

# REPORT ON THE DRUG SITUATION 2012 OF THE REPUBLIC OF SLOVENIA





European Monitoring Centre  
for Drugs and Drug Addiction



**IVZ**

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EMCDDA  
by the Reitox National Focal Point**

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

**REITOX**

## REPORT ON THE DRUG SITUATION 2012 OF THE REPUBLIC OF SLOVENIA

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## Chapter 1

Amendments to the Criminal Code were adopted in 2011, which also amend both articles governing drug-related problems. The amended Article 187 of the Criminal Code allows the purchase or possession of illicit drugs and facilitation of illicit drug use under specific legal and health conditions, and thus enables the establishment of safe injecting rooms. The Government of the Republic of Slovenia added a new substance, namely mephedrone, to the list of drugs included in the Decree on the scheduling of illicit drugs. The Ministry of Health adopted the following two sets of rules in 2011 relating to driving and methods for assessing physical and mental capacity, including in cases of illicit drug use: the Rules on health conditions of drivers of motor vehicles, and the Rules on the list of narcotic drugs, psychoactive drugs or other psychoactive substances and their metabolites. In July 2012 the Government of the RS adopted the National Crime Prevention and Crime Control Strategy, which also covers drug-related criminal offences.

Most drug-related programmes in Slovenia are still funded from the National budget and by the Health Insurance Institute of Slovenia. Some financial resources come from various foundations and membership dues paid by members of non-governmental organizations. Based on available data, we estimate that at least EUR 10,416,949.61 was spent on prevention and treatment of drug-related problems in Slovenia in 2011. This year, for the first time, the amount includes the financial resources provided by Slovenian city municipalities to help solve drug-related problems.

## Chapter 2

According to the Survey on the use of tobacco, alcohol and other drugs, 16% of inhabitants of Slovenia have used an illicit drug on one or more occasions in their lifetime. Most of those who reported lifetime drug use (15.8%) used cannabis or hashish. The survey also brought attention to the phenomenon of polydrug use, which is most prevalent among young adults. And, a comparison with the European Union showed that the lifetime prevalence of cannabis use in Slovenia is below the European average, and so is the use of some other drugs.

In 2011, the European School Survey Project on Alcohol and Other Drugs (ESPAD) was conducted for the fifth time in Slovenia. According to survey results, 24.8% of surveyed 15- and 16-year-old students have used at least one illicit drug in their lifetime. The data also show a trend similar to those in other countries, namely the stabilization of the prevalence of illicit drug use after 2007. On the other hand, Slovenian prevalence rates of lifetime use of inhalants and cannabis stand out in comparison with the ESPAD countries average rates; 20% of Slovenian students reported lifetime use of inhalants, and 23% reported lifetime use of cannabis. The study of drinking environments and young people's drinking behaviours in four European cities (Liverpool, Palma de Mallorca, Utrecht and Ljubljana) shows that the number of young people who preload (drink before going out) is significantly lower in Ljubljana than in other cities. As regards the assessed features, such as noise, crowding, ventilation, temperature, lighting and cleanliness, the bars and night clubs in Ljubljana proved less problematic than those in other participating cities.

### Chapter 3

Environmental prevention measures focus mainly on restricting access to alcohol and tobacco products, and include the implementation of the Act Restricting the Use of Alcohol and the Restriction of the Use of Tobacco Products Act, measures regarding excise duties, alcohol and tobacco advertising restrictions, tobacco product tax and price increases, and statutory blood alcohol concentration limits for drivers. Focus groups of high-school students aged between 15 and 19 years show that students wish for more experiential programmes and small group discussions where they would not be ashamed to ask questions.

The Faculty of Social Work of the University of Ljubljana has developed a community-based model of work with children, their parents and school workers. Its primary purpose is to promote community responses to risky situations in individual school environments. The Institute Utrip has issued Guidelines and Recommendations for School-based Prevention. Preliminary evaluation of the "Izštekanj" (Unplugged) programme showed that it has reduced the actual use of alcohol, tobacco and other drugs in the intervention group when compared with preliminary predictions of students. An analysis of the obstacles to the implementation of family prevention programmes showed that more than 63% of parents participate in preventive activities in Slovenia. The most common reason for non-participation of parents is lack of time. The evaluation of the effects of the Strengthening Families Program showed positive results for 89% of all measurable indicators. The most significant effects of the programme include positive changes in parenting skills and parenting styles of both parents, and an increase in positive parenting and parent effectiveness. In the framework of the international Addiction Prevention within Roma and Sinti Communities project, researchers found that tobacco, alcohol, cannabis and heroin are present in the lives of Roma children, whereas medications are present in the adult world. The Svit Association implements an indicated prevention programme aimed at children of drug users, at-risk children, drug using



parents, girls with associated problems, and grandparents of drug users' children. The programme focuses on solving drug-related problems and promoting safe leisure activities.

## Chapter 4

The results of a study on drug users participating in harm reduction programmes, who are classified as problem drug users according to the definition of problem drug use, show that there was a significant increase in the use of drugs other than heroin in 2011 compared to the previous year. This is probably due to the decreased availability of heroin and its poor quality in 2011. The most commonly used drug was cannabis, followed by heroin, cocaine and synthetic drugs; the use of alcohol increased significantly in 2011. Most drug users used substitute medicines, and more than half also used other medicines (hypnotics and benzodiazepines). Most heroin or cocaine users use drugs intravenously. In comparison with 2010, intravenous use of heroin decreased in 2011, while intravenous use of cocaine, heroin and cocaine combinations, and medications increased.

## Chapter 5

According to the data collected using the Treatment Demand Indicator questionnaire 3,021 people were treated in 17 centres for the prevention and treatment of drug addiction (CPTDA) and the Centre for Treatment of Drug Addiction at the Psychiatric Clinic Ljubljana in 2011; 2,500 of them were in continuous maintenance treatment, and 521 people entered a treatment programme again or for the first time in 2011. The average age of drug users who were re-treated or treated for the first time was 30.58 years, and most of them were male (78%).

The data on drug users who were admitted into a programme again or for the first time show that, in most cases, heroin was the reason why users sought help in 2011. The proportion of drug users who sought help due to heroin decreased compared to previous years, and the proportion of those who sought help due to cannabis increased. In 2011, cocaine was the most common secondary drug, followed by alcohol, cannabis and hypnotics. More than half of drug users used their main drug heroin every day; injection remained the most common route of administration in 2011. However, it is interesting that a large proportion of heroin users smoked heroin. Two thirds of drug users who entered a programme again or for the first time were unemployed, and there was an increase in the unemployment rate among drug users compared to previous years. As regards education levels, most drug users had completed secondary education.

## Chapter 6

Of all saliva samples collected from injecting drug users in 2011 in the framework of unlinked anonymous testing for the purposes of HIV infection control, there was one sample positive for HIV antibodies. The prevalence of antibodies against hepatitis B virus (HBV; anti-HBc) among confidentially-tested injecting drug users who were in treatment in CPTDAs was 8.1% in 2011, and the prevalence of antibodies against hepatitis C virus (HCV) was 28.5%. In both cases, the proportions of infected drug users were the highest in 2011 compared to other years in the period 2007–2011. Medical emergency units in Ljubljana treated 43 patients for illicit drug poisoning in 2011. The number of cases of ecstasy, amphetamine or cannabis poisoning was much higher in 2011 than in 2010, when heroin poisoning cases prevailed. There were 24 direct drug-related deaths registered in the Mortality Database in Slovenia in 2011. These death cases included 19 men and 5 women. Heroin was the most common cause of fatal poisoning, followed by methadone and cocaine.

## Chapter 7

10 Prevention of drug-related emergencies and deaths as well as prevention of infectious diseases are performed in the public health network – in centres for the prevention and treatment of drug addiction – and by nongovernmental organisations, primarily through low-threshold harm-reduction programmes. In addition, the Ministry of Health RS has founded an interministerial working group for Early-warning System on new Psychoactive Substances which regularly informs expert public and drug users of the emergence of dangerous or new psychoactive substances. The Poison Control Centre of the University Medical Centre Ljubljana also includes a 24-hour toxicological information-consultation service which provides support to all Slovenian doctors treating patients poisoned with illicit drugs. The nongovernmental organisation Združenje DrogArt enables users of psychoactive substances to have substances tested if they suspect that the drugs contain unusual substances or have effects different than expected. Low-threshold programmes include free distribution of sterile materials among injecting drug users as well as counselling. In 2011, there were 632,462 needles and syringes distributed among low-threshold programmes.

## Chapter 8

Centres for Social Work recorded 298 cases of treatment related to drug problems in 2011. In centres for social work, most drug-related problems are dealt with in the framework of social first aid. In 2011 the Ministry of Labour, Family and Social Affairs co-funded 36 drug-

related social security programmes, which received financial resources totalling EUR 4,490,697.60. More than 6,400 users participated in these programmes; most of them (4,491) in low-threshold programmes, 1,048 in high-threshold programmes, 890 in medium-threshold programmes and 12 in reintegration programmes.

## Chapter 9

In 2011, the police recorded 1,925 criminal offences (according to the Criminal Code) and 3,691 offences (as defined in the Production of and Trade in Illicit Drugs Act) involving illicit drugs, and investigated 2,229 people on suspicion of criminal offence involving illicit drugs. In 2011, cannabis remains the illicit drug that accounts for the largest proportion of criminal and minor offences. In 2011, the police treated 128 suspects who were under the influence of illicit drugs at the time they committed the offence, and recorded 210 criminal offences committed with the intention of acquiring money to purchase illicit drugs. The police ordered 1,162 expert examinations to establish the presence of illicit drugs and other psychoactive substances in drivers, 648 of which tested positive for drugs. Most drivers were driving under the influence of methadone, opiates or benzodiazepines. In 2011, there were 81 cases of judicial police officers discovering illicit drugs in prisons, and cannabis accounted for the largest number of finds. There were 4,975 people imprisoned in Slovenian prisons in 2011; of 1,073 prisoners who had drug-related problems, 623 received substitution treatment. According to available data on test results, there were no HIV virus positive prisoners in 2011. 15 prisoners tested positive for hepatitis B, and 55 for hepatitis C.

## Chapter 10

The total quantities of most illicit drugs seized in Slovenia decreased in 2011 compared to the year before. The only exceptions were cannabis and hashish, in the case of which the police noted an increase both in smuggling over the Slovenian territory to other EU member countries as well as in the quantity intended for sale in the Slovenian market. The police also noted an increase in the production of cannabis; in 2010 they recorded 42 spaces adapted for cultivation of cannabis under artificially created conditions, whereas in 2011 it recorded 52 such spaces. Average prices of heroin, cocaine, amphetamine, cannabis and hashish rose slightly in 2011 in comparison with the year before, particularly because of the increased availability of particular illicit drugs of higher purity. In 2011, average concentrations of illicit drugs such as cocaine, amphetamine, cannabis and hashish were similar as in previous years, while the average concentration of heroine was much lower in 2011.

With the outbreak of heroin use in the early nineties, Slovenian non-governmental organizations started cooperating with Italian therapeutic communities. Initially, these NGOs only made arrangements for drug users to enter treatment in various therapeutic communities in Italy, but later they started to establish such communities in Slovenia. Today, there are 8 therapeutic communities in Slovenia, and they have 116 beds in total. In addition, there are places available in communities abroad, as some NGOs cooperate with foreign residential treatment providers.

The legal basis for the operation of therapeutic communities in Slovenia comprises: the Act Regulating the Prevention of the Use of Illicit Drugs and the Treatment of Drug Users, Social Security Act, and the Resolution on the 2004 - 2009 National Programme in the Field of Drugs. Therapeutic communities are funded from several sources; the Ministry of Labour, Family and Social Affairs (MLFSA) provides the largest proportion of financial resources (up to 80%) through public tendering, and the remaining funds are obtained by therapeutic communities through donations, participants' contributions and local community calls for tenders.

12 Most therapeutic communities in Slovenia are self-help communities based on mutual help between their members; there are only two therapeutic communities that cooperate with external professionals or have professional personnel, who are responsible for medication therapy for drug users in the programme. All therapeutic community programmes are also connected with the network of Centres for the Prevention and Treatment of Drug Addiction, which carry out medical examinations before drug users enter a therapeutic community, vaccinate them against hepatitis B and test them for HIV and hepatitis C. All therapeutic communities offer drug users the possibility to complete or obtain education, develop new skills or learn about positive personal experience, and gradually become more independent; only a few communities also offer diagnostic services, programmes to ease the transition from a therapeutic community to everyday life, individual and group therapies, behaviour therapy, and systemic family therapy.

Therapeutic communities collaborate with each other and with other drug-addiction treatment programmes, thus allowing for drug users to move from one therapeutic community to another or to other programmes.

Information on all therapeutic communities, i.e. information on programmes and requirements for admission to a therapeutic community, is publicly available. Internal evaluations of programmes and goal attainment evaluations are carried out in all programmes. External evaluation is occasionally carried out by the MLFSA, which can evaluate programmes in accordance with contractual terms and check whether financial resources have been used in accordance with the mutual agreement. The last such evaluation was carried out in 2011.

Slovenia's gross domestic product (GDP) per capita adjusted for purchasing power was 27.545 USD in 2010. The economic crisis that started in 2008 has also affected Slovenia, and thus the percentage decline in real GDP in Slovenia was second largest among OECD countries in 2009. The general government deficit increased after the negative growth in 2009, which indicates that there were no radical cuts in government spending before 2011. The Fiscal Balance Act was adopted in May 2012, which is the first step of the current government towards reducing the government deficit to 3% GDP by 2013.

Annual total sums of monitored (constant) drug-related expenditure in the period 2005–2011 show a continued moderate increase in the total amount of allocated financial resources; in 2005 EUR 6,967,107.49 was allocated for MLFSA's funding of programmes and for Ministry of Health's drug-related expenditure, for sterile materials for safe drug injection, centres for the prevention and treatment of drug addiction, substitute medicines, acute hospitalizations, and for drug-related police investigations and technical equipment, while the resources allocated in 2011 amounted to EUR 10.054.779,54.

By 2011, the effects of the economic crisis had not yet led to significant cuts in public expenditure, and there was also no apparent decrease in drug-related public expenditure. Since more radical austerity measures aimed at the balancing of public finances were first adopted in 2012, the impact on drug-related public expenditure and the scope or number of drug-related services and programmes will only become visible in the future.

# **PART A:**

## **NEW DEVELOPMENTS AND TRENDS**

In the Republic of Slovenia, the field of illicit drugs is regulated by the following acts and decrees: The Criminal Code of the Republic of Slovenia (Official Gazette of RS, No. 55/08, 66/08 and 39/09), The Production of and Trade in Illicit Drugs Act (Official Gazette of RS, No. 108/99, 44/00, 2/04 and 47/04), Act Regulating the Prevention of the Use of Illicit Drugs and the Treatment of Drug Users (Official Gazette of RS, No. 98/99), Decree on the Scheduling of Illicit Drugs (Official Gazette of RS, No. 49/00, 8/01).

In 2011 the National Assembly of the Republic of Slovenia adopted draft amendments to the Criminal Code (Official Gazette RS, No. 91/2011), amending both articles governing the issue of illicit drugs. After amendment, Article 187 of the Criminal Code allows the purchase or possession of illicit drugs and facilitation of illicit drug use under specific legal and health conditions, thus enabling the establishment of safe injecting rooms.

Last year the Government of the Republic of Slovenia added a new substance, namely mephedrone (4-methylmethcathinone), to the list of drugs included in the Decree on the scheduling of illicit drugs, and classified it into Schedule I of illicit drugs, that is in the same schedule with MDMA, which is not used for medical purposes.

The Ministry of Health adopted two sets of rules in 2011 relating to driving and methods for assessing physical and mental capacity in cases of illicit drug use, among others. These rules are the Rules on health conditions of drivers of motor vehicles (Official Gazette RS, No. 47/11) and the Rules on the list of narcotic drugs, psychoactive drugs or other psychoactive substances and their metabolites (Official Gazette RS, No. 83/11).

In July 2012 the Government of the RS adopted the National Crime Prevention and Crime Control Strategy, which gives much attention to drugs. The solutions to drug-related problems set out in the Strategy include the prevention of illicit drug supply, drug use prevention, and treatment and social rehabilitation of drug users. As a competent institution responsible for coordination in the field of drugs, the Ministry of Health (together with other competent ministries and non-governmental organizations) is responsible for the implementation of the mentioned strategy, especially the chapter on illicit drugs.

The latest analysis of the operation of the local action groups (LAGs) network in Slovenia shows a decline in the number of LAGs in Slovenia. According to the analysis, there are currently 42 active LAGs in Slovenia.<sup>1</sup>

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<sup>1</sup> Source: Report of the Regional Institute of Public Health Ravne - available from the author

Drug-related programmes in Slovenia are funded by various sources. Most of these programmes are still funded from the national budget and by the Health Insurance Institute of Slovenia. Some financial resources come from various foundations and membership dues paid by members of non-governmental organizations. This year, for the first time, we present information on financial resources provided by Slovenian city municipalities to help solve drug-related problems. Based on available data, we estimate that at least EUR 10,416,949.61 was allocated to the prevention and treatment of drug-related problems in Slovenia in 2011.

