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REPORT ON THE DRUG SITUATION 2003 OF THE REPUBLIC OF SLOVENIA

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Experience, persistence, maturity

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Lector:
Murray Bales

Editor:
Mercedes Lovrečič, MD
REITOX National Focal Point Co-ordinator

Editorial Board:
Tatja Kostnapfel Rihtar, M.Sc.
Radivoje Pribaković Brinovec, MD

Technical assistance:
Vili Prodan

Address:
Institute of Public Health of the Republic of Slovenia
Information Unit for Illegal Drugs
REITOX National Focal Point
Trubarjeva 2, 1000 Ljubljana, Slovenia
Tel.: + 386 1 2441 400; + 386 1 2441 401; + 386 1 2441 479
Fax.: + 386 1 2441 447

e-mail: mercedes.lovrecic@ivz-rs.si
e-mail: tatja.kostnapfel@ivz-rs.si
e-mail: rade.pribakovic@ivz-rs.si

EXPERTS CONTRIBUTING QUALITATIVE INFORMATION AND DATA

Mercedes Lovrečič	National Focal Point - Institute of Public Health of the Republic of Slovenia
Tatja Kostnapfel Rihtar	National Focal Point - Institute of Public Health of the Republic of Slovenia
Radivoje Pribaković Brinovec	National Focal Point - Institute of Public Health of the Republic of Slovenia
Miljana Vegnuti	National Focal Point - Institute of Public Health of the Republic of Slovenia
Miran Belec	National Focal Point - Institute of Public Health of the Republic of Slovenia

in alphabetical order:

Alenka Curk	Government Office for Drugs
Vito Flaker	School for Social Work
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Marta Grgič Vitek	Institute for Public Health of the Republic of Slovenia
Tomo Hasovič	Ministry of Internal Affairs of the Republic of Slovenia
Jože Hren	Government Office for Drugs
Andrej Kastelic	Centre for Treatment of Drug Addiction, Psychiatric Clinic Ljubljana
Irena Klavs	Institute of Public Health of the Republic of Slovenia
Nuša Konec	Regional Institute of Public Health Celje
Matej Košir	Government Office for Drugs
Rajko Kozmelj	Ministry of the Internal Affairs of the Republic of Slovenia
Miloš Kravanja	Institute of Public Health of the Republic of Slovenia
Milan Krek	Government Office for Drugs
Lidija Kristančič	Ministry of Health of the Republic of Slovenia
Boris Novak	Ministry of the Internal Affairs of the Republic of Slovenia
Olga Uršič Perhavc	Administration for the Enforcement of Penal Sentences
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Ljubo Pirkovič	Ministry of the Internal Affairs of the Republic of Slovenia
Peter Stefanoski	Ministry of Labour, Family and Social Affairs of the Republic of Slovenia
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WORKING GROUPS

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Čuk Rupnik Jasna, Centre for the Prevention and Treatment of Drug Addiction Logatec
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Kocmur Dare, Aids Foundation Robert – project Stigma
Konec Nuša, Regional Institute of Public Health Celje
Kristančič Lidija, Ministry of Health of the Republic of Slovenia
Perhavc Uršič Olga, Administration for the Enforcement of Penal Sentences
Vegnuti Miljana, Head, NFP - Institute of Public Health of the Republic of Slovenia

Drug-related infectious diseases in alphabetical order:

Belec Miran, NFP - Institute of Public Health of the Republic of Slovenia
Fras Stefan Tamara, Centre for the Prevention and Treatment of Drug Addiction Ljubljana
Grgič Vitek Marta, Institute of Public Health of the Republic of Slovenia
Klavs Irena, Head, Institute of Public Health of the Republic of Slovenia
Leskovšek Evita, Aids Foundation Robert
Matičič Mojca, Department of Infectious Diseases, University Medical Centre, Ljubljana
Perhavc Uršič Olga, Administration for the Enforcement of Penal Sentences
Poljak Mario, Department of Microbiology and Virology, Medical Faculty

Drug-related death in alphabetical order:

Belec Miran, NFP- Institute of Public Health of the Republic of Slovenia
Brvar Miran, National Poison Control Centre, Clinical Centre Ljubljana
Čelan Lucu Branka, Centre for the Prevention and Treatment of Drug Addiction Ljubljana
Kravanja Miloš, Institute of Public Health of the Republic of Slovenia
Možina Martin, National Poison Control Centre, Clinical Centre Ljubljana
Novak Boris, Ministry of Internal Affairs of the Republic of Slovenia
Šelb Šemerl Jožica, Head, Institute of Public Health of the Republic of Slovenia
Zorec Karlovšek Majda, Institute for Forensic Medicine, Medical Faculty, University of Ljubljana

General population surveys in alphabetical order:

Markota Mladen, Institute of Public Health of the Republic of Slovenia
Pečar Čad Silva, Institute of Public Health of the Republic of Slovenia
Stergar Eva, Head, Institute of Public Health of the Republic of Slovenia
Šešok Janja, Institute of Public Health of the Republic of Slovenia
Šircelj Milivoja, Statistical Office of the Republic of Slovenia

Prevalence estimates in alphabetical order:

Belec Miran, NFP - Institute of Public Health of the Republic of Slovenia
Grebenc Vera, School of Social Work – University of Ljubljana
Grgič Vitek Marta, Head, Institute of Public Health of the Republic of Slovenia
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Šelb Jožica, Institute of Public Health of the Republic of Slovenia
Zaletel Kragelj Liljana, Faculty of Medicine – Institute of Social Medicine
Žagar Alenka, Aids Foundation Robert – Project Stigma

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SUMMARY

This is the third time the REITOX National Focal Point at the Institute of Public Health of the Republic of Slovenia has presented its annual Report on the Drug Situation, drawn up for the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The report for 2000 was compiled in March 2002 and that for 2001 in November 2002.

Slovenia was already developing its information system for drugs at the start of the nineties, with the support of various Phare projects and international organisations dealing with the area of illegal drugs. During the process of meeting requirements stemming from Chapter 24 of the Association Agreement between Slovenia and the EU, there arose a definite need for co-operation with the EMCDDA. An Information Unit for Illegal Drugs, the main part of which was formed by the National Focal Point (NFP), was founded to co-operate with the REITOX network.

The current legal basis for this can be found in the Act Regulating the Prevention of the Use of Illicit Drugs and the Treatment of Drug Users (Official Gazette 98/99, Article 15). In March 2001, the Minister of Health of the Republic of Slovenia issued an order to establish the Information Unit for Illegal Drugs (IUID).
This unit only started operating in 2002. Slovenia is thus, via the NFP, included in the REITOX NFP network, together with the EU Member States, Norway, the European Commission, the acceding states and the candidate countries.

The IUID and NFP became fully operative with the fulfilment of the EMCDDA requirements. In March 2002, it submitted statistical tables and the National Report in line with the EMCDDA guidelines, based on data from 2000. A few months later, in spite of there being a change in the head of the IUID and the national co-ordinator for REITOX NFP, another set of statistical tables and the National Report based on data from 2001 was sent. The short period required for the drawing up of these documents is proof that the information system for drugs in Slovenia is stable and that the interministerially co-ordinated gathering of data and exchange of information at both national and international levels are running smoothly. Prior to being sent abroad, the Report was dealt with and approved by both the NFP Advisory Board and the Government Commission for Drugs. Last year Slovenia was the first candidate country to submit this report.

This year, the NFP of the IUID has already sent statistical tables and drafted the National Report for 2003. The latter will first be presented to the Advisory Board of the NFP and then submitted for inclusion on the agenda of the Government Commission for Drugs. This year, new national information networks have been set up and co-operation with additional national partners has been established.

MAIN TRENDS AND DEVELOPMENTS

The IUID, together with the NFP, was formally founded on the basis of the Act Regulating the Prevention of the Use of Illicit Drugs and the Treatment of Drug Users (Official Gazette 98/99, Article 15) in March 2001, and became operative a year later by fulfilling the EMCDDA requirements. In line with the guidelines, in 2002 it submitted statistical tables and the National Reports for 2000 and 2001.

In addition to fulfilling the EMCDDA requirements, the IUID also fulfils those of other international organisations in the area of illegal drugs, such as the UNDCP, the Pompidou Group and the WHO. It also draws up reports to meet the requirements of national bodies.

The IUID was the only organisation in Slovenia to draw up the National Action Plan for Drug Information System (NAPDIS) for 2002-2004, which has already been dealt with and approved by the Government Commission for Drugs and sent abroad. Moreover, the IUID is the only organisation in Slovenia for which various foreign independent evaluations have been carried out, which have also assessed the development of the information system for drugs used. These assessments, in addition to the numerous materials and results produced, indicate the progress made in relation to the Drug Information System (DIS), whilst they also show a need for financial, personnel and political support for maintaining existing activities and developing new ones.

Working groups for the five key epidemiological indicators were formally established in 2002. These groups had been formed and were carrying out some activities even before Slovenia signed the agreement for the Phare Twinning Covenant project. During implementation of the Phare project, these activities continued, strongly supported by the Austrian NFP. Thus, all activities planned in the NAPDIS have been carried out. In 2002, for the first time prevalence estimates for problem drug use and of drug-related acute death were prepared the national level, following the EMCDDA guidelines.

The IUID-NFP co-ordinated the activities and took part in the setting up of the EWS in Slovenia. The related promotional activities started at the end of 2002 and continued within the framework of the Phare Twinning Covenant. A national co-ordinator for EWS in Slovenia has been appointed who regularly attends European meetings. A model for Slovenia has been created. Activities related to the fulfilment of the EWS' obligations to Europol have been taking place for a year and a half and are being carried out by the General Police Administration within the Ministry of the Interior. These activities represent the basis for upgrading the EWS. The exchange of information between EMCDDA-REITOX and IUID-NFP and the national co-ordinator is already taking place. The formation of a working group to draw up an action plan has been proposed. The IUID will submit the model for Slovenia for debate by the Government Commission for Drugs.

The IUID-NFP has taken part in activities related to establishment of the EDDRA in Slovenia, too. In December 2002, promotional activities took place, which then continued within the Phare Twinning Covenant project. A national EDDRA manager was appointed who regularly attends European meetings. The EDDRA database, which draws upon information from assistance programmes for 1999 and 2001, is located at the documentation centre of the Government Office for Drugs. The drafting of a translated and adapted questionnaire for national purposes is planned.

Initial steps in forming the ELDD (European Legal Database on Drugs) were taken by the IUID-NFP in terms of providing information, legal documents and proposed to the Ministry of Health of the Republic of Slovenia to nominate a responsible person.

In 2002, the Government Office for Drugs co-ordinated and drew up a national drug strategy for 2003-2008 to replace the one from 1992. At first, it was planned as a national strategy for 2000-2004 in line with the EU strategy, but later the time scale was changed to 2003-2008. A draft

national strategy for 2003-2008 was debated and approved by the Government Commission for Drugs at the end of 2002. By June 2003, the strategy had not yet been debated or approved by the Government of the Republic of Slovenia[1]. After this is done, it will have to be debated by the Parliament. An action plan for 2004-2008 will subsequently have to be drafted. The EU will produce its action plan for the same period. The EU is also envisaging intermediate and final evaluations, which will assess the effectiveness and implementation of drug strategies. However, in Slovenia we have not yet carried out any strategy evaluations.

[1] The National Drug Strategy was adopted by the Government at the end of September 2003.

PART 1

NATIONAL STRATEGIES: INSTITUTIONAL & LEGAL FRAMEWORKS

1. Developments in Drug Policy and Responses: Jože Hren, Matej Košir, Alenka Curk, Milan Krek

1.1. Political framework in the drug field

The Government Commission for Drugs accepted the new national strategy at the end of 2002. The National Parliament put discussion and deciding about the strategy on the agenda in 2003. The main objectives and programmes included in the strategy are strengthening and development of the information system in the field of drugs, drug demand reduction programmes, drug supply reduction programmes, international co-operation, co-ordination at different levels (national, regional and local) and the evaluation of programmes, research activities and education. The strategy also includes activities to prevent or reduce the use/abuse of new synthetic drugs. Other components of the strategy are the methodology for preparing the strategy, principles, objectives and priorities of the strategy, actors (holders of different activities), mechanisms for achieving the objectives (e.g. instruments), financial plan, methodology for preparing action plans etc.

The Government started an important re-organisation of governmental bodies and offices in 2002. There are intentions to change the status of several governmental offices, including the Government Office for Drugs. The aim is to incorporate it within the Ministry of Health as a professional body with responsibilities for interministerial co-ordination, but not before 1 January, 2004. Future status and competences of the office are not precisely defined yet.

The Phare Twinning project started in April 2002 (in co-operation with Spain and Austria). A pre-accession advisor (PAA) from Spain was sent to Slovenia for 15 months to co-ordinate project activities. The project's main objectives are to strengthen the National Focal Point, drug demand reduction programmes and drug supply reduction programmes in Slovenia. The project is financed by the European Union and the Slovenian Government. Our country finally consolidated the way the National Focal Point functions during this project.
Expenses within the Twinning project were distributed between the EU and Slovenia as follows: € 931,400 directly from the EU budget (financed by the EC) and € 156,177 from the Slovenian Government (taxes for equipment and programme activities up to 31 August, 2003).

Slovenia also started or continued to co-operate in other Phare and pre-accession projects, e.g. Phare programmes for synthetic drugs and money laundering. Slovenia was supplied with different items of equipment for the police, customs, health services, National Focal Point and Government Office for Drugs through a Phare tender in 2002. Slovenia was invited to start co-operation in the Cordrogue group in Brussels.

Slovenia was also very active in regional co-operation. The Government started to prepare for the Slovenian presidency of the Visegrad group, which occurred in 2003. There was to be a conference organised during this presidency in 2003. The Government also started to co-operate with the Croatian government and its Office for Drugs. Preparation of a Balkan conference on the Balkan drug trafficking route started in 2002. The conference was to take place in Dubrovnik (Croatia) in 2003.

The Government Office for Drugs continued its active programme for the development and functioning of the Local Action Groups (LAGs) network. One of the new national strategy priorities in 2002 was the establishment of new LAGs. The total number of LAGs increased by 10%. Preparation of an Action Plan for LAGs started recently. The Government Office for Drugs established a consultative group of representatives from different LAGs, which is responsible for preparing the Action Plan. The Office also took the initiative to encourage the cross-border co-operation of local action groups from Slovenia and Austria.

1.2. Legal framework

A new national strategy was introduced and accepted by the Government Commission for Drugs at the end of 2002. Some changes to the legislation on precursors were introduced at the end of 2002. The purpose of these changes and completion of the legislation on precursors is to do away with some imperfections and lack of clarity in the present legislation with regard to EU definitions in that field, the classification of precursors in different groups, regulation of trafficking, production and control on precursors etc. The Government was preparing new legislation on the cultivation of cannabis for industrial purposes in 2002.

1.3. Implementation of laws

Legislation was well implemented in practice. Although the National Strategy was still not accepted by the National Parliament, many activities to realise the priorities were already introduced and implemented.

1.4. Developments in public attitudes and debates

The Government Office for Drugs organised a conference on the medicinal use of cannabis in November 2002, which was well covered by the national media. One public survey presented in the Delo newspaper shows that people generally support the medicinal use of cannabis, but not the legalisation of cannabis and its products for recreational purposes.

The Government Office for Drugs organised the 5th National Conference of Local Action Groups (LAGs) in December 2002 in Murska Sobota. The main topic of the conference was the perspective of LAGs with regard to the professional or volunteer functioning of these organisations. Some experts from Austria and Spain were invited to present their experience in this area. The main result of the conference was an appeal to local authorities to establish LAGs as soon as possible, especially in those areas which have no similar organisations and activities in the field of drug prevention etc.

The Local Action Group (LAG) in the Municipality of Grosuplje organised a seminar on drug demand reduction programmes at the local level in October 2002 in co-operation with two British experts (Brian Dobson and Karen Sharp). The seminar was financed by the British Embassy in Ljubljana. There were more than 70 participants from different LAGs and other community-based programmes in Slovenia.

