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"SLOVENIA"

New Development, Trends and in-depth information on selected issues

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Ljubljana, December 2004

INSTITUTE OF PUBLIC HEALTH OF THE REPUBLIC OF SLOVENIA

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Lector:
Murray Bales

Editor:
Mercedes Lovrečič
REITOX National Focal Point Co-ordinator

Editorial Board:
Manca Drobne
Rok Tavčar

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 479
Fax:+ 386 1 2441 536

e-mail:
mercedes.lovrecic@ivz-rs.si

EXPERTS CONTRIBUTING QUALITATIVE INFORMATION AND DATA

Institute of Public Health of the Republic of Slovenia- National REITOX Focal Point:

Mercedes Lovrečič
Manca Drobne
Ines Kvaternik Jenko
Miljana Vegnuti
Radivoje Pribaković Brinovec

in alphabetical order:

Lidija Apohal Vučkovič	Ministry of Labour, Family and Social Affairs of the Republic of Slovenia
Mateja Becele Dujunov	Centre for Treatment of Drug Addiction, Psychiatric Clinic Ljubljana
Breda Bizjak	Centre for the Prevention and Treatment of Drug Addiction Celje
Miran Brvar	National Poison Control Centre, Clinical Centre Ljubljana
Aleksander Caran	Centre for the Prevention and Treatment of Drug Addiction Trbovlje
Dušica Cvitkovič	Emergency Department of the Clinical Center of Ljubljana
Fani Čeh	National Education Institute
Branka Čelan Lucu	Centre for the Prevention and Treatment of Drug Addiction Ljubljana
Jasna Čuk Rupnik	Centre for the Prevention and Treatment of Drug Addiction Logatec
Mojca Zvezdana Dernovšek	University Psychiatric Hospital Ljubljana & Institute of Public Health of the Republic of Slovenia
Polona Dremelj	Social Protection Institute of the Republic of Slovenia
Andreja Drev	Institute of Public Health of the Republic of Slovenia
Goran Dubajič	Centre for the Prevention and Treatment of Drug Addiction Piran
Marjeta Ferlan Istinič	Ministry of Labour, Family and Social Affairs of the Republic of Slovenia
Vito Flaker	Faculty for Social Work
Julijana Florjančič Kristan	Association of NGO's
Dragica Fojan	Association SVIT Koper
Tamara Fras Stefan	Centre for the Prevention and Treatment of Drug Addiction Ljubljana
Mojca Goltnik	Ministry of the Interior of the Republic of Slovenia, Police
Vera Grebenc	Faculty for Social Work
Marta Grgič Vitek	Institute for Public Health of the Republic of Slovenia
Zvezdana Hartman Veber	Ministry of Health of the Republic of Slovenia
Jože Hren	Ministry of Health of the Republic of Slovenia, Office for Drugs
Mateja Hrovat	Centre for the Prevention and Treatment of Drug Addiction Ljubljana
Rade Iljaž	Centre for the Prevention and Treatment of Drug Addiction Brežice
Veronika Jazbec	Centre for the Prevention and Treatment of Drug Addiction Celje
Magda Justin	Aids Foundation Robert Ljubljana
Majda Karlovšek Zorec	Institute for Forensic Medicine, Medical Faculty , University of Ljubljana
Andrej Kastelic	Centre for Treatment of Drug Addiction, Psychiatric Clinic Ljubljana
Ivan Kauzlarič	Centre for the Prevention and Treatment of Drug Addiction Ilirska Bistrica
Nataša Kern	Centre for the Prevention and Treatment of Drug Addiction Kranj

Irena Klavs	Institute of Public Health of the Republic of Slovenia
Irena Kmetec	Centre for the Prevention and Treatment of Drug Addiction Maribor
Nuša Konec	Regional Institute of Public Health Celje
Mila Korene	Centre for the Prevention and Treatment of Drug Addiction Kočevje
Marika Kosi	Centre for the Prevention and Treatment of Drug Addiction Maribor
Branka Kozina Zorman	Centre for the Prevention and Treatment of Drug Addiction Kranj
Tatja Kostnapfel Rihtar	Prohealth
Matej Košir	Ministry of Health of the Republic of Slovenia, Office for Drugs
Elizabeta Kovačič	Centre for the Prevention and Treatment of Drug Addiction Izola
Rajko Kozmelj	Ministry of the Interior of the Republic of Slovenia, Police
Ljudmila Kramar	Centre for the Prevention and Treatment of Drug Addiction Brežice
Violeta Krampelj	Centre for the Prevention and Treatment of Drug Addiction Novo mesto
Miloš Kravanja	Institute of Public Health of the Republic of Slovenia
Milan Krek	Ministry of Health of the Republic of Slovenia, Office for Drugs
Lidija Kristančič	Ministry of Health of the Republic of Slovenia
Vilma Kutnjak	Centre for the Prevention and Treatment of Drug Addiction Velenje
Evita Leskovšek	Aids Foundation Robert Ljubljana
Karel Lipič	Aids Foundation Robert Ljubljana
Barbara Loboda	Centre for the Prevention and Treatment of Drug Addiction Piran
Mojca Matičič	Department of Infectious Diseases, University Medical Centre, Ljubljana
Martin Možina	National Poison Control Centre, Clinical Centre Ljubljana
Zoran Muidža	Centre for the Prevention and Treatment of Drug Addiction Nova Gorica
Maksimiljan Nežman	Centre for the Prevention and Treatment of Drug Addiction Celje
Boris Novak	Ministry of the Interior of the Republic of Slovenia
Neda Pečar	Centre for the Prevention and Treatment of Drug Addiction Sežana
Olga Perhavc Uršič	Prison Administration of the Republic of Slovenia
Vesna Kerstin Petrič	Ministry of Health of the Republic of Slovenia
Nenad Petrovič	Centre for the Prevention and Treatment of Drug Addiction Murska Sobota
Ljubo Pirkovič	Ministry of the Interior of the Republic of Slovenia, Police
Andrej Pišec	Centre for the Prevention and Treatment of Drug Addiction Maribor
Mario Poljak	Department of Microbiology and Virology, Medical Faculty
Barbara Prosen	Centre for the Prevention and Treatment of Drug Addiction Kranj
Nino Rode	Faculty for Social Work
Cvetka Rogač Cvetko	Ministry of Health of the Republic of Slovenia
Matej Sande	DrogArt
Nataša Sedmak	Centre for the Prevention and Treatment of Drug Addiction Sežana
Nardo Stegel	Centre for the Prevention and Treatment of Drug Addiction Pivka
Eva Stergar	Institute of Public Health of the Republic of Slovenia
Ervin Strbad	Centre for the Prevention and Treatment of Drug Addiction Novo mesto
Jožica Šelb Šemerl	Institute of Public Health of the Republic of Slovenia
Simona Špital	Centre for the Prevention and Treatment of Drug Addiction Velenje
Milena Šterbenc	Centre for the Prevention and Treatment of Drug Addiction Kočevje
Zlatan Šušteršič	Ministry of the Interior of the Republic of Slovenia, Police
Zlata Švab	Centre for the Prevention and Treatment of Drug Addiction Izola

Dušan Valentinčič	Prison Administration of the Republic of Slovenia
David Vrban	Centre for the Prevention and Treatment of Drug Addiction Nova Gorica
Darko Žigon	General Customs Directorate

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Introduction

This is the fourth time the REITOX National Focal Point (NFP) at the National Institute of Public Health of Republic of Slovenia (NIPH) has presented its Annual Report on the Drug Situation, drawn up for the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Different ministries, institutions and professionals were involved in preparing the Report. The Report has been discussed at a meeting of the NFP Advisory Board and the Government Commission for Drugs. Slovenia already started developing its information system for drugs in the early 1990s, with the support of various Phare projects and international organisations working in the area of illicit drugs.

Slovenian drug policy did not change significantly in 2003. The relevant laws were regularly implemented by the competent authorities. The resolution on the national programme in the field of drugs (2004-2009) was a key subject of discussion. As a strategic document it was discussed at the inter-ministerial and governmental levels in 2003. It was also discussed and adopted in 2003 by the Government Commission for Drugs. The resolution on the national programme in the field of drugs was adopted by the National Assembly in February 2004.

The second important issue was the placement of the Government Office for Drugs (GOD) within the Ministry of Health. It was moved from the governmental level to within the organisational structure of the Ministry of Health as a result of the reform of the public administration. The Office for Drugs (OD) has been part of the Ministry of Health since 1 April 2004. All the Office's tasks remain the same, including inter-ministerial co-ordination as its most important task.

The PHARE Twinning project with the Spanish and Austrian Governments came to an end in September 2003. Project activities were mostly connected with supporting drug-demand-reduction programmes and reducing the supply of drugs.

In January 2003 Slovenia received a new Centre for the Treatment of Drug Addicts at the Psychiatric Clinic of Ljubljana (CTDA) in a renovated building offering greater capacity. The CTDA provides improved possibilities for outpatient and inpatient detoxification. In fact, it is still part of the Psychiatric Clinic instead of an independent service as formally planned.

The IUID (Information Unit for Illegal Drugs)-NFP has already sent in statistical tables, all planned activities have been performed within the framework of the Exchange on Drug Demand Reduction Action (EDDRA) requirements. This year, the General Population Survey (GPS) was not performed due to a lack of financial sources. The European School Project on Alcohol and Drugs (ESPAD) research in 2003 was carried out by the NIPH in 2003.

The IUID-NFP participated in activities related to establishment of the EDDRA in Slovenia. A national EDDRA manager regularly attends European meetings. The database, drawing upon information from assistance programmes for 1999 and 2001, is located within the documentation centre of the OD. It provides the basic starting points for the development of the EDDRA database in Slovenia. A modified questionnaire (including many EDDRA elements) was prepared and sent to all known programmes in the field of reducing drug demand in Slovenia.

The activities of the Early Warning System on new synthetic drugs (EWS) in Slovenia in 2003 were co-ordinated by the IUID-NFP and performed in line with the Action Plan. The EWS co-ordinator has been regularly attending European meetings. In

May 2004 a New/Synthetic Drugs Web Monitoring System was developed with the co-financing of the Phare - EMCDDA Project. It was established for internal use.

In Slovenia it is necessary to prepare an Action Plan for different sectors in the field of drugs, to evaluate the strategy as well as different activities and programmes. These will be priorities in the coming year.

Summary

Slovenian national report 2004 consists of two basic parts, new developments and three selected issues. The report itself expresses the necessity for systematic evaluation of programmes active in the field of drugs in Slovenia, which is also one of the main priorities mentioned in the Resolution on the National Programme in the field of drugs (2004-2009). At the end, systematic evaluation of the whole policy in the field of drugs would be an important issue for the future.

Our treatment demand data regarding persons seeking treatment in the specialised centres for prevention and treatment of illegal drug addiction in Slovenia, show the prevailing type of drug user remains heroin user who is frequently poly drug user and combines primary drug mostly with cannabis, it is characteristics for both genders. He or she is most frequently unemployed and lives with their parents.

In the period from 1992 to 2003 we observed decreasing trend of injecting drugs among first treatment demands, at the same time sharing of needles and equipment for injecting is decreasing also. On the other hand, poly drug use among people in treatment is increasing, more than 60% of drug users in 2003 reported poly drug use, most frequently cannabis, cocaine and other illicit drugs were combined with primary drug.

Since 1996 and 2002 the increasing trend for cannabis as a primary drug problem was observed among first treated clients, but decreased in 2003.

Noticeable is problematic drug use in Slovenian prisons. According to data of Prison Administration of the RS, number of people with illegal drug use problem is increasing. The proportion of people having problems with drug use raised from 3% in 1995 to approximately 15% in 2003. Compared to total prison population in 2003 (4725 prisoners), 727 people had problems with drug use, of them 46% were involved in methadone therapy.

Slovenian law foresees the compulsory treatment for those who are dependent on alcohol or drugs, in case of committing criminal offence as a consequence of drug or alcohol dependency. 26 people were treated under above mentioned law in Slovenian prisons in 2003 for drug dependency. No alternatives to prison targeting drug using offenders are implemented so far in Slovenian law.

In the year 2003 the working group for drug related deaths indicator for the first time managed to record indirect drug related deaths. The dramatic fall in drug related deaths due to heroin from 2002 to 2003 was noticed and a slight increase in methadone deaths.

According to the available data, driving under the influence of illicit drugs is increasing in Slovenia, very frequently among drivers driving under the influence of illicit drugs, a combination of two or more drugs is detected.

The number of detected illicit drug related criminal offences has increased in the last 11 years by more than seven times and the number of detected offences with respect to illicit drug possession rose dramatically, with some exceptions in 2003.

Part A:

New Developments and Trends

1. National policies and context prepared by Matej Košir

Legal framework

Slovenia is a party to numerous United Nations (UN) conventions or is the successor to them after they were signed by the former Yugoslavia. The most important of these include the Single Convention on Narcotic Drugs of 1961, the Protocol on amendments to the Single Convention on Narcotic Drugs of 1972, the Convention on Psychotropic Substances of 1971, and the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988. In addition to these, in June 1998 Slovenia also signed the Declaration on the Guiding Principles of Drug Demand Reduction adopted by the UN General Assembly in New York.

There were no changes to any laws, regulations or guidelines in the field of drug issues in 2003. Laws were regularly implemented by the competent authorities (e.g. ministries, police, customs, inspectors etc.). The Ministry of Health issued the Regulation on the list and trade in precursors in July 2004. However, some changes to laws and regulations are expected in the near future since a new national strategy has been adopted, especially in the field of criminal legislature, alternatives to prison for drug using offenders and the definition of amounts of drugs for personal use.

The expected changes of legislation with regard to the new national strategy are as follows:

- more rigorous sentences or penalties for drug traffickers/dealers and persons who sell illicit drugs and give an opportunity for their use/abuse near/in schools or near/in settings intended for children/youth activities, or who abuse an influence on children/youth who are unaware of the real consequences of drug use/abuse;
- new measures for quicker criminal justice procedures, especially where addiction is the main cause of the criminal act;
- to provide alternatives to prison for drug using offenders; and
- to define the amounts of drugs for personal use.

Institutional framework, strategies and policies

The new national strategy[*] in the field of drugs was adopted by the National Assembly in February 2004. This strategic document was discussed at inter-ministerial and governmental levels in 2003. It was also discussed and adopted in 2003 by the Government Commission for Drugs. Public debate about the national strategy was organised by the National Assembly's Committee on Health, Labour, the Family, Social Policy and the Disabled in January 2004.

The GOD was moved from the governmental level to within the organisational structure of the Ministry of Health as a result of the reform of the public administration. A law on the transfer of the tasks of several government offices to ministries was adopted by the National Assembly in December 2003. It came into operation on 1 April 2004. OD has been part of the Ministry of Health since 1 April 2004. All tasks of the Office remain the same, including inter-ministerial co-ordination as the Office's most important task. Some petitions against the abolition of the GOD

[*]Editors' note: the terminology from the new national strategy used in Chapter 1 National policies and context is the shortest expression used for the formal name of the Resolution on the national programme in the field of drugs (2004-2009) which was adopted by the National Assembly in February 2004 and encompasses the national strategy in the field of drugs, where at a principle level the policy and objectives in the field of drugs are defined.

and its move to the Ministry of Health were submitted by non-governmental organisations (NGOs) and local action groups (LAGs), but they were unsuccessful.

The OD started activities to prepare the national action plan in February 2003 and inter-ministerial meetings were organised for that purpose. Some action plans were already prepared by the Ministry of Interior and the NIPH-IUID. Other action plans are in the preparatory phase.

The PHARE Twinning project with the Spanish and Austrian governments was concluded in September 2003. Related activities (e.g. lectures, study visits, workshops, seminars etc.) were mostly connected with supporting local community-based programmes, strengthening drug-demand-reduction programmes, supporting prevention programmes and NGOs, synthetic drugs, educational programmes, treatment network, evaluation, risk reduction programmes.

The OD continued activities to further develop the project in Slovenia in 2003. A modified questionnaire (including many EDDRA elements) was prepared and sent to all known programmes in the field of drug demand reduction in Slovenia. The OD verified 112 different programmes in 2003. All programmes were published in a catalogue issued in March 2004. The programmes are chiefly located in the main regions, e.g. the Ljubljana region (33.9%), the Celje region (16.1%), the Koper region (10.7%) etc. Most programmes are run by government (public) institutions or local authorities (53.6%), 33% of them are NGOs' programmes while 13.4% of them are private (see Figure 1.1.).

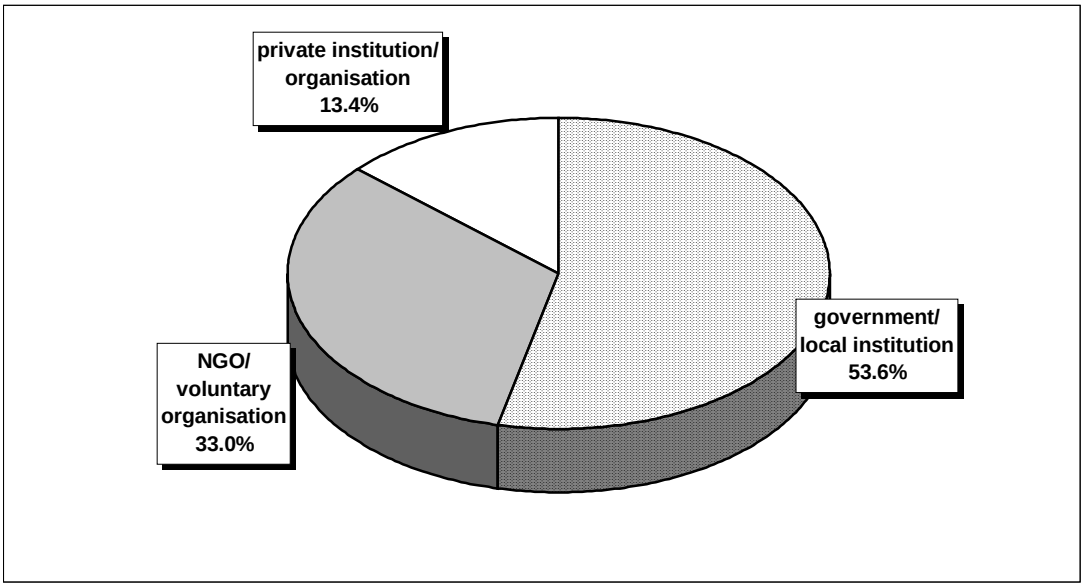

Figure 1.1. Status of institutions/organisations, which implement programmes
Source: Ministry of Health, Office for Drugs, 2004

The lion's share of programmes was established in the 1996 to 2000 period (40.2%).

Most programmes deal with primary prevention activities (40.2%), social reintegration/rehabilitation (32.1%), medical treatment (17.0%), risk (or harm) reduction (6.3%) etc. (see Figure 1.2).

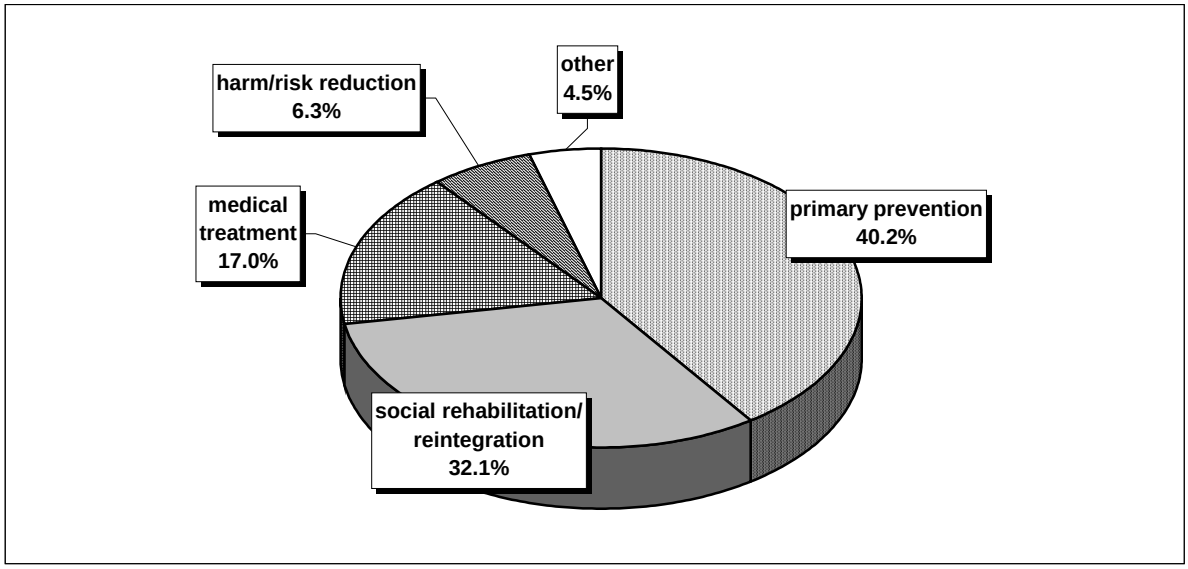

Figure 1. 2. Field of work
Source: Ministry of Health, Office for Drugs, 2004

The core target groups are families (60.7%), drug users/addicts (58.9%) and children/youth (53.6%) (see Figure 1.3.).

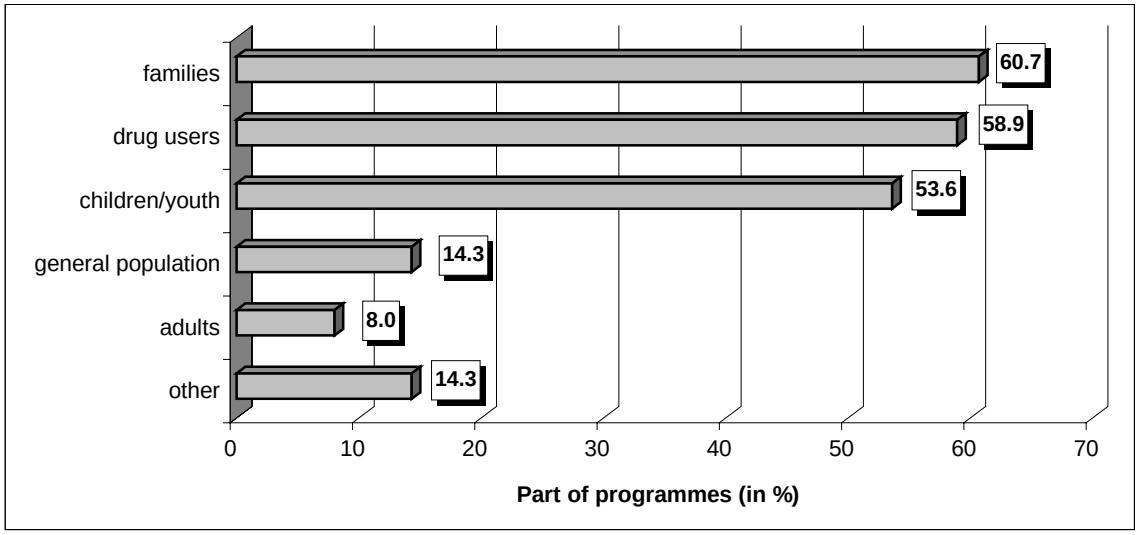

Figure 1.3. Target groups
Source: Ministry of Health, Office for Drugs, 2004

The programmes are mostly co-financed by the government (76.8%), local authorities (58.0%) and the private sector (33.0%).

Figure 1.4. shows the average number of users of services in the programmes in the last five years.

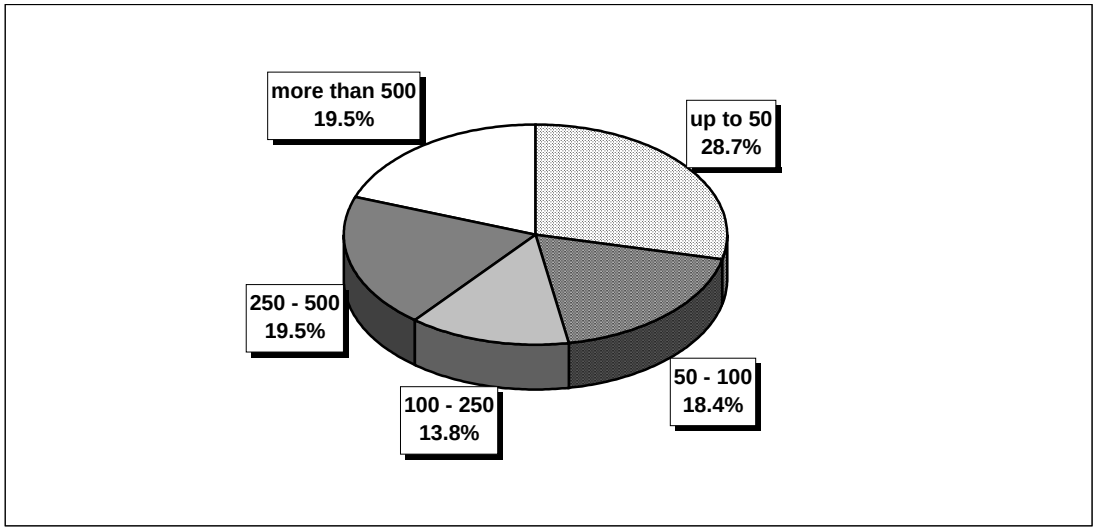

Figure 1. 4. Number of users of services in programmes
Source: Ministry of Health, Office for Drugs, 2004

The OD prepared an analysis of verified programmes which will provide the grounds for the selection of programmes for the EDDRA database. The EDDRA questionnaire was translated into the Slovenian language at the beginning of 2004.

Several activities were implemented as regards the development of low-threshold programmes in Slovenia in 2003. A meeting with the mayors of certain cities was organised in February 2003 and two conferences were organised in Koper (September 2003) and Nova Gorica (June 2004) in this field.

The OD established bilateral co-operation with the Croatian Office for Drug Abuse in 2003. Both offices organised a conference on regional co-operation with the aim to establish a common system in the field of drugs in South-eastern Europe. The conference was held in Dubrovnik in November 2003.

Budget and public expenditure

a) Public Budget

At the moment it is impossible to describe all the public 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 for prevention programmes and in the field of drug-supply reduction. For this reason, any comparison between budget expenditure in different sectors is difficult.

Different ministries and offices helped co-finance the programmes of NGOs and/or financed their own activities in the field of drugs in 2003 as shown in Table 1.1. Budget and public expenditure in the field of drugs.

Table 1.1. Budget and public expenditure in the field of drugs (estimates in EUR), Slovenia, 2002-2003

	INSTITUTION (competent authority)	**PURPOSE**	**2002 (EUR)**	**2003 (EUR)**
1.	Ministry of Work, Family and Social Affairs	- social rehabilitation programmes	1,050,400	1,137,564
2.	Ministry of Interior (Police Department)	- staff and material costs	680,800	680,800
3.	Ministry of Finance	- staff, training and equipment	106,900	174,100
4.	Ministry of Health	- Addiction prevention programmes - CTDA*	44,100 78,260	45,790 -
5.	Health Insurance Institute of the RS	- methadone as medicine - operation of network of CPTDA** - CTDA	2,397,100 2,188,300 (17 CPTDA) -	2,674,000 2,080,000 (18 CPTDA) 460,251
6.	Office for Youth (Ministry of Education, Science and Sport)	- drug demand reduction programmes and other prevention activities	595,700	368,630
7.	Ministry of Education, Science and sport	- prevention programmes in schools - prevention programmes / projects of youth organisations	38,300 89,600	n.a. n.a.
8.	Government Office for Drugs	- staff and material costs - own programmes, projects	308,800 54,800	312,730 78,900
9.	Prison Administration (Ministry of Justice)	- treatment for prisoners - urine tests - methadone as medicine	n.a. 38,300 10,600	105,000 30,000 30,000
10.	Information Unit for Illegal Drugs (NFP) at The Institute of Public Health of the RS	- staff and material costs	94,394	106,772
11.	Local Action Groups	- prevention programmes / projects in local communities	n.a.	n.a.
12.	Association of NGOs Slovenia		17,391***	11,450***
	TOTAL		**7,793,745**	**8,295,987**

Source: Ministry of Health, Office for Drugs, 2004

* CTDA-Centres for prevention and treatment of Illegal Drug Addiction
** CPTDA - Centre for treatment of Drug Addicts at Psychiatric Clinic in Ljubljana
*** financed by Office for Drugs
n.a. – data not available

In 2003 the Ministry of Work, Family and Social Affairs spent EUR 1,137,564 on social rehabilitation programmes. The Ministry of Interior (Police Department) spent EUR 680,800 on drug police officers and their material expenses. The Ministry of Finance spent EUR 174,100 on customs officers' training and equipment. The Ministry of Health spent EUR 45,790 on different addiction prevention programmes. The Health Insurance Institute of the Republic of Slovenia spent EUR 2,674,000 on methadone as a medicine and EUR 2,080,000 for the operations of the network of

the CPTDA. The Office for Youth, located within the Ministry of Education, Science and Sport spent EUR 368,630 directly on drug-demand-reduction programmes carried out by youth organisations (annual programmes, projects, prevention campaigns, education, training etc.). There were also many other activities co-financed by the Office for Youth, which included some prevention activities in the field of drugs, but it is impossible to separately describe the costs of those activities at the moment. The OD spent EUR 208,610 on staff, EUR 104,120 on material costs (material costs for programmes and projects are also included) and EUR 78,900 on programmes and projects, mostly in the field of prevention. The Prison Administration of the Republic of Slovenia (PA) within the Ministry of Justice spent EUR 105,000 in 2003 for treating prisoners who have problems related to drug use. The PA also spent EUR 30,000 for urine tests and EUR 30,000 for methadone as a medicine. According to data from the NIPH, the IUID was financed by the Ministry of Health in the amount of EUR 106,772 in 2003 for staff and other material costs.

Approximately 30 municipalities (local communities) spent an unknown amount on the functioning of LAGs in 2003, mostly for preventive activities (lectures, training, preventive materials etc.). The budgets for LAGs varied between EUR 850 and 22,500 in different municipalities.

OD provided EUR 11,450 for the activities of the Association of non-governmental organisations in the field of drugs in its 2003 budget. OD and the Association signed a contract pursuant to the Promulgation of the Prevention of the Use of Illicit Drugs and Dealing with Consumers of Illicit Drugs Act (PPUDD). The OD also financed and co-financed some other programmes and projects in the area of drugs (e.g. publishing books and prevention materials, organising seminars, conferences, workshops etc.).

b) EU budget - PHARE Twinning Project

The Phare Twinning project: "Strengthening the National REITOX Focal Point and strengthening the drug supply reduction and drug demand reduction programmes in Slovenia" was carried out between 2002 and 2003 in collaboration with and supported by Spain and Austria.

For more information on the financing of the PHARE Twinning project, please see the Annex, and List of Tables in the Annex (Tables 15.13. and 15.14.).

Social and cultural context

Several issues were discussed in 2003, mostly initiated by civil society organisations (NGOs). There was strong public debate about heroin on prescription in which representatives of drug users/addicts played an important role. There were also some initiatives by several NGOs with regard to establishing safe consuming rooms, especially in the city of Ljubljana. The first night centre and shelter for homeless drug users/addicts opened in Ljubljana in 2003.

The OD organised a prevention month in November 2003 under the title "More information – less risk". The OD also published a catalogue listing the many prevention activities across the country during that month. Activities were organised by many different organisations and institutions.

The OD organised the 6th National Conference of Local Action Groups (LAGs) in Grosuplje in October 2003. This was organised in co-operation with the LAG of the Municipality of Grosuplje and the main topic was "A Local Action Group (LAG) as a holistic approach in the field of drugs at the local level". The OD published a catalogue of presentations at a conference held in March 2004.

As a result of the PHARE Twinning project 250,000 copies of the publication "Drugs – your guide" were published in November 2003. It was translated into the Slovenian language and modified on the basis of the similar Spanish guide. The OD and Slovenian Red Cross also issued the publication "Drugs – a guide for parents" in November 2003. The print run involved 7,500 copies.

The OD published a catalogue of programmes (in connection with the EDDRA project). 112 programmes are included in the publication. A leaflet including telephone numbers, general warnings about drugs, and first-aid guidance was also published together with the catalogue.

The OD produced and released the Internet game "Fly on Drugs", whose purpose was the promotion of the new design and content of the Office's web site. The game was published in June 2003 and has proved to be a very successful tool in the media campaign.

Media representation prepared by Andreja Drev

The Slovenian National Focal Point (NFP) regularly informs the mass media, individual experts and users, the general public and in-house public about various activities in the field of illicit drugs through various communication tools such as providing information in press releases, on the web site of the NIPH, through interviews and statements in the media, press conferences, conferences and expert meetings.

Media relations and other public relations activities

In 2003 the NFP in co-operation with the Public Relations Office (PRO) at the NIPH issued 6 press releases, organised 2 press conferences as well as the first National Conference on the information system in the drug field. The contents of press releases were as follows: 2002 data on drug users treated in the CPTDA network with social and demographic correlates and patterns of illicit drug use, data provided by the Police (the Ministry of Interior) about seizures of illicit drugs; about the Phare Twinning Project, about the visit of a delegation from the EMCDDA, about the NFP's contribution at the conference in Dubrovnik and the EMCDDA's reports on the drug situation in the EU.

The NFP also organised two press conferences. At the first, representatives of the NFP, the Police (the Ministry of Interior) and the PA presented 2002 data regarding drug users treated in the CPTDA network, data on drug seizures and the pilot project for drug users in prisons. At the abovementioned conference all major media outlets were present, including national television, national radio, the Slovenian Press Agency, all national newspapers, and one of the largest commercial Slovenian television stations. After the press conference, 6 radio stations recorded a statement and 2 newspapers asked for press materials.

The second press conference was organised upon the release of two EMCDDA reports on the drug situation in the EU and Norway and the then acceding and candidate countries for the EU. Seven journalists from all of the most important media outlets were present at the press conference. The statement made by an EMCDDA representative about the work and progress made by the NFP and other national key partners received special attention.