## 1.1 Legal framework

In the Republic of Slovenia, the field of illicit drugs is regulated by the following acts and decrees:

- The Criminal Code of the Republic of Slovenia (Official Gazette of RS, No. 55/08, 66/08 – amend. and 39/09) regulates two (major) criminal offences related to illicit drugs in the chapter relating to criminal offences against human health. Article 186 of the Criminal Code regulates the criminal offence of "Illicit production of and trafficking in illicit drugs, illicit substances in sports and precursor substances for manufacturing illicit drugs" and Article 187 of the Criminal Code regulates the criminal offence of "enabling consumption of illicit drugs or illicit substances in sports."
- The Production of and Trade in Illicit Drugs Act (Official Gazette of RS, No. 108/99, 44/00, 2/04 and 47/04) deems illicit drugs as plants and substances of natural or synthetic origin which have psychotropic effects and which can influence a person's physical or mental health or threaten a person's appropriate social status.
- The Act Regulating the Prevention of the Use of Illicit Drugs and the Treatment of Drug Users (Official Gazette of RS, No. 98/99) among other points defines treatment and solving social problems related to drug use.
- Decree on the Scheduling of Illicit Drugs (Official Gazette of RS, No. 49/00, 8/01) holds the classification of illicit drugs.

### New developments

The Criminal Code (Official Gazette RS, Nos. 55/08, 66/08, 39/09 and 91/2011), more specifically its chapter on criminal offences against public health, covers two (serious) criminal offences in connection with illicit drugs. Article 186 of the Criminal Code defines the criminal offence of "Unlawful manufacture and trafficking of narcotic drugs, doping substances and precursors used to manufacture illicit drugs", and Article 187 thereof defines the criminal offence of "Facilitating the consumption of illicit drugs and doping substances". On 14 November 2011 the National Assembly of the RS adopted draft amendments to the Criminal Code, including draft amendments to both articles covering drug-related criminal offences. The most important amendment concerns the possibility of creating safe injecting rooms, which could become a part of officially approved treatment programmes or a means to help manage or reduce and control drug addiction. These amendments to the Criminal Code provide that the facilitation of drug use (safe injecting rooms) is not unlawful when it is



part of an addiction treatment programme or a supervised drug use programme which is approved under applicable laws and implemented within the public healthcare framework. The basic purpose of safe injecting rooms is the prevention of blood borne virus infections (HIV, hepatitis) and bacterial infections, overdose prevention and the possibility of effective social assistance for drug users. In addition, safe injecting rooms will reduce drug use in public places, and decrease the number of discarded needles.

In 2011 the Government of the RS added a new substance, namely mephedrone (4-methylmethcathinone), to the list of drugs included in the Decree on the scheduling of illicit drugs, and classified it into Schedule I of illicit drugs, that is in the same schedule with MDMA, which is not used for medical purposes. Mephedrone was included in the Decree because the Council of the European Union adopted a decision on 30 November 2010, requiring that EU Member States submit 4-methylmethcathinone (mephedrone) to control measures on the basis of their obligations arising from the United Nations Convention on Psychotropic Substances of 1971.

The main reasons for the control or regulation of the mentioned substance are:

1. Mephedrone is a synthetic cathinone. Its physical effects are similar to those experienced by ecstasy (MDMA) or cocaine users, and it is used as a substitute for these two substances.
2. Mephedrone can cause acute health problems and lead to dependency.
3. It is not used for medical purposes.

The Ministry of Health adopted two sets of rules in 2011, relating to driving and methods for assessing physical and mental capacity in cases of illicit drug use, among others. These rules are the Rules on health conditions of drivers of motor vehicles and the Rules on the list of narcotic drugs, psychoactive drugs or other psychoactive substances and their metabolites.

Annex I of the first Rules sets out the criteria and methods for assessing physical and mental capacity of driver candidates and drivers with various medical conditions in different cases, including illicit drug use, the use of psychotropic substances and their metabolites, and in cases of past abuse of psychoactive medications or successfully completed treatment of addiction and stable abstinence from the mentioned substances.

The second set of rules allows a driver who is in treatment for illicit drug addiction in a drug addiction treatment programme (in accordance with applicable laws governing illicit drug addiction treatment) and is undergoing substitution therapy, i.e. is using drugs that are labelled as trionics (absolute or relative prohibition from operating a vehicle) in accordance with drug labelling requirements and contain illicit substances from illicit drug schedules I, II or III (according to the Decree on the scheduling of illicit drugs), to drive a vehicle if his or her driving capacity has been assessed in a medical examination and found adequate in accordance with regulations governing driver health assessment. This means that a person undergoing substitution therapy in a treatment programme is allowed to drive a vehicle under certain conditions, including regular examinations or capacity assessments, despite the fact

that the substitution therapy includes the use of illicit drugs (e.g. methadone), since driving is very important for drug users' comprehensive rehabilitation and reintegration.

Draft amendments to the Production of and Trade in Illicit Drugs Act are pending due to negotiations within the governmental coalition. Further consideration of the Act was suspended at the end of 2011 due to early elections to the National Assembly, which is also why further consideration of the new national programme on illicit drugs was postponed.

## **1.2 National action plan, strategy, evaluation and coordination**

The Ministry of Health and the Commission on Narcotic Drugs of the Slovenian Government are responsible for coordination in the field of drugs at the government level. At the local level, local action groups remain the main coordinators of activities in local communities.

The highest coordinating body in the field of drugs is the Commission on Narcotic Drugs of the Slovenian Government, which is an inter-ministerial body at the government level. The Commission held two meetings in 2011. Among other things, it considered the annual national report on the drug situation and the reports on the implementation of harm reduction programmes in Slovenia as well as the report and proposal on the operation of Local Action Groups. The Ministry of Health ensures that the Commission on Narcotic drugs stays operational by preparing materials for meetings and arranging for the Commissions decisions to be implemented. Drug-related measures are implemented within different governmental departments: the Ministry of the Interior, the Ministry of Labour, Family and Social Affairs, the Ministry of Education and Sports, the Ministry of Justice, the Ministry of Finance, the Ministry of Foreign Affairs, the Ministry of Higher Education, Science and Technology, the Ministry of Agriculture, Forestry and Food, the Ministry of Defence and the Ministry of Health.

With the aim of revitalizing local action groups, the Regional Institute of Public Health Ravne drew up a plan, which was approved by the Commission on Narcotic Drugs of the Slovenian Government. Already a few years ago Slovenia introduced an efficient model of local community work in the form of local action groups (LAGs) for the prevention of addiction. A local action group is a technical advisory body of the mayor and the municipal council. Past analyses and experience show that the main problems regarding LAGs' work are loose structure and insufficient coordination between the groups. Therefore it is necessary to strengthen the links and improve the coordination between LAGs to ensure successful cooperation in the future.

The Commission on Narcotic Drugs has confirmed that the competent LAG coordinator at the national level is the Regional Institute of Public Health Ravne. The national coordinator is the main coordinative, research and development body, which is responsible for interdisciplinary coordination, ensures the implementation of national policies and programmes in local communities and monitors and evaluates programmes. It is a body responsible for the coordination between the state, its regions and local communities.

In addition to coordination, the Institute would also be responsible for the establishment of:

- a system of continuing education and training of regional coordinators and LAG members (participation in professional events, education of teachers, etc.),
- a uniform system for monitoring and evaluating all LAGs' activities (quality criteria and professional guidance),
- an information system (a single system for data collection and dissemination; continuous management and analysis of the current situation in a local community; regular communication between important players or authorities, etc.).

The main objectives of LAGs are to promote health and healthy lifestyle through different activities, which include the implementation and promotion of preventive activities and development of leisure activities, provision of information, coordination, assessment of problems, and activities aimed at encouraging the public to participate.

### 1.3 Economic analysis

Drug-related programmes in Slovenia are funded by various sources. Most of these programmes are still funded from the national budget and by the Health Insurance Institute of Slovenia. Some financial resources come from various foundations and membership dues paid by members of non-governmental organizations. There are still very few donations or there are no available information on donations.

#### **Budget appropriations**

Through public tendering the Ministry of Health dedicated EUR 140,000.00 to drug-related programmes for 2011 and 2012. Half of this amount was paid to selected programmes in 2011. In the same year the Ministry co-funded some other events and activities, which accounted for EUR 177,326.67 (prevention month, the Student Arena event, the meeting of permanent correspondents of the Pompidou Group and, in this context, a regional ministerial conference and a Correlation Conference, a population-based study on the use of illicit drugs, alcohol and tobacco; a proportionate share of resources was allocated for the operation of the Illicit Drug Unit of the Institute of Public Health). Financial resources allocated by the Ministry of Health to address drug-related problems in 2011 amounted to EUR 247,326.67.

The Office for Youth of the RS co-funded activities or those programmes that can be identified as direct implementation of activities in the field of illicit drugs. It provided EUR 58,994.00 for such activities and programmes.

In 2011 the Ministry of Labour, Family and Social Affairs (MLFSA) distributed EUR 3,213,519.00 among drug user treatment programmes through public tendering.

Table 1.1: MLFSA's financial resources allocated to drug-related social security programmes, 2008–2011

MDDSZ's resources allocated to:	Social rehabilitation programmes for addicts (EUR)	Therapeutic community programmes and other programmes that provide housing for drug users, together with associated networks of reception and day centres, reintegration centres, programmes for parallel therapeutic support for the families of drug addicts, and other programmes for drug users or alternatives to therapeutic communities (EUR)	Low-threshold programmes for drug users, networks of centres for counselling and social rehabilitation of illicit drug addicts who need treatments or assistance every day (EUR)
Year:			
2011	3,213,519.00		
2010	2,713,129.37*	1,575,993.26	587,876.52
2009	2,558,798.00*	1,514,458	544,492.50
2008	2,290,728.00*	1,445,691	399,013.40

\*This figure does not represent the sum of the amounts in the third and fourth column of the table, since, in addition to drug-related programmes, some other social security programmes (prevention programmes, programmes dealing with alcoholism and other forms of addiction as well as eating disorders) are funded with resources from the "Social rehabilitation programmes for addicts" budget line

Source: Report of the Ministry of Labour, Family and Social Affairs of the RS<sup>2</sup>

The Ministry of Public Administration issued a public tender for the implementation of European Cohesion Policy projects for the period 2010–2012, and selected two substantive networks of non-governmental organizations. The Institute for Research and Development Utrip received EUR 160,000.00 for the establishment of a prevention platform of NGOs working in the field of addiction prevention. The DrogArt Association received EUR 156,426.00 for the project of empowerment of NGOs working in the field of harm reduction. The purpose of public co-funding is to promote the development of the non-governmental sector and the civil dialogue in relevant thematic areas. Financial resources were allocated for the implementation of all activities carried out over the mentioned two-year period, and are not included in the summary tables in this year's financial report.

The Slovenian Criminal Police uses more than half a million Euros each year in its fight against organized crime. Data show that financial resources used for the implementation of covert investigative measures and technical equipment amounted to EUR 657,254.05 in 2011, whereas a year before they amounted to EUR 576,040.00. A large part of these resources is allocated to the fight against illicit drugs. Since information on such resources often refer to a number of different offences, we cannot present accurate data on the amounts of financial resources allocated to the field of illicit drugs.

The Health Insurance Institute of Slovenia provided EUR 5,623,535.27 for the operation of centres for the prevention and treatment of drug addiction in 2011. EUR 2,709,098.00 was spent on operational costs (personnel, facilities, etc.), and EUR 2,914,437.27 on substitute drugs (methadone and other drugs).

<sup>2</sup> Available from the author. Received via e-mail. The report is not publicly available yet

Furthermore, the Health Insurance Institute of Slovenia provided EUR 152,850.00 for the purchase of sterile material for safer drug injection in 2011. The said amount was distributed by the Regional Institute of Public Health Koper between harm reduction programme operators.

In 2011 the Fiho foundation dedicated EUR 342,991.97 to drug-related programmes organized as NGOs.

In this year's report we report for the first time on the co-funding of drug-related programmes by Slovenian municipalities. A city municipality is a political territorial unit which encompasses a large city and its near surroundings; more precisely, it is a dense settlement or several settlements connected into a single spatial organism and its urban surroundings, which are connected by daily commuter flows. Article 16 of the Local Self-Government Act (Official Gazette RS, No. 94/2007) provides that a city can attain the status of an urban municipality if it has at least 20,000 inhabitants and can offer at least 15,000 jobs, at least half of which must be in the tertiary and quaternary sectors, and if it is the geographical, economic and cultural centre of its gravitation area. In exceptional cases, a city may attain the status of an urban municipality for historical reasons. The state may delegate to a municipality part of its tasks or duties relating to the development of the city. Slovenia has 11 city municipalities: Ljubljana, Maribor, Celje, Novo mesto, Kranj, Koper, Nova Gorica, Murska Sobota, Velenje, Ptuj and Slovenj Gradec. Co-funding of drug-related programmes is presented in the table below.

Table 1.2: *Financial resources used in the field of drugs by city municipality, 2011*

	Municipality	Amount
1.	Celje	28,545.63
2.	Koper	45,000.00
3.	Kranj	87,210.00
4.	Ljubljana	342,214.30
5.	Maribor	106,773
6.	Murska Sobota	700.00
7.	Nova Gorica	38,831.00
8.	Novo mesto	30,000.00
9.	Ptuj	22,801.93
10.	Slovenj Gradec	66,786.84
11.	Velenje	8,870
	<b>Total</b>	<b>777,732.70</b>

Source: City municipalities

Table 1.3: Aggregated data on financial resources used in the field of drugs, 2011

	Funder	Amount
1.	City municipalities	777,732.70
2.	FIHO	342,991.97
3.	Office for Youth	58,994.00
4.	ZZZS	5,776,385.27
5.	MH	247,326.67
6.	MLFSA	3,213,519.00
	<b>Total</b>	<b>10,416,949.61</b>

Sources: Budget of the RS, Health Insurance Institute of Slovenia, Fiho, city municipalities

The report contains only information from available reports on the funding of various drug-related programmes. Reports of some programme co-funders show that they co-fund various organizations and projects as a whole, therefore it is difficult to determine the amount used in the implementation of the entire programme and the amount used only in the field of drugs. We can estimate that the resources used to address drug-related problems in Slovenia amounted to at least EUR 10,416,949.61 in 2011 (Table 1.3).

### Report of the Pompidou Group meeting in Ljubljana

On the initiative of Ministry of Health and the permanent correspondents of the Pompidou Group, there was a high-level meeting held in Ljubljana on 13 December 2011. It was attended by 72 delegates from 30 European countries and Morocco. The purpose of the meeting and the initiative itself was to revitalize regional cooperation between the competent bodies in the Southeast Europe responsible for legislation, politics, treatment programmes and programmes designed to reduce the supply of illicit drugs.

A special political declaration which stresses the importance of regional cooperation in the field of drugs and the role of the Pompidou Group in this regard was adopted at the high-level meeting. The declaration gives countries the opportunity to develop programmes and contents that take into account the needs and interests of participating countries in tackling drug-related problems. This offers an opportunity to form a special working group within the Pompidou Group which would elaborate more in detail the selected drug-related contents in the region, which is known for one of the most famous drug trafficking routes used to transport various drugs, not only heroin, from the East to Western and Central Europe, and to transport drug precursors in the opposite direction.

The declaration also stresses that the common drug policy must be balanced, comprehensive, multidisciplinary and transparent in order to be successful. All verified measures and activities aimed at reducing the demand for and supply of drugs should be equally taken into account and developed, including harm reduction programmes.

The declaration also highlights the important role of civil society which generally represents the force that promotes and strives towards the progress of the society in all fields, for the general good of all or at least of the majority, thus preserving the wealth of social diversity, which is a precondition for social cohesion, peace, coexistence and cooperation.

Two new members joined the Pompidou Group at the high-level meeting, namely Montenegro and Morocco. Therefore, the Pompidou Group now consists of thirty-eight active Council of Europe member states.

#### **Amendments to the Criminal Code-1B (KZ-1B) regarding drugs**

Unlawful manufacture of and trafficking in narcotic drugs, doping substances and precursors used to manufacture illicit drugs

##### Article 186

(1) Whoever unlawfully manufactures, processes, sells or offers for sale plants or substances, which are classified as illicit drugs or illicit doping substances, or the precursors used to manufacture narcotic drugs, or whoever purchases, possesses or transports such drugs or substances with intent to resell them or “make them available”, or arranges the sale or purchase or otherwise unlawfully makes available for sale such drugs or substances, shall be sentenced to imprisonment for not less than one and not more than ten years.

(2) Whoever sells, offers for sale or hands out free of charge illicit drugs “or doping substances” or precursors used to manufacture illicit drugs to a minor, mentally disabled person, person with a temporary mental disorder or severe mental retardation or person who is in addiction treatment or rehabilitation process, or if the offence is committed in educational institutions or in immediate vicinity thereof, in prisons, military units, public places or at public events, or if the offence under paragraph 1 is committed by a civil servant, priest, doctor, social worker, teacher or educator, and thereby exploits his or her position, or whoever uses minors to commit the mentioned offence shall be sentenced to imprisonment between three and fifteen years.

(3) If the offence specified in paragraph 1 “or” 2 hereof was committed within a criminal organisation which exists with the aim of committing such criminal offences, or if the perpetrator of this offence organised a network of resellers or agents, the perpetrator shall be sentenced to imprisonment between five and fifteen years.

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

“(5) Illicit drugs or illicit doping substances and the means of their manufacture shall be seized. Means of transport shall be seized if they have specially adapted space or compartment for the purposes of transport and storage of drugs or illicit doping substances or if their owner was aware or should have been aware that the means of transport would be used for such purposes.”