1.5. Budgets and funding arrangements (2002)

At the moment it is impossible to describe all funds dedicated to the different programmes and professionals working in the field of drugs because some activities and funding arrangements are direct while others are indirect. Data are incomplete especially in the prevention programmes and in the field of drug supply reduction. For this reason, the comparison between budget expenditure in different sectors is difficult.
Different ministries and offices spent € 8,639,500 in co-financing the programmes of NGOs and/or financing their own activities in the field of drugs in 2002.

- The Ministry of Work, Family and Social Affairs spent € 1,050,400 on social rehabilitation programmes.
- The Ministry of Internal Affairs spent € 680,800 on drug police officers and their material expenses.
- The Ministry of Finance spent € 106,900 on customs officers' training and equipment.

- The Health Insurance Institute of the Republic of Slovenia spent € 2,018,100 on the operation of Centres for the Prevention and Treatment of Drug Addiction, € 170,200 on the operation of the Centre for the Treatment of Drug Addiction in Ljubljana, and € 2,397,100 on methadone as a medicine.
- The Ministry of Health spent € 44,100 on different preventive programmes and € 35,800 on programmes of therapy and control.
- The Ministry of Justice spent € 38,300 on urine tests and € 10,600 on methadone in prisons.
- The Ministry of Education, Science and Sport spent € 38,300 on prevention programmes in schools and € 89,600 on the prevention programmes and projects of youth organisations.
- The Office for Youth which is located within the Ministry of Education, Science and Sport spent € 595,700 on youth programmes in the field of drugs.
- The Government Office for Drugs spent € 308,800 on staff and material costs and € 54,800 on programmes and projects, mostly in the prevention field. The Office also spent € 1,000,000 within the PHARE/Twinning project on equipment (for police, customs, centres for the prevention and treatment of drug addiction, the National Focal Point and the Government Office for Drugs) and training. Some municipalities spent an unknown amount for the activities of Local Action Groups in 2002, mostly preventive activities (lectures, training, preventive materials etc.).

PART 2

EPIDEMIOLOGICAL SITUATION

2. Prevalence, Patterns and Developments in Drug Use

2.1. Main developments and emerging trends

Length of the latency period in heroin users from 1991 to 2000 in Ljubljana: Miljana Vegnuti

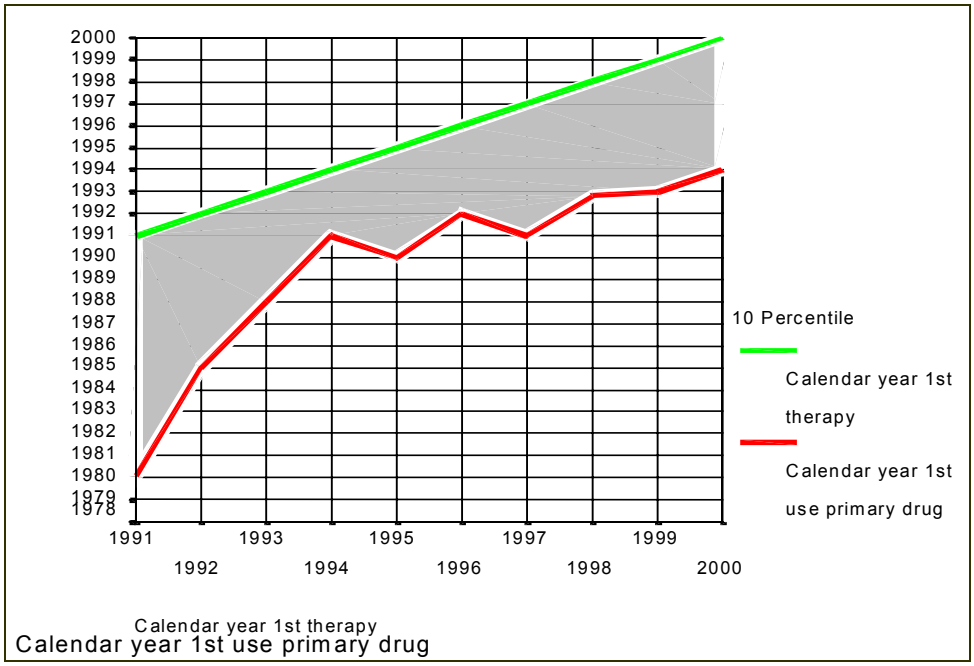
In the period from 1991 to 2000 in the capital, Ljubljana, 1874 heroin users entered into a treatment programme as new or returning (after an interruption) clients. The main drug problem in Ljubljana is heroin. It represents more than 85% of all drug cases.

The aim of the study was to determine the length of the latency period (r), the time spent on using heroin before entering the treatment programme, and whether the factors influencing the length should be recognized.
It is assumed that a special identification code prevents any double counting in the core database.

The second therapeutic centre in Ljubljana was established in 1995 (data provided from 1997), and at this time the number of clients in treatment almost doubled. A reasonable explanation here is that the new centre, established as a Department for Detoxification at the Psychiatric Clinic with inpatient and outpatient units, has been offering a different approach based mainly on detoxification and that patients do not only involve city residents.

Kaplan-Meier and Cox regressions were used for analysing the predictors of the length of the latency period.
With the 'status' variable only first-treated clients are included, while the others are excluded.
The crude latency period estimation for the first treatment is 2.51 years on average, 50% of heroin drug users come for treatment within two years, while for 90% of them it takes 5 years from the beginning of their heroin use to start treatment. The maximum value for the latency period is 22 years in Ljubljana.

Figure 2.1.1. 90 percentile estimation of the latency time of heroin users from 1991 to 2000 in Ljubljana



Source: Institute of Public Health of the Republic of Slovenia

Those who came for treatment in 1991 (specialised treatment for drug use in Slovenia started in 1991) had been on heroin for up to ten years. Entering later on the 90 percentile latency period tends to be three years shorter.

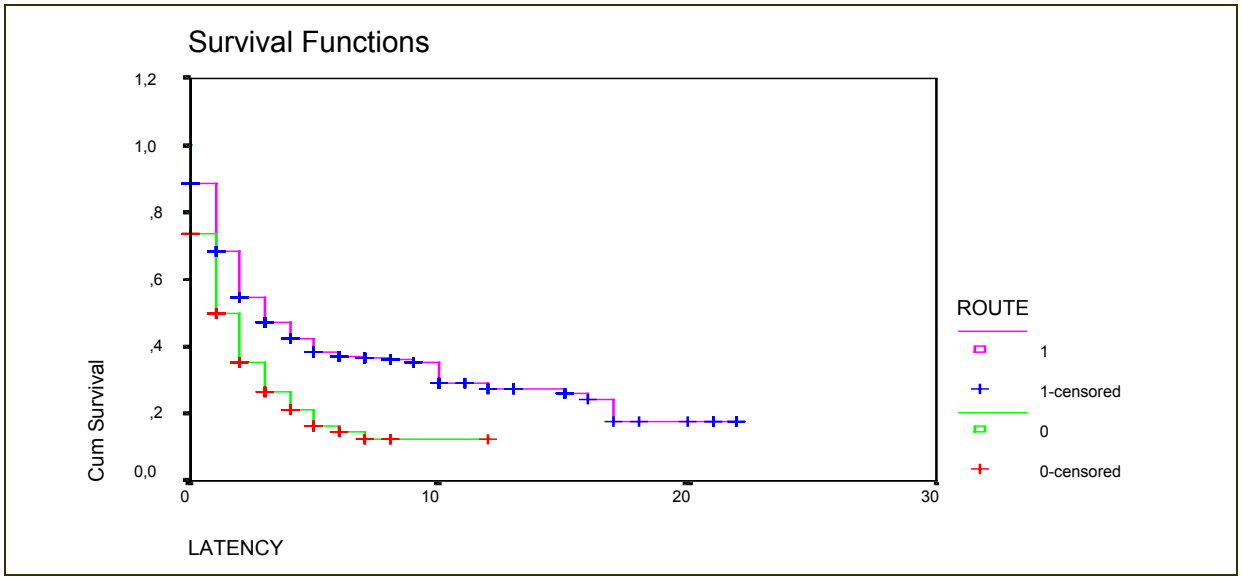
The route of the administration of heroin is an important factor which influences the duration of the period from the first use of heroin and the onset of treatment.

Using the Kaplan-Meier method we estimate the latency period as a function of the route of administering heroin. The test (null) hypothesis is that the route of administration of the drug does not influence the latency time.

Table 2.1.1. No. of drug users from 1991 to 2000 in Ljubljana

Route of administration	N
Non-injector	316
Injector	1558
Overall	1874

Figure 2.1.2. Survival times for injectors and non-injectors



Source: Institute of Public Health of the Republic of Slovenia

The median latency period in Ljubljana with heroin addicted clients who are injectors is 3 years and for non-injectors it is 1 year.
The difference among injectors and non-injectors regarding the period between the two time points is significant (p=.0000). The probability of taking a shorter period to start treatment is bigger for those who are non-injectors.
The influence of possible covariates such as gender, age of the first use of heroin and the route of administration are tested in the regression model (Cox Regression) to evaluate whether they impact on latency time.

Table 2.1.2. Impact of different variables on latency time

	B	SE	Wald	df	Sig.	Exp(B)	95,0 % CI for Exp(B)	
							Lower	Upper
GENDER	.063	.086	.535	1	.464	1.065	.899	1.262
STARTING YEAR OF THERAPY	.061	.012	24.421	1	.000	.941	.918	.964
ROUTE	-.0465	.095	23.776	1	.000	.521	.521	.757
AGE OF 1ST USE HEROIN	.019	.008	5.197	1	.023	1.019	1.003	1.036

Source: Institute of Public Health of the Republic of Slovenia

The route of administration is coded 0 for non-injectors and 1 for injectors and is likely to be an appropriate predictor of the latency time. While Exp (B) is less than 1 (and B is negative) we assume that the step from being a non-injector (0) to an injector (1) indicates decreasing predicted survival time. Those who are heroin injectors are significantly more hazardous actors than non-injectors regarding latency time.
Age of one's first heroin use is also an important predictor of the latency period. Being a year older when starting with heroin means that the time that passes before starting therapy is longer.

The earlier calendar years of treatment coincide with the beginning of drug treatment in Slovenia. People in the treatment system in this early period were 'cumulatives' of those who started heroin use before the treatment system was introduced.
They probably would have started treatment before had it been available.

The starting year of therapy is a significant predictor of the length of the latency period.

If we add a unit to the calendar year we indicate a decreasing value of hazard (latency). Those who start therapy a year later have a greater chance of having a shorter latency compared to previous year starts.
For those starting late there is a possible explanation regarding the availability of facilities and an awakened awareness of drug risk behaviour. Considerable changes in latency time are also due to the availability and price of heroin.

The influence of possible covariates such as age groups of the first use of heroin, employment status, year of the start of therapy and the route of administration are tested in the model to evaluate whether they impact on latency time.
The route of administration of heroin, starting year of therapy, age group and employment status are significant predictors on the length of the latency time.
From the previous model we also know that the route of administration, year of starting therapy and age do influence the latency period. We assume that injectors and those who were involved later in the system (in the whole 1991 to 2000 period) have shorter latency than those who started sooner.
Being older when someone starts heroin use is reflected in significantly more time being involved to enter the treatment process. In other words, it is possible that the age of one's first heroin use reflects a parent-free life and having employment.
We can observe that unemployed heroin users and others together with those still at school have shorter latency times. The model consists of the resulting latency period as a combination of an individual's age, route of administration of the drug, his employment status and the time point of inclusion in the treatment system.
In the case of Ljubljana the age of the start of heroin use, injecting behaviour and employment are reliable predictors of the length of the period before a drug user undertakes treatment.
Having the information on the first use of the primary drug we can estimate the true incidence of heroin users by means of the latency method, which should be used where we consider that the social and individual characteristics of drug users and treatment facilities are stable.
For more information, please see: 2.1 Main developments and emerging trends, 3.1. Drug treatment demand, 3.2. Drug-related mortality, 3.3. Drug-related infectious diseases, 6. Trends per Drug, and 7. Discussion.

2.2. Drug use in the population:

a) Main results of surveys and studies

No data on drug use in the population 18+ were available for 2002. ESPAD studies were done in Slovenia in 1995, 1999, 2003.
The last wave of ESPAD, covering the school population aged 15 - 16, was done in 2003. Results will be presented in the next National Report . For more information, please see previous reports.

Characteristics of heroin use in Slovenia

For more information, please see 2.1 Main developments and emerging trends, 3.1. Drug treatment demand, 3.2. Drug-related mortality, 3.3. Drug-related infectious diseases.
The last study was conducted at the Faculty for Social Work (Flaker et al., 1999). For detailed data, please see the previous National Report.
No new data on these topics were referred to.

b) General population

No new data on studies on drug use among the general population in accordance with the EMCDDA recommendations is available. A working group was established in 2002 and a study is planned for 2004. The main reason for not previously performing this study is the lack of human and financial resources.

c) School and youth population

No new data on studies on drug use among the school and youth population at the national level in 2002 is available. For previous data, please see the previous National Report. ESPAD studies in Slovenia were done in 1995, 1999 and 2003. Data for 2003 will be presented in the next National Report (data for 2003).

2.3. Problem drug use: Marta Grgič Vitek

Activities carried out in the framework of the PHARE Twinning Covenant Project on the epidemiological key indicator Prevalence Estimates provided some preliminary results at the end of one-and-a-half years of co-operation.

To obtain some data on the prevalence of problem drug use, a group of experts in prevalence estimates was formally established at the National Focal Point in July 2002.

At the beginning of the project several potential data sources for Prevalence Estimates (PE) were identified which could be used with different methods proposed by the EMCDDA.

- Treatment data: includes a personal identifier (SOUNDEX), date of birth and information about the main drug
- Notifications to the police: data on misdemeanours and felonies in connection with drugs on a personal basis
- Drug-Related Deaths: data from the general mortality register on a personal basis
- Data from low-threshold programmes

It was decided to follow a twofold strategy. First, existing routine data would be used (e.g. the capture recapture (CRC) method using treatment data, police data and drug-related deaths data) since no extra funding was available. Second, a survey amongst the drug using population should be conducted to get different multipliers (in-treatment rate, proportion of drug users that have come into contact with the police…), which would then be used to estimate the entire drug using population (multiplier method for Prevalence Estimation). This would be done in collaboration with representatives of the group of experts on the infectious diseases indicator.

For pilot implementation of the key indicator PE it was decided to carry out a three-sample CRC estimation for 2000 using police data, treatment data and drug-related deaths data. Regulations concerning data protection were clarified and it was found that a legal basis does exist for data exchange between respective institutions for Prevalence Estimation purposes.

The group adopted the EMCDDA definition for the target population. While trying to carry out the three-sample CRC estimation it became obvious that the drug-related death database is too small to use as one of the three data sources.
After succeeding in carrying out a two-sample CRC estimate for 2000 (for all Slovenia without Koper and the coast region) the results and possible problems within the data and their consequences were discussed. Within training activities carried out in the framework of the Phare Twinning Covenant Project data for 2001 were also used and an estimation was obtained as well as a deeper insight into problems in the data. Since the quality of CRC estimates depends on the quality of the personal identifier used, activities to check and improve these identifiers should be

carried out. Since the date of birth is part of the identifier it is necessary to improve treatment data from the Koper region to obtain a CRC estimation for the whole country. At the moment it is only possible to carry out a two-sample CRC estimation which makes it impossible to take into account the interaction between these two data sources. To obtain a third source of data which would allow us to do so, the availability and suitability of hospital data should be examined.
In addition, exact case definition should be reconsidered (which cases should be included in the CRC estimation). A standard for delivering data for CRC estimations in the same way each year (the format of variables, which variables to include…) should also be established.
The results of Prevalence Estimations would have to be discussed in a broader reference group, including experts from the field and policy.

