenje odvisnosti od prepovedanih drog Rudarska cest 12 1420 Trbovlje
<b>Zdravstveni dom Tržič</b>	Ambulanta za preprečevanje in zdravljenje odvisnosti od prepovedanih drog Blejska cesta 10 4290 Tržič
<b>Zdravstveni dom Velenje</b>	Center za preprečevanje in zdravljenje odvisnosti od prepovedanih drog Vodnikova cesta 1 3320 Velenje

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<b>Združenje DrogArt</b>	Kolodvorska ulica 20 1000 Ljubljana
<b>Zveza društev na področju drog</b>	Sketova ulica 5 1000 Ljubljana
<b>Zveza društev prijateljev mladine Jesenice</b>	Pod gozdom 2 4270 Jesenice

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*Source: Governmental Office for Drugs*

## **ANEX 7**

### **Standardised Epidemiological Tables**