Facilitating the consumption of illicit drugs and doping substances.

#### Article 187

(1) Whoever solicits another person to use illicit drugs or illicit doping substances or provides a person with drugs to be used by him or her or by a third person, or whoever provides a person with a place or other facility for the use of illicit drugs or illicit doping substances or otherwise enables a person to use illicit drugs or doping substances shall be sentenced to imprisonment for not less than six months and not more than eight years.

(2) Whoever commits the offence specified in paragraph 1 against several persons, a minor, mentally disabled person, person with a temporary mental disorder or severe mental retardation or a person who is in addiction treatment or rehabilitation process, or if the offence is committed in educational institutions or in immediate vicinity thereof, in prisons, military units, public places or at public events, or if the offence under paragraph 1 is committed by a civil servant, priest, doctor, social worker, teacher or educator, and thereby exploits his or her position, shall be sentenced to imprisonment between one and twelve years.

(3) Illicit drugs, doping substances and the tools or devices for their consumption shall be seized.

(4) The act specified in paragraph 1 or paragraph 2 hereof is not unlawful if it is performed as part of an addiction treatment programme or a supervised drug use programme which is approved in accordance with applicable laws and implemented within the public health system or under its control.



## DRUG USE IN THE GENERAL POPULATION AND SPECIFIC TARGETED GROUPS

# 2.

The National Institute of Public Health (NIPH) conducted a survey on the use of tobacco, alcohol and other drugs in 2011 and 2012. The target population of the survey included inhabitants of Slovenia aged between 15 and 64 years living in private households. 15,200 people aged between 15 and 64 were included in the survey. 7,516 people answered survey questions, which means that the survey response rate was 50%. To determine the prevalence of drug use in the general population, three standard time frames were used, namely lifetime use (use of drugs at any time in an individual's life), use of drugs in the past 12 months before the survey (past-year drug use) and use of drugs in the past 30 days before the survey (past-month drug use). According to the Survey on the use of tobacco, alcohol and other drugs, 16% of inhabitants of Slovenia have used an illicit drug on one or more occasions in their lifetime. Most of those who reported lifetime drug use (15.8%) used cannabis or hashish. 2.1% of people reported lifetime use of cocaine, and the same proportion of people reported lifetime use of ecstasy. 1% reported lifetime use of LSD, and amphetamines and heroin were used by less than one percent of people each. 6.4% of people reported lifetime polydrug use. Data broken down by sex shows that prevalence rates of drug use are higher among men than among women for all the mentioned drugs. A comparison with the European Union showed that the lifetime prevalence of cannabis use in Slovenia is below the European average, and so is the use of some other drugs.

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In 2011, the European School Survey Project on Alcohol and Other Drugs (ESPAD) was conducted for the fifth time in Slovenia. The survey is carried out with a representative sample of students who turn 16 years old in the data collection year. The main objective of the ESPAD survey is to collect comparable data on the use of various psychoactive substances among 15- and 16-year-old students in Europe to monitor trends in individual countries and between countries. The questionnaire contains questions about the use of different drugs in lifetime, 12 months and 30 days before the survey. According to survey results, 24.8% of respondents have used at least one illicit drug in their lifetime. The data also show a trend similar to those in other countries, namely the stabilization of the prevalence of illicit drug use after 2007. Slovenian prevalence rates of lifetime use of inhalants and cannabis stand out in comparison with the ESPAD countries average rates; 20% of Slovenian respondents reported lifetime use of inhalants, and 23% reported lifetime use of cannabis.

The study of drinking environments and young people's drinking behaviours conducted in four European cities (Liverpool, Palma de Mallorca, Utrecht and Ljubljana) shows that the

number of young people who preload (drink before going out) is significantly lower in Ljubljana than in other cities. Furthermore, Ljubljana had the lowest blood alcohol concentration for women, and the second lowest blood alcohol concentration for men. As regards the assessed features, such as noise, crowding, ventilation, temperature, lighting and cleanliness, the bars and night clubs in Ljubljana proved less problematic than those in other participating cities.

## 2.1 Drug use in the general population

### Survey on the use of tobacco, alcohol and other drugs in the population aged 15-64

*Romana Štokelj, Andreja Drev, Darja Lavtar, Nataša Delfar*

The National Institute of Public Health conducted a Survey on the use of tobacco, alcohol and other drugs in 2011 and 2012. The target population of the survey included inhabitants of Slovenia aged between 15 and 64 years living in private households.

#### Methodology and sample

The basis for the sampling frame comprised the framework of survey districts and data from the Central Population Register. The sample was prepared by the Statistical Office of the Republic of Slovenia in accordance with the National Statistics Act. The sample was two-stage stratified. Information for each person in the sample included the person's first and last name.

The survey was conducted in two parts, i.e. in 2011 and 2012. The sample used in 2011 comprised 7,200 people, and the one used in 2012 comprised 8,000 people. Thus, 15,200 inhabitants aged between 15 and 64 were included in the survey. 7,516 people answered survey questions, which means that the survey response rate was 50%. 51.4% of respondents were male, and 48.6% were female. More than a third of respondents (36.9%) were between 15 and 34 years old, and 63.1% were 35-64 years old. 57.9% of respondents had lower secondary or vocational education or vocational or general secondary education; 13.1% of respondents had primary or lower education, and the remaining 28.9% respondents had higher education. More than half (55.1%) of respondents were employed, 13.9% were pupils or students, 13.3% were retired, 9.1% unemployed, and 4.7% self-employed. The remaining 3.9% were farmers, housewives, unpaid family workers or people incapacitated for work due to old age, illness or disability.

The survey was conducted using a mixed-mode methodology, which included:

- online survey;
- telephone survey follow-up (including all online survey nonrespondents whose telephone numbers were available);
- face-to-face survey follow-up (including all online and telephone survey nonrespondents, and persons whose telephone numbers were not available).

Selected persons were informed about the survey by an invitation letter sent by the NIPH, informing them about the survey, the possibility to answer the survey questions online, and about the planned visit of an interviewer or a telephone interview.

The EMCDDA recommendations: Handbook for Surveys on Drug Use Among the General Population<sup>3</sup> were taken into account in preparing the questionnaire, which contains questions about smoking, illicit drugs (cannabis, ecstasy, amphetamines, cocaine, heroin, LSD, and other drugs) and attitudes towards drug use. In addition to questions about tobacco and drug use, an extensive set of questions about alcohol, more precisely about alcohol consumption (beer, wine, spirits) and attitudes towards alcohol, was added to the questionnaire.

To determine the prevalence of drug use in the general population, three standard time frames were used, namely lifetime use (use of drugs at any time in an individual's life), use of drugs in the past 12 months before the interview (past-year drug use) and use of drugs in the past 30 days before the interview (past-month drug use).

Preliminary data are presented below.

## Results

### Attitudes towards illicit drugs

The Survey on the use of tobacco, alcohol and other drugs also included questions about people's opinions or attitudes towards drug users, drug use and the associated risks. More than half of the Slovenian population (56%) perceives drug users as sick people. More than two thirds (64.3%) of Slovenians are of opinion that cannabis should not be legalized, 16.5% are undecided on this issue, and 13% think that cannabis should be legalized. More men than women agree that cannabis use should be legal. 35.8% of inhabitants have no arguments against occasional cannabis use, while more than two thirds (64.2%) are against or strongly against occasional cannabis use. 65% of inhabitants also think that regular cannabis use poses great risks, 31.8% think that it poses slight or moderate risks, and only 3.1% of people believe that regular cannabis use is not associated with any risks. 35% of respondents associate one- or two-time use of ecstasy with great risk, and 47% associate one- or two-time use of cocaine with great risk.

### Illicit drug use

According to the Survey on the use of tobacco, alcohol and other drugs, 16% of inhabitants have used an illicit drug on one or more occasions in their lifetime. Most of those who reported lifetime drug use (15.8%) used cannabis or hashish. 2.1% of people reported lifetime use of cocaine, and the same proportion of people reported lifetime use of ecstasy. 1% reported lifetime use of LSD, and amphetamines and heroin were used by less than one percent of people each. 6.4% of people reported lifetime polydrug use<sup>4</sup> (Table 2.1). Data broken down by sex shows that prevalence rates of drug use are higher among men than

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<sup>3</sup> Available at: <http://www.emcdda.europa.eu/html.cfm/index58052EN.html>

<sup>4</sup> As regards polydrug use, the questionnaire included the following drug combinations: alcohol and cocaine or LSD or heroin; alcohol and cannabis or hashish; alcohol and sedatives; cocaine and heroin or LSD or amphetamines (speed) or cannabis

among women for all the mentioned drugs (Table 2.1). Men to women ratio regarding lifetime use of cannabis, hashish, ecstasy or LSD is 2:1, while the ratio regarding lifetime use of cocaine, amphetamines or heroin is 3:1.

Table 2.1: Lifetime use of illicit drugs by type of drug and sex, and total

Type of illicit drug	Men (%)	Women (%)	Percentage of population (%)	Indicative number
Cannabis/hashish	19.6	11.8	15.8	223,000
Cocaine	2.9	1.2	2.1	29,000
Ecstasy	2.7	1.4	2.1	29,000
LSD	1.4	0.6	1.0	14,000
Amphetamines	1.4	0.5	0.9	13,000
Heroin	0.7	0.3	0.5	7,000
Polydrug use	8.5	4.3	6.4	91,000

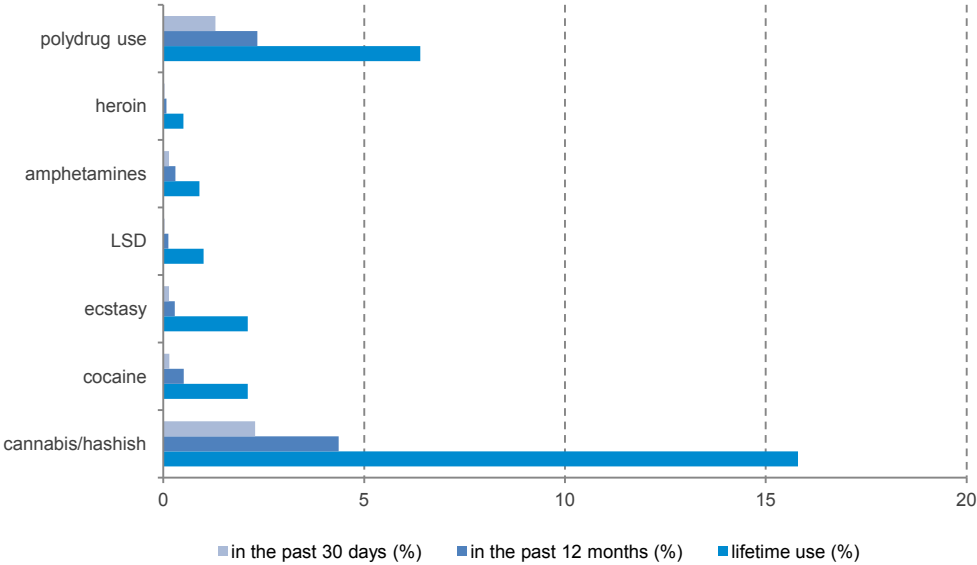
Source: NIPH, Survey on the use of tobacco, alcohol and other drugs 2011-2012

Data regarding past-year drug use show that 4.4% of people used cannabis or hashish, while other illicit drugs such as cocaine, ecstasy, LSD, amphetamines and heroin were used by less than 1% of people each. 2.3% of people reported polydrug use during the 12 months before the interview (Figure 2.1).

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2.3% of people used cannabis or hashish during 30 days before the interview, 8% of which used the drug every day. Less than 1% of people used other drugs in the past month before the interview, and 1.3% reported past-month polydrug use (Figure 2.1).

Figure 2.1: Lifetime, past-year and past-month use of illicit drugs by type of drug



Source: NIPH, Survey on the use of tobacco, alcohol and other drugs 2011-2012

As regards frequency of use in the past 30 days, cannabis was used most frequently, namely for 8 days on average (this data applies to those who used cannabis during the 30 days before the interview), followed by amphetamines with an average of 4 days of use, and cocaine with an average of 3 days of use. The average number of days of polydrug use was 4.

Cocaine accounted for the highest average age of first illicit drug use (22 years), followed by heroin with 21 years, LSD with 20 years, and cannabis, ecstasy and amphetamines with 19 years. It is interesting that the average age of first polydrug use was 18 years. The reason for the lower average age of first polydrug use is probably the fact that the questionnaire included, among other drug combinations, the simultaneous use of alcohol and sedatives.

#### Comparison with the European Union

Similarly as in the European Union (EU), cannabis is the most prevalent illicit drug in the general population. A comparison between Slovenia and the EU shows that lifetime cannabis use is lower than the EU average of 23.2% (Table 2.2). However, there are significant differences between individual EU countries, since their prevalence rates range from 1.5% to 32.5% (EMCDDA 2011a). Slovenia belongs to the largest group of countries where the prevalence of cannabis use ranges from 10% to 30% of all adults. Slovenia's lifetime cannabis use prevalence rate is comparable with those in Slovakia (16.1%) and Norway (14.6%) (EMCDDA Statistical bulletin 2012). Furthermore, a comparison of data on past-year and past-month cannabis use shows that Slovenia's prevalence rates are lower than the EU averages, which are 6.7% and 3.6% respectively (Table 2.2).

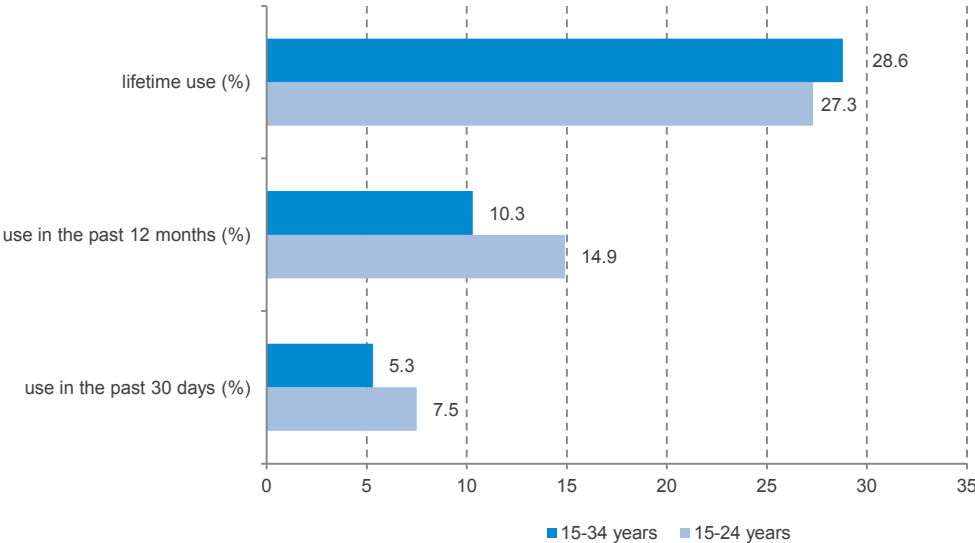
*Table 2.2: Lifetime, past-year and past-month cannabis use in the general population in Slovenia, and the European Union averages*

	Slovenia (%)	EU average (%)
Lifetime use	15.8	23.2
Use in the past 12 months	4.4	6.7
Use in the past 30 days	2.3	3.6

Source: NIPH, Survey on the use of tobacco, alcohol and other drugs 2011-2012; EMCDDA, 2011a

Cannabis is used mainly by young people (15-34 years old), and the 15-24 age group generally has the highest frequency of use in the past year (EMCDDA, 2011a). Also in Slovenia, according to the aforementioned survey, the prevalence of lifetime cannabis use is the highest in the 15-34 age group, and the 15-24 age group has the highest frequency of cannabis use in the past year (Figure 2.2).

Figure 2.2: Lifetime, past-year and past-month cannabis use in the 15–34 and 15–24 age groups

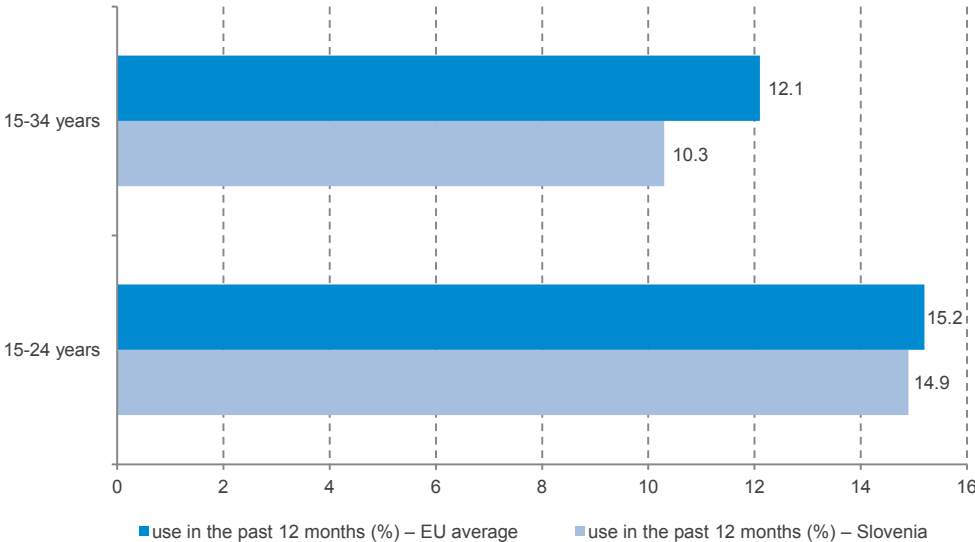


Source: NIPH, Survey on the use of tobacco, alcohol and other drugs 2011-2012

A comparison with the EU shows that the prevalence rates of lifetime, past-year and past-month cannabis use among young people in Slovenia are lower than the European averages (Figure 2.3).