3. Health Consequences

3.1. Drug treatment demand: Mercedes Lovrečič, Miljana Vegnuti, Radivoje Pribakovic Brinovec, Miran Belec

The drug information system in Slovenia has been developing since the early 1990s in line with the support of different Phare projects and international organisations dealing with drugs. The reporting system on drug treatment demand in Slovenia started in 1991 at the National Institute of Public Health of the Republic of Slovenia (NIPH). The NIPH has always been the lead actor in drug treatment demand data collection.
In March 2001 the Minister of Health of the Republic of Slovenia issued a decree on organising the new Information Unit for Illegal Drugs (IUID) with its main part – the National Focal Point (NFP) at the NIPH, under the Ministry of Health. In fact, the IUID is also involved in drug treatment demand data collection and the database on the treatment demand indicator is situated at the IUID.

The drug treatment demand indicator is already being implemented to a large extent in the network of Centres for the Prevention and Treatment of Illegal Drug Dependence. An update of the questionnaire was made in 2001 and it is now fully compatible with the EMCDDA's core items and Pompidou Group Protocol. Data collection for 2002 is based on the improved questionnaire according to the new protocol which is compatible with the EMCDDA's guidelines; only slight changes compared to former years was necessary.

The questionnaire Drug Users Treatment Evidence (*Evidenca obravnave uživalcev drog*), harmonised with the PG/EMCDDA TDI standard protocol also includes additional items on risk behaviour, infectious diseases, sexual behaviour and legal experiences. All data include personal identifiers based on SOUNDEX (double-counting controlled). Some analysis of data concerning infectious diseases and risk behaviour within the TDI data were carried out by short-term experts (Phare Twinning Covenant) and experts from working groups on drug-related infectious diseases. The main result was that there should be a modification of the TDI questions concerning infectious diseases and risk behaviour to improve the quality of data (reformulation of questions concerning risk behaviour, inclusion of the date of the test, whether tests for HIV, HBV and HCV were carried out within the treatment centre or if the information concerning the status of infection came from anamnestic data). The TDI questionnaire is filled in at the beginning of treatment (information at the moment of clinical observation). In many cases, test results are not available at this time so the part of the questionnaire concerning infectious diseases and risk behaviour should be filled in later when the test results are available. It was recommended to carry out a well-designed revision of TDI questions based on the recommendations. Besides discussions with experts working in practice a small-scale pilot study is necessary. The possibility to change data collection procedures (to fill in the part concerning the status of infection later) also has to take into consideration the reality of professionals working in the network of centres. The second option is to prepare and develop a new and separate questionnaire concerning infectious diseases and risk behaviour.

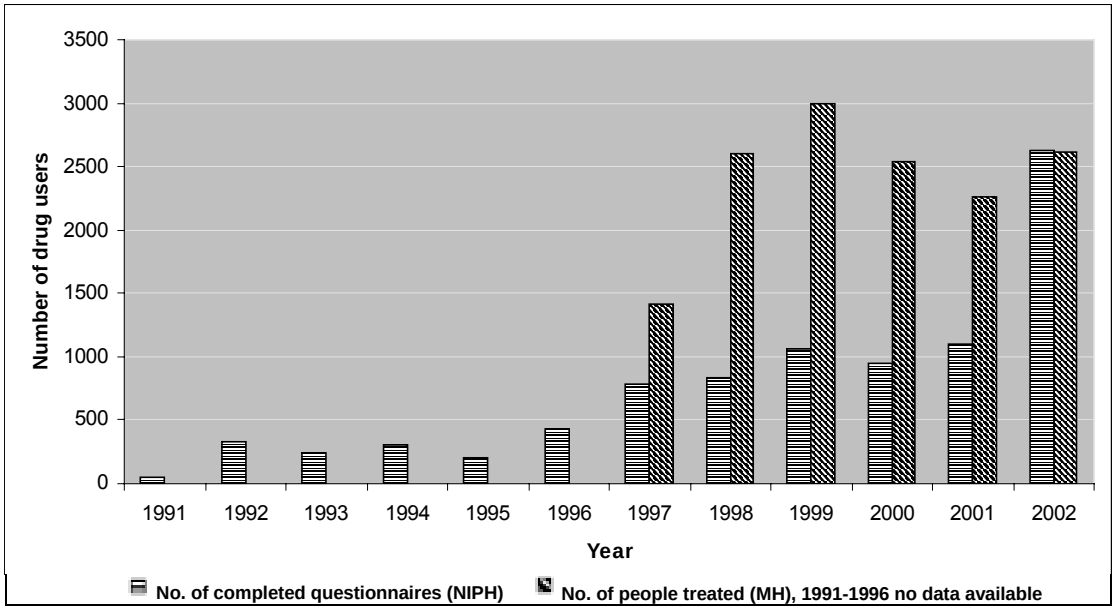
The drug treatment demand indicator actually covers the national network of Centres for the Prevention and Treatment of Illegal Drug Addiction (CPTDA). The network of CPTDA was officially established in 1995 but treatment with opioid agonist methadone was also possible before (since 1991). In 2002 the network and its coverage were enlarged, there were 18 centres: 17 CPTDA (outpatient units) within primary health care centres and the Centre for the Treatment of Drug Addiction within the Psychiatric Clinic Ljubljana (outpatient and inpatient units) being included in the national network. The network of CPTDA provides health care and is available to all people who are health insured. The methadone maintenance programme is considered one of the fundamental harm reduction programs.

In terms of the number of questionnaires collected between 1997-2002 we found an enormous increase in the number of completed questionnaires sent to the IUID in 2002. This was due to

improved co-operation with the centres and professionals working in the field, closer communication with them (the professionals involved were asked for their comments, received feedback and additional instructions) and also reflects the high level of devotion of professionals working in field. There were also two important changes with positive consequences at the national level, one concerning the head of the National Focal Point and one concerning the head of the working group on TD indicator. In addition, since 2000 a law has existed as the basis for the treatment reporting system which binds the centres to co-operate. There is also the possibility of changing the funding system from health insurance (flat rate) to a performance-related funding system.

About 1000 questionnaires a year have been collected by the NIPH in the last few years. The comparison between the number of people treated for drug problems in the network of centres in Slovenia (source: Ministry of Health[2]) and the number of completed questionnaires (source: NIPH) shows on one hand a more than doubling in the number of completed questionnaires in 2002 (N=2633) while, on the other hand, the number of drug users seeking treatment for drug problems appears not to be growing in the same way (Figure 3.1.1.). This has to be taken into consideration when interpreting the data since the increase in cases first of all reflects the increased coverage (while in 2002 only one another CPTDA was established and the bed capacity in the Centre for the Treatment of Drug Addiction also slightly expanded) and not increased treatment demand. This also becomes clear when looking at the increase in first treatment demand which is not as dramatic as for all treatments. The case definition for all treatments did not change and refers to all clients in treatment in the respective year in the centres involved. We assume that the majority of people treated in the Centres were reported.
For the future it would also be useful to analyse the missing cases – which cases are not reported and what are the reasons for this.

Figure 3.1.1. Number of people treated for drug problems in the network of centres in Slovenia (source: Ministry of Health (MH)) compared with the number of completed questionnaires Drug Users Treatment Evidence (source: Institute of Public Health of the Republic of Slovenia (NIPH)).



In 2002 2633 completed Drug Users Treatment Evidence questionnaires were reported. According to methodological guidelines on the completion of questionnaires every person seeking help for

[2] Ministry of Health data: no data available from 1991 to 1996 about drug users in treatment; the data are not always comparable; from 1997 to 2000 the number of drug users in treatment in the year is reported, for 2001 and 2002 the number of drug users in treatment in a three-month period (from January 1 to March 31) is reported.

illegal drug use problems in 2002 should be reported (but only once). While analysing and interpreting data from the questionnaires we found that we can well distinguish first treatments and prior treatments, but we cannot clearly distinguish people undergoing continuous long-term treatment from people entering the programme again in this year. Drug Users Treatment Evidence also does not enable a long-term follow up of treatment (which methods of treatment were applied and changed during a longer period, patient flow and reasons for leaving the programme).

Centres reported 2633 drug users in 2002. 93% of them entered the programme on their own initiative or on the advice of family or friends. The rest were referred by GPs, hospitals, social services, courts or other.

78% of drug users were male. The mean age was 26.2 years which is 7% above the mean age in 2001 and 2000. This was expected because of the higher number of questionnaires where most long-term treatment drug users were also reported. The youngest person in the programme was 13 years old while the oldest was 59 years.

62% of drug users live with their parents, 14% with their partners, 11% live alone, and 6% with a partner and a child. Only 35 drug users were homeless. 49% of drug users are unemployed, 25% are employed and 21% are students. 44.5% of all drug users finished secondary school, while 29% finished primary school (missing answers 22%).

Table 3.1.1. Number of reported drug users in treatment in the CPTDA in Slovenia in 2002 by main/primary drug and secondary drug use

	All treatments			**First treatments**			**In treatments before**		
	Male	**Female**	**All**	**Male**	**Female**	**All**	**Male**	**Female**	**All**
No. of cases	2051	582	2633	390	138	528	1661	444	2105
Main drug (%):									
Heroin	91.1	85.7	89.9	76.7	65.9	73.9			94.6
other opiates	0.6	0.3	0.5						
Cocaine (ClH)	0.4	1.2	0.6	0.5	1.4	0.8			0.6
Stimulants (total)	0.35	0.9	0.5	0.8	1.4	1			0.4
Amphetamines	0.05	0.2	0.1	0.3		0.2			
MDMA, derivatives	0.3	0.7	0.4	0.5	1.4	0.8			
Barbiturates	0.05		0.04						
Benzodiazepines	0.3	0.9	0.5	0.8	1.4	0.9			0.5
Others	0.1	0.5	0.2	0.3	1.4	0.6			
LSD	0.05		0.04						0.05
Volatile inhalants (total)	0.1		0.1	0.3		0.2			0.1
Cannabis (total)	6.8	10.5	7.6	21	28.3	22.7			3.8
2nd drug (%):									
Heroin						7.9			6.8
Cocaine (ClH)						11.5			25.0
Stimulants (total)						7.2			2.5
Benzodiazepines						4.3			6.4
LSD						0.7			0.5
Cannabis						59.9			56.2
Other substances						8.6			2.8

Source: Institute of Public Health of the Republic of Slovenia

The main drug (primary drug) remains heroin (90.4% of all treatments). In second place was cannabis, followed by cocaine. We observed an increase in the use of tranquilizers. The main secondary drug was cannabis (56.2% of all treatments), followed by cocaine and heroin.
The most frequent way of primary drug use was injecting (71.4% of all treatments). We observe a decrease in the proportion of intravenous drug-injecting users (all treatments and first treatments) from 1996 on (Annex 6, Table A5).

The mean age at the first use of any illegal drug (predominantly cannabis) was 16.1 years (ranging from 7 to 47). The mean age at the first use of a primary drug was 18.9 years (ranging from 10 to 48). The mean age at the first injecting of any illicit drug was 20.5 years (ranging from 10 to 48).

62.6% of drug users who have ever injected a drug have shared needles (life-time event). 15.5% of those who injected a drug within the last month shared needles. We may conclude that there is less risk behaviour among drug users treated in the Centres. The question remains open whether this represents a general trend or there is a hidden and more vulnerable population where risk behaviour remains high.

Among drug users treated in the network of centres 0.4% were anti-HIV antibodies positive, 4.9% were anti-HBc antibodies positive, 6.2% were anti-HBs antibodies positive, 1.7% were HBs antigen positive, 14.4% were anti-HCV antibodies positive and 8.3% were PCR RNA HCV positive. What is of concern is the high proportion of people who had never been tested at the moment of filling in the questionnaire. Considering this fact and the fact that needle sharing is still present, the proportion of infected drug users (especially HCV and HBV) could be higher. This presumption is confirmed by the research of some Centres.

528 drug users were undergoing their first treatment. Compared to past years the number of first treatments is still growing but this should be interpreted carefully because of the increase in the number of completed questionnaires and enlargement of the national network. Better accessibility usually means that drug users can more easily enter a programme.

Among first treatments 26% were female. The number of women among first treatments is still increasing. The mean age of first treatment was 22.4 years and has remained stable during the last 7 years. On the other side we observe a further decrease in mean age at the first use of any illicit drug and at first use of the primary drug. Consequently, the time gap between the first use of a primary drug and entering the programme was higher than before.

The main drug (primary drug) remains heroin (73.9% of first treatments). Cannabis was the main drug in 22.7% of first treatments (tranquilizers in 1.5%, stimulants in 1%, cocaine in 0.8%, solvents in 0.2%). There is a growing trend in the number of cannabis users among first treatments. We cannot currently explain whether this phenomena really reflects trends among drug users or whether it means a higher awareness of the potential harm of regular cannabis use (by parents, friends, the environment, drug users themselves) or reflects other reasons.

The main secondary drug was cannabis, followed by cocaine. We observed an increase in the use of tranquilizers also among first treatments. The most common way of primary drug use was injecting (48.7% of first treatments).

Table 3.1.2. Proportion in % of reported types of treatment in the CPTDA in Slovenia in 2002

Year 2002	% of all cases
Hospital detoxification	2.0
Out-patient detoxification	11.3
Short-term maintenance programme	8.4
Long-term maintenance programme	52.5
Long-term psychosocial therapy	10.1
Counselling/support	9.0
Referred to another Centre	1.9
Other	1.5
Not yet decided	3.3

Source: Institute of Public Health of the Republic of Slovenia

Aggregated statistics are published at the national level and feedback is provided to the network of centres and other data users (Ministry of Health). In the past no feedback was received from the centres but since then co-operation has improved in the last year, some meetings were organised and existing problems discussed (lack of a division between long-term and repeated treatments, lack of information on follow-up treatments etc.) and of possible changes in order to solve them. This should allow treatment centres to understand proposals for additional questions or changes.

Currently extension of the treatment reporting system is ongoing. A pilot study on the implementation of questionnaires in prisons in 2002 resulted in joining treatment programmes in prisons to the national monitoring system in 2003. The treatment questionnaire was implemented in prison successfully on a routine basis. To implement the treatment demand indicator within low-threshold facilities the same strategy is planned to be followed. In 2003 it is also expected to extend the national monitoring system. Extension of the national reporting system will enable a better coverage of drug users in the treatment system. Low-threshold agencies, prisons and voluntary organizations which are the bridges to some therapeutic communities outside the country had not been included in the reporting system till now. But it remains as one of the work priorities to establish communication among those bodies taking part in the treatment process.

3.2. **Drug-related mortality:** Jožica Šelb Šemerl

In 2003 the group for the key indicator Drug-Related Deaths continued its activities in the Twinning programme where we worked on definitions of mortality due to the immediate action of drug in the body in contrast to deaths in drug users.
We had good cooperation with the General Police Office (GPO) in exchanging data, but were less successful with Forensic Medicine due to the lack of their time. We also explored possibilities to link the Mortality Database with the Database of Hospital Admissions due to intoxication at the Poisoning Centre at the Clinical Centre in Ljubljana. Co-operation between us has not been brisk enough.
Within the Twinning Programme a meeting with pathologists from all Slovenian hospitals was organised at the beginning of June where drug-related deaths and the EMCDDA's demands were discussed. Two pathologists, an expert in forensic toxicology, two doctors working on mortality statistics and a person from the Slovenian Focal Point visited Vienna where a Special Register of DRD and the National Focal Point were presented to us. We also looked at the National Statistical Office and the WHO reference laboratory for drugs at the WHO International Centre
In October 2003 data from the General Mortality Register and General Police Office were linked to form a database on Direct Drug-Related Deaths. As a result of this data linkage, 38 drug-related deaths according to the EMCDA - DRD methodology were registered. This means 4 deaths less than in 2001 when the data linkage was also first performed with Toxicology data and data from the First Treatment Demand Database. In this case, we cannot talk about fewer direct deaths due to drug abuse than in 2001 because in 2002 we linked only two bases and not four as we did previously. In 2002 we chose our cases of direct drug-related death even more in accordance with the EMCDDA methodology than in 2001 as a result of our co-operation in the Twinning project.