The mass media covered the information released by the NFP regularly and only one media source published a few unfavourable articles. The topics of illicit drugs were interesting for local and national media. The majority of articles about illicit drugs published or broadcasted in 2003 presented data about drug users in treatment.

All the press releases, press materials and photographs were also published on the web site of the NIHP (www.gov.si/ivz) under the heading 'Drugs'. This site has been developed since 2003 by both the NFP and the PRO at the NIPH.

To inform the internal public, the NFP also published articles in the internal newspaper of the NIPH.

In the first six months of 2004 the NFP has, in co-operation with the PRO, enhanced its media relations and other public relations activities. In this period, the NFP issued 7 press releases, organised 2 press conferences, held an expert meeting, contributed to the World Health Day expert meeting and gave several interviews and statements.

The content of press releases were as follows: 2003 data on drug users treated in the CPTDA network including drug poisoning, communicable diseases, criminality and illicit drug-use trends in Slovenia; the NFP also issued two press releases within the EWS on new synthetic drugs; one press release concerned the EMCDDA delegation's visit to the NFP; another one was about the ABSO (scale for the assessment of psychoactive substances- PAS) expert meeting, on the International Day against Drugs a press release was issued about synthetic drugs, on the same day the NFP also organised an inter-sectoral press conference at which other topics like the health consequences of synthetic drug use, urgent medical help and EWS on new synthetic drugs were also presented. The Head of the NFP, the National Co-ordinator for EWS from the Police (the Ministry of Interior), a representative of the Urgent Medical Help Service and a representative of the Psychiatry Clinic from Ljubljana participated in the press conference. Seven media outlets were present, including the national television, national radio, the Slovenian Press Agency and a national newspaper. After the press conference three radio stations recorded a statement and three newspapers asked for press materials. There were 14 publications in the media and one special radio transmission dedicated to the press conference.

The NFP was also present at a press conference organised by the NIPH on Women's Day. The Head of the NFP presented the topic of women and illicit drugs. Twelve media outlets covered that press conference and there were 15 related publications and television and radio transmissions.

At the World Health Day expert meeting, the Head of the NFP gave a lecture 'Driving under the influence of PAS'. The media showed interest in the topic and the national radio broadcaster also prepared a transmission in which the Head of the NFP participated.

For experts, the NFP organised an experts' meeting to introduce the ABSO (see above), at which the main topics were: suicide and drug users, reasons for and characteristics of violence, treatment for depressed and psychotic drug users.

In the first six months 2004 the mass media covered the information released by the NFP regularly and there were no unfavourable articles. The majority of articles about illicit drugs published or broadcast in 2003 covered information on synthetic drugs and data on drug users treated in the CPTDA network. The mass media was also interested in the press release published within the EWS for new synthetic drugs. The NFP continues to publish all press releases and other press materials on its web site and prepares articles for its internal newspaper to inform in-house experts.

2. Drug use in the population

Drug use in the general population

No new information available and data on drug use in the population aged over 18 years were available for 2003.

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

Drug use in the school and youth population prepared by Eva Stergar

a) Health Behaviour in School-aged Children – a WHO Cross-national Study, HBSC Slovenia 2002

In 2002 Slovenia participated for the first time in the HBSC (Health Behaviour in School-aged Children) survey. The survey is carried out every 4th year in more than 30 European countries and North America. A common methodology comprising study design, sampling, questionnaires, piloting and data collection, and coding is used.

Data collection procedure

At the end of 2001 the questionnaire was translated from English to Slovenian by the leader of the survey. An independent translation back into English was then carried out. The latter was sent to the Co-ordinating Centre to be checked and for any semantic problems to be revealed.

Pilot testing of the questionnaire was carried out in two classes of students involved in 2.5 years of vocational training at the beginning of 2002. This type of programme is generally opted for by children with lower learning potential. We were mainly interested in how much they understood the questions, their responses to individual issues, the time needed to complete the questionnaire etc. The pilot survey posed no special problems, except for the "family – two homes" question. After final editing, the questionnaire was sent to the printing office.

The Ministry of Education, Science and Sports was contacted in February 2002 so as to acquaint it with the project and its aims. The questionnaire and data collection procedure was presented, as were the measures taken to keep the information obtained strictly confidential (the questionnaires contained no identity-revealing data; they were to be handed out in sealed envelopes), the handling of the collected data and data processing. The Ministry was asked for its formal approval and support of the project, as well as its opinion about the study which was to be forwarded to all head teachers of the selected schools. A letter from the Ministry offering its full support of the project, stressing that the survey had been well prepared and that the presented technique of data collection fully adhered to the principles of personal data protection, was received. The Ministry invited all head teachers, pupils and other staff of the selected schools to take part in the study.

The schools were contacted for the first time when they were asked to provide data

on 1st year classes in autumn 2001. In February, a letter to all headmasters was sent to the schools included in the sample, explaining the rationale of the survey, emphasising the European dimension of the research project and informing them about the classes selected and the time for data collection. The letter of approval from the Ministry of Education, Science and Sports was also enclosed.

In all Slovenian secondary schools, counselling services are provided by a special team consisting of a psychologist, education specialist and/or social worker. The number of team members is proportional to the size of a school. Knowing that school counselling staff are skilled in various forms of testing and data collecting, they were invited by the research team to participate in the survey as data collectors.

Counsellors from the selected secondary schools were personally contacted in order to:

- inform them briefly and concisely about the aims of the survey;
- find out how they felt about the survey and about collecting the data in classrooms;
- make sure that the main data on the selected class/es, e.g. the number of students, school type, class label were correct;
- remind participants that data collection would take place during the period March 29 to April 2;
- ensure the effective co-operation of the data collecting staff; and
- inform them about the terms of payment.

In the second half of March the questionnaires and all other materials were distributed to the data collectors. For each class a box containing questionnaires, envelopes and a classroom report sheet was prepared. The box was clearly labelled (classroom label, data collector's name, school address) and the return mailing address of the NIPH was enclosed. Each data collector received a letter giving all particulars about HBSC Slovenia 2002 (Health Behaviour in School-aged Children), thorough information on the data collection procedure and the behaviour of data collectors during testing, and the payment contract to be returned to the NIPH together with the completed questionnaires.

The completed questionnaires were mailed to the NIPH or, in some cases, brought there by school counsellors personally. Instructions for coding and scrutinising the questionnaires in the Slovenian language were drawn up. A coding book was prepared (schools, classes, socio-economic status). A group of students was engaged for coding and scrutinising the answers in each questionnaire.

The data scrutinising procedure involved:

- checking whether the number of completed questionnaires tallied with the data entered in the classroom reports; and
- reading through the answers given and rejecting any questionnaires with missing key data (sex, year of birth), and those with answers that were obviously not serious.

The coding procedure involved putting down individual codes (region, state, school, class, person, type of school) and coding the socio-economic status.
All questionnaires considered unsatisfactory or in some way doubtful were set apart for a control review by the project leader.
At the same time, preparations for the programme for entering data into the database (Access) were underway. Special instructions were written for feeding the information into the computer (e.g. how to mark a missing or incorrect answer).

The PC SPSS 8.0 programme was used for data processing. During the first control analysis we identified the input errors and made suitable corrections after comparing them with the original questionnaire.

Sampling framework

A representative sample of 1st year students of secondary schools was surveyed. Traditionally, secondary education is offered in four types of schools:
grammar schools,
4-year technical schools (technical, medical...),
3-year vocational schools, and
2.5-year vocational schools.

Some secondary schools (e.g. grammar schools) offer a single form of education while others (e.g. 2.5-year, 3-year vocational and technical schools) provide several types of education.

Since in Slovenia there are no class registers to be used as the basis for the sampling procedure, classes have to be identified through personal contacts with school staff or by mail. The Health Education Department at the NIPH started to collect data on 1st year classes (number of students, number of boys) of all secondary schools at the end of 2001. Letters presenting the HBSC survey and the purpose of collecting the data, such as the class label, number of students, number of boys, type of programme, were sent to all secondary schools. Sheets with the name and address of the school were attached to each letter, together with the envelope with the Institute's address and a stamp for reply. Most schools sent their reply within one month, others were contacted by phone. At the beginning of December, data on all 1st year classes were available, and 4 lists of 1st year classes by type of secondary school were drawn up.

Statistics on the 2001/02 school year enrolment by class in the 1st year of secondary schools (in November 2001) were supplied by the NIPH.

Table 2.1. Statistics supplied on the 2001/02 school year by class in the 1st year of secondary schools (in November 2001)

SCHOOL TYPE	No. of classes	No. of pupils	%	Male	%
GRAMMAR SCHOOL	318	9.600	34.8	3.905	26.9
TECHNICAL	311	8.923	32.2	4.703	32.4
VOCATIONAL (3-YEAR)	312	8.114	29.4	5.142	35.5
VOCATIONAL (2.5-YEAR)	66	954	3.5	751	5.2
Σ (TOTAL)	1.007	27.591	99.9	14.501	100

Source: NIPH

60 classes were chosen for the random stratified sample.

Sampling procedures

In autumn 2001, lists of all 1st year classes of Slovenian secondary schools were prepared separately for 4 types of secondary education, i.e. grammar schools, technical schools, 3-year vocational and 2.5-year vocational schools. The classes were denoted by:

a) consecutive number;
b) class label;
c) name of the school;
d) programme;
e) number of pupils; and
f) number of boys.

After determining the sample size, classes were randomly chosen from each of the 4 lists of classes. This step was determined for each list separately. The first class on each list was chosen at random: each person in a group of four picked one number, and the sum of these numbers was taken as the consecutive number of the 1st class chosen.

A list of classes selected for the national sample was drawn up.

Absents of school at the time of survey

Not available.

Results

The 2001/02 HBSC data show that in Slovenia the lifetime prevalence of cannabis use among 15 to 16 year-old pupils (N=1,069 persons; response rate: 89%) was 28.3% (for males 31.0%, for females 25.4%). The last 12 months prevalence of cannabis use among 15-16 year-old pupils was 24.4% (for males 27.3%, for females 21.4%).

b) European School Project on Alcohol and Drugs (ESPAD)

The main purposes of ESPAD 2003 survey were**:**

- to collect data on alcohol, tobacco and other drug use among students, born in 1987, in Slovenia;
- to contribute national data to the European survey;
- to study trends 1995 – 1999 – 2003 in alcohol and other drug use among students, born in 1979, 1983 and 1987, respectively, in Slovenia;
- to compare data about drug use in Slovenia with trends in Europe as well as in neighbouring countries.

The knowledge about drug use and trends 1995 – 1999 - 2003 in drug use will be also used as a base for health education and health promotion programs planning.

The survey is planned to be repeated every fourth year.

Sampling frame, sample size and sampling procedure

The survey was conducted in the Republic of Slovenia (national sample). A representative sample of 1st year secondary school students was surveyed. According to ESPAD methodology answers of students born in 1987 were presented.

In 1987, there were 25,480 live births in Slovenia; (13,013 boys and 12,467 girls). According to past elementary school law Primary School Act, all children who have reached 7 years of age in the current calendar year enter the first grade of primary

school on September 1. Provisional enrolment in the first grade was possible for children who would have reached 7 years of age by the end of February in the next calendar year. Primary education is compulsory and lasts 8 years. With scholastic year 2003/04 the 9-year elementary education is being introduced in Slovenia. Children will enter schooling one year earlier than before.

Most children continue after elementary school their education in various types of secondary schools. The goal to extend secondary schooling to the whole generation has not yet been achieved in Slovenia. It is estimated that up to 5 % of children who have successfully completed elementary school do not proceed to secondary education.

Table 2.2. School enrolment of 1987 birth cohort at the beginning of scholastic year 2002/2003

1987 GENERATION – ENROLMENT	**NUMBER**	**%**
Elementary school	1,225	4.81
Secondary school – 1st year	21,564	84.63
Secondary school – 2nd year	1,908	7.49
Secondary school – 3rd year	6	0.02
Unknown	777	3.05
Total	**25,480**	**100.0**

Source: Statistical Office of the Republic of Slovenia

While planning the ESPAD 2003 survey it was assumed that in spring 2003 most of the 1987 cohort would be attending the first year of secondary schools.

Traditionally, secondary education in Slovenia is offered in four types of programs:
1. Grammar schools,
2. 4-year technical education (technical, medical,...),
3. 3-year vocational education, and
4. 2.5-year vocational education.

According to data of Ministry of Education, Science and Sports, there were 181 secondary schools in Slovenia at the beginning of scholastic year 2002/03 if we pay regard to the single program offered. One of them had no students enrolled in the 1st year.

Some secondary schools (e.g. grammar schools) offer a single form of education and others provide several types of education (e.g. 2.5-year, 3-year vocational and technical schools). If we take regard to the latter organisational structure than there were 138 secondary schools in Slovenia at the beginning of scholastic year 2002/03. One of them had no pupils enrolled in the 1st year.

The Ministry of Education, Science and Sports collects data on enrolment in secondary education at the beginning of each scholastic year. According to their statistics there were 28,511 pupils enrolled in 1,033 1st classes at the beginning of 2002/03.

Since the previously mentioned data on enrolment do not include data on each class enrolment and no other institution collects data about classes and enrolment there were no class registers to be used as a basis for the sampling procedure. Classes had to be identified through personal contacts with school staff or by mail. Health Promotion Centre at the NIPH started to collect data on 1st year classes (label,

number of students, number of boys) of all secondary schools at the beginning of December 2002. Letters, presenting the ESPAD 2003 and the purpose of collecting data, such as the class label, number of students, number of boys, type of program, were sent to all secondary schools. Sheets for each program offered by school with the name and address of the school were attached to the letter together with the envelope with the Institute's address and a stamp for reply. Most schools sent back their reply by the end of December. Others were contacted by phone. At the end of December, data on all 1st year classes were available, and 4 lists of 1st year classes by the type of secondary school were drawn up.

Table 2.3. Enrolment in 1st year of secondary schools by program, s.y. 2002/03

SCHOOL TYPE	No of classes	No of pupils	% within sch.ty-pe	Male	% within each school type	av. no of pupils/ class
GRAMMAR SCHOOL	339	10,317	36.4	4,216	40.9	30.4
TECHNICAL	331	9,384	33.1	4,852	51.7	28.4
VOCATIONAL (3-YEAR)	304	7,751	27.4	4,960	64.0	25.5
VOCATIONAL (2.5-YEAR)	60	883	3.1	669	75.8	14,7
Σ	1,034	28,335	100.0	14,697	51.9	27.4

Source: NIPH, December 2002

The difference of number of pupils according to two sources (176 pupils) could be explained by dropping out from schools after the beginning of scholastic year 2002/2003.

There should be approximately 4,000 pupils, i.e. 14% of the pupils enrolled, in a stratified random sample. Considering the average class size and the percentage of students in individual types of secondary schools, the following number of classes were to be randomly selected for each school type in the national sample:

Table 2.4. Sample plan

SCHOOL TYPE	No of classes	No of pupils
GRAMMAR SCHOOL	48	1,444
TECHNICAL	46	1,314
VOCATIONAL (3-YEAR)	43	1,085
VOCATIONAL (2.5-YEAR)	8	124
Σ	145	3,967

Source: NIPH, 2004

150 classes from 116 secondary schools were randomly chosen.

Approximately 14.5% of the enrolled pupils (4,120) was included in the sample considering the average class size and percentage of students in each type of secondary education.

Table 2.5. Sample size

School types	Number of Classes	Number of students		
		Boys	Girls	All
GRAMMAR SCHOOL	49	603	914	1,517
TECHNICAL	47	673	662	1,335
VOCATIONAL (3-YEAR)	44	745	372	1,117
VOCATIONAL (2.5-YEAR)	10	119	32	151
Totals	150	2,140	1,980	4,120

Source: NIPH, 2004

Step-by-step description of the sampling procedure

1. In winter 2002, lists of all 1st year classes of Slovenian secondary schools were prepared separately for 4 types of secondary education programs, i.e. grammar schools, technical schools, 3-year vocational and 2.5-year vocational schools. The classes were denoted by:

c) Consecutive number
d) Class label
e) Name of school
f) Program
g) Number of pupils
h) Number of boys.

2. After determining the sample size, classes were randomly chosen from each of the 4 lists of classes separately. The step was determined for each list separately. The first class on each list was chosen at random: each person in a group of three picked one number, and the sum of these numbers was taken as the consecutive number of the 1st class chosen.

3. The list of the selected classes in the national sample was drawn up.

Field procedures

January 2003

The questionnaire was translated from English to Slovene and back to English. The questionnaire was piloted in two classes of 2.5 years program. This type of program is generally opted for by children with a lower learning potential. The main interest was to estimate the level of understanding of questions, pupils' responses to individual issues, the time needed to complete the questionnaire, etc. The pilot survey posed no special problems. After final editing the questionnaire was sent to the printing office. The samples were drawn by the end of January.

February 2003

Ministry of Education, Science and Sports was contacted acquainting them with the project and its aims. The questionnaire and the data collection procedure were described, and the measures taken to keep the obtained information strictly confidential were presented (the questionnaire contained no identity-revealing data; they were to be handed out in sealed envelopes), as well as the handling of the collected data and data processing. The Ministry was asked for a formal approval and support of the project, as well as for their opinion about the study which was to be forwarded to all head teachers of the selected schools. On February 20th a letter by the Ministry offering full support to the project, stressing that the survey was well

prepared and that the presented technique of data collection fully adhered to the principles of personal data protection was received. The Ministry invited all head teachers, pupils and other staff of the selected schools to take part in the study.

The schools were contacted for the first time when they were asked to provide data on 1st year classes in December 2002. On February 28, 2003 a letter was sent to all headmasters of the schools included in the sample, explaining them the rationale of the survey, emphasising the European dimension of the research project and informing them about the classes selected and the time of data collection. The letter of approval sent by the Ministry of Education, Science and Sports was attached to the mail.

March 2003

In all Slovenian secondary schools, counselling services are provided by a special team consisting of a psychologist, education specialist and/or social worker. The number of team members is proportionate to the size of the school. Knowing that the school counselling staff is skilled in various forms of testing and data collecting, the research team invited them to participate in the survey as data collectors.

From March, 3rd till March 12th, the counsellors from the selected secondary schools were contacted personally (by phone call) in order to:

- Inform them briefly and concisely about the aims of the survey;
- Find out how they felt about the survey and about collecting the data in classrooms;
- Make sure that the main data on the selected class/es, e.g. number of students, school type, class label were correct;
- Remind the participants that data collection will take place during the period from April 7 till April 18;
- Ensure effective co-operation of the data collecting staff;
- Inform them about the terms of payment.

After our first contact, the majority of school counsellors stated they were willing to participate in the project. Some head teachers even sent a written confirmation of their participation in ESPAD 2003 to the NIPH. A few head teachers complained about many surveys going on in the same time. Namely just one month before a World Smoking Survey was carried out and some of the classes chosen were the same.

Instructions for the data collection procedure and classroom report sheets were prepared at the beginning of March and printed in the same time as the questionnaires. They were based on the materials supplied by CAN, except for some minor details which were adapted for use in Slovenia.

The questionnaires were being printed during the first half of March.

During the last week of March the distribution of questionnaires was organised. For each class a box with questionnaires, envelopes and class-room report sheet was prepared. The box was clearly labelled (classroom label, data collector's name, school address) and the mailing address of NIPH was enclosed. Each data collector received a letter giving all particulars about ESPAD 03, a thorough information on the data collection procedure and behaviour of data collectors during testing, and the payment contract to be returned to NIPH together with the completed questionnaires.

NIPH was responsible for data gathering of all national classes.

The mask for entering the data was prepared in EpiInfo program. A lot of problems were encountered with Access not accepting more than certain number of variables, so the decision was to use EpiInfo.

April 2003

Data gathering took place from April 7 till April 18. During that time period 150 classes from national sample were surveyed. The completed questionnaires were mailed to the NIPH, or in some cases, brought there by school counsellors personally.
Coding books and guidelines for scrutinising the questionnaires (translation of the materials supplied by CAN) were prepared.

May 2003, June 2003

A group of six students who were engaged to scrutinise and code the questionnaires was formed. The data scrutinising procedure involved:

- Checking whether the number of filled in questionnaires tallied with the data entered in the classroom reports;
- Reading through the given answers and rejecting questionnaires with missing key data (sex, year of birth), and those with answers which were obviously not meant seriously, answered systematically or with more than half unanswered questions.

The coding procedure involved putting down individual code: region, state was pre-coded, school, class, person, and type of program. All questionnaires which were considered unsatisfactory or doubtful in some way were set apart for control review by the project leader. After coding and scrutinising they proceeded with entering the data into database. They finished entering the data on June 15.

July 2003, August 2003

The entered data were controlled. The SPSS for Windows 11.0 program was used for data processing and classroom reports analysis. On the first control analysis the input errors were identified. Due corrections after comparing input errors with the original questionnaire were made.

The classroom reports data were entered in SPSS and analysed.

Data on the enrolment in secondary schools were to be supplied by the Statistical Office of the Republic of Slovenia. The preparation of the 1st part of Country report was going on.

Data collection

Data were collected by school counsellors - educationalists, psychologists, and social workers who were paid remuneration for their extra work. A total of 121 data collectors participated in the survey.

Apart from data collectors and students no other persons were present in the classroom during data collecting.

All the counsellors gave approximately the same instructions to students before they began to answer questions. Instructions for students and instructions for data collectors on how to behave during testing had been formulated at NIPH and sent enclosed with other materials.

Of the 150 classroom reports reviewed, 107 (71.3%) comprised no comments on the data collection procedure. Other comments reported by the data collecting staff (some reported several different comments) were as follows:

a) Positive comments – 19 (12.7%): The students took the task very seriously. The confidentiality was assured. The survey was used as a starting point for further discussion with pupils. The pupils as well as counsellors were interested in results. They were pleased to be chosen for participating in the survey. The school counsellors would like to get further guidelines for preventive work in the classroom.
b) Negative comments – 19 (12.7%): The questionnaire is too difficult and too long for the pupils enrolled in lower vocational education. The students had difficulty understanding the questions, mostly because of their poor reading skills, inadequate understanding of some terms, and limited capacities. Some questions are being repeated.
c) Additional explanations: 5 (3.3%); pupils needed additional explanation regarding alcopops, GHB (gamma-hydroxydbutyric acid), mushrooms…

Absents from school at the time of survey

Approx. 10% (397) of sampled students failed to attend, mostly because they were ill on the day of data collection. In general, however, students included in the sample were willing to take part in the project.

On the day of surveying 208 boys were absent: 115 because of illness, 71 because of other reasons, 20 skipped, for 2 there are no data why they were not present at school.

Among girls 189 were absent on the day of survey: 119 were ill, 59 were absent because of other reasons, 11 skipped the lessons.

All together 397 (9.6% of sample elected) persons were absent on the day when ESPAD was done.

Additional exclusions from data entering in scrutinising process

As indicated by the classroom reports and scrutinising process 4 students refused to take part in the project. In the scrutinising phase, 43 questionnaires were excluded from the study. For 23 it is known they had been completed by boys and 5 by girls, and 15 contained no data on gender. More than one-half (27) were excluded because of the missing or obviously wrong (year 1996) year of birth.

Response rate

The response rate for boys was 88%, for girls 87.7%, and for all students 87.9%.

According to the school program the response rates were 90.4% for students from grammar schools, 87.6% for students from technical schools, 85.1% for students from 3-year vocational schools and 85.4% for students from lower vocational schools.

Results

Lifetime drug use

The students were asked about the use of various drugs in their lives, i.e. until the first and second week of April 2003.

As for the use of all illicit drugs in a lifetime, 71.2% of the surveyed students said they had never used any of the listed substances, i.e. marijuana, amphetamines, LSD or other hallucinogenic drugs, crack, cocaine, heroin, ecstasy, or GHB. Using any of these illicit drugs once to twice was reported by 9.7%, and 3 to 5 times was reported by 4.8% of the respondents. 3.1% had used these substances 6 to 9 times, 2.3% 10 to 19 times, 2.3% 20 to 39 times in their lives, and 6.6% acknowledged the use of illicit drugs 40 times or more.

The differences by gender were found were significant at $p<0.06$ ($C=0.07$). A larger proportion of girls compared to boys said they had never used illicit drugs.

71.6% of respondents have never smoked marijuana in their lifetime, 14.4% smoked marijuana once to 5 times, 3.1% 6 to 9 times, 2.3% 10 to 19 times, 2.2% 20 to 39 times, and 6.3% 40 times or more. Gender differences were not statistically significant.

When asked about the use of illicit drugs (excluding marijuana), 95.3% of the surveyed 1st grade students said they had never taken illicit drugs, 2.9% had used them once to 5 times, 1.8% 6 to 9 times or more. No statistically significant gender difference was found.

Inhalants use was reported by 14.9% of the surveyed students (using inhalants once to 5 times in a lifetime was reported by 11.3%, 6-19 times by 2.3%, and 20 times or more by 1.3% of the respondents), 85.2% of surveyed answered they had never used inhalants in their life. There were no statistically significant differences between the surveyed boys and girls concerning the frequency of inhalants use in a lifetime.

Using sedatives not prescribed by a doctor was reported by 5.2% of the students (2.8% of boys and 7.6% of girls). A significantly higher proportion of boys have never used them in their lives (χ^2 was significant at $p<0.0001$; $C=0.11$).

Ecstasy was used by 3.3% of the students: 1.7% of them had used it on one or 2 occasions in their lives, 0.5 on 3 to 5 occasions, 0.4% on 6 to 9 occasions, 0.4% on 10 to 19 occasions, and 0.2% on 20 or more occasions.

Using LSD, cocaine, heroin or magic mushrooms was reported by less than 2% of the surveyed group.

Using amphetamines, crack, GHB or anabolic steroids was reported by less than 1% of the group surveyed.

Illicit drug use in the last 12 months

The responses showed that 77.1% of the surveyed (75.9% of boys and 78.4% of girls) had not smoked marijuana/hashish in the last year. Among the students who had used the drug, 35.6% had done so once to twice, 20% 3 to 5 times, and 10.4% 6 to 9 times, 10.7% 10 to 19 times, 7.1% 20 to 39 times, and 16.2% 40 times or more. The observed gender differences were not statistically significant.

When asked about inhalants used in the last year in order to get "high", 93.4% of the surveyed students marked the category "0". 3.8% used inhalants once to twice, 1.1% 3 to 5 times, and 1.7% more frequently. The observed gender differences were not statistically significant.

Tranquillisers or sedatives without doctor's prescription were used by 3.4 % of respondents (1.5 % of boys and 5.3 % of girls) during past 12 months. Gender difference were statistically significant (χ^2 was significant at $p<0.0001$; $C=0.11$).

Ecstasy was used by 2.2 % of respondents – 1.6% of boys and 2.8% of girls – during last year. Gender differences were statistically significant (χ^2 was significant at $p<0.02$; $C=0.04$).

»Magic mushrooms« were used by 1.2% of respondents. All other illicit drugs were used by less than 1% of respondents during last year.

Drug use in the last 30 days

Any illicit drug use other than marijuana or hashish in the last 30 days was reported by 1.7% of respondents – 1.5% of boys and 1.9% of girls.

Marijuana or hashish use in the last 30 days was reported by 13.8% of respondents. 86.2% (86.1% of boys and 86.2% of girls) had not smoked marijuana/hashish in the past 30 days. Among those who reported using marijuana/hashish, 43.8% had smoked the drug once or twice, 19.9% 3 to 5 times, 10.1% 6 to 9 times, 11.7% 10 to 19 times, 5.8% 20 to 39 times, and 8.8% 40 times or more.

The responses of male students who used marijuana differed significantly from those of their female counterparts (χ^2 was significant at $p<0.0001$; $C=0.24$). Using marijuana on one or two occasions, or using it on 3 to 5 occasions was reported by more girls than boys who answered they had used marijuana in last month. Boys indicated more frequently the responses indicating frequent use of marijuana in the last 30 days.

When asked about the use of inhalants to get "high", 96.7% of the surveyed responded they had not used them in the last 30 days. Among those who reported inhalants use, 67.9% had used inhalants once to twice, 13.2% three to five times, 9.4% 6 to 9 times, and 9.4% 10 times or more. No statistically significant gender differences were found.

Trends in use of different drugs among Slovenian secondary school students, 1995 – 1999 – 2003

The analysis of trends in use of different drugs among Slovenian school population, age 15 – 16 years, is based on comparison of the data gathered in three consequent ESPAD surveys in Slovenia. The data was gathered following the ESPAD methodology in years 1995, 1999 and 2003 for the representative stratified random samples of Slovenian secondary school pupils born in 1979, 1983, and 1987. All types of secondary school programs were included in sampling procedures. In 1995 2,420, in 1999 2,375 and in 2003 2,785 records were included in the reports.

The sampling and field procedures for 2003 were described in section Sampling frame, sample size and sampling procedure
.

The same questions for lifetime use of different drugs (marijuana/hashish, heroin, cocaine, crack, amphetamine, ecstasy, LSD and other hallucinogens, sedatives without doctor's prescription, inhalants, anabolic steroids) were used in the three surveys.

Questions on past year/past month use of marijuana/hashish and inhalants were used in the three surveys.

In 1999 question on lifetime use of magic mushrooms was introduced and used also in 2003. In 2003 question on lifetime use of GHB was introduced. In 2003 questions on past year and past month use of all illegal drugs were introduced.

Lifetime use of marijuana/hashish, 1995 – 1999 – 2003

The frequency of lifetime use of marijuana in 1995, 1999, and 2003 is represented in Figure 2.1. The differences in prevalence of lifetime use of marijuana in 1995, 1999, and 2003 were statistically significant (χ^2 was significant at $p < 0{,}0001$, C=0,17). There were more respondents in 1999 and 2003 who answered they have used marijuana compared to 1995. The increase in lifetime use between 1995 and 1999 was greater than between 1999 and 2003. The most prominent increase of marijuana use was in the category of regular users (= "40 times or more"): there were 1,3% of respondents who answered they have used marijuana/hashish "40 times or more" in 1995, 4.5% in 1999, and 6.3% in 2003.

Use of marijuana/hashish in past 12 months, 1995 – 1999 – 2003

The frequency of use of marijuana during past 12 months in 1995, 1999, and 2003 is represented in Figure 2.2.

The differences in prevalence of marijuana use in past year for the years 1995, 1999, and 2003 were statistically significant (χ^2 was significant at $p < 0.0001$, C=0.15). There were more respondents in 1999 and 2003 who answered they have used marijuana (all categories) compared to 1995. The increase in prevalence of past year marijuana/hashish use between 1995 and 1999 was greater than between 1999 and 2003. The most prominent increase from 1995 till 1999 and 2003 of past year marijuana/hashish use was found in the categories "20-39 times" and "40 times or more".

Use of marijuana/hashish in past 30 days, 1995 – 1999 – 2003

The frequency of use of marijuana during past month in 1995, 1999, and 2003 is represented in Figure 2.3. The differences in prevalence of marijuana/hashish use in past month for the years 1995, 1999, and 2003 were statistically significant (χ^2 was significant at $p < 0{,}0001$, C=0.13). There were more respondents in 1999 and 2003 who answered they have used marijuana (all categories) compared to 1995. The increase in prevalence in past month use of marijuana/hashish between 1995 and 1999 was greater than between 1999 and 2003.

Lifetime use of ecstasy, 1995 – 1999 – 2003

The frequency of lifetime use of ecstasy in 1995, 1999, and 2003 is represented in Figure 2.4.

The differences in prevalence of marijuana/hashish use in past month for the years 1995, 1999, and 2003 were statistically significant (χ^2 was significant at $p < 0{,}0001$,

C=0.09). There were more respondents in 1999 and 2003 who answered they have used ecstasy (all categories) compared to 1995. There was a raise of lifetime use of ecstasy between 1995 and 1999. Between 1999 and 2003 there was a decrease of initiations and an increase in frequent use.

Lifetime use of inhalants, 1995 – 1999 – 2003

The frequency of lifetime use of inhalants in 1995, 1999, and 2003 is represented in Figure 2.5.

The differences in prevalence of inhalants lifetime use for the years 1995, 1999, and 2003 were yet statistically significant (χ^2 was significant at $p < 0.02$, C=0.06); but will not be interpreted since significance of χ^2 was influenced by the sample size and C was 0.06.

Use of inhalants in past year, 1995 – 1999 – 2003

The frequency of use of inhalants in past year for the years 1995, 1999, and 2003 is represented in Figure 2.6.

There were no statistically significant differences in past year inhalants use between 1995, 1999, and 2003 found.

Use of inhalants in past month, 1995 – 1999 – 2003

The frequency of use of inhalants in past month for the years 1995, 1999, and 2003 is represented in Figure 2.7.

There were no statistically significant differences in the past month inhalants use between 1995, 1999, and 2003 found.

Lifetime use of sedatives without doctor's prescription, 1995 – 1999 – 2003

The frequency of lifetime use of sedatives without doctor's prescription for the years 1995, 1999, and 2003 is represented in Figure 2.8.

The differences in prevalence of lifetime use of sedatives without doctor's prescription for the years 1995, 1999, and 2003 were yet statistically significant (χ^2 was significant at $p < 0.0001$, C=0.07), but could be caused by the sample sizes since contingency coefficient was 0,07.

Lifetime use of any illegal drug use, 1995 – 1999 – 2003

The frequency of any illegal drug use (e. g. marijuana/hashish, heroin, cocaine, crack, amphetamines, ecstasy, LSD and other hallucinogens, sedatives without doctor's prescription, inhalants) for the years 1995, 1999, and 2003 is represented in Figure 2.9.