Figure 2.3: Comparison of Slovenia's prevalence of past-year cannabis use with the EU average

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Source: NIPH, Survey on the use of tobacco, alcohol and other drugs 2011-2012; EMCDDA, 2011a

The EU average prevalence rates of lifetime cocaine, ecstasy and amphetamine use are 4.3%, 3.2% and 3.8% respectively, and the prevalence of lifetime LSD use ranges from 0 to 5.5% (EMCDDA, 2011a). A comparison with Slovenia shows that its prevalence rates of the use of these drugs are lower than EU average rates.

Age group comparison shows that the majority of Slovenian cocaine users are a bit younger than 30, while ecstasy and amphetamines are mostly used by people aged about 30 or a bit older; Slovenian LSD or heroin users are slightly older, as most of them are aged between 35 and 39 years.

#### Trends

Due to different sampling and survey mode, it is very difficult to compare data on lifetime illicit drug use in Slovenia obtained in past surveys; therefore it is currently not possible to determine the trends. The trends determined in ESPAD 2011 and HBSC 2010 surveys show that the prevalence of illicit drug use and the prevalence of cannabis use among adolescents have stabilized (Stergar et al. in press, Jeriček et al. 2012).

#### Conclusion

The Survey on the use of tobacco, alcohol and other drugs shows that 16% of people living in Slovenia aged 15-64 years have used illicit drugs at least once in their life. The most prevalent drug among the general population is cannabis. A comparison with the European Union shows that the prevalence of cannabis use in Slovenia is below the European average, and so is the use of some other drugs. More men than women use cannabis, and the prevalence of cannabis use is the highest among young adults. Even though cannabis is the most prevalent drug in Slovenia, more than two thirds of Slovenians think that it should not be legalized.

The survey also brought attention to the phenomenon of polydrug use, which is most prevalent among young adults. Polydrug use in young adults might be a sign of established patterns of simultaneous use of several different drugs, which is often associated also with frequent and excessive drinking of alcohol (EMCDDA 2009). Since polydrug use poses high risks and brings long-term health and other consequences, this phenomenon should be monitored more closely in the future.

#### Review of other past surveys in the field of drugs in the general population

In the 2008 survey on the prevalence of illicit drug use among the Slovenian population aged between 18 and 65, 15.8% of respondents stated that they had used illicit drugs at least once in their life; 15% of these respondents had used cannabis (Stergar 2010). According to the EHIS 2007 survey (European Health Interview Survey), 2.6% of people aged 15 years or older used cannabis during 12 months before the survey, and 0.9% of respondents used other illicit drugs in the past 12 months (Krek and Štokelj 2009). According to the data obtained in the Slovenian Public Opinion Survey (SPOS), 4.3% of respondents reported lifetime use of illicit drugs in 1994, while in 1999 lifetime drug use was reported by 10.6% of respondents (Toš et al. 1999, Toš et al. 1994) (Table 2.3).

Table 2.3: Proportions of respondents in individual surveys who reported lifetime illicit drug use, and proportions of respondents who reported lifetime cannabis or hashish use

	2008 survey on the prevalence of PAS in the general population n=1251 (%)	EHIS 2007 (past-year illicit drug use) n=2112 (%)	SPOS 1999 n=1012 (%)	SPOS 1994 n=1037 (%)
Any illicit drug	15.8	0.9	10.6	4.3
Cannabis/hashish	15.0	2.6	8.1	3.9

Source: Drev et al. 2011

## 2.2 Drug use in the school and youth population

### ESPAD 2011

*Eva Stergar*

The European School Project on alcohol and other drugs (ESPAD) has been implemented in accordance with a standardized international methodology and coordinated by the Swedish Council for Information on Alcohol and other Drugs (CAN) since 1995 at four-year intervals. The main purpose of the ESPAD survey is to collect comparable data on the use of various psychoactive substances among 15- and 16-year-old students in Europe to monitor trends in individual countries and between countries. Slovenia has participated in all five surveys carried out so far.

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### Methodology

#### Sample

Data is collected in stratified random samples consisting of students turning 16 years of age in the year of data collection – thus, the 2011 survey covered students born in 1995. The primary sampling unit is the class. Classes are randomly selected from four lists of first-grade classes in Slovenian secondary schools drawn up according to the type of study programme. 4,386 first-grade students from 180 secondary school classes were included in the sample in 2011, and 3,851 of them filled out questionnaires. 3,186 students (1,561 boys and 1,625 girls) born in 1995 are included in the final database. Their average age was 15.8 years.

#### Questionnaire

The questionnaire consists of core questions, multiple-choice questions, and modules. Core questions must be used by all countries. They relate to selected demographic variables, frequency of lifetime, last 12 months and last 30 days use of various drugs, age at initiation and onset of regular drug use, attitudes and beliefs about drugs (accessibility, health risks), assessment of frequency of drug use among peers and older siblings, family background, school performance, leisure activities, satisfaction with relationships (with parents, peers). Each participating country may select some optional questions and questions from up to two modules. In addition to core questions, the Slovenian questionnaire contains the psychosocial and the integration modules.



## Field procedure

Data collection was done by school counsellors. All students were informed that their participation would be on an anonymous and voluntary basis (questionnaires are to be returned in sealed envelopes). Data were collected in one week chosen according to principle that no public or school holidays occurred one month before.

Data entry and data processing are carried out using the SPSS software.

## Definition of selected terms

Regular use: regular users are those respondents who answered the question about the lifetime use of a certain drug by stating that they had used it 40 or more times.

Any illicit drug: this variable encompasses cannabis, amphetamines, cocaine, crack, ecstasy, LSD or other hallucinogens, heroin and GHB.

ESPAD countries: countries that participated in the survey in 2011 and whose data are included in the 2011 international report.<sup>5</sup>

## Results

### Any illicit drug; cannabis

Almost every other Slovenian respondent (45%) perceives cannabis to be fairly or very easily accessible, one quarter of respondents perceive sedatives to be readily available, one fifth consider ecstasy easily accessible, and 13% of respondents consider amphetamines fairly or very easily accessible.

One quarter of respondents said that they had used illicit drugs at least once in their lifetime – there was a statistically significant difference between males and females, as more boys than girls had used drugs in their lifetime ( $\chi^2=27.831$ ,  $df=5$ ,  $p<0.0001$ ,  $C=0.09$ ) (Table 2.4).

Table 2.4: *Lifetime use of any illicit drug, 1995–2011*

Year	Used any illicit drug (%)		
	Male	Female	All
1995	14.8	11.9	13.4
1999	27.6	23.3	25.6
2003	31.0	26.6	28.8
2007	25.9	21.3	23.6
2011	27.3	22.3	24.8

Sources: Stergar 1999, Stergar et al. 2001, Stergar et al. 2005, Stergar et al. 2010, Stergar et al. in press

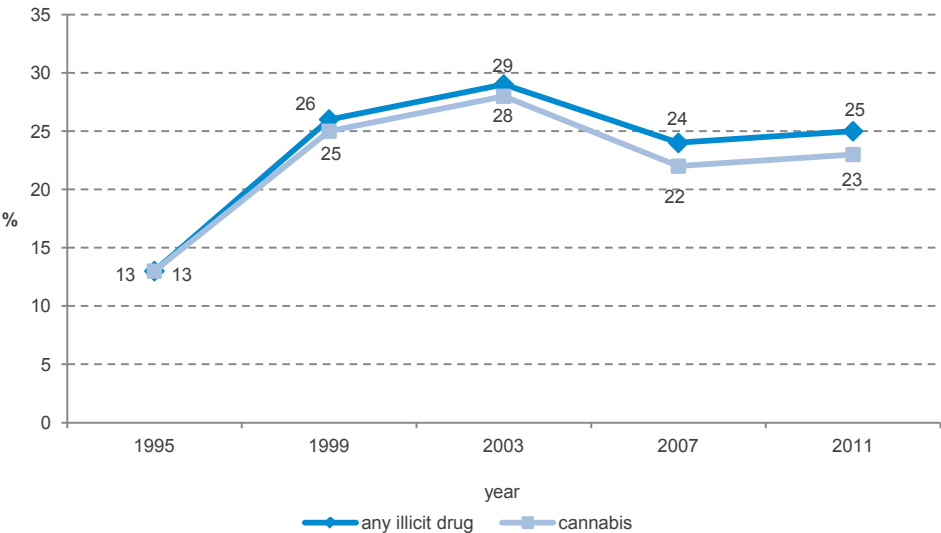
<sup>5</sup> Albania, Belgium (Flanders), Bosnia and Herzegovina (Republic of Srpska), Bulgaria, Cyprus, Czech Republic, Montenegro, Denmark, Estonia, Faroe Islands, Finland, France, Greece, Croatia, Ireland, Iceland, Italy, Latvia, Liechtenstein, Lithuania, Hungary, Malta, Moldova, Monaco, Germany (5 provinces), Norway, Poland, Portugal, Romania, Russian Federation (Moscow), Slovakia, Slovenia, Serbia, Sweden, Ukraine and the United Kingdom

Changes in the use of any illicit drug in the period 1995–2011 are statistically significant ( $\chi^2=227.391$ ,  $df=20$ ,  $p<0.0001$ ,  $C=0.13$ ); there was a sharp rise between 1995 and 1999, followed by a more gradual increase until 2003, and by a typical decrease between 2003 and 2007; the percentage remained stable between 2007 and 2011.

Cannabis accounts for the largest proportion of cases of lifetime use of any illicit drug, as lifetime cannabis use was reported by 23% of respondents surveyed in 2011. 19% of respondents used cannabis in the past 12 months, and 10% of respondents reported cannabis use in the past 30 days. Gender differences are statistically significant: more boys than girls have used cannabis. Perceptions of cannabis availability were statistically significantly associated with the frequency of lifetime cannabis use – most of those respondents who perceived cannabis to be impossible, very or fairly difficult to buy stated that they had never used it ( $\chi^2=977.273$ ,  $p<0.0001$ ,  $C=0.49$ ).

Cannabis use trends for the period 1995–2011 are almost identical with the trends in the use of any illicit drug (Figure 2.4).

Figure 2.4: Lifetime use of any illicit drug and lifetime use of cannabis, 1995–2011



Sources: Stergar 1999, Stergar et al. 2001, Stergar et al. 2005, Stergar et al. 2010, Stergar et al. in press

Comparison with the ESPAD countries average shows that the proportion of Slovenian respondents who reported lifetime use of any illicit drug was 7% higher, and the proportion of Slovenian respondents reporting lifetime experience with cannabis was 6% higher than the average.

Any illicit drug other than cannabis

6% of respondents stated that they had tried illicit drugs other than cannabis at least once in their lifetime; this figure is equal to the ESPAD average for this variable. Trends between 1995 and 2011 in Slovenia show statistically significant differences in the frequency of use of illicit drugs other than cannabis, which are characterized by a sharp increase between 1995 and 1999, after which the rate fluctuated between 5 and 7% (Table 2.5).

Table 2.5: Lifetime use of illicit drugs other than cannabis, 1995–2011

Year	Lifetime (%)		
	Male	Female	All
1995	3.3	2.2	2.8
1999	7.1	6.6	6.9
2003	4.3	5.0	4.7
2007	6.7	7.9	7.3
2011	6.6	6.0	6.3

Sources: Stergar 1999, Stergar et al. 2001, Stergar et al. 2005, Stergar et al. 2010, Stergar et al. in press

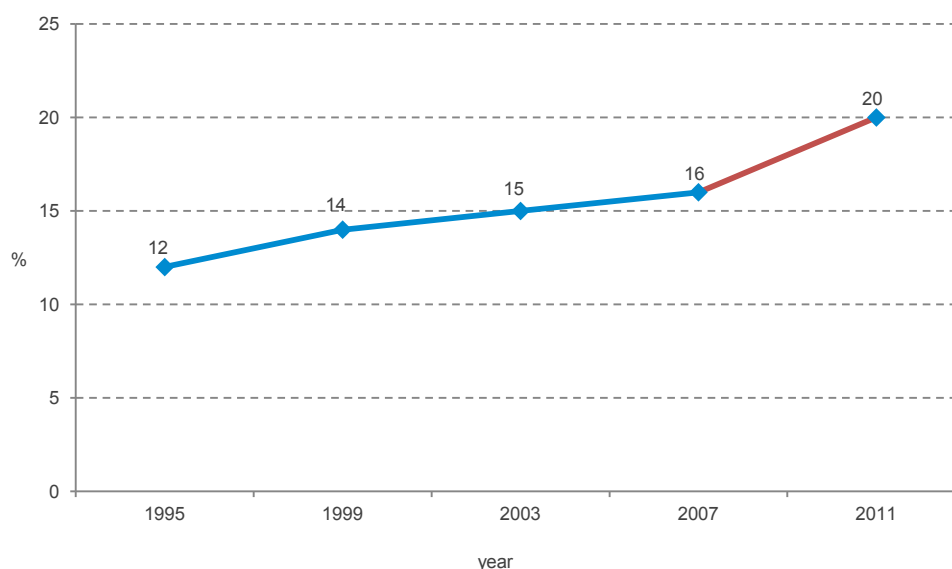
#### Ecstasy, heroin, cocaine, crack

In 2011, 2% of respondents reported lifetime use of ecstasy, 3% reported use of cocaine, and 2% reported lifetime use of amphetamines. Lifetime use of amphetamines, crack, LSD or other hallucinogens were reported by 2% of respondents each, and use of heroin or GHB by 1% each. Like in past ESPAD surveys, we have found that the use of above mentioned drugs was relatively rare among students in the sample also in 2011.

#### Inhalants

In 2011, 20% of respondents reported lifetime experience with inhalants, 9% reported use of inhalants in the past 12 months, and 4% used inhalants in the past 30 days. Trends for the period 1995–2011 show a statistically significant growth in the prevalence of the use of inhalants ( $\chi^2=86.737$ ,  $p<0.0001$ ,  $C=0.08$ ), and a considerable increase between 2007 and 2011 (Figure 2.5).

Figure 2.5: Lifetime use of inhalants, 1995–2011



Sources: Stergar 1999, Stergar et al. 2001, Stergar et al. 2005, Stergar et al. 2010, Stergar et al. in press

Comparison with the ESPAD countries average (which is 9%) shows that the prevalence of inhalant use is statistically significantly higher among Slovenian students (Figure 2.6).

**Non-prescription use of tranquillisers or sedatives**

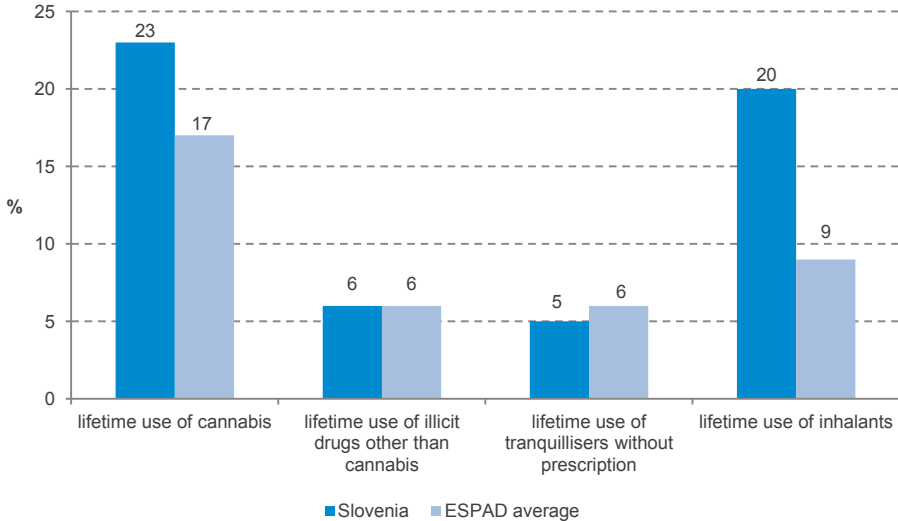
5% of respondents used tranquillisers or sedatives without a doctor's prescription. The relationship between non-prescription tranquiliser use and gender, which shows that more girls than boys have used tranquillisers without a doctor's prescription, is statistically significant at  $p < 0.01$ , but weak ( $C = 0.07$ ).

Trends for the period 1995–2011 show a statistically significant, but weak relationship between the prevalence of non-prescribed use of tranquillisers or sedatives and the year: the prevalence rates were higher in 1995 and 1999 than in 2003, 2007 and 2011.

**Comparison of Slovenian drug-use prevalence rate with the ESPAD averages**

In comparison with the ESPAD countries average, Slovenian respondents stand out especially on two key variables, namely on lifetime use of inhalants and lifetime use of cannabis.

Figure 2.6: Comparison of selected variables with the ESPAD average, 2011



Source: Hibell et al. 2012

**Conclusion**

ESPAD 2011 data on the prevalence of illicit drug use among students aged between 15 and 16 years show that trends in Slovenia are similar to those in other countries: the prevalence of illicit drug use is gradually decreasing after the peak in 2007, and the proportion of students who have experienced illicit drug use has stabilized – in Slovenia at 25%.