In 2002 there were 38 drug-related deaths. 31 of them were men and 7 women. Within men, the mean age at death was 28.2 years, the median was 25.4 years and the mode 25.3 years, with the minimum age at death of 18.1 years and the maximum of 52.3 (intentional poisoning with other opioids and another, not illicit drug). Within women, the mean age at death was 43.5 years, the median age at death was 31.7years, while the minimum age at death was 21.7 years and the maximum 71 years (also intentional poisoning with other opioids).

Within the group of drug-related deaths according to the value 1 of the filter-B variable there were 31 deceased drug victims, 27 of whom, were men and 4 women. Within men, the mean age at death was 28.0 years, the median 25.2 years while the minimum age at death was 18.7 years and the maximum 52.3. There were four women with a mean age at death of 35.8, the median 25.3 and minimum and maximum ages at death of 21.7 and 71.0, respectively (the same people as before).

In 2002 there were 12 deaths due to accidental poisoning (DRD 88 to DRD 107). Among them 7 were due to heroin, 2 due to other opioids, 2 due to methadone and one due to opium. There were seven suicides – two by opioids and one by one by methadone and unspecified narcotics. Besides these, there were also three suicides by benzodiazepines. There were also 13 poisonings of an undetermined intent – seven by heroin, three by methadone and one each by other opioids and other unspecified narcotics and unspecified psychotropics. We also had three ill-defined cases which we strongly believe could be due to illicit drug use. In 2002 altogether we had 31 deaths due to opiate use in contrast to 2001 when we recorded 15 deaths due to opiate use.
We also recorded in GMR one death due to acute haemorrhagic pancreas inflammation but we do not have enough human resources for any detailed search for deaths in drug users. Our group also discussed the possibility of a cohort study where people coming to First Treatment Demand Centres would be included and followed up. We are planning to start with a cohort study next year.

Trends

Because we are still adjusting our methodology to the EMCDDA's methodology and given the short time period in which we have worked within the Slovenian Focal Point we think that calculating trends is not necessary.

Conclusions

In 2002 we managed to improve our understanding of the EMCDDA methodology.

It is not clear that the high increase in deaths due to opiate use is a consequence of the actual situation in the field or whether it is due to the better filling in of death certificates by medical examiners, pathologists or forensic specialists.

For the second time two different databases on drug-related mortality were linked with the outcome of drug-related mortality numbers in Slovenia.

We also improved our knowledge on direct drug-related deaths' cohort follow-up due to our co-operation within the Twinning project.

Carrying out the drug-related mortality cohort study still depends on the human resources available.

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. According to all available information, the rapid spread of HIV infection seems not to have started yet among injecting drug users (IDUs). During the last five years (from 1998 to 2002) HIV prevalence has consistently remained below 1% among confidentially-tested IDUs treated in the network of Centres for the Prevention and Treatment of Drug Addiction (CPTDA). Similarly, HIV prevalence among IDUs 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 remained consistently below 1%. Regrettably, for the period before 2003 no information on HIV infection prevalence is available from needle-exchange or other lower threshold harm reduction programmes, nor from community-based surveys among IDUs.

During the period 1998 to 2002 the annually reported newly diagnosed HIV incidence rate varied between the lowest of 6.5 per million in 2000 to the highest of 10.5 per million in 2002 while the reported AIDS incidence rate decreased from 6.5 per million population in 1998 to only 1.0 per million population in 2002. With respect to IDUs, the reported newly diagnosed HIV incidence rate calculated per total population has remained below 1.0 per million population (two reported cases in 1998, no case in 1999, one case in 2000 and 2001, and again no cases in 2002) and the AIDS incidence rate below 0.5 per million population (only one reported case in 1998 and 1999 and no cases in 2000, 2001 and 2002).

HBV

During the 1998 to 2001 period the prevalence of antibodies against hepatitis B virus (HBV) among confidentially-tested IDUs treated within the network of CPTDA ranged from the lowest 4.3% in 1998 to the highest 6.6% in 1999. For 2002 it is possible to distinguish between the prevalence of antibodies against HBV (anti-HBc, anti-HBs) and the prevalence of current HBV infection (HBs Ag). The prevalence of HBs Ag was 3.0% and the prevalence of anti-HBc 8.3%. Surprisingly, only a low proportion of those reported to be testing for anti-HBs (11.2%) were positive.

During the same five-year period, the reported acute HBV infection incidence rate in the Slovenian population fell from 1.8/100,000 population in 1998 to 0.8/100,000 population in 2002. Due to underreporting, HBV reported incidence rates greatly underestimate the burden of the disease. Nevertheless, the downward trend should be noted. Regrettably, for cases reported during the 1998 to 2002 period, information on transmission routes is available only for a minority of cases (16.5%). Injecting drug use was implicated in 10.5% of these cases. Of 16 cases reported in 2002, information on the transmission route was only available for one case and it did not involve injecting drug use.

HCV

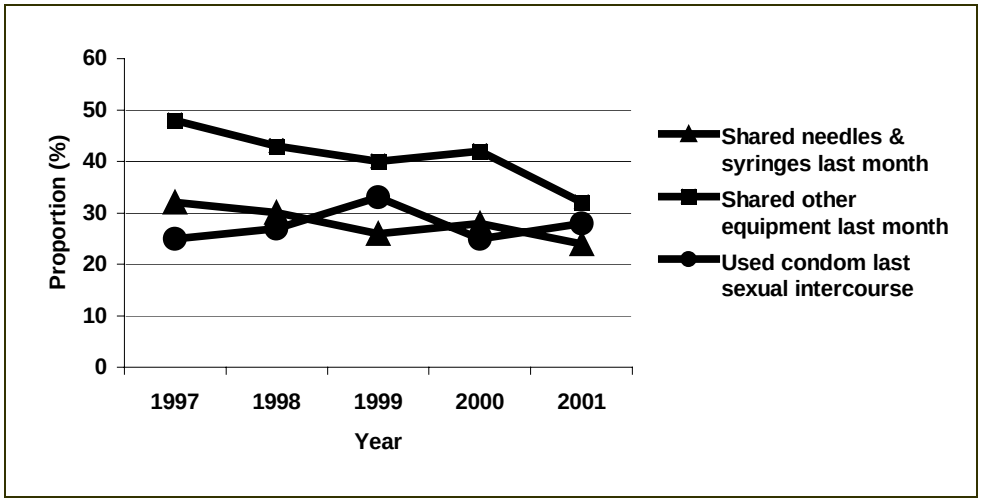
During the period from 1998 to 2002 the prevalence of antibodies against hepatitis C virus (HCV) among confidentially-tested IDUs treated in the primary health care network of CPTDA ranged between 20.1% in 1998 to 26.1% in 2002. Information on the proportion of chronic HCV infections among these individuals is not available.

During the same five-year period, the annually reported acute HCV infection incidence rate in the Slovenian population fell from 2.6/100,000 population in 1998 to only 0.4/100,000 population in 2002. Due to underreporting, reported HCV incidence rates greatly underestimate the burden of the disease. Regrettably, for cases reported during the 1998 to 2001 period information on transmission routes is available only for a minority of cases (11.4%). Injecting drug use was implicated in 68.4% of these cases. For all 7 cases reported in 2002, information on the transmission route was not available.

HIV, HCV, and HBV related behavioural surveillance

The spread of HIV, HBV and HCV infections among IDUs is mainly determined by injecting risk behaviour, notably »needle and syringe sharing«, and also through the sharing of other equipment. Sexual transmission of HIV and HBV infections among IDUs and their sexual partners is also important, while the sexual transmission of HCV is thought to be low. Since our efforts to prevent and control the spread of these infections to a great extent depends on preventing high-risk behaviour and supporting behavioural change, monitoring high-risk behaviour trends among IDUs demanding treatment within the network of CPTDA was established in Slovenia already in the early 1990s. We started collecting information about a few injecting risk behaviour indicators. In 1996, we expanded the list of high-risk injecting behaviour indicators with a few high-risk sexual behaviour indicators. In the revision of the variables list in 2002, we added questions about non-injectors' sexual partners during the past year to obtain some information about the sexual link between IDUs and non-injectors. Some of our results are presented in Figure 3.3.

Figure 3.3. Selected behavioural indicators for current IDU at FTD, Slovenia, 1997 - 2001



Base:	311	322	260	231	177	(injecting behaviour)
	271	282	240	217	174	(condom use)

Strengths and limitations of the key indicator infectious diseases

The sources of information on reported incidence rates of HIV, HBV, and HCV are two national communicable diseases data sets managed at the Institute of Public Health of the Republic of Slovenia (IPHRS). In contrast to the relatively reliable AIDS reported incidence data the information about reported newly diagnosed HIV infection cases among IDUs 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 the transmission route, for example through the sharing of injecting equipment, is only available for a minority of reported HBV and HCV cases. Interventions to increase the sensitivity of HCV and HBV surveillance based on passive reporting are urgently needed.

Information on HIV, HCV and HBV infection prevalence and high-risk behavioural indicators change is available from the reported results of voluntary confidential testing of injecting drug users in treatment in the national primary health care network of CPTDA and data collection at treatment demand within this network. To partially overcome the 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. Until the end of 2001 it was impossible to distinguish between the prevalence of antibodies against HBV and the prevalence of current HBV infection (HBs Ag). In 2002 data collection was revised and information on different HBV infection markers collected (anti-HBc, anti-HBs, and Hbs Ag). Although these results are very valuable it is impossible to extrapolate them to the whole population of IDUs and there is a clear need to

increase the coverage of such surveillance and include IDUs in other harm reduction programmes (e.g. needle exchange programmes) and in the community. Targeted behavioural surveillance surveys with integrating HIV, HCV, HBV, HCV and HAV biological markers should be conducted.
The great strength of such a surveillance system among IDUs at treatment demand in the network of CPTDA is the potential consistency of data collection methods, relative feasibility and appropriateness of such an approach to monitor trends within a sustainable national treatment network. With respect to the behavioural surveillance component, the obvious limitation 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.

3.4. Other drug-related morbidity

No data on non-fatal drug emergencies in 2002 in Slovenia are available and there are no data on other important health consequences in 2002 in Slovenia.
For psychiatric co-morbidity, please see Chapter 16.

4. Social and Legal Correlates and Consequences

4.1. Social problems

The issue is partly covered in Chapter 11.3. For more information, please see previous the National Report.

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

Some data on drug-related crime are available.
Compared to the previous year there were some changes in the number of arrests for drug-law offences and in the distribution of arrests through a specific drug reported. We found a decrease of 6% in the total number of arrests, an increase of 11% in the total number of arrests due to drug-related use and possession, a decrease of 47% in the total number of arrests due to drug-related dealing and trafficking and a decrease of 77% in the total number of arrests due to drug-related use and trafficking.

Table 4.2.1. Arrests for drug-law offences, Slovenia, 2002

SUBSTANCE	OFFENCE TYPE	N
Cannabis	Drug-related use/possession	4131
	Drug-related dealing/trafficking	339
	Drug-related use and trafficking	72
	TOTAL	4542
Heroin	Drug-related use/possession	414
	Drug-related dealing/trafficking	138
	Drug-related use and trafficking	16
	TOTAL	568
Cocaine	Drug-related use/possession	60
	Drug-related dealing/trafficking	49
	Drug-related use and trafficking	0
	TOTAL	109
Amphetamines	Drug-related use/possession	35
	Drug-related dealing/trafficking	16
	Drug-related use and trafficking	1
	TOTAL	52
'Ecstasy'	Drug-related use/possession	80
	Drug-related dealing/trafficking	45
	Drug-related use and trafficking	0
	TOTAL	125
LSD	Drug-related use/possession	0
	Drug-related dealing/trafficking	0
	Drug-related use and trafficking	0
	TOTAL	0
Benzodiazepines	Drug-related use/possession	5
	Drug-related dealing/trafficking	0
	Drug-related use and trafficking	0

SUBSTANCE	OFFENCE TYPE	N
	TOTAL	5
Methadone	Drug-related use/possession	59
	Drug-related dealing/trafficking	14
	Drug-related use and trafficking	2
	TOTAL	75
Other substances	Drug-related use/possession	51
	Drug-related dealing/trafficking	1
	Drug-related use and trafficking	0
	TOTAL	52
TOTAL	Drug-related use/possession	4835
	Drug-related dealing/trafficking	602
	Drug-related use and trafficking	91
	TOTAL	5528

Source: Ministry of the Internal Affairs

4.3. Social and economic costs of drug consumption

There are currently no studies and assessments of the social or economic costs caused by drug consumption. We are also unable to estimate the consumption of, demand for and resources spent on drugs.

5. Drug markets: Ljubo Pirkovič, Boris Novak, Darko Žigon, Rade Pribaković Brinovec

5.1. Availability and supply

In our estimation, Slovenia is one country 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 the area of security, which is directly and indirectly related to illicit drugs.

5.2. Seizures

The number of seizures in 2002 remained at approximately the same level as the year before. However, there was substantial increase in the quantity of seized cannabis, cocaine and ecstasy. This was due to larger shipments of seized illicit drugs, e.g. 50 kg of cocaine was seized in one single seizure.

In Table 5.2.1. data for 2002 reported from the General Customs Directorate are also included. They reported 17 cases of seizures which included 58,686 kg of heroin, 862.5 kg marihuana and small amounts of other drugs.

Table 5.2.1. Illicit drug seizures in 2001 and in 2002 in Slovenia by number and quantity

YEAR	Unit of measure for quantities	2001		2002	
		Number	Quantity	Number	Quantity
Cannabis (total)	kg	4438	177.46	4542	1127.81
Resin	kg	60	2.36	52	0.12
Leaves	kg	3952	175.1	4071	1099.94
Plants	no	426	1925	415	9425
Heroin	kg	*	88.93	568	68.67
Cocaine (total)	kg	*	1.08	109	55.38
of which crack	kg	*	*	*	*
Amphetamines	kg	*	0.06	*	0.03
	(tablets)	*	89	*	256
'Ecstasy' (total)	tablets	*	1852	*	7877
	(kg)	*	*	*	*
LSD	doses	*	0	*	0

Source: Ministry of the Internal Affairs
** data not available*

5.3. Price, purity

Street prices of illicit drugs in 2002 in Slovenia remained at approximately the same level as the year before. Since there are some indications of increased illicit drug availability in the country we might expect prices to go down in the future.

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 in euro of illicit drugs (street level) in 2002 in Slovenia.

	Min.	Max.	Average
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 Internal Affairs
** data not available*

6. Trends per Drug: Radivoje Pribaković Brinovec & Mercedes Lovrečič

Compared to the previous National Report no progress has been made in the last year in the field of population surveys. Our analysis is therefore based mainly on treatment demand, drug-related infectious diseases, drug-related deaths data and data on seized illegal drugs.

Due to the increase in the number of reported people demanding treatment for drug-use health problems (see Chapter 3) comparisons may not always be possible or consistent. On the other hand, data from first treatment demand showed considerable consistency.

We may assume that **cannabis** remains the illegal drug that most people undertake lifetime experiences with. The treatment demand (first treatment and all treatments) for cannabis use increased progressively from 1994 (Table 15.1) for reasons we cannot explain completely at the moment; whether this phenomena really reflects trends among drug users or higher awareness of the potential harm of regular cannabis use (by parents, friends, the environment, drug users themselves) or medical-psychiatric complications or other reasons (availability of specific interventions as counselling, psychotherapy).
In 2002 one-fifth of drug users in their first treatment in the network of the Centres for the Prevention and Treatment of Drug Addiction (CPTDA) reported cannabis as the main drug. Among all treatments cannabis was reported in second place as the main drug (7.6%; the primary drug remains heroin) and the main secondary drug (56.2% of all treatments). Among first treatments, cannabis was reported as the main drug in 22.7% and the main secondary drug in 59.9% of cases. Cannabis users represented the youngest age group among drug users treated in the CPTDA; in most cases they still attended schools and lived with their parents. Combining cannabis and alcohol was very common.
No cannabis-related death was reported in 2002.
According to the Ministry of the Internal Affairs a substantial rise in seizures (by number and quantity) of cannabis was registered in 2002 (especially the quantity of plants) compared to the previous year (see Chapter 5.2).