Statistically significant differences were found in prevalence of any illegal drug use between the years 1995, 1999, and 2003. The percentage of those who never used any illegal drug decreased from 1995 to 1999 and from 1999 to 2003. The decrease was greater in the first interval compared to the second. The most significant increase occurred in the category of regular users (= "40 times or more") where in 1995 the percentage was 1.3, in 1999 4.8 and in 2003 6.6.

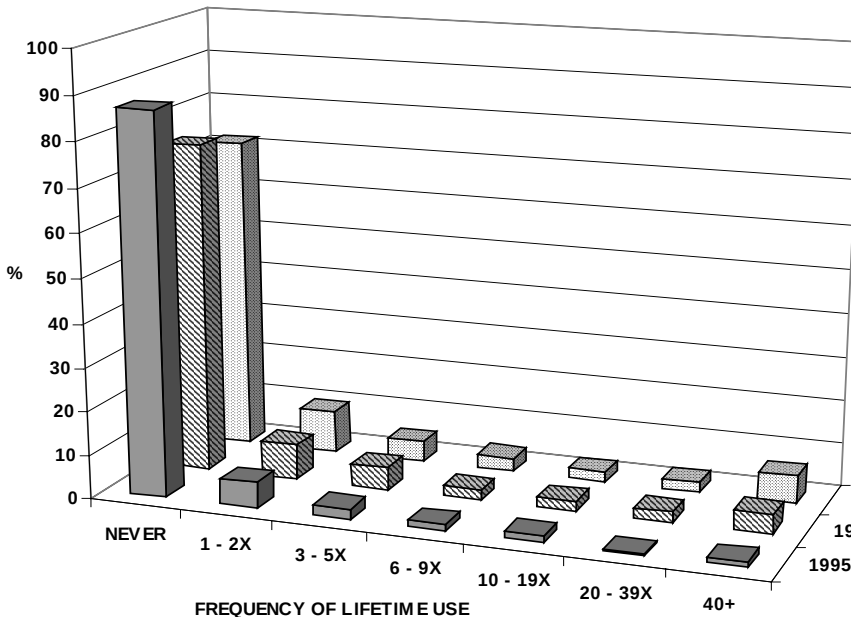

Figure 2.1. Lifetime use of marijuana, ESPAD 1995 – 2003

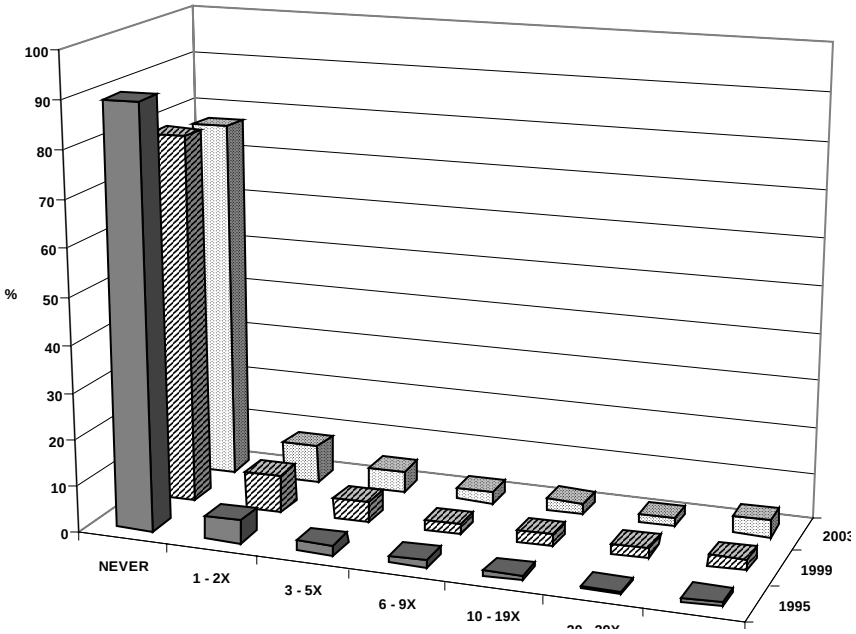

Figure 2.2. Marijuana/hashish use in last 12 months, ESPAD 1995 – 2003

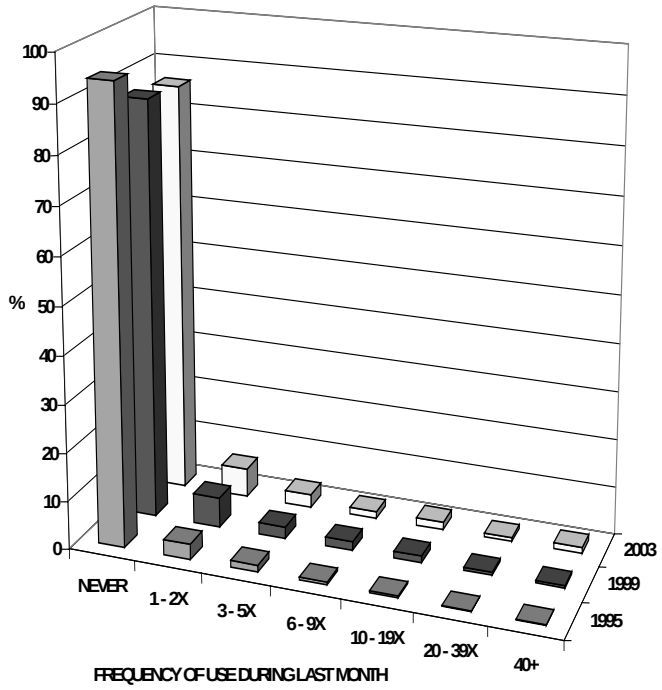

Figure 2.3. Marijuana/hashish use in last 30 days, ESPAD 1995 – 2003

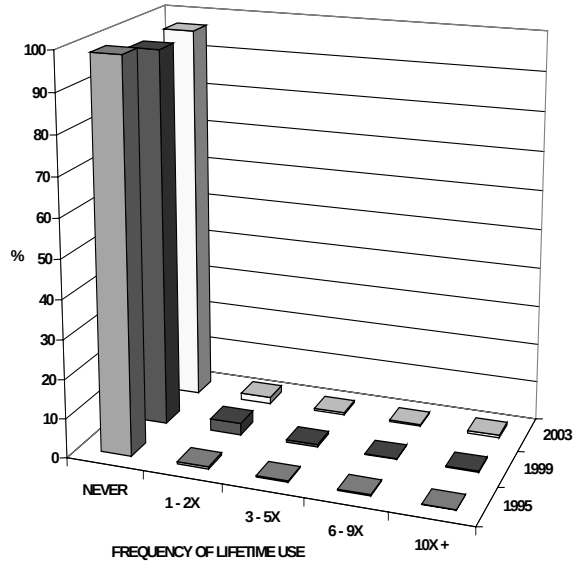

Figure 2.4. Lifetime use of ecstasy, ESPAD 1995 – 2003

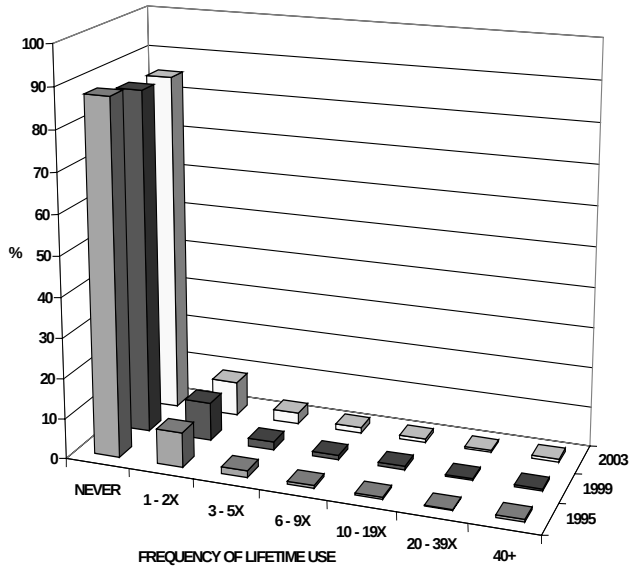

Figure 2.5. Lifetime use of inhalants, ESPAD 1995 – 2003

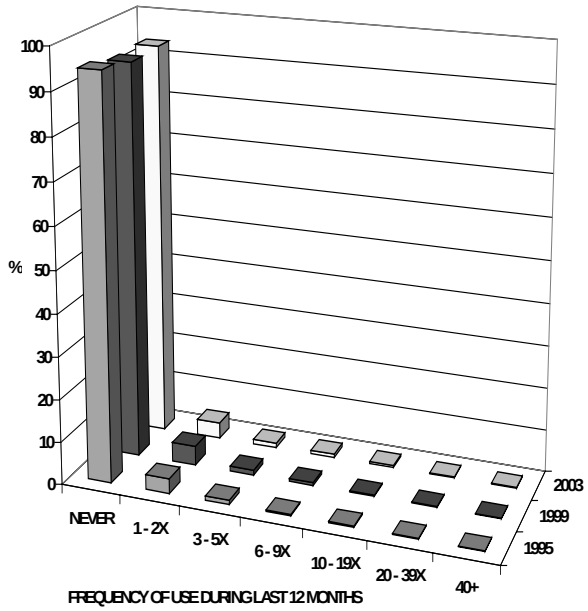

Figure 2.6. Inhalants use in past year, ESPAD 1995 – 2003

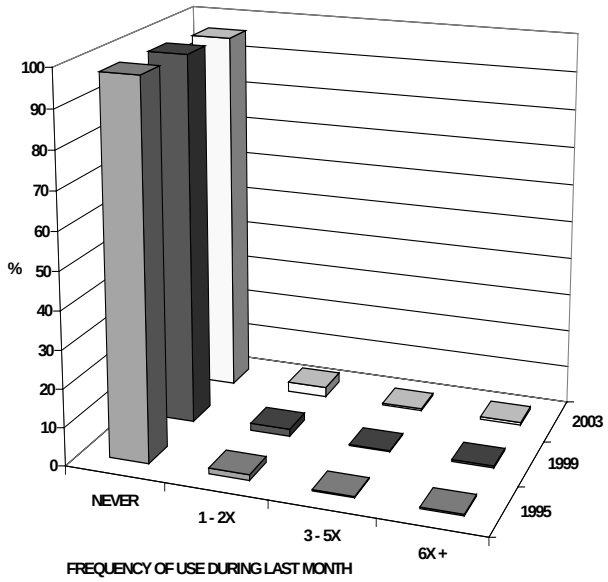

Figure 2.7. Inhalants use in past month, ESPAD 1995 – 2003

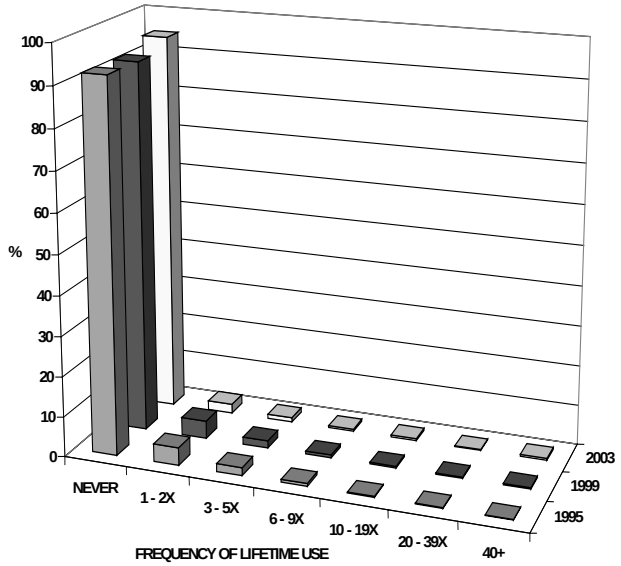

Figure 2.8. Sedatives without doctor's prescription use, ESPAD 1995 – 2003

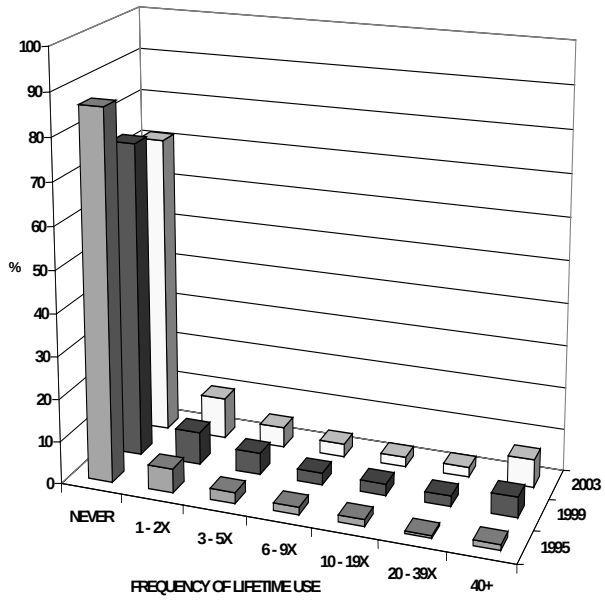

Figure 2.9. Lifetime use of any illegal drug, ESPAD 1995 – 2003

Drug use among specific groups prepared by Ines Kvaternik Jenko

Ethnicity: In some locations it appears that there are relatively more immigrants among drug users, and the other way around. However, the networks dealing with illicit drugs are to a great extent in the domain of the ethnic minorities (Albanians, Montenegrins, Serbs). Since there are no data showing that ethnicity can be a predisposition for drug use or for drug dealing, the assumption of drug use among specific groups is mainly based on field work (Flaker 2003; Kvaternik, Jenko 2004).

Minorities. There are no data on drug use among the members of specific groups such as minorities.

Attitudes to drugs and drug users

The last wave of European Values Study Surveys was done in 1999/2000. According to data from the abovementioned survey, 65.3% of Slovenians responded that they do not want to have a drug addict[**] as a neighbour (Miheljak, 2002).

Public attitudes to drug use and drug users have changed recently and persons have become more tolerant. Nevertheless, according to this survey from among the categories of Muslims, Jews, homosexuals, HIV-infected persons, immigrants, Roma, persons of other races, it is drug addicts who take last place on the list of who Slovenians want as a neighbour.

a) Main results of new study

According to qualitative data from the doctoral dissertation entitled *Drugs as an Element of Political Relations. Human Rights on the Example of the Subculture of Drug Users* (Kvaternik Jenko, 2004*)*, the subculture of drug users in Slovenia is

[**] The original questionnaire of the European Values Study Survey (1999/2000) used the term drug addict.

divided into the subculture of legal drugs and the subculture of illicit drugs. The methodological basis of the present research points out the significance of several years of field work and the qualitative approach to research. [***]What is important to the research are the life stories of the participants and the experiences they gained through using drugs, entering various rehabilitation and treatment programmes and the stigma arising from that. The qualitative approach in research is used for gathering information as well as in its processing and interpretation, where finding differences rather than just confirming basic starting points was crucial.

Unlike the subculture of the users of legal drugs, the subculture of the users of illicit drugs is distinctively non-homogeneous. It consists of various subgroups differing significantly from each other, they have different values and different lifestyles and are very intolerant of each other. These are: the group of cannabis users, the group of heroin users, the group of cocaine users, the group of ecstasy users and the group of poly-drug users.

Within the cannabis sub-group we can confirm that there are two types of cannabis user: juveniles and users who make lifetime experiences with it. According to this qualitative research, the number of young persons using cannabis seems to be falling because the drug seems to be losing its previous status and is a less popular drug. Regular users of cannabis use it individually or most often in a group in which cannabis represents some kind of social ritual. Qualitative research in the presented study shows that cannabis users are more intolerant of the users of opiates than non-users.

Since opiates continue to be the most relevant substance with regard to problem drug use, the sub-group of heroin users is still expanding although heroin drug users are growing older. The abovementioned research shows that the typical heroin user is more than 30 years old, is more or less stabilised on methadone treatment, tries to control his drug use and seeks to be included in society. This is significant for both genders.

Synthetic drugs are the second-most consumed illicit drugs after cannabis and are especially popular among young persons. The presented qualitative research into the "party scene" confirms the high prevalence of ATS (amphetamine-type stimulants) drug use amongst the included group of young persons. The sub-group of ecstasy users has been increasing since this drug has become very popular in Slovenia. The research shows this sub-group is also very intolerant of opiate users.

The presented qualitative research also indicates high levels of cocaine use amongst young party goers, heroin users, certain elites (political, experts, intellectuals); these involve the most hidden sub-group which is almost unseen.

According to the presented research the biggest group of drug users is the group of poly- drug users. Mostly, they start to use almost all (legal and illegal) drugs, they are involved in methadone treatment and regularly abuse their therapeutic agreements.

Analyses of trends in a wider context

According to the qualitative research, the number of illicit drug users is increasing, the number of heroin and cannabis users has more or less stabilised, while the

[***] Qualitative research has been performed in different places in Slovenia between 1997-2004, with typical anthropological methodology. The main aim has been to include drug users' perceptions and reflections of medical treatment, rehabilitation, patterns of drug use and Slovenian drug policy. 25 users of different drugs were included, and 5 professionals. The data has been interpreted according to anthropological methodology.

number of synthetic drug users (ecstasy and cocaine) and the number of poly-drug users is increasing.

The qualitative research sheds light on the phenomenon of drugs in all its dimensions.[****] The analysis of human rights in the subculture of drug users shows that drugs are an element of political relations because they regulate relationships between persons beyond the politically constituted boundary. On the basis of the analysis of field work and the empirical and scientific research on drugs and drugs policies we have developed a typology of drug policies and determined the degrees at which the gradation of the political nature of the drugs-politics continuum takes place.

Drugs, especially illicit drugs, regulate relations between persons and divide persons into different categories, which are accepted in different ways within different socio-cultural contexts. In a wider society or culture, illicit drugs are used to instill fear in persons. Stories about illicit drugs and their users are interesting for the public because they cause fear, terror and intolerance. While tobacco and alcohol are social drugs in most countries, i.e. they are socially and culturally acceptable, all other drugs are unacceptable. Above all, it is their users who are unacceptable. In the Western socio-cultural context, the users of illicit drugs are placed in the category of 'THEM', i.e. the category of "enemies", while the users of legal drugs are put in the category of "friends". Global drugs policy is based on this distinction.

Three paradigms are distinguished within international drug policy: the policy of war; the public health paradigm; and the classical liberal paradigm. The public health model, whose main goal is to care for public health, tries to reduce the harmful consequences of drug use such as the spread of infectious diseases (hepatitis B, C, HIV/AIDS), or deaths (overdoses). Advocates of this model claim that the recurrent use of drugs is a chronic repeating illness. Hence, it follows that drug users are chronic patients. By classifying drug use as an illness and drug users as patients, this model can reduce the harmful consequences of drug use and the criminalisation of drug users in the short term but, in the long term, it imposes on them the stigma of patients – mentally ill patients. In Slovenia, where the dominant approach of drugs policy is the public health paradigm, we are witnesses to the so-called negative medicalisation (qualitative research among drug users with a lot of experience with different types of treatment shows that the user of drugs becomes stigmatised after they enter a treatment programme and that this aspect of treatment is not managed with special attention, public campaigns… The biggest problematic issue was long-term methadone maintenance treatment). The analysis of the research and the findings on illicit drugs show that the existing paradigms of drugs policies are inefficient.

The presumption that in the "world" of human rights individuals have the right to use drugs leads to the debate on the limits of human rights – the rights of the individual. Most drug users and drug users' associations advocate the right to use drugs and appeal to the right to live. Within international drugs policy, which normatively prohibits the use of illicit drugs, these claims are not realisable. The drug issue reveals the conflict between the individual (drug user) and his wishes or needs on one hand, and the community (interests) on the other hand.

[****] It is common that these data are difficult to obtain with quantitative research and evaluation, accordingly this social sciences approach with a political anthropological perspective has enabled a significant insight into values, decision-making, tolerance between sub-groups, stigmatisation, minorities, human rights, drug use, and the type of drug policy.

Qualitative research and analysis of interviews with users confirm that drugs are always an element of political relations. Illicit drugs are a criterion for differentiating persons, given that individuals who use drugs are beyond the tolerance threshold. Persons push such persons into the area of unacceptability. The users of illicit drugs are placed in the category of the sick, pathological, unacceptable, deviant, criminal, or alien. At the level of everyday life, the universalisation of the stigmatised differences linked with drug use is taking place.

The contribution of this qualitative study is that it shows different approaches and reveals some otherwise hidden information about the policy of drug use in Slovenia.

3. Prevention

Universal prevention

Prevention is carried out at different levels (primary, secondary and tertiary).

Primary drug-prevention activities are performed in the school system and are directed towards a healthy lifestyle.

Secondary prevention is performed by health system services, NGOs/civil society and LAGs.

Tertiary prevention is carried out by specialist health institutions.

School based prevention prepared by Manca Drobne, Matej Košir

School-based prevention is part of the new national strategy adopted in February 2004 and is included in the chapter “Primary prevention in educational area”. The main objectives of the national strategy in the field of school drug prevention are as follows: preventive activities should be implemented on the basis of a holistic approach; they should include pedagogical and non-pedagogical staff in education institutions, along with pupils, students and their parents; drug prevention should be part of the curriculum and education institutions should develop specific preventive programmes or projects; all these programmes should be adapted to the age of the target children or youth; education institutions should also act preventively by encouraging the inclusion of the individual in the community etc.; attention should also be focused on activities for preventing drug use among the student population etc.

The Ministry of Education, Science and Sport is responsible for the preparation of an action plan in the field of school prevention.

School-based prevention is included in some local action plans as part of LAGs or teams. Schools are still relatively autonomous, the main actual co-ordinators of drug prevention efforts in schools are school authorities.

The consumption of alcohol and smoking of cigarettes are strictly prohibited in schools by national law. Many primary schools organise information days on different topics related to drugs, addictions, eating disorders etc., yet topics from this area are also included in many subjects at school (ethics and society, class teachers’ hours, health education etc.). Social/counselling workers are regular staff in all schools and their task is early identification and intervention regarding drug-related problems of pupils, there are also many regular and informal meetings and lectures for parents that are organised by schools or LAGs.

Prevention activities are very common especially in our primary schools and in kindergartens with regard to building self-esteem and legal drug prevention (alcohol and tobacco). Recently, a network of “anti-smoking” schools was established in which training for teachers is included.

The OD is organising a National Conference of LAGs on preventive activities where the preparation of an Action Plan is to be discussed.

For more information, please also see previous reports.

Selective/indicated prevention

a) Recreational settings (for more information please see previous reports)

b) At-risk groups

School drop-outs (for more information please see also previous reports);
Younger drug users (for more information please see also previous reports);
Dual diagnosed drug users-mental disorders (for more information, see Chapter 7 Interventions Related to Psychiatric Comorbidity);
Unemployment (for more information, see Chapter 8 Social Correlates and Consequences);
Homelessness (for more information, see Chapter 8 Social Correlates and Consequences);
Special programmes with methadone clients (for more information, see Chapter 4 Problem Drug Use and Chapter 5 on the Treatment System); and
Special programmes with prisoners (for more information, see Drug-related Crime in Chapter 8.)

At-risk families (for more information please see also previous reports)

Some CPTDA's are performing: special programmes for drug-using women, parents and children; special training for work with drug-using women; conferences, training for professionals.
There is a reported good co-operation between CPTDA's and gynaecologists or maternity homes.

4. Problem drug use

Prevalence and incidence estimates indicator prepared by Marta Grgič Vitek

After carrying out a national prevalence estimate of problem drug use for 2000 and 2001, no further estimates were obtained. The EMCDDA's definition of the target population was adopted (intravenous drug use (IDU) or long duration/regular use of opiates, cocaine or amphetamines, during a one-year period, in the age group 15-64). The preliminary results for these two years were 5.4/1000 and 5.3/1000 of the population aged 15 to 64, respectively.

The group for prevalence estimates adopted the protocol for the procedure of prevalence estimation in the future, stating which databases will be used and which data will be needed.

In July 2004 the group of experts for prevalence estimates in Slovenia participated in the REITOX Academy Workshop which was co-ordinated by the EMCDDA and organised by the NIPH and the IUID. Our prevalence estimation experience of using the capture-recapture method and preliminary results for 2000 and 2001 were presented.

Incidence estimates (research on problem drug use on local level) prepared by Miljana Vegnuti

In the 1992 to 2003 period, there were in Slovenia 4.216 reported drug users (mostly heroin users) entered in two of CPTDAs in Ljubljana, the rate of crude incidence was 0.2 per 1000 inhabitants (the specific incidence at the age of 15 to 19 is 1 person/1000 per year).

Figure 4.1. shows a summary plot based on the median and quartiles. The box represents the interquartile range which shows that half the cases inside the values for the length of using drugs. The whiskers are lines that extend from the box to the highest and lowest values, excluding outliers. The line across a box indicates the median length of any drug career in the particular year.

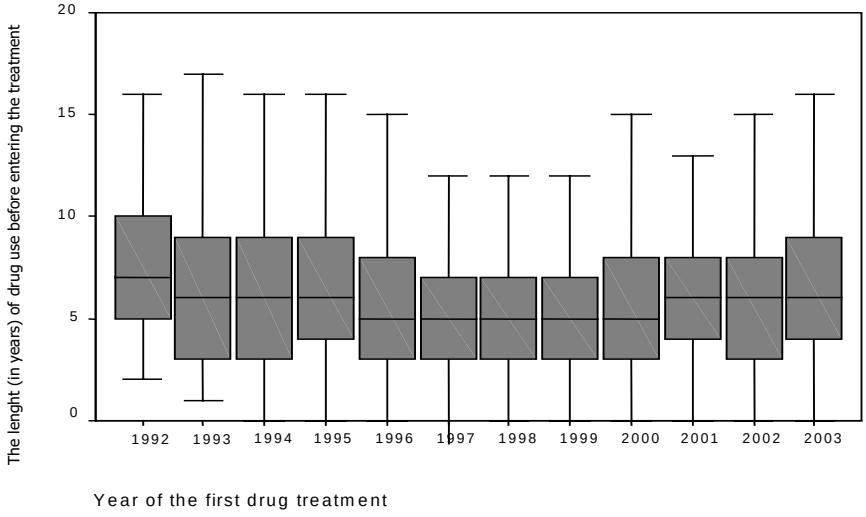

Figure 4.1. Interquartile range showing half of cases inside the values for the length (years) of using drugs.
Source: NIPH

Before entering treatment the average career of drug use is 4.5 years. The Figure 4.1. shows a smoothed wave in the twelve-year history of assessing drug treatment which primarily means that we are observing a stable process.

Without considering the order (primary or secondary drug) of the drugs used, heroin is used by 97% of clients in treatment.

Those who came for treatment at the time of the establishment of the first CPDTAs had been using 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 how long the period is from one's first use of heroin to the start of treatment. The probability of taking a shorter period to start treatment is bigger for those who are non-injectors.

There is also a possible explanation involving the availability of facilities and the enhanced awareness of drug-risk behaviour. Considerable changes in latency time are also due to the availability and price of heroin.

While estimating the incidence of problem drug use we found that, given the different concentrations found in different regions in Slovenia, this figure should only be provided locally.

By substance used

For more information, please see previous reports and chapter 2 on Drug use in the school and youth population.

By injecting drug use (ever and current) prepared by Miljana Vegnuti, Mercedes Lovrečič, Manca Drobne

In the 1992 to 2003 period, we noticed a decreasing trend of injecting among new clients in drug treatment programme of CPTDA, but it is also not common for old clients in the programme. The sharing of needles and equipment for injecting has also been falling. The mean age of first injecting is constant (20 years). According to the analysis injecting behaviour is one of the most important cutting back factors for inclusion in treatment. The period of risk involved in injecting drugs is longer than for drug users who do not inject. Compared to those who inject, drug users who do not inject enter a treatment programme over one year earlier.

According to EMCDDA methodology standard protocol in 2003 there were 1485 clients (new and prior treated, not old clients included). Current injecting was reported by 41.2% of clients, and 6.1% of those who were currently injecting a drug had shared needles in the last 30 days. Lifetime injecting was recorded for 75.5% of persons, and 44.1% had shared needles at least once in their lifetime.

In 2003 among first-treatment clients (FTCs), current injecting was reported by 44% of them, and 5% of those were sharing needles. Lifetime injecting was reported by 58.9% of persons, with 27% of FTCs having shared needles at least once in their life.

Profile of clients in treatment prepared by Miljana Vegnuti, Manca Drobne, Mercedes Lovrečič

Although we have noticed the decreased use of heroin among new clients due to the use of cannabis, and less due to cocaine and synthetic drugs, there we still have the prevailing type of drug user who consumes heroin.

More than 60% of persons in programmes are poly-drug users, every second person in treatment uses cannabis, while every fourth or fifth person uses cocaine.

In 2003 there were 2.860 clients reported in drug treatment (healthcare system) in Slovenia, according to data from the questionnaire Drug Users Treatment Evidence (for more information please see previous reports) provided by the CPTDA network. 18 CPTDAs from the total of 19 included in the CPTDA information network (see Figure 4.2) reported data on clients treated on the basis of the abovementioned questionnaire.

Figure 4.2. Distribution of the network of CPTDAs in Slovenia
Source: NIPH, 2004

In Ljubljana there are two drug-treatment services: an outpatient CPTDA and the CTDA (outpatient, inpatient units) at the Psychiatric Clinic.

On the basis of all treated clients (2.860) the data show the following: the mean age was 26 years, the youngest person seeking help was 13 years old and the oldest was 54 years. Heroin was the primary drug problem in 90.9% of all clients treated; yet cannabis, cocaine and other stimulants were also detected as a primary drug problem. 68.3% of persons treated in the programme used more than just one drug. The mean age of the first use of an illicit drug was 19 years for heroin, 15 years for cannabis, 21 years for cocaine and 17 years for stimulants. The length of the average drug career (drug use) was four to five years in 2003. In 2003 the proportion of females toward males was stable, and the mean ages were higher for both genders. By substance use, no big differences were detected compared to 2002. 31.7% used only one drug, others used a primary drug in combination with several substances. On average, amongst those who used a primary drug in combination with others, 2.4 drugs were used per person, most frequently opioids, cannabis, while

every third person in a programme used cocaine and alcohol was registered for 11% of drug users.

Drug treatment demand indicator (TDI) in line with the EMCDDA standard

Collecting data according to the drug treatment demand indicator (TDI) in line with the EMCDDA standard represents an important source for revealing the epidemiological situation of the prevalence and characteristics of problematic drug use in Slovenia. The TDI for 2003 includes first clients and repeatedly (prior) treated clients who had been out of the programme for more than three months, but excludes those who are in a treatment programme for a longer time.

1.485 clients were reported according to this methodology in 2003. 75.9% of those in treatment were males. The mean age was 25.3 years, for males it was 25.9 and for females 23.5 years. More than half of the treated persons lived together with parents, 11.2% lived alone with a partner, and less than 11% lived alone. 17.5% of clients were regularly employed, more than half the clients were unemployed or temporarily employed, and 26.2% persons were still in the education process (high school, university).

Most clients in treatment sought help due to heroin as a primary drug problem (88% of recorded cases), followed by cannabis (10.4%), cocaine (0.8%), stimulants (0.5%).

The mean age of the first use of heroin as a primary drug was 19.1 years, for cannabis 15.2 years, for cocaine 20.5 years and for stimulants 16.4 years. Most clients were injecting the primary drug, 27% of clients smoked or inhaled it, 6.7% of persons sniffed it, while the primary drug was eaten by 0.8% of persons who were treated.

The mean age of the first use of the primary drug was 18.7 years, the mean age of the first use of any illicit drug was 15.9 years, whereas the mean age of first injecting any illicit drug was 20 years.

More than half the clients in treatment were already in procedures involving a court, police or in prison.

In 2003, 504 first-treated drug users were reported, namely 122 females and 382 males. Their mean age was 23.2 years, for females it was 21.9 and for males it was 23.7 years. 79.3% of clients sought treatment for heroin use (primary drug), 18.3% for cannabis, and cocaine 1%. The mean age of the first use of the primary drug was 18.9 years, for the first use of any illicit drug it was 16.1 years and first injecting was done at 20.8 years. 60.7% of the 504 first-treatment cases were poly-drug users, whereby the primary drug was mostly used in combination with cannabis (51.6%), cocaine (17.6%), stimulants (9.2%) and heroin (7.5%). Alcohol was detected as a secondary drug with 8.2% of clients.

The increasing trend among FTCs who had sought treatment for cannabis use as a primary drug problem, which has been noticed in previous years, decreased in 2003. One reason for this could, in our estimation, include the lack of data for one regional CPTDA.

Main trends of FTCs in 1996-2003:

- an increasing trend in demanding drug treatment for cannabis as a primary drug problem (except for a decrease in 2003, following the lower proportion of drug users demanding treatment for heroin (as the primary drug));
- a reduction in current injecting;
- a decrease in sharing needles;
- a drop in sharing injecting equipment;
- the increased use of condoms; and

increased poly-drug use among drug users demanding treatment (several drugs used among recidivists than among first-treatment clients).

By substance used prepared by Miljana Vegnuti, Manca Drobne, Mercedes Lovrečič

a) Heroin

In terms of the history of treatment and extent of addiction, the predominant type of client in health treatment in Slovenia is a heroin user (both genders), who is often a poly-drug user and who uses cannabis as a second drug. Most often he or she lives with their parents, and is unemployed. Among 399 first treated clients entering treatment for heroin as a primary drug use problem in 2003, the intensity measured by frequency and route of administration was high, meaning that 74% of those used drug by injecting and every day.

b) Cannabis

Among the 528 drug users undergoing their first health drug treatment (CPTDA) in 2002, 22.7% reported cannabis use as their primary drug problem. The proportion of clients in the age group below 19 years has been constantly higher than the proportion in the age group aged over 19.

In Slovenia in 2003 18.3% of 504 drug users undergoing their first health treatment (CPTDA) reported cannabis use as their primary drug problem (excluding data for one CPTDA).