It is worrying that the prevalence of the use of inhalants for the purpose of intoxication has been increasing steadily among Slovenian respondents since the first ESPAD survey.

The fact that data on the prevalence of marijuana use are comparable with the data on the prevalence of marijuana use among 15-year-olds from the HBSC 2010 study (Drev et al. 2011) supports the hypothesis that the prevalence of marijuana use is stabilizing.

### 2.3 Drug use among targeted groups

#### AMPHORA – study of drinking environments

Matej Košir

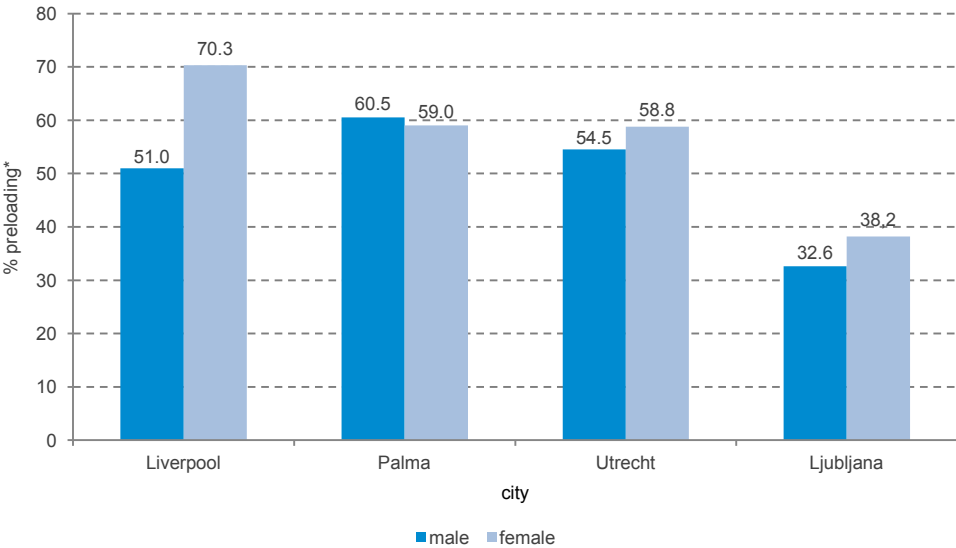
In the framework of the AMPHORA project ([www.amphoraproject.net](http://www.amphoraproject.net)), partner institutions from United Kingdom, Spain, the Netherlands and Slovenia carried out a study on young people's drinking behaviours and drinking environments in four European cities: Liverpool, Palma de Mallorca, Utrecht and Ljubljana. The study, which was conducted between September and November 2010, included a cross-sectional survey and breathalyzer tests carried out among young drinkers in the said cities, and a quantitative observational study carried out in selected night venues (Hughes et al. 2012). In Ljubljana, the Institute Utrip carried out 221 interviews and breathalyzer tests, and conducted covert observation in 15 night clubs which are mainly frequented by young people.

#### Results

##### Preloading

Study results showed that the proportion of young people preloading (drinking before going to night clubs or bars) is significantly lower in Ljubljana than in other three cities (Figure 2.7). Almost half of young people (45.1%) in all four cities drink before going out.

Figure 2.7: Percentage of respondents having preloaded\* by city and sex



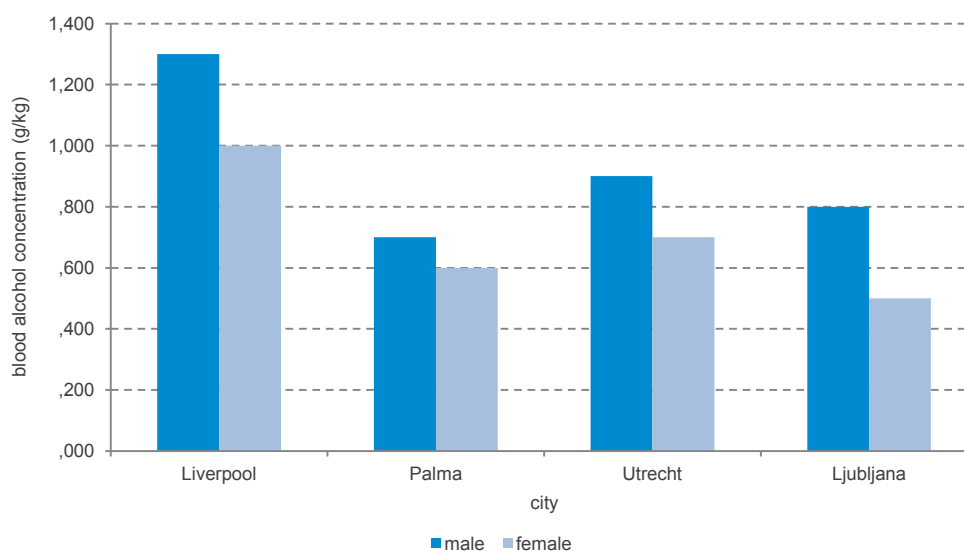
\*Including participation in *botellón* (i.e. group drinking of off-licensed alcohol in public settings such as streets and parks) in Palma de Mallorca

Source: Hughes et al. 2012

## Blood alcohol concentration

The average blood alcohol concentration measured at interview in Ljubljana was 0.50 grams of alcohol per litre of blood for women and 0.80 grams per litre of blood for men. In comparison with other cities, Ljubljana had the lowest blood alcohol concentration for women, and the second lowest blood alcohol concentration for men (after Palma de Mallorca) (Figure 2.8).

Figure 2.8: Average blood alcohol concentration (g/kg) by city and sex



Source: Hughes et al. 2012

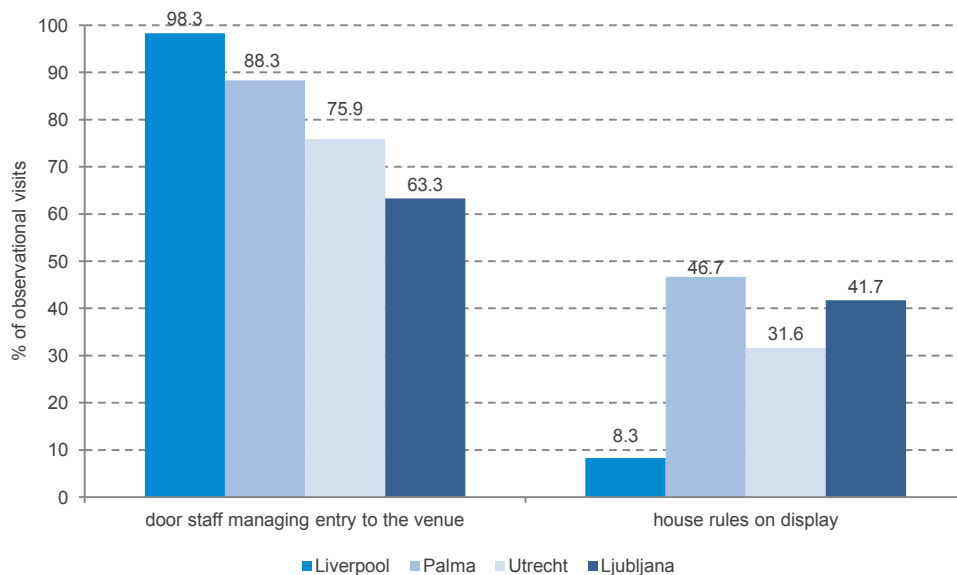
In Ljubljana, males had mainly consumed spirits before interview (39.3%), followed by beer (35.2%), wine (24.6%), and mixed alcoholic beverages (alcopops; 0.9%). Most females had consumed wine before interview (45.8%), 36.5% consumed spirits, 17.2% drank beer, and only 0.5% of females drank alcopops. Proportions for individual alcoholic beverages were quite different in other cities. Beer accounted for a large proportion of alcohol consumed before interview by males in Utrecht (72.9%) and Liverpool (53.1%), while Palma de Mallorca had the lowest proportion of beer consumed by males (20.8%). The proportion of spirits consumed before interview was the highest in males in Palma (63.3%), and the proportion of spirits consumed by males in Ljubljana was higher than in Liverpool (33.6%) and Utrecht (14.3%). The proportion of women who had consumed beer before interview was the largest in Utrecht (39.6%). In Palma (14%) and Liverpool (12%) proportions of women having consumed beer were lower than in Ljubljana. In comparison with Ljubljana, all other cities had lower proportions of wine consumed by females prior to interview (Utrecht 37.6%; Liverpool 20.7%; Palma 11.8%). Proportions of males and females having consumed alcopops before interview were highest in Palma (males – 12.1%; females – 9.6%).

### Observational visits in night venues

In the second part of the study, 238 hours of observations were undertaken in bars and night clubs, where the operation of premises and their physical and social features (those that influence drinking of alcoholic beverages and other risk behaviours, and those that do not) were assessed. In Ljubljana, observation visits were undertaken in 15 selected youth-focused night venues in or near the city centre.

The proportion of observations that recorded the presence of door staff or security guards was lower in Ljubljana (only 63.3%) than in other cities. The results were better regarding the display of house rules near the entrance of clubs and bars in Ljubljana, reaching 41.7% (Figure 2.9).

Figure 2.9: The proportion of observational visits recording selected features at entrance to the venue

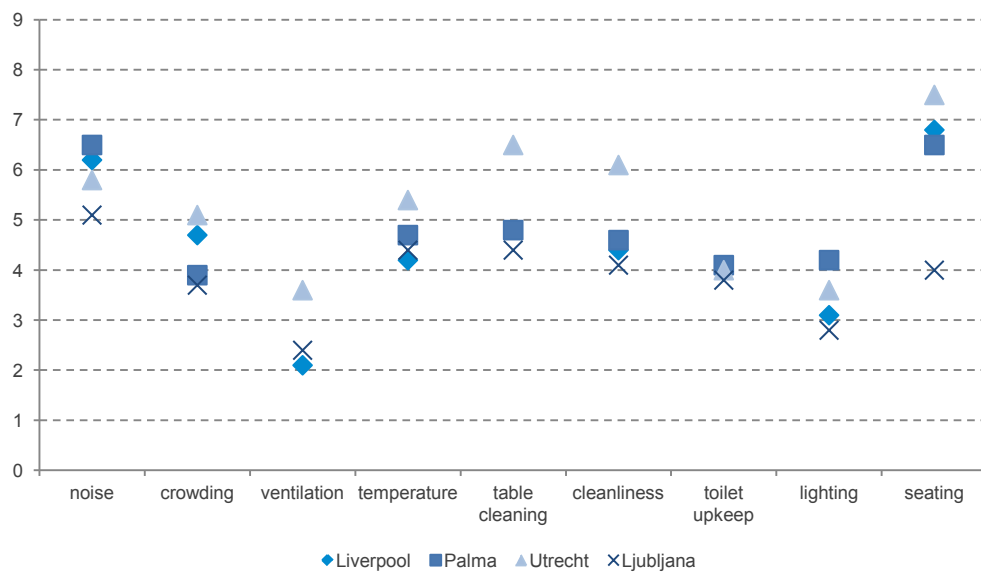


Source: Hughes et al. 2012

### Physical environment

The physical environment within venues was assessed using rating scales (from 0 to 9) to measure noise levels, crowding, ventilation, temperature, levels of lighting and factors regarding cleanliness. Higher values represented more 'problematic' levels. According to assessment results, bars and other night venues in Ljubljana proved to be less problematic than venues in other cities (Figure 2.10).

Figure 2.10: Mean ratings on physical environment scales for night venues in selected cities



Source: Hughes et al. 2012

#### Food and drink sales

Food (mostly snacks and fast food) was rarely being served in bars in all cities, recorded most often in bars and night clubs in Ljubljana (16.7% of observations) and least often in Liverpool and Utrecht (4%). The service of alcoholic beverages to tables (rather than just at the bar) was most often recorded in Ljubljana (78.3% of observations) and least often in Liverpool (3.3%). Ljubljana also had the highest proportion of observations that recorded the use of plastic glassware (73.3%) and Utrecht had the lowest (8.6%). Alcoholic beverage promotions were most common in Liverpool (46.7% of observations) and least common in Palma (13.3%). Palma also had the highest average alcoholic drink prices across the four cities.

#### Staff in night venues

Palma had the lowest staff to patron ratios as well as lowest proportions of younger and male bartenders. Ljubljana had the lowest proportion of observations that recorded the presence of designated glass collectors. Staff monitoring was rated as poorest in Utrecht, and staff coordination was poorest in Palma. Permissiveness (e.g. tolerance of abusive behaviour) was rated as highest in Liverpool.

#### Customer types and behaviours

Ljubljana had the highest proportion of observations that recorded a male-dominated customer base (81.7 %), and Liverpool had the lowest (60.0%). Bars and night clubs in Palma had the smallest proportions of customers aged 21 or younger (8.3%), and night venues in Utrecht had the largest (32.8%). At least 70% of observations in Liverpool and Utrecht found that the majority (at least 50%) of customers were in single sex groups, whereas in Palma and Ljubljana there were approximately one third of such customers.



### Customer intoxication and incidents

There were no significant differences between cities in ratings of customer intoxication or incidents of alcohol-related harm (e.g. overt intoxication, accidents, vomiting and aggression). Customer intoxication was measured on a scale of 0 (no sign of intoxication) to 9 (everyone is drunk), and mean ratings were 3.5 in Ljubljana, 3.7 in Utrecht, and 4.0 in both Palma and Liverpool. There were significant differences in the proportions of visits that recorded alcohol-related harm (Palma 3.3%, Utrecht 20.7%, Ljubljana 21.7% and Liverpool 45%).

### Conclusion

The study found that the proportion of young people overloading (drinking before going to bars or night clubs) is significantly lower than in other cities. Also as regards blood alcohol concentration at the time of interview, the lowest median concentration was recorded in females in Ljubljana, while Ljubljana had the second lowest median concentration in males after Palma de Mallorca. The majority of males in Ljubljana drank spirits, and the majority of women drank wine, while the proportions in other cities were completely different.

Night venues in Ljubljana had the lowest percentage of door staff presence, while they received better ratings regarding the display of house rules near the entrance. According to the assessment of different features, bars and other night venues in Ljubljana proved to be less problematic than venues in other cities. Food (mostly snacks and fast food) was rarely available in bars in all selected cities, but it was most often served in bars and night clubs in Ljubljana. Also the service of alcoholic beverages to tables (rather than just at the bar) was most often recorded in Ljubljana, as was the use of plastic glassware. Ljubljana had the lowest proportion of observations that recorded the presence of designated glass collectors in night venues.

The proportion of observations that recorded a male-dominated customer base was the highest in Ljubljana, and one third of customers in clubs and bars in Ljubljana were in single sex groups. There were no significant differences between cities in ratings of customer intoxication or incidents of alcohol-related harm (e.g. overt intoxication, accidents, vomiting and aggression); however, customer intoxication was rated as lowest in Ljubljana. However, there were significant differences in the proportions of visits in which alcohol-related harm was observed. The proportion of such observations was relatively large in Ljubljana.

# 3.

## PREVENTION

Preventive activities in the field of drug use prevention are coordinated by the Ministry of Health of the Republic of Slovenia in collaboration with nine line ministries. Such collaboration also includes interministerial bodies and structures. The Slovenian Commission on Narcotic Drugs ensures the coordination of prevention policies. Key partners include providers of preventive services or activities (governmental and non-governmental institutions and associations), local authorities (municipalities, regions), universities and research institutions.

The main objectives and activities in the field of drug-related prevention are set out in the Resolution on the 2004–2009 National Programme in the Field of Drugs (ReNPFD), since the consideration of the new draft resolution for the period 2011–2020 has been suspended due to coalition coordination problems.

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Prevention in Slovenia is divided into environmental, universal, selective and indicated prevention, which are defined according to the definitions of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Environmental prevention is aimed at altering immediate cultural, social, physical and economic environments in which people make their choices about drug use. Universal prevention includes all interventions and programmes which are designed for and targeted at entire populations (e.g. local communities, students, etc.) and aim at deterring or delaying the onset of drug use by providing all the necessary information and by building certain skills. Selective prevention comprises strategies targeting specific subpopulations whose risk of a disorder is significantly higher than average, either imminently or over a lifetime. Indicated prevention aims to identify and target individuals who are showing indicators that are highly correlated with an individual risk of developing drug use later in life or are showing early signs of problematic drug use (EMCDDA 2011).

Since data in the field of drug-related prevention is not collected systematically in Slovenia, the data needed for the preparation of national reports on the drugs situation in Slovenia are obtained from prevention providers.

Environmental prevention measures focus mainly on restricting access to alcohol and tobacco products by implementing the Act Restricting the Use of Alcohol and the Restriction of the Use of Tobacco Products Act, and by imposing excise duties, restricting alcohol and tobacco advertising, increasing taxes and prices of tobacco products and setting statutory blood alcohol concentration limits for drivers.

Focus groups of high-school students aged between 15 and 19 years show that students consider drug-related prevention programmes too similar and mostly uninteresting. They wish for experiential programmes and small group discussions where students would not be afraid to ask questions.

The Faculty of Social Work of the University of Ljubljana has developed a community-based model of work with children, their parents and school workers. Its primary purpose is to promote community responses to risky situations in a school environment or a classroom community.