Synthetic drugs were not covered extensively by the CPTDA and no trends could be reported. Synthetic drug users, particularly ecstasy users, generally do not consider themselves drug addicts or problematic drug users irrespective of their particular pattern of drug use. On the other hand, the CPTDA in Slovenia do not offer any routine specific treatment for synthetic drug users. Usually synthetic drug users do not demand treatment before a comparison of the medical consequences or complications which could also lead to an intensive medical unit (for physical complications such as hyperthermia or neuropsychiatric disorders like psychosis) or to psychiatric services and general practitioners for later synthetic drug-use consequences such as flashbacks, depression, anxiety, psychosis.
However, the party scene was still very strong and some NGOs worked actively on harm reduction and prevention.
No ecstasy-related death was reported in 2002.
The amount of seized tablets of ecstasy in 2002 hardly increased compared to the previous year (in 2001 there were 1852 seized tablets of ecstasy and in 2002 7877 seized tablets of ecstasy).

Although a significant increase in the quantity of **cocaine** seized in 2002 compared to 2001 was reported, this was not reflected in any increased treatment demand for cocaine use problems. In the last decade cocaine users have represented only a small minority of clients in the CPTDA. This can be explained by the lack of specific substitution treatment and by the very difficult psycho-social treatment and rehabilitation for cocaine users. The latter is only partly available in the CPTDA. Cocaine was the second most used secondary drug in poly-drug users.
No cocaine related death was reported in 2002.

Opiates, particularly **heroin**, continue to be the most relevant substance with regard to problem drug use. In the last decade heroin users represented 98.6% (in 1993) to 73.9% (in 2002) of first treatments in the CPTDA. Also taking into consideration the number of heroin users demanding first treatment (new clients) we may conclude that the trend is stabilised or decreasing. The reason for the decreasing proportion of heroin users in treatment is the proportional increase of users of other drugs, especially cannabis. The reason for stabilisation of the number of heroin users in treatment is probably based on the end of the heroin epidemic that was evident in the 1990s. Current injection of drugs among drug users treated in the CPTDA is constantly decreasing. The same goes for the lifetime prevalence of injecting drugs. Both facts may in the long-term potentially reduce the risks of spreading infectious diseases. In 2002 31 acute deaths were reported due to opiate use.

Characteristic of drug users in treatment is poly-drug use. 65% of all clients use a secondary drug and 25% of all clients use a tertiary drug. Probably more drugs would appear in the data if the question were extended to fourth and other drugs used. Cannabis is the first most used secondary and tertiary drug, followed by cocaine, alcohol, heroin, benzodiazepines and ecstasy.

7. Discussion: Radivoje Pribaković Brinovec & Mercedes Lovrečič

The data available on the epidemiological drug situation in Slovenia support the continuation of some emerging trends.
The drug treatment demand indicator actually covers the national network of Centres for the Prevention and Treatment of Illegal Drug Addiction. Sex distribution and average age of drug users in treatment within the CPTDA network remains almost unchanged although we might expect an increase in the proportion of women in drug-related treatment (as with foreign experience; Annex 6, Tables A2 and A6). The number of heroin users in treatment has stabilised, and the increase in cannabis users in treatment follows trends in the EU. Synthetic drugs are limited to certain areas and lifestyles. Some data show that cocaine use might increase in the next few years. Infectious diseases among drug users (HIV, HCV) remain at relatively low and stable levels. Risk behaviour also seems to be improving (Annex 6, Tables A4 and A5).

In 2002 there were 31 acute deaths due to opiate use in Slovenia, but calculating the trends is still difficult because of the adjusting of the methodology to the EMCDDA's guidelines.
In 2002 there were 12 deaths due to accidental poisoning: 7 were due to heroin, 2 to other opioids, 2 due to methadone and one due to opium. There were 7 suicides – two by opioids and one each by methadone and unspecified narcotics. Besides these, there were also 3 suicides by benzodiazepines. In addition, there were 13 poisonings of an undetermined intent, 7 by heroin, three by methadone and one each by other opioids and other unspecified narcotics and unspecified psychotropics.
On the whole, the drug situation has remained stable, especially with regard to problem drug use. The drug policy is still not responding consistently, partly due to the slow process of acquiring a national drug strategy. There is also a lack of evaluation of the drug strategy. Activities addressing drug problems are not optimally co-ordinated and there is a lack of good internal and external evaluation. For these reasons, we cannot estimate whether or not services are tailored to meet all demands.

The problems of not conducting general population surveys and some other drug-focused surveys have already been mentioned. Another concern is poly-drug use in the majority of clients in treatment demand and probably among the whole population of drug users.

7.1. Consistency between indicators: Mercedes Lovrečič

Within the Phare Twinning Covenant project, and with the strong support of the Austrian Focal Point from June 2002 to July 2003, experts in five working groups on the epidemiological key indicators provide information and data on the drug epidemiological situation in Slovenia.
In 2002 experts from the Prevalence Estimate and Drug-Related Death working groups were able to provide for the national level and for the first time data on these two indicators in line with the EMCDDA's recommendations. At the end of the project the Austrian experts provided an evaluation and recommendations for future activities. Some of them are summarised.

Treatment Demand indicator (TD)

The drug treatment demand indicator is already implemented to a high extent in the CPTDA network and is also being applied in the prison system. At the Central Prison Administration the data sources were examined for their usefulness for the key indicators TD and DRID. There is also a proposal to implement an adapted questionnaire in the low- and high-threshold programmes (NGOs, therapeutic communities).
The key indicator DRD might also influence the TD indicator as the linkage between TD data and the General Mortality Register can be used to improve the data quality of DRD statistics as well as

implementing a routine mortality cohort study. Concerning a mortality cohort study, standardised mortality rates can easily be achieved using the numbers of dead people registered in the TD database.

A study to gather incidence rates of problematic drug use was also carried out using the existing TDI data.

Prevalence estimates (PE)

Several potential data sources for Prevalence Estimates (PE) were identified in 2002: TD data (all centres with the exception of CPTDA Koper due to incomplete data), DRD data, data from low-threshold programmes, and police data. Regulations concerning data protection were clarified and since the police force was willing to co-operate it was decided to carry out a three-sample CRC-estimation for 2000 using police data, TD data and DRD data as pilot implementation of the key indicator PE. Preliminary two-sample CRC results are available for 2000 and 2001.

Drug-related infectious disease (DRID)

Data about infectious diseases can be found at the Centre of Communicable Diseases at the Institute of Public Health of the Republic of Slovenia where three separate data sets are managed: one database about reported HIV/AIDS cases and AIDS deaths, a database about reported STD (both using SOUNDEX) and one database on about 70 other reportable communicable diseases including HCV and HBV infections. Data on TD also includes information on HIV, HCV and HBV infection status.
It was decided that the main focus of activities should be on TD data and special studies. Discussion concerning close co-operation between TD, PE and DRID started and will help to improve the situation in the distant future. The working group on DRID decided to co-operate with the PE working group in elaborating a study concept for the sero-prevalence study.

Drug-related death (DRD)

Some independent data sources were identified in 2002 such as the General Mortality Register (GMR): data based on ICD-10 collected by the Institute of Public Health of the Republic of Slovenia; Special Register (SR): results of toxicological analysis collected by the Institute for Forensic Medicine; police data: data stored at the Ministry of the Internal Affairs; the Poison Control Centre / toxicological centre data.

The GMR was defined as base for the national statistics on DRD and extraction of DRD-codes were done according to the EMCDDA's guidelines. Data exchange between SR, TD data (with the exception of data from CPTDA Koper due to incomplete data) and GMR was established and served as basis for improving data quality (allowing an in-depth analysis of death cases with no DRD-code in the GMR). But the case coverage between GMR and police data showed that there were hardly any cases within the police data that were not included as DRD in the GMR.

General Population Survey (GPS)

To date there has been no study on drug use in the general population in line with the EMCDDA's recommendations covering national level in Slovenia. The study was planned for next year but human and financial sources are urgently needed.

7.2. Methodological limitations and data quality: Mercedes Lovrečič

Treatment Demand (TD)

The assessment of data quality should be carried out to gain an insight into the weak points of data collection and coverage to identify a basis for improvement. TD data from the CPTDA Koper are delivered incomplete (date of birth missing); a fact that should be changed in the near future as it also negatively influences the work of experts and working groups on other key indicators.

Prevalence Estimate (PE)

A SPSS syntax was produced which can be used each year (with slight modifications) to make CRC analyses on a routine basis. After succeeding in carrying out the CRC for 2000 (whole Slovenia without Koper and stratified estimations by sex, age and region) the results and possible problems within the data and their consequences were discussed. One consequence was that the three-sample CRC using DRD is impossible due to the numbers in the statistical sense. At the moment, it is just possible to carry out a two-sample CRC with police data and TD.

Preliminary two-sample CRC results are available for 2000 and 2001. A SPSS syntax for concrete statistical analysis for a two-sample as well as for three-sample CRC was elaborated which will allow us to update the estimations in an easy way and also to carry out CRC estimations based on other data sources.

Drug-related infectious disease (DRID)

Some analysis of data concerning infectious diseases and risk behaviour within the TDI data was carried out by short-term experts (Phare Twinning Covenant) and experts from working groups on DRID. The main result was that there should be a modification of the TDI questions concerning infectious diseases and risk behaviour to improve the data quality (reformulation of the questions concerning risk behaviour, inclusion of the date of the test, whether tests for HIV, HBV and HCV were carried out within the treatment centre or if information concerning the status of infection came from anamnestic data).

Drug-related death (DRD)

The linkage of TD with GMR was used to obtain the first results of a mortality cohort for the whole of Slovenia with the exception of the CPTDA Koper due to the incomplete reporting within the Drug Users Treatment Evidence. Two routine treatment mortality cohorts are running for 1996 and 2001 at the national level (with the exception of the CPTDA Koper) starting with the drug-related CPTDA treatment network .

General Population Survey (GPS)

In the National Action Plan on the Drug Information System (NAPDIS) 2002-2004 a general population survey for 2004 is planned which will only be possible in the case of additional human and financial support.

PART 3

DEMAND REDUCTION INTERVENTIONS

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

8.1. Major strategies and activities

The new national strategy is a fundamental document for implementing different activities in the field of drug supply and drug demand reduction. Operationalisation of these activities and the vision of the strategy will be achieved through action plans. An interministerial co-ordination body led by the Director of the Government Office for Drugs will start to prepare particular action plans immediately after Parliament's adoption of the National Drug Programme 2003-2008.

The Information Unit for Illegal Drugs – National Focal Point has already prepared NAPDIS 2002-2004, which was discussed and adopted at the Government Commission for Drugs.
The Ministry of Internal Affairs (police department) and the Ministry of Finance (customs department) prepared a national action plan for drugs (drug supply reduction), which has also been adjusted with the Ministry of Defence (Slovenian Army) and the Ministry of Justice (department for prisons).

The strategy includes different objectives and programmes in the field of drug demand reduction, e.g. to strengthen and/or develop preventive activities in schools/kindergartens, families, the workplace, local communities and civil society, to strengthen and/or develop harm reduction programmes, to strengthen and/or develop treatment programmes and social services etc.

8.2. Approaches and new developments

The Government Office for Drugs took the initiative in 2002 to also develop the EDDRA system in our country. The Office organised a seminar on collecting data at the local level recently, which was organised in co-operation with the Slovenian and Austrian Institutes of Public Health within the Phare Twinning Project. A representative of the Office was invited to co-operate and participate in the EMCDDA expert group for developing structured questionnaires in the field of prevention (school-based prevention, community-based prevention, family-based prevention, selective/indicated prevention).

Within the Phare Twinning Covenant Project and in accordance with the recommendations of EMCDDA and Reitox network, the National Focal Point continues the activities for nomination of the EDDRA national manager and activities to promote and set up an EDDRA database in Slovenia.

The new strategy also introduces some new approaches and innovations in the field of drugs, e.g. safe (injection) rooms, heroin on prescription etc.

9. Prevention: Jože Hren, Matej Košir

National Strategy

The new National Drug programme 2003-2008 focuses significantly on the field of prevention. It defines the content and systemic diversification of prevention and the key actors and main co-ordinator for implementing the strategy (the Ministry of Education, Science and Sport). The strategy also gives an important role to the evaluation of programmes. Prevention is divided into prevention in schools/kindergartens, families, the workplace, local communities and civil society.

Organisation and co-ordination within national structures

The new strategy envisages the establishment of a special body at the national level, which will be responsible for forming the standards of prevention work and evaluation of programmes in educational institutions. An interministerial body involving the co-operation of professionals/experts and NGOs will be established by the Ministry of Education, Science and Sport.

Expenditures on prevention

The exact amount of expenditure on prevention in Slovenia for the reporting period cannot be provided. Prevention is divided into primary, secondary and tertiary prevention and various ministries are responsible for different prevention programmes. For example, the Ministry of Work, Family and Social Affairs co-finances almost all prevention programmes, which are identified as good programmes and selected through tenders or calls for proposals. Some prevention programmes are also co-financed by the Ministry of Health. Community-based prevention programmes are mainly co-financed by local authorities (municipalities).

9.1. School programmes: Eva Stergar

Primary prevention programmes in primary and secondary schools have mostly been oriented to the promotion of a healthy lifestyle. Drug prevention programmes were part of these activities. Preventive activities in primary and secondary schools are included in education in the health programme developed as a cross-curricular field within the education system.

The preventive programmes described in the previous National Report ran continuously during 2002 and during the first half of 2003. The programmes are listed as follows:

The Slovenian Network of Health Promoting Schools (SNHPS)

1. General programs (health promotion, life skills)
A mental health promotion programme developed within the ENHPS. Slovenian schools have participated in it from the pilot phase on. The programme consists of the in-service training of teachers and a manual written by Gay Gray and Katherine Weare (University of Southampton). The manual was translated into the Slovenian language and adapted to our conditions. The long-term goal of the SNHPS is that all participating schools organise in-service training on the mental health promotion for all their teachers and staff. From 1993 till December 2002 77 seminars were organised – more than half of member schools and their staff (nearly 2000) attended the seminar. The programme covers the following topics:

- What is mental health?
- Building self-esteem
- How to assess the situation in our school?
- Effective listening and responding effectively

- Managing stress in school
- Managing change in school
- Energisers (ice-breakers)
- Group forming.

Three more general programmes were developed within the SNHPS:

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

All these programmes are incorporated in the system of permanent in-service teacher training. They are most effective when implemented by the majority of staff of one school. Up until December 2002 40 seminars on communication were held, 9 on stress management in primary school, and 2 on stress management in adolescence.

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

Each year schoolchildren have the opportunity to participate in the **children's parliament**. The initiative comes from an NGO, the programme is implemented within those schools that decide to participate. Every year pupils choose the theme for discussion (in 2002 Violence and Child Abuse, in 2001 it was Spare Time, and in 2000 Personal Relations). They discuss it at several levels (school, community, region). The programme culminates with the delegates' discussion in the Slovenian parliament: delegates reveal their views, suggest solutions, and the theme for the next year is chosen. Teachers follow the seminar in the preparatory phase. They get written materials and guidelines.

2. Specific programmes (for high-risk groups)

The Institute of Public Health of the Republic of Slovenia has helped develop three specific programmes:

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

Non-smoking promotion in schools

The initiative to develop the programme came from members of the Slovenian Pulmonary Patients Association. Their members prepared the programme (manual for teachers and work sheets for pupils) in co-operation with the NIPH's professionals. Production was organised by the NIPH. The programme has been introduced gradually within the **SNHPS** (it started with 11 schools in 2000/2001; in 2001/2002 44 more schools entered the programme; in 2002/2003 4 more schools entered the programme). The programme starts with a one-day seminar for teachers from the relevant class. The programme is delivered in a cross-curricular way from the 4th to 9th classes of primary school and is evaluated on a pre-test/post-test basis. Feedback from the teachers implementing the programme is analysed.