In 2003, 66% of all heroin users in treatment reported cannabis as the first illicit drug that they used. Amongst first-treatment clients the number of poly-drug users has been increasing, but the results analysed by year show that older persons who enter treatment because of cannabis as a primary drug problem more frequently use several drugs in combination than those who are aged below 19 years.

c) Ecstasy

In the CPTDA network between 1996 and 2003 amongst first-treatment clients 140 persons were recorded who had used ecstasy among illicit drugs. 43.6% of those were aged between 20-24 years, while 37.1% were aged between 15 and 19 years. In the abovementioned period, only 5 ecstasy users were recorded as indicating ecstasy as the most problematic and only illicit drug underlying their reason for seeking treatment in CPTDAs. 74.3% of clients (104) used heroin besides ecstasy as an additional drug. In the last 8 years the number of clients who have used ecstasy and sought help has oscillated, while treatment demand for ecstasy increased in 2002 and 2003.

Regarding their mean age, compared to other drug users ecstasy users seek treatment in CPTDAs almost two years earlier despite the fact that on average they started to use illicit drugs at approximately the same age.

d) Cocaine

In 2003 there were 2.860 all treated drug users reported by CPTDAs, 606 of whom (21.2%) also used heroin besides cocaine. Cocaine as a primary drug problem was recorded for just one person. 29 persons used cocaine as a secondary drug, although for them their primary drug problem was not heroin but some other illicit drug.

By centre types

For more information please see chapter 5 Drug-Related Treatment (Inpatient treatment and outpatient treatments).

Main characteristics and patterns of use from non-treatment sources (NGO) prepared by Ines Kvaternik Jenko, Manca Drobne

Measures to minimise drug-related health damage, reduce deaths and mitigate public nuisance have become an integral part of Slovenian harm-reduction policy in the field of illicit drugs. Syringe-exchange programmes, outreach initiatives and other low-threshold services have continued to work with injecting drug users in Slovenia. On the other side, there are many high threshold NGOs which offer drug abstinence or drug-free programmes and psychosocial rehabilitation (for more information, please see Social Rehabilitation).

The Association of NGOs in the Republic of Slovenia

The Association of NGOs was formally established in June 2000. It involves 16 organisations that are active in the field of illicit drug-related problems, social rehabilitation, harm reduction related to drug use, and which are establishing and leading some therapeutic abstinence programmes. These organisations are dealing with addiction and the problems of drugs to prevent an epidemy of addiction in Slovenia.

According to the Association of NGOs the main problem they are encountering is financing. The Association argues that because of their wide range of activities they need more finances and material help for their work (for more information, please see Table 1.1. in part A: New developments and trends).

The Association's action plan (till the end of 2005) is based on the Law on Prevention of the Use of Illicit Drugs and Dealing with Consumers of Illicit Drugs Act (PPUDD). According to the action plan the Association sees the linking of NGOs and co-ordination of joint activities as one of its primary goals. Other objectives include: implementing the national strategy, encouraging new NGOs to develop, appearing in front of state organs and the public, promoting the work of NGOs, training members of the Association, perceiving the use of illicit drugs and the consequences of their use, preventive programmes and the results of prevention work, the preparation of evaluation studies in different fields and co-operation in the establishment of a central information point.

For NGOs that work with risk groups such as injecting heroin users or persons infected with HIV, the prevention of drug addiction is not the main activity. Here, we can include the Aids Foundation Robert, Svit Koper (see below) etc.

For more information on the financing and organising of NGOs in Slovenia, see the provisions of the PPUDD in Chapter 5.

By substance use

NGOs offering harm-reduction programmes mostly deal with clients who are injecting heroin users.

By injecting drug use

Aids Foundation Robert Ljubljana – Project Stigma

The Aids Foundation Robert from Ljubljana (the catchment area of inhabitants in Ljubljana is 268.084 according to data from the Statistical Office of the RS for 2003) was established in 1995 and is also very active in the field of HIV/AIDS prevention. According to their final report for 2003 in its needle-exchange programme – Project Stigma – 913 persons were included (158 women and 755 men). Harm-reduction, counselling, and informing are the main objectives of this project.

The stationary needle-exchange programme in the framework of the Stigma Association started back in 1992. Consequently, it is a basis for the activities of other programmes included in the Project. Users can receive needles, alcohol wipes and citric acid, they return used equipment and it is destroyed by the NGO's staff.

In 2001 it recorded 7.718 visits, in 2002 8.635 visits and in 2003 it recorded 8.513 visits to its Drop-in Centre, which was open from Monday to Friday between 10 a.m. and 4 p.m. The main objective of the Stigma programme is the provision of a safe place or a meeting place where drug users can spend their free time.

Social workers and volunteers and drug users have been performing outreach services twice a week in fifteen different locations in Ljubljana. They organised some campaigns to collect and destroy used needles.

In January 2003 they started with the Project's vending machines which offered injecting drug users anonymity and does not require prior entrance to a drug treatment programme. According to data from the Aids Foundation Robert, there are two such vending machines in the Ljubljana area. In 2003 23.239 needles were dispensed through these vending machines.

One of the new activities of the Project AIDS is anonymous testing for HIV in the population of injecting drug users who are visitors to the daily Drop-in Centre Stigma. According to data from the pilot project which was performed in co-operation with the NIPH in 2003, there were no positive cases of HIV.

Visitors are recorded on the basis of codes where the age and sex of the visitor is evident. With the stationary needle-exchange programme at each code they register the quantity of materials for injecting delivered and received, and for each user they specifically record their possible inclusion/participation in methadone treatment, or some other important notes concerning the programme user (statements, first contact, health condition, arranged health insurance, number of condoms delivered). In 2002 they recorded 133 first visits.

According to data from the Aids Foundation Robert in 2003, 164.712 needles were delivered and 115.728 used needles were received (the proportion of used needles received was 70.3%). The mean age of visitors within the programme was 27.9 years, for males it was 28.4 and for females 25.2 years. Data from the list of their evidence show that 45.3% of users were contemporary included in methadone treatment services.

Svit Association Koper

The Svit Association Koper provides a low-threshold programme and is mostly based on outreach work in three municipalities (the catchment area of inhabitants in Koper is 48.885, in Izola it is 14.928 and in Piran 17.494 according to data from the Statistical Office of the RS for 2003). It performs the project Oscar (a mobile van is used to deliver needles and other materials).

Table 4.1. Outreach results - Svit Koper, April - December 2003

Month	**No. of working Hours**	**No. of contacts**	**No. of needles delivered**	**No. of needles returned**	**Percentage of returned needles**
April	98	96	364	133	31%
May	175	144	615	179	29%
June	203	234	2093	739	35%
July	203	251	3489	1513	43.4%
August	203	293	5291	2603	49.2%
September	153	272	4586	2285	49.83%
October	166	248	5446	2789	51.21%
November	144	276	4298	1027	23.90%
December	153	333	6870	1850	26.93%
Total	**1498**	**2147**	**33 052**	**13 118**	**39.69%**

Source: Svit Koper, 2004

In 2003 the so-called, special “speaking code” (programme users are coded with the first letter of their first name and the third and last letter of their surname, sex, month and year of birth). The code helps reduce the duplication of users. 261 users were registered with the Svit Association Koper. It is also possible that users indicate the wrong or a different code when contacting the programme, which is why the duplicating of users under different codes could be possible. The mean age of users in the programme was 27.81 years. Most of them (99) were between 25 and 29 years old. In the 20-23 age group there were 60 persons registered. The oldest drug user was 47 years, while the youngest was 18 years old (1 person). 38 females were included in the outreach programme. 21.5% of the 261 users were not included in any other drug-related programme before entering this programme.

According to the data, on average (9 months in 2003) they delivered 3672.4 needles a month.

Table 4.2. Comparison between the number of users included in the programme, the share of the hidden population, the proportion of females, mean ages of users and the number of delivered and returned needles, 2003, Svit Koper

Year	**2003**
No. of persons included in the programme	261
Proportion of those not previously recorded	21.5% (56)
Proportion of females	14.6% (38)
Mean age	27.81
Delivered needles	33.052
Returned needles	13.118 (39.69%)

Source: Svit Koper, 2004

Anonymous testing for HIV was carried out in three municipalities in the Koper region in April and May 2004. There were 71 samples collected and 69 questionnaires were filled in. According to the results all 71 samples were HIV negative. The Association Svit Koper was financed by the OD at the Ministry of Health to provide the following equipment: 27.000 needles and 16.500 alcohol wipes.

Drug-treatment initiatives, especially substitution programmes, also make an important contribution to reducing drug-related health damage.

At the Ilirska Bistrica CPTDA syringes have been delivered since 1998, in 2003 its Pharmacy sold 10.355 needles to drug users and 225 used ones were exchanged.

Syringe exchanges are also offered at the Nova Gorica CPTDA, but it does not collect data on this programme.

According to data, in the Celje region there were 9.818 used needles exchanged and 40.034 needles were sold to drug users in its Pharmacies.

Other Specific Sub-populations

No new information available.

5. Drug- Related Treatment prepared by Mercedes Lovrečič

Treatment systems

Drug users have different treatment needs. Drug-related treatment systems should offer a range of approaches which cover preventive, curative and rehabilitative interventions and should be tailored to patients' needs. The integration of treatment and rehabilitation services is necessary and this should take place wherever possible.

Drug-related treatment in Slovenia is provided through different systems: health, social and civil society organisations (NGOs). Together, they provide a comprehensive range of services which cover prevention, curative and rehabilitation approaches and include different types of drug-treatment programmes: short-term programmes (e.g. drug-free treatment: outpatient, inpatient or residential; socio or psycho therapy: outpatient, inpatient or residential; medication therapy;) and long-term programmes (e.g. methadone maintenance outpatient treatment for opiate addicts, residential therapeutic community treatment). Within the various drug treatment programmes, some are also able to provide contemporary different services such as counselling, therapy or medical care.

Drug-related treatment in Slovenia is performed on the formal basis of the Health Care and Health Insurance Act (Official Gazette 9/92) and the Law on Prevention of the Use of Illicit Drugs and Dealing with Consumers of Illicit Drugs Act (PPUDD) (Official Gazette 98/99), which regulates all three systems. Articles from the abovementioned laws regarding the different systems are cited below from the official English translation to show the extent of the regulations.

a) Health system

Medical treatment is defined in Articles 8 and 9 of the PPUDD: treatment of the consumers of illicit drugs shall be carried out in the form of hospital and outpatient clinic treatment programmes approved by the Health Council, which shall be carried out by natural and legal persons who fulfil the conditions set for the performance of medical activities in accordance with the act governing medical activity.

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

For the implementation of outpatient clinic activity for the prevention and treatment of addiction, centres for the prevention and treatment of addiction to illicit drugs shall be organised at the primary level as part of the public health service network. The activity of the centres shall be carried out by professionals on the basis of a concession or by public health institutions.

The minister responsible for health shall appoint the body for the co-ordination of the centres for the prevention and treatment of addiction to illicit drugs, which shall propose a treatment doctrine, verify the implementation of the addiction treatment doctrine and co-ordinate professional co-operation between the centres for the prevention and treatment of addiction to illicit drugs.

The composition and method of work of the co-ordination body for the centres for the prevention and treatment of addiction to illicit drugs shall be set out in more detail by the minister responsible for health.

For the implementation of hospital and specialist outpatient clinic treatment, the Government of the Republic of Slovenia shall establish a public health institution – the Centre for the Treatment of Illicit Drug Addicts.

Hospital treatment shall be deemed to be hospital detoxification, psychosocio-therapeutic treatment, extended treatment, and health rehabilitation.

Financing is defined in Article 16 of the PPUDD: funds for the implementation of treatment pursuant to this Act shall be provided in accordance with the Act governing health protection and health insurance.

For more details, please also see chapter 1. National policies and context (Budget and public expenditure).

Supervision is defined in Article 18 of the PPUDD: supervision of the work of the centres for the prevention and treatment of illicit drug addicts and of the treatment of consumers of illicit drugs shall be exercised by the ministry responsible for health.

The method of exercising the supervision referred to in the preceding paragraph shall be set out in more detail by the minister responsible for health.

For more information, please also see the Report on the Audit of the National Supervision Commission in the CPTDA in 2003.

Article 19 of the PPUDD states that administrative supervision of the legality of implementation of this Act shall be exercised by the competent ministries.

b) Social system

Social security services and programmes for the resolution of social problems related to the consumption of illicit drugs are also defined in the PPUDD. In fact, in Slovenia there are 62 public services, centres for social work, at the national level.

Article 10 of the PPUDD defines social security services intended for the prevention and elimination of social hardship and problems related to the consumption of illicit drugs provided in the form of public services shall in particular comprise social prevention, emergency social assistance, help for individuals and help for the family. Services shall be provided in accordance with the act governing social security and in accordance with the norms and standards prescribed by the minister responsible for social affairs.

Article 11 states that programmes for resolving social problems related to the consumption of illicit drugs carried out in the form of public services shall be professionally defined sets of professional social security actions intended for individuals, families, and various groups of the population for the purpose of eliminating hardship and problems related to the consumption of illicit drugs. Programmes for resolving social problems related to the consumption of illicit drugs provided outside of public services may also take the form of organised units for mutual help among the consumers of illicit drugs, relatives and other interested persons.

Programmes for resolving social problems related to the consumption of illicit drugs which are co-financed through public funds shall be verified by the Council for Drugs, which shall be appointed by the minister responsible for social affairs on the proposal of the Social Chamber of Slovenia.

The Council for Drugs shall consist of one representative of the ministry responsible for social affairs and experts in the area of dealing with the consumption of illicit drugs.

Article 12 states that when the Council for Drugs believes that part of the verified programme for the resolution of social problems contains elements of treatment, it shall propose that the Health Council approve this part of the programme as part of the treatment of illicit drug addicts. The Health Council may approve that part of the programme and determine which part shall be considered to be part of treatment and how long it will last.

The related financing is regulated in Articles 16 and 17: funds for co-financing social security services and programmes for the resolution of social problems related to the consumption of illicit drugs referred to in this Act shall be co-financed from the national budget.

For more details, please also see chapter 1. National policies and context (Budget and public expenditure).

The consumers of illicit drugs included in a programme for resolving social problems related to the consumption of illicit drugs which is financed from the national budget and which covers care throughout the day shall be obliged to contribute part of the costs of implementing the programme to the extent that they can afford this in accordance with their material means, but should not exceed the cost of one day of care.

The method of determining the contribution referred to in the preceding paragraph shall be set out by the provider of the programme.

Supervision of the determination of the amount of contributions within the programmes specified in the first paragraph of this article shall be exercised by the ministry responsible for social affairs.

The supervision is defined in Article 18: the provisions on supervision in accordance with the act governing social security shall apply *mutatis mutandi* to the supervision of the implementation of social prevention, other social security services and programmes for the resolution of social problems related to the consumption of illicit drugs.

Article 19 prescribes that administrative supervision of the legality of implementation of this Act shall be exercised by the competent ministries.

c) Civil society organisations: non-governmental organisations

Civil society organisations/non-governmental organisations can also find formal bases for help programmes for drug users in the PPUDD.

Article 13 of the PPUDD states that non-governmental organisations shall carry out activities which have been co-ordinated with the National Programme on drugs and which supplement public service activities in the area of prevention and dealing with addiction to illicit drugs.

The activities of non-governmental organisations may cover schooling and educational activities, preventive activities, harm-reduction programmes,

programmes for establishing and maintaining abstinence, social rehabilitation and reintegration, and other forms of dealing with the consumers of illicit drugs and their relatives and the National Programme on drugs.

The abovementioned activities may be carried out by non-governmental organisations within resident communities, non-resident programmes and as part of other forms of work co-ordinated with the National Programme on drugs.

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

Non-resident programmes are day centres carrying out programmes of organised help in which the consumers of illicit drugs and the persons closest to them are included alongside their everyday life, centres carrying out programmes intended for the reduction of harmful consequences of the use of illicit drugs, and programmes carried out in the form of field work.

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

Programmes carried out in the form of field work shall be programmes for the dissemination of informational materials, dissemination of medical materials, and other programmes carried out in the form of field work.

Article 14 says the abovementioned non-governmental organisations may voluntarily join together in the Association of Non-governmental Organisations.

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

Financing is defined in Article 16: the activity of non-governmental organisations shall be co-financed from the national budget and other funds.

For more details, please also see chapter 1. National policies and context (Budget and public expenditure).

The method of co-financing non-governmental organisations is specified in the conditions and criteria applying to the individual users of budgetary and public funds in accordance with the National Programme on drugs.

Verified non-governmental, non-profit programmes shall, to the extent specified in the National Programme by the competent user of budgetary funds, be co-financed in the amount of a minimum of 80 percent of the programme's value. The extent, norms and standards regarding the calculation of the recognised amount of the programme's value shall be specified in the National Programme on drugs.

The Association of Non-governmental Organisations shall be co-financed through budgetary funds of the Republic of Slovenia's Government Office for Drugs.

For more information, please also see chapter 1. National policies and context (Institutional framework, strategies and policies).

Report on the Audit of the National Supervision Commission in the CPTDA in 2003 prepared by Mojca Zvezdana Dernovšek, Cvetka Rogač Cvetko

Introduction and methodology

According to the first paragraph of Article 2 of the Regulations on Performing Supervision in the Centres for the Prevention and Treatment of Illicit Drug Addiction (CPTDA) (Official Gazette RS 43/00) the Minister of Health (Act No. 5809-3/01:13, October 27, 2003) nominated members of the Supervisory Commission to examine and analyse the situation in the CPTDA. The main goals of the audit were to assess the sufficiency and proportionality of financial resources, staff structure and treatment in CPTDAs.

The Commission prepared two special forms to explore indicators of the situation in CPTDAs. The first one "The report on expenditure of funds in Centres for the Prevention and Treatment of Illicit Drug Addiction from January to October 2003" sent to CPTDAs in advance and discussed at the time of the audit. The second one was filled in during a discussion with the team members and inspection of a particular CPTDA and contained an assessment of the process and structural quality of care. We later added some calculations using a few indicators to analyse the situation.

The assessment in CPTDAs was limited to the most important features listed below: assessment of the number of persons in a CPTDA; assessment of the organisation and quality of care (the Commission's task was to examine the organisation and operation of CPTDAs – staff meetings, plans of annual and monthly work and the performing of these plans, examination of organisational solutions and expert matters etc.); an assessment of the heterogeneous use of care programmes (existence of particular programmes in CPTDAs – special programmes for adolescent users); assessment of the accessibility of care (waiting lists); assessment of the continuity of care; assessment of the use of some medicaments (problematic prescription of benzodiazepines and methadone pills); assessment of inter-sectoral co-operation (co-operation of staff in CPTDAs with social services and others (prisons and NGOs)); assessment of prevention programmes (extension and sets of prevention programmes); assessment of safety (number of violent incidents, number of overdoses); assessment of the quality of documentation; assessment of facilities (adequacy of facilities); other questions related to the safekeeping of data, research in CPTDAs, the staff situation in CPTDAs, assessment of staff's co-operation with the Supervisory Commission.

Selected results of the audit

a) Financing of services

For every year the agreement between a CPTDA and the Health Insurance Institute of Slovenia states that the financial plan is based on estimated mean expenditure for each person in the methadone programme. The audit found that some centres spend less money per person (minimum expenditure was 68% of estimated mean expenditure), while others spend more (up to 130%).

Data from the financial report show that almost half the centres spend exactly the given amount. The remaining centres spend less (for example 78% of given funds) or more (170% of given funds).

The agreement also determines a standard for staff numbers (per 100 persons in the methadone programme). Only two centres reported a lower number of staff members, while others exceeded the allowance markedly. The same goes for reported expenditures on staff (labour and material costs).

We were unable to establish the efficacy of the programmes in the centres in this audit. The data used for this analysis were taken from questionnaires sent to each centre and later discussed at the time of the audit. The only conclusion was that some discrepancies do exist between the reported data and the present state.

One of the audit's conclusions is that the users of services in some centres have greater needs than what can be supplied. The reasons for this lie in unitarian and rigid staff, inflexible monetary allowances or the inappropriate use of resources, or all of them.

b) Organisation of the work in the CPTDA and quality of the procedure

In all centres methadone clients sign an agreement before their inclusion in the programme.

The personnel of almost all centres reveal knowledge of motivational interviewing techniques, while work with suicidal behaviour and diagnostic procedures was satisfactory.

Other data are presented in Tables 5.1 and 5.2.

Table 5.1. Organisation of the work in the CPTDA I (n = 18 centres)

	The frequency of team meetings *	Case conference before including person in MP **	Medical doctor (GP) decide about inclusion of a person in MP **	Psychiatrist decide about inclusion of adolescent persons in MP **	Psychiatrists decide about inclusion of persons with dual diagnosis in MP **	Plan of work in CPTDA **	Assessment of plan accomplishment ***
Median value	**2**	**2**	**1**	**1**	**1**	**1**	**1**

Source: Report of the Audit Commission, 2004

Legend:
* The frequency of team meetings: 1 daily; 2 weekly; 3 monthly; 4 other
** 1 yes; 2 no; 3 no objective data
*** Assessment of plan accomplishment: 1 exceeded; 2 accomplished; 3 less than planned
MP – methadone programme

Table 5.2. Organisation of the work in the CPTDA II (n = 18 centres)

	Supervision of the person at a time of taking urine sample *	Data on previous treatments **	Evaluation of therapeutic plan **
Median value	**1,5**	**1**	**1**

Source: Report of the Audit Commission, 2004

Legend:
* Supervision of the person at a time of taking urine sample (*****rapid qualitative toxicological analysis of urine - presence of PAS-metabolits): 1 strict; 2 discreet; 3 no supervision; 4 no objective data
**1 yes; 2 no; 3 no objective data

Assessment of the accessibility of care

The accessibility of care is represented by waiting for different kinds of care (in days). There are huge differences between centres. A summary of the data is presented in Table 5.3.

Table 5.3. Waiting list for certain treatments (n = 18)

	Methadone Programme	Medical doctor	Psychiatrist	Psychologist	Inpatient Detoxification in CTDA at Psychiatric Clinic Ljubljana	Inpatient Detoxification in other Psychiatric hospitals
- Minimum – maximum	**0-14**	**0-7**	**0-24**	**0-30**	**30-180**	**14-120**
- median (days)	**0**	**0**	**14**	**0**	**90**	**60**

Source: Report of the Audit Commission, 2004

Prescription of benzodiazepines with methadone

Data on how persons are given benzodiazepines in a methadone programme are presented in Figure 5.1. Only in some centres did staff report the source of a prescription for benzodiazepines for their clients from other services.

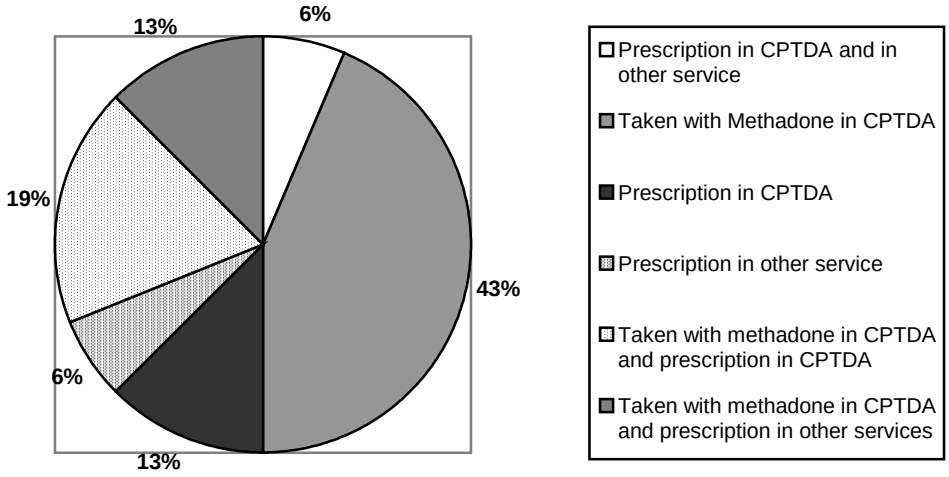

Figure 5.1. Prescription of benzodiazepines with methadone (n = 16)

c) Some preventive programmes in centres

Persons in a methadone programme are motivated to be vaccinated against hepatitis B in all centres. The data on the estimated frequency of taking blood samples from persons in a methadone programme in all centres are presented in Figures 5.2 and 5.3.

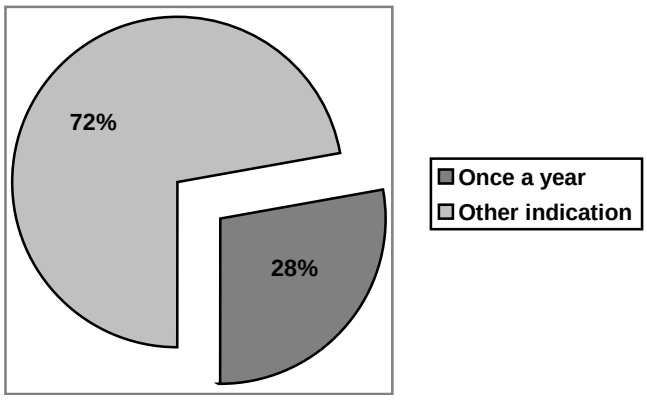

Figure 5.2. Frequency of taking blood samples from drug users in methadone programme in all centres (n = 18)

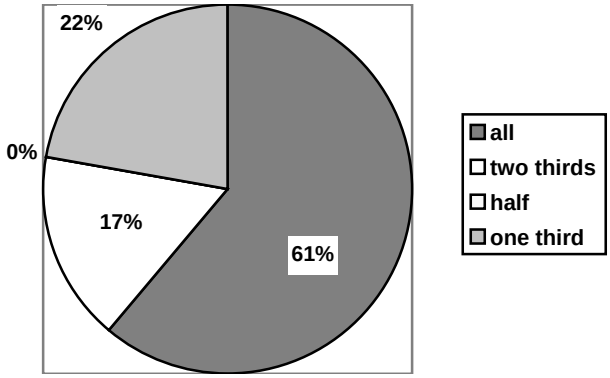

Figure 5.3. Drug users in a methadone programme whose blood was tested for HIV and HBV in all centres (n = 18)

d) Proposals according to CPTDA staff

The Commission noticed that treatment expenses differ among CPTDAs (differences are quite perceivable). The actual expenses of a particular case are not easy to obtain as a different methodology and a detailed analysis would be required to provide this information. The staff structure in CPTDAs according to the norm is unsuitable – the norm is exceeded or not met (most often with health technicians/nurses). The quality and continuity of care consequently depend on the organisation of work (schedule of work, burden on staff). Problems of some centres include inappropriate facilities which do not provide a safe and sufficient work environment.

Staff employed in the centres noticed three main groups of persons who are treated in CPTDAs: in the first group are persons seeking counselling – the ratio of users in this group is increasing. The second group involves persons included in a methadone programme for a short period, persons on rehabilitation and those included in detoxification procedures (intensive treatment in this group is noticeable). The third group is most seriously disabled and usually need a long time to become stabilised in a methadone programme. The programme for them is based on the principle of harm reduction where therapeutic goals are very limited.

Three CPTDAs have problems with violent incidents. They are extremely negative for the treated persons and staff (stigmatisation is increasing).

The assessment of the CPTDA network at the national level could involve other indicators, i.e. assessment of the effectiveness and acceptability of the health programme. Unfortunately, the legal basis of the Commission's competencies and limited time did not allow us to assess these indicators.

In one centre the Commission had legitimacy problems regarding the examination of documentation (undisclosed identity of users in treatment).

Proposals of the Supervisory Commission

1. Pilot research on the treatment payment system among a few CPTDAs is necessary to assess actual expenses for each person treated in a programme.

2. The permanent presence of nurses/health technicians is required (a full-time job is better, part-time jobs should be avoided) to provide the quality, continuity and accessibility of care.
3. Representatives of public health services where a CPTDA is located are responsible for applying normative provisions to employ skilled staff, provide suitable work schedules and for the performing of programmes. Stricter supervision in this field is required. CPTDA expenses should be managed and documented separately from other expenses of the public health service.
4. Representative of public health services where a CPTDA is located are responsible for providing sufficient facilities to carry out a programme adequately.
5. The increased demand for counselling, psychotherapeutic treatments and the different needs of persons seeking help and treatment in CPTDAs require specific knowledge and skills from staff. Psychiatric comorbidity and trends of new illicit drugs were detected (cocaine, new synthetic drugs, poly-drug users). Regular control of therapeutic plans (3-6 months) is recommended.
6. Measures to reduce violent incidents and behaviour in CPTDAs are needed.
7. Expertise and scientific research reflecting activities in CPTDAs should be supported.
8. The opinion of the Commission regarding the ethical question of personal identity data during the examination of documentation is that undisclosed personal data be invisible to Commission members in compliance with the law on the protection of personal data.

Drug free treatment prepared by Mercedes Lovrečič

In Slovenia drug-free treatment (without medication) can be outpatient, inpatient or residential and is performed by the health system (the CPTDA network, the CTDA at the Psychiatric Clinic Ljubljana, some GPs, some drug treatment departments of psychiatric hospitals) and NGOs offering high-threshold programmes.

Usually drug-free treatment is integrated with counselling, and socio- or psycho-therapy.

Inpatient drug treatment in Slovenia is usually performed by the new CTDA which opened in January 2003 (prior to that and from 1995, inpatient drug treatment was performed with less capacity – 9 beds).

From the data reported directly by the CTDA in 2003 the CTDA performed 175 inpatient treatments (117 males and 58 females) and, during the first six months of 2004, the CTDA performed 95 inpatient treatments (64 males, 31 females). From drug user treatment records at the NIPH, 348 of all treated patients in this centre were reported, among these 72 (20.7%) inpatient treatments were reported by the CTDA for 2003 of all reported treated cases, which represents 2.5% of all reported treatments in 2003 in Slovenia (Table 5.4.). This data should be carefully interpreted since there is no record of how many reported outpatient treatments start at the CTDA and continue as inpatient treatment; usually the fulfilment of drug user treatment evidence is carried out at the beginning of treatment which could be outpatient and in some cases continue as inpatient treatment. These cases were reported as outpatient treatment.

Inpatient treatment at the CTDA is usually preceded by an outpatient preparation phase during which the patient must already be drug free, they are allowed to receive substitution treatment with an opioid agonist (methadone). In this phase, the patient

is on a waiting list (on average for 3 months – for more information, please also see the report on the audit of the Commission). Inpatient detoxification treatment lasts for 6 weeks (according to CTDA data in some cases treatment can continue for 8 weeks in the form of long-term intensive treatment, which can also continue as treatment in a day hospital), after which the discharged patient should be involved in outpatient or residential treatment.

For more information on the programme and activities of the CTDA, please see previous reports.

Inpatient drug treatment is also performed by the drug-treatment departments of psychiatric hospitals. In Slovenia there are psychiatric hospitals and departments located in: Ljubljana, Idrija, Begunje, Vojnik, Ormož and Maribor (psychiatric department in general hospital). In this case, the drug user also usually has a mental disorder, where the mental disorder is a predominant disorder and in an acute phase they are treated like other psychiatric patients. The treatment for their drug problem in these cases could be drug-free, involve counselling, socio- or psycho- therapy or be medically assisted. Unfortunately, inpatient specific illicit drug-free treatment at the Idrija Psychiatric Hospital, which was very active in the past, is no longer performing only illicit drug treatment.

In 2002 in Slovenia 1.015 inpatient psychiatric treatments were reported combined with almost two diagnoses according to the ICD-10, one for a predominant severe mental disorder combined with a diagnosed drug-use problem: 704 of them were patients with alcohol use problems, 26 with opioid use problems, 28 with a cannabis use problem, 105 with a benzodiazepines use problem, 2 with a stimulant use problem, 145 with a tobacco use problem while 4 were poly-drug users.

Among the 939 reported inpatient psychiatric treatments for a drug-use problem combined with a mental disorder or complicated by a mental disorder during inpatient treatment in 2002 in Slovenia there were 851 patients with an alcohol use problem, 13 with an opioid use problem, 5 with cannabis use, 33 with benzodiazepine use, 2 with other stimulant use and 35 with poly-drug use problems.

In 2002 in Slovenia 3.042 inpatient psychiatric treatments with a principal diagnosed drug use problem were reported and, of these, there were 2.592 patients with an alcohol use problem, 114 with an opioid use problem, 24 with a cannabis use problem, 82 with a benzodiazepine use problem, 5 with a cocaine use problem, 4 with other stimulant use problems, 1 with a hallucinogen use problem, 1 with a tobacco use problem, 4 with an inhalant use problem and 215 with poly-drug use problems.

Outpatient treatments include: drug-free treatment (without medication) provided by the health system (CPTDAs, CTDA) and NGOs, medication therapy (medication with opioid agonist and antagonist (CPTDAs, GPs), individual or group counselling and socio or psycho-therapy (CPTDA, NGOs, Centres for Social Work), and are offered to patients who visit a programme at regular intervals.

Residential treatment includes: inpatient, usually drug-free treatment (CTDA, drug treatment departments in psychiatric clinics, therapeutic communities). The aim of this treatment is a drug-free and crime-free lifestyle with adequate social reintegration and rehabilitation of the patient.

Medically assisted treatment prepared by Mercedes Lovrečič

Withdrawal treatment

The treatment of withdrawal from a PAS-related disorder requires an assessment of the clinical condition and evidence of the cessation or reduction in substance use should be obtained by history and toxicology.

Withdrawal treatment or detoxification may take place in different inpatient or outpatient settings (Table 5.4.). For the pharmacological management of withdrawal an opioid agonist (methadone) for opioid detoxification (inpatient or outpatient settings) or other not cross-tolerant medication for easing the signs and symptoms of withdrawal (e.g. benzodiazepines, analgesics) are frequently used. Medication should be always linked with psychological support.

