



**Institute of Public
Health of the
Republic of Slovenia**



**REPORT TO THE EMCDDA
BY THE REITOX NATIONAL FOCAL
POINT
THE REPUBLIC OF SLOVENIA
DRUG SITUATION 2001**

NOVEMBER, 2002

REITOX

INSTITUTE OF PUBLIC HEALTH OF THE REPUBLIC OF SLOVENIA

Ljubljana, November 2002

Published by:
Institute of Public Health of the Republic of Slovenia

For the publisher:
Andrej Marušič

Printed by:

Edition:
? copies

Lector:
Murray Bales

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Introduction

This is the second time the REITOX Focal Point at Institute of Public Health of the Republic of Slovenia presents its annual Report on the Drug Situation drawn up for the European Monitoring Agency for Drugs and Drug Addiction (EMCDDA).

A Drug Information System has been developing in Slovenia since 1991 in agreement with the Pompidou Group methodology and the Phare Programme.

A decision was taken at ministerial level in 1994 whereby the Ministry of Health would act as the Slovenian Focal Point, co-operating with the Institute of Public Health of the Republic of Slovenia in strait connection with epidemiological approach. The current legal basis is found in the Act on Preventing Drug Consumption and Treating Drug Addicts (Official Gazette 98/99). The Minister of Health issued an order in March 2001 establishing the Information Unit for Illegal Drugs, whose main part is constituted by the National Focal Point for cooperation with the EMCDDA. The NFP is located at the Slovenian National Institute of Public Health within the Ministry of Health. The Phare Project 'Strengthening of the national REITOX Focal Point and strengthening the drug-supply reduction and drug-demand reduction programmes in Slovenia' is recognised as a facilitating phase of co-operation with the EMCDDA and REITOX.

Slovenia is participating in several international programmes and co-operating with several international organisations dealing with drug issues. International co-operation has played an important role in facilitating certain activities such as realising harm-reduction approaches. It has also provided knowledge and international experience to our experts. Although international co-operation has clearly influenced drug policy in Slovenia, all the programmes and measurements have been adapted to national circumstances. Drugs, organised crime and money laundering are considered a serious international problem. Efficient supply reduction will no longer be possible without closer co-operation among prosecuting authorities in all European countries.

PART 1
NATIONAL STRATEGIES:
INSTITUTIONAL & LEGAL FRAMEWORKS

1. Developments in Drug Policy and Responses: Milan Krek, Matej Košir

1.1. Political framework in the drug field

The main objective and priority at the national level in 2001 was the preparation of a new national strategy and national action plan in the field of illicit drugs. The Government Office for Drugs was responsible for co-ordination with regard to joint preparation of the draft version of the national strategy by different competent ministries, non-governmental organisations, experts and others. The new strategy is based on a balance of different approaches, and the co-ordination of activities at the national, regional and local levels. The network of programmes in the field of prevention, treatment and social reintegration was improved. Control over the trade in illicit drugs, precursors and money laundering was also improved. At the national level, the main co-ordinating bodies in the field of illicit drugs were the Government Commission for Drugs, the Government Office for Drugs and the inter-ministerial law enforcement commission. The main holders at the local level were Local Action Groups.

The permanent and ongoing evaluation of programmes co-financed through the national budget was introduced in 2001. A comprehensive information system in the area of illicit drugs came with the foundation of the Information Unit for Illegal Drugs within the Institute of Public Health of the Republic of Slovenia and the Documentation Centre within the Government Office for Drugs. Slovenia applied for admission to the EMCDDA.

The methodology of forming an action plan was introduced in 2001, involving the wide co-operation and participation of many experts, practitioners and drug users. The Government laid great stress on research and studies. The trade and use/abuse of synthetic illicit drugs was included in a draft version of the national strategy as a very important part. Slovenia was included in the joint early warning system in the sphere of synthetic illicit drugs in the EU. Slovenia became a member of Europol in 2001.

The Minister of Health took a new initiative in the field of alcohol policy. He announced rigorous measures against excessive alcohol use, especially among young people.

1.2. Legal framework

There were no changes in laws in the area of drug demand, supply, precursors and drug-related money laundering. The legislation here remained the same without any changes. For previous data, please see the National Report 2001. GHB was put on the list of illicit drugs in 2001 pursuant to the List of Illicit Drugs Decree (Official Gazette, RS 49/01). The Government Office for Drugs, the Ministry of the Interior and the Ministry of Health took the initiative to adapt the law on precursors to the new EU standards.

Slovenia accepted a new approach in the area of detecting drivers under the influence of illicit drugs. Traffic police officers were educated for more efficient work here. The Government Office for Drugs prepared a proposal for how to regulate the granting of driving licences to methadone substitution patients.

Draft provisions on the cultivation of cannabis for industrial purposes were introduced in 2001.

Provisions on conditions for organising rave parties were adopted in 2001. The following measures were taken: a proper air conditioning system, security for the building, prevention of bringing in drugs, ensuring clean and cold water, a sufficient number of medical doctors and mobile equipment for first aid, a separate cooling area/rooms and a separate room for the medical team in the event of any complications etc.

Provisions on the treatment of drug addicts in prisons were adopted in 2001.

1.3. Implementation of laws

There were no changes in prosecution policy in 2001. The judicial authorities had warned the Government Office for Drugs and competent ministries on difficulties in implementing the Production of and Trade in Illicit Drugs Act. The law provides alternative punishment for minor offences in institutions defined by Council for Drugs (within the Ministry of Labour, Family and Social Affairs) and the Health Council (within the Ministry of Health). The fact is that these ministries have not yet defined the institutions competent for alternative punishment.

1.4. Developments in public attitudes and debates

The Government Office for Drugs organised roundtables together with some faculties and colleges (Faculty of Social Science, Faculty of Arts, College of Police and Security) and professional associations (Slovenian Political Science Association and Association of Journalists). The aim of those roundtables was to perceive as many different aspects as possible in the period of preparing the national strategy. There was a relatively good response in the mass media. The Government Office for Drugs improved its active work with the media.

Public attitudes regarding drug use/addiction or drug users/addicts improved, but they are still subject to stigmatisation and fear, especially among local people in areas where the treatment programmes are supposed to be established.

Most people participating in the 'Delo' daily newspaper's public survey expressed their views against the legalisation of cannabis, but the sample was not representative. Some student groups and NGOs were founded to promote the legalisation or decriminalisation of cannabis. The public discussion on the decriminalisation of drug users was also strengthened in 2001. A member of the Dutch parliament Mr. Dittrich gave a lecture about Dutch drug policy at the Faculty of Social Science.

1.5. Budget and funding arrangements

The funding arrangements for law enforcement were divided among the Ministry of the Interior (police), the Ministry of Finance (customs) and the Ministry of Justice (especially for administering the carrying out of criminal law sanctions). The budget for social and health care was divided among the Ministry of Labour, Family and Social Affairs (programmes of social rehabilitation) and the Ministry of Health (centres for preventing and treating drug addiction, methadone substitution treatment etc.). The budgets for research and international activities were divided among all competent ministries and the Government Office for Drugs. Funding of the preparation of the National Strategy and co-ordination between competent ministries, non-governmental organisations, local action groups etc. was entirely the responsibility of the Government Office for Drugs. The total budget in the field of illicit drugs in Slovenia in 2001 was approximately EUR 6.74 million. In percentage shares, funding for illicit drug programmes and projects in 2001 was divided among the Ministry of Health and the Health Insurance Company (55.2%), the Ministry of Labour, Family and Social Affairs (13.0%), the Ministry of the Interior (10.4%), the Ministry of Finance (6.8%), the Government Office for Drugs (6.2%), local communities (municipalities) (5.2%), the Ministry of Education, Science and Sport (2.4%), the Ministry of Justice (0.5%) and the PHARE (Twinning) programme (0.3%). The Government Office for Drugs supported the association of non-governmental organisations in the amount of EUR 20,000.

Many programmes and projects (especially those led by NGOs) were co-financed by donors and sponsors from the private sector and through international tender calls. The majority of local programmes and projects were co-financed by local governments (i.e. purchasing the houses for treatment programmes etc.) and the national budget through many tender calls announced by competent ministries and government offices.

Notes of the editors:

*On the basis of the Act on production of and trade in narcotic drugs and psychotropic substances (Official gazette RS 108/99, 44/00) **The Regulation on Terms and Proceedings to Issue Permissions for the Export and Import of Drugs** was prepared (Official gazette RS 8/02).*

1.6. Police activities in drafting legislation in the area of illicit drugs: Ljubo Pirkovič, Boris Novak, Rajko Kozmelj

In 2001 the Criminal Police Directorate of the General Police Directorate, within the framework of the project of modifying substantive penal legislation, proposed a change to provisions of Article 196 of the Penal Code, incriminating the unlawful manufacture of and trade in illicit drugs, and of Article 197 of the Penal Code, incriminating the rendering of an opportunity to consume illicit drugs.

The proposed amendments involve the introducing into both articles of the Penal Code definitions of individual criminal actions that would represent aggravated circumstances of their perpetration. Such aggravated circumstances could be a specific object of protection (for example, selling illicit drugs to children and minors), the status of the person dealing with illicit drugs (for example, a teacher or person employed in a penitentiary institution etc) or other objective or subjective circumstances. If the proposed modifications were to be introduced in the Penal Code, this would of course entail an increase in penal sanctions for such aggravated forms of perpetration of these criminal offences.

Among the more important modifications to legislation regulating the field of illicit drugs we should also mention that at present **Rules on Conditions to Acquire a Hemp Cultivation Permit** are being drafted.

In Slovenia, the manufacture of and trade in illicit drugs are regulated by the Act on Manufacture of and Trade in Illicit Drugs (Official Gazette of the Republic of Slovenia, no. 108/99), Article 9 of which states that 'more detailed conditions for the acquisition of a permit for hemp cultivation are prescribed by the minister competent for agriculture, in agreement with the minister competent for health and the minister competent for the interior'. Considering the fact that at the moment Slovenia does not have any rules to regulate this field in more detail, these rules would specify the following:

- conditions and procedure for the acquisition of a permit to cultivate hemp;
- the cultivating permit; and
- data that a producer must provide to the competent institutions in order to acquire the permit.

These draft rules also include an annex entitled 'Method of Sampling Hemp Plants for THC content analysis'.

Further, it should be mentioned that in 2001 an initiative was given to introduce provisions to the National Programme in the Field of Illicit Drugs to regulate the possibility to provide, by applying positive legislation, that property seized in procedures against persons dealing with illicit drug abuse can be used for preventive and other programmes aimed at reducing illicit drug abuse and eliminating its consequences.

PROJECTS

Phare Synthetic Drugs Project - First Phase

In the framework of the PHARE Synthetic Drugs Project the following activities were carried out:

1. Regional workshop on introduction of the Early Warning System

Main objective: earlier identification of new synthetic drugs

This provided an occasion to get to know more about the Early Warning System for New Synthetic Drugs.

2. Basic training on synthetic drugs and precursors

Main objective: reduced clandestine production and reduced trafficking in illicit synthetic drugs

A four-day basic training session on synthetic drugs and precursors was organised to give health inspectors, police officers and customs officers fundamental knowledge of synthetic drugs and precursors with the aim to become more efficient in implementing the new Precursor Act and to reinforce methods and ways of combating illicit production and trafficking in synthetic drugs.

3. Study visit to the forensic laboratory in Wiesbaden (BKA) - CAPE Project

Main objective: strengthening the capacity of the police laboratory to test and identify synthetic drugs

The subject of the visit was synthetic-drug profiling and CAPE Analysis, respectively. In addition, the visit is helping to create the conditions for upgrading existing expert co-operation with this laboratory at BKA.

4. Special training course for combating clandestine synthetic drug laboratories

Main objective: strengthening law enforcement capacity in the fight against illicit manufacture and trafficking in synthetic drugs

The course was carried out in accordance with the programme developed by Europol in co-operation with EU member-states. Types of clandestine laboratories, the locations of clandestine labs, preservation of clandestine lab evidence, clandestine lab hazards and safety measures, chemical disposal and the environment are subjects in which the Slovenian police and customs are very interested. This was the first training session to deal with clandestine labs in which Slovenian customs and police participated.

5. Study visit to the regulatory and inspection authorities in Germany

Main objective: reinforced control of legally manufactured synthetic drugs

A four-day visit of three representatives of the Ministry of Health at relevant regulatory and inspection authorities in EU member-countries was carried out. Reflecting the different responsibilities involved, the Slovenian delegation was composed of representatives of the Health Inspection, Agency for Medical Products and Department for Drugs.

We believe that the objectives envisaged were fully met through the abovementioned activities.

Phare Precursors Project - Fifth Phase

The fifth phase of the PHARE-Precursors Project started with an inaugural meeting in Brussels at which we drew up a draft list of activities to be carried out in Slovenia in the following two-year period with a view to establishing an efficient system of precursor traffic control. Planned and accomplished activities in the framework of this project are as follows:

National workshop - a two-day workshop aimed at reviewing Slovenian legislation on precursors and its alignment with the legislation in force in the EU. The workshop was attended by decision-makers in competent authorities who make proposals for the provisions of acts and implementing regulations, prescribe special rules of control and also carry out control over traffic in precursors.

Inter-agency workshop - a two-day workshop where were included decision-makers in the authorities competent for controlling precursor traffic. The purpose of the workshop was to determine ways of co-operating and exchanging information between authorities competent for precursor control.

Awareness-raising seminar - a two-day seminar attended by decision-makers from competent authorities and representatives of the chemical industry and trade. The purpose of the seminar was to introduce to representatives of the chemical industry the importance of co-operating with the competent authorities, with a view to preventing the diverting of chemicals for illegal purposes.

Train-the-trainers course - a five-day training session which was attended by people who had already participated in previous training programmes and will, in the future, train the staff responsible for exercising control over precursor traffic - health inspectors, police officers, criminal investigators, customs officers.

Awareness-raising seminar for health inspectors which took place in June 2001.

A four-day basic training on synthetic drugs and precursor was organised to give health inspectors, police officers and customs officers basic knowledge of synthetic drugs and precursors, with the aim to become more efficient in implementing the new Precursor Act and to reinforce methods and means in combating illicit production of and trafficking in synthetic drugs.

Slovenia received enormous help with the precursors project in the legislative field and in introducing efficient control of precursors traffic for all competent authorities. A review and comparison of the Slovenian Precursors Act with the EU legislation and the very precise written analysis given by the PHARE legislation expert will contribute to the Act being amended. During Phase V we were very well informed about all novelties and changes adopted within the EU.

All forms of training and technical assistance we received during the PHARE Precursors programme form the basis for the efficient continuation of future work in the area field of precursors.

PART 2
EPIDEMIOLOGICAL SITUATION

2. Prevalence, Patterns and Developments in Drug Use

2.1. Main developments and emerging trends: Eva Stergar

Due to lack of financial resources Institute of Public Health of the Republic of Slovenia has not been able yet to carry out the general population survey on drug use in general population. The only available data on drug use in general population are from 1994 and 1999 deriving from Slovenian opinion pool.

In 1994 4,3% (5,3% men, 3,4% women) of the representative sample of inhabitants of the Republic of Slovenia (age 18+) stated they have ever used one or more of the following drugs: marijuana/hashish, cocaine, heroin, LSD, mescaline. In 1999 the data were as follows:

Table 2.1.1. *Prevalence of illegal drug use in 18+ population, 1999*

DRUGS	YES		NO		TOTAL	MISSING
	n	%	n	%	n	n
MARIJUANA	82	8,8	854	91,2	936	76
HEROIN	6	0,6	923	99,4	929	83
COCAINE	7	0,8	922	99,2	929	83
AMPHETAMINES	4	0,4	925	99,6	929	83
LSD/HALLUCIN.	8	0,9	921	99,1	929	83
ECSTASY	13	1,4	916	98,6	929	83
SEDATIVES N.P.	21	2,3	909	97,7	930	82
ALCOHOL+PILLS	12	1,3	916	98,7	928	84
DRUGS BY INJ.	1	0,1	928	99,9	929	83

Source: Slovenian Public Opinion Pool

98 (10,6%) out of 928 persons who answered the question have used one or more of mentioned illegal drugs. Majority of those who have tried marijuana in their lifetime have tried heroin, cocaine, LSD and ecstasy, too. In marijuana users significant differences were found according to age and gender. Those of age 18 - 29 and 30 - 39 more often answered they used marijuana. Men were more often marijuana users.