Alcohol? Adults may have an influence

The programme was developed in 2001 within the Ljubljana – Healthy City project. The long-term goal is to reduce harmful alcohol consumption among young citizens of Ljubljana. The short-term goals are: to inform parents about alcohol and its effects on human beings and their health in the broadest sense; to inform parents about parental skills; to educate teachers to carry out the programme. The programme consists of: training for teachers, a manual for teachers, a booklet and leaflet for parents, a booklet for pupils, and a Bulletin for all three groups (published within the

SNHPS during the Message in a Bottle project). All materials and books were prepared – this is true for all programmes prepared within the NIPH – on the basis of pre-testing the relevant groups (relevant surveys were carried out).
The programme is delivered by teachers who were trained at the NIPH.
The programme was offered to the Ministry of Health for further dissemination in Slovenia. In 2001 two regions disseminated the programme.

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

9.2. Youth programmes outside schools

Preventive programmes described in the previous National Report ran continuously during 2002 and the first half of 2003.

9.3. Family and childhood

For more information, please see the previous National Report. Where necessary, new information is included.

Preventive programmes described in the previous National Report ran continuously during 2002 and the first half of 2003. The programmes are listed as follows:

a) Intervention in different fields:
- during pregnancy/for future parents
- aimed at young parents
- aimed at families with adolescent children

b) Interventions in crèches/kindergartens and other specific interventions ("The Healthy Kindergarten" project)

10. Reduction of drug-related harm: Jože Hren, Matej Košir

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

Harm reduction programmes have been a constituent part of the holistic, balanced and multidisciplinary drug policy in Slovenia for the last few years. The new national strategy also regards this field as important.

b) Harm reduction practice

We have more than 10 years of experiences in the field of harm reduction. Activities in the reporting period were mainly oriented to the prevention and reduction of social harm caused by drug use/abuse and the prevention of infectious diseases and, connected with that, the prevention of worse health and social conditions of drug users/abusers.

c) Range of services

Harm reduction activities include informing and educating drug users/abusers about the risks, safer ways of using drugs, counselling and peer help. Harm reduction also includes needle-exchange programmes, outreach work, a methadone maintenance programme and daily (drop-in) centres for drug user/abusers.
Non-professionals and former or actual drug users can also actively participate and help in these programmes. The first day and night shelter for homeless drug users opened recently in Ljubljana. There is also a very big need for such shelters in other parts of the country.

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, reduce overdoses among them and to cut criminality.

d) Networking between HR professionals

There are several harm reduction programmes underway in Slovenia, but they are still not enough. Networking between professionals is well-established mainly in the major cities. There is a lack of networking in other parts of the country, where harm reduction programmes are very poorly developed.

The Co-ordination of CPTDA at the Ministry of Health is a co-ordinating body established to provide a uniform treatment approach and HR activities within the network of centres and exchanges of treatment experience.

e) Co-ordination of national policies and local practice

Co-ordination of national policies in the field of drugs is ensured through two co-ordinating bodies. The political and executive co-ordination (experts are also invited) is implemented by Government Commission for Drugs. The operational interministerial co-ordination is led by the Government Office for Drugs.
Local practices are co-ordinated by local programmes, especially Local Action Groups (LAGs). The co-ordination of LAGs is carried out by the Government Office for Drugs.

10.1. Description of interventions

a) Outreach work in recreational settings

Outreach work is mostly implemented by several NGOs specialised in preventive activities in recreational settings. These NGOs e.g. DrogArt, "Svit" Association, AIDS Foundation "Robert" - project Stigma" etc.) implemented different preventive activities in 2002, especially at rave parties, discos and other places of mass entertainment.

b) Prevention of infectious diseases

Mostly public health institutions but especially the Centres for the Prevention and Treatment of Drug Addiction, Centre for the Treatment of Drug Addiction at the Psychiatric Clinic Ljubljana and some specialised NGOs implement preventive activities regarding infectious diseases. Several activities and media campaigns in 2002 were realised, especially in the field of preventing HIV/AIDS and hepatitis B infections.

c) Prevention of drug-related overdoses

Generally specialised public health institutions, but especially the Centres for the Prevention and Treatment of Drug Addiction, the Centre for the Treatment of Drug Addiction at the Psychiatric Clinic Ljubljana and NGOs implement preventive activities regarding drug-related overdoses. Several activities and media campaigns were realised in 2002. A leaflet for drug users was also prepared by the Co-ordination of the CPTDA at the Ministry of Health and The Sound of Reflection Foundation.

d) User Rooms / Safe Injection Rooms

There have been several initiatives to establish safe injection rooms in the past in our country. The new national strategy pointed out the need for such institutions and envisages their establishment as an important part of harm reduction policy.

10.2. Standards and evaluations

a) Existence of professional standards on HR interventions

In 2002 the same or similar professional and ethical standards on HR interventions as in other health and social services and programmes existed and were co-financed by different ministries responsible for those programmes (especially the Ministry of Health and the Ministry of Work, Family and Social Affairs).

These standards were adopted by the Chamber of Social Work and the Medical Chamber as general professional and ethical standards.

b) Evaluation studies on HR measures

There were several analyses and studies implemented in the field of harm reduction in and before the reporting period. One of the most representative studies was made in 2002 by Vito Flaker ("*Živeti s heroinom*" – "Living with Heroin").

Other analyses and studies were done by Bojan Dekleva on drug demand reduction in Ljubljana and Slovenia with regard to international comparisons (September 2002) and by Matej Sande on the use/abuse of synthetic drugs in Slovenia (the study "On speed" – "*Na spidu*").

Two studies in the past regarding evaluation were also published. The first was by Cvelbar R. concerning an evaluation of the evolution and effectiveness of social policy in the sphere of drug demand reduction (a comparison between Denmark, the UK and Slovenia), published by the Faculty of Social Sciences in 1996 and the second by Dekleva B. and Cvelbar R. on the institutional response to drug-related problems in Slovenia (balancing between harm reduction and abstinence approaches), published in 2001.

c) Training of staff in HR techniques: organisation, access, target groups for training

There were several organisations and institutions that carried out different training on methods and techniques of harm reduction. One of the most important institutions in this field is the Faculty for Social Work, which regularly runs a host of training courses.

The 13th International Conference on Drug-Related Harm with almost 1000 participants from different countries and fields took place in Ljubljana from March 3 to 7, 2002. It was organised by The Sound of Reflection Foundation, together with the International Harm Reduction Association.

d) Major research projects on HR topics carried out in past five years; amount of public research funding available in 2002

This was already mentioned in Chapter 12.b): Vito Flaker, "*Živeti s heroinom*" ("Living with Heroin").

11. Treatments

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

Drug-free treatment and health care are 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 drugs users should be carried out in the form of hospital and outpatient clinic treatment programmes approved by the Health Council at the Ministry of Health of the Republic of Slovenia.
The treatment referred to in the preceding paragraph should be carried out in accordance with the act governing medical treatment.
In accordance with this act, treatment should also be deemed to be maintenance with methadone and any other substitution drugs approved by the Health Council.

Drug-free treatment in therapeutic communities is defined as social rehabilitation and reintegration programmes and is not part of the health care system but of the social care system. There are several therapeutic community programmes like Project Človek, Skupnost Srečanje etc..

a) Objectives and definitions of drug-free treatment

Drug-free treatment is performed as outpatient treatment in the Centres for the Prevention and Treatment of Drug Addiction (CPTDA), in the Centre for the Treatment of Drug Addiction at the Psychiatric Clinic in Ljubljana, as inpatient treatment in the Centre for the Treatment of Drug Addiction, and at some psychiatric hospitals in Slovenia.

1. Outpatient treatment is performed in the Centres for the Prevention and Treatment of Drug Addiction (CPTDA) located within the primary health care system establishing the network. There are 18 centres and two outpatient clinics in Slovenia, covering most regions in the country.

These drug prevention and treatment centres provide outpatient drug-free and substitution treatment and other activities such as:

- prevention;
- harm reduction;
- detoxification;
- individual, group, and family counselling, psychosocial treatment and psychotherapy;
- community health services;
- dual diagnosis treatment;
- counselling services for clients, professionals and institutions;
- consultations for health, social, education services, and the police;
- rehabilitation and psycho-social reintegration;
- preparation for inpatient drug-free treatment;
- co-operation with NGOs, TCs, self-help groups;
- education;
- research;
- publishing of the magazine 'Odvisnosti' (Addiction) issued by the Co-ordination of the CPTDA at the Ministry of Health and published by The Sounds of Reflection Foundation – *Ustanova Odsev se sliši*.

2. Inpatient treatment and care is performed in the Centre for the Treatment of Drug Addiction located at the Psychiatric Clinic in Ljubljana. The new Centre for the Treatment of Drug Addiction at the Psychiatric Clinic in Ljubljana opened on 28 January, 2003.

The old much smaller one with just nine beds had been in the same hospital since 1995.

Activities:

- Outpatient programmes, including a day hospital
- Detoxification – 15 beds
- Treatment of patients with a dual diagnosis;
- Long-term intensive treatment – 15 beds and one for drug user mothers with babies
- After-care, including a day hospital
- Programmes for the treatment of adolescents using drugs
- Crisis intervention – 4 beds
- Treatment for prisoners
- Professional, organisational and other co-ordinative activities of the whole network of Centres for the Prevention and Treatment of Drug Addiction.

Inpatient treatment and care are also performed in some psychiatric hospitals which offer detoxification (the Psychiatric Hospital in Ormož), in (5) other psychiatric hospitals mostly for double diagnosed patients when some other mental disorders are the primary diagnosis.

b) Criteria for admission to drug-free treatment

- Voluntary
- Referral from the CPTDA, or other governmental and non-governmental organisations
- Compulsory treatment order
- Health insurance (free of charge) for citizens of the Republic of Slovenia.

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

The programmes for the medical treatment of drug users are covered by the Health Insurance Institute of the Republic of Slovenia.

d) Evaluation results, statistics, research and training

Number of patients treated in the CPTDA.

Table 11.1.1. Number of patients in the CPTDA from 2001 until 2003 in Slovenia

Year	Methadone maintenance programme (at the specified date)	All patients in CPTDA treatment in 1-year period
March 31, 2001	1347	2264
March 31, 2002	1559	2617
January 31, 2003	1814	2463

Source: Co-ordination of Centres for the Prevention and Treatment of Drug Addiction, 2003

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

1-year period	Women	Men	All
2001	35	79	114
2002	36	81	117
January 1 - August 31, 2003	39	83	122

Source: Centre for the Treatment of Drug Addiction 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

1-year period	No. of clients in outpatient treatment
1995-2002	3250
January 1, 2003 – August 31, 2003	227 - new clients

Source: Centre for the Treatment of Drug Addiction at the Psychiatric Clinic Ljubljana

Basic training for medical doctors, nurses, social workers, pharmacists, psychologists, volunteers and professionals working in prisons is organised by the Co-ordination of Centres for the Prevention and Treatment of Drug Addiction at the Ministry of Health, while the technical organiser is 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 to increase the number of drug users making contact with the medical services, reducing the spread of HIV and hepatitis B,C, reducing overdoses and cutting criminality.

National guidelines for the treatment of drug users, including the methadone maintenance programme, were adopted by the Health Council at the Ministry of Health in 1994.
Methadone guidelines in Slovenia were updated in 2001.

Treatment is carried out according to the EU's 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 methadone programme have been fulfilled (assessment, laboratory tests…) the final decision for prescribing methadone should be made after consultations with the team in a few days or on the same day and methadone is prescribed by a medical doctor. There are practically no waiting lists.

Inclusion criteria for substitution treatment:

- opiate addiction and current physical dependence;
- previous detoxification attempts;
- signed consent for inclusion in the MMP;
- minimum age of 16;
- permanent residence in the region where a drug prevention and rehabilitation centre is located;
- family doctor; and
- health insurance (free of charge).

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

The network of Centres and two outpatient clinics (Jesenice, Tržič) for the Prevention and Treatment of Drug Addiction has existed in the Republic of Slovenia since 1995.

The Co-ordination of the CPTDA at the Ministry of Health is a co-ordinating body established to provide a uniform treatment approach in all treatment centres and exchanges of professional treatment experience.

The following activities of the Network of the CPTDA were undertaken in 2002 and 2003:

1. *Regular monthly sessions*

2. *Organisation of conferences, seminars and workshops together with The Sound of Reflection Foundation.*

    - 13th International Conference on the Reduction of Drug-Related Harm (March 3-7, 2002, Ljubljana)
    - 2nd International Harm Reduction Congress on Women and Drugs (March 3, 2002, Ljubljana)
    - 1st Adriatic Drug Addiction Conference: treatment, harm reduction, rehabilitation; Poreč, May 21-22, 2003
    - 1st Central and South Eastern European Symposium on Addictive Behaviours: substitution treatment, regional networking, Portorož, May 23, 2003

3. *Most important changes emerging through the network:*

    - Enlargement of the network with new centres and expansion of the existing centres and outpatient clinics in the network.
    - Co-operation in developing the doctrine of treating drug addiction in penal institutions
    - New drug-free programmes in prisons
    - Support for completion of the Drug Users Treatment Evidence questionnaire (Drug Treatment Demand) in the CPTDA network
    - Computerisation of the network
    - Development of prevention programmes

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

5. *Members of the Co-ordination body published their articles in both Slovenian and international publications.*

6. *Publishing the magazine: Addiction 'Odvisnosti', issued by the Co-ordination of the CPTDA at the Ministry of Health and published by The Sounds of Reflection Foundation – Ustanova Odsev se sliši.*

7. In 2002 representatives of the CPTDA Network received:

- The National Roleston Award at the ICHRD Conference in Ljubljana, Slovenia in March;
- The EUROPAD Award at the 5th EUROPAD Conference in Oslo, Norway in May.

d) Substitution drugs and mode of prescription

Methadone is prescribed and dispensed in the form of a solution (with fruit juice) in the Centres for the Prevention and Treatment of Drug Addiction. It can also be dispensed by GPs and pharmacies.

e) Psycho-social counselling (requirements and practice)

Individual and group psycho-social counselling is performed in the Centres for the Prevention and Treatment of Drug Addiction and by psychologists and social workers in some NGOs.

For more evaluation data, please see previous reports.

f) Diversion of substitution drugs

For more data, please see previous reports.

g) Evaluation results, statistics, research and training

No new data are available. Evaluations in the CPTDAs were done in 1995, 1997, 2000 and 2003. For more data, please see previous reports. Results for 2003 will be available next year.
Some studies were made in the CPTDA.

Training programmes for GPs have been organised by the Co-ordination of the Centres for Preventing and Treating Drug Addiction at the Ministry of Health and the Sound of Reflection Foundation:

- Debeli Rtič, November 2002
- PHARE Twinning Project “Strengthening of the National REITOX Focal Point and strengthening the supply reduction and drug demand reduction programmes in Slovenia”: Treatment of drug addicts, Relapse Prevention, March 26-27, 2003

11.3. After-care and reintegration: Peter Stefanoski

In Slovenia we have a large network of providers of public services and training programmes for resolving the social problems related to illicit drug use. Within the social welfare and care system all activities focus on encouraging the process of social inclusion. All high-threshold programmes are oriented to reintegration (services of personal assistance and assistance to the family for the home). Some programmes have organised specific after-care activities. There are no reintegration programmes open to all, they usually accept clients previously treated in a high-threshold programme.

An important share of social reintegration activities is provided through the social services of the centre for social work.

The goal of the network of services and programmes is:
1. 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):
2. improvement in the quality of living;
3. the assurance of active forms of social care;
4. development of expert networks of social assistance; and
5. establishment and development of the plurality of the activity; and the design of new approaches to the management of social hardship.