The Institute Utrip has issued Guidelines and Recommendations for School-based Prevention, which were drawn up during the pilot implementation of the school-based prevention programme “Izštekanj” (Unplugged). Preliminary evaluation of the effects and results of the Unplugged programme showed that it has reduced the actual use of alcohol, tobacco and other drugs in the intervention group in comparison with preliminary predictions of students. There were significant differences regarding tobacco smoking (predicted 8%, actual 3.8%), alcohol drinking (predicted 31.7%, actual 18.4%) and drinking to intoxication (predicted 10.5%, actual 2.8%).

An analysis of the obstacles to the implementation of family prevention programmes showed that more than 63% of parents participate in preventive activities in Slovenia. The most common reasons for parents' non-participation are lack of time, the fact that schools do not organize such activities, and the fact that parents prefer to discuss these issues at home.

The evaluation of the effects of the Strengthening Families Program showed excellent results for 89% of all measurable indicators. The most significant effects of the programme include positive changes in parenting skills and parenting styles of both parents, and an increase in positive parenting and parent effectiveness.

In the framework of the international Addiction Prevention within Roma and Sinti Communities project, researchers have reviewed the legislation governing the status of Roma communities, their healthcare and social security coverage, and the use of licit and illicit drugs. Furthermore, they studied the situation concerning licit and illicit drug addiction problems in Roma population.

The Svit Association upgraded its low-threshold programme with a programme for families, children and adolescents; the programme is aimed at children of drug users, at-risk children, drug using parents, girls with associated problems, and grandparents of drug users' children. In addition to addressing the problem of drug use, the programme also promotes and carries out safe leisure activities.

### 3.1 Environmental prevention

Environmental prevention is aimed at altering immediate cultural, social, physical and economic environments in which people make their choices about drug use. In the context of environmental prevention, individuals do not become involved with drugs solely on the basis of personal characteristics, but also under the influence of a complex set of factors in the environment such as: what is expected or accepted in the communities in which the individuals live; national regulations, rules and taxes; publicity messages to which the individuals are exposed; and availability of alcohol, tobacco and illicit drugs (EMCDDA 2011). In Slovenia, environmental prevention measures are focused mainly on restricting access to alcohol and tobacco products.

#### Some environmental prevention measures in the field of hazardous and harmful alcohol consumption prevention in Slovenia

*Maja Zorko, Tadeja Hočevar, Nataša Blažko*

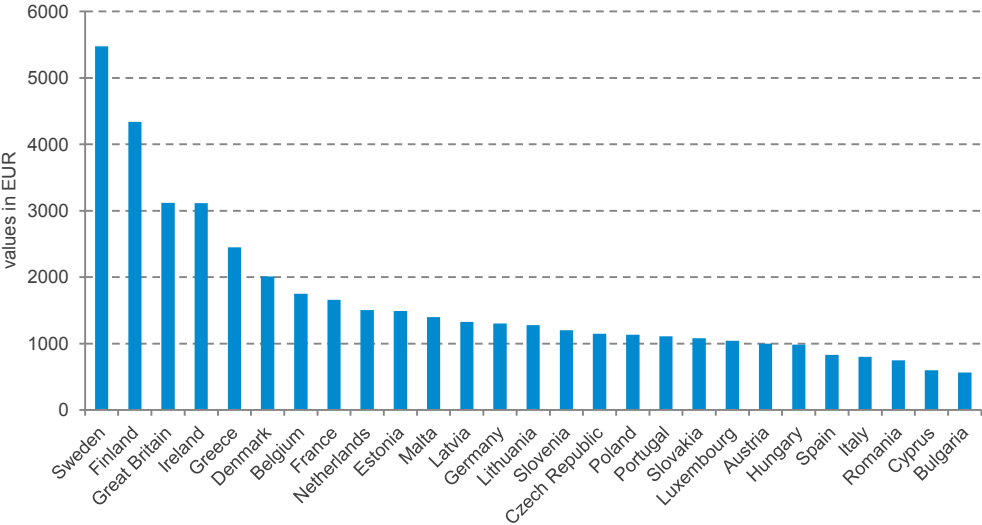
The proportion of abstainers among the adult population of Slovenia increased in the period 2001–2008, while the proportion of moderate drinkers remained unchanged, and the proportion of hazardous drinkers decreased (Maučec Zakotnik et al. in print). Drinking to intoxication among adolescents increased in the period 2002–2010, especially among girls. The proportion of weekly drinkers among adolescents in Slovenia, which is higher than the international average, also remained unchanged (Jeriček et al. 2012). Studies show that alcohol-related problems could be mitigated if several alcohol policy measures that have proved effective were implemented simultaneously (WHO 2009, Babor et al. 2010, DHS 2008).

Restricting physical and financial access to alcohol products is one of the most effective alcohol policy measures (WHO 2009, Babor et al. 2010). The Act Restricting the Use of Alcohol (ZOPA Official Gazette RS, No. 15/2003) came into force in Slovenia in 2003; it restricts physical access to alcohol for all residents in Slovenia<sup>6</sup>. By prohibiting the sale and provision of alcoholic beverages and mixed alcoholic drinks to persons under 18 years of age, the ZOPA specifically focuses on restricting the access to alcohol for minors. Despite legislation, more than half of adolescents or young adults in Slovenia have no trouble buying or ordering alcoholic beverages (Eurobarometer 2011, Boben Bardutzky 2009); therefore, greater attention should be given to monitoring the implementation of the said Act.

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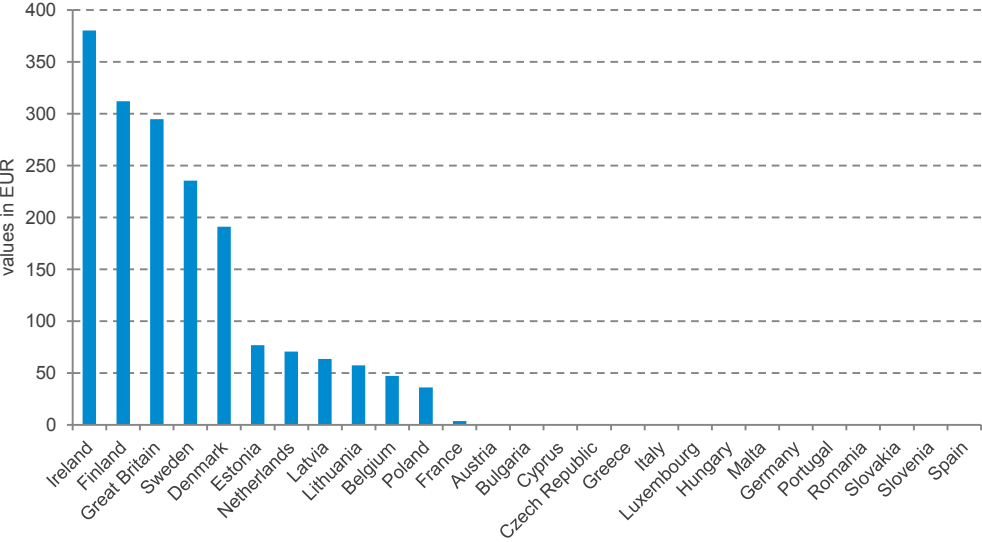
<sup>6</sup> Ban on the sale of alcoholic beverages between 9 p.m. and 7 a.m. the following day

Figure 3.1: Excise duty per hl of ethyl alcohol in EU countries



Source: EC 2012

Figure 3.2: Excise duty per hl of wine in EU countries



Source: EC 2012

In Slovenia, the excise duty on beer increased by 38%<sup>7</sup> between 2007 and 2012, the excise duty on intermediate products increased almost by 50%<sup>8</sup> and the excise duty on ethyl alcohol increased by 42%<sup>9</sup>, but still remains among the lowest in Europe (Figure 3.1) (Official Gazette RS, Nos. 84/1998 – 48/2012). However, Slovenia is still one of the countries that do not pay excise duty on still wines, sparkling wines and other fermented beverages (Figure

<sup>7</sup> From 6.86 EUR per hl of beer/1 degree of alcohol in 2007 to 11 EUR in 2012  
<sup>8</sup> From 62.59 EUR per hl of intermediate product in 2007 to 120 EUR in 2012  
<sup>9</sup> From 694.79 EUR per hl of pure alcohol in 2007 to 1,200 EUR in 2012

3.2) (EC 2012). In the period from June 2011 to June 2012, the average purchase prices of beer increased by 8%, average prices of wine by 12%, and average prices of spirits produced in Slovenia by 7% (SURS 2011 and 2012<sup>10</sup>). In recent years, the Ministry of Health (MH) has tried to achieve the highest possible increase in excise duties on alcoholic beverages, and to ensure that also public health reasons are taken into account in this context.

Restrictions on alcohol advertising, sponsorships and donations are also effective measures for reducing alcohol consumption (WHO 2009), since exposure to alcohol product advertising affects individuals' desire, intention and decision to drink alcohol (Anderson 2007, Anderson 2009, Anderson et al. 2009, Babor et al. 2010). The Media Act (Official Gazette RS, No. 35/2001) completely banned alcohol product advertising in 2001; however, this ban was lifted in 2002 when the Act Regulating the Sanitary Suitability of Foodstuff, Products and Materials Coming into Contact with Foodstuffs (Official Gazette RS, No. 42/2002) was amended. The latter Act now allows advertising of alcoholic beverages containing less than 15 percent alcohol by volume under special conditions set out in the Act. Despite legislation, there are many forms of marketing communication (e.g. sales promotion, product placement, sponsorship, donations, etc.) that circumvent the law and are used by alcohol industry to promote alcohol consumption.

Drink-driving policies and countermeasures are also an important area of prevention. In 2007, the Resolution on National Programme on Road Traffic Safety (Official Gazette RS, No. 2/2007) strengthened the measures designed to achieve road safety. Lowering statutory limits of blood alcohol concentration (or breath alcohol concentration) and frequent random breath testing of drivers for excess alcohol in the blood have proven to be the most effective measures for reducing drink-driving (DHS 2008). Zero blood alcohol concentration limits for beginner drivers also have positive effects (DHS 2008). All these measures are also implemented in Slovenia, where the number of accidents caused by drink-driving and the proportion of drink--driving fatalities have been decreasing significantly in recent years (Ministrstvo za zdravje 2012).

A study on alcohol prevention programmes shows that there are 42 such programmes in Slovenia (MOSA – Community mobilization for a more responsible attitude towards alcohol, 2012). Most of them are aimed at young people and include the provision of information on harmful consequences of risky drinking, and promotion of safe driving. Some of these programmes strive to change environments and thus create new ones that promote healthy life-style and restrict access to alcohol. "18 je zakon!" (18 rules!) is one of these programmes; it strives to ensure that the rules on checking or showing personal identification when ordering or buying alcoholic beverages are followed strictly and consistently.

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<sup>10</sup> Source: SURS, 2011 and 2012. Department of consumer prices (Oddelek za cene življenjskih potrebščin). Ljubljana: Statistical Office of the Republic of Slovenia (unpublished material)

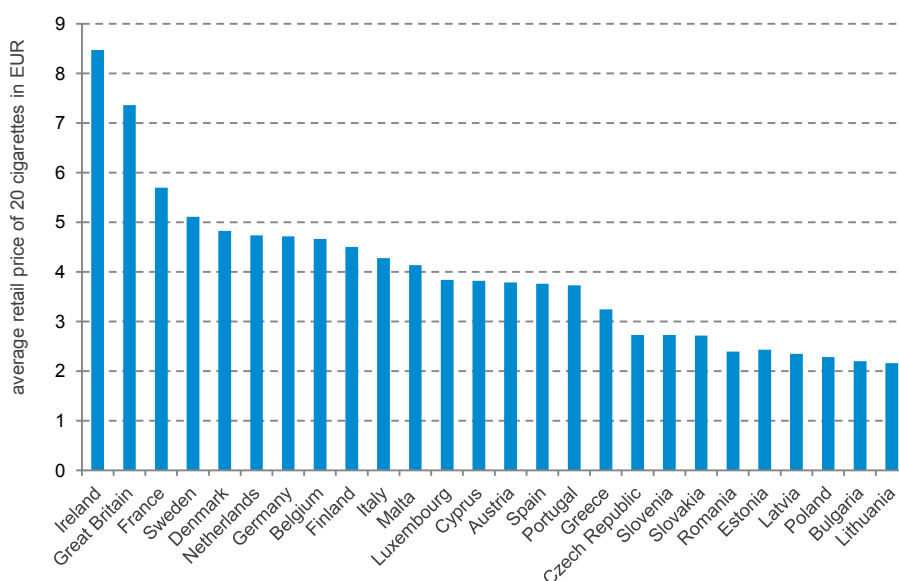
## Some tobacco control measures in Slovenia

*Helena Koprivnikar*

Implementation of effective tobacco control measures can bring significant health and economic benefits (World Bank 2011). Slovenia has already introduced several such measures, the most recent one being the total ban on smoking in all enclosed public and work places (Restriction of the Use of Tobacco Products Act – ZOUTI 2007), which was introduced in 2007 and has significantly reduced exposure to tobacco smoke in these places as well as in private homes (EC 2012a, Koprivnikar 2008). Before the ban was introduced, the proportion of smokers had remained constant at about a quarter of the adult population for a long time. The proportion decreased significantly after the ban, but the decrease was only temporary. After 2008 and until 2011, the proportion of smokers gradually increased again and most probably reached the same level as before 2007 – direct comparison is impossible due to differences in research methodologies (Koprivnikar and Zupanič 2011). This increase is largely a reflection of the fact that there have been no significant changes or new measures in the field of tobacco control since the ban.

Raising taxes and prices of tobacco products is the most effective tobacco control measure, also the most cost-effective (World Bank 2011, WHO 2010, WHO 2008, NSSP 2006). Prices of tobacco products in Slovenia have increased significantly in recent years, but still remain among the lowest in Europe (Figure 3.3) (EC 2012b). In April 2012, retail prices of tobacco products increased by 3.5%. The Act Amending the Excise Duty Act (Official Gazette of RS, No. 48/2012) provided for a further increase in excise duties in July (retail cigarette prices have already increased by 3.5%). At that time Slovenia has reached the target rate of excise duty on cigarettes, which is set out by the EU Tobacco Products Directive as the minimum that the member states must reach by January 2014. The said Act also stipulates further increases in October 2012 (retail cigarette prices are expected to rise by 3.9%) and in January 2013 (the increase rate is yet unknown), when excise duty of EUR 97 per 1,000 cigarettes will have been reached. Slovenia's current specific excise duty rate is low (20% of the total tax burden on the weighted average retail selling price of cigarettes) (EC 2012b). The Act provides for a gradual increase in share of specific excise duty on cigarettes, which is expected to increase to 50% of the total tax burden on the weighted average retail selling price. The Act only provides for changes in cigarette taxes, and not other tobacco product taxes (Official Gazette of RS, No. 48/2012).

Figure 3.3: The weighted average retail selling price of 20 cigarettes in EU member states in January 2012



Source: European Commission, Taxation and Customs Union, EC 2012b

Bans on advertising and marketing of tobacco products are also important measures to prevent and reduce smoking, especially among adolescents and young adults (World Bank 2011, WHO 2008). Such bans should not be partial, since past experience shows that the tobacco industry skilfully adapts to them and circumvents them (NCI 2008, WHO 2008; Krugman et al. 2005). Current Slovenian law allows point-of-sale tobacco products advertising (ZOUTI Official Gazette RS, No. 93/2007), which has widely expanded in recent years (TIRS 2011). The number of tobacco outlets in Slovenia is high, about one per 1,000 inhabitants (Cigut 2008), therefore advertising opportunities are extensive and tobacco products readily available. 71% of Slovenian adolescents aged 15–16 find it easy to very easy to get hold of cigarettes if they wanted to (Hibell et al. 2012). Non-governmental organizations stress that it is particularly worrying that new outlets or points of sale (kiosks) are being set up near faculties, high schools and bus stops, where young people congregate (Youth Association No Excuse Slovenia 2011). The large number of tobacco outlets and their proximity to schools or homes increase the likelihood of smoking among adolescents; on the other hand, reductions in the number of outlets or effective restriction of access to tobacco products can reduce smoking among adolescents (Chan and Leatherdale 2011, Chilenski 2011, Leatherdale and Strath 2011, Ranney et al. 2006, USDHHS 2001). The sale of tobacco products to persons under 18 years of age is banned in Slovenia, but it is difficult to enforce and monitor the implementation of such a measure (TIRS 2011, Chen and Lancaster 2006, Stead and Lancaster 2000).

The tobacco industry strives to increase the attractiveness of tobacco products by adding flavours which make it easier for people to start smoking (fresh, sweet and fruity flavours). Tobacco industry documents show that such products are aimed especially at adolescents and girls or women (EC 2010). Flavoured tobacco products are also available in Slovenia, and perhaps some changes in smoking habits are partly due to these products; however,



data on the sale of these products, which could possibly support such claims, are not available.

As mentioned, Slovenia has already introduced several effective tobacco control measures. Nevertheless, new or updated measures should be introduced as soon as possible to complement the existing package of tobacco control measures. It is particularly necessary to further substantially increase the prices of tobacco products by imposing comparable and harmonised excise duty rates on all tobacco products, to completely ban tobacco advertising and displays at points of sale, to ban sale of flavoured tobacco products and to reduce the availability of tobacco products by introducing of licensing tobacco retailers and limitation of the number, location and types of tobacco retailers.