2.2. Drug use in the population

a) Main results of surveys and studies

1. There are no data on drug use in the population 18+ available for 2001. The last wave of ESPAD, covering school population of age 15 - 16, was done in 1999, the next will go on in 2003. (Eva Stergar)

2. Characteristics of heroin use in Slovenia: Vito Flaker

(The follow information is done on the base of the research started in end of 1998 as part of the research project on Harm reduction in Slovenia, which was a part of a regional project of Phare's Technical Assistance to Drugs Demand Reduction and was concluded in the end of 1999 (Flaker *et al.*, 1999) and on the later research work of the research team (Flaker, 2002).)

Number of users. On the basis of users and treatment professionals estimates of number of users in Ljubljana and surroundings, comparing these with numbers of treated users and numbers of users in the syringe exchange programmes and having observed the drug related crime and health statistics in other regions of Slovenia we came to the estimate of 9.000 intravenous heroin users and approximately not less than 15.000 and not much more than 18.000 regular but not necessarily intravenous users in Slovenia. Which makes about 4% of total population between 15 and 30 years.

Age. The age of users ranges between 15 and 50 years. Most users are between 20 and 30 years old. The impression is that the average age of beginners has fallen recently since the average age of users the methadone treatment has dropped from 26.9 in 1995 to 25.5 in 1997 (Kostnapfel Rihtar, 2000), and in needle exchange programme from 26 to 23 years (Kocmur, 1999). Since the same users have reported a significantly later age of begging (from 16.6 to 17.4), we can discard this impression as being the result of better and wider availability of treatment. Whatever the issue might be, the drug use is definitely and almost exclusively the youth problem.

Gender. Users generally claim that the numbers of male and female users are approximately the same or, on the other hand, that there are more male users. The former statement applies of course to beginners (Dekleva, 1998), while on the basis of the number of returned syringes the conclusion can be drawn that the number of boys is significantly higher among addicted users - ration 1:4 (Kocmur, 1999). Therefore we can conclude that although there are no gender differences among the young experimenting users gender figures as an important vector in embarking on the heavy career, i.e. there are more intravenous male users, they tend to be addicted in greater numbers and the style of use may be more problematic.

Class. Users do occasionally say that more users come from the working class. This corresponds to the data collected by Dekleva (1998). We can assume that the class is only a minor vector on becoming a junky.

Ethnicity. In some locations it appears that there are relatively more immigrants among users and the other way round, in some places the number of immigrant users was relatively lower. However the dealing networks are to a great extent in the domain of the ethnic minorities (Albanians, Montenegrins, Serbs). It may seem that the uprooted ness of the immigrants can make them an easier prey to the use and subsequent junkisation, but at the same time close-knit social network and the youth subculture of the second generation immigrants (called *Čapci*) on some occasions can function as a protection to the culture of drug use.

Geographical location. The drug use is spread evenly in the regions of Slovenia. Heroin use, however tends to be more present in the urban areas, while less present in the rural areas. There are many small towns where the heroin users are present, especially the satellite towns to the cities, but there other small town where the heroin use is not present at all. When examining this phenomenon in two neighbouring towns of the same size, where in one the heroin use was present and the other not, we could account the these differences on the different moments. One had a declining mining industry, was more working class, the other had a strong antiheroine and procannabis youth subculture based on the home production of grass and thus impregnated drug market, with a lot of rock and other youth culture production, while the other less so and with more of a disco scene.

Another feature of rural users of heroin is that they gravitated to the metropolitan areas and hide their use in the home environment.

In the towns we could observe the two types of groupings regarding the geographical distribution: metropolitan and suburban. The former consisting of very loosely connected networks, which included more or less atomised single users, couples or cliques, while the suburban groups retaining more contacts with their non-using peers and being more situated in the local communities.

Family background. Neither our research nor any other known data do not warrant any conclusion regarding the differences in the family structures of people who use drugs, there is no evidence that would seriously point to the users being from single parent families, broken homes etc.

Other characteristics. There were no major social characteristics that would point to different groups. Perhaps we could assume that drug users have to be a bit more adventurous, inclined to experiments or already bit marginalized in order to dare to cross the prohibition line. Dropping out of school might be a part of this process, being hard to determine whether this being a consequence or a cause for a destructive drug using career.

We can conclude that the drug use is a youth phenomenon, radiating from urban areas into the countryside, with minor differences of vulnerability among the class and ethnic groupings but with major difference regarding the gender. The users on other hand perceive themselves as fairly equal as if there are no major structural differences in terms of gender, class, ethnic affiliation, or level of education. In this egalitarian ideology heroin functions as an equaliser. Heroin plays the role of the most important instance, which diminishes the importance of other things in life. Being preoccupied with drug scoring and addiction, heroin rules. In other words, heroin has the function of the ultimate counter-good, the counter-equivalent of money, in short, the fatal equaliser.

b) General population

No new data on studies on drug use in the general population is available. For previous data, please see the National Report 2001.

c) School and youth population:

No new data on studies on drug use in the general population is available. For previous data, please see the National Report 2001.

2.3. Problem drug use: Nuša Konec

National and local estimates, trends in prevalence and incidence

In 2002, no national studies on prevalence estimates, based on methods recommended by the EMCDDA, have been done.

The last one was concluded in 1993 by the National Institute of Public Health and Koper's Centre for the Treatment of Drug Addicts, using snowballing and treatment multiplier methods. As in many European countries, an indicator on prevalence estimates is more or less undeveloped in Slovenia. To get more reliable data on the prevalence of problem drug use, which could help us in building a network of different activities, a group of experts for prevalence estimates was established at the National Focal Point in July 2002. The group involves experts from different governmental institutions and NGOs. There are representatives from: National and Regional Institutes of Public Health, the Slovenian Government Drug Office, the Faculty of Medicine, the Ministry of the Interior, High School of Social Work and the NGO *Aids fondacija Robert*.

The group prepared a programme of activities for 2002. First of all, in autumn an educational course will be organised for all members in co-operation with Austrian Focal Point where methods used in prevalence estimates will be presented.

A twofold strategy then seems to be useful. The first one will focus on carrying out a prevalence estimate study based on the treatment multiplier method in a similar way as the study in 1993. The second will focus on checking possibilities to use routine data for the capture recapture method. The quality of different data should first be verified and ways of improving it should be discussed. Potential data sources available at the moment are: treatment data, drug-related deaths, notifications to the police and data from harm-reduction programmes like needle-exchange programmes.

The situation on prevalence estimates of problem drug use is similar at the regional and local levels. Because there are important differences in the amount and patterns of drug use between regions and communities in Slovenia, more studies should be conducted on this topic in the future. To achieve this, regional Public Health Institutes and Local Action Groups for preventing drug abuse and addiction should be involved in providing and analysing data for prevalence estimates studies. Since there are nine regional Public Health Institutes and about twenty active Local Action groups in Slovenia, we have a strong structure which could be used not only to provide data, but also to provide feedback to the data sources at the local and regional levels.

3. Health Consequences: Dušan Nolimal

Epidemiological indicators concerning drug-related health consequences are essential for scientific comparisons and help explain observed trends in drug use.

The main body of the report on drug-induced health consequences consists of reports based on public health data managed by the Institute of Public Health of Slovenia. It should be noted that in the past there was considerable methodological development of these indicators and data collection within the Pompidou Group Multi-city Network (PGMCN). Slovenia's participation in the PGMCN has delivered valuable experiences and epidemiological information and has been useful for the further development of the five epidemiological key indicators. Thus, the structure for collecting data on drug-related health consequences and the key indicators - drug-treatment demand, drug-related mortality and drug-related infectious diseases - is well established. It should also be noted that the prime objective of the PGMCN in the past was primarily the methodological development of the indicators. Within this objective, not much attention was paid to filling in the gaps where data do not yet exist. Thus, the epidemiology of other drug-related morbidity, including acute and chronic drug effects, is difficult to report as there have been few researches specifically directed at these areas. Also, it should be stressed that the occurrence of a health consequence in a patient with an addiction does not mean the addiction was necessarily the cause. Although the Institute of Public Health is improving the availability and comparability of these indicators and the quality of collected data, much remains to be done.

3.1. Drug-treatment demand: Dušan Nolimal

In Slovenia, the definition of drug-use-related health disorders and drug treatment is not understood merely in terms of medical disorders and interventions, but includes a wide range of disorders and activities aimed at ameliorating the medical, social, psychological and spiritual health who seek help for illicit drug problems. Thus, treatment in the country is based on medical and non-medical structures that are governmental or non-governmental, public or private.

Given addiction is a chronic disorder with a frequent tendency to relapse into active drug taking, drug-treatment demand is determined by many factors and the contribution of each factor to drug-treatment demand is not yet fully identified. More information is available on the connection between injection drug use and (imminent) epidemics of infectious diseases among users. This information urged us to reconsider the traditional addiction treatment and drug-abuse control policies in the early and mid 1990s. It was concluded that, even if the risks associated with illegal drug use are not entirely preventable, proper harm-reduction strategies can considerably reduce them. These approaches have gained increasing support in the last decade, while more conventional psychiatric approaches have appeared ineffective, expensive and counterproductive. There has been considerable progress in the development of medications and the availability of the programme for the treatment of opiate addiction for heroin addicts, as well as maintenance treatment with a long-term-acting opioid such as methadone, have contributed substantially to the growing number of addicted people seeking treatment. The methadone maintenance programmes are the most common examples of harm reduction as an approach to the health care of drug users in Slovenia. Drug-treatment demands increased considerably in the period from 1991 to the 1990s when most of the methadone maintenance programmes were introduced.

The current drug reporting system started in 1992 at the National Institute of Public Health when the collection of treatment-demand data, followed by preparation of a draft version of a Pompidou Group protocol and a questionnaire being introduced to two cities (Ljubljana and Koper). In 1994 the system was extended to the national level with good geographical coverage. Since medical treatment centres were the main source of help and support for drug users, the treatment reporting system was established for the outpatient programmes and the inpatient detoxification centre within the medical structures. Currently, the system covers 18 outpatient centres and the centre for mental health which has outpatient and inpatient units. This system covers about 60% to 70% of all treatment demand in Slovenia. Also, in October 2002 the 12 treatment programmes underway in prisons joined the reporting system on a pilot basis. In 2003 it is expected that the system will be extended to encompass hospital inpatient and outpatient units, therapeutic communities, NGOs, including self-help

groups and programmes for drug users provided within social care facilities. The latter will include 13 big programmes and 20 smaller programmes.

Since the early introduction of the drug-treatment-demand project and the use of the Pompidou Group (PG) Treatment Demand protocol to collect data on drug-treatment demand, the Institute of Public Health and its national partners have made significant efforts to build up the treatment reporting system which is now one of the most successful programmes in the area of drug-reporting systems and is harmonised with the PG/ EMCDDA TDI standard protocol. Some additional questions on sexual risk behaviour (numbers of partners, condom use and promiscuity), HIV and hepatitis infection and criminal behaviour were added to the list of information collected by the PG/ EMCDDA questionnaire. Also, we are collecting more detailed information on injecting-risk behaviour. All data include personal identifiers based on SOUNDEX methodology.

About 1000 questionnaires are collected by the Institute of Public Health every year. Aggregated statistics are published at the national level and feedback is provided to the treatment centres and other data users.

The treatment reporting system has worked successfully within the network of centres for the prevention and treatment of illicit drug use for over seven years. In most of this time we have done our best to improve data quality and the comparability of treatment-demand data and to provide annually descriptive data reports for different cities and for the country. Starting in 2002, a new PG/EMCDDA questionnaire on treatment demands has been introduced and the risk behaviour list of questions has been revised. The data on drug users entering treatment centres for drug addiction represent the basis for planning the activities of these centres. The planners and providers of health care use this information to identify the types of patients opting for specific activities, and to formulate incentives for the treatment of individual sub-groups. Further, the data indirectly show the changing patterns of more problematic drug use among the population. It is therefore necessary to differentiate between data on those users seeking drug-abuse treatment for the first time and those who have already undergone 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 research into the efficacy and cost-effectiveness of drug-abuse treatment.

According to first-treatment-demand data, in the 1996 to 2001 period the most commonly sought treatment was for heroin use (84.8% in 2001) and, to a considerably lesser extent, for other drugs; 1.2% for cocaine; 0.9 for hypnotics; 0.6% for hallucinogens; and 12.7% for cannabis. In recent years, the proportion of cases involving stimulants, hypnotics and cannabis have grown considerably. Problems involving combinations of illicit drugs, alcohol and benzodiazepines are common. Most drug users were male (78.9%). The mean age was 22.2 years. Injection drug use was part of the risk behaviour of half of the heroin users, which is the lowest percentage since 1996 when reliable national data have been available. The share of those currently injecting was 44% and those who have injected at least once in their life was 62.4%. A high, but not increasing, level of injecting drug use is occurring in Slovenia. The injecting behaviour that prevails among at least half treated drug users is associated with a high risk of local infections, necrosis, breakdown of the circulatory system and generalised septicaemia, overdoses and many potentially fatal infectious diseases, such as HIV and hepatitis B and C infections.

The proportion of treated current injectors (those having injected in the last month) reporting sharing needles and syringes during the month prior to treatment has been steadily falling and reached its lowest in 2001, namely 7.2% of all treated drug users covered by the reporting system. In the period from 1996 to 2001 the prevalence of HIV infections has consistently remained below 1% among tested drug users. No upward trends in reported HIV incidence rates and HIV prevalence among treated drug users have been observed.

Activities relating to implementation and improvement of key epidemiological indicators defined by the EMCDDA and Pompidou will be the most important tasks for the future. These joint activities should result in the capacity of the Focal Point to build a more comprehensive and general epidemiological picture.

3.2. Drug-related mortality: Jožica Šelb Šemerl

In April 2002 a working group for a key indicator (8 experts from: Department for mortality research, Police, Forensic Medicine, Toxicological Centre at the University Clinical Centre in Ljubljana, the Slovenian Focal Point and Ljubljana's CPTDA) - Drug-related Mortality - was set up with the main aim to provide accurate data on drug-related mortality from the General Mortality Register and Special Registers.

From April to July 2002 the group met three times to discuss the EMCDDA methodology and our ways of adjusting to it reconsidered. The group also held meetings within the framework of the PHARE Twinning programme.

Within the group the following tasks were discussed:

- a) The legal link between personal mortality data from the General Mortality Register with Special Registers from the police, forensic medicine and CPTDA. We received an answer that for this purpose all requests are met and that we are allowed to link personal data on drug-abuse victims between the police department and medical statistics.
- b) How to start with the education of doctors in charge of filling in death certificates and those who record the underlying cause of death. We agreed that a short course is needed in which topics from forensic medicine and mortality statistics would be covered with a special emphasis on drug abuse victims.
- c) Preparations for meetings within the Twinning project.

In September 2002

- a) Standard tables with preliminary data were prepared and forwarded to the EMCDDA.
- b) A meeting with doctors who record underlying causes of death was held to introduce the EMCDDA methodology for drug-related deaths.
- c) An article about filling in death certificates according to ICD -10 was prepared with a special emphasis on violent deaths and including an example of a drug-related death and sent to 'Zdravniški zbornik', a professional journal for Slovenian medical doctors.
- d) We managed to link the Mortality Register database for 2001 with data on drug-related deaths from the police, forensic medicine, and the first treatment demand database.

As a result of that data linkage, 42 drug-related deaths according to the EMCDDA - DRD methodology were registered. This means 15 deaths more than in 2000 when such a data link was not performed. Because of changed methodology in 2001 we did not calculate time trends.