The goals are stated in the draft National Social Care Programme (identified by the Ministry of Labour, Family and Social Affairs: Official Gazette, RS, No. 31/2000) up until 2005.

Description of activities

Number of clients of the Centres for Social Work which reported drug-related problems in 2002 in Slovenia:
Adults - 879, Under-age - 694.

The social rehabilitation programmes (N=195), which are mainly provided by NGOs, were in 2002 co-financed through a public tender in a total amount of EUR 3,940,936, and specifically for drug programmes the amount was EUR 1,061,277.

Long-term co-finance contracts have been entered into with 53 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: 220 drug users, 500 parents of drug users, the number of clients in low-threshold programmes: 175.

One of the programmes is focused on rave parties and has reached thousands of ravers, and has also reported ten of thousands of visitors to its web site www.DrogArt.org.

For more information, please see the previous National Report.

12. Interventions in the Criminal Justice System: Olga Perhavc

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 wanting 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 co-operation with the National Focal Point. In this regard it co-operates with the Government Office for Drugs and the Institute of Public Health of the Republic of Slovenia.

When implementing programmes of assistance to prisoners with drug-related problems, the Administration also co-operates with the Ministry of Health, the network of the CPTDA, the Clinic for Infectious Diseases and regional hospital departments for infectious diseases, the Clinical 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 forms 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 the CPTDA 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 with 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 harm reduction in prisons there are voluntary and confidential blood tests for the presence of antibodies of HIV virus and hepatitis, and preventive tests for tuberculosis and vaccinations against hepatitis B. Detergents, disinfectants, condoms and latex gloves are available. 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 implementing 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 the CPTDA, 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 the enforcement of penal sentences in the Republic of Slovenia allows no alternative treatments for addicts.

12.3. Evaluation and training

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 people 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; and
- the number of imprisoned users seized drugs, by individual prisons.

In prisons a pilot project on recording data on the treatment of drug users has been established. In the pilot stage, data were sent to the Institute of Public Health where they were analysed and a competent worker from the prison administration, responsible for drugs, got 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 the EMCDDA's recommendations the system of enforcing penal sentences has committed itself to establishing the missing parameters.

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

In March 2003 a three-month pilot project on recording data on the treatment of drug users in prisons was concluded. The data were statistically analysed at the Institute of Public Health – Informational Unit for Illegal Drugs - on a sample of 76 people who gave their consent. From April 2003 recording the data on the treatment of drug users occurs regularly in all prisons.

13. Quality Assurance: Jože Hren, Matej Košir

a) Description of new trends and developments

Ministries and local authorities are directly responsible for quality assurance of the co-financed programmes. There were some developments of tender documentations in some ministries in 2002, which are important elements of quality assurance. An important task of the ministries is to ensure quality through professional, administrative and financial control of the programmes they co-finance. The Council for Drugs is responsible for this task at the Ministry of Work, Family and Social Affairs. The Health Council has the same task at the Ministry of Health. The Ministry of Work, Family and Social Affairs recently started to prepare procedures for the verification of programmes in the field of drugs.

b) Formal requirements for quality assurance

There are similar formal requirements for quality assurance for all governmental and non-governmental programmes, especially regarding the staff and people responsible for implementing programmes. They must have proper professional education, a professional national examination and additional expert knowledge, especially regarding competing for state grants. Control over the spending of grants and implementing of programmes is assured through partial and final reporting questionnaires. Some academic institutions monitor and evaluate several programmes. There were some developments in this area in 2002, especially regarding quality assurance elements in tender documentations and in the field of assuring quality reporting about the implementation of programmes.

c) Criteria and instruments applied in quality assurance

Please also see Chapter 13.b). Ministries and other competent institutions started to provide wider accessibility to analysis and evaluation results regarding the criteria and instruments applied in quality assurance.

d) Application of quality assurance procedures and results

Procedures for better quality assurance were introduced recently. Plans for the examination of the achieved results in terms of the purposes, aims, preparation, implementation, financing and leading of the programmes were introduced in 2002.

PART 4

SELECTED ISSUES

14. Evaluation of National Drug Strategies: Jože Hren, Matej Košir

14.1. Existence of evaluation

The new national strategy envisages the regular evaluation of implementation of the strategy and the procedures of implementation, evaluation of achievement of the aims regarding results (through indicators) and evaluation of all verified programmes. The Government Office for Drugs took the initiative in 2002 to establish an interministerial group responsible for preparing a draft programme of evaluation procedures, especially for evaluating the strategic documents and legislation.
However, in Slovenia we have not yet carried out any strategy evaluations.

14.2. Methodology of evaluation

There were several discussions in 2002 about the proper methodology of evaluation and actors involved. Different ministries and offices are preparing foundations for evaluations regarding their competences. These activities are strongly connected with developments in the field of quality assurance.

15. Cannabis problems in context: understanding the increasing treatment demand

15.1. Demand for treatment for cannabis use: Radivoje Pribaković Brinovec & Mercedes Lovrečič

In 2002 2633 drug users demanding treatment were reported through the network of 18 Centres for the Prevention and Treatment of Drug Addiction (Centres). The Network of Centres represented the only stable reporting system on treatment demand for drug problems in 2002.

During the last ten years we have observed an increase in demand for treatment for cannabis use. The increase was higher among first treatments but also noticed among all treatments (Table 15.1).

Table 15.1.1. Reported proportion in % of cannabis users in treatment in the CPTDA in Slovenia from 1993 to 2002

Year		1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Cannabis (total)	All treatments (%)	0.4	1.0	1.9	3.5	2.6	5.1	4.9	6.6	7.3	7.6
Cannabis (total)	First treatments (%)		1.3	2.4	3.9	3.8	8.4	10.8	14.3	12.7	22.7

Source: Institute of Public Health of the Republic of Slovenia

528 reported drug users were undergoing their first treatment in 2002. Cannabis was the main drug for 120 (22.7%) drug users in the first treatment (heroin was the main drug in 73.9% of first treatments, tranquilizers in 1.5%, stimulants in 1%, cocaine in 0.8%, and solvents in 0.2%).
Of all first treatments 327 drug users were using cannabis either as the primary or a secondary drug. The main secondary drug for cannabis users at the first treatment was alcohol (for 20% of them). Approximately 6% of them used heroin as a secondary drug but they were not injecting.

Cannabis users were referred either by themselves or by family and friends in more than 90% of cases. Other sources of referral were GPs, hospitals and social services. The pattern of referral has not changed much in the last few years. We can conclude that at the moment law enforcement measures do not play any important role in referring cannabis users to treatment. Besides the legislation on illicit drug use has not changed recently.

According to the Ministry of the Interior's data on illicit drug seizures there was a substantial increase in the total quantity of seized cannabis (177 kg in 2001, 1127 kg in 2002). Unfortunately, the Ministry of the Interior did not provide any additional comments about this.

Thus we cannot currently explain whether the increase in treatment demand for cannabis use really reflects the potential increase in the availability of cannabis and consequently a new trend among drug users or whether it means greater awareness of the potential harm of regular or problematic cannabis use (by parents, friends, the environment, drug users themselves) or reflects other reasons (treatment options like counselling, psychotherapy).

Of 120 cannabis users undergoing their first treatment 67.5% were male, the mean age was 18.77 ± 4.06 years. The youngest was 13 and the oldest was 43 years old. 70% of cannabis users were within the age group 15-19 years. Cannabis users represented the youngest age group among drug users in treatment demand. The mean period of regular cannabis use before entering treatment was 21 months. 66% of cannabis users used cannabis every day or up to six days a

week. 90% of cannabis users lived with their parents, 78% were students (primary school to university). Solvent users were even younger, but their number in treatment was very small.

15.2. Prevalence of problematic cannabis use and patterns of problems: Radivoje Pribaković Brinovec & Mercedes Lovrečič

Problematic cannabis use is defined as the long-duration/regular use of cannabis. Until 2002 there was no general population survey on drug use conducted in Slovenia. However, ESPAD surveys (1995, 1999, 2003 in progress) and the 1999 public opinion poll yielded some important information on the prevalence of cannabis use.

Data from ESPAD surveys and the 1999 public opinion poll were published in the previous National Report. Here we summarise the most important data on cannabis use from the ESPAD 1999 survey.

In 1999 24.9% of surveyed pupils (N=3184) 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.

Last-year prevalence was 21.2% (having used marijuana/hashish at least once). Last-month prevalence was12.8% (having used marijuana/hashish at least once).

Concerning problematic cannabis use there was a certain proportion of surveyed pupils who admitted having used marijuana/hashish 40 times and more in their lifetime, in the last year and in the last month, which we could approximate to problematic cannabis use. Lifetime prevalence was therefore 4.5%, last-year prevalence was 2.3% and last-month prevalence was 0.5%.

No data is available regarding driving accidents and social problems related to cannabis use in 2002 in Slovenia.

In 2002 in Slovenia there were 30 inpatient treatments (out of 1015 reported inpatient treatments for drug use problems diagnosed due to ICD-10, more precisely in all cases there was a combination of diagnoses: the main from Chapter V and the second from F10 – F19) in hospital units reported due to cannabis use (first or second diagnosis) associated with another psychiatric disorder. Of these 30 hospitalised cannabis users, 21 also had a psychotic disorder (ICD-10: F 20 - F 29). In all these cases, the use of cannabis was reported as a second diagnosis. Unfortunately, we cannot estimate whether these reported cases represent the real level of cannabis-related psychiatric problems, nor can we conclude that the psychotic problems reported were only due to cannabis use.

No data is available regarding health (non-psychiatric) problems related to cannabis use in 2002 in Slovenia.

15.3. Specific interventions for problematic cannabis use: Mercedes Lovrečič

While all of the long-term effects of marijuana use are not yet known, some studies show serious health concerns. Findings so far show that the regular use of marijuana or THC (delta-9-tetrahydrocannabinol) may play an important role in cancer and problems in the respiratory and immune system. Cannabis has been implicated as a cause of toxic psychoses (acute, chronic) and also an important factor in functional psychoses (may precipitate or cause a relapse).

In the period between 2002 and 2003 in Slovenia there was some debate (mostly the media, meetings) about the possible medical use of marijuana, but it is important to stress that marijuana, at least in its smoked form, has no commonly accepted medical use. It is important to distinguish between whole marijuana and pure THC. Whole marijuana contains hundreds of chemicals and some are clearly harmful to health.

THC taken by mouth in pill form (and not smoked!) can be used in some cases for treating the nausea and vomiting that go along with certain cancer treatments and is available upon medical prescription. It is also used to help some AIDS patients eat more to keep up their weight.

Scientist are still studying whether marijuana, THC, and related chemicals (cannabinoids) may have other medical uses. According to these scientists, more research needs to be done on marijuana's side effects and the potential benefits before it can be recommended for medical use.

There are several reasons to study the relationship between psychiatric disorders and substance abuse. Several drugs can cause a variety of behaviours and experiences that are associated with psychiatric illness and may precipitate such illness.
The prevalence and clinical importance of cannabis use in patients with chronic psychosis has not been systematically explored. In particular, whether the diagnostic and symptomatological features of chronic psychosis can be differentiated on the basis of cannabis use status is still an unanswered question.

Psychotic symptoms attributable to the use of cannabis have been widely documented. It is quite difficult to determine whether cannabis use is primitive or secondary to psychotic symptomatology, however, cannabis use mostly precedes or is concomitant with the onset of psychotic symptoms.

It is still hard to find in Slovenia treatment programmes specifically aimed at marijuana users. Treatments for marijuana dependence are much the same as therapies for other drug abuse problems performed in the CPTDA network and NGOs. These include different approaches ranging from detoxification, behavioural therapies and to regular attendance at support group meetings.

There are currently no medications for treating marijuana dependence. Treatment programmes focus on counselling and group support systems. Some programmes are located in independent adolescent treatment facilities. General practitioners are also a good source of information and support for young adult marijuana users.

Substance abuse in general, but also marijuana use, is potentially hazardous to psychical health and can exacerbate mental illness. Greater effort should be made to devise prevention and therapeutic strategies, especially those for double-diagnosed patients, to reduce consumption.

16. Co-morbidity

16.1. Psychiatric comorbidity: Mercedes Lovrečič & Icro Maremmani

When two independent medical disorders affect the same subject, the term 'Dual Diagnosis' (DD) can be used. In the fields of psychiatry and addictive diseases, the term indicates the meaning of "the coexistence of a psychiatric disorder with a substance use disorder".

Psychiatric illness and substance use share several features: substance use may elicit or otherwise mask a concurrent but independent psychiatric symptomatology, thus making it difficult to discriminate between them. The use of substances generally causes such a wide variety of psychiatric symptoms that almost any known psychiatric syndrome may be mimicked. The drug use may bring forward the onset of psychiatric disorders for which an independent proneness already exists, exacerbate symptoms of current psychopathology or favour relapses into major syndromes. Conversely, mentally ill individuals may resort to substances in order to soothe psychiatric symptoms or to counter the side-effects of administered agents. Withdrawal of substances can be another cause of psychopathology. Addictive disorders may also coexist side by side independent psychiatric disorders like autonomous entities.

The most frequent diagnostic combinations are: cocaine abuse with major depression; panic disorder with alcohol dependence; schizophrenia with alcohol dependence and the abuse of other substances; borderline personality disorders with intermittent poly-abuse.
It is not uncommon to assess the same individual for more than two disorders; in that case the same considerations hold as with dual diagnosis.

The first step in structuring an effective treatment for dual-diagnosis patients is the definition of a correct psychiatric diagnosis; this is not always easy because there is an overlap area between outbursts of primary psychiatric disorders and drug- or alcohol-related psychopathology.

Mentally ill subjects run a high risk of developing substance use disorders and, conversely, substance abusers are likely to have future psychiatric disorders. Approximately one-third of all psychiatric patients abuse substances, a frequency which is twice that found among the general population. Over 50% of substance abusers report symptoms of psychopathology, though these are mostly interpretable as substance-induced rather than as due to any independent mental disease.

DD patients must be evaluated in terms of case severity, chronicity, and the degree of functional impairment. The wide range of different clinical conditions call for specific particular interventions, but there is a trend for patients to be clustered round certain treatments instead of others on whose basis clinical features are prominent.

No data are available regarding the prevalence of mental disorders diagnosed among drug users in 2002 in Slovenia. No studies are available among drug users with concurrent mental health disorders in 2002 in Slovenia.

16.2. Impact of co-morbidity on services and staff: Mercedes Lovrečič & Icro Maremmani

Several categories of operators work together in psychiatric services: psychiatrists, psychologists, nurses, social workers, counsellors and others. Treatment strategies vary from one service to another and within the same service. It is crucial for psychiatric patients to be provided with integrated treatments comprising counselling, case management, hospitalization, rehabilitative and residential programmes so as to satisfy needs arising from both acute and chronic conditions.

As with the treatment of psychiatric patients in general, teams working in addiction medicine units (CPTDAs) should comprise physicians, psychiatrists, psychologists, nurses, social workers, and counsellors. Other operators may also be involved, offering a variety of adjuvant skills. A bio-psychosocial approach, comprising and integrating various professional skills, should lie at the core of any service for addictive diseases.

Unless dual-diagnosis patients are provided with effective treatment for their psychiatric illness, the risk of a relapse is bound to remain high. Self-help associations such as Alcoholics Anonymous and Narcotics Anonymous may have much to offer to other types of patients.

Self-help interventions should not be viewed as alternative treatment options but be made part of integrated treatment programmes. On the other hand, unfounded fears and misinformation may spread within self-help contexts as long as participants only report opinions and views based on strictly personal experiences. Specific self-help programmes for dually diagnosed patients have recently been developed in the USA; these do focus on the improvement of patients' compliance with psychopharmacological therapies.

Dual-diagnosis patients frequently get in touch with their GPs but they usually receive little attention. Moreover, GPs are likely to deal with cases of dual diagnosis by prescribing generic psychotropics (antidepressants, anxiolytics). GPs are the category of physicians most likely to prescribe anxiolytic drugs, especially benzodiazepines, which are those most likely to be abused. Generally speaking, GPs show they are most concerned about the side complications of addiction such as withdrawal, overdosing or somatic issues rather than aiming for a specific intervention directed at the core of the addictive disease.