### **3.2 Universal prevention**

Activities in the field of universal prevention include all interventions and programmes designed for and aimed at the entire population or its subgroups (e.g. individual local communities, schools, etc.). It is assumed for each individual in this population that he or she has the same level of risk of drug use as others, and that this individual can gain the same benefits from prevention programmes as other members of the group. Universal prevention programmes are usually implemented in large groups, without a preliminary analysis of the characteristics of the target population (EMCDDA 2011). Children and adolescents remain the main target population for universal prevention measures aimed primarily at preventing risk behaviours that could lead to psychoactive substance abuse.

#### **Drug-related prevention programmes and young people: focus group analysis**

*Branka Božank, Nina Pogorevc, Manca Rebula*

Regional Institute of Public Health Ravne conducted focus groups among high-school students in 2011 and 2012, where Institute workers talked with students about addiction prevention programmes to find out whether young people know such programmes, what experience they have, what contents they would prefer in a programme, who should implement these programmes, what they think about the effectiveness of such programmes and of peer education. The Institute conducted 6 focus groups which in total comprised 28 students between 15 and 19 years of age. The most important findings are presented below.

##### **Addiction prevention programmes**

Young people recognize the following as addiction prevention programmes: different (media) preventive actions, lectures and presentations given by healthcare workers in the framework of health education, lectures given by police officers about road safety, and other lectures and workshops conducted by various professionals (nurses, police officers, doctors and other professional workers) in both primary and secondary schools. In addition, some students also mentioned movies, posters and books on this topic, and programmes in the framework of the Project Learning for Young Adults programme.

According to students, prevention programmes in which they participated mostly comprised lectures combined with PowerPoint presentations, and discussions with various professional workers about different psychoactive substances and harmful effects of their use. Most programmes were aimed at providing information.

In students' opinion, all activities are usually quite similar. One of the students said: "... *they came twice and spoke about the same things; in fact, I think that they never tell us anything useful and that people find it boring and consider it a good opportunity to avoid lessons.*" Students wish that preventive activities would be different and more experiential. They wish that prevention topics would be presented to them by somebody with experience; they would consider such information more credible if it was presented by such a person rather than by a professional worker who has no personal experience. On the other hand, some students pointed out that they would appreciate combined activities performed by several professional workers, especially practitioners who have experience in the field of addiction – e.g. police officers, doctors, treatment programme employees – who would present the issues and topics in their field of work.

Students also consider problem-solving skills and the ability to make decisions as prevention. All of them emphasized that an individual's decisions play an important role in drug use. They also believe that active leisure time, good and healthy company, and obligations and goals focused on the future have preventive effects.

#### Reasons for drug (non)use in young people

Students most often state that the reasons for the use of psychoactive substances (PAS) are problems which individuals have to face in their life or inability to solve problems by other means than seeking solutions and comfort in PAS use. Students also consider the social environment, family problems and especially an individual's company (friends) to be important factors. The effects of PAS, which bring a feeling of comfort, are also significant factors. Many students also pointed out that the choice to use drugs depends on the individual, his or her personality traits, boredom and curiosity. "*If you are only interested in it, then you can say: no, I won't do it. But if you resort to it, it is difficult to end it by yourself.*" Of course, they distinguish between experimenting and regular use and the path to addiction, but they do not think that experimental drug use is problematic or harmful. "*To be surrounded by people who use drugs is totally different than to try drugs out of curiosity on a Friday night.*"

In their opinion, parents act preventively by setting limits and exerting control: "*...like, parents, if they knew with whom their child hangs out ... they should do something too, ... they could talk, ... and prohibit their child from hanging out with people who are addicted, for example.*" Students also stated that things forbidden have a certain "charm"; for example, when you hide from your parents when you start smoking, you feel excited. In their opinion, the reasons keeping young people from using PAS include set goals, obligations and opportunities which they do not want to lose by using PAS. Students think it important for an

individual to have an (imparted) sense of limits, so that, even if the individual experiments with drugs, he or she does not become addicted.

Contents and manner of implementation that students wish for in prevention programmes

Regarding the preferred manner of implementation of programmes, most students wish that they could talk to (former) addicts, and participate in various activities – especially debates, visits to actual treatment programmes, etc. They would like to participate in discussions where they could ask questions, especially small group discussions, as they do not dare to ask questions in large groups – *“That’s it, I’m afraid to ask if there are too many people around.”* They think that professional workers should talk to them about the basics, e.g. classification of drugs and their effects and ingredients; they would also like to hear practitioners working in an addiction-related professional field speak about their personal experience.

According to some participating students, media can also have preventive effects – *“Maybe even greater than these lectures and stuff.”* Therefore, they think it sensible to show students a film, followed by a discussion. Some focus group participants consider social skills enhancement a good start of a continuous programme that could be upgraded over the years with other, more specific contents which would not be connected only with addiction, but would also include other topics that students are interested in (physical and psychological violence, sex education, etc.). They also wish to get specific information about where to turn for help. In their opinion, prevention programmes should start as early as possible, be tailored to the age of the target population and upgraded in a meaningful manner.

Programmes intended only for certain students

Most students believe that 'special' selective and indicated prevention programmes intended only for certain students would be a subject of mockery, and their participants stigmatized and too exposed *“if they attended these lectures, workshops, like a class of drug users, so to say, I mean, very figuratively.”* *“They would feel excluded, I don’t know, it probably wouldn’t be fair.”* Students think that whole classes, and not only ‘offenders’, should participate in preventive activities to address current problems at school. They also believe that offenders would really ‘learn their lesson’ if there were more students present. Students were not enthusiastic about peer education; they consider lectures boring, *“they always tell us the same things...”*, and they would rather have discussions with somebody who has experienced drug use.

Prevention for parents

Some students believe that parents are largely responsible for their children’s actions. They think that parents should reprimand their children and deprive them of certain benefits when they ignore agreements or rules (e.g. when to be home, etc.). In students’ opinion, parents should also be familiar with the signs of drug use, so that they could recognize them and act accordingly in such a situation. Parents set important examples for children, therefore students consider them as having a potential preventive role; on the other hand, they see parents who have an unhealthy lifestyle as risk factors. Most participating students agree that

parents should participate in prevention programmes, but admit that it would be hard to convince them to do so, especially those who have problems – *“parents who have most problematic children think: ‘I don’t know why you are talking smart to me, I am a good parent and there’s nothing wrong with my child.’ I don’t know, they pretend there’s nothing wrong.”* *“Or they just don’t show up.”*

#### Effectiveness of prevention programmes

Regarding the effectiveness of prevention programmes, students agree that such programmes 'contribute' to some degree, but that is not all. They believe that prevention programmes should start already in primary school, and should not only present drug-related contents, but also contents concerning responsibility. One of the students gave the following tip for designing prevention programmes: *“... well, if something is reproachful it can’t be effective ...”* Students find parents’ preventive role, i.e. “good parenting”, very important – they stressed that parents should set limits for their children and reprimand them for inappropriate behaviour. Students also think it is necessary for adolescents to engage in certain (low) risk behaviours, so that they can become responsible adults.

Satisfaction of participants in addiction prevention programmes is an important factor of quality of individual programmes, but enough attention must be given also to the monitoring of constant changes in participants, their values and expectations. The fact is that, in order to achieve the set objectives, we sometimes have to use a method or approach that might displease participants.

## Prevention in educational institutions

### Guidelines and recommendations for school-based prevention

*Matej Košir and Sanela Talić*

In June 2012, the Institute Utrip issued a document entitled “Guidelines and Recommendations for School-based Prevention”, which was drawn up in cooperation with Mentor Foundation International in the framework of pilot implementation of the Unplugged school-based prevention programme in the school year 2010/2011.

The document presents in detail some of the key assumptions of effective school-based prevention and basic principles that schools can use in practice or to develop and implement high-quality prevention programmes. Guidelines and recommendations take into account available scientific evidence and research data as well as practical experience resulting from years of preventive work of experts and professional workers from around the world.

Guidelines and recommendations are available in English and Slovenian on the EMCDDA website as an example of good practice in the field of standards and guidelines: <http://www.emcdda.europa.eu/themes/best-practice/standards/prevention>.

## Co-creating community responses in the school environment

*Ines Kvaternik and Tadeja Kodele*

The Faculty of Social Work of the University of Ljubljana (FSW) has developed a community-based model of work with children, their parents and school workers. Its primary purpose is to promote community responses to risky situations in a school environment or a classroom community. To achieve greater success in the field of universal prevention, they actively engaged children, their parents and professional school workers (teachers, counsellors) in the discussion about risky situations and ways to deal with such situations connected with the (ab)use of illicit drugs and alcohol. Safe environments, relaxed discussions about the (ab)use of illicit drugs and alcohol, and about the irresponsible use of modern technology, risks connected with the use of drugs and ways of managing them, as well as respectful attitude towards children, who are “experts by experience” (Čačinovič Vogrinčič 2008) have proven to be prerequisites for successful implementation of measures aimed at influencing children in school environments to internalize abstinence as a value and defer potential experimentation with psychoactive substances to a later period. The programme's objectives are to draw up a map of needs and interests of all target groups to be used when preparing workshops on selected topics; to widen cooperation between children, parents and school workers; to broaden the engagement of school communities by using approaches that create confidential and creative atmosphere; to provide target groups with more information about responsible behaviour regarding psychoactive substances and modern technologies, and about the risks of experimenting with psychoactive substances and modern technologies; to teach both children and parents about the strategies for controlling encounters with the said substances and modern technologies.

FSW researchers conducted a survey in 33 primary schools in the Municipality of Ljubljana (MOL) between 2007 and 2009. On the one hand, the purpose of the survey was to find out why the activities aimed at preventing addiction (such as “schools for parents”) have low participation rates; on the other hand, the purpose was to learn about the needs and interests of parents regarding the planning and implementation of the mentioned activities. The researchers identified topical issues, studied the ways in which parents would be more willing to participate, explored the reasons why parents do not participate in existing activities, etc. The survey included 2077 parents and children (of 1st to 9th grades). On the basis of survey results, the researchers designed a community-based model of work with children and their parents and pilot-tested it in a selected primary school. 56 children who attended 8th grade in the school year 2008/2009 and their parents and teachers participated in the model testing phase. The model of work was later upgraded, and two more schools in the MOL area were included in the project; the researchers selected one class of 7th grade children in each of the two primary schools (in the school year 2010/2011) to participate in the project along with their parents and professional school workers (altogether 41 students, their parents, 2 class teachers and 2 school counsellors). The programme comprised workshops conducted on a monthly basis by programme operators who talked with children about topics that they find problematic and interesting. On the basis of workshop contents, programme operators organized meetings with children's parents and school workers (about

two meetings in one school year). The model was evaluated over the course of the programme by using pre-prepared evaluation forms to evaluate the contents and the manner of work, the attitude of programme operators towards participants, relationships between participants, and new knowledge gained by workshop participants. In addition, programme operators filled out a form after completing a workshop to evaluate and monitor the whole workshop process. The data obtained show that most parents and school workers were very satisfied with the meetings. They appreciated the fact that the meetings addressed topical issues which were presented clearly and related to experience from everyday life. They described the attitude of programme operators as open and appropriate, because it created a safe environment for such discussions. Participants felt that they had enough opportunities and space to participate in the discussion, ask questions and present their own opinions. They appreciated the fact that they acquired new knowledge and new information at the meetings, and consolidated their existing knowledge at the same time.

The above mentioned model of work is presented in a scientific monograph entitled *Let's Talk: Community-based Approach in Schools* ("Pogovarjajmo se. Skupnostni pristop v šoli") which was published in 2010 by the Faculty of Social Work.

### **Evaluation of the Unplugged school-based prevention programme (EU-Dap)**

*Sanela Talić and Matej Košir*

#### **Evaluation of the effects and results of the Unplugged school-based prevention programme**

Situation before the implementation of the programme

48 Slovenian primary schools (26 in the intervention group and 22 in the control group) participated in the pilot phase of the Unplugged school-based prevention programme. However, 4 schools from the intervention group decided not to participate in the evaluation of effects. Thus, the evaluation of programme effects covered 2,937 students from 44 schools or 155 classes in the school year 2010/2011.

49.3% of students who participated in the survey were male. 27.5% of students were 12 years old, 50.4% were 13 years old, and 21.5% were 14 years old. 66.6% lived with both parents, and 83.6% had brothers and/or sisters. 98% of surveyed students stated that they had one car in the family, and 99% percent stated that they had at least one computer at home.

17.9% of students stated that they had smoked at least one cigarette in their life, and only 2.8% of students stated that they had smoked at least one cigarette in the past 30 days. About 59% of students reported that they had drunk alcohol on at least one occasion, and 26% of students reported drinking alcohol in the past 30 days. 15% of students drank to intoxication at least once in their life, and 4.3% of students reported getting drunk in the past 30 days. About 2% of students had smoked marijuana on at least one occasion, and 0.5% had smoked it in the past 30 days. Less than 1% of students had used other illicit drugs on at least one occasion, and 0.3% had used illicit drugs in the past 30 days.

As regards the intention of students to drink alcohol or use other drugs within one year after the survey (initial situation), 8% of surveyed students stated that they intend to smoke cigarettes the next year, 31.7% stated that they intend to drink alcoholic beverages, 10.5% expressed their intention to drink to intoxication, 2.0% to smoke marijuana, and 1.4% to use other illicit drugs.

82% of all students stated that they would get in trouble with their parents if they smoked cigarettes, and 72% stated that they could become addicted if they smoked. Some students stated that smoking can positively affect their lives.

In general, students' awareness of the negative effects of drinking alcohol seems high; however, not many students (62%) stated that one can become addicted to alcohol. They consider alcohol consumption a form of risk behaviour, because it can result in problems with parents, in school, with the police, with money (e.g. debts) and lead to loss of employment or inability to find employment. A few students stated that alcohol use can have positive effects; however, 34% of all students believe that they can have more fun if they drink alcohol.

A large proportion of students were of opinion that marijuana use can lead to bad consequences. Nevertheless, the proportion of students who stated that marijuana use could have positive effects (relaxation and the fact that it makes one forget about one's problems) was 38%, which makes it higher than the proportion of students who think alcohol or tobacco have positive effects.

The programme's effectiveness in reducing the use of tobacco, alcohol and other drugs  
To evaluate the effectiveness of the Unplugged programme in reducing smoking, alcohol drinking and intoxication, and cannabis use, the researchers used the same questionnaires in the initial phase (showing the initial situation) and in both subsequent phases (four months after the implementation of the programme, and one year after the implementation). The final sample of students participating in the first phase of evaluation, which was compared to the initial situation (before the implementation), included 2,218 students, that is 75.5% of all participants from the initial phase of the survey.

Preliminary evaluation results show that the programme was very successful in the intervention group of schools in comparison with the control group. The comparison was made on the basis of the initial situation and the evaluation carried out four months after the implementation of the programme in the intervention group. Results show that smoking, occasional drinking, frequent drinking and intoxication as well as marijuana use and the use of other illicit drugs decreased significantly among students who participated in the implementation (intervention group), while it had not changed much among students in the control group.

As regards smoking in the past 30 days, there was a 3.7% increase (from 2.5 to 6.2%) in the control group, while smoking increased only by 0.9% (from 2.9 to 3.8%) in the intervention group. The best results were achieved regarding the use of alcohol in the past 30 days, as the percentage decreased by 6.7% in the intervention group (from 25.1 to 18.4%), while it

increased by 8.3% (from 27.7 to 36.0%) in the control group. Although frequent alcohol use also decreased in the intervention group (by 0.2%) and increased in the control group (by 0.6%) this difference is not significant. As regards drinking to intoxication in the past 30 days, there was again a significant difference between the intervention and the control groups, as the percentage in the control group remained almost unchanged (it increased by 0.1% from 4.5 to 4.6%) and the percentage in the intervention group decreased by 1% (from 3.8 to 2.8%). The prevalence of marijuana use did not change much in either group, but it was very low in all surveyed primary school students to begin with. There were also no significant differences in the prevalence of the use of other illicit drugs, and the percentages were also very low.

If we compare these data to the initial situation, also as regards the predictions of children about the future use of alcohol, tobacco and other drugs, we find that the Unplugged programme has significantly reduced the actual use in the intervention group. The actual use of drugs also decreased slightly in the control group when compared to predictions, but this decrease was not as significant as the one in the intervention group. The most noticeable differences were in tobacco use (predicted 8%, actual 3.8%), alcohol drinking (predicted 31.7%, actual 18.4%), and drinking to intoxication (predicted 10.5%, actual 2.8%).

### **Process evaluation of the Unplugged school-based prevention programme**

In 2011, the Institute Utrip also carried out a process evaluation of the programme. 63 school teachers and 406 7th and 8th grade students participated in the evaluation.

Most participating teachers (80%) were satisfied or very satisfied with the Unplugged programme, and one fifth did not express their satisfaction. Most teachers stated that they had significantly or at least partly improved their skills and knowledge about drug-related prevention and their pedagogical skills during the implementation of the programme. Almost half of the teachers (45%) improved their relationships with students after the implementation, and the classroom atmosphere also improved. The majority of teachers (87%) said that the interest in cooperation in the programme and the level of student interaction had been considerable or very high, and 13% of the teachers stated that students had showed only slight interest for cooperation and had mostly avoided interaction. During the implementation of the programme, 87% of all planned activities were carried out during individual lessons, and there were significant differences between lessons as regards realization. There were 12 lessons, and the execution of individual activities was problematic in four of them. In most cases, the problem was that there was not enough time to complete the lesson or carry out all planned activities. Regarding the usefulness of the manual for teachers, 70% of surveyed teachers stated that it had proved quite helpful during the implementation, and 25% stated that it had been very helpful. All teachers said that they had benefited from the training designed to improve skills and knowledge, which had helped them in the implementation.