In 2001 there were 42 drug-related deaths. 36 of them involved men and 6 women. Within men, the mean age at death was 34.3 years, the median 28.5 years and the mode 27.0 year, with the minimum age at death of 17 years and the maximum of 74 (due to cocaine use). Within women, the mean age at death was 32.0 years, the median 27.5 years and the mode 16.0 year, with the minimum age at death of 16 years and the maximum of 69 years (a woman who committed suicide with benzodiazepines).

Within the group of drug-related deaths, according to value 1 of the filter variable there were 27 deaths, 26 of which involved men and 1 woman. Within men, the mean age at death was 23.5 years, the median 27.0 years and mode 25.0 years, with the minimum age at death of 17 years and the maximum of 74 (due to cocaine use). There was only one woman, aged 24 years.

In 2001 there were 10 deaths due to accidental poisoning (DRD 88 to DRD 107). Of these, three were due to heroin, three to morphine and one each to opium, methadone, cocaine and a psychotropic substance. To the eight deaths caused by accidental poisonings of opiate use, we added two opiate or opioide dependency deaths, one methadone death due to intentional poisoning and four poisonings of undetermined intention, meaning a total of 15 deaths due to opiate use. Another four opiate deaths were possible due to multiple drug use. We recorded four deaths due to cocaine use. The other 19 deaths were due to the multiple use of drugs, undetermined drugs, undetermined causes of death, sedatives and psychotropic substances.

Nine deaths were attributed to traffic accidents (Toxicological Laboratory at the Institute of Forensic Medicine of the Medical Faculty in Ljubljana), but these are only numbers for the Ljubljana region. Our group discussed the possibility of study in which people coming to First Treatment Demand Centres would be included and followed. We are planning to start with a cohort study next year or later depending on our human and material resources.

3.3. Drug-related infectious diseases: Irena Klavs

HIV and AIDS

Slovenia has a low-level HIV epidemic. The prevalence of HIV infection has not reached 5% in any population group. The rapid spread of HIV infection seems not to have started yet among injecting drug users. During the period from 1996 to 2001 HIV prevalence consistently remained below 1% among confidentially-tested injecting drug users treated in the network of CPTDA. 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 1995 to 2001 period HIV prevalence among injecting drug users demanding treatment for the first time at 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.

The average annually reported newly diagnosed HIV incidence rate during the last five years (1997 to 2001) has been 6.5 per million of population (8.0 per million in 2001) and a reported AIDS incidence rate of 3.5 per million of population (2.5 per million in 2001). In the same period, the reported newly diagnosed HIV incidence rate among injecting drug users calculated for the total population has remained below 1.0 per million of population (one case in 1997, two in 1998, no cases in 1999, and one case each in 2000 and 2001) and an AIDS incidence rate below 0.5 per million of population (no cases in 1997, 2000 and 2001 and one case each in 1998 and 1999). In contrast to the 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 2001 the prevalence of antibodies against hepatitis B virus (HBV) among confidentially-tested injecting drug users treated within the network of CPTDA ranged between 2.6% to 6.6% (2.6% in 1996, 2.7% in 1997, 4.3% in 1998, 6.6% in 1999, 5.3% in 2000 and 4.9% in 2001). In 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, 3.3% in 2000 and 0% in 2001). Unfortunately, it is impossible to distinguish between the prevalence of antibodies against HBV and the prevalence of current HBV infection (HBsAg). In 2002 data collection has been revised. Information on different HBV infection-markers will be collected (anti HBc, anti HBs, and HbsAg).

During the last 10 years (1992 to 2001) the reported acute HBV infection incidence rate in the Slovenian population fell 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 1997 to 2001 period, information on transmission routes is available for a minority of cases. Injecting drug use was implicated in 0% to 25% of those cases.

HCV

In the period from 1996 to 2001 the prevalence of antibodies against hepatitis C virus (HCV) among confidentially-tested injecting drug users treated in the primary health care network of CPTDA ranged between 20.8% to 30.1% (30.1% in 1996, 21.1% in 1997, 20.1% in 1998, 21.2% in 1999, 20.8% in 2000 and 23.5% in 2001). 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 between 8.2% to 32.1% (32.1% in 1996, 12.7% in 1997, 12.5% in 1998, 13.3% in 1999, 8.3% in 2000 and 8.2% in 2001). Information on the proportion of chronic HCV infections among these individuals is not available.

For the period from 1994 to 2001 the annually reported acute HCV infection incidence rate in the Slovenian population ranged between 0.5/100,000 population in 2001 to 2.6/100,000 population (in 1998 and 2000). Due to underreporting, reported HCV incidence rates greatly underestimate the burden of the disease. For the period from 1997 to 2001 information on transmission routes 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).

3.4. Other drug-related morbidity

Psychiatric comorbidity: Mercedes Lovrečič

Illegal drug use in Slovenia has increased in the last 10 years. Drugs are accessible and the market offers different and mixed drugs. Recently it has become evident that younger patients with mental disorders also abuse illegal drugs and alcohol. From our country, in 2001 two articles were published in order to point out the problems of the sub-group of patients with drug-related problems and comorbid mental illness who need special attention and care.

Drug abuse or dependence and psychiatric comorbidity have recently generated extensive research and clinical interest all over the world. There are several combinations of mental disorders and substance dependence. Sometimes clients seek help due to substance abuse or dependence, sometimes due to mental disorder and the comorbid condition might be unrecognised, especially when there is no close collaboration between mental health services and services for illegal drug treatment programmes.

A recent study found that one-fifth of patients in treatment programmes for drug dependence received additional psychiatric treatment. In methadone maintenance programmes for opioid addicts, the most prevalent comorbid psychiatric diagnoses are: depressive episodes, anxiety disorders and personality disorders. Psychiatric comorbidity is often in correlation with an unfavourable outcome and higher dropouts from treatment programmes. Increased knowledge on the prevalence and appropriate management of comorbid patients is therefore very important for clinicians dealing with patients with substance-use disorders. The increasing incidence and prevalence of comorbidity, unfavourable outcomes and special needs call for an adjusted approach.

The aim of our first survey (Lovrečič *et al.*, 2001) was to verify the interplay of mental disorders in addictive behaviour and to find out the clinical and socio-demographic differences between comorbid patients (substance abuse and mental illness (SAMI)) who sought help in two different settings (psychiatric hospitals (PH) or outpatient methadone clinics (OMC)).

In our survey in two different settings, a relatively large number of SAMI patients was identified. Similar to other studies, our survey supports the view that psychiatric-treatment-seeking individuals represent a mixed population.

In our survey we identified a huge number of SAMI patients seeking psychiatric help in hospitals and in the methadone outpatients' programme. In people seeking help in PH, serious mental illnesses were diagnosed: schizophrenia and bipolar disorders. OMC patients had depressive episodes and anxiety disorders. Half the SAMI patients from the group who seek help in PH were addicted to heroin and abused many other substances as well. Half of the patients abused heroin probably due to self-medication. We can say that those patients are in danger, all could in the future develop an addiction, have a serious mental illness involving delusions, hallucinations, mood symptoms, sleeping problems. The majority of them had legal problems and show aggressive behaviour. Legal problems in SAMI patients are not always a consequence of criminal activity. Many times it is disorganised and violent behaviour that is the source of legal problems.

In OMC all patients were addicted to heroin and abused other psychotropic substances as well.

Due to huge differences in the diagnostic structure and small sample, only a few statistical analyses were possible. Patients in PH seek help or were admitted to hospital after a shorter length of dependence. The severity of psychotic illness acted as a protective factor.

We found huge differences in diagnostic structure, but those differences were not significant when comparing age, age at first use and age of continuous drug use.

On average, those patients were 26 years old, had almost 7 years of drug dependence or abuse, with serious consequences of mental illness and drug-related behaviour. In the near future, we can expect an increased number of SAMI patients. Therefore, in every setting patients must be carefully diagnosed and the abuse of substances managed to prevent the developing of an addiction or, at least when addiction is already present, to reduce the severity of the consequences (22).

The aim of the second study (Lovrecic *et al.*, 2001) was to ascertain the clinical and socio-demographic differences between heroin addicts without (AWC) and with comorbidity (substance abuse and mental illness - SAMI) who seek help at the outpatient service for drug dependence.

This is one of the first studies in Slovenia to explore the clinical and socio-demographic differences between heroin addicts with or without comorbid mental disorders. The most prevalent comorbidities were depression and anxiety disorders, while only one patient had psychosis. We were unable to demonstrate any differences between SAMI and AWC patients in terms of the length of dependence and socio-demographic characteristics. This was probably due to the small sample which limited the scientific weight of the tests. There was a tendency towards more frequent legal problems in AWC patients. This finding is difficult to explain since serious mental illness (psychosis) usually increases legal problems due to disturbing, disorganised or violent behaviour. Emotional symptoms were much more prevalent in SAMI patients. At the same time, SAMI patients more frequently abused sedatives, hypnotics and amphetamines. Both findings are in accordance with Marsden, who more frequently found psychiatric symptoms in polyabusers. All SAMI patients used heroin more than once a day and this was assessed as an automedication of a coexisting mental disorder in almost 40% of them.

The most common psychiatric comorbidities were mood disorders and anxiety disorders. Due to multiple problems, SAMI patients need an intensive treatment approach directed towards managing their special needs. In our sample, SAMI patients more frequently received psychopharmacotherapy and were simultaneously engaged in psychotherapy. A small subgroup of SAMI patients requested detoxification but continued methadone maintenance treatment in our service. SAMI patients were prescribed slightly higher doses of methadone (23).

There is a trend towards more precise evidence-based working practice for the special needs of these subgroups of patients in our service.

Part of one CPTDA (Izola) is specialised in the treatment of dual diagnosed patients.

4. Social and Legal Correlates and Consequences

4.1. Social problems: Peter Stefanoski

Social exclusion

The main starting points for treating difficulties related to illicit drug use in the social care system are defined in the National Social Care Programme up until 2005 (Official Gazette, RS, No. 31/2000).

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

- improvement in the quality of living;
- the assurance of active forms of social care;
- development of expert networks of social assistance;
- establishment and development of the plurality of the activity; and
- design of new approaches to the management of social hardships.

Drug use in the social care system is treated as one of the many behavioural patterns which may lead to a lower level of social inclusion of a drug user or the people close to them. The fact is that drug use represents a behavioural and relational pattern on whose basis the variety of responses to life's everyday 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 relating to drug use.

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

In social care, professional support for drug users and people close to them is directed to the development of individuals and groups in order to control as much as possible 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. processes enabling the social inclusion of individuals and groups within a broader social context. Social care engages in the prevention and elimination of the conditions and actions of individuals and groups which cause their social exclusion (ex-communication, marginalisation, incapacity to exert an influence etc.)

Part of the social context used by the individual when solving their 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 a request for help, this is just one more piece of evidence that this person is 'properly' socially integrated. This is another reason why it is so important that part of the social care system is composed of providers of public service of social care, with the greatest possible evident and standardised offer of professional support. Providers of public services here are the holders of already established and operationalised professional treatments. The network of providers which complements the offer of public services should try to specify the needs of its users even more and to include them more in the planning of the activity intended for them. They enable an even higher level of (re)-organised implemented programmes in accordance with the specific problems of users.

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

Providers of programmes which complement the public service offer are selected through regular annual tenders. Thus, in 2000 thirty organisations were co-financed in the total amount of SIT 142,000,000 and in public institutions (social work centres) 834 individuals were treated whose fundamental problem was related to illicit drug use. In the same year, 496 of them were treated for the first time.

4.2. Drug offences and drug-related crime: Ljubo Pirkovič, Boris Novak, Rajko Kozmelj

Some data on drug related crime are available.

Table 4.2.1. *Arrests for drug-law offences in 2001*

SUBSTANCE	OFFENCE TYPE	
CANNABIS	Drug-related use/possession	4201
	Drug-related dealing/trafficking	418
	Drug-related use and trafficking	279
	TOTAL	4898
HEROIN	Drug-related use/possession	419
	Drug-related dealing/trafficking	259
	Drug-related use and trafficking	62
	TOTAL	740
COCAINE	Drug-related use/possession	72
	Drug-related dealing/trafficking	29
	Drug-related use and trafficking	5
	TOTAL	106
AMPHETAMINES	Drug-related use/possession	50
	Drug-related dealing/trafficking	25
	Drug-related use and trafficking	1
	TOTAL	76
'ECSTASY'	Drug-related use/possession	125
	Drug-related dealing/trafficking	57
	Drug-related use and trafficking	6
	TOTAL	188
LSD	Drug-related use/possession	0
	Drug-related dealing/trafficking	2
	Drug-related use and trafficking	0
	TOTAL	2
BENZODIAZEPINES	Drug-related use/possession	18
	Drug-related dealing/trafficking	0
	Drug-related use and trafficking	0
	TOTAL	18
METHADONE	Drug-related use/possession	52
	Drug-related dealing/trafficking	16
	Drug-related use and trafficking	15
	TOTAL	83
TOTAL	Drug-related use/possession	4352
	Drug-related dealing/trafficking	1140
	Drug-related use <u>and</u> trafficking	397
	TOTAL	5889

Source: Ministry of the Interior

4.3. Social and economic costs of drug consumption:

There are as yet no studies and assessments of the social costs caused by drug use. We are also unable to estimate the consumption, demand and resources spent on drugs.

5. Drug markets: Ljubo Pirkovič, Boris Novak

5.1. Availability and supply

In our estimation, Slovenia is one of the countries with a high level of the presence and abuse of illicit drugs, of illegal traffic in illicit drugs and of the operation of organised criminal groups. This situation also results from the particular influence of nearby economically unstable regions following normalisation of the situation in the Balkans area. All this gives a special character to the perilous situation of our country in area of security, which is directly and indirectly related to illicit drugs.

5.2. Seizures

Table 5.2.1. *Illicit drug seizures in 2001*

YEAR 2001	Unit of measure for quantities	Number	Quantity
Cannabis (total)	Kg	4438	177,46
resin	Kg	60	2,36
leaves	Kg	3952	175,1
plants	Nb	426	1925
Heroin	Kg	*	88,93
Cocaine (total)	Kg	*	1,08
of which Crack	Kg	*	*
Amphetamines	Kg	*	0,06
	(tablets)	*	89
'Ecstasy' (total)	Tablets	*	1852
	(kg)	*	*
LSD	Doses	*	0

Source: Ministry of the Interior

* data not available

5.3. Price and purity

Some information on price is available (standard table 16): 'Price at street level of some illegal substances'.

Some data on purity are available (standard table 14): 'Purity at street level of some illegal substances'.

Table 5.3.1. *Prices of illicit drugs (street level)*

YEAR 2001	Min.	Max.	Average
Price in EUR			
Cannabis resin (per gram)	8	9	8.5
Cannabis leaves (per gram)	2.5	4.4	3.45
Heroin brown (per gram)	35	44	39.5
Heroin white (per gram)	*	*	*
Cocaine powder (per gram)	65	70	67.5
Crack (per rock)	*	*	*
Amphetamine powder (per gram)	*	*	*
'Ecstasy' (per tablet)	6.6	8.8	7.7
LSD (per dose)	7	9	8

Source: Ministry of the Interior

* data not available

6. Drug trends: Sabine Haas, Mercedes Lovrečič

Since no new data is available on surveys or prevalence estimates, the analysis of trends by drugs can mainly only be based on data on treatment demand and drug-related deaths.

Opiates continue to be the most relevant substance with regard to problem drug use. According to first treatment demand data, in the period from 1996 to 2001 the most commonly sought treatment was for heroin use (84.8% in 2001). In 2001 there were 10 deaths due to accidental poisonings (DRD 88 to DRD 107) and most of these were due to opiates: three due to heroin, three to morphine and one each due to opium, methadone, cocaine and a psychotropic substance. To the eight deaths due to accidental poisonings from opiate use, we add two opiate or opioide dependencies deaths, one methadone death due to intentional poisoning and four poisonings of undetermined intention, meaning a total of 15 deaths due to opiate use. Four extra opiate deaths were possible due to multiple drug use. Injection drug use was part of the risk behaviour of half of the heroin users, which is the lowest percentage since 1996 when reliable national data have been available. The percentage of those currently injecting was 44% and those who have injected at least once in their life was 62.4%. A high, but not increasing, level of injecting drug use is found in Slovenia.