16.3. Service-provision for psychiatric comorbidity: Mercedes Lovrečič & Icro Maremmani

In Slovenia on one hand there is a quite good network of CPTDAs providing treatment for drug users. On the other hand there are still some real and objective obstacles to the integrated treatment of DD drug users.

In fact, some programmes require a drug-free condition as a starting point whereas that condition is simply the long-term end result of other programmes. Some programmes such as methadone maintenance do not invariably aim at the complete elimination of heroin use. Controlled heroin use may be acceptable when no evolution towards abstinence is feasible as long as methadone maintenance ensures satisfactory personal and social readjustment.

Some treatment programmes require patients to be drug-free as a condition for admission. In most patients with a severe dual-diagnosis condition (such as schizophrenics), a drug-free state should only be thought of as a possible long-term outcome of adequate methadone maintenance. On the other hand, a drug-free condition may be useful for patients suffering from depression or panic disorder in order to allow an earlier, better-defined diagnosis and, later, a correct therapeutic plan. For dual-diagnosis patients, the requirement of a drug-free condition as being preliminary to programmes actually functions as an obstacle. We therefore suggest that the concept of a "drug-free state" be redefined as a therapeutic goal to be approached step by step along a route mapped out by an adequate treatment programme. Homeless patients who dwell in highly drug-polluted environments cannot be expected to be brought to a drug-free condition by any deadline, especially an early one.

In cases of dual diagnosis there is a clear trend towards greater chronicity and severity and more serious somatic, social and psychological problems than in cases of uncomplicated addiction. Moreover, relapses into substance use are more likely; this, in turn, causes psychiatric symptoms to become exacerbated thereby setting up a vicious circle. DD patients take longer to complete any

treatment successfully, are likely to undergo several critical phases over time, and tend to recover more slowly.

When psychiatric illness and substance abuse coexist, the medical approach to the patient is inevitably awkward. This is due both to the patient's psychiatric condition and abuse behaviours, and to a cultural context which does not favour a scientific approach to mental illness in general or, more emphatically, to addictive diseases. On one hand, depression and doubts about effectiveness are unlikely to hold patients back from resorting to medical services. On the other hand, environmental issues interfere with a correct medical intervention: patients are unlikely to know what kind of treatment is provided by which service; some kinds of facilities are only available if paid for; and some kinds of service, though effective, are only available in some areas so that addicts in some parts of the country face disadvantages.

Usually, when DD patients apply to local services for the treatment of their addiction, acute psychiatric syndromes are often mistaken for substance-induced alterations or, conversely, withdrawal or intoxication phenomena are misinterpreted as psychiatric illness. In the latter case, patients are usually referred to psychiatric services. Paradoxically, the same happens with psychiatric patients who apply for treatment at psychiatric centres if they are also current substance abusers. The intensity and frequency of psychiatric symptoms and substance-induced symptoms usually fluctuate. Accordingly, it may be that the need to buffer intermittent acute variations on a basis comprising a chronic psychiatric illness and an addictive condition catch the clinician's attention more than the need to control the independent aspects of the case, which will be psychiatric, addictive and social. The end result may be that the health system becomes an obstacle to patients seeking treatment rather than a way of providing them with adequate health facilities.

Currently, a correct approach to DD patients requires not only attention to the specific issues of each case but also an awareness of the continuing divergence between the health system, as it is implemented now, and the needs of dual-diagnosis patients.

16.4. Examples of best practice and recommendations for future policy: Mercedes Lovrečič & Icro Maremmani

Traditionally, the public health system has always given patients the responsibility of seeking treatment, as if that were a sign of their motivation to be cured. More recently, the same issue has been raised in connection with what is called 'case management'' (CM), considering that most patients with additional psychiatric illness are reluctant to resort to services or are incapable of taking advantage of the available facilities. CM may be a crucial resource in dealing with addiction when the aim is to start patients on treatments and favour retention in treatment. CM may also be valuable in attenuating the negative results of dropping out of treatment. Conversely, programmes lacking a CM approach are more likely to be hampered by psychopathological crises and hospitalization episodes, while the most severe cases are unlikely to be successfully handled. The broad aim of CM is to encourage reluctant patients to enter treatments, and limit the negative impact of treatment failures on the personal history of subjects.

DD patients need to be followed up for both their conditions, applying strategies devised to fit their individual condition. Physicians and patients should share the responsibility for treatment. At present, patients who deny the presence or minimize the severity of their condition are treated with excessive severity by physicians. DD patients require a completely different approach in order to be persuaded to enter and comply with treatment programmes. It is advisable to avoid confrontation with patients whose conditions are particularly severe, such as psychotic ones, because they are unlikely to comply with the rules of the programme until the severity of their condition has been at least partly improved. Too often, addictive diseases are regarded with a 'here and now' attitude by physicians themselves, who also tend to overrate the background

aspects of associated psychiatric disorders. Substance abuse tends to be interpreted as symptomatic of a previous psychic trauma, rather than as an independent condition. Too often treatment strategies focus on the resolution of some evolutional problem, in the mistaken conviction that addiction will achieve remission once its background has been readjusted. So far, the main outcome of this attitude has been a perpetuation of the vicious circle of addictive behaviours.

The psychiatrists should broaden their knowledge of substance-related medical issues, while physicians who deal with drug addicts should also be knowledgeable about psychiatry, especially the use of psychotropics.

As in the field of general psychiatry, a variety of therapeutic solutions is available for the treatment of substance use disorders (short- and long-term detoxification programmes, agonist maintenance, therapeutic communities and self-help programmes), which often apply divergent basic principles and may be incompatible with each another.

The **sequential model** is the first to have been applied and to date has been the most frequently employed. Here, the psychiatric disease and the addictive disease are approached in two different stages. Some clinicians believe that the addictive disease should always be approached first, and that it only makes sense to treat the co-morbid psychiatric illness once any abuse has been halted. Others argue that specific treatments for the psychiatric illness may be feasible even when there is ongoing substance use, before any specific intervention for addiction has been started. Another view is that the decision on treatment priority should take into account the severity of each condition, the preference going to the condition most urgently calling for intervention. To exemplify all this, we could select the case of a dual-diagnosis, depressed heroin addict who seeks treatment at a mental health service when still suffering from depression, and also attends a specific programme for substance abuse to cure recurrent alcohol binges.

In the **parallel model**, the patient is enrolled in two programmes simultaneously, the first targeting the psychiatric illness and the second focusing on substance abuse. A twelve-step programme, such as those provided by AA, may for instance be combined with psychiatric treatment under the supervision of mental health operators. As with the previous (sequential) model, this model also consists of a combination of already running programmes. Psychiatrists deal with the psychiatric illness, and addiction physicians or operators manage the addiction-related issues.

The **integrated model** couples psychiatric treatment with intervention against substance abuse within a single programme, specifically planned for dual-diagnosis patients. Theoretically, two distinct categories of physicians and skills should be involved, together with a twofold CM approach, so as to allow patients to overcome both psychiatric and addictive relapses.

Each of these treatment models has its pros and cons. Requirements for treatment adequacy vary with different states of comorbidity, symptom severity and global functioning impairment. In fact, the sequential and parallel models may be those that best fit severely addicted patients who also suffer from a minor form of psychiatric disease.

The main drawback of these approaches is that patients may be given contradictory information in the two different settings they attend. Conversely, when a CM facility is available, and is embodied in a single operator possessing two sets of skills in a specific setting, patients get the benefit of a homogeneous treatment approach.

No data and no studies were available in 2002 in Slovenia regarding the policies and/or specific interventions in field of DD drug users.

ANNEX 1

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ANNEX 2

Drug Monitoring Systems and Sources of information (Prepared from the 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 the school survey.
The reporting system according to the treatment demand indicator has not been completely established yet. Only data from CPTDAs are routinely reported.

Health care information system (network) for the NIPH in Slovenia:

Health statistics (primary, secondary, tertiary health care, health care manpower, facilities etc.) are almost fully centralised, and the Institute of Public Health of the Republic of Slovenia (the Institute), together with regional Institutes of Public Health are responsible for collecting, analysing and processing medical data from all HC levels, except for health care finance data which are handled by a health insurance office. Health care providers will submit annual reports to the regional Institutes of Public Health, but also every time data to the Institute of Public Health (first treatment demand data). There are nine regional institutes. After formal and logical control, the regional institutes will forward it to the Institute. Diskettes are the most frequently used means of data transfer, but an electronic data interchange network has also been developed and implemented for communication between these institutions. Every year the Institute prepares a statistical health report. The Institute provides data for government institutions (Health Plan till 2004) and other institutions like the World Health Organisation, UNICEF, World Bank etc. The new Health Care Register law adopted in July 2000 introduced some new registers (cardiovascular diseases, injury, suicides, drug users etc.) managed by other data collection managers, but the main data collection manager is still the Institute of Public Health. With regard to the availability of data, the new Health Care Register law defines general accessibility, in particular access to personal data. Because of its position within national statistics managed by the National Statistical Office, the Institute of Public Health is entitled to demand data from all Health Care data collection managers (depersonalised data).

- **The Ministry of Health**
  Various data on CPTDA and the 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 the 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 the INDOK Centre at the Institute of Public Health.
A lot of information and publications are also available at the Government Office for Drugs, where a drug documentation centre is being established.
Slovenia is reporting to several international organisations on a regular and occasional basis. UNDCP questionnaires are completed, reports to international organisations such as Phare and Pompidou Group are prepared. The police reports to INTERPOL and EUROPOL. Reports are prepared according to international co-operation in specific projects. 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
CPTDA	Centres for the Prevention and Treatment of Drug Addiction
CRC	Capture Recapture Method
CEECs	Central and Eastern European Countries
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
FTD	First Treatment Demand
HPS	Health Promoting Schools
ICD	International Code of Diagnoses
IDU	Injecting Drug Users
IUID	Information Unit for Illegal Drugs
ISAM	International Society of Addiction Medicine
LAT	Local Action Team
MEPA	Middle European Police Academy
MMP	Methadone Maintenance Programme
MSM	Man who had Sexual contact with another Man
NAPDIS	National Action Plan Drug Information System
NFP	National Focal Point
NGO	Non-governmental Organisation
PG	Pompidou Group
NIPH	Institute of Public Health of the Republic of Slovenia
REITOX	European Information network on Drugs and Drug Addiction (Réseau Européen d,Information sur les Drogues et les Toxicomanies)
SNHPS	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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MAPS, TABLES

Table A1: Number of reported drug users in treatment in the CPTDA in Slovenia from 1991 to 2002

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
No. of all treatment cases	49	327	237	301	208	434	781	835	1057	946	1094	2633
No. of first treatment cases	21	174	144	229	168	309	478	491	409	377	402	528

Source: Institute of Public Health of the Republic of Slovenia

Table A2: Number of reported drug users in treatment in the CPTDA in Slovenia from 1991 to 2002 by sex

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
(%) of all treatment cases – male	85.7	74.2	78.5	77	77.4	77.4	76.6	75.7	77.1	77.3	79.4	77.9
(%) of all treatment cases – female	14.3	25.8	21.5	23	22.6	22.6	23.4	24.3	22.9	22.7	20.6	22.1
(%) of first treatment cases – male	85.7	76.2	77.1	73.4	77.4	79.6	75.9	76.2	76.5	77.5	78.9	73.9
(%) of first treatment cases - female	14.3	23.8	22.9	26.6	22.6	20.4	24.1	23.8	23.5	22.5	21.1	26.1

Source: Institute of Public Health of the Republic of Slovenia

Table A3: Number of reported drug users in treatment in the CPTDA in Slovenia from 1991 to 2002 by main/primary drug

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Heroin - % of all cases	85.7	94.5	97.5	96.7	94.7	94.2	95.1	94	93.6	92.4	90.3	89.9
Cocaine ClH - % of all cases	4.1		1.3			0.5	0.9	0.5	0.5	0.8	0.8	0.6
Hypnot. and sedat. (total) - % of all cases		0.6			1.0	0.2	0.1	0.1	0.3	0.1	0.4	0.74
Cannabis (total) - % of all cases	6.1		0.4	1.0	1.9	3.5	2.6	5.1	4.9	6.6	7.3	7.6
Heroin - % of first cases	85.7	98.9	98.6	98.7	93.5	93.5	93.7	90.4	86.6	84.6	84.8	73.9
Cocaine ClH - % of first cases	4.8		1.4			0.3	0.6	0.8	1	1.1	1.2	0.8
Hypnot. and sedat. (total) - % of first cases					1.2	0.3	0.2	0.2			0.9	1.5
Cannabis (total) - % of first cases	9.5			1.3	2.4	3.9	3.8	8.4	10.8	14.3	12.7	22.7

Source: Institute of Public Health of the Republic of Slovenia

Table A4: Number of reported drug users at first treatment in the CPTDA in Slovenia from 1991 to 2002 by route of administration of heroin

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Injecting - % of first cases	0.94	0.84	0.87	0.90	0.90	0.80	0.78	0.78	0.77	0.76	0.59	0.66
Smoking - % of first cases		0.01		0.03	0.02	0.05	0.06	0.10	0.11	0.16	0.28	0.28
Sniffing - % of first cases	0.06	0.15	0.12	0.06	0.07	0.14	0.14	0.10	0.12	0.08	0.11	0.06
Inhaling - % of first cases							0.02	0.01	0.01	0.00	0.02	

Source: Institute of Public Health of the Republic of Slovenia

Table A5: Number of reported drug users in treatment in the CPTDA in Slovenia from 1991 to 2002 by injecting behaviour

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Current Injecting - % of all cases	95.8	85.9	76.4	84.5	83.9	69.8	66.7	67.8	53.9	56.4	42.0	35.9
Lifetime Injecting - % of all cases	98.0	94.4	91.7	95.6	92.7	87.3	85.7	86.3	83.6	83.8	77.24	79.5
Current Injecting - % of first cases	95.2	82.9	78.6	88.5	86.7	68	65.1	65.6	63.6	61.3	44	41.7
Lifetime Injecting - % of first cases	100	91.3	90.6	96.5	94.6	84.7	80.5	82.5	72.9	72.1	62.4	53.4

Source: Institute of Public Health of the Republic of Slovenia

Table A6: Number of reported drug users in treatment in the CPTDA in Slovenia from 1991 to 2002 by average age: at treatment, at first use of primary drug, at first use of any illicit drug and by sex

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Age at entering FTD - all	24.7	24.6	23.9	23.5	23.9	22.2	22.2	21.7	22.0	22.1	22.6	22.4
Age at first use of primary drug - all	20.4	19.7	20.0	19.7	20.2	19.3	19.0	18.7	18.7	18.6	18.7	18.3
Age at first use of any illicit drug - all	16.3	17.2	17.0	16.9	16.6	16.4	16.3	16.2	16.3	15.9	16.0	15.9
Age at entering FTD - male	25.3	25.3	24.4	24.1	24.5	22.7	22.7	22.1	22.5	22.5	22.9	22.7
Age at first use of primary drug - male	20.8	19.8	20.1	20.2	20.6	19.7	19.3	19.0	18.9	19.0	18.8	18.6
Age at first use of any illicit drug - male	16.5	17.2	17.0	17.0	16.8	16.5	16.3	16.2	16.3	15.9	15.9	16.0
Age at entering FTD - female	21.3	22.3	22.4	21.9	22.0	20.6	20.7	20.4	20.6	20.7	21.4	21.4
Age at first use of primary drug - female	18.0	19.3	19.8	18.5	19.0	18.0	18.2	17.9	18.1	17.3	18.4	17.5
Age at first use of any illicit drug - female	16.0	17.1	16.8	16.6	16.0	15.9	16.3	16.1	16.2	15.8	16.2	15.6

Source: Institute of Public Health of the Republic of Slovenia