Table 5.4. Number and proportion (in %) of reported types of treatment in the CPTDA network in Slovenia in 2003

Type of treatment	**Number**	% of all reported cases
Inpatient detoxification (performed by CTDA)	*72*	*2.5*
Outpatient detoxification	*264*	*9.2*
Short-term substitution therapy	*334*	*11.7*
Long-term substitution therapy/maintenance	*1575*	*55.1*
Long-term psychosocial therapy	*266*	*9.3*
Advice/counselling/support	*231*	*8.1*
Referred to another treatment centre	*28*	*1.0*
Other	*41*	*1.4*
Decision pending/not known	*49*	*1.7*
TOTAL	***2860***	***100***

Source: Drug use treatment evidence, NIPH

Detoxification with an opioid agonist is frequently used not only in the CPTDA network during outpatient treatment but also in the CTDA during inpatient treatment. The most common treatment strategy is the stabilisation of heroin addicts on methadone, followed by detoxification (decreases in methadone doses).

Detoxification with other not cross-tolerant medication is more frequent in outpatient treatment in the framework of the CPTDA network and is also performed by GPs.
There is no information available on the use of clonidine or buprenorphine detoxification in Slovenia (for more information, please also see Chapter 11 Buprenorphine, treatment, misuse, and prescription practices).

Substitution treatment

In Slovenia treatment with opioid agonist methadone has been possible from the beginning of the 1990s and is performed in the CPTDA network where it is possible to offer short-term or long-term detoxification with methadone or short-term and long-term substitution therapy (maintenance treatment) using methadone (Table 5.4).

For more information, please see previous reports.

There is no information about detoxification or maintenance with buprenorphine (partial opioid agonist). For more information, please also see Chapter 11

Buprenorphine, treatment, misuse, and prescription practices.

LAAM maintenance treatment in Slovenia is not performed.

Other medically-assisted treatment

Naltrexone (opioid antagonist) is currently used to treat heroin users because of its property of blocking the subjective effects of self-administered heroin. Its use is mostly confined to detoxification-related procedures, it prevents a relapse to opioid use by blocking opioid receptors. After dependent patients are detoxified of heroin (or alcohol) use, Naltrexone could help reduce craving and support the continuation of abstinence and prevent a relapse (with adequate compliance).

Treatment with Naltrexone in opioid addiction in Slovenia is possible in the framework of the CPTDA network or the CTDA. The prescription of this medication in Slovenia is quite complicated as this is allowed only to psychiatrists working in the CPTDA network and, at the same time, they have to be on the official national list which is “supervised” by the Health Insurance Institute of the Republic of Slovenia. Two lists of authorised psychiatrists (one for opioid and one for alcohol treatment) were proposed to the National Board of Psychiatry and this official body then passed on lists to the Health Insurance Institute of the Republic of Slovenia. It seems that in the future, the lists will probably see radical changes (abolition of the list).

After the authorised psychiatrist has issued the medical prescription for naltrexone this has to be also approved by the regional Health Insurance Institute and only after this is the patient allowed to receive the medication in a pharmacy without any additional payment for it.

In any case, only a small proportion of heroin users in treatment is receiving naltrexone.

6. Health Correlates and Consequences

Drug related deaths and mortality of drug users prepared by Jožica Šelb Šemerl

In the year 2004 the activity of key indicator Drug Related Deaths (DRD) group was not as intense as in the previous year when the group was working in Twinning programme in co-operation with Austrian Focal Point. In Slovenia, the major work and responsibility on key indicator DRD, are on the persons working at General Mortality Register (GMR) whose major task is running GMR, coding underlying cause of death and analysing mortality data. Because of recent organisational changes in running GMR the staff work load has enlarged and they could only prepare a report on the base of standard activities and no introduction of new activities was possible.

To get the number of DRD, as real as possible, data on DRD were matched with data DRD from General Police Office (GPO), Institute of Forensic Medicine – Toxicology Department (IFM) and data from the First Treatment Demand Data Base (FTD). As a result of linkages we come up with 32 deaths due to accidental poisoning, intentional poisoning or due to poisoning of undetermined intent and 15 deaths in drug users. According to EMCDA - DRD methodology all together there were 47 deaths in connection with drugs in Slovenia in 2003. We also registered in Slovenia an Austrian citizen died due to heroin overdose.

Direct drug related deaths

In Slovenia in 2003 there were, according to EMCDDA methodology (causes of death with DRD 56 to DRD 147), 32 drug related deaths. 23 of them were men and 9 women. The mean age of men death was 33,3 years, median 29,9 year with minimum age at death at 14,4 years and the maximum at 78,2 (intentional poisoning with other psychotropic substances). The mean age of women death was 36, 5 years, median age at death 33, 1 year, with minimum age at death at 23, 2 years and the maximum at 69, 8 years (also intentional poisoning with tramadol).

There was one death due to F112 and 10 deaths due to accidental poisonings (DRD 88 to DRD 107). Among them 4 were due to methadone, two due to other opioids and one by one to opium, heroin, other and unspecified narcotics and the last other psychotropic. Among 10 suicides (DRD 108-127) there were 3 due to other psychotropic, two by two to heroin and other opioids, and one by one to methadone, benzodiazepine, and unspecified psychotropic drugs. Within 11 poisonings of undetermined intent (DRD 128-147) there were three due methadone, two by two to heroin and other opioids and three to benzodiazepines and one due to psycho stimulants. We also had three ill defined cases for which we are seriously suspicious that they could be due to illicit drugs use.

Within a group of drug related deaths according to value 1 of filter-B variable there were 24 deceased drug victims, 18 of them were men and 7 women. Within men the mean age at death was 26,4 years, median 26,0 years with minimum age at death at 14,4 years and the maximum at 37,9. There were seven women with mean age at death at 35,9 median 33,0 and minimum and maximum age at death at 23,2 and 69,8 respectively (the same women as in the upper group).

Table 6.1. Number of drug related deaths due to drug use (T400-T406) in the 2002 and 2003

Number of drug deaths (T400-T406)	**2002**	**2003**
Opium T400	1	1
Heroin T401	14	5
Other opioids T402	5	6
Methadone T403	6	8
Other synthetic narcotics T404	0	0
Cocaine T405	0	0
Other and unspecified narcotics T406	2	1
Sum	**28**	**21**

Source: NIPH

In the year 2003 we altogether had 23 deaths due to drug use (T400-T406) in contrast to the year 2002 when we recorded 28 deaths due to drug use. There were drastic decrease in heroin deaths and an increase in methadone deaths.

Indirect drug related deaths

After matching data from Forensic toxicology at Institute for Forensic Medicine at Medical Faculty of Ljubljana with GMR and data from Treatment Demand Centres with GMR, 15 deaths among drug users not directly connected to death; 13 men and 2 women, were recorded in the year 2003.

Within the group of indirect drug related deaths the mean age of death for men was 30,6 years, median age at death 26,1 year and minimum and maximum age at death were 16,1 and 64,3 years respectively. Women had 19, 5 and 29, 7 years at the moment of death.

For 12 out of 15 results of toxicological analyses of urine and/or blood were obtained, for three out of 15 we only have got the information that they had been drug users, all three used heroin and one also benzodiazepines and the other cocaine. For 5 out of 12 THC was found in body fluids, methadone, opium and other opioids were two by two found in six persons and heroin in one case.

Concerning underlying causes of death two persons died due to cancer: one due to pulmonary and the other due to post hepatic HCV liver carcinoma. For person who died in Spain we have not got the underlying cause of death.

Among 12 deceased with external cause of death there were 6 suicides, two transport accidents, one person died due to unspecified multiple injuries and the other due to unspecified fall and one due to unspecified explosion. 26 old man in whom unlethal concentration of tramadol was found in body fluid had heart disease with hypertrophy and dilatation of left heart.

Trends

In the year 2003 there were 4 direct drug related deaths less then in previous year but there were more women deceased in 2003 than 2002. In 2003 women also died younger than in 2002, measured by the median age of death, in contrast to men whose median age at death increased. Also the number of illicit drug use (filter B=1) decreased in men but not in women. Median age at death in this group was almost

the same in men in both years while in women also decreased. There was an increasing number in suicides due to overdose; the number of accidental poisonings remained the same while deaths of undetermined intent were less in the 2003 than 2002.

We are still adjusting our methodology to methodology of EMCDDA and there are still some obstacles which have to be clarified. In the year 2002 we did not succeed in matching GMR with data from Toxicological Department of Forensic Medicine, one reason why indirect drug related deaths are increasing this year. We are also not sure if there was any crossing over of particular causes of death between direct and indirect group of drug related deaths in 2003 in comparison to 2002. There short time period we are working within Slovenian Focal Point we think calculating trends is not needed.

Conclusions

In the year 2003 we for the first time managed to record indirect drug related deaths. As we made an additional matching of GMR data for 2003 with data from Forensic Toxicology what we did not perform for data from 2002, we hope the decreasing number of DRD is real.

The number of women deceased due to drug abuse increased from previous year and the median age at death decreased. We also noticed a dramatic fall in DRD due to heroine from 2002 to 2003 and a slight increasing in methadone deaths.

It was not possible to start with drug related mortality cohort study because of lack of human resources.

Drug related infectious diseases prepared by Irena Klavs

HIV

Slovenia has a low level HIV epidemic. The prevalence of HIV infection has not reached 5% in any population group. The rapid spread of the HIV infection seems not to have started yet among injecting drug users and the prevalence of HIV infection among injecting drug users in Slovenia remains low. During the 1999 to 2003 period HIV prevalence consistently remained below 1% among confidentially tested injecting drug users demanding treatment in the CPTDA network (0% in 2003). Similarly, HIV prevalence among injecting drug users demanding treatment for the first time in two of these Centres (Ljubljana and Koper) and consenting to be tested unlinked anonymously for HIV surveillance purposes has been consistently below 1% (0% in 2003). Also, none of the 148 injecting drug users visiting a non-governmental needle-exchange programme in Ljubljana during a two-month period in 2003 and consenting to be tested unlinked anonymously for HIV surveillance purposes was found to be HIV infected.

HBV

In 2003, the prevalence of antibodies against the hepatitis B virus (antiHBc) among confidentially tested injecting drug users demanding treatment in the CPTDA network was 10.4%. During the last 5 years (1999 to 2003) the reported newly diagnosed acute HBV infection incidence rate in the Slovenian population ranged from the highest level of 1.5/100.000 of population in 1999 to the lowest level of 0.8/100.000 of population in 2002. Due to underreporting, reported HBV incidence rates greatly

underestimate the burden of the disease. Information on the transmission route is only available for a minority of cases. Injecting drug use was not implicated in the two cases whose transmission route was known in 2003.

HCV

In 2003, the prevalence of antibodies against the hepatitis C virus (antiHCV) among confidentially tested injecting drug users demanding treatment in the CPTDA network was 22.2%. The prevalence among short-term injecting drug users (less than 2 years) was 0% and among longer-term users 23.5%. Information on the proportion of chronic HCV infections among these individuals is unavailable. During the 1999 to 2003 period the annually reported newly diagnosed acute HCV infection incidence rate in the Slovenian population ranged between the lowest 0.4/100.000 of population in 2002 to the highest of 2.6/100.000 population in 2000. Due to underreporting, reported HCV incidence rates greatly underestimate the burden of the disease. Information on the transmission route is available for a minority of cases. Injecting drug use was implicated in both cases whose transmission route was known in 2003.

Psychiatric co-morbidity (dual diagnosis)

For more information please see chapter 5 Drug Related-Treatment and previous reports.

Other drug related health correlates and consequences

Somatic comorbidity prepared by Dušica Cvitkovič

The Pre-hospital Emergency Unit is one of the units of the Community Health Centre of Ljubljana and is situated on the premises of the Emergency Department of the Clinical Centre of Ljubljana. It is responsible for first-aid services on a 24-hour basis for all kinds of medical emergencies like sudden deteriorations of sickness, accidents or poisonings which can endanger lives. The Pre-hospital Emergency Unit has a twofold function. In co-operation with the First Aid Post of the Clinical Centre it acts as a mobile pre-hospital unit which sends an expert team (a medical doctor and two first aid technicians) to situations where there are patients with life-threatening problems. They set off with a reanimation vehicle which is equipped with complete equipment for resuscitation procedures. This mobile pre-hospital unit operates over the 900 km² territory of the capital city Ljubljana and its surroundings, which has 325.000 inhabitants. The second responsibility of the Pre-hospital Emergency Unit is the orderly provision of all medical services of the Community Health Centre of Ljubljana. It also operates in the Emergency Department of the Clinical Centre every day from Monday to Saturday from 7:00 p.m. to 7:00 a.m., as well as on Sundays and holidays on a 24-hour basis.

Within the scope of emergencies doctors of the Pre-hospital Unit also treat patients who abuse illicit drugs or are drug addicts. The interventions of the medical team in the field related to drug addicts are 90% due to the abuse of opiates. Life-threatening situations happen due to deliberate or unintentional overdose of opiates which cause the depression of the breathing centre and consequently apnea. Only timely medical interventions can save lives. Those patients who need further observation are directed either to the Internal Emergency Department, where there is a hospital unit for 24-hour observation or the Psychiatric Unit for Crisis Situations.

Unfortunately, each year there are still a few cases of death due to an overdose of opiates.

In the first half of 2004 there were 2 cases of death due to this cause. From 1 January 2004 to 30 June 2004 the Pre-hospital Emergency Unit treated 60 drug addicts, which is 0.3% of all patients. 8 out of 60 patients were treated for problems of the abuse of amphetamine, cocaine and other non-opiate drugs, and all the others had problems with opiates.

In 2003 the Pre-hospital Emergency Unit treated 88 drug users (which was 0.2% of all treated patients): 7 patients for amphetamine abuse, 4 due to cocaine abuse, and all the others were due to opiate abuse. 28% of treated drug users received medical aid in the field, 78% sought help in the Pre-hospital Emergency Unit. Interventions in the field were 98% due to opiate overdoses. The visits of patients to the Unit were a consequence of abstinent problems, psychological problems and various infections. Precise statistics about deaths due to drug overdoses in 2003 are not available.

Driving and other accidents prepared by Mercedes Lovrečič, Manca Drobne

According to the available data (Lovrečič, Drobne 2004), driving under the influence of illicit drugs is increasing in Slovenia, it is an important factor enhancing the risk of and reasons for traffic accidents, very frequently a combination of two or more drugs is detected.

The data available in Slovenia (Figure 6.1.) show an increasing trend of tests ordered for alcohol (breath samples) and clinical expert examinations (clinical examinations and blood, urine samples) among drivers (see below). This could indicate the growth of driving under the influence of drugs by Slovenian drivers but, on the other side, the proportion of positive tests examined (alcohol in the range from 29% to 56.8%, and other illicit drugs in the range from 19.8% to 26.5%) could also indicate the efforts and awareness of Slovenian policemen in carrying out adequate procedures and measures (Lovrečič, Drobne 2004).

Procedures on legal measures regarding traffic safety in Slovenia are defined in the Law on Road Traffic Safety (LRTS) which was subject to some changes in July 2004. Special provisions of the LRTS (Articles 131, 132 and 133) on driving under the influence of psychoactive substances (PAS), psychoactive medications and alcohol and different procedures are defined for police enforcement measures and other institutions (forensic laboratories, physicians).

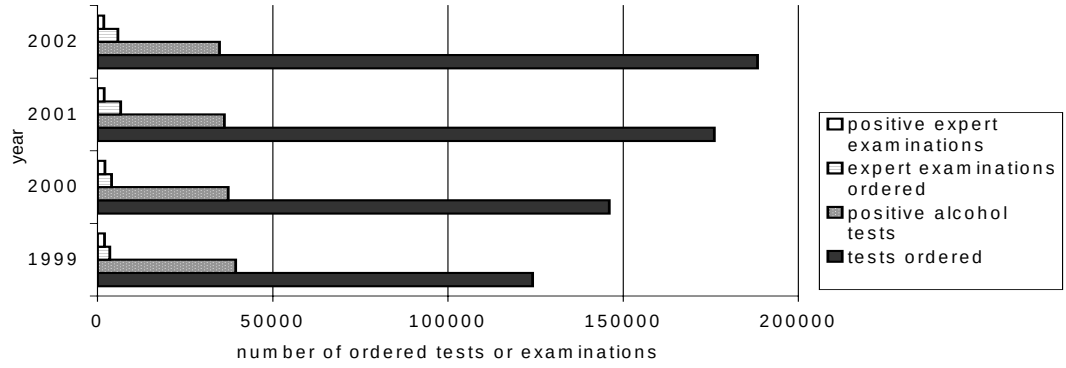

Figure 6.1. Enforcement measures taken by the police when suspecting drunk and drugged driving during traffic surveillance, Slovenia 1999-2002
Source: General Police Office and Ministry of the Interior

According to data on police enforcement measures during traffic surveillance regarding the suspicion of driving under the influence of alcohol or another PAS the trend of the number of tests or expert examinations ordered for PAS, including alcohol, since 1999 shows an extreme rise. In 1999 124.161 alcohol tests were ordered, 31.8% of those were positive for alcohol. In 2000, 146.042 alcohol tests were ordered, 25.5% of those tests were positive for alcohol. In 2001 176.042 alcohol tests were ordered, and 20.6% of these tests were positive for alcohol. In 2002 tests ordered for alcohol rose to 188.326, 18.4% of those were positive for alcohol. It is obvious that, while the number of tests ordered for alcohol is increasing, the proportion in % of positive tests for alcohol is decreasing (see Figure 6.1.).

The number of expert examinations ordered to analyse alcohol in blood rose from 1999 to 2001, while the proportion of expert examinations ordered to be later recognised as positive for alcohol was decreasing in the same period. The number of expert examinations ordered for alcohol in 1999 was 3.532, 56.8% of those were positive for alcohol. In 2000, 3.969 expert examinations for alcohol were ordered, 53.11% of those were positive for alcohol. In 2001, 6.609 expert examinations were ordered, and 29.2% of these were positive for alcohol. In 2002 the number of ordered expert examinations compared to the last year decreased somewhat, the number of examinations was 5.826 while the share of positive examinations for alcohol was 30.4% and was increasing (Figure 6.1.).

For other PAS in 1999 1.451 expert examinations were ordered, 26.5% of these examinations were positive for PAS. In 2000 the number of ordered expert examinations for other PAS rose to 2.175, and 19.8% were positive for PAS, in 2001 3.008 expert examinations were ordered and 21.2% of these tests were positive for PAS. In 2002 the number of expert examinations grew to 3.588, and 14.3% of these tests for PAS were positive, whereas the proportion of positive tests compared to the previous year decreased (data for 21 results of expert examinations are unavailable) (Figure 6.2.) (Lovrečič, Drobne 2004).

The interpretation of the data requires the consideration of different methodological limitations, such as collecting the data and the reports. Data show an increased trend of ordered tests and expert examinations, which could lead to the presumption of an increase in driving under the influence of PAS on Slovenian roads. However, on the other hand, the proportions of positive expert examinations (for alcohol in the range from 29.2% to 56.8%, for other PAS in the range of 19.8% to 26.5%) could also point to the increased efforts of the police to implement measures, and a greater sensitivity for the issue. The primary judgement made by police officers could be appropriate about the suspicion of drunken/drugged driving but it is extremely difficult to define under which PAS or combination of illicit drugs the driver is suffering.

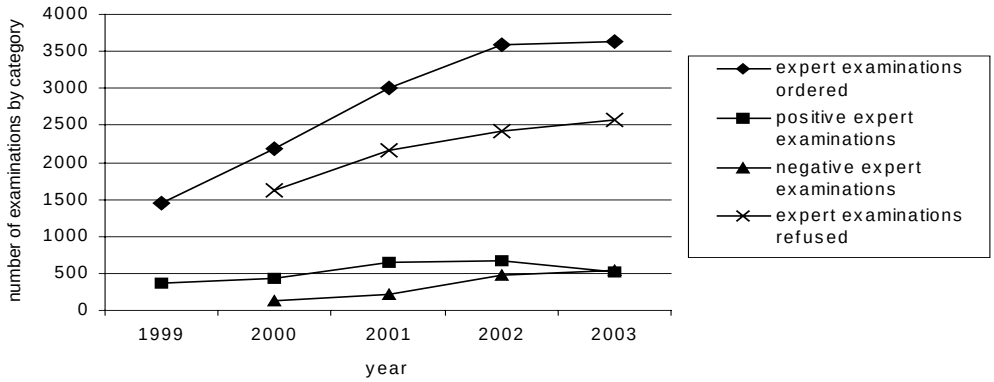

Figure 6.2. Enforcement measures taken by the police during traffic surveillance-number of tests for PAS (excluded alcohol), Slovenia, 1999-2002
Source: General Police Office and Ministry of the Interior

Note*: data not available
Note**: results for 21 expert examinations not available
Note***: results for 9 expert examinations not available

Trends regarding the number of ordered expert examinations due to suspected driving under the influence of PAS (alcohol excluded) is increasing. In 1999 there were 1.451 expert examinations ordered, and 26.05% (378) of them were positive for PAS. In 2000 the number of expert examinations compared to 1999 grew by 49.9%, 19.8% of them were positive for PAS, 5.8% of them were negative for PAS, 74.4% of persons refused to have an expert examination. In 2001 compared to 2000 the number of expert examinations ordered increased by 38.3%, examinations for PAS were positive in 21.2% of these cases, and negative for PAS in 7.1% of them, while 71.7% (2.156) of persons refused to carry out the examination. In 2002, 3.588 expert examinations were ordered, the proportion of positive examinations for PAS was 18.8%, and negative results for PAS were 13.3%, while 67.3% of persons refused the examination and for 21 examinations the result was unknown. Data for 2003 show an increasing trend, the number of examinations increased by 3.642, and 14.3% were positive for PAS (less than in 2002), 14.9% were negative for PAS, and 70.6% of tests were refused, while for 9 examinations the result was not available (Figure 6.2.) (Lovrečič, Drobne 2004).

The National Institute of Forensic Medicine (Karlovšek, Štefanič 2001) in the 1991 to 2000 period analysed 2.337 samples of body fluids of drivers suspected of drugged driving (data for alcohol are excluded). In 1.307 samples (55.9%) the presence of some PAS was recorded. In 35.2% of cases only one drug or a group of drugs were detected, in 12.2% of case there were two drugs, in 8.5% three drugs or more. The trend of positive samples (blood, urine) for cannabis, opioids and benzodiazepine was increasing from 1991 to 2000. In 1999, compared to previous years, there was an increase in positive samples for all groups of drugs: cannabis, cocaine, methadone, benzodiazepine, amphetamines and opioids. On average, 60.8% of all tests were positive for cannabis, 28.6% for opioids, 26.4% for methadone, 17.5% for benzodiazepine. Cannabinoids are detected as the main illicit drug in the case of traffic/road accidents (38.0%), following by benzodiazepines (31.6%), methadone (25.6%), and opioids (24.0%) (Table 6.1.).

Table 6.2. Presence of PAS (excluding alcohol) in driver samples analysed in Slovenia between 1991 and 2000

PAS	**Traffic surveillance (%)**	Road accidents (%)	**Total (N=1307)**
Benzodiazepine	14.2%	31.6%	17.5%
Opiate	19.7%	24.0%	28.6%
Canabinoid	66.2%	38.0%	60.8%
Cocaine	8.7%	5.2%	8.0%
Methadone	26.6%	25.6%	26.4%
Amphetamine	11.5%	8.0%	10.9%
Other	4.0%	18.0%	6.7%

Source: Institute of Forensic Medicine, 2001

The LRTS considers methadone a drug. Drug addicts do not meet the health standards required of drivers. The data on the attitude of drivers who are in methadone maintenance treatment programmes with respect to their driving ability as well as the effects of methadone use in combination with other drugs on driving show us that drivers undergoing a methadone maintenance programme regularly drive not only under the influence of methadone but also under the influence of marijuana (20%) and heroin (18%) and sometimes under the influence of marijuana (58.6%), heroin (55.7%), and alcohol (48.6%). Certain initiatives have been taken by some therapists to give, in certain circumstances, a clean bill of health to responsible

methadone maintenance patients who have an adequate level of responsibility for themselves and their deeds in order to help them obtain a driving licence. Since it has been established that methadone maintenance patients use methadone quite commonly in combination with illicit drugs and/or alcohol, the classification of this type of addict among possible driving candidates remains disputable. Long-term interdisciplinary research is still required to determine the main principles required to assess and possibly admit this type of driver to participate in traffic, as well as to determine which professional therapists can participate and evaluate the driving capabilities of these patients (Bilban, Jakopin 2002).

The results of study about the percentage of road traffic offences (RTO) and road traffic accidents (RTA) involving inebriated drivers one year before and one year after the passing of the LRTS (1998) indicate without any doubt that the LRTS was not successful enough with its repressive and preventative measures for drunk drivers. One year before the passing of the LRTS, there were 40.702 RTAs in the Republic of Slovenia (12.2% caused by drunk drivers). The average alcohol concentration in exhaled air of those analysed was 1.19 g/kg. One year after the passing of LRTS there were 36.479 RTAs (8.6% caused by drunk drivers). The average alcohol concentration in exhaled air of those analysed was 1.32 g/kg (the differences were statistically significant). In 13.8% of cases the reason for performing a measurement of the alcohol concentration in exhaled air was an RTA involving an average alcohol concentration in exhaled air of 1.22 g/kg and in 86.2% of cases an RTO with an average alcohol concentration in exhaled air of 1.25 g/kg (the differences were statistically significant). The number of events involving lower concentrations decreased, but the percentage involving higher alcohol concentrations even increased. Experts on alcohol believe that punishment cannot make alcoholics and other drivers abandon their behavioural patterns and stop driving under the influence of alcohol. This can only be achieved through treatment and the practice (police-misdemeanour counts-repeat general medical check-up) has been ineffective as a form of prevention among alcoholic drivers (Bilban, Jakopin 2000).

7. Responses to health correlates and consequences

Prevention of drug related deaths

Prevention activities are performed by some CPTDAs and NGOs. Some CPTDAs organise small groups of drug users and train them to offer first aid in the case of drug overdoses. Individually, they are informed about the risks and consequences of different drugs.

Prevention and treatment of drug related infectious diseases

The prevention and treatment of drug-related infectious diseases are carried out by CPTDAs: laboratory testing for infectious diseases, vaccination against HBV, treatment of infections (HBV, HBC, HIV/AIDS), counselling, informing and educating.

NGOs provide prevention especially with low-threshold programmes (distribution of needles and other equipment for injecting, distribution of condoms, counselling etc.).

Interventions related to psychiatric co-morbidity prepared by Mojca Zvezdana Dernovšek

A new programme for patients with psychiatric comorbidity was started at the Department of Psychiatry in Maribor Hospital in 2002.

The aim of the new programme was to satisfy the growing demand seen in the hospital.

In the programme there are 6 to 8 patients at the same time, the average length of a stay is longer than for patients who only have one diagnosis. The most frequent diagnoses are schizophrenia or a bipolar mood disorder with addiction (alcohol and illicit drugs). Cognitive behavioural psychotherapy and psycho-education are used and combined with pharmacotherapy (naltrexone).

The personnel is not specially trained. There is research trial going on in the programme. The programme is financed as part of the public health care system and is not organisationally connected to CPTDAs. There is a connection between the local CPTDA and the programme. The catchment area involved covers 350.000 inhabitants.

Other Health consequences reduction activities prepared by Andrej Kastelic, Tatja Kostnapfel Rihtar

The CTDA, the CPTDA network and the NGO the Sound of Reflection Foundation organised different meetings involving international participants as mentioned below:

a. 1st Adriatic Drug Addiction Conference: treatment, harm reduction, rehabilitation; Poreč, May 21-22, 2003 (principal organiser the Sound of Reflection Foundation);
b. 1st Central and South Eastern European Symposium on Addictive Behaviours: substitution treatment, regional networking, Portorož, May 23, 2003;

c. Annually training for doctors and staff working at the Centres for the Prevention and Treatment of Drug Addiction, Ljubljana, November 18-19, 2004;
d. Annually training for staff in prisons (together with the Prison Administration), Maribor, April 2-3, 2004;
e. 2nd Slovenian Conference on Addiction, Ljubljana, June 17-18, 2004;
f. Establishment of the SEEA (South Eastern Adriatic Addiction Network).

8. Social Correlates and Consequences prepared by Marjeta Ferlan Istinič, Lidija Apohal Vučkovič

Drug use is treated in the social assistance system as a behavioural form which may adversely affect the social inclusion of the user or his/her immediate family and close friends. In order to prevent and eliminate social exclusion resulting from or occurring simultaneously with the use of illicit drugs, the ministry provides for the operation of expert services organised within the framework of public services. These are activities that supplement the work of public services and activities enabling the provision of mutual assistance for drug users, their immediate family, close friends and other interested parties. The basic starting points for addressing problems concerning the use of illicit drugs within the social assistance system are defined in the National Programme of Social Assistance and Social Services until 2005 (Official Gazette of the Republic of Slovenia, no. 31/2000). Professional activities aimed at resolving social problems arising from the use of illicit drugs are carried out by public services (62 centres for social work) which provide drug users, their immediate families and close friends with social assistance services, namely first social aid, personal assistance and family assistance for a home. Supplementary social assistance programmes are outside the scope of public services and are mainly implemented by NGOs which provide expert support in addressing drug use and searching for a different way of life.

Social exclusion

The preventive social assistance activities are indirectly geared to the prevention of drug use. Experimenting with drugs and above all the regular use of drugs are indirectly prevented through different activities aimed at improving social inclusion. Social preventive services are performed by centres for social work in co-operation with various NGOs which run programmes for young persons.

Professional activities aimed at resolving social problems connected with the use of illicit drugs are carried out by public services (primarily centres for social work), by providers with concessions for social assistance services on the basis of tenders and by NGOs as supplementary activities. Above all, the public service includes social prevention, first social aid, personal assistance and family assistance for a home. Outside the scope of the public service, there are programmes designed for individuals, families and groups to overcome social hardships and difficulties arising from the use of drugs. These programmes include organised forms of mutual assistance between the users of illicit drugs, their immediate family, close friends and other interested parties.

The providers of social assistance services as a public service are currently public social assistance institutes – centres for social work (a total of 62) which provide drug users and their immediate family and close friends with social assistance services, in particular first social aid, personal assistance and family assistance for a home. Centres for Social Work are, for the purposes of these services, directly financed from the national budget.

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

- services and programmes raising the awareness of as many drug users as possible (first social aid, field work and other low-threshold programmes);

- services and programmes for short-term interventions (personal assistance, family assistance for a home, low-threshold programmes and mutual assistance programmes);
- programmes aimed at permanent abstinence (therapeutic communities, communes, day care programmes);
- services and programmes for reintegration (personal assistance and family assistance for a home, reintegration programmes); and
- forms of self-help and self-organisation of drug users and their immediate families and close friends.

Professional tasks are therefore performed through different forms of work:
– field work according to the principle of harm reduction makes it possible to establish contact with drug users (the key precondition!). The basis for this kind of work is the low-threshold approach. The forms of organisation here include field work and drop-in centres, various residential forms of shelters, the promotion of mutual assistance between drug users and similar;
– first social aid and other social assistance services performed by public services (centres for social work) and other providers. Professional work is focused on recognising personal and social hardship and on finding forms of assistance which can be realised and will enable the social inclusion of individuals, thus encouraging individuals to decide for a change in their drug use;
– different forms of high-threshold programmes declaratory geared to abstinence – reception and drop-in centres, therapeutic communities and communes. Individuals who wish to stop using drugs participate in these programmes;
– "reintegration centres" as a professional form of working with persons of stable abstinence and their immediate families and close friends thereby enabling their concrete social inclusion. Therapeutic care or treatment is followed by the most important component: the social reintegration of former drug users into society. This reintegration means inclusion at all levels and in all fields, and especially in the development of social skills and the promotion of education and employment. It also implies the maximum degree of social participation of former and current drug users. Various programmes have only recently been intensively developed in this area and, according to the expectations, different initiatives will emerge in the coming years. Social reintegration implies the restriction or elimination of social causes leading to drug use, especially social exclusion. In the period between the end of a residential form of treatment and full independence "residential groups for reintegration" must be set up so that suitable professional help is still available. Social reintegration is also important for people released from a prison or correction facility. Social rehabilitation and reintegration of drug users are two areas of work carried out by centres for social work. The expert staff of these centres with suitable additional training must be the key actor in the comprehensive reintegration of former drug users into the community;
– programmes for mutual assistance between drug users, their immediate families, close friends and other interested parties;
– special attention should be paid to a follow-up to activities for preventing the social exclusion of those groups of drug users that participate in activities from other fields – e.g. methadone maintenance programmes, drug users in prisons etc. These activities require full co-operation between experts of various professions, and various providers in various systems.

In 2003, 922 persons (the situation as at 31 December 2003) whose primary problem was connected with the use of illicit drugs and 410 minors (the situation as at 31 December 2003) with such problems were treated in public institutions (there are 62 Centres for Social Work in Slovenia).

In 2003, EUR 1,137,564 was spent on social rehabilitation (56 programmes). In 2004, the 14th public invitation to tender was issued in which EUR 1,380,753 was earmarked for social rehabilitation. All funds are earmarked exclusively for the implementation of different programmes (for labour costs or material costs but only if these are essential for the operation of a programme). Programmes co-financed by the Ministry of Labour, Family and Social Affairs within the framework of social rehabilitation also include programmes targeting people who participate in programmes concerning social hardships connected with alcohol abuse and eating disorders. The majority of funds are earmarked for programmes addressing the social hardship arising from the use of illicit drugs.

Around 700 drug users are currently participating in NGOs' programmes which are co-financed under contract for several years and aimed at stabile abstinence. An additional 700 parents are participating in programmes requiring active parent participation. Low-threshold programmes cover 1.400 drug users and around 500 family members. One of the programmes addressing dance drugs is carried out at rave events and therefore is exposed to several thousand young persons annually. This programme also attracts tens of thousands of visitors to its web page: www.DrogArt.org. Individual programmes are designed for informing and providing assistance over the telephone. No provider solely provides this kind of assistance to drug users, their immediate family and close friends.