Students gave the Unplugged programme an average rating of 3.6 on the scale of 1 to 5. What they liked most about the programme was that they did not have to attend classes



according to the usual schedule during the implementation. Apart from that, they were very satisfied with the manner of implementation; they appreciated the different work methods, i.e. the playing of games, group work, a lot of talking and socializing, and different examples presented during the lessons. They also liked the fact that they learned a lot; they found drug-related topics, especially those about alcohol use, most interesting.

A large number of students did not enjoy working with the workbook. Some of them did not like the fact that they had to share the thoughts they had written in their notebooks with other classmates, and especially with teachers. Nevertheless, more than half of the students (51%) stated that the programme had helped them answer questions about themselves and their choices, and 40% said that the programme had changed the way they thought about themselves. Most students (75%) gained new information about the effects of the use of tobacco, alcohol and other drugs during the programme.

## **Family-based prevention**

### **Study on obstacles to the implementation of family-based prevention programmes**

*Sanela Talić*

The main purpose of the European Family Empowerment project, whose participating countries include Spain, Portugal, United Kingdom, the Czech Republic, Sweden and Slovenia, is to study the situation in the field of preventive possibilities of current European families, and, on this basis, to find appropriate ways or approaches that would be more effective as regards the prevention of risk behaviours among children and adolescents. The most common obstacles to family-based prevention programme implementation are: poor attendance of parents; the fact that programmes are limited to closed family environments, while the potential role of families in the wider community is largely neglected; and possible gaps between parents and children. These gaps can become even wider during adolescence, when parents have less control over the environments where their children frequently spend time. The factors that further widen such gaps are new information technologies, friends, modern age lifestyles of young people, and the interests of the “unhealthy” industries (e.g. alcohol and tobacco industries) and the entertainment industry. Thus, project partners (including the Institute Utrip) conducted a study aimed at exploring the mentioned obstacles and finding ways of eliminating them and of mobilizing families to strengthen their influence on various negative environmental factors which are not favourable to children and young people. The researchers were interested in topics such as drug use among parents and children, norms regarding drug use, and family life (rules, family structure, parenting skills and styles, Internet use, etc.). Young people aged 12–18 and their parents participated in the study. Mostly mothers filled out questionnaires in all participating countries. The total number of completed questionnaires was 12,143; 3,878 of them were completed by parents, and 8,256 by children (2,163 questionnaires were completed in Slovenia – 785 by parents and 1,378 by children).

The most significant differences were those between parents' and children's answers regarding the use of alcohol and related family rules. Parents normally have strict rules

concerning the use of alcohol and other drugs. If their children got drunk, they would reprimand them and talk to them; 37% of Slovenian parents said that they would even punish them. It is interesting that only 20% of parents said that they talk to their children about alcohol, tobacco, other drugs and sex (children's answers show that this percentage is even lower, as only 10% of them said that they talk about the said issues at home). 81% of Slovenian parents believe that their children have never drunk alcohol; however, the analysis of children's answers shows that only 48% of children reported they have never drunk alcohol. Only 6% of Slovenian parents stated that their children had been drunk on at least one occasion, but children's answers show that 31% of children got drunk on at least one occasion. It is also worrying that minors usually get alcoholic beverages in bars or restaurants, from friends or at home. They usually steal alcohol or get it from their siblings, which means that their parents do not have enough control or are possibly in denial. The researchers reached similar conclusions when analysing answers about the use of tobacco and illicit drugs.

As regards family life, parents stated that they usually talk to their children about school work, household chores, their children's friends, leisure activities, etc. In all cases, parents' answers differ significantly from children's. According to children, they do not talk with their parents about the said topics as often as reported by parents. Most parents stated that there are rules and limits set in their families. In comparison with other European families, there is a lack of mutual communication and a lack of father's or mother's attention and warmth in many Slovenian families.

The overall conclusion of the study is that there is definitely a gap between parents and children. For example, parents recount more conflict with their children than children do; furthermore, parents believe they have more control than they actually do.

The study also shows that more than 63% of parents participate in preventive activities in Slovenia. Among all participating countries, the Czech Republic had the lowest participation rate (almost 90% of Czech parents stated that they did not participate in preventive activities), and Portugal and Sweden had the highest rates (73.5% and almost 69%, respectively). As regards these results, it is necessary to keep in mind all preventive activities that parents had participated in at any time during their children's education before the study. The most frequently reported reasons for parents' non-participation are lack of time (more than 44%), the fact that schools do not organize such activities (almost 35%), and more than 31% of parents stated that they preferred to talk about such topics at home (surveyed parents could select more than one answer).

## Community-based prevention

### Analysis of the network of local action groups working in the field of addiction prevention

*Matej Košir and Maša Crnkovič*

Of 42 active local action groups (LAG) in Slovenia, 24 participated in the analysis of the network of LAGs, which was conducted by the Institute Utrip in 2011<sup>11</sup>. The analysis showed that most LAGs engage in preventive activities in the field of illicit drug use, risky and harmful alcohol use and other types of addiction (non-chemical addictions). Their activities are aimed mainly at primary school students and families, and some LAGs also implement programmes for high school and university students as well as preschool children. Usually they organize lectures or workshops, mostly in the school environment. Almost half of LAGs never evaluate their work, and those who do evaluate their work mostly carry out internal process evaluations.

Most LAGs are funded solely by municipalities, since most of them comprise mayors' consultative bodies or municipal councils. According to LAGs, the advantages of such a structure are the support from municipalities and the influence LAGs have on municipal-level decision-making and coordination, and the disadvantages are the limited financial resources and over-reliance on voluntary work of LAG members. Most LAGs believe that the Ministry of Health of the Republic of Slovenia should ensure coordination at the national level and provide professional help in the form of strategic guidance and co-organization of the annual national conference (a short description of past analyses is included in the 2011 National Report on the Drug Situation in Slovenia).

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### 3.3 Selective prevention

Selective prevention comprises strategies targeting specific subpopulations whose risk of a disorder is significantly higher than average, either imminently or over a lifetime. (EMCDDA 2011). The purpose of selective prevention is to defer the onset of psychoactive substance use in members of these at-risk subpopulations by strengthening protective factors (such as self-confidence, problem-solving ability, etc.) and by teaching them how to effectively deal with risk factors (such as genetic predisposition or association with people who use drugs).

#### The addiction prevention Strengthening Families Program

*Matej Košir and Sanela Talić*

The Strengthening Families Program (SFP) is a family-based prevention programme that has been scientifically proven to be effective, and is based on family skills training. The program strives to build protective factors by improving family relationships, parenting skills and children's and adolescent's social and other life skills. A comparative overview of effective

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<sup>11</sup> The results of the analysis of the network of local action groups working in the field of addiction prevention in Slovenia are available from the author

alcohol- and drug-related prevention programmes has shown that the Strengthening Families Program is the most effective prevention programme in the world (Foxcroft et al. 2003).

The Institute Utrip implemented the pilot phase of the program in 2011 and 2012 in 8 families that agreed to participate after discussing it with school counsellors. Given the age of children in the selected families, they implemented the program version that is aimed at children between 6 and 11 years of age. External evaluation of the pilot programme implementation was carried out by a group of experts led by Karol Kumpfer of the University of Utah, USA.

Evaluation of the effects was carried out by means of quasi-experimental repeated measurements of different variables and measurable indicators,<sup>12</sup> and an analysis of the behaviour and opinions of parents and children before and after the implementation of the programme,<sup>13</sup> as recommended by Campbell and Stanley (1967). The training program consisted of 14 family sessions which were carried out in an organized and interactive manner. Evaluators monitored the program implementation and concluded that the families were actively involved in the implementation and that they actually strengthened their relevant family skills.

The evaluation showed that 16 of 18 measurable indicators (89%) had excellent results, in some points even better than the average results and effects of past studies. The measurable indicators (protective and risk factors) included: the organization of a family, family cohesion, family communication, family conflicts, family resilience, positive parenting, parent involvement, parenting skills, parental control, parenting efficiency, overt and covert aggression, concentration problems, criminal behaviour, hyperactivity, social behaviour, depression and the use of alcohol and other drugs. Major effects of the programme include positive changes in parenting skills and parenting styles in both parents (as regards individual variables, the effect sizes ranged from  $d = .78$ <sup>14</sup> (large effect size) for positive parenting to  $d = .60$  (moderate effect size) for parenting efficiency). Also regarding family changes, the programme brought about significant positive changes in all variables; the effect sizes ranged from  $d = .95$  (large effect size) for family resilience to  $d = .50$  (moderate effect size) for family conflicts. The mentioned results regarding changes in Slovenian families are better than those obtained in several other studies on the effectiveness of the

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<sup>12</sup> This method includes longitudinal repeated measurements of the same intervention variable or indicator with the purpose of measuring changes over time. A quasi-experiment is an empirical study used to estimate the results or impact of an intervention on the target population. It is similar to experiments or randomized controlled trials, but it lacks the "randomness" (the target population sample for the SFP pilot implementation in Slovenia was not selected randomly). Nevertheless, we took into account certain criteria such as vulnerability of children (hyperactivity, behavioural or learning problems, etc.)

<sup>13</sup> The pre- and post-intervention analysis is a research method which includes a comparison between different target groups, and a comparison between rates of change which represent programme or intervention results. This method can also be used to determine the rates of change within one target group before and after an intervention or programme implementation

<sup>14</sup> In addition to Glass's  $\Delta$  and Hedges's  $g$ , Cohen's  $d$  is one of the most common effect size measures used to assess differences between groups. Cohen has defined a small effect as  $d = .20$ , a medium effect as  $d = .50$ , and a large effect as  $d = .80$ . The largest effect size ( $d = 1.00$ ) means that the change or effect on an individual or a group was one standard deviation. When evaluating the effects of prevention programmes (depending on the intervention specifics), Kumpfer uses a slightly modified scale of effect sizes, namely  $d = .00 - .30$  is a small size,  $d = .31 - .60$  a moderate size, and  $d = .61$  a large size effect

programme carried out in the USA and elsewhere. There were also many improvements observed in children who participated in the program. The following 6 (of 7) variables improved: overt and covert aggression, situation concerning the lack of attention, hyperactivity and depression, and children's social skills and concentration. Results show that it is necessary to maintain a high family participation rate throughout the program implementation, and to focus on improving parental disciplinary practices. During the evaluation, parents reported a very modest use of alcohol, tobacco and other drugs before participating in the program, and the use of these substances decreased even further after the implementation of the program. Due to very low use of alcohol, tobacco and other drugs before the program, the achieved effects were not significant. In general, the program brought about moderate to significant improvements in parenting skills, and small to significant improvements in family relationships and children's behaviour.

External evaluators (Kumpfer et al. 2012) have included some recommendations in the evaluation report; they suggest that the program implementation should continue in Slovenia, as its pilot phase was implemented in accordance with all guidelines and recommendations, and that the same evaluation process should be used in future implementation, including the evaluation of effects and results (which will enable international comparisons). The evaluators also recommend that the program be extended to at-risk and high-risk families as well as socially excluded or isolated families, and that funding for the program be ensured for all subsequent cycles and future implementations on the basis of a plan of work of providers and operators.

In evaluators' opinion, the Institute Utrip could be more successful in implementing the program if it had ensured wider support from the community, especially from centres for social work and other institutions and organizations working in the field of social security and family assistance (e.g. child welfare organizations, counselling centres for children, adolescents and parents, etc.).

### **SRAP - Addiction Prevention within Roma and Sinti Communities**

*Tea Sulič and Branka Božank*

The Slovenian Roma community represents one of the populations at high risk for developing different forms of addiction. Most Roma people still live in settlements isolated from the rest of the population or just outside populated areas, and their living conditions are below the minimum living standards. Data show that 39% of Roma people live in brick houses, and only 12% live in apartments (Ministry of Health 2010). The rest of them live in shelters – shacks, containers, caravans, etc. Only a small proportion of Roma people live in populated areas together with the rest of the population (mostly in Prekmurje); they have achieved a satisfactory level of socialization and have become integrated into the environment and the society.

Low levels of education, high unemployment rates, and socio-spatial isolation are the reasons for their lack of health information and low health awareness, which reflect in the absence of preventive healthcare.

It is difficult to explore addiction problems among Roma people, or compare them with those of other members of the population. Studies on the health status of the Roma population focus mainly on their access to health care. Where data are available, they show high rates of various health conditions.

Substance abuse among the Roma people is usually addressed through safety measures and law enforcement, while their health problems remain ignored. Representatives of the Development and Education Centre Novo Mesto (RIC) and ten organizations from Bulgaria, France, Italy, Romania, Slovakia and Spain are partners in the SRAP project - Addiction Prevention within Roma and Sinti Communities, whose main purpose is to prevent licit and illicit drug addiction among young Roma people aged between 11 and 24.

So far, all partners have:

- reviewed national laws governing the status of Roma communities, health and social security coverage of Roma communities, and licit and illicit drug use;
- explored the situation regarding licit and illicit drug addiction problems among the Roma population by conducting focus groups in three target groups, namely representatives of the local community, representatives of young Roma people, and representatives of professional healthcare and social workers. They found that there is a lack of information about the value system and the lifestyle of Roma people, about their willingness to seek help and their awareness of the help and support available to them in case of addiction (SRAP Network 2012).
- studied young people's attitudes towards drugs by using an action research method in three age groups (1st group: 11–14 years; 2nd group: 14–16 years; 3rd group: 17–24 years). They held a workshop for the 11–14 and the 14–16 age groups in a Roma settlement, where adolescents expressed their attitudes toward drugs and presented the problems they associate with drugs through drawing. Older adolescents were interviewed. Researchers found that both licit (tobacco, alcohol) and illicit drugs (cannabis, heroin) are present in the lives of Roma children, whereas medications are present in the adult world. They also found that tobacco use is acceptable among young Roma people. The children also described negative social and economic effects of alcohol use and abuse in their families. As regards illicit drugs, they showed lack of knowledge and expressed concerns. Children believe that illicit drug addiction leads to death, and they do not know who they could ask for help if they were addicted (SRAP Network 2012).
- underwent training for preventive work with young Roma people at the meeting in Dolenjske Toplice. Experts Gian Paolo Guelfi and Richard Ives presented to them a method for building life skills, and a motivational interviewing method.

They also plan to conduct workshops and motivational interviews in three age groups of Roma adolescents, and present the results at the partner meeting in Bucharest. After that, they will design and implement a training programme for social and healthcare workers with the aim of raising their awareness of the importance of taking into account cultural and social differences when working with young Roma people. Information on all events connected with project work or activities from the lives of Roma people as well as different materials are available at the website [www.srap-project.eu](http://www.srap-project.eu), which was created in the framework of the project.

### **3.4 Indicated prevention**

According to EMCDDA (2011) indicated prevention aims to identify and target individuals who are showing indicators that are highly correlated with an individual risk of developing drug use later in life or are showing early signs of problematic drug use. The aim of indicated prevention efforts is not necessarily to prevent the initiation of drug use but to prevent the (fast) development of dependence, to diminish frequency of use, or to prevent progression to more harmful patterns of drug use.

#### **Svit Association Koper - Support programme for families, children and adolescents**

*Ingrid Kristančič Šomen and Branka Božank*

The programme is a combination of elements of both selective and indicated prevention, and is implemented by the Svit Association from Koper. 112 people participated in the programme in 2011. In terms of health care, the system takes good care of pregnant women (drug users and former drug users), who are highly motivated for seeking help during pregnancy. Problems arise when they return to their homes, which are marked by drug use, and have to assume a parental role which becomes more demanding and difficult to manage as their children grow older.

The programme for families, children and adolescents is a social prevention programme which is implemented by the Svit Association as an upgrade or addition to the existing low-threshold programme for people addicted to psychoactive substances. Its target group includes children whose parents are PAS users; at-risk children; parents who use PAS; girls with associated problems; and grandparents of addicts' children. Any family who is in a stressful situation due to drug-related problems can turn to the Association for help. The programme is an important complement to the existing programmes in the local and the wider communities.

The programme addresses drug-related problems and promotes and carries out safe leisure activities to encourage participants to adopt a healthy lifestyle. The programme's basic methods of work are individual work (with a child, a mother, etc.); work with couples; group work; creative holiday socializing, assistance through art (visual-art psychotherapy and integrative psychotherapy) and systemic psychotherapy.

Programme objectives are achieved through different activities: creative, holiday and youth workshops, learning assistance, individual work with an individual or a family, prevention workshops held in schools, field work, and education for professional workers and students. In 2011, holiday activities were aimed at primary school children of people participating in Association's programmes, and at children from socially disadvantaged families. During the implementation of activities, the need arose for learning assistance for children, especially migrant children, who accounted for the majority of participants in learning assistance activities. Through working with children participating in these activities, the Association also came in contact with migrant families, who receive financial assistance, but are not provided with support for integration.

The Association has found that, because it is recognized in its environment as an organization that deals with addicts, stigmatization of children participating in the programme is one of its major problems.



'Problem drug use' is defined by the EMCDDA as 'injecting drug use or long duration / regular use of opioids, cocaine and/or amphetamines