Even though no new data is available, we can assume that **cannabis** remains the illegal drug which most people make life time experiences with. In 2001 12.7% of all first treatment demands involved cannabis which means that, after growing in recent years, the proportion of treatment demand for cannabis is now stable. Cannabis was not involved in any of the drug-related death cases reported in 2001.

Synthetic drugs, primarily ecstasy, are the second-most consumed illegal drugs after cannabis and are especially popular among young people. Recent research in the 'party scene' confirmed the high prevalence of ATS drug use amongst this specific group of young people. But this data must be interpreted very carefully since it is not representative of young people in general but just for the specific sub-group of party goers. According to this study, the use of ATS in this sub-group has to be considered problematic due to the frequent and chaotic use of stimulants with a lot of mixing of different drugs. Two cases of death relating to MDMA were reported in Slovenia in 2001.

Research into the party scene (see above) also indicates high levels of **cocaine** use amongst young party goers. Crack use also exists but is at a much lower level. Once again it is important to note that the life time prevalence in representative surveys is very low compared to the data collected in this specific sub-group. The share of first treatment demand related to cocaine is still very limited at just 1.2%. Four drug-related deaths due to cocaine use were reported in 2001.

7. Discussion

7.1. Consistency between indicators: Tatja Kostnapfel Rihtar, Mercedes Lovrečič

No analysis of the relationship between different indicators based on a scientific approach has been published.

For policy planning to be based on relevant research data, greater quality research should be introduced. Implementing the reporting system for different key indicators (drug-related: treatment, mortality, infection disease, prevalence estimates, problem drug use) at the national level should be one of the future priorities, along with an analysis of the relationships between different indicators. There is still also a need for more qualitative information on risk behaviour and the psychosocial and cultural context of drug use in Slovenia.

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

7.2. Methodological limitations and data quality

- **First treatment demand indicator:** Dušan Nolimal

Only the methodological limitations and data quality of treatment-demand data are reported. The analysis of treatment-demand data is restricted by the large number of missing data. Indicator data reflect the environment in which they were collected. This context is important for assessing data quality. Of course, if the data are unreliable then the validity of analysis and interpretation made on the basis of those figures are compromised. In general, the level of quality by individual data providers varies from treatment centre to centre and is subject to many factors. At the moment it is difficult to check if all drug users that come in contact with different agencies are reliably identified and recorded by those agencies. The database administrator always checks individually reported data, variable by variable. Data-check routines and internal consistency checks were developed (together with the PG experts). Any comments and reactions to unclear information are exchanged by phone or mail. This process allows for better data quality in reporting. It also serves as a training opportunity. Of course, there are limitations of this sort of surveillance regarding the validity of self-reported information. Also, there are missing values for some variables. But during the course of building the treatment-reporting system data quality has improved remarkably. However, the problem of incomplete data due to the fact that the physicians do not send reports in all cases of treatment demand still exists. Yet analyses of first treatment demand data, which is considerably more complete, related to drug use, injecting risk behaviour and sexual risk behaviour trends are the most challenging outcomes. There are specific plans to assess and improve the quality of treatment demand data. In addition, the treatment-reporting system will be extended to non-medical structures, such as the treatment system in prisons and NGOs.

- **Drug-related death indicator:** Jožica Šelb Šemerl

1. In 2002 we managed to set up a group for the drug-related deaths key indicator.
2. For the first time, four different databases on drug-related mortality were linked with the outcome of drug-related mortality numbers in Slovenia.
3. We also gathered some insight into traffic accidents connected with illicit drugs.
4. Carrying out a drug-related mortality cohort study depends on the available human and material resources.

- **Infectious diseases indicator:** Irena Klavs

HIV, HCV and HBV infection prevalence information is available from voluntary confidential testing of injecting drug users in the treatment of the national primary health care network of CPTDA. The strengths of this approach are the national coverage and sustainability of such a surveillance system. However, the voluntary confidential testing approach results in a participation bias. To partially overcome this participation bias problem for HIV surveillance purposes, additional unlinked anonymous HIV testing of injecting drug users at first treatment demand is conducted in two of these centres. Up until the end of 2001 it was impossible to distinguish between the prevalence of antibodies against HBV and the prevalence of current HBV infection (HBsAg). In 2002, data collection has been revised and information on different HBV infection-markers will be collected (anti HBc, anti HBs, and HbsAg). These HIV, HCV and HBV seroprevalence monitoring results are very valuable, but inferences about the prevalence in the whole population of injecting drug users should be made with caution. There is a clear need to increase the coverage of HIV, HBV and HCV seroprevalence monitoring and include injecting drug users in other harm-reduction programmes (e.g. needle-exchange programmes) and in the community.

In contrast to the relatively reliable AIDS reported incidence data, the information about reported newly diagnosed HIV infection cases among IDU does not reliably reflect HIV incidence in this population. Due to underreporting of diagnosed cases, HBV and HCV reported incidence rates are even less reliable and greatly underestimate the true burden of diagnosed infections in this population. Also, information on transmission routes (e. g. IDU) is only available for a minority of reported HBV and HCV cases. Activities to increase the sensitivity of HCV and HBV surveillance based on passive reporting are needed.

The spread of infections (HIV, HBV and HCV) among injecting drug users is mainly determined by injecting risk behaviour, notably »needle-sharing«. 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. Thus, in 1996 behavioural surveillance to monitor risk behaviour trends among injecting drug users was established in Slovenia. We started collecting information about a few injecting risk behavioural indicators and a few higher risk sexual behaviour indicators within the primary health care network of CPTDA. In 2002 we also added questions about sexual partners' non-injectors during the past year to obtain some information about the sexual link between injecting drug users and non-injectors. The great strength of such a behavioural surveillance approach is the potential consistency of data collection methods, relative feasibility and appropriateness of such an approach to monitoring trends within a sustainable national treatment network. An obvious limitation of such 'crude' behavioural surveillance information is the validity of self-reported information. Thus, it is important to try to improve the quality of self-reported behavioural data in the future. Although these results will be very valuable, it will be impossible to extrapolate them to the whole population of injecting drug users and there is a clear need to increase the coverage of such higher risk behavioural patterns monitoring and include injecting drug users in other harm-reduction programmes (e.g. needle-exchange programmes) and in the community. Targeted behavioural surveillance surveys integrating HIV, HCV and HBV biological markers should be conducted.

- **Prevalence estimates indicator:** Marta Grgič-Vitek

In 2001, no national studies on prevalence estimates based on methods recommended by the EMCDDA were done. The national estimate of 50-200 IDU per 100,000 of population during 1991 to 1996 obtained by the key informant approach and nomination technique was relatively unreliable (26). However, injecting drug use seems to be growing rapidly. The number of clients on methadone maintenance rose from 26.5 per 100,000 of population in 1995 to 45.3 per 100,000 of population in 1998 (29). To get more reliable data on the prevalence of problem drug use, which could help us in building a network of different activities, a group of experts for prevalence estimates was established at the National Focal Point in July 2002. The group has prepared a programme of activities for 2002. In autumn 2002 an educational course will be organised for all members in co-operation with the Austrian Focal Point where the methods used in prevalence estimates will be presented. Priorities for future work: carrying out a prevalence estimate study based on the treatment multiplier method and assessing ways to use routine data for the capture recapture method. The quality of different data should be assessed first and ways of improving their quality should be explored. Potential data sources available currently: treatment data, drug-related deaths, notifications to the police and data from harm-reduction programmes (e. g. needle-exchange programmes).

- **General population indicator:** Eva Stergar

As mentioned before the data are from the Slovenian public opinion pool which has a long tradition. Usually the researchers use a representative sample of inhabitants of the Republic of Slovenia (n= 1.000 approximately), age 18+.

In 1994 the following question was formulated to measure the lifetime prevalence of illegal drug use:

- Have you ever tried one of the following drugs (multiple choice):
- Marijuana, hashish,
- Cocaine, heroin
- LSD, mescaline
- Other drug (please write down)

In 1999 the questions on lifetime prevalence of drug use were worded as follows:

Have you ever tried marijuana in your life?	Yes	No		
Have you ever tried heroin in your life?	Yes	No		
Have you ever tried cocaine in your life?	Yes	No		
Have you ever tried amphetamines in your life?	Yes	No		
Have you ever tried LSD/other hallucinogens in your life?			Yes	No
Have you ever tried ecstasy in your life?	Yes	No		
Have you ever tried sedative or tranquillisers that were not prescribed by the doctor in your life?				
	Yes	No		
Have you ever tried alcohol and pills together in your life?			Yes	No
Have you ever tried drugs by injection with a needle in your life?	Yes	No		

In spite of the different wording of lifetime prevalence drug use questions in 1994 and 1999 we can get an impression about trends in drug use in general population, age 18+. It is definitely rising.

PART 3
DEMAND REDUCTION INTERVENTIONS

8. Strategies in Demand Reduction at the National Level: Milan Krek, Matej Košir

8.1. Main strategies and activities

The new national strategy in the field of illicit drugs was in the process of preparation. Drug-demand reduction is included as a very important part of the strategy. The measures were oriented to the early prevention of drug use/abuse. The Government also started to develop a wide range of medical treatment and social reintegration/rehabilitation programmes for helping drug users/addicts. The risk-reduction strategies were oriented mostly to needle-exchange programmes and outreach. Slovenia started an active approach in the field of prevention of synthetic illicit drugs and building up the conditions for young people's healthy entertainment and leisure time.

8.2. Approaches and new developments

The new approaches and developments in the field of drug-demand reduction in 2001 particularly focused on active work and research into young people attending rave parties, establishing the network of local action groups, introducing the evaluation of some programmes, introducing the annual prevention month (November), establishing the early warning system, developing different Internet contents in the area of illicit drugs, and developing a peer-education approach etc. Slovenia also started with a co-ordinated and comprehensive approach in the field of drug-demand reduction.

9. Prevention: Milan Krek, Matej Košir

a) National Strategy

The prevention field was exposed as the main priority in the draft national strategy on the national level. Prevention was implemented at the national and local levels, especially by the Government Office for Drugs, the Ministry for Education, Science and Sport (schools and kindergartens) and Local Action Groups. The main measures were oriented to parents' education, activities in youth leisure facilities (like youth centres), prevention in the workplace, local community-based prevention programmes and civil society's involvement in prevention activities.

b) Organisation and co-ordination within national structures

The prevention field was mostly co-ordinated on the national level by the Government Commission for Drugs and the Government Office for Drugs. In addition, the Ministry for Education, Science and Sport and the Ministry of Health play a very important role in the field of prevention. The association of non-governmental organisations carried out a lot of preventive activities.

c) Expenditure on prevention in member-states

The estimate of expenditure on prevention in Slovenia in 2001 is approximately EUR 1 million for both local and national levels.

9.1. School programmes: Eva Stergar

Mandatory, recommended or voluntary solutions at different school levels

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 school, gimnazija (grammar school), 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). The topics are carried out within several subjects (foreign language, mathematics, geography, etc). In Slovene educational system there 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 as well as on those

- from foreign countries e.g. Hungary, the Netherlands, Norway, United Kingdom, France,
- from international organisations (e.g. WHO) and
- 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. The supportive school environment (at micro and macro level) should be developed. The hidden curriculum, which means quality of interpersonal relations, cooperation with local community, school nutrition, is very important. Everyday life should offer opportunities for strengthening 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 organizational 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, break for recreation, 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 realize 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 (diluent, 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 or not drugs.
- 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 realize 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 steps for successful completion of the curriculum:

- Preparation of detailed interrelations of education for health contents with curricula of other subjects.

The program paper on education for health should be approved by the national council of experts for general education. In 2002 a new intersectoral council was established that will prepare - among other - the program paper on education for health.

The Slovene Network of Health Promoting Schools (SNHPS)

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

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

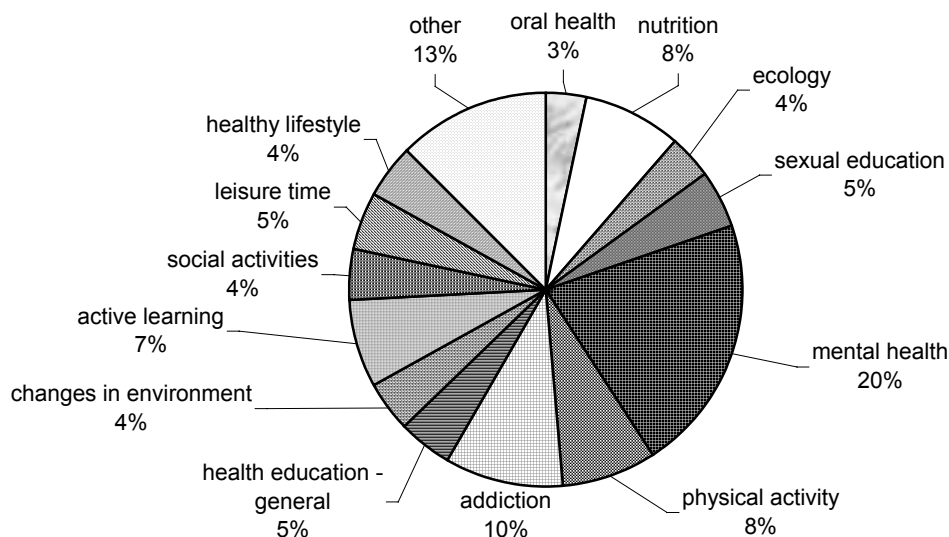
The Slovene project developed the whole school approach to health; it strives to follow 12 internationally set goals. The recommendations from Ottawa charter for health promotion were borne in mind while structuring the programme.

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 organized by the national Institute of Public Health (the national support centre for the project) or by other institutions. The national Institute of Public Health analyses activities within network on a yearly basis.

Figure 9.1.1. *The most frequent contents 2001/2002*



In 2001/2002 the most frequent contents were mental health promotion (21% of all activities; 21% in primary schools, 20% in secondary schools) and drug use prevention (9,9% of all activities; 7% in secondary schools, 11% in elementary schools).

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 drug use prevention. The initiative for programs derives from at least 4 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 programs.
- 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.

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

1. General programs

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 organize in-service training on mental health promotion for all their teachers and staff. From 1993 till June 2002 75 seminars were organized - more than half of member schools and their staff attended the seminar, nearly 2002 teachers followed 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 programs 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 in-service training of teachers. They are most effective when implemented with majority of staff of one school. Till June 2002 37 seminars on communication were performed, 8 on stress management in primary school, and 2 on stress management in adolescence.

Besides mentioned seminars there is 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 **childrens' 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 discussion of delegates 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.

2. 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

a) Non-smoking promotion in schools

The initiative for development of the programme derived from the members of Slovenian Pulmonary Patients Association. Their members prepared the programme (manual for the teachers and work sheets for pupils) in co-operation 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 3rd to 8th class of primary school. The programme is evaluated on a pre-test post-test basis. Feed-back from teachers implementing the programme is analysed.

b) 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 to 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 the three groups (it was published within the SNHPS in the occasion of Message in the bottle project). 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).

The programme is delivered by teachers who were trained at NIPH.

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

c) 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.

Involvement of: Teacher, parent, community

As it is probably seen from the previous text all the three groups are involved in prevention efforts in Slovenia. Since there was enough said 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. Slovene LAGs organize meetings since 1996 on a yearly basis.

It is estimated the role and influence of LAGs are very important for holistic approach to drug use problem.

Guidelines for school policy

Not yet prepared.

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 mental health skills learned were inadequate to be used effectively in everyday life situations. Both the students and the 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 3rd grade.

9.2.1. Youth programmes outside the school: Eva Stergar

a) Types, settings of activities

There are programmes run by GO (usually based in 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 co-ordinator. Their role is to inform and advise young people, to plan and implement various programmes. They organize 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 to play more active role in society.

c) Target groups

Different target groups are addressed by prevention programmes. 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.