Homelessness

Recently, the Ministry of Labour, Family and Social Affairs recorded an increase in the number of homeless drug users. Therefore, already in 2003 the Ministry supported a programme to provide shelter for homeless users of drugs in Ljubljana within the network of low-threshold programmes. This shelter is also operating in 2004 and has around 15 drug users. In the coming two years we plan to open such shelters in Maribor, Celje, Nova Gorica and Koper.

Unemployment

On the basis of the available data we concluded that a great number of regular drug users are unemployed. If they satisfy the conditions prescribed by the Social Security Act they are entitled to benefits in cash.

School drop-outs

The system of social assistance does not include data allowing us to estimate the correlations between drug use and accommodation, unemployment, school drop-outs and other problems.

Financial problems

Programmes within regular activities are financed as regular activities of the centres for social work. Programmes within supplementary social assistance programmes are co-financed by the Ministry of Labour, Family and Social Affairs, but only up to 80% of the total programme's cost. The remaining funds must be provided by those carrying out the programme. The funds are particularly earmarked for employment expenses and material costs when urgently needed for operating a programme. Those carrying out the programmes find it very difficult to agree on co-financing with local communities.

Social network etc.

Since we are aware that drug users have “unspecific” needs and since we are searching for a suitable professional response to these “unspecific” needs, the social assistance system supports very diverse programmes: ranging from the services of public institutions (centres for social work), programmes of NGOs, low-threshold approaches in the field, extremely structured therapeutic communities, to the methods of direct personal contact with drug users and self-help groups, and the use of electronic media to establish such contacts.

Programme of the Fight against Poverty and Social Exclusion prepared by Ines Kvaternik Jenko

Since February 2000 when the Government of the Republic of Slovenia adopted the *Programme of the Fight against Poverty and Social Exclusion,* several measures for combating poverty and social exclusion have been accepted. After two years of running the programme, the Government of the Republic of Slovenia finds that the majority of measures have been implemented in accordance with the outlined orientations and mutually co-ordinated in such a way as to follow the common objectives of reducing poverty and social exclusion. The preparation of the Joint Inclusion Memorandum (JIM) signifies the further implementation of this policy and its direct linkage to the EU policy on social inclusion. In 2003 the Slovenian government signed the *Joint Memorandum on Social Inclusion (JIM)* with the European Commission, indicating both the more enhanced fulfilment of this policy and its direct link to the social inclusion policy at the EU level.

In June 2004 the government of the Republic of Slovenia adopted the *National Action Plan on Social Inclusion (NAP/Inclusion) (2004-2006)* according to which one example of good practice is the Dispensary for persons without health insurance in the City of Ljubljana. It began operating in 2002. According to the report mentioned above, in 2003 the Dispensary was attended by a total of 8.101 persons, or 103% more patients compared to 2002 when there were 3.988 visits. The Dispensary is most often visited by persons with serious chronic illnesses, pregnant women, persons with chronic hypertension, circulatory problems and cancer. We can assume that, within the category of chronic illnesses, there are also illicit drug users.

According to the research on *Social and Economic Inclusion of Deprived Groups – Possible Measures to Increase the Employability of the Most Vulnerable Categories of Long-term Unemployed and Inactive People* it is a prevailing belief in society that they became homeless due to different addictions. An addiction is not necessarily the primary cause of homelessness but there seems to be a connection between the two phenomena. Professionals at the Centres of Social Work noted that almost all homeless persons who were interviewed also had addiction problems, even though the interviewees did not perceive themselves as such. The professionals indicated alcohol abuse problems, except for one interviewed person indicated as an illicit drug abuser (Trbanc et al., 2003).

On average, about 400 homeless persons are treated every year by Slovenian Centres of Social Work. The number seems to have been constant in the last few years. However, in two Centres – Maribor and Murska Sobota – the number is increasing. Professionals from the Centres of Social Work suspect there are also many persons who do not seek help and simply sleep outdoors.

Among all drug users treated in the CPTDA network, 1% of them were homeless in 2003 (28 of 2.860). According to FTD data, among 504 drug users in 2003 1.2% (6) were homeless.

Among drug users treated in the CPTDA network 51.7% (1.479 of 2.860) were unemployed or currently not working. According to FTD data, among 504 drug users in 2003 43.5% (219) were unemployed.

According to the research *Social and Economic Inclusion of Deprived Groups – Possible Measures to Increase the Employability of the Most Vulnerable Categories of Long-term Unemployed and Inactive People* (Trbanc et al., 2003), the most addicted persons are unemployed; some perform occasional jobs (jobs that do not contribute to one's working years as they are not duly recorded in the work book and for which no social or pension contributions are paid) or work on the black market. Those who were once employed have or had good relations with their co-workers and note as good work experience the fact that work increases their vocational or professional knowledge or skills. On the other hand, they pointed out several basic job experiences connected with insufficient payment for their work (in some cases they were not paid, payment was low or irregular); unsuitable work schedules (different work hours each day due to the employer's needs, night work); besides this, they felt they had no rights (Trbanc et al., 2003).

Professionals from the Centres of Social Work, counsellors from the Employment Offices, representatives of NGOs and most respondents with drug addiction problems who participated in the research mentioned above agree that most persons with drug addiction problems are in fact unemployed; those who work usually do not hold regular employment but occasional jobs or jobs on the black market without the guaranteed rights deriving from legal work contracts.

Among drug users treated in the CPTDA network 51.7% were unemployed or currently not working.

Main results of new research projects and studies prepared by Vera Grebenc

The Faculty for Social Work in Ljubljana is permanently involved in researching into the field of drug use and supporting the development of those organisations that provide low-threshold services for drug users. The main activities are research, training, consultancy, local community actions, public meetings etc. The most important work has been done in the last few years, carrying out activities that enable co-operation among researchers, practitioners and drug users.

The Faculty has established strong and continuing work in the field of drug use and harm reduction. Much of this work is done as part of regular education (lectures, workshops), practical work for students (e.g. each year students volunteer to work in organisations that work in the field of drug use) and individual research work (e.g. students carrying out rapid assessments of drug use in the local community).

The year 2003/2004 was also important as it saw the beginning of a postgraduate specialist study called Drug-related Harm Reduction. The programme of study includes the bases of harm reduction, approaches to harm reduction and methods of harm reduction, methodology, practical work and individual study.

The Faculty for Social Work is also regularly involved in the development of new and innovative approaches in the field of drug use. Through past work (training, research) a lot of contacts and networks have been created, including co-operation with

different state and non-governmental bodies, associations and individuals. It is important that, at the same time, the place is also open to non-formal and civil initiatives (e.g. self-organising of drug users). The example of this co-operation is training for workers at the shelter for homeless drug users in Ljubljana.

Training for workers at the shelter for homeless drug users in Ljubljana

In summer 2003 the first shelter for homeless dug users opened in Slovenia. The shelter was established by the association Areal (initially involving the self-organisation of drug users) and is located in the city of Ljubljana. Data collected by Areal showed that homelessness is a big problem in Ljubljana, by their estimates it involves in Ljubljana between 70 to 90 homeless drug users. At the beginning they offered 11 beds but they soon realised this was not enough. They worked on the principles of harm reduction, provided a place to stay during the night, needle exchanges, information, consultancy and support for individual drug users in settling specific problems.

The shelter's opening was accompanied by training for workers and volunteers organised by the Faculty for Social Work in co-operation with the association Areal and financed by the British Embassy in Ljubljana. Participants were workers at the shelter and students of social work who were co-operating with Areal as volunteers. The programme was well accepted and was important, on one hand, for giving the opportunity to listeners to gain knowledge and, on the other hand, for providing a situation in which to create networks and important contacts with different institutions and individuals working in the field of drug use in Ljubljana and who were invited to presentations.

The programme included lectures and workshops covering a variety of issues and topics:

- the principles and concepts of harm reduction;
- the safe use of drugs and safe sex;
- a rapid assessment of homelessness among drug users;
- outreach work methods;
- the legal and human rights of drug users;
- the health and social harm of drug use; and
- first aid in the case of an overdose.

Drug related Crime prepared by Rajko Kozmelj, Ljubo Pirkovič

Illicit drugs are a general social problem requiring a complex and comprehensive approach. They generate other safety-related phenomena as reflected in the fields of traditional crime, traffic safety, public order and peace and several others. The crime detected relative to the problems of illicit drugs is mainly reflected in the activities of the police and other law enforcement bodies.

Problems in the field of illicit drugs in Slovenia are increasing. This can be concluded on the basis of several analyses and surveys as well as the data available to the police. This situation results from the increased demand for illicit drugs as well as the increased supply of illicit drugs in the Slovenian market. One fact that should be taken into account is that so-called designer drugs are becoming more and more prevalent, and are particularly used by younger users of illicit drugs.

Organisation of the police as a law enforcement body and co-operation with other authorities

Drug enforcement in the Republic of Slovenia is primarily the responsibility of the General Police Directorate (GPD), which is part of the Ministry of the Interior. The Slovenian Customs Administration (CA) is responsible for drug issues at airports and border crossings.

In relation to drugs, the GPD operates at three levels – national, regional and local. The Criminal Investigation Directorate (CID), forming part of the GPD, has seven sections, one of them being the Organised Crime Section. Within this section, there is a Drugs Division (National Drug Unit). It is the highest authority responsible for carrying out drug-related police activities. The core function of this unit at the national level is to co-ordinate the work of regional units, particularly with respect to international drug trafficking and organised crime operations, and to work closely with other authorities and law enforcement agencies in other countries.

At the national level within the CID there is also a Special Tasks Section, which supplies surveillance capabilities, undercover officers and other operational assistance.

The country has eleven – regional – Police Directorates (PD), and within these there are eleven drug units with 40 operative agents – specialists and some operative agents who also have to carry out other tasks concerning the investigation of organised crime. Although they are situated in Organised Crime Divisions at PD, they are professionally directly responsible to the National Drug Unit. Regional drug units are responsible within their areas for investigating drug-related crimes and their perpetrators, and providing information on drug trends and major drug trafficking. In the framework of local border co-operation based on bilateral agreements, these units can make direct contacts with foreign law enforcement authorities at the border area of a neighbouring country.

At the local level, drug-related activity is part of a broader function performed by officers within local crime units, which are part of police stations, currently numbering 98. Local crime units together with uniformed officers (constables) investigate lower-level drug offences and misdemeanours, and provide a two-way flow of drug-related information with the regional drug unit.

Between the police and the CA there is an interministerial Commission for preventing trafficking in illicit drugs, which consists of representatives of the criminal police and customs as well as an appointed representative of the uniformed police.

The Commission's tasks of preventing trafficking in illicit drugs are:

- harmonisation of activities between the GPD and the CA in the field of preventing trafficking in illicit drugs;
- harmonisation of international projects for the prevention of illicit drug supply and implementation of those projects;
- harmonisation of educational programmes and training activities with a view to improving the operational skills of services preventing trafficking in illicit drugs;
- supplying operative-technical equipment for services;
- providing co-operation with international institutions and the services of other countries involved in preventing international trafficking in illicit drugs; and

- co-operating with the services and working bodies of the government of the Republic of Slovenia competent in the field of drugs, and other ministries.

An important occasion was the signing of the Agreement on Co-operation of the Police and the CA (20 February 2003), which formalised co-operation between the institutions that was already very good.

Obviously the police does not have the right to assess legislation but has to comply with it. The police is obliged to comply with the existing legislation regarding its basic function as it does not have an alternative or discretion. As a body within the Ministry of the Interior, the Police is committed to co-operate in the preparation of new legislation. On the other hand, ever more Slovenians take part in transporting and smuggling illicit drugs which reflects unfavourably on all citizens. Slovenian passports allow the easy crossing of almost all national borders, and certain of our inventive and greedy individuals exploit this.

At the same time, we are facing another problem – Slovenian citizens do not suitably protect their documents and consequently thefts of personal documents are not very difficult, which are then falsified and given to foreigners who commit different criminal offences abroad. The carrying and transport of illicit drugs is relatively common. Slovenian citizens sometimes even sell their passports and other documents to get money, including for the purchase of illicit drugs.

Customs Administration of the Republic of Slovenia and co-operation with other authorities prepared by Darko Žigon

In the Republic of Slovenia drug law enforcement lies within the competence of the police (criminal investigation police and general uniformed police) within the Ministry of the Interior, and the Customs service within the Ministry of Finance.

The division of competencies is such that the criminal investigation police are responsible for the investigation of criminal offences in connection with drugs and the implementation of special methods and measures (the use of informants, undercover operations, controlled deliveries, etc.) as well as co-operation with foreign law enforcement agencies.

The CA is responsible for the prevention of smuggling at the border-crossings and inland, which is co-ordinated through the customs branches or operative groups.

Another very useful approach to this problem is the use of mobile units, which the operative sector of the CA has allocated to border crossings depending on needs and current trends. The entire operative work of customs as regards preventing smuggling into Slovenia is co-ordinated by the Investigation Division of the General Customs Directorate (GCD). It is the highest authority responsible for the implementation of drug-related customs activities. The key function of this division at the national level is to co-ordinate the work of regional units particularly with respect to international drug trafficking and to work closely with other authorities and law enforcement agencies in other countries. Within this division there are three sections for inspection, anti-smuggling and intelligence.

At the moment, we have eleven operative anti-smuggling mobile units which are located at the regional Customs Houses. Our country has ten regional Customs Houses. Each mobile unit is composed of four customs officers and a dog handler. They are professionally and directly responsible to the Investigation Division. Mobile units are equipped with up-to-date technical equipment for examining vehicles and goods.

Within the entire territory of the Republic of Slovenia they can execute stops, examine and search any means of transport; they have the right to examine personal documents; persons who could provide useful information may be invited to the office; they have the right to seize and detain any commercial document, contract, record or any other document required; and they have the right to enter business premises.

In the framework of local border co-operation based on bilateral agreements, these units can make direct contacts with foreign law enforcement authorities at the border area of a neighbouring country.

An important occasion was the signing of the Agreement on Co-operation of the Police and the CA and in the field of dog-breeding, which formalised co-operation between the institutions that was already very good.

The co-ordination of the whole area of reducing the supply of drugs in the sense of law enforcement is carried out through the Commission for the Prevention of Illicit Drug Trade consisting of senior representatives of customs, uniformed and criminal investigation police.

Other characteristics of illicit drugs related crime in Slovenia prepared by Ljubo Pirkovič, Rajko Kozmelj

It is typical and characteristic of criminal illicit drug-related offences that they involve covered, that is crime detected by the law enforcement authority - police on the basis of its own initiative and work. The relationships between the actors are specific as they depend on each other, there is no reporting or information and there are almost no cases where an individual involved in a criminal offence reports it. Such cases do exist, but they are extremely rare.

It is estimated that internal affairs authorities detect only about 10% of such crimes, whereas about 90% remain undetected.

Police work in the field of detecting and investigating illicit drug-related crime is characterised by the fact that the victim does not want to be identified as such. The relationships between the drug addict and the dealer are specific as none of them is interested in reporting the other. This makes police work much more difficult.

The number of detected illicit drug-related criminal offences has increased in the last 11 years by more than seven times (from 281 in 1993 to 1.534 in 2002, but then decreased in 2003). Data on the number of detected suspects show the same trend. In addition, the number of detected offences with respect to illicit drug possession rose dramatically (from 365 in 1993 to 3.744 in 2003).

On average, detected criminal offences in the area of illicit drugs grow by 10% to 25% per year, with the exception of 2003. The number of detected violations of illicit possession is increasing by around 25% per year, again with the exception of 2003.

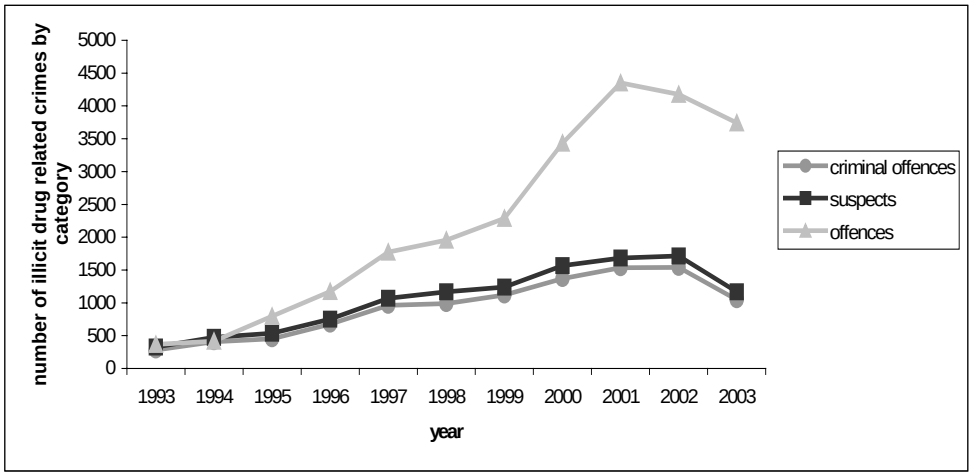

Figure 8.1. Number of illicit drug related criminal offences, suspects and offences, 1993-2003, Slovenia
Source: Ministry of the Interior, 2004

The Penal Code of the Republic of Slovenia (PC RS) defines two criminal offences as follows: the manufacture and trafficking of illicit drugs (Article 196) and facilitating the consumption of illicit drugs (Article 197).

In addition to criminal offences, the Manufacture and Trafficking of Drugs Act prescribes the criminality of the possession of illicit drugs. It separately defines the possession of an illicit drug, possession of a small quantity for one-off use, and the possession of a small quantity for one-off use by a person who decides on medical treatment or treatment in health or social programmes.

Consumption itself is not defined as criminal conduct unless the person involved operates a motor vehicle. The mentioned provision is defined in the LRTS. The manufacture and trafficking of illicit drugs is covered by the PC RS in Article 196 where in the first paragraph it alternatively defines the forms of this offence, which are as follows:

- illicit manufacture;
- processing;
- offering for sale;
- purchase in order to sell;
- storage in order to sell;
- carrying in order to sell;
- intermediation in a sale or purchase; and
- any other illicit putting into circulation of substances or preparations proclaimed as illicit drugs.

All offences are directed against the same protected object, namely human health, and it is common to all of them that they are committed in an unauthorised way, the object of offence is the same and they are committed intentionally.

In Article 196 of the PC RS the purchase of drugs for own use and consumption is not considered a criminal offence. In practice, this means that in each case it has to be assessed whether it was a purchase for one's own use or a purchase for resale.

Any illicit putting into circulation is also considered a criminal offence. According to some persons this could include the exchange of drugs or other goods (exchange of goods), giving illicit drugs to another person to be used where this other person will later return the same quantity and type of drug, as well as the extremely common offering of a certain amount of illicit drugs for free in order to attract certain buyers etc.

It is very important that the offender is aware that it is a substance or preparation which has been proclaimed as a narcotic drug. The offender must know and be aware that it is an illicit drug – a narcotic drug – and which one it is.

The qualified cases referred to in the second paragraph, define or criminalise the following cases:

- where an offence is committed by several persons who joined together in order to commit such offences; and
- where the perpetrator organises a network of dealers and agents.

It is also clear that organising a network of dealers or agents means a qualificatory circumstance referring only to the organisers, and not to those participating in such a network.
The third paragraph defines the illicit manufacture, acquiring and possession of equipment, materials and precursors. However, some problems are arising in practice. It should be known whether these will be used for the manufacture of illicit drugs.

The offence of facilitating the consumption of illicit drugs (Article 197 of the PC RS) is committed by:

- someone who encourages another person to consume illicit drugs;
- someone who gives another person a narcotic drug for later consumption;
- someone who makes premises available for the consumption of illicit drugs; or
- someone who makes it possible in any other way for another person to consume a narcotic drug.

Encouraging the consumption of drugs encompasses all acts of a perpetrator that are aimed at motivating the other person to decide to take the drug. In this case, giving another person narcotic drugs which are free of charge and not done with the intention of putting them into circulation would imply a criminal offence under Article 196 of the PC RS. Premises which are made available by a perpetrator may be a house or any other enclosed premises used by the perpetrator. Making premises available for the consumption of drugs must be done for the purpose of facilitating the other person to consume drugs. The offence is completed by making the premises available and it is not necessary that the place was actually used for the consumption of drugs.

a) **Manufacture and trafficking of illicit drugs, Article 196 of the Penal Code of the Republic of Slovenia**

Table 8.1. Manufacture and trafficking of illicit drugs, 2003, Slovenia

Crime definitions	931*	1031**	Share in %
Sale of illicit drugs		535	51.9
Manufacture of illicit drugs		152	14.7
Transfer of illicit drugs		76	7.4
Purchase of illicit drugs in order to sell them		80	7.8
Storage of illicit drugs		109	10.6
Intermediation in purchasing or selling		47	4.6
Offering illicit drugs for sale		13	1.3
Groups of more persons		11	1.1
Possession of substances for manufacture of illicit drugs		0	0.0
Possession of equipment for manufacture of illicit drugs		0	0.0
Processing illicit drugs		6	0.6
Organising a network of dealers		2	0.2

Source: Ministry of the Interior, 2004

Notes:
*number of all drug related criminal offences
**number of repetitions (in each committed criminal offence which can be performed in different ways, several persons committing a crime can be involved)

b) Facilitating consumption of illicit drugs, Article 197 of the Penal Code of the Republic of Slovenia

Table 8.2. Facilitating the consumption of illicit drugs, 2003, Slovenia

Crime definitions	280*	347**	Share in %
Offering illicit drugs for consumption		243	70.0
Offering premises for consumption of illicit drugs		42	12.1
to a minor		33	9.5
to several persons		16	4.6
Encouraging consumption		13	3.7

Source: Ministry of the Interior, 2004

Notes:
*number of all drug related criminal offences
**number of repetitions (in each committed criminal offence which can be performed in different ways, several persons committing a crime can be involved)

Tables 8.1. and 8.2. show the highest percentage of committed criminal offences of manufacture and trafficking of illicit drugs for sale, followed by the manufacture (manufacture of cannabis), storage and transfer of illicit drugs. The abovementioned

forms of manufacture and trafficking of illicit drugs as well as facilitating the consumption of illicit drugs and their shares have remained at approximately the same levels in the last five years.

Other Drug related Crime prepared by Ljubo Pirkovič, Rajko Kozmelj

The use of illicit drugs is necessarily accompanied by the supply of illicit drugs. It is an illegal activity defined as criminal on the basis of international UN conventions that have been ratified by the Republic of Slovenia. On the other hand, we face the consequences of the use or abuse of illicit drugs.

On the basis of the above, delinquency related to illicit drugs can be divided into these three main categories:

1) primary crime in the field of drugs, which includes all types of criminal offences defined in the Articles 196 and 197 of the PC RS;
2) supplying crime with direct offences, which includes the purchase and possession of illicit drugs, breaking into dispensing pharmacies and falsification of prescriptions, and indirect offences which include thefts, break-ins, robberies, fraud, the sale of drugs for money in order to obtain money for one's own subsequent purchase and use etc.; and
3) consequential delinquency such as street violence, association in gangs, prostitution, begging and similar.

Like elsewhere in Europe, in Slovenia the interdependence of the problems of illicit drugs in the primary sense and crime or safety conditions in other fields has been established, particularly offences against property which are the most common criminal offences recorded. It is impossible to give accurate data for the whole country but we can refer to a pilot survey conducted in 1999 in the area of the Maribor Police Directorate where criminal offences dealt with in the area of two police stations were analysed, which annually deal with about 65% of property crimes in the area of the Maribor Police Directorate. The Police Directorate annually deals with about 13% of criminal offences against property in the Republic of Slovenia. The survey reveals that about 70% of the investigated criminal offences against property were committed due to the supply crime, and about 90% of serious crime against property (break-ins, bold thefts, robberies, violent thefts and blackmail) the suspects of which are the users of illicit drugs.

On the basis of some other sources it can be confirmed that about 50% of all criminal offences against property in the Republic of Slovenia are committed by the users of illicit drugs. Such data is comparable with the findings of surveys in Germany and Great Britain, where more than 60% of break-ins and thefts are related to illicit drugs. On the basis of the above and many other figures, it can be confirmed that the users of illicit drugs have a decisive effect on the trend of mass crime against property, which is the crime that Slovenian citizens feel most threatened by as it usually affects their personal property.

Drug use in prison prepared by Olga Uršič Perhavc, Dušan Valentinčič, Manca Drobne

PA which is a constituent body of the Ministry of Justice of the Republic of Slovenia, among other tasks under the PPUDD provides data and available information on illicit drug use in prisons in Slovenia for the Slovenian NFP. The PA published its 2003 annual report which also contains basic information on drug use in prisons in

Slovenia. The department dealing with drugs at the PA collaborates with other institutions (the Ministry of Health and OD at the mentioned ministry, the CPTDA network, psychiatric hospitals, NIPH-project on health education, evidence on drug users and vaccination against HBV, other clinics or regional hospitals, NGOs).

Among those persons who have problems with drugs, the PA includes long-time drug users and persons who periodically use drugs. There are also persons who started experimenting with drugs in prison. The prison system obtains information about persons who are dependent on drugs or who periodically use drugs on the basis of the documentation accompanying the person on their path to prison (e.g. court rulings, compulsory treatment measures imposed on a drug addict, report from Social Work Centres etc.), but generally at the beginning of their sentence the drug addict himself discloses his problem because he/she is concerned about a withdrawal crisis or because he/she is on methadone therapy.

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

Figure 8.2. shows prisoners in Slovenia with drug-related problems in % in the 1995 to 2003 period. The total prison population grew from 1996 to 2000, but dropped from 2000 to 2003. At the same time, the number of persons with drug problems in prison is constantly increasing (also see Figure 8.3).

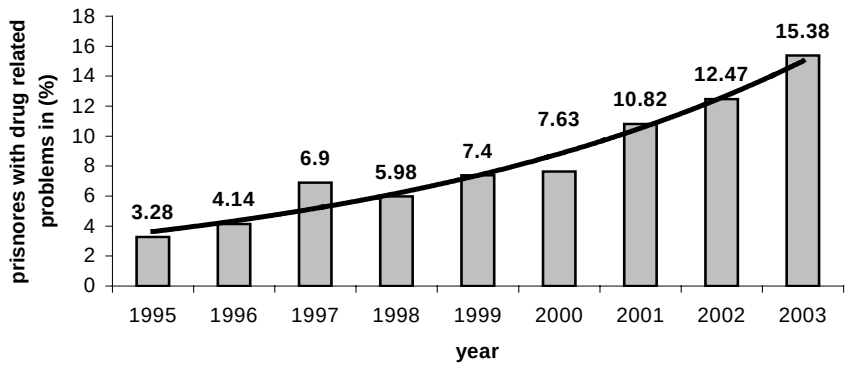

Figure 8.2. Proportion of prisoners (in %) with illicit drug related problems compared to total prison population, Slovenia, 1995-2003.
Source: Prison Administration of the Republic of Slovenia, 2004

The number of those who are evidenced in a current year as problematic drug users in prison are persons who are imprisoned on the first day in a month of the year (imprisoned persons from the previous year) and the number of problematic drug users among prisoners from the current year. Data show relatively a high number of persons who have illicit drug-related problems and are staying in prison for a longer period of time, including new prisoners from the current year who also have drug-related problems. We assume that the increasing trend among prisoners with drug-related problems is influenced by their long prison sentences and the increased use of illicit drugs in the general population. Figure 8.3. compares drug-related problems and alcohol-related problems in the prison population, noting that the proportions for alcohol-related problems were higher up until 2002 but decreased in 2003, while illicit drug-related problems are constantly on the increase.

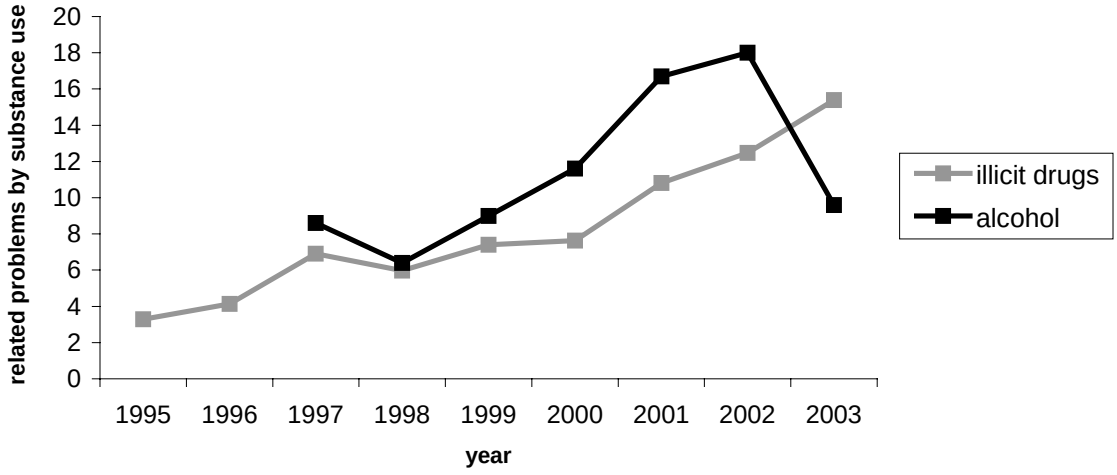

Figure 8.3. Persons with alcohol and illicit drug problems in prisons (in %), Slovenia, 1995-2003
Source: Prison Administration of the Republic of Slovenia, 2004
Note: data not available for alcohol related problems in 1995 and 1996

This decreasing trend of persons who have alcohol-related problems (Figure 8.3.) could be due to fact that in 2002 there were also fewer imprisoned persons than in the previous year and the number of new prisoners noticeably decreased. Regarding the new Misdemeanours Act (Law on Offences) which will start operation in 2005 and will do away with related imprisonment by 2005, the effects were already noticeable in 2002 (more than 1.000 persons less were treated according to the Misdemeanours Act). In previous years persons treated by the Misdemeanours Act strongly raised the level of alcohol-related problems, i.e. in this category there were many prisoners with alcohol-related problems.

Drug-dependent prisoners are treated in accordance with the Strategy for dealing with prisoners with drug problems in the framework of the PA. The Strategy includes the fight against drugs at the levels of preventing drugs from being brought into prisons and giving assistance to prisoners who want to give up drugs and change their lifestyles. The latter includes low-threshold, higher-threshold and high-threshold programmes of assistance. The Strategy is implemented in co-operation with other services (the Ministry of Health, the CPTDA network, the hospital for infectious diseases and its regional units, the central hospital for pulmonary diseases and its regional dispensaries, NGOs).

The legal basis for carrying out the Strategy is the Enforcement of Penal Sentences Act and its supporting executive regulations, the PPUDD and the Health Care and Health Insurance Act of the Republic of Slovenia (for more information on the implementing strategy, see Chapter 9 below, Responses to Social Correlates and Consequences).

The pilot project “Drug Users Treatment Evidence” in co-operation with the NIPH which was carried out in prisons by health workers, medical doctors and other professionals in prisons was finished in February 2003. Prisoners participated voluntarily and the anonymity of data was assured. The data were processed by the IUID. 63 questionnaires were completed by five prisons and one correctional home in 2003 (Vegnuti, Belec 2004).

The research into risk behaviour in prisons was performed by a Slovenian NGO and the OD. On the request of the Central and European Network of Drug Services in Prison (CEENDSP), in September 2003 a researcher from the Cranstoun NGO from England finished a comparative study on substitution treatment in Slovenia, Poland and the Czech Republic. The results have not yet been presented.

Social costs

There are no data available on the social and economic costs of drug use at the national level.

9. Responses to Social correlates and consequences prepared by Marjeta Ferlan Istinič, Lidija Apohal Vučkovič

Social Reintegration

The social assistance system comprises activities geared to enhanced social inclusion. The implementation of programmes addressing drug use is suitably adjusted with this end in mind. All high-threshold programmes carried out in Slovenia include elements of reintegration, which means that the programme is partly aimed at detecting ways of participating and encouraging participation in daily activities. Some providers have designed a special part of programmes aimed at reintegrating and targeting those users who have previously taken part in their programmes for stable abstinence. There is no special reintegration programme that is accessible to everyone, irrespective of prior treatment.

The social assistance services provided by the centres for social work to individuals, families and groups in social hardship or difficulties represent an important part of the social reintegration process.

The existing programmes also include programmes which provide accommodation after intensive treatment has been completed. Such a programme is implemented by Društvo Up (the Hope Society) which has a residential facility. Additional facilities are planned for the future.

The existing programmes include a network of programmes covering, among other things, the education and training of persons taking part in social reintegration. There is still no programme specifically dedicated to education and training.

There is no special employment programme for persons involved in the process of social rehabilitation. However, drug users may participate in active employment policy programmes.

Social and economic inclusion of deprived groups prepared by Ines Kvaternik Jenko

The research entitled *Social and Economic Inclusion of Deprived Groups – Possible Measures to Increase the Employability of the Most Vulnerable Categories of Long-term Unemployed and Inactive People* (Trbanc et al., 2003) shows that in Slovenia there are no special employment measures or employment programmes for (ex-)drug addicts. All persons with drug addiction problems can take advantage of the counselling available at the Centres of Social Work and Employment Offices. They are usually treated as difficult-to-employ persons, although they are registered as drug addicts. In reality, counsellors in Employment Offices only know of the drug addiction problems of an unemployed person if they talk about the problem as long as possible while avoiding stigmatisation. According to the research mentioned above, serious drug addicts have a chance to take part in measures to address their main problem, namely addiction, i.e. healing and rehabilitation programmes. Serious drug addicts who still have to decide on treatment are offered participation in motivation programmes. Those wanting to resolve their addiction problems can enrol in the programmes of an NGO. Whilst they are involved in healing programmes they are deleted from the register of unemployed persons (since they are not active job-seekers) (Trbanc et al., 2003).

All employment measures are only available for those individuals who have managed to resolve their core addiction problem. In the Koper area, drug addicts who have started to resolve their problems can join the workshop »My Future – My Responsibility« intended for difficult-to-employ persons. In the Celje area, the »Skala PUM« education programme is very successful (Trbanc et al., 2003).

Currently, there are no specific employment measures intended only for (former) drug addicts, although such programmes did exist a few years ago. They were prepared with the co-operation of the National Employment Office, health services and the Ministry of Interior but were halted due to insufficient financial resources that were only available from the National Employment Office. One of such programmes was the »Žarek (Ray)« programme carried out in the Murska Sobota area. It was intended for unemployed former drug addicts who had completed their treatment in therapeutic communities and those unemployed drug addicts who were simultaneously enrolled in a regular methadone programme.

Prevention of drug related Crime

Strategy for dealing with prisoners with drug problems and assistance to them
prepared by Olga Uršič Perhavc, Dušan Valentinčič

The treatment phases relate to the status of a prisoner, from admission at the beginning of their prison sentence or admission on remand to the serving of the sentence and preparation for release. The goals of treating prisoners with drug problems are specific and realistically attainable. They include abstinence, preventing a return to drug use (learning to recognise risk situations), learning to resolve difficulties and conflicts.

Table 9.1. Status of prisoners, treatment phases and assistance to prisoners with drug - related problems

Status of prisoner	**Treatment phase**	**Field of intervention**	**Activities**
Admission period(on remand or at the start of a prison sentence)	Low – threshold programmes of help	Abstinence oriented programmes Harm Reduction Measures Substitution Treatment	Detoxification with medicine or methadone Blood screening Vaccination against hepatitis B Provisions of disinfectants Provision of condoms and latex gloves Informing prisoners and staff about infectious diseases, risk behaviour and ways of transmitting diseases Methadone therapy
During the Serving of the sentence	Higher – threshold programmes	Education programmes Motivation programmes	Therapeutic groups and work with individuals

	High – threshold programmes	Abstinence oriented programmes Community links	Drug – free units Pre – release groups Social work Centres Working with families Therapeutic communities outside prisons Community Health Structures Non – governmental organisations

Source: Prison Administration of the Republic of Slovenia, 2004

a) Admission period (on remand or at the start of a prison sentence)

Low-threshold programmes of help

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

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

Among the 727 prisoners who had illicit drug problems in 2003, 334 persons were included in methadone therapy. The Administration estimates the number of patients in methadone therapy increased by one-half compared to the previous year.

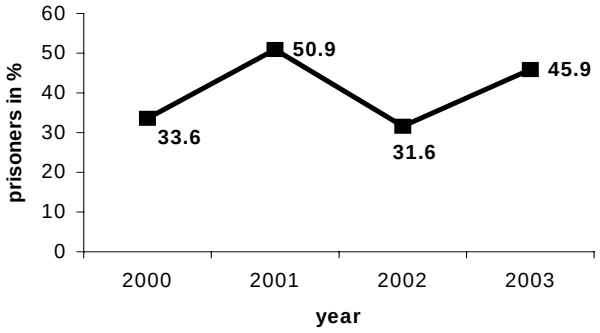

Figure 9.1. Proportion of imprisoned persons receiving methadone compared to number of imprisoned persons with illicit drug related problems, Slovenia, 2000-2003
Source: Prison Administration of the Republic of Slovenia, 2004

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

Medical assistance in prisons is provided by health workers employed full-time, by doctors in the public health care system and psychiatrists from the CPTDA network.

The aim of the medical treatment of illicit drug-dependent prisoners is to detoxify them and strengthen their psychophysical abilities.

b) During the serving of the sentence

Higher-threshold programmes

Higher-threshold programmes are divided into education programmes and motivation programmes.

Through the education programmes we raise awareness among the entire prison population of the harmful effects of drugs on one's health, of the development of addictive illnesses, about existing programmes of help for drug-dependent persons in society etc.

In connection with reducing the harm caused by drug use and other hazardous behaviour, and the possibility of HIV or hepatitis infections, a programme of health education is carried out in the form of lectures and discussions with prisoners and prison staff.

The aim of the programme is to teach persons preventive behaviour, to overcome fear of these diseases, and to counter the stigmatising of those infected. For this purpose, pamphlets have been produced and distributed among prisoners, as well as medical advice, such as encouraging prisoners to maintain good personal hygiene, disinfecting their living quarters, using latex gloves whenever there is a possibility of contact with blood, using condoms etc.

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

The motivation programme proceeds through five phases:
1. recognising the problem;
2. thinking about a change;
3. deciding to make a change;
4. carrying out the change; and
5. maintaining the change.

High-threshold programmes in drug-free units

A private decision by an individual to attempt to live without drugs means a step up to the high-threshold treatment programmes, which offer regular health checks and checks to ensure the individual is "clean" by means of urine tests, employment in workshops or employment in work therapy, active free-time activities depending on the individual's interests (sport, music etc.), participation in education programmes (within or outside the prison), restoring and maintaining contacts with family members, free leave from prison with a gradual approach being applied, familiarisation with the programmes of NGOs and participating in them while serving sentences (Robert AIDS Foundation, "Projekt Človek", "Skupnost srečanje", "Društvo Up", etc.), planning for release.

Almost half the total number of prisoners with drug problems decide on treatment, yet only a few individuals are successful.

Abstinence is relatively quickly achieved, but it is difficult to sustain because they are living in a heterogeneous community during treatment, which is maligned in its very composition. There are addicts within it who do not have the will to achieve personality changes, as well as drug dealers and those experimenting with drugs. The core of positive prisoners who can encourage the efforts of those who decide on treatment is too weak.

Based on our experiences so far we find that prisoners make progress along the road to rehabilitation in an environment free of drugs. Three central prisons and the correctional home have put in place the conditions for drug-free units.

What do we want to achieve by opening drug-free units?

- we have to protect those prisoners motivated for treatment and give them a chance to achieve their aim
- to reduce tension among prisoners
- to prepare drug addicts to take part in their local CPTDA
- to prepare them to enter suitable programmes after release and continue treatment (enter a commune)

Conditions to be admitted to the programme (voluntary):

- to pass a 2-3 month motivation phase during which total abstinence has to be achieved
- to agree to be urine tested
- to work in prison workshops
- to take part in all activities of the work
- to sign a written agreement

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

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

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

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

From the total number of 727 prisoners in 2003 with drug-related problems, 359 (49.4%) of them were included in any type of programme (low-, higher-, or high-threshold).

Table 9.2. Prisoners included in low-, higher- and high-threshold programmes relative to all prisoners with illicit drug-related problems in 2003, Slovenia.

Year/ Programme	Low-threshold programme	Higher-threshold programme	High-threshold programme	Total
2001	217	102	29	**348**
2002	238	108	31	**377**
2003	241	96	22	**359**

Source: Prison Administration of the Republic of Slovenia, 2004

Table 9.2. reveals prisoners who were included in low-, higher- and high-threshold programmes relative to the total prison population with drug-related problems. In 2003 the biggest share of prisoners was included in a lower-threshold programme (33.1%), only 3.02% of prisoners were in a high-threshold programme.

10. Drug Markets

Availability and supply prepared by Ljubo Pirkovič, Rajko Kozmelj

Illicit drug trafficking is one of the prime activities of organised crime and the Slovenian police is attentive to this type of crime. As a rule, substantial quantities of illicit drugs are seized during such police operations, or crime activity is detected or proved regarding persons suspected of being engaged in such crime. Slovenia is a transit country and organised criminal groups engaged in organisation, logistical support and carrying out criminal activities are active here.

However, statutory responsibilities alone are insufficient for ensuring the effectiveness of police work since the appropriate human and material resources must also be available. When these conditions are met, they should be followed by the appropriate organisation and specialisation of staff aimed at the final objective, namely the reduced supply of illicit drugs to the market. The police not only makes efforts in Slovenia but tries to follow criminal groups whose activities do not know or recognise regional, national or continental borders. We are co-operating here and, in spite of the fact that we are small, our contribution to the global decrease in the supply of illicit drugs in global and European markets is relatively big.

The international nature of organised illicit drug trafficking requires the dynamic and co-ordinated response of the wider international community, including Slovenia. In the total number of detected criminal offences of organised forms, offences account for about 16%. Despite this, we need a reliable estimate of the consequences of illicit drug trafficking as a whole as well as the roles of individual groups of organised crime. This requires both operational and empirical information on the profile, motives and ways of perpetrators' work, the dynamics of the illicit drugs market, illegal paths, the extent of organised crime as well as the prevailing trends and last, but not least, its effect on society. Such estimates can only result from quality strategic analysis, which is already being conducted in Slovenia.

It is estimated that organised crime in the field of the manufacture and trafficking of illicit drugs is increasing and therefore co-operation between the police and customs, as well as with the administration of justice, needs to be strengthened, particularly for combating money-laundering and corruption. In addition to internal inter-agency co-operation in the country, international co-operation also needs to be strengthened and promoted, along with the exchange of information and establishing of joint investigation teams. Slovenia is open to these kinds of measures and activities.
In the future only joint and co-ordinated activities carried out by different countries, security authorities and a great deal of patience due to taking national distinctive features into account can lead to better results in this field.

As Slovenia is involved in European and other integration processes the following can be expected in the future:

- in Slovenia the supply of synthetic drugs, including from some EU member-states will increase;
- due to the single European market goods traffic across EU borders will expand, resulting in more cases of redirecting precursors for the manufacture of illicit drugs; and

- considering the country's geographical position, as Slovenia joins the Schengen system it is very likely that the flow and supply of all kinds of illicit drugs on the so-called Balkan route will increase.

Consequently, in the future control at the Schengen border will have to be of the highest possible quality. In order to ensure this, the police and customs staff are being trained to become well acquainted with the problems of illicit drugs and consequently to contribute to cutting the supply of illicit drugs to the market. Only the close co-operation of the police and customs can result in success in detecting illicit drugs at the border.

Seizures prepared by Rajko Kozmelj, Ljubo Pirkovič, Darko Žigon, Zlatan Šušteršič, Mojca Goltnik, Manca Drobne, Mercedes Lovrečič

The number of seizures of illicit drugs is also growing, particularly the most prevalent drugs and drugs that are more dangerous. The geostrategic position of Slovenia should be mentioned here as it is located on the so-called Balkan route, which is the path for the illegal trafficking of heroin from South-east Europe to Central and Western Europe. Criminal groups engaged in illicit drug trafficking, particularly cannabis and its derivatives from Albania to Central Europe, and cocaine from the Mediterranean to Central Europe also seem to be more active.

In the last few years most illicit drugs were seized at international border crossings with Croatia (along the central Balkan route). Usually, passenger cars have been used for this purpose and mainly heroin and cannabis have been seized. The analysis of detected smuggling shows that there are some similarities – in most cases the persons involved in smuggling illicit drugs were foreign citizens, namely the citizens of Serbia and Montenegro, Croatia, Austria, Germany and the Republic of Srpska. As for nationality, in most cases Albanians with temporary or permanent residence in the EU were involved. It has also been noticed that German and Austrian citizens are engaged in smuggling; they are hired by Albanian criminal groups and police officers at border crossings do not pay so much attention to them.

In most cases the persons smuggling illicit drugs took it over in the territory of former Yugoslavia, often involving the loading of contraband in the territories of Priština, Podgorica, Sarajevo and Banja Luka. In detected cases the final destination was one European country, very often Austria, Germany, Italy or Sweden. In some cases, the usual route regarding the final destination was recorded, for example from Bosnia and Herzegovina across Croatia and Slovenia to Italy and then across Austria to Germany.

Members of criminal groups are acquainted with the checking procedures at national borders. In the past, drivers who had spent only one or two days in the states of former Yugoslavia, which was evident from the entry and exit stamps in their passports, were more often subject to checks. Consequently, the travelling route has been changed. Couriers travel by car to the country where they take over the illicit drug, they do not take the shortest way (e.g. across Slovenia to Croatia, Bosnia and Herzegovina...) but travel across Hungary and then into Serbia and Montenegro, or across entire Italy and then by ferry across the Adriatic. Then they return across the territory of Slovenia and Croatia carrying illicit drugs.

In all cases where smuggling was detected, an older personal vehicle were used, namely 5 to 10 years old and in the medium-price class. Another common characteristic is the time when the vehicle was registered in the name of the driver (in most cases the vehicle was registered in the driver's name immediately before

departure or travelling to the territory of former Yugoslavia, which is evident from checking the certificates of registration).

One special problem is dealing with precursors used for the illicit manufacture of illicit drugs. Nearly 20 tonnes of acetic anhydride was seized in the past two years (such a quantity is sufficient to manufacture about 8 tonnes of heroin) and, in 1995, 2.700 kg of ephedrine was seized, which was intended to go across Slovenia to Mexico for the manufacture of methamphetamines.

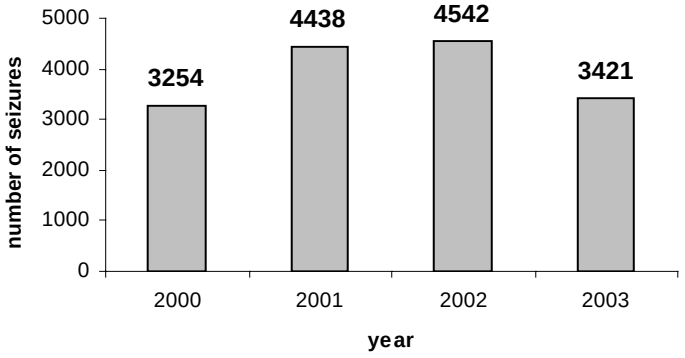

Figure 10.1. Number of seizures for cannabis in (total), 2000-2003, Slovenia
Source: Ministry of the Interior, 2004
Note: data include all enforcement agencies (police, customs service).

The highest number of seized cannabis in total (including plants, resin, marijuana) was seized in 2002 (4.524 number of seizures). According to data from the Ministry of the Interior, seizures for cannabis compared to 2002 show that seized cannabis plants in pieces decreased by 61.15%, but increased by approximately the same percentage for seized cannabis plants expressed in kilograms. In 2003 there were around 80% fewer seizures of marijuana in kilograms compared to 2002 but, at the same time, seizures of hashish increased by more than 400% compared to 2002 (0.11 kg).

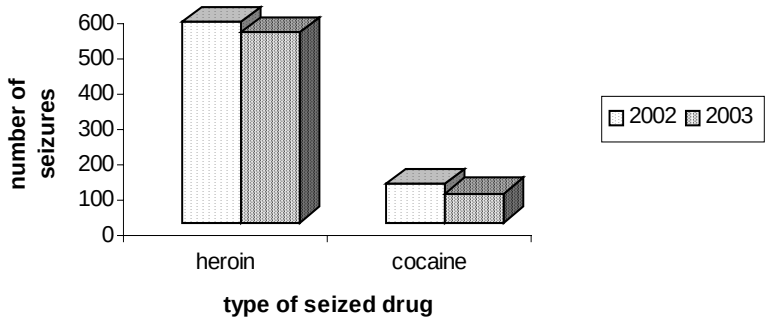

Figure 10.2. Number of seizures of heroin and cocaine, 2002-2003, Slovenia
Source: Ministry of the Interior, 2004
Note: data include all enforcement agencies (police, customs service).

The number of heroin and cocaine seizures dropped in 2003 compared to 2002 (Figure 10.2.). The highest quantity of seized heroin in kilograms was in 2000 when 392.65 kg of heroin was seized, in 2003 seized heroin in kilograms increased compared to 2002 (89.03 kg)

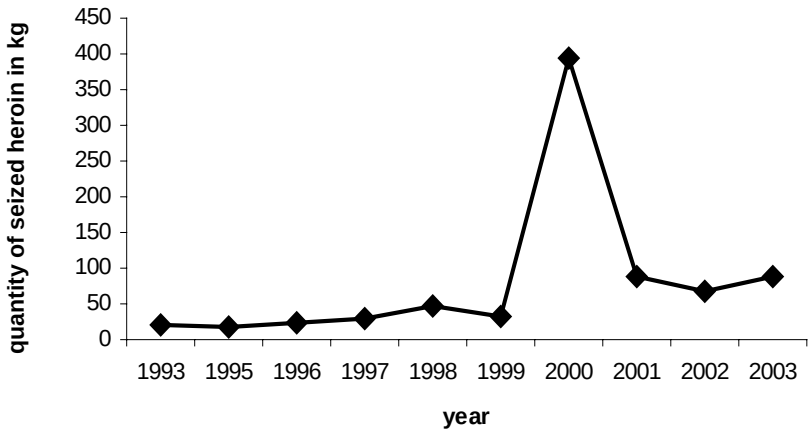

Figure 10.3. Quantity of seized heroin in kilograms, 1993-2003, Slovenia
Source: Ministry of the Interior, 2004
Note: data include all enforcement agencies (police, customs service)

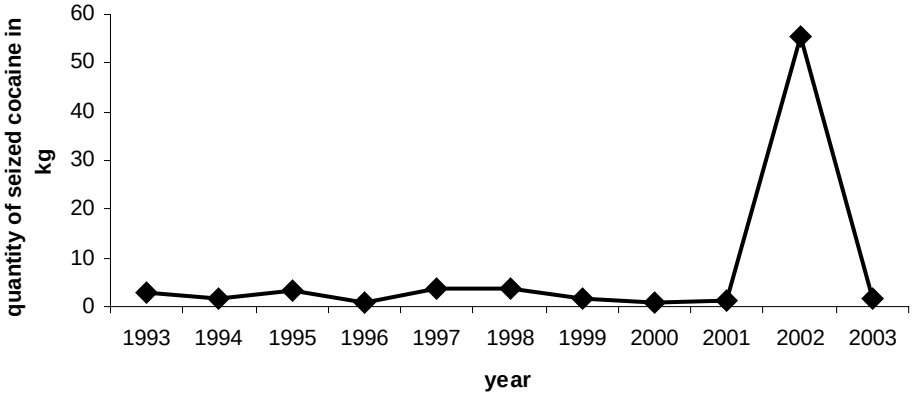

Figure 10.4. Quantity of seized cocaine in kilograms, 1993-2003, Slovenia.
Source: Ministry of the Interior, 2004.
Note: data include all enforcement agencies (police, customs service)

The biggest of cocaine in kilograms in the last ten years was in 2002 when 55.38 kilograms were seized. Compared to previous years and 2003 there was no quantity of seized cocaine that exceeded 3.6 kilograms (3.57 kilograms were in 1997).

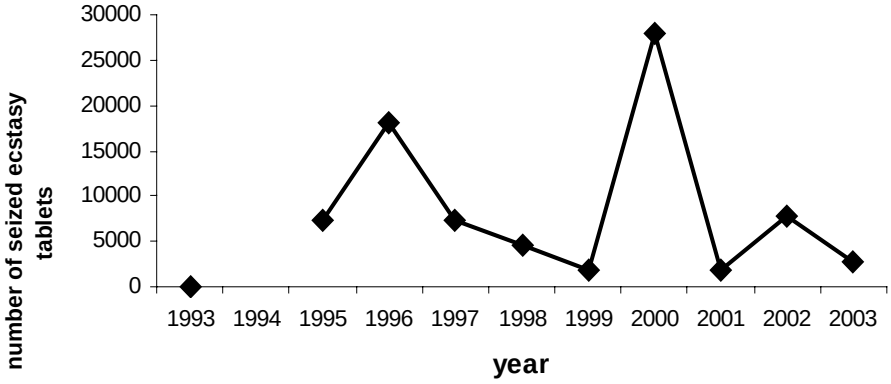

Figure 10.5. Quantity of seized ecstasy tablets, 1993-2003, Slovenia
Source: Ministry of the Interior, 2004.
Note: data include all enforcement agencies (police, customs service)

Most ecstasy tablets were seized in 2000 (27.928 tablets), following the next biggest seizure in 1996 (18.086 tablets). In 2003, 2.831 ecstasy tablets were seized.

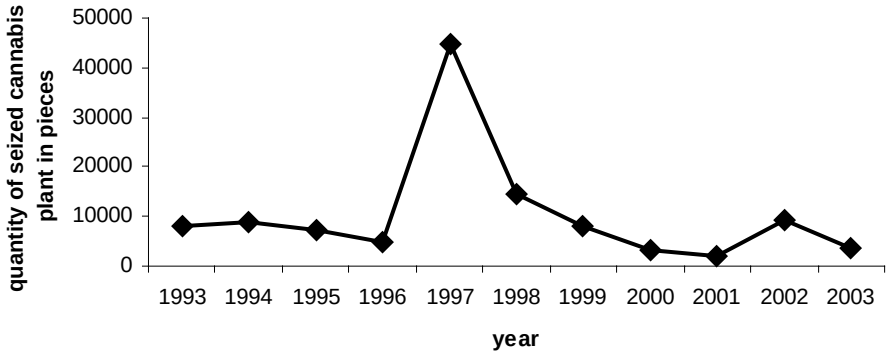

Figure 10.6. Quantity of seized cannabis plant in pieces, 1993-2003, Slovenia
Source: Ministry of the Interior
Note: data include all enforcement agencies (police, customs service)

The highest number of cannabis plant in pieces was seized in 1997 (44.944 kilograms), while seizures of cannabis plants decreased up until 2001 (1.925 kilograms) but again increased in 2002 (9.425 kilograms). In 2003, 3.662 kilograms of cannabis plants in pieces were seized.

The quantity of marijuana seizures in kilograms is constantly changing; the highest seizures were recorded in 1998 (2.772.60 kilograms), in 2000 (3.413.25 kilograms) and in 2002 (1.099.94 kilograms). In 2003 seizures of marijuana did not exceeded 220 kilograms.

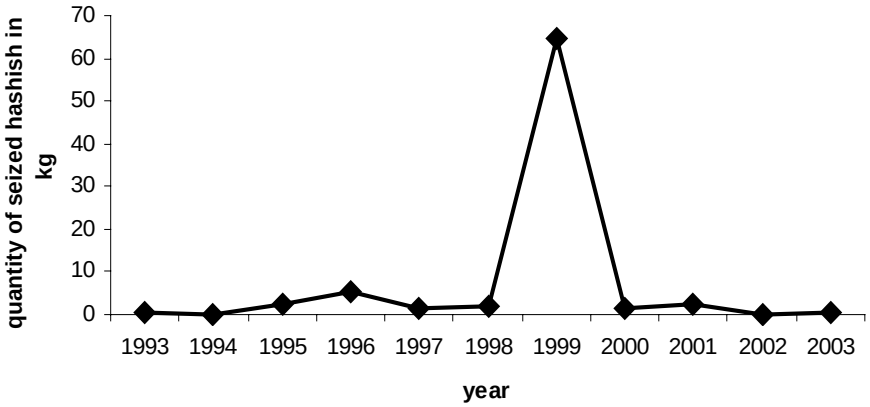

Figure 10.7. Quantity of seized hashish in kilograms, 1993-2003, Slovenia
Source: Ministry of the Interior, 2004.
Note: data include all enforcement agencies (police, customs service).

According to police data, most hashish was seized in 1999 (64.62 kg), whereas before and after 1999 only small seizures of hashish were recorded in Slovenia (Figure 10.7.).

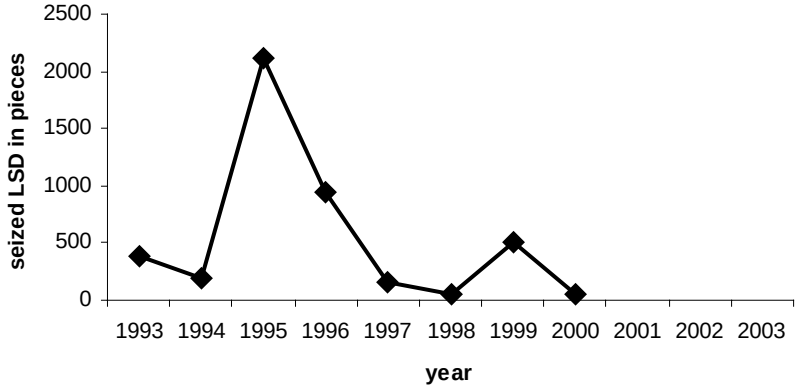

Figure 10.8. Quantity of seized LSD in pieces, 1993-2003, Slovenia
Source: Ministry of the Interior, 2004
Note: data include all enforcement agencies (police, customs service).

Data show that since 2000 there have been no seizures of LSD in Slovenia. The biggest quantity was recorded in 1995 (2.115 pieces), following seizures in 1996, 1999 and 1993 (Figure 10.8.).

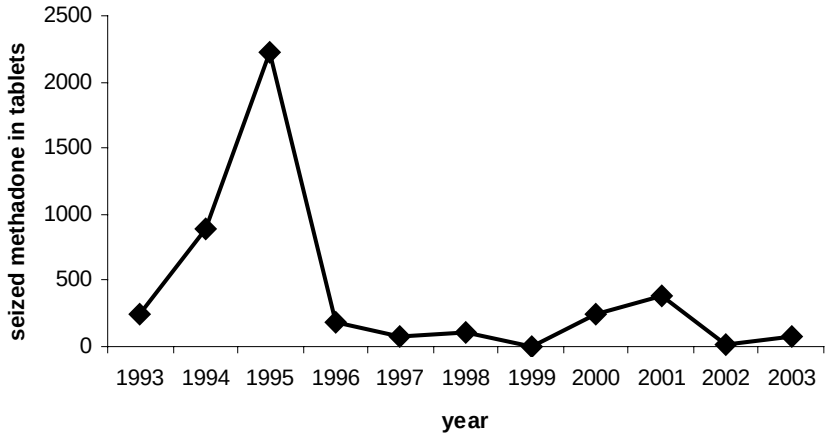

Figure 10.9. Quantity of seized methadone tablets, 1993-2003, Slovenia
Source: Ministry of the Interior, 2004.
Note: data include all enforcement agencies (police, customs service).

From 1993 to 2003 the data also show seizures of methadone tablets, with the biggest seizure being made in 1995 (2.227) (Figure 10.9.), while methadone in solution (ml) has also been seized since 1997 (the highest doses were in 1998 when 4.052 ml of methadone solution was seized (Figure 10.10.).

Methadone treatment has been available since the beginning of the 1990s. At the time substitution treatment was only carried out in the form of methadone tablets which were prescribed and the patient received a prescription allowing the patient to receive tablets from a pharmacy. In the second half of the 1990s substitution treatment with methadone was permitted only in the form of a solution. The decreased trend of seized methadone tablets since 1996 coincides with the systemic regulation and establishment of the CPTDA network. In fact, methadone substitution treatment for opioid addiction is only allowed in the CPTDA network in the form of a methadone solution which should be taken under the supervision of the staff of the CPTDA. Methadone in a soluble form for opioid addiction treatment in CPTDAs has been available since the second half of the 1990s. The sources of illegal methadone in soluble form could differ: from CPTDA programme users, illegal markets of other countries (Croatia), pharmacies (city, in hospitals).

In 2003 in Slovenia there were five seizures of illegal methadone related to Article 196 of the PC RS, no seizures under 197 Article of the PC RS, and 43 related methadone seizure offences. Greater quantities of seized methadone (solution in ml) in 2003 in Slovenia were found in Ljubljana, Koper and Maribor. The total amount of seized methadone (solution in ml) in 2003 in Slovenia was 14.8% lower than seizures made in 2002.

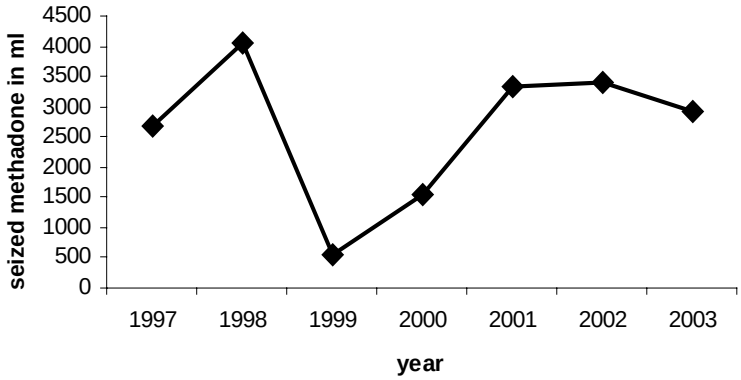

Figure 10.10. Quantity of seized methadone in ml (solution), 1993-2003, Slovenia
Source: Ministry of the Interior, 2004.
Note: data include all enforcement agencies (police, customs service).

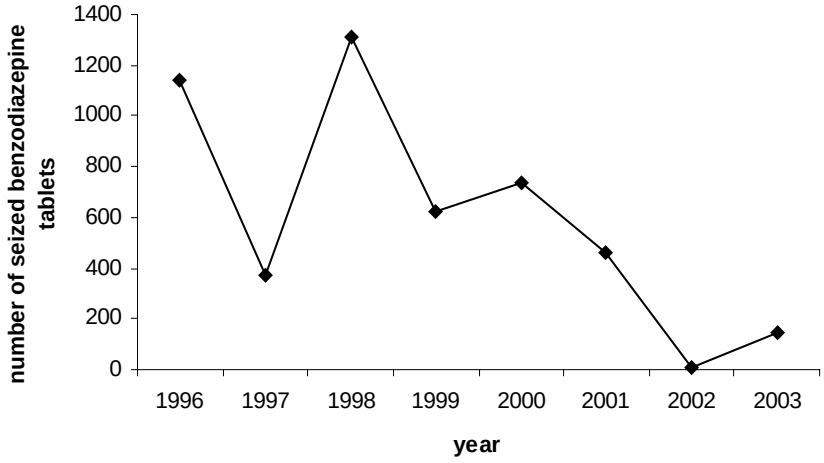

Figure 10.11. Quantity of seized benzodiazepine tablets, 1996-2003, Slovenia
Source: Ministry of the Interior, 2004.
Note: data include all enforcement agencies (police, customs service).

Benzodiazepine tablets have been seized since 1996, with the biggest seizure coming in 1998 (1.312 tablets), following 1996, 2000, 1999 and 2001 (Figure 10.11.). Since 2000 the trend in seizures of benzodiazepine tablets fell dramatically up until 2002 (from 480 tablets to 8 seized tablets) and in 2003 145 tablets were seized.

According to data from the Ministry of the Interior, in 1999 there was a unique seizure of fenetylin (345 tablets of the substance were seized). Acetic anhydride was also seized in two years, in 2000 (9.900 kilograms) and, in 2001, 10.000 kilograms of the substance were seized.

Price/Purity prepared by Ljubo Pirkovič, Rajko Kozmelj, Manca Drobne

No data are available as to the purity of some illicit substances for 2003. Routine analysis of some seizures at the national level at the Forensic Laboratory at the Ministry of the Interior in 2001 on a small seizure (dealer's level) for brown heroin (N=350) showed a minimum purity of 6% and a maximum of 65% (an average of 36%).

Average prices for illicit drugs at the street market level in EUR remain almost the same according to data from the Ministry of the Interior from 1996 to 2003 (see Figures 10.12. - 10.14. below).

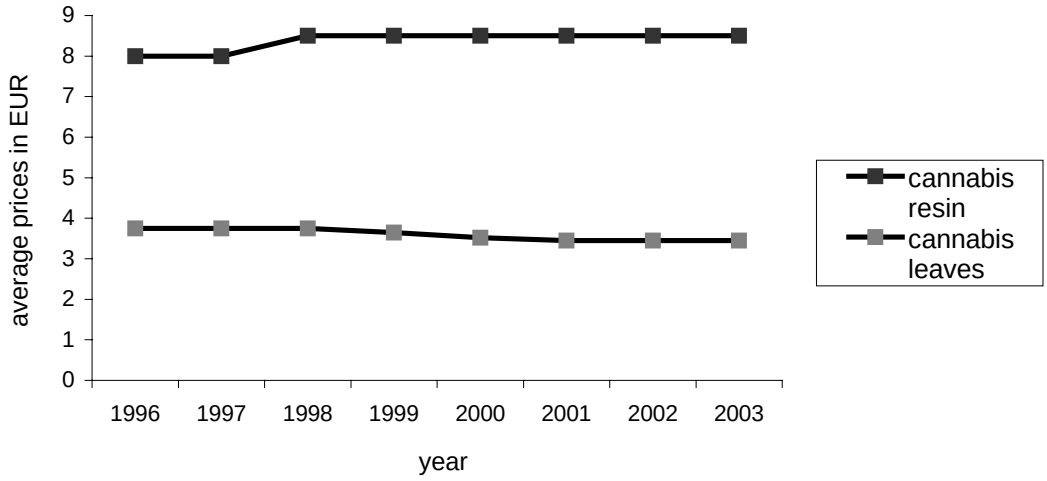

Figure 10.12. Average prices in EUR for cannabis leaves and cannabis resin per gram at street level, 1996-2003, Slovenia
Source: Ministry of the Interior, 2004

We recorded a decreasing trend in average prices (EUR) at street level for cocaine powder (from 2000 to 2003 there was the same price - EUR 67.5 per gram).

For heroin (per gram), average prices in EUR from 1996 to 2000 remained the same, with the exception of a small decrease in 2001, which remained the same up until 2003 (see Figure 10.13.).