9.2.2. Youth programmes outside regular school programmes: Nada Glušič

There are different departments that deal with the prevention of addiction for young people. When supporting programmes and projects for young people we understand the approach in the broadest sense, which means support not only for the contents relating to drugs but also for activities addressing all kinds of abilities of children and youth (including self-esteem, self-confidence, communication, relations at different levels etc.)

a) Within the **Office for the Youth** 105 different projects for young people between the age of 14 and 27 were supported with EUR 92,500 through 70 tenders. Projects deal with, or support:

- informal ways of education and training;
- reducing of bullying among young people;
- promotion of voluntary work for young people and among young people for the purpose of establishing civil society;
- raising awareness and the acceptance of differences among people (multicultural education, human rights, solidarity and tolerance, intergenerational relations);
- advocacy for young people;
- psycho-sociological projects, based on active participation of the young (young for young); and
- independent activities.

b) Within the **Office for the Prevention of Addiction** 31 projects were supported with EUR 64,200.

Most of those projects were more oriented to drug prevention. They cover the population aged from 5 to 27 years. The projects referred to legal or illegal drugs (some were aimed at cigarettes, alcohol or synthetic drugs)

Two projects dealing with the population 15-19 outside schools	50,135
One project dealing with people attending rave parties	8,130

The Office for the Prevention of Addiction has provided us with information about three projects:

15 projects dealing with children from 5-15 years within schools	26,091 children
9 projects from 15-19 years	831 children
4 projects from 6-1 years	2,560 children

There were 15 schools for parents, attended by 2,600 parents.

Schools for parents are organised so they offer a complex of 3-10 meetings on different subjects for certain groups of parents.

We spent EUR 20,264 on schools for parents.

9.3 Family and childhood: Eva Stergar

a) Intervention in different fields:

- during pregnancy/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 that are offered to all pregnant women and their partners do not offer information regarding drug use and how it affects health of mother and child.

- Aimed at 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 creche/kindergarten and other specific interventions

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, it lives within education sector) addresses education, teaching methods, communication, risk factors (e.g. physical activity, safety, smoking, nutrition, hygiene...) etc. The aim of the project is co-operation 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.

9.4 Other programmes: Eva Stergar

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).

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.

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 in 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 press and on TV).

b) Cooperation with mass media (costs and costs-sharing 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

Klipping is gathered but not analysed.

d) Specific training

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

Internet

a) Use of internet for:

- prevention (type of intervention, target, other relevant characteristics)
- 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) to information of marijuana growing. Many pages offer conferences, counselling, visitors have possibility to ask a question and they get answers.

According to the research of use of Internet in Slovenia 21% of Slovene households have access to Internet. Nearly all the schools have access to 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

www2.arnes.si/~ljmiss1

www.drogart.org

www.uradzamladino.org

www.uradzadroge.gov.si

www.ustanova-odsevseslisi.si

b) Statistics and evaluation results

Not available.

10. Reduction of drug-related harm: Milan Krek, Matej Košir

a) Role of harm reduction within the national drug policy/strategy

The reduction of drug-related harm was also included in the draft national strategy as a very important component. Public discussion on this topic was very intensive in 2001, especially about heroin prescription and the medicinal use of cannabis. Slovenia developed many new programmes at the local level in this area, especially outreach with mobile units. The non-governmental organisation 'Odsev se slisi' organised an international conference on harm reduction in 2001. Dr. Vito Flaker (School of Social Work) conducted a study on rapid assessment. Slovenia also introduced some harm-reduction programmes and projects regarding synthetic illicit drugs, especially at rave parties and other youth events and in schools.

b) Harm-reduction practice

The aims on this field particularly involved risk reduction as regards the use/abuse of different illicit drugs. Target groups were drug users on the streets and participants at rave parties. The programmes and projects were oriented to the risk of using heroin, cocaine and synthetic illicit drugs.

c) Range of services

Harm-reduction programmes were carried out in different centres for the prevention and treatment of drug addiction. There were some education programmes for drug addicts on the dangerous use of drugs, needle-exchange programmes and outreach (mostly in the non-governmental sector). The non-governmental organisation 'DrogArt' ran a harm-reduction programme in the field of synthetic illicit drugs. Many faculties and colleges were included in the education process in the field of harm reduction.

d) Networking between HR professionals

Networking between experts in the field of harm reduction was established through the Social Chamber and the association of non-governmental organisations.

e) Co-ordination of national policies and local practice

The co-ordination of national policies in the field of harm reduction was implemented by the Government Commission for Drugs and the Government Office for Drugs. Local practice co-ordination was made through Local Action Groups. The network of local action groups is connected with the Government Office for Drugs.

f) Expenditure on specific harm-reduction projects

Harm-reduction projects were co-financed by local communities (municipalities), donors and calls for tenders announced by competent ministries and governmental offices. The expenditures here were approximately EUR 300,000 from all resources. There were many volunteers in these programmes and projects, so it is difficult to estimate the value of their work.

10.1. Description of activities: Dare Kocmur, Evita Leskovšek, Alenka Žagar

The most important provider of data about harm reduction is the Stigma Association founded in 1991 and which started with a needle-exchange programme in 1992. The Aids Foundation Robert was founded in 1994. After their merger at the beginning of 2000, the Stigma Association has become Project (Stigma) of Aids Foundation Robert. The Stigma Project is in its 10th year of operation.

This project involves programmes of harm reduction for intravenous drug users exposed to the highest risk level in terms of infection. The importance of so-called low-threshold programmes lies in their accessibility to clients, user-friendly assistance, which predominantly encompasses the so-called hidden population of drug users.

Within the Project we currently provide:

- a needle-exchange programme;
- distribution of condoms and informational leaflets;
- a 'drop-in' day centre for drug users;
- field work;
- a counselling programme (help-line service on drugs, AIDS, safe sex);
- some types of social help;
- some forms of medical help;
- support for drug users to organise themselves (with the aim to support users in organising themselves and addressing the political and social barriers that prevent users (and other individuals) from voicing their needs, demands and experiences);
- a drug users' newsletter;
- a pilot project to launch vending machines;
- prevention and harm reduction in prisons: lectures, counselling, written materials about HIV/AIDS, hepatitis B,C, tuberculosis, outreach work of social workers with drug users in prisons;
- a project targeting mobile drug users;
- activities towards heroin prescription for long-term, heroin-addicted drug users;
- training and lectures for individuals interested in harm-reduction policy and practise;
- multidisciplinary and international co-operation; and
- work with the media.

Needle exchange - the stationary programme of needle exchange started its way up within the Stigma Association in 1992 and, as such, represents the framework for other programmes carried out within the Project. Users can obtain sterile syringes, pre-injection skin-cleansing swabs and ascorbic acid. However, they need to return used injection kits which are subsequently discarded and burned.

The 'drop-in' day centre programme aims to provide a secure place to meet, socialise and spend free time and is especially intended for those users who, for different reasons, cannot meet the requirements of high-threshold abstinence programmes. The drop-in day centre is open every working day from 11 a.m. - 5 p.m.

Field work aims at discovering the phenomena encompassing the real-life situations of users, identifying the needs of marginalised and stigmatised people and their ideas of the existing activities/jobs - their accessibility, possibilities, drawbacks of the existing system of offering assistance. Occasionally, we organise field 'cleanings' which involve the removal of large quantities of used and discarded syringes at selected locations.

The counselling programme ensures the possibility of anonymous and widely accessible information or counselling. With the intention of bringing the programme closer to the different target groups, the following activities are carried out:

1. Telephone counselling and informing, which is available on the telephone number 01/241 9 999 every workday between 9 a.m. and 8 p.m. and is available to anybody needing counselling or merely information. It covers the following areas: counselling for drug users, their families and others directly affected; information related to lower risk drug use and the practising of safe sex; statistical data related to drugs; passing on information about different services or organisations offering assistance in the area of drugs and AIDS.
2. Internet counselling related to the abovementioned area which takes place via the e-mail address: stigma@email.si
3. Individual counselling: takes place on the initiative of clients previously having made contact over the phone, through the Internet or personally, in contacts made within the scope of field work, the needle-exchange programme or the day centre programme.

10.2. Standards and evaluations: Dare Kocmur, Evita Leskovšek, Alenka Žagar

Within the Stigma Project there are some internal professional standards on harm-reduction interventions, mostly based on the principles of the 'harm-reduction' paradigm and the code of social work.

As a non-governmental organisation we can develop projects that are a pragmatic answer to an actual situation in our society and are accepted as both part of the social context and by users as well, because the projects do not set high demands for them and hence encourage users to co-operate.

*Indicators of the Stigma Project**Attendance at Drop-in Centre/ Involvement in needle exchange:*

- Number of visits: 7,718
- Number of visitors in programme: 1,131
- Number of delivered needles - total: 144,693
- Number of returned needles - total: 98,815 (68.3%)
- Share of male visitors: 80.6%
- Share of female visitors: 19.4%
- Average age of users:
 - Male: 28.1
 - Female: 27.4
- Users' involvement in any other medical help: 28.0%
- Users not involved in any treatment ('hidden population'): 72.0%
- Number of telephone counselling services: 1,430
- Contents of counselling: HIV/AIDS prevention, safe sex, problems with drug use

There were 51,410 needles issued and 39,333 returned within the outreach programme.

Method(s) of needle exchange used (e.g., stationary, mobile, secondary exchange) or method/ type of replacement therapy given:

Stationary needle exchange is located in the Drop-in Centre in the mentioned working time.

The main goal of **outreach work** is to reach hidden IDUs in Ljubljana and motivate them to use Stigma's needle exchange and other forms of our help. The availability of sterile injecting equipment on the streets provides another source of preventing the spread of HIV and hepatitis viruses. The current focus of the outreach team is to assess the current level of HIV risk behaviour in order to motivate users for the most appropriate and safest injecting. Also, we motivate them to use Stigma's drop-in centre on a regular basis.

In 2001 we made 1,148 contacts with drug users on the streets; 953 of them being male and 195 female. Outreach contacts were made two times per week (Tuesdays and Thursdays), three hours each day.

Secondary needle exchange includes the co-operation of some active drug users who distribute needles in private locations, where all used syringes are returned to Stigma's premises. Secondary needle exchange forms part of outreach work.

A counselling programme related to drugs and AIDS is offered each working day from 9 a.m. to 8 p.m. from Monday to Friday. In this area of work we had 1,428 contacts in 2001 (721 male, 707 female). Individuals are included in this programme by phone or personal contacts. Counselling includes facts about drugs and AIDS, safer drug use, safe sex, information about other helpful institutions, HIV testing etc. Mainly there are 'one off callers. If some clients need a longer period of counselling and more contacts to resolve their problems this is also possible here.

Training about safer use is not formally included in our day centre because it is too small, and does not allow a more structured plan of activities. But, on the other hand, our staff responds to this issue whenever needed. We also distribute leaflets to our clients about safer use, safer injecting, OD prevention.

Impact and evaluation of the Stigma Project

- With the needle exchange and outreach programmes we reach what is for many other health and social institutions the hidden population of injecting drug users which, conversely, do not search for any medical or social help.
- Co-operation with some drug users from other Slovenian cities (secondary outreach work) also makes the distribution of sterile injecting equipment possible in country areas, where harm-reduction programmes are not available.
- We are campaigning for the establishing of a 'Safe Injecting Room'
- We can best assess our effectiveness through informal contacts with drug users and through statistical data: number of visits/clients, number of needles issued and returned, number of contacts within the counselling programme and outreach work etc.
- We cannot observe the direct impact of needle exchange on HIV prevention. But since there are very few cases of HIV infection reported among the group of IDUs in Slovenia, we believe that the pragmatic and symbolic impact of needle exchange is evident.

Other information about harm-reduction forms is unavailable.

Training and research: Vito Flaker, Vera Grebenc

a) Training

School of Social Work is regularly (once per year) organising educational and training program for law threshold workers in the field of harm reduction. The program is verified by the Social Chamber of Slovenia.

The program of training includes a theoretical and practical part.

Main topics are:

- principles and concepts of harm reduction
- ethnography of drug use
- outreach work methods
- legal and human rights of drugusers
- researching

Last year the training was organised as a part of the 13th International Conference on the Reduction of Drug Related Harm. There were 32 participants from different countries.

b) Research

In 2001 the School of Social Work finished research on the Development of Community Work in the Field of Drug Use on the Principles of Harm Reduction. The research was done on the invitation of the Ministry of Labour, Family and Social Affairs.

Outcomes:

- rapid assessment and research of drug use in a local area (Fužine, Ljubljana);
- search conference in the local community (a meeting with the local population and key institutions);
- implementation of the community project in Fužine; and
- a handbook for the development of community work.

The handbook provides information on how to organise and run a community project focusing on the special issues of drug use and following the principles of harm reduction.

11. Treatments

11.1. Drug-free treatment and health care at the national level: Andrej Kastelic, Tatja Kostnapfel Rihtar

This is performed according to the Health Care and Health Insurance Act (Official Gazette 9/92) and the Prevention of the Use of Illicit Drugs and Dealing with Consumers of Illicit Drugs Act (Official Gazette 98/99).

Article 8 states that the treatment of illicit drug consumers is 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 is carried out by natural and legal persons fulfilling the conditions set for the performance of medical activities in accordance with the law governing medical activity.

In accordance with this Act, 'treatment shall also be deemed to include maintenance with methadone and with other substitutes approved by the Health Council.'

Article 9 prescribes that for realising hospital and specialist outpatient clinic treatment, the Government shall establish a public health institution - the Centre for Treating Illicit Drug Addicts. Hospital treatment shall be deemed to include hospital detoxification, psychosocio-therapeutic treatment, extended treatment and health rehabilitation.

a) Objectives and definitions of drug-free treatment

1. Outpatient treatment

- CPTDA located within the primary care health system

Some of the main goals already met concerning HIV/AIDS epidemics in establishing the network of CPTDA have been:

CPTDA:

- Outpatient drug-free and substitution treatment; and
- Preparing drug users for inpatient treatment.
- To provide medical care to all people with health insurance in the Republic of Slovenia.
- To further develop and strengthen the methadone maintenance programme and other substitution programmes.
- To develop a manual for the methadone maintenance programme.
- To develop community and outreach harm-reduction programmes.
- To assess the extent of HIV-risk behaviour and HIV infection among injecting drug users.

2. Inpatient treatment and care

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

The Centre for Treating Drug Addicts at the Clinical Department for Mental Health of the Psychiatric Clinic in Ljubljana has nine beds and is the only specialised hospital unit offering inpatient treatment.

Centre for Treating Drug Addicts, *Clinical Department for Mental Health, Psychiatric Clinic in Ljubljana*:

- inpatient and outpatient treatment;
- detoxification; and
- counselling for users, relatives and professionals.

Intensive work regarding building of the new Centre was completed in 2001.

The new building is already finished. Funds from the Health Insurance Company for activation were provided.

Activities include:

- detoxification;
- day hospital;
- crisis intervention;
- treatment of patients with a dual diagnosis;
- programmes for adolescents;
- outpatient programmes (including a day hospital); and
- rehabilitation.

- Psychiatric hospitals in the Republic of Slovenia

Most psychiatric hospitals in Slovenia offer detoxification.

b) Criteria for admission to drug-free treatment

- Voluntary
- Compulsory treatment order
- Referral from Centres for Preventing and Treating Drug Addiction

c) Availability, financing, organisation and delivery of drug-free treatment services

The programme for treating drug addiction is covered by the Health Insurance Company of the Republic of Slovenia.

d) Evaluation results, statistics, research and training

- Number of patients treated in CPTDA

Table 11.1.1. Number of patients in CPTDA in 2001

Year	Methadone maintenance programme	All patients
March 31, 2001	1347	2264
January 1, 2001-March 31, 2001	1558	2617

Source: Ministry of Health, 2001

Table 11.1.2. Number of patients in the Centre for Treatment Drug Addicts at the Psychiatric Clinic Ljubljana - hospital unit

Year	Women	Men	All
2001	35	79	114
Total since 1995	209	448	657

Source: Centre for Treatment Drug Addicts at the Psychiatric Clinic Ljubljana

Table 11.1.3. Number of patients in the Centre for Treatment Drug Addicts at the Psychiatric Clinic Ljubljana - outpatient unit

Year	No. of clients in outpatient treatment
1995-2001	3250 patients

Source: Centre for Treatment Drug Addicts at the Psychiatric Clinic Ljubljana

Basic training for doctors, nurses, social workers, pharmacists, psychologists was performed by the Sound of Reflection Foundation.

11.2. Substitution and maintenance programmes: Andrej Kastelic, Tatja Kostnapfel Rihtar

a) Objectives of substitution treatments

The methadone maintenance programme 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 making contact with the medical service, to reduce the spread of HIV and hepatitis B,C among them and to cut criminality.

National guidelines for managing drug addicts, including the methadone maintenance programme, were adopted by the Health Council at the Ministry of Health in 1994. The Ministry adopted a set of recommendations for doctors concerning the treatment of drug addicts.

Methadone guidelines in Slovenian were published in 2001.

Treatment is carried out 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 months or less; and
- Long-term maintenance: stable prescribing over more than six months.

b) Criteria for admission to substitution treatment

After establishing that the criteria for inclusion in 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 in the methadone programme.

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

A discussion about certain changes has begun.

c) Availability, financing, organisation and delivery of substitution services

The network of Centres was confirmed in the Republic of Slovenia in 1995. A new CPTDA in Izola was established in 2002.

The Co-ordination of CPTDA at the Ministry of Health is a co-ordinating body established to provide uniform treatment approach in all treatment centres and exchanges of treatment experience. Representatives of therapeutic communities and harm-reduction programmes are invited to meetings as non-members of the Co-ordination - representatives from the Ministry of Health, the Institute of Public Health, the Ministry of Labour, Family and Social Affairs, the Ministry of Justice and representatives of NGOs.

At its regularly monthly meetings, the Co-ordination of CPTDA invites all people responsible in the field of drugs: health, social, justice sectors, NGOs etc.

The Network of CPTDA was recognised as a 'Best Practice Case' at the 'UNDCP Meeting on Lessons Learned on Preventing the Transmission of HIV/AIDS among IDUs in Central and Eastern Europe and Central Asian Republics' in Minsk, July 2000. Details were published in the UNDCP book in 2001.

Representatives from the Network of CPTDA received the Nyswander-Dole 'Marie' Award at the AMTA Conference in St. Lois, USA in October 2001.

The following activities of the Network of CPTDA were undertaken in 2001:

1. *Regular monthly sessions*
2. *Organisation of conferences, seminars and workshops (The Sound of Reflection Foundation, together with the Co-ordination of Centres):*
 - *WHO Workshop on Agonist Treatment of Opioid Dependence (Ljubljana, September 16-18, 2001)*
 - *ISAM Satellite Symposium on Pharmacological Treatment (Ljubljana, September 15, 2001)*

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 CPTDA were opened, bringing the total number of centres in 2001 to fifteen.

- Developing guidelines for the treatment of addiction, especially with regard to drug users' work and driving ability
- Revised *Methadone Guidelines* (Eurometwork: Annette Verster and Ernst Buning, June 2000) - translation into Slovenian by Andrej Kastelic and colleagues, 2001

- Co-operation in developing the doctrine of treating drug addiction in penal institutions
- New drug-free programmes in prisons

- Implementation of the Pompidou Group questionnaire 'First Treatment Demand'

- Realisation of substitution programmes

- Computerisation of the network

- Development of prevention programmes

4. *The Co-ordination of Centres prepared:*

- the leaflet 'Overdose' - updated version

5. *Some research studies were completed in the Centres.*

6. *Members of the Co-ordination body published their articles in Slovenian and international publications:* Eurometwork, European Addiction Research, Journal of Heroin Addiction

7. *The Co-ordination organised conferences in conjunction with foreign organisations:*

- EUROPAD (European Opiate Addiction Treatment Association)
- IHRA (International Harm Reduction Association)
- WHO

8. *Publishing magazine: Addiction* (Issued by: The Sound of Reflection Foundation - Ustanova Odsev se sliši)

d) Substitution drugs and mode of prescription

- Methadone
- Buprenorphin and long-acting morphine studies were prepared

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

e) Psycho-social counselling (requirements and practice)

No new data available.

f) Diversion of substitution drugs

No new data available.

g) Evaluation results, statistics, research and training

No new data available.

Some researches were made in the CPTDA.

Training programmes for GPs are organised by the Ministry of Health (Co-ordination of Centres for Preventing and Treating Drug Addiction) and the Sound of Reflection Foundation.

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.

11.3. After-care and reintegration: Peter Stefanoski

Designed implementation of reintegration activity is assured by three large programmes (Projekt Človek, Društvo UP, Centri za preprečevanje odvisnosti) and some small programmes.

There are no figures on the link between unemployment and homelessness with drug use.

Training programmes for work with drug addicts and the people close to them are encouraged and co-financed by the Social Chamber of Slovenia.

Within the social welfare and care system, all activities are focused on encouraging social inclusion. All high-threshold programmes are oriented to reintegration. Some programmes have organised specific after-care activities. There are no reintegration programmes that are open for all, they usually accept clients previously treated in one of the high-threshold programmes.

An important part of social reintegration activities is provided through social services of centres for social works.

Description of activities

The network of public services and the network of programmes for resolving social problems related to drug use involves the following:

- h)** services and programmes for sensitisation of the highest possible number of drug users (first social assistance, programmes of fieldwork and other low-threshold programmes);
- i)** services and programmes of short-term intervention (personal assistance, assistance to the family for the home, low-threshold programmes and programmes of mutual assistance),
- j)** programmes focused on the achievement of permanent abstinence (therapeutic communities, programmes of whole-day treatments);
- k)** services and programmes of reintegration (services of personal assistance and assistance to the family for the home, reintegration programmes); and
- l)** forms of self-help and self-organisation of drug users or the people close to them.

The goal of the network of services and programmes is to ensure active participation when resolving one's own problems and to allow the possibility of a selection of the various ways of solving these problems. Therefore, it is necessary to support the work of the various programme providers and the related development of new approaches to manage social issues. This is also part of the strategy when implementing social-care rights, and this strategy was identified by the Ministry of Labour, Family and Social Affairs in its National Social Care Programme up until 2005.

Individual programmes also include forwarding information and providing assistance by telephone. There are no providers which exclusively offer this form of assistance to drug users and the people close to them.

Number of clients of Centres for Social Work which reported drug-related problems in 2001:
Adults - 3,051, Under-age - 561.

Number of programmes co-financed through public tender: 61 in a total amount of SIT 200,439,000.

Long-term contracts of co-finance have been entered into with 10 programmes which meet higher standards of quality of service and management. These programmes are mainly provided by NGOs. The number of clients in high-threshold programmes: 369 drug users, 225 parents of drug users, the number of clients in low-threshold programmes: 117.

12. Interventions in the Criminal Justice System: Olga Perhac

The Administration for the Enforcement of Penal Sentences implements the strategy of fighting drugs at the levels of preventing drugs from being brought into prisons and of assuring assistance to prisoners who want to give up drugs and change their lifestyles. The latter includes low-threshold, higher-threshold and high-threshold programmes of assistance.

The Administration is actively involved in designing the national programme in the field of drugs as well as in establishing an information point for drugs. In this regards, it co-operates with the RS Drug Office and the RS Institute of Public Health.

When implementing programmes of assistance to prisoners with drug-related problems, the Administration also co-operates with the Ministry of Health, the network CPTDA, the hospital for infectious diseases and its regional units, the central hospital for pulmonary diseases and its regional dispensaries, as well as non-governmental organisations.

The legal basis for carrying out the set strategy is the Enforcement of Penal Sentences Act and its supporting executive regulations, the Act Regulating the Prevention of the Use of Illicit Drugs and the Treatment of Drug Addicts, and the Health Care and Health Insurance Act of the Republic of Slovenia.

12.1. Assistance to drug addicts in prisons

Within the framework of treatment aimed at achieving abstinence, detoxification programmes and programmes in no-drug departments are being carried out. The legal basis for implementation of these programmes is the Enforcement of Penal Sentences Act and related executive regulations.

Detoxification programmes are run at the medical level and include a gradual reduction of the therapy, control of one's psychophysical condition and checks by urine tests that an individual is 'clean'. The psychosocial assistance comprises motivation and support programmes when establishing abstinence and stimulation for promotion to high-threshold programmes. The ultimate form are the no-drug departments where prisoners learn how to master living situations, to overcome troubles and acquire an active lifestyle.

The methadone therapy is carried out pursuant to the principle of gradual reduction. The therapy is prescribed by doctors - specialists from the network of addiction treatment centres who treat addicts in prisons. Only as an exception do doctors decide to continue a methadone-maintaining therapy. All methadone patients in prisons are tested by rapid urine tests.

The legal basis for the substitution treatment is the Enforcement of Penal Sentences Act and the Act Regulating the Prevention of the Use of Illicit Drugs and Treatment of Drug Addicts.

Among programmes for the reduction of damage, in prisons voluntary and confidential blood tests for the presence of antibodies of HIV virus and hepatitis, preventive tests for tuberculosis and vaccinations against hepatitis B are being carried out. Detergents, disinfectants, condoms and latex gloves are given away. Programmes for raising awareness and medical consultation are underway. They are intended for prisoners and workers in prisons with regard to infectious diseases, hazardous behaviour and ways of transmitting diseases as well as preventive behaviour. The latter are implemented in the form of lectures by a doctor-specialist and by distributing leaflets drawing attention to preventive behaviour.

The legal basis for implementation of the above programmes is the Enforcement of Penal Sentences Act, the Health Care and Health Insurance Act, and the Contagious Diseases Act.

Treatment in prisons also includes co-operation and connections with external institutions and communities. Prisoners are allowed to participate in individual programmes in addiction treatment centres, in programmes of non-governmental organisations and therapeutic communities after they have served their sentences.

These forms of assistance also find their legal basis in the Enforcement of Penal Sentences Act.

12.2. Alternative forms for addicts

The system of enforcement of penal sentences in the Republic of Slovenia allows no alternative treatments for addicts.

12.3. Evaluation and training

At the Administration our work in the system of enforcing penal sentences is evaluated in the form of an annual report. The Administration for the Enforcement of Penal Sentences carries out an evaluation on the basis of databases managed by prisons during the year. The Administration has no methodologist or special service for data processing and data analysis. Every expert worker of the Administration analyses the data for their own sphere of activity.

In the field of drugs, the following data is acquired:

- the number of people having trouble with drugs (including drug users using drugs for many years and periodically experimenting drug users - regardless of the type of drug), by categories of prisoner (detainees, convicts, minors), by sex, by individual prisons;
- the number of persons participating in assistance programmes in prisons (low-threshold, higher-threshold and high-threshold), by categories of prisoner, by individual prisons;
- the number of prisoners participating in assistance programmes outside prisons while serving and after having served their sentences (dispensaries of addiction treatment centres, programmes of non-governmental organisations, therapeutic communities or communes), by categories of prisoner, by individual prisons;
- the number of prisoners in methadone therapy (maintenance, reduction), by individual prisons;
- the number of voluntary tests for HIV and hepatitis, the number of positive tests entrusted by prisoners to institutional doctors, by individual prisons;
- the number of imprisoned users seized drugs, by individual prisons.

In prisons a pilot project of keeping records on the treatment of drug users has been established. In the pilot stage, data will be sent to the Institute of Public Health where the data will be analysed and a competent worker from the prison administration, responsible for drugs, will get the opportunity to be trained to work with the data.

On the basis of discussions with European experts in databases and on the basis of recommendations of the EMCDDA, the system of enforcing penal sentences will establish the missing parameters.

The legal basis for evaluation is the Enforcement of Penal Sentences Act and the Health Care Records Act.

13. Quality Assurance: Milan Krek, Matej Košir

a) Description of new trends and developments

Slovenia has established many different programmes that have started to evaluate their activities. Usually programmes are evaluated internally. Those programmes co-financed by the government or ministries are also evaluated externally. Expertise was mostly the responsibility of professional associations or chambers. The control of the organisational and administrative implementation of programmes was the responsibility of different competent ministries or government offices through specialised councils or similar committees.

b) Formal requirements for quality assurance

Formal requirements were formed within professional associations or chambers and the association of non-governmental organisations.

c) Criteria and instruments applied in quality assurance

In addition, criteria and instruments were prepared by professional associations or chambers and ministerial councils or committees. The main instruments for controlling quality assurance were reports and internal/external supervisions.

d) Application of quality assurance procedures and results

Quality assurance in the field of health was under the control of the Medical Chamber, in the field of social care under the control of the Social Chamber and a special group of professionals at the Ministry of Work, Family and Social Affairs. In the case of insufficiency the programmes have had to be revised. Finally, if they did not achieve the appropriate quality they lose their support from the national budget.

PART 4
KEY ISSUES

14. Demand-reduction expenditures on drugs in 1999: Milan Krek, Matej Košir

Expenditure for medical treatment in 1999 was approximately EUR 3.5 million, especially for improving the network of centres for treatment and preventing drug addiction. The expenditure on social rehabilitation/reintegration were approximately EUR 1.5 million (therapeutic communities, day centres, social help for addicts, reintegration programmes, harm-reduction programmes, education of experts, supervision of programmes etc.). Expenditure for local community-based programmes were approximately EUR 800,000 (buildings, co-financing programmes of local action groups etc.). The expenditures for school-based programmes were approximately EUR 500,000 (prevention).

14.1. Concepts and definitions

Implementation of co-financing was realised through the national budget, the budgets of local communities (municipalities) and donations from the private sector. The main intentions in this field in 2001 were to improve co-financing by the private sector (donations, sponsorships etc.).

14.2. Financial mechanism, responsibilities and accountability

The main financial mechanisms were:

- government resources (calls for proposals - tenders, long-term financing, ad hoc financing, financing by the Health Insurance Company etc.); and
- non-governmental resources (donations, co-financing by PHARE/EU, by NGOs' own incomes etc.).

14.3. Expenditure at the national level (geographical extension)

The Government financed programmes and projects on the basis of need, not on the basis of geographical extension. Local authorities were mostly oriented to local needs. The Government ensured the money for staff and activities, while local communities took care of purchasing houses or offices for implementing different local programmes and projects. Usually the programmes and projects were mostly co-financed through the national budget.

14.4. Expenditure of specialised drug treatment centres

The expenditure of specialised drug treatment centres in 1999 was approximately EUR 1.5 million.

14.5. Conclusions

The situation shows that there is obviously not enough money for the many good programmes and projects, especially in the field of social care and co-financing of NGOs. There was also a lack of evaluated programmes and projects which means it was relatively difficult to prepare financial plans and reports for specific programmes and projects.

14.6. Methodological information

Data was collected from reports prepared by different competent ministries and NGOs and a report on implementation of the national budget in 2001.

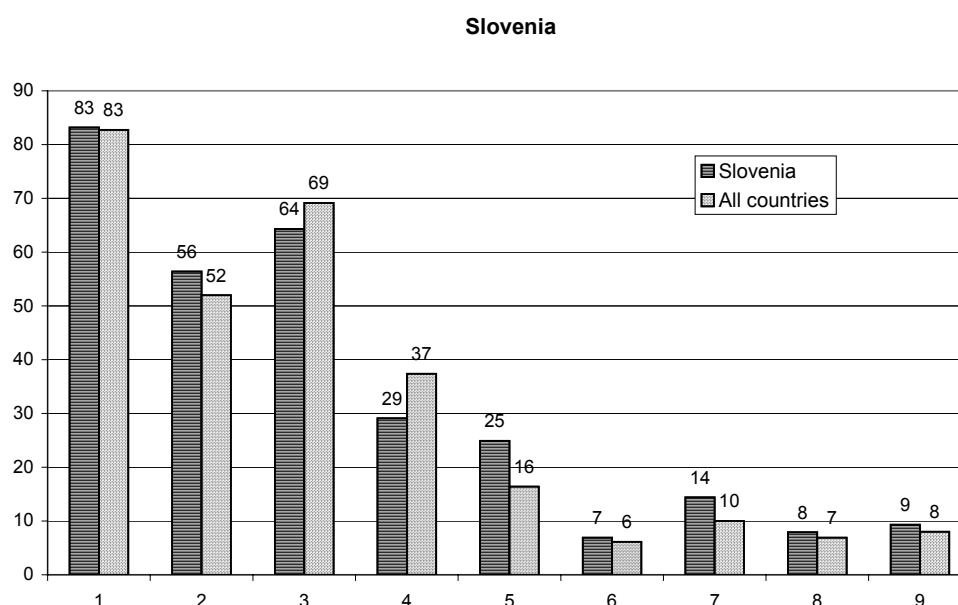
15. Drug and alcohol use among young people aged 12-18

15.1. a) Prevalence, trends and patterns of use: Eva Stergar

The data on drug use among young people are gathered for the age group 15 - 16 in the framework of ESPAD survey. The last data collection was done in 1999.

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 tranquillisers 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).

Figure 15.1.1. *Prevalence of drug use of Slovenian pupils compared to ESPAD countries average*



Source: ESPAD, 1999

Data from ESPAD surveys

Data was gathered in two ESPAD surveys (1995, 1999) for a representative sample of secondary school pupils born in 1979 and 1983, respectively. Data for 1999 and 1995-1999 trends will be presented.

In 1999 25.6% of surveyed pupils admitted having used an illegal drug i.e. marijuana, amphetamines, LSD or other hallucinogenic drugs, crack, cocaine, ecstasy or heroin at least once. Statistically significant differences between boys and girls were found (χ^2 was significant at $p < 0.005$; $C = 0.09$). A larger proportion of girls compared to boys said they had never used illicit drugs. More boys than girls indicated all frequency categories of illicit drug use, except the category '10-19 times'.

24.9% admitted having used marijuana at least once. Gender differences were statistically significant. More girls denied having used marijuana/hashish, or admitted to having used this drug 10 to 19 times. A greater proportion of boys marked all other frequency categories of marijuana/hashish use.

When asked about the use of illicit drugs excluding marijuana, 93% of the surveyed first-grade students born in 1983 said they had never taken illicit drugs, 5% had used them once to 5 times, 1% 6 to 9 times, and 1% 10 times or more. No statistically significant gender differences were found.

A combined use of alcohol and marijuana/hashish was reported by 16% of the students surveyed: 10% acknowledged the use of both drugs once to 5 times in their lives, 3% had used them 6 to 19 times, and 2% 20 times or more. Statistically significant differences were found between male and female respondents. A greater proportion of girls had not used alcohol and marijuana at the same time, or had used these drugs 6 to 9 times or 10 to 19 in their lives.

Inhalant use was reported by 14.5% of the surveyed students. Using inhalants once to 5 times in a lifetime was reported by 12%, 6-19 times by 2% and 20 times or more by 1% of the respondents. There were no statistically significant differences between the surveyed boys and girls concerning the frequency of inhalant use.

Using sedatives not prescribed by a doctor was reported by 7.9% of the students (7% of boys and 9% of girls). A significantly higher proportion of boys had never used them, or had taken them 20 times or more in their lives

Hallucinogens were used by 5.1% of the surveyed group, 4.6% reported use of heroin, ecstasy was used by 4% of the students, crack/cocaine by 3.3%, LSD by 2.4%, anabolic steroids by 2.3%, and amphetamines by 1.2%.

The difference between *lifetime prevalence use in 1995 and 1999* was statistically significant for the following drugs:

- any illegal drug use during one's lifetime (sedatives/tranquillisers without a doctor's prescription, amphetamines, LSD or other hallucinogens, crack, heroin - smoking and other, ecstasy);
- any illegal drug use with the exception of marijuana during one's lifetime;
- marijuana use;
- ecstasy; and
- alcohol, together with pills.

For all the abovementioned drugs the lifetime prevalence in 1999 was significantly higher than in 1995.

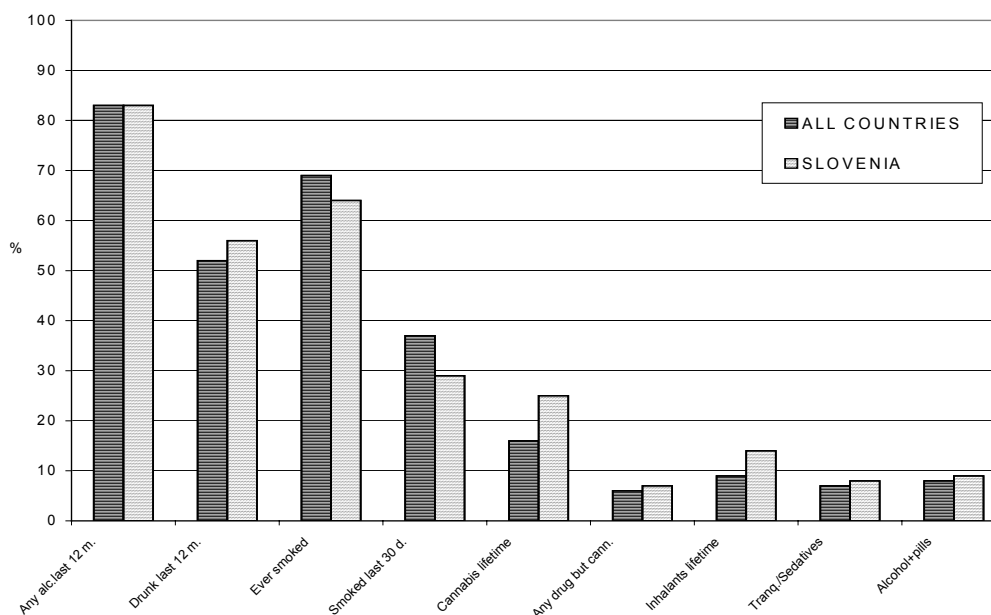
The difference between *prevalence of the use of marijuana in the last 12 months in 1995 and in 1999* was statistically significant. The prevalence in 1999 was significantly higher than in 1995.

The difference between *prevalence of the use of marijuana in the last 30 days in 1995 and in 1999* was statistically significant. The prevalence in 1999 was significantly higher than in 1995.

The ESPAD survey does not cover the broader context of drug use in the school population. There is not enough data to interpret the reasons for the detected trends, which can be put into three main groups:

- characteristics of drugs;
- developmental and other characteristics of pupils; and
- characteristics of different settings (e.g. family, school, whole society, policy towards drugs, availability of drugs).

Figure 15.1.2. Key Slovenian results, compared to the European average, 1999



Source: Eva Stergar, Institute of Public Health

The proportions of Slovenian students who had drunk 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 tranquillisers 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).

15.1. b) Prevalence, trends and patterns of use: Matej Sande

Our knowledge of ATS use between young people (aged 15-25) is based from two research projects dating from 1996 to 1998 (both projects were directed by Bojan Dekleva Ph.D. - Faculty of Education). The first, qualitative research concerned ecstasy users and their perceptions of preventive programmes, harmful use, dealer networks etc. and the second concerned drug use in secondary schools in Ljubljana, with an emphasis on new synthetic drugs (ESPAD 1998).

The first study used snowball sampling and field interviews with ecstasy and other dance drug 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 drug dealing and using networks, in their relations with other drug using subcultures and similar issues. Our finding was that users are mostly interested in 'objective' information on drugs, that they are trying to minimise harm and they feel that there is an absolute lack of any information on ecstasy and related drugs available to them (except their own experience and information transferred through peer networks).

The second study was a cross section study using ESPAD-type methodology and a representative sample of 15-year-old youngsters from Ljubljana. Its main finding is that the use of ecstasy has grown most in the last three years. In 1998, 7% of our 15-year-old sample had already used it at least once, while among pupils of less academically oriented schools the respective percentage is about 13%. Ecstasy has become the second most common illegal drug (to the question - *already used once*),

following cannabis. At the same time, it is (for some youngsters) becoming the first illegal drug which they have used (instead of marihuana).

The recent research project *The use of amphetamine, methamphetamine and other synthetic drugs in Slovenia (Sande, 2001)* was oriented to the use of ATS in the population of Slovenian partygoers (aged 15-25). The goal of the research project was to evaluate the state of amphetamine, methamphetamine and MDMA use at rave parties and to compare the results with results for the general population and results from selected European countries. The next goal was to answer the question of 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 results point to a high level (86%) in the lifetime prevalence of MDMA use and the relatively high popularity of synthetic drugs (2. MDMA, 3. Cocaine 4. Amphetamine¹). Methamphetamine is known but used by a small percentage of the sample. GHB, on the other hand, is used by 4% of the sample.

The research sample included 1,500 visitors to electronic dance events in Slovenia. One-third of the sample replied to the questionnaire over the Internet and two-thirds of the sample answered the same questionnaire as distributed at dance events in Slovenia. The lifetime prevalence of ATS (and other drugs) use is shown in Table 1.

Table 15.1.1. *The number and percentage of partygoers (n=779) which have already tried the drugs listed below. The results are compared to the preliminary Mixmag Survey (Winstock, 2000) for the UK and the ESPAD school survey for Slovenia (Stergar, 1999).*

Research	Winstock, 2000 M=23 years %	Sande, 2001 M=20.3 years %	Stergar, Ljubljana, 1999 M=15 years %
Marihuana	98.2	93.8	32.2
Cocaine	84.7	46.7	2.0
Heroin	16.5	25.0	2.2
Ecstasy	97.7	86.0	5.2
Amphetamine	93.8	71.9	1.8
Methamphetamine	7.1	9.8	/
LSD	79.7	47.1	5.2
Magic mushrooms	65.0	43.1	/
GHB	23.8	4.7	/
Sedatives	43.0	26.8	/
Ketamine	46.5	2.3	/
Crack	20.1	3.1	/

15.2. Health and social consequences: Matej Sande

The health consequences of ATS use in Slovenia are mostly connected with the short-term physical effects of ATS use (overheating, increased pulse and blood pressure, sickness), usually treated on the spot (by harm-reduction volunteers, emergency vehicles) or at a nearby hospital. The link between two parties is well established and in 2002 an emergency vehicle has almost always been present at larger dance events. However, last year (2001) there were two deaths due to MDMA in Slovenia. One died because of a brain edema (a possible MDMA-induced side-effect) and the other died of heat stroke. In 2001 there were more reports on brain edema connected with MDMA use, but they were successfully treated in hospital. From the findings of the research on ATS we can conclude that the use of synthetic (and other drugs) in Slovenia by young people is problematic due to the frequent and chaotic use of stimulants. Young partygoers often mix different drugs together (37.4% of the sample) or with alcohol (21.0% of the sample). Almost half of the research sample (42.8%) mixed ecstasy and amphetamines.

¹ In response to the question: 'What is your favourite drug?', the first drug of choice remains cannabis.

More common are psychical long- and short-term side effects and complications (depression, insomnia, depersonalisation, 'amphetamine psychosis', panic attacks, PTTS), which are treated on the spot (panic attacks) or via professional counsellors.

Social effects of ATS use are also quite frequent for young users. The most common is poor school performance and troubles at home or with the police.

15.3. Demand- and harm-reduction responses: Matej Sande

The first harm-reduction response to the increased use of ATS was the NGO DrogArt, established in 1998 (formally 1999). The NGO focuses on dance-drug-related harm-reduction and performs outreach work at bigger and smaller dance events in the country. The outreach work includes the distribution of informational leaflets, peer education, basic quality control of the event, basic medical assistance and help for partygoers. The NGO was also involved in the development of standards for safer dance events at the Office for Drugs in 2000 and 2001. It is also running an info point for synthetic (and other) drugs in Ljubljana, it also provides psychosocial assistance and counselling for ATS drug users. One of the activities of the NGO is research into the prevalence and trends of ATS use in Slovenia.

Prevention of new synthetic drugs was added to the recent national programme (Office for Drugs) on drug prevention.

The demand-reduction response is present in many prevention workshops in primary and secondary schools, performed by different institutions and NGOs around the country.

15.4. Methodological information: Matej Sande

For data collection in the general population of secondary school students we are using ESPAD-based methodology with our own supplementary questions on the prevalence and patterns of ATS use. The research sample is always representative. For special populations (dance-drug users), we have developed our own questionnaire, which is in some parts similar to the Calafats SONAR 98 research. The sample was self-selected, therefore the results cannot be generalised for the general population.

ESPAD-based research projects are relatively frequent in Slovenia. So far, we have conducted research in 1995, 1998, 1999 and 2002 (in progress). Accordingly, we have a relatively good insight into the prevalence and patterns of drug use by young people in Slovenia.

We completed just one quantitative research on ATS in Slovenia in 2001, however, we will need more in-depth research into special population groups and their drug use in the future.

16. Social exclusion and reintegration: Peter Stefanoski

16.1. Definitions and concepts

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16.2. Drug-use patterns and consequences observed among socially-excluded people

There have been no studies and assessment of drug-use patterns and consequences among socially-excluded people.

16.3. Relationship between social exclusion and drug use

There have been no studies and assessment of the relationship between social exclusion and drug use. But it is recognised that drug users who need professional help usually report unemployment, dropping out from school, housing problems etc. On the other hand, there are some problems connected to stigmatisation. As well as drug users, former drug users are recognised as a risky population group and have problems integrating into day-to-day activities.

16.4. Political issues and reintegration programmes

There is a debate about positive discrimination of drug (and former drug) users. The issues of employment and housing are particularly sensitive.

For a detailed description of services involving social reintegration, please see Chapter 11.3.

Drug-use patterns and consequences observed among socially-excluded people: Vito Flaker

Social consequences

Employment

It has been observed that many people who use heroin, even regularly and addicted, succeed to obtain and maintain a job, but still many, especially addicted ones have troubles in these area. Various statistics (police, first treatment demand and methadone programmes; Ministry of Interior, 1999; Nolimal, 2000; Rihtar; 2000) show that there is about 20-30% of employed drug offenders or patients in the health institutions, 20% students, 30% unemployed and about 20% occasionally employed.

The work environment is a very sensitive one to the stigma of drug use and the most frequent reason for covering the stigma. This is on one hand consequence of the working living space, which in comparison with family, peer or public spaces is more subject to formal rules and control, so stigma is more visible and consequence more fixed. At the other hand we have seen that stigma is not only an interactional or moral category but also economical. We have seen that it does not only enable exclusion of a social group from the realm of work but also concrete manifestations of profit being extracted by it on the side of the employers and also being used economically on the part of the users.

Housing

For the great majority of users housing poses no pressing problem. Most users live at home with their parents (which is a normal thing for young people in Slovenia, where housing is a problem for young people in general). This is almost as a rule true in smaller towns. Some users even own their own flats. Generally speaking, however, housing remains a problem for a drug user. Although a minority of users is sleeping rough the likelihood of being homeless is about 10 times higher for a heroin user than to his non-using counterpart.

Housing problems and homelessness can be seen as major contribution to the destructive outcomes of a drug user's career even more than drugs themselves. Rows with parents, being pushed in the street, semi-nomadic life style, sleeping rough, having nowhere to go, nowhere to wash and cook, magnifies the visibility of the stigma by the fact of being present in the public, an easy catch for the police, pressed into the position of being a client of social and health services.

Family problems

This family *drama of disclosure* is a frequent phenomenon. Its main features are: strong reaction, panic and lack of orientation of the parties involved, who do not know what action to take in a given moment. A feeling of guilt is present in both sides, in the children because they hurt and disappointed their parents, and in the parents because they consider the fact that their children use drugs as their failure as parents. The role of mother seems to be more prominent and involved as an actor in this drama (as it is in Slovene culture generally). In single parent families the drama fares with even more difficulties, the responsibilities, feelings and dilemmas concentrated on one parent, typically mother. The discharge and "resolution of dramatic plot" may be destructive. Not only contacts (temporarily or even permanently) may be cut off, but the drama may also push the user even harder into the role of a junky while the parents may become zealous prosecutors of drug abuse.

This may lead to alienation or disruption of the relationship between users and their parents, and even to physical violence. The reason for breaking the relationship is often the parents' insisting that users seek medical assistance, i.e. "get cured". As mentioned above, they often throw their children out of the house. The result is that they move to their partners, friends or, more generally, they seek their place in the world that is closer to them, in the world of their peers. This process may also take place not as a result of a drama but as the ordinary process of emancipation, sometimes it is true that the relationship with the parents was cold anyway and that parents and their children were already strangers to each other. The parents' insisting that help be sought, which their children are not prepared to do is in the least hand sterile, and also establishes an atmosphere of *fundamental misunderstanding*. They are frequently left alone or with the support of the environment that is not adequate. Drugs remain the family matter but at the same time catapult the user from the family into society at large.

Loosing or gaining friends

Drugs are potent socialising props. The beginners, as we have seen, use drugs almost exclusively in the group. It is not only that the group facilitates the drug use, contrary is also valid; the drugs facilitate the socialising. They provide a theme for social gatherings of the youth; they provide the group cohesion, the action and involvement in something exciting. They facilitate the contacts, belonging to the group, its creativity and the group values. It makes the cross gender contacts easier, sexual experience more pleasurable; it involves young people in some kind of very autonomous economy.

Once they embark on the career of a drug user, many users lose contacts with their friends and acquaintances from before. Usually this is an effect of the stigma of being a user. People simply avoid them. It may even happen that this is the result of a deliberate campaign against them, where the environment incites users' friends not to socialise with users anymore. The stigma effects instantly and people avoid users and gossip about them. Users themselves begin to anticipate this attitude coming from their friends and they withdraw or avoid contact with them in order to avoid awkward situations, which emerge in such situations.

In this way users who lose their friends have two options. They are either condemned to socialising with other users or to loneliness. Some users slowly fall into isolation. Even if in principle contacts with other persons remain, users frequently run out of time for maintaining them. Many users, however, keep their regular contacts and never experience this kind of loss. For maintaining contacts with the environment it is important that the user has something to offer (for example, in one case a user offered his neighbours his drawing abilities).

The effect of the drug use on the contact with peers is tremendous and manifold. The drugs on one hand induce the sociability of the users, other hand it isolates them. This can be seen as a progression parallel to the progression of the career, contact becoming more and more monothematic and the user more and more excluded from his former networks by the operation of stigma. If added by the enhancement of the stigma by institutionalisation the process being so very strong that it is very difficult to reverse when people return from the therapeutic communities.

Social harm: a consequence of the use or of a role?

Examining the different social consequences we have seen that drug use *may* lead to adverse social consequences. People using drugs can have serious employment problems in obtaining the job, not being fired etc., they can have minor or even major housing problems, they can be ostracised by the family and isolated from the friends they had. But on the same time we have observed that probable majority of the users experiences these problems in a mild form, comparable to the experience of any young person, if any. There are definitely drug users who do not experience these problems as a result of their use. This can be accounted by the fact that there are different styles of drug use and many of them do not lead to such situations.

There are people who only experiment with the drugs generally and heroin specifically, there are people who take them casually, on different occasions, there are people who take them regularly (e.g. weekends) but do not get addicted, and there are addicted users who have the means to accommodate their habit. Our research did not provide the evidence to calculate the proportions, but the evidence we have suggests that the figures would be very similar to the ones reported elsewhere suggesting that there is one out of three addicted users who becomes a *junky*, or one out of ten regular users becomes addicted (Flaker, 1993; 2002). These proportions might be different for Slovenia but our assertions that the *junkies* are only the most visible, most obtrusive figure of users, which are perceived by the different agencies and public at large, at the same time being the minority of total number of people who use heroin, or even smaller proportion of all illicit drug users.

The styles of heroin use can be differentiated along some other dimensions of user other than frequency and intensity: to the type of intake (nasal, oral, intravenous), the degree of control over use, the degree of responsibility to the social environment, the period of use, cultural matrix of use (medical, recreational, traditional or non-conformist), the number of people involved (group use, solitary) etc.

Table 16.4.1. *Social consequences as a function of a type of use*

Type of use Type of consequence	Non problematic use (controlled, experimental, casual)	Problematic use (junky)
Work	Threat/ opportunity	Difficult to obtain or maintain Illegal income sources
Housing	Threat	Semi-nomadic or even semi-homeless existence
Contacts with relatives	Strain of concealing use Means of emancipation	Drama of disclosure Broken ties
Contacts with peers	Enhanced sociability	Narrowing of the contacts to the users Isolation

We can clearly conclude that the adverse social consequences of drug use are very marginally consequences of the drug use itself, but more of how the drug is used, i.e. the type of use, the style, the circumstances of the use. The question is therefore: What pushes people from unproblematic use to the styles that are harmful? What are the vectors that facilitate such use and gear the drug-using career towards the destructive outcomes?

Before we seek the answers to these questions we must note that this progression is structured as career. We have to note also that the progression is not a necessity. There are as many careers as types of use. The dominant mater role hovering over the drug use and as it happens the most destructive outcome of the career is the role of a *junky*. On the level of social representation it is a perfect example of a "folk devil" that cause "moral panic" in the society regarding the drug use, it has also a "black hole" effects being a constant threat to drug users of being sucked into a type of use that will be detrimental to their well-being. On the practical level it is a set of learned behaviour that someone is being pushed into by being denied other possibilities on the account of heavy stigma of drug use. This results in the abandonment of various social roles people entertain and in the end having nothing left but a junky role to act in. High prices and criminalisation of illicit drugs are contributing to the fact that "scoring dope" and "getting the bread" this becoming the main and almost exclusive activity of a person in such a role. Thus producing a total immersion in the subculture of the users and a fatalistic attitude towards life in general which reflects also in the appearance and the poise of such a person.

This process, which is sometimes termed *junkisation*, can be seen as a major contributor to adverse social consequences. It is important to note here that our dissuasion is about two phenomena. One is cultural; it is about the general questions of drug use in the society. The other is more *social* in the narrow sense of the word and is about the adverse social outcomes of drug use. It is about different populations, number but also about different registers of discussion.

Political issues and reintegration programmes: Vito Flaker

Institutional response

Social reaction to drugs represents an important issue. Further on still, the militant and intolerant attitude and the system of repression, termed sometimes as “war against drugs”, dominate the agencies that deal with the drug use. In the case of Slovenia the harm reduction as a more pragmatic orientation has been present from the very start of the drug boom. This having an impact on more moderate and liberal policies. These services serve different functions and want to fulfil different goals. Some want to help people to abstain; some are to maintain on methadone, some to prevent harms associated with drug use and some to improve their quality of living. Some are designed to persecute, control and punish the users.

Within this framework the agencies as police, media, juridical system, health and social agencies, including the NGO's were developed in the wake of drug use expansion. Some of them, mainly abstinence programmes, were established due to concerned public (parents, professionals, prominent public figures) while the users themselves directly provoked the other. The methadone programmes and syringe exchange were established as a result of drugs users campaign and self-organisation. Previously existing services and agencies like general health and social services, and also police and prison services, had also to adapt to the new situation and develop new response. In the health sector a whole network of Centre for prevention and treatment has developed which together with the detoxication centre form a system of care with people with drug related problems. This system covers the whole territory almost evenly and reaches a substantial number of users. In social sector the offer is more diverse. Besides general social services, who have a great degree of contacts with users this sector finances also abstinence programmes and programmes of harm reduction. These are implemented by the NGO sector and almost exclusively in urban centres. Repressive agencies are spread all over the country. Their policy and attitude varies and is influenced by the contradiction of two o ideas of police work - to upkeep the public order and to persecute the illegal traffic.

Table 16.4.2. *Estimate of the heroin users number reached by different services and agencies*

Service	Diffusion of the service	Number of client per year	Estimate of the coverage (for 10.000-20.000 users)
Detoxication centre	1 unit	500	2,5-5 %
Methadone programmes	14 units	(1247 ²) 2342 ³	12-24 %
Abstinence programmes	3 communities in SLO and several abroad, few preparatory programmes	200	1-2 %
Syringe exchange programme -Stigma	1 unit	963+547=1510	7,5-15 %
Police	10 police inspectorates and 99 police stations	2000 misdemeanours 1150 criminal offences 3150 total	5-15 %
Prison	7 units	300	1,5-3 %
Centres for social work	62	2160	10,5-22 %
Labour bureaux	Central office, 12 regional services and 59 bureaux.	1296	6,5-13 %
Total		(4000)	20-40 %

² Methadone maintenance programmes in 1999.

³ All treated in 1999.

However large the proportions of covered users, majority stay out of reach of these services. Reasons for this are different. A simple one is that the services are not offering the services needed. This is especially true for the users that are not addicted, namely casual and controlled users, whose distress is not so pressing as to risk the stigmatisation related to frequent such programmes. Another group of user not covered by the services are those users who do experience the distress and maybe even do not fear the stigmatisation, but do not want or are not wanted in the services. In other words these are most problematic users, “junkies” from lower social strata. They would need more than the existing services are ready to offer.

ANNEX 1

Bibliography

1. Brooner R.K., King V.L., Kidorf M., Schmidt C.W Jr., Bigelow G.E. (1997): Psychiatric and substance use comorbidity among treatment-seeking opioid abusers. *Arch Gen Psychiatry*. 54(1): 71-80.
2. Dekleva B: Droge med srednješolsko mladino v Ljubljani. Ljubljana, Mestna občina, Mestna uprava, Oddelek za predšolsko vzgojo, izobraževanje in šport, Urad za preprečevanje zasvojenosti in Inštitut za kriminologijo pri Pravni fakulteti, 1998.
3. EMCDDA (2001)- European Monitoring Centre for Drugs and Drug Addiction. Annual Report on the state of the drugs problem in the European Union 2001. EMCDDA. Lizbon.
4. EMCDDA (2001)- European Monitoring Centre for Drugs and Drug Addiction. Report on the drug situation in the candidate CEECs 2002. EMCDDA. Lizbon.
5. Flaker V, Grebenc V, Rode N, Belin J, Fojan D, Grošičar A, Feher I, Šantelj M, Kastelic A, Zupančič D, Merdanović Z: Podobe uživanja heroina v Sloveniji z vidika zmanjševanja škode : preliminarno poročilo o raziskavi. *Soc delo*, 38, 4-6: 341-393. An English version: *Landscapes of Heroin Use in Slovenia: Harm Reduction Point of View (Preliminary Research Report)* available as a manuscript with the author.
6. Flaker V, Nolimal D, Krek M, Kocmur D, Rode N: *Droge in nasilje*. Ljubljana, Mirovni inštitut, 1993
7. Flaker V: *Živeti s heroinom I.: Družbena konstrukcija uživalca v Sloveniji*. Ljubljana, *cf, 2002.
8. Flaker V: *Živeti s heroinom II.: K zmanjševanju škode*. Ljubljana, *cf, 2002.
9. Fulwiler C., Grossman H., Forbes C., Ruthazer R. (1997): Early-onset substance abuse and community violence by outpatients with chronic mental illness. *Psychiatr Serv*. 48: 1181-1185.
10. Hibell B, Andersson B, Ahlstrom S, Balakireva O, Bjarnason T, Kokkevi A, Morgan M, Stergar E: The 1999 ESPAD report. Alcohol and Other Drug Use Among Students in 30 European countries. Stockholm: The Swedish Council for Information on Alcohol and Other Drugs, CAN. Council of Europe, 2000; 383
11. Institute of Public Health of the Republic of Slovenian- Information Unit for illegal drug (2002): Standardised epidemiological tables 2002.
12. Institute of Public Health of the Republic of Slovenian- Information Unit for illegal drug (2001): Report on the state of drugs problem in the Republic of Slovenia. Institute of Public Health of the Republic of Slovenia. Ljubljana.
13. Kastelic A, Kostnapfel Rihtar T. Javna zdravstvena služba. Mreža centrov za preprečevanje in zdravljenje odvisnosti od prepovedanih drog. Kako preprečujemo in zdravimo odvisnosti od prepovedanih drog v sistemu zdravstvenega varstva, Ljubljana; Ministrstvo za zdravstvo, 2000.
14. Kastelic A, Kostnapfel T: Kako preprečujemo in zdravimo odvisnosti od prepovedanih drog v sistemu zdravstvenega varstva., Ljubljana, Koordinacija centrov za preprečevanje in zdravljenje odvisnosti od prepovedanih drog pri Ministrstvu za zdravstvo RS, 2000.
15. Kostnapfel Rihtar T, Kastelic A. Zakonodaja na področju drog; *Med Razgl* 1996; 35: Supl 5: 39-41
16. Kostnapfel Rihtar T. Quality of services in the Methadone Maintenance Program, Master study, Zagreb, 2000.
17. Kostnapfel Rihtar T. Kakovost storitve vzdrževalnega metadonskega programa v letih 1995 in 1997. *Odvisnosti*, leto 2, supl., September 2001; 13-54.
18. Kastelic A, Kostnapfel Rihtar T. Slovenia- Network of Centres for the Prevention and Treatment od Drug Addiction. UNAIDS Best Practice Collection. Drug Abuse and HIV/AIDS: Lessons learned. Case Studies Booklet. Central and Eastern Europe and the Central Asian States. United Nations, New York, 2001.
19. Kastelic A, Kostnapfel Rihtar T. Mreža centara za prevencijo i liječenje narkomana u Republici Sloveniji. The network of centres for the prevention and treatment of drug addiction in the Republic of Slovenia. *MED ARH*, Sarajevo, 2001; 55(3): 135-139
20. Kostnapfel Rihtar T. Najnovejše smernice v zdravljenju opioidne odvisnosti v Združenih državah Amerike. *Odvisnosti*, leto 1, štev.1-2, maj 2000; 70
21. Kostnapfel Rihtar T: Dvogodišnje pračenje kvalitete metodonskog programa. Zagreb, Sveučilište u Zagrebu, Medicinski fakultet, 2000.
22. Lovrečić M, Dernovšek M. Z, Tavčar R, Maremmani I (2001). The differences between inpatients and outpatients with illegal drug use : prevalence of comorbid mental disorders. *Heroin addiction and related clinical problems*, 3: 41-46.

23. Lovrečič M, Dernovšek M. Z, Tavčar R, Maremmani I (2001) The differences between heroin addicts with and without comorbidity. *Heroin addiction and related clinical problems*, 3: 39-44
24. Marsden J., Gossop M., Steward D., Rolfe A., Farrell M. (2000): Psychiatric symptoms among clients seeking treatment for drug dependence. *Br J Psychiatry*. 176: 285-289.
25. Milby J.B., Sims M.K., Khuder S., Schumacher J.E., Huggins N., McLellan A.T., Woody G., Haas N. (1996): Psychiatric comorbidity: prevalence in methadone maintenance treatment. *Am J Drug Alcohol Abuse*. 22: 95-107.
26. Nolimal D. Estimating the extent of heroin problem in Slovenia: application of the key informant approach and the nomination technique where there are no other reliable sources of information. *Bulletin of Narcotics* 1996;48(1,2):121-134.
27. Nolimal D: Tehnike souporabljanja pribora za vbrizgavanje, družbeni okvir in preprečevanje okužb s krvjo pri uporabnikih drog, *ZdravVar* 2000, 39:56-62.
28. Pani P.P., Trogu E., Contu P., Agus A., Gessa G.L. (1997): Psychiatric severity and treatment response in a comprehensive methadone maintenance treatment program. *Drug Alcohol Depend*. 48: 119-126.
29. Rihtar-Kostnapfel T, Kastelic A. Methadone maintenance programme quality. *Zdrav Varst* 1997;36 (Suppl 1): S5 - S13.
30. Simpson D.D., Joe G.W., Rowan Szal G.A., Greener J.M. (1997): Drug abuse treatment process components that improve retention. *J Subst Abuse Treat*. 14: 565-572.

ANNEX 2

Drug Monitoring Systems and source of information (Prepared from National report 2001)

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.

- **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 Foundation 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...

2. Demand reduction

Information about demand reduction is primarily available at the Government Office for Drugs since the president was also DDRP co-ordinator.

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. 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 Government 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 co-operation in specific projects reports are prepared.

There is no common report, covering all structures and activities, that could be used as a national report.

ANNEX 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 Biro 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 Slovenian 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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