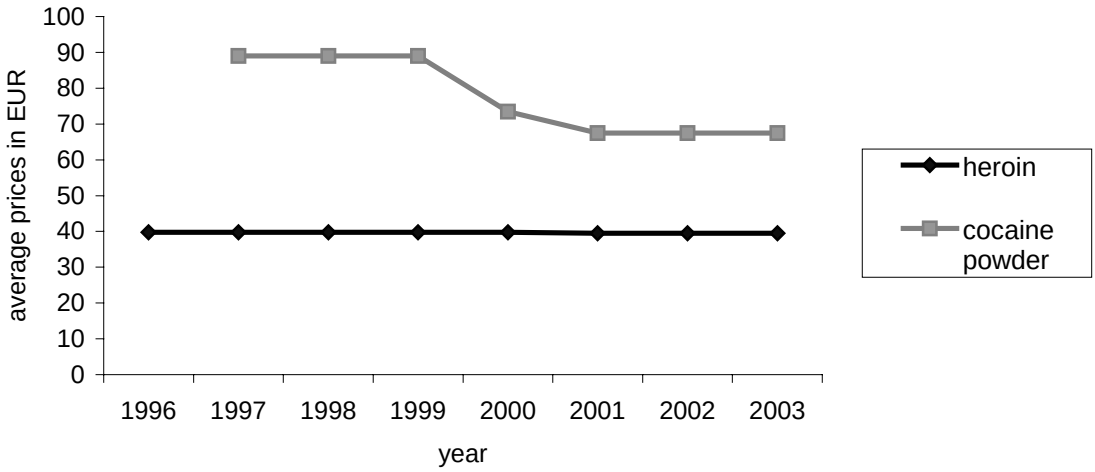

Figure 10.13. Average prices in EUR for heroin and cocaine powder per gram at street level, 1996-2003, Slovenia
Source: Ministry of the Interior, 2004
Note: data not available for price of cocaine powder per gram in 1996

From 1997 to 1999, the average price of an ecstasy tablet was EUR 10, but this decreased in 2000, and also from 2001 to 2002. Average prices for amphetamine tablets according to available data were the same in 1998, 1999 and 2000 (EUR 12), in 2003 the average price of these tablets was EUR 7,7.

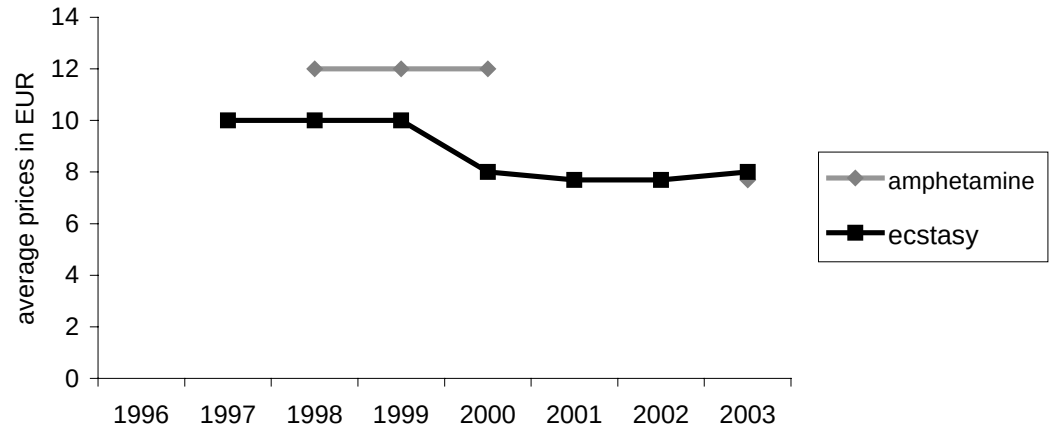

Figure 10.14. Average prices in EUR for amphetamine and ecstasy tablets at street level, 1996-2003, Slovenia
Source: Ministry of the Interior, 2004
Note: data not available for prices of amphetamine tablets for 1996, 1997, 2001 and 2002 and for ecstasy tablets for 1996.

Part B:

Selected issues

11. Buprenorphine, treatment, misuse, and prescription practices prepared by Mojca Zvezdana Dernovšek

Buprenorphine was registered in 2004 and the drug is included in the official drug list in Official Gazette RS (51/2004) under the number 008485, 008486 and 008487 representing Subutex 0.4 mg, 2 mg and 8 mg lingvalets, respectively.

The legal basis for using buprenorphine is the same as for methadone (for the treatment of opiate dependence). Funding of treatment is the same as for methadone treatment.

At the time of preparing this report buprenorphine was still not being used for substitution treatment and there were no guidelines for its use.
The delivery of buprenorfin is supposed to be the same as the delivery of methadone – through the CPTDAs.

There is no information as to whether a specific accreditation will be needed for the prescription of buprenorphine.

One conference was organised in spring 2004 and one lecture was dedicated to buprenorfin use. Another conference is planned for September 2004.
We suppose that the staff of CPTDAs will be educated during their regular courses and that the pharmaceutical industry will play an important role in additional education.

Some studies on buprenorfin were planned but not performed. Those studies were clinical trials sponsored by the pharmaceutical industry.

Since buprenorfin entered the legal market there has been almost no data on its misuse. There are no measures taken to prevent misuse.

12. Alternatives to prison targeting to drug using offenders prepared by Matej Košir

The new national strategy was adopted in February 2004. It is expected that some legislative changes will be adopted in the near future (2004-2005), including the area of alternatives to prison for drug-using offenders, which are defined in the strategic document for the first time in our country's drug policy.

The OD is responsible for the preparation of proposed legislative changes in this field. Comparative analysis of measures in selected countries will be made by the Office in the next few months. Different types of interventions will also be proposed in the analysis. The proposals will also be adjusted with the EU strategy in the field of drugs and UN conventions. The government will then discuss the proposals and adopt the new regulations or propose new legislation to the National Assembly for its adoption.

There were several professional debates on this topic during preparation of the national strategy, but there have still been no significant public discussions in the mass media.

Proposed legislative changes must provide alternatives such as professional help to drug-using offenders, administrative sentences/penalties etc. Alternatives to prison

will only be implemented in the case of the proper response and collaboration of a drug-using offender.

State of alternatives to Prison targeting drug using offenders in the Republic of Slovenia prepared by Manca Drobne, Mercedes Lovrečič

According to the definition of alternatives targeting drug-using offenders by the EMCDDA, Slovenia does not have a specific defined strategy or action plan in place regarding alternatives to prison. The only specific focus on drug-using offenders is so far implemented within the system of prisons under the PA (see Chapter 8).

The National Strategy in the Field of Drugs (2004-2009) was adopted in February 2004 and foresees alternatives for prison targeting drug-using offenders regarding some of the following objectives: to improve actions against organised crime, illicit drug trafficking and other illicit drug-related crime and to legally specify the possibilities of alternatives to drug users, especially for offenders who commit smaller (secondary) criminal offences; to allow faster procedures within the justice system related to decisions on offences and criminal offences especially where drug addiction is the reason for a criminal offence; the possibility to change some of the provisions of the Law on Illicit Drug Production and Trafficking.

Article 66 of the PC RS defines compulsory treatment for alcohol- and drug-addicted persons. According to this law, the Court may order the provision of obligatory medical treatment. This provision can be provided in the institution where the sentence is being served (uninterruptedly, in prison) or in a health institution, while in the case of a suspended sentence medical treatment can be given while a patient's movements are unrestricted (Pišec, 2003).

For alcohol-related problems, under Article 66 of the PC RS compulsory treatment is performed in a formally specified health institution, while for illicit drug-related problems the competent institution has not yet been formally defined. Instead of this, persons requiring compulsory treatment for an illicit drug addiction can be treated in the CTDA (inpatient treatment).

Good co-operation is also seen between the PA and the CPTDA network: professionals from CPTDAs treat drug users as they serve their sentence.

Prisoners with drug-related problems who successfully achieve abstinence have the possibility to obtain additional treatment outside prison: in 2003, 42 persons were treated in health services (psychiatric clinics, the CTDA and the CPTDA network) and in psychosocial rehabilitation programmes (NGOs: Društvo Up, Skupnost srečanje, Karitas etc.) (Prison Administration, 2004).

In 2003 there were 26 persons in prisons requiring compulsory treatment under Article 66 for an illicit drug-related problem, including 2 females and 3 juveniles (Table 12.1.)

Table 12.1. Number of prisoners treated under Article 66 of PC RS - compulsory treatment of drug addicts compared to prisoners with drug-related problems, 2000-2003, Slovenia

No. of Prisoners	2000	2001	2002	2003
Compulsory treatment for illicit drugs (Article 66 of the PC RS)	**14**	**24**	**39**	**26**
Prisoners with drug-related problems	498	658	664	701
Total	512	682	703	727

Source: Prison Administration of the RS, 2004

Paragraph 3 of Article 33 of the Order on the Promulgation of the Production of and Trade in Illicit Drugs Act (Official Gazette 108/99, 44/00) defines the following: in accordance with the provisions of the Misdemeanours Act persons who commit an offence specified in the first paragraph of this article and who possess a smaller quantity of illicit drugs for one-off personal use and persons who commit the offence specified in the preceding paragraph may be subject to more lenient punishment if they voluntarily enter a programme for the treatment for illicit drug users or social security programmes approved by the Health Council or the Council for Drugs.

According to information from the Ministry of Interior, this particular article is not being implemented sufficiently since the mentioned law (Article 33) fails to specify the actual quantity of illicit drugs possessed for one-off personal use.

13. Public nuisance: definitions, trends in policies, legal issues and intervention strategies prepared by Matej Košir, Manca Drobne

The reduction of public nuisance is a relatively new issue in Slovenia, if we understand it within a whole (holistic) approach. There are such problems in our country related to public nuisance, e.g. violence, intimidation, recruitment into crime, annexation of public space by members of so-called "sub-cultures", antisocial and objectionable behaviour etc. The debate on public nuisance has never focused on any systematic way of resolving those problems, but only on case-by-case approaches. Mostly, those problems are defined within "public order disturbance" or "juvenile criminality" categories etc., so it is more or less a general categorisation and not linked separately with drugs. It is also not only related to illicit drugs but to alcohol and other legal PAS (e.g. medicines).

Interventions against public nuisance are mostly measures adopted at the national level and are based on criminal, administrative and civil laws. They do not target specific groups, e.g. drug users or dealers, but offenders generally. The measures are funded from the national budget (police, criminal justice system, social services etc.). Enforcement services are connected with social services where juvenile offenders are involved in a public nuisance. Parents are usually involved in the process in such cases too. Health services are also involved in the process in the event of health problems, e.g. drug use/addiction.

On the basis of police statistics (2003), 11.4% of all suspects of criminal offences were juveniles.

According to data from the Ministry of Interior in 2002 there were 254 drug-related crime offences with at least one juvenile being included and, in 2003, there were 118 drug-related crime offences with at least one juvenile being included (see Table 13.1).

Table 13.1. Number of illicit drug-related crime offences with at least one juvenile being included under Articles 196 and 197 of the PC RS, 2002-2003, Slovenia

	2002		2003	
	Number	Share in % of all	Number	Share in % of all
Article 196	168	14%	114	15%
Article 197	86	23%	74	27%
Total	254	17%	118	18%

Source: Ministry of the Interior, 2004

Part C:

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15. Annexes

Early Warning System in the Republic of Slovenia prepared by Rajko Kozmelj

The EWS in Slovenia was set up through the nomination of a Europol liaison officer and with the establishment of the Europol National Unit in May 2002. In 2003 the National Correspondent was nominated. He formulated and developed a new proposal for the Slovenian EWS (SLO EWS) model in 2003 which was presented at the 1st National Conference on Information System on Drugs (24 October 2003, Ljubljana). In the line with the conclusions of this conference, the National Correspondent also presented the proposed SLO EWS model to the Advisory Board of the NFP (5 November 2003). At the Advisory Board-NFP meeting the following proposals were presented by the National Correspondent:

- to present the model to the Government Commission for Drugs;
- to establish a national EWS working group; and
- to motivate the partners identified for collaboration in the working group.

In the meantime the planned intranet support for the EWS was set up in Law Enforcement by the National Correspondent on the basis of Ministry of the Interior software and hardware and represents all of its expenses. The system is currently being used as a platform for rapid information exchanges within the police system (between central, regional and local levels) and it also provides information about:

- introduction of the EMCDDA and functioning of the EWS;
- EMCDDA information;
- the NSD (new synthetic drugs) in Slovenia;
- the online LOGO profile system of XTC pills;
- synthetic drugs and precursors;
- the production of illicit synthetic drugs (Clan. Labs, etc).; and
- legislation in the field.

The network of undercover drugs agents and key informants could be used for more pro-active information collection (active monitoring etc.) in the future. They could provide information or samples of an NSD before it spreads to the black market and causes harm.

The forensic laboratory is in charge of the analysis of substances. It is possible to analyse seized drugs and in particular cases its staff are able and willing to analyse pills that are submitted. But in the future additional funding is required to ensure the continuation for this type of additional analysis. There are two relevant NGOs working in the field of synthetic drugs in Slovenia – good co-operation exists with both of them but it can still be improved in the future.

Regarding the extension of the EWS system, the National Correspondent is planning to involve in the system in the network of CPTDA, although it needs to be clarified whether they should initially take part just as a receiver or also as a provider of information. Finally, it needs to be clarified and defined who will be responsible for media information/warning in the context of the EWS. It is proposed that the Ministry of Health be in charge – but this needs to be discussed and agreed with the relevant partners.

The New/Synthetic Drugs Web Monitoring System (SDWMS) was developed with the co-financing of the Phare-EMCDDA Project.

In May 2004 the Police Intranet, which forms part of the SLO EWS, was developed with an information infrastructure able to report periodically (on a daily, weekly or monthly basis) about any modifications to the observed Web pages concerning NSD. The programme prepares for us an internal register of Web pages covering Synthetic Drugs subjects, with a special emphasis on NSD and is also able to monitor changes on the Web concerning NSD problems fluently and with minimal efforts. The programme is still being tested and, together with the network of informants and undercover agents, it represents very proactive work in the framework of the EWS.

The SDWMS application searches the Web for pages that cover drug-based themes. These pages are indexed and scanned daily for any possible changes. Alterations are automatically processed and evaluated according to the number of key words detected. A report is formed and sent by email to the specialist using this solution (the National EWS Correspondent). Access to the application is suitably protected with a username and password.

Future plans include the possible development of SDWMS with successive modules:

1. The returned results could be verified by a smaller group of specialists (SLO EWS network). They would eliminate less important information and grade the remaining content by data relevance. The »cleansed« data would then be appropriately distributed.
2. Development of a feedback system for the evaluation of indexed Web sites according to data relevance.
3. Tracking of user activities, which would reduce the chances of any system abuse.
4. Determination and reporting of the geographical location of the observed Web pages, allowing us to act faster in threatened areas.
5. Upgrading the system with a software module for newsgroup monitoring (for example, Usenet).
6. Development of a module that connects to an online translation service. This would allow us to monitor non-English information sources.
7. An algorithm, acting on the artificial intelligence principle, that will search the Web for any results based on the prior analysis of Web pages.

LIST OF ABBREVIATIONS

ABSO	Scale for assessment of PAS use
AIDS	Acquired Immunodeficiency Syndrome
ATS	Amphetamine type stimulants
CA	Custom Administration of the Republic of Slovenia
CEENDSP	Central and European Network of Drug Services in Prison
CID	Criminal Investigation Directorate
CPTDA	Centres for the Prevention and Treatment of Drug Addiction
CTDA	Centre for treatment of Drug Addicts at Psychiatric Clinic of Ljubljana
DRD	Drug Related Deaths
EDDRA	Exchange on Drug Demand Reduction
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ESPAD	European School Project on Alcohol and Drugs
EU	European Union
EWS	Early Warning System
FTC	First Treated Clients
FTD	First Treatment Demand
GCD	Division of the General Customs Directorate
GHB	Gamma-hydroxydbutyric acid
GMR	General Mortality Register
GOD	Government Office for Drugs
GPD	General Police Directorate
GPS	General Population Survey
GPO	General Police Office
GP	General Practitioners
HAV	Hepatitis A Virus
HBC	Hepatitis B Virus
HBSC	Health Behaviour in School aged Children
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
ICD-10	The International Statistical Classification of Diseases and Related Health Problems
IDU	Intravenous drug use
IUID	Information Unit for Illegal Drugs
IFM	Institute of Forensic Medicine-Toxicology Department
LAG	Local Action Group
LAAM	Levo-Alpha Acetymetadol
LRTS	Law on Road Traffic Safety
MMP	Methadone Maintenance Programme
NIPH	Institute of Public Health of the Republic of Slovenia
NFP	National Focal Point
NGO	Non-governmental Organisation
NR	National Report
NSD	New Synthetic Drugs
OD	Office for Drugs
PA	Prison Administration of the Republic of Slovenia
PAS	Psychoactive substances
PC RS	Penal Code of the Republic of Slovenia
PD	Police Directorates
PRO	Public Relation Office
REITOX	European Information network on Drugs and Drug Addiction (Réseau Européen d´Information sur le Drogues et les Toxicomanies)
RS	Republic of Slovenia
RTA	Road traffic accidents
RTO	Road traffic offences
SDWMS	New synthetic Drug Web monitoring system
SEEA	South Eastern Adriatic Addiction Network
SFRJ	Socialist Federal Republic of Yugoslavia (Former Yugoslavia)

TDI	Treatment Demand Indicator
PPUDD	Promulgation of the Prevention of Use of Illicit Drugs and Dealing with Consumers of Illicit Drug Act
WHO	World Health Organisation
XTC	Ecstasy pill

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Table 15.1: Seized Illicit drugs in units, 1993-2003, Slovenia

Illicit Drug	Unit	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
HEROIN	kg	20.03	13.82	18.15	24.57	29.83	46.11	32.27	392.65	88.93	68.67	89.03
COCAINE	kg	2.81	1.72	3.24	0.83	3.57	3.52	1.58	0.98	1.08	55.38	1.66
ECSTASY	tablet	60		7.350	18.086	7.440	4.496	1.749	27.928	1.852	7.877	2831
AMPHETAMINE	kg					1.41	0.34	0.63	0.19	0.06	0.03	0.04
AMPHETAMINE	tablet			1.302	662		267	473	309	89	256	218
CANNABIS PLANT	piece	8.000	8.920	7.145	5.019	44.944	14.453	8.196	3.354	1.925	9.425	3662
CANNABIS PLANT	kg								6.11	2.78	27.75	
CANNABIS (marijuana)	kg	94.5	61.26	29.91	34.59	47.55	2.772,60	249.15	3.413,25	175.10	1.099,94	219.57
CANNABIS RESIN (hashish)	kg	0.51	0.15	2.45	5.43	1.41	1.95	64.62	1.22	2.36	0.12	0.59
METAMPHETAMINE	tablet									9	390	155
LSD	piece	391	184	2.115	947	156	53	512	59	0	0	0
METHADONE	tablet	249	886	2.227	186	81	106	2	245	382	16	80
METHADONE	ml					2.685	4.052	551	1.545	3.346	3.408	2.903
BENZODIAZEPINE	tablet				1.138	376	1.312	621	735	460	8	145
FENETYLINE	tablet							345			0	
ACETIC ANHYDRIDE	kg								9.900	10.000		

Source: Ministry of the Interior, 2004

Table 15.2. Seized Illicit drugs in units regarding drug related category of crime, 2003, Slovenia

Illicit Drug/Unit	Seized Quantity (TOTAL)	Seized quantity at criminal offences	Seized Quantity at offences
HEROINE /kg	89.03	88.61	0.41
COCAINNE /kg	1.66	1.62	0.03
ECSTASY/tablet	2.831	2.643	188
AMPHETAMINE /kg	0.045	0.029	0.016
AMPHETAMINE/tablet	218	169	49
CANNABIS PLANT/piece	3.662	2.839	823
CANNABIS PLANT/kg	44.7	43	1.7
CANNABIS (marijuana) /kg	219.57	205.03	14.53
CANNABIS RESIN (hashish) /kg	0.59	0.49	0.1
METHADONE/tablet	80	0	80
METHADONE/ml	2903.80	452.00	2451.80
METAMPHETAMINE /tablet	155.8	150	5.8
BENZODIAZEPINE /tablet	145	0	145

Source: Ministry of the Interior, 2004

Table 15.3. Decreases/increases in % of seized illicit drugs in units in 2003 compared to 2002, Slovenia

Illicit Drug	Unit	2002	2003	Decrease/ Increase (%)
HEROIN	Kg	68.67	89.03	29.65
COCAINE	Kg	55.38	1.66	-97.00
ECSTASY	Tablet	7.876	2.831	-64.06
AMPHETAMINE	Kg	0.03	0.04	33.33
AMPHETAMINE	Tablet	256	218	-14.84
CANNABIS PLANT	Piece	9.425	3.662	-61.15
CANNABIS PLANT	Kg	27.75	44.69	61.05
CANNABIS (marijuana)	Kg	1100	219.6	-80.04
CANNABIS RESIN (hashish)	Kg	0.11	0.58	427.27
METHDONE	Tableta	16	80	400.00
METHADONE	Ml	3408	2.903	-14.82
METAMPHETAMINE	Tablet	390	155	-60.26
BENZODIAZEPINE	Tablet	8	8	0.00

Source: Ministry of the Interior, 2004

Table 15.4. Decreases/increases of seized illicit drugs at criminal offences in 2002 and 2003, Slovenia

Illicit Drug	Unit	2002	2003	Decrease/ Increase (%)
HEROIN	Kg	68.43	88.61	29.49
COCAINE	Kg	55.278	1.62	-97.07
ECSTASY	Tablet	7.646	2.643	-65.43
AMPHETAMINE	Kg	0.024	0.029	20.83
AMPHETAMINE	Tablet	219	169	-22.83
CANNABIS PLANT	Piece	9.320	2.839	-69.54
CANNABIS PLANT	Kg	24.556	43	75.11
CANNABIS (marijuana)	Kg	1084.16	205.03	-81.09
CANNABIS RESIN (hashish)	Kg	0.023	0.49	2030.43
METHADONE	Tablet	16	0	-100.00
METHADONE	Ml	305	452.00	48.20
METAMPHETAMINE	Tablet	356	150	-57.87

Source: Ministry of the Interior, 2004

Table 15.5. Decreases/increases of seized illicit drugs at offences in 2002 and 2003. Slovenia

Illicit Drug	Unit	2002	2003	Decrease/ Increase (%)
HEROIN	Kg	0.236	0.41	73.73
COCAINE	Kg	0.103	0.03	-70.87
ECSTASY	Tablet	231	188	-18.61
AMPHETAMINE	Kg	0.0083	0.016	92.77
AMPHETAMINE	Tablet	37	49	32.43
CANNABIS PLANT	Piece	91	823	804.40
CANNABIS PLANT	Kg	3.194	1.7	-46.78
CANNABIS (marijuana)	Kg	15.78	14.53	-7.92
CANNABIS RESIN (hashish)	Kg	0.0966	0.1	3.51
METHDONE	Tablet	0	80	100.00
METHADONE	Ml	3103	2451.80	-20.99
METAMPHETAMINE	Tablet	34.3	5.8	-83.09
BENZODIAZEPINES	Tablet	8	145	1712.50

Source: Ministry of the Interior, 2004

Table 15.6. Number of seizures for illicit drugs at criminal offences* and offences in 2003, Slovenia

Illicit Drug	**Article 196**	**Article 197**	**Criminal offences (Total)**	**Offences**	**TOTAL**
HEROIN	137	8	145	394	539
COCAINE	33	0	33	47	80
ECSTASY	14	2	16	52	68
AMPHETAMINE	6	1	7	28	35
CANNABIS PLANT	69	5	74	219	293
CANNABIS (marijuana)	197	46	243	3107	3350
CANNABIS RESIN (hashish)	10	1	11	60	71
METAMPHETAMINE	2	0	2	15	17
METHADONE	5	0	5	43	48
BENZODIAZEPINES	0	0	0	4	4
TOTAL	**473**	**63**	**536**	**3969**	**4505**

Source: Ministry of the Interior, 2004
*According to Penal Code of the RS - Article 196 and Article 197

Table 15.7. Seizures for illicit drugs in regional police units in 2003, Slovenia

Illegal Drug	**Unit**	Celje	Koper	Krško	Kranj	Ljubljana	Maribor	Murska Sobota	Nova Gorica	Novo mesto	Postojna	Slovenj Gradec	Total
HEROIN	kg	0.098	25.37	60.66	0.019	1.57	0.022	0.009	0.96	0.25	0.033	0.0009	88.9919
COCAINE	kg	0.12	1.1	0.007	0.11	0.13	0.17	0	0.012	0.012	0	0	1.661
ECSTASY	tablet	21	134	8	16	532	1.055	977	1	80	5	1	2830
AMPHETAMINE	kg												
AMPHETAMINE	tablet	48	4	0	166	0	0	0	0	0	0	0	218
CANNABIS PLANT	piece	1144	60	76	0	784	501	648	313	127	0	9	3662
CANNABIS PLANT	kg	0.32	0.004	0.27	6.45	3.06	2.48	0.098	0.018	0.18	0.031	31.78	44.691
CANNABIS (marijuana)	kg	2.42	22.16	49.62	29.69	67.43	2.75	12.02	0.89	5.4	17.14	10.03	219.55
CANNABIS RESIN (hashish)	kg	0	0.019	0	0.003	0.28	0.018	0.006	0.005	0.22	0.031	0	0.582
METHADONE	tablet	0	0	80	0	0	0	0	0	0	0	0	80
METHADONE	ml	0	624	155	166	1.602	250	34.5	0	0	55	17	2903.5
METAMPHETAMINE	tablet	0	0	0	0	102	47	0	6	0	0.8	0	155.8
BENZODIAZEPINES	tablet	2	0	0	0	0	11	0	0	0	0	0	13

Source: Ministry of the Interior, 2004

Table 15.8.Number of drug related crimes* by category, 1993-2003, Slovenia

Category of crime	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**
criminal offences	281	407	453	675	964	988	1121	1370	1537	1539	1046
Suspects	329	475	539	752	1072	1168	1241	1568	1681	1715	1167
Offences	365	418	796	1174	1773	1954	2289	3433	4352	4178	3744

Source: Ministry of the Interior, 2004

*****According to Penal Code of the RS - Article 196 and Article 197

Table 15.9. Enforcement measures taken by the police when suspecting drunk and drugged driving during traffic surveillance, Slovenia 1999-2002

ENFORCEMENT MEASURES	**1999**	**2000**	**2001**	**2002**
ALCOHOL				
Number of alcohol tests ordered	124161	146042	176042	188326
Number of positive alcohol tests	39463	37292	36223	34759
Number of expert examinations ordered	3532	3969	6609	5826
Number of positive expert examinations	2006	2108	1931	1769
OTHER PAS				
Number of expert examinations ordered	1451	2175	3008	3588
Number of positive expert examinations	378	431	638	675

Source: General Police Office and Ministry of the Interior, 2004

Table 15.10.Enforcement measures taken by the police during traffic surveillance-number of tests for PAS(excluded alcohol), Slovenia, 1999-2002

Enforcement measures	**1999**	**2000**	**2001**	**2002**	**2003**
Number of expert examinations ordered	1451	2175	3008	3588**	3642***
Number of positive expert examination results	378	431	638	675	520
Number of negative expert examination results	*	126	214	477	541
Number of expert examinations refused	*	1618	2156	2415	2572

Source: General Police Office and Ministry of the Interior, 2004

Note*: data not available
Note**: results for 21 expert examinations not available
Note***: results for 9 expert examinations not available

Table 15.11. Number and proportion (in %) of prisoners with illicit drug related problems compared to total prison population

Year	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**
Total prison population	4046	3767	3882	5113	6348	6703	6302	5219	4725
Number of persons with drug problems	133	156	268	306	471	512	682	703	727
Proportion in (%)	3.28	4.14	6.90	5.98	7.40	7.63	10.82	13.47	15.38

Source: Prison Administration of the Republic of Slovenia, 2004

Table 15.12. Average prices for illegal drugs on street level in EUR from 1996 to 2003, Slovenia

Ilicit drug	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**
Cannabis resin	8	8	8,5	8,5	8,5	8,5	8,5	8,5
Cannabis leaves	3,75	3,75	3,75	3,65	3,52	3,45	3,45	3,45
Heroin	39,75	39,75	39,75	39,75	39,75	39,5	39,5	39,5
Cocaine powder	*	89	89	89	73,5	67,5	67,5	67,5
Amphetamine tablet	*	*	12	12	12	*	*	7,7
Ecstasy tablet	*	10	10	10	8	7,7	7,7	8

Source: Standard Tables 16 - EMCDDA and Ministry of the Interior, 2001-2004
Note: * Data not available

PHARE Twinning project

Table 15.13. Equipment (invitation for tenders)

Institution / organisation	Type of equipment	Amount (EUR) (incl. VAT)*
Ministry of Interior – Police	- Digital radio-station (3 x) - Car (3 x)	4,529,00 76,704,00
Ministry of Finance – Customs	- Endoscope (4 x) - Contraband detector (4 x) - Van (2 x)	56,640,00 64,320,00 75,480,00
Ministry of Health - AIDS Foundation Robert, Ljubljana - Association Ptica, Hrastnik - SVIT – Association helping drug users and their families, Koper - Institute of Public Health, Celje - Association for Health Life, Maribor - Centre for the Prevention and Treatment of Drug Addiction, Nova Gorica	- Insulin Needle (60.000 x) 40.000 x 2.000 x 5.000 x 5.000 x 4.000 x 4.000 x	7,200,00
Ministry of Health - Centres for the Prevention and Treatment of Drug Addiction (Ljubljana, Maribor, Koper, Kranj, Piran)	- Methadone dispenser (5 x) + training	99,138,00
Government Office for Drugs	- Personal computer (2 x) - Laser printers (2 x)	4,248,00 4,094,00
Institute of Public Health RS	- Personal Computer (3 x) - Laser printers (3 x) - Photocopy machine (1 x) - Fax machine (1 x)	6,372,00 6,142,00 1,746,00 504,00
TOTAL COST		**407,117,00 (incl. VAT)**

Source: Ministry of Health, Office for Drugs, 2004

* Government Office for Drugs spent within PHARE grant 339,264 EUR for equipment; recipients spent additional 67,853 EUR for VAT.

Table 15.14. Twinning project: "Strengthening of the National REITOX Focal Point and strengthening the drug supply reduction and drug demand reduction programmes in Slovenia

Action / phase / activity	Amount (EUR)
Pre-Accession Adviser (PAA) costs	**153,660,00**
PAA Adviser	**45,000,00**
Project Leader - 5 visits of 3 working days	**16,480,00**
Translation	**10,800,00**
Phase 1 – Planning phase	**24,887,50**
Component 1 *- Collecting, processing and analysis of comparable drug epidemiological data*	***14,999,50***
Activity 1 - Analysis of the mechanisms for co-operation with relevant institutions and for data collection	3,768,50
Activity 2 - Assessment of the existing data collection and monitoring system	11,231,00
Component 2 *- Development, piloting and evaluation of effective drug demand, supply and harm reduction programmes*	***9,888,00***
Activity 1 - Needs assessment	
Activity 2 - Identification and formulation of specific pilot projects	6,592,00
	3,296,00
Phase 2 – Implementation phase	**391,036,00**
Component 1 *- Collection, processing and analysis of comparable drug epidemiological data*	***160,639,00***
1. Support to the Institutional Building of the Focal Point	28,181,50
Activity 1 - Training for staff members of the Focal Point	*7,537,00*
Activity 2 - Study visits	*9,339,00*
Activity 3 - Development of the networking and dissemination strategies	*11,305,50*
2. Data Collection and Monitoring System	132,457,50
Activity 1 - Definition of institutions for 5 key indicators	*31,350,00*
Activity 2 - Training on 5 key indicators	*19,721,00*
Activity 3 - Evaluation workshops on the pilot implementation of 5 key indicators	*27,304,00*
Activity 4 - Further development of the data collection/monitoring system	*7,537,00*
Activity 5 - Advise on the data collection map for additional core data sources	*11,305,50*
Activity 6 - Training of trainers on Information Collection (4 seminars for 2 groups of experts)	*35,240,00*
Component 2 *- Development, piloting and evaluation of effective drug demand, supply and harm reduction programmes*	***230,397,00***
1. Support to Local Action Groups	34,368,00
Activity 1 - Assist in setting up the network of LAGs	*13,184,00*
Activity 2 - Organise two seminars on the organisation and management of LAGs	

Action / phase / activity	Amount (EUR)
	21,184,00
2. Strengthen Drug Demand Reduction Programmes	
Activity 1 - Develop a programme for working with problematic youth	23,534,00
Activity 2 - Organise a traineeship for three Slovenian expert-four nights- on working with problematic youth	*21,571,00*
	1,963,00
3. Prevention Programmes	
Activity 1 - Preparation and implementation of awareness activities and prevention programmes	86,132,00
Activity 2 - Develop community-based programmes and prevention efforts outside the school system	*39,684,00*
Activity 3 - Assist in the development of community prevention infrastructure	*6,592,00*
Activity 4 - Assist in the development of the role of NGOs on drug dependence - seminar	*13,184,00*
Activity 5 - Prevention activities in the field of synthetic drugs	*10,488,00*
	16,184,00
4. Education Programmes	
Activity 1 - Develop primary prevention curricula and programmes for young people, parents and teachers	30,970,00
Activity 2 - Assist in setting up a distance education programme	*13,184,00*
	17,786,00
5. Treatment network	
Activity 1 - Organise a seminar on early diagnosis and early intervention	11,286,00
Activity 2 - Seminar on treatment (outpatient drug free treatment regimes, one gender specific model)	*4,694,00*
Activity 3 - Organise a seminar on rehabilitation and social re-integration	*3,296,00*
	3,296,00
6. Assessment and evaluation of projects	
Activity 1 - Assist in setting up the monitoring system	21,935,00
Activity 2 - Organise a study visit to Spain for 3 members of the working group on monitoring	*18,523,00*
	3,412,00
7. Drug Supply Reduction Programmes	
Activity 1 - Workshop on the Spanish Drug Supply Reduction Model	22,172,00
Activity 2 - Training for law enforcement officers	*6,592,00*
Activity 3 - Seminar on maritime supply control	*8,988,00*
	6,592,00
Reserve for adjustment of estimated costs (max. 2,5 %)	*16,047,00*
TOTAL COST	**657,910,50**

Source: Ministry of Health, Office for Drugs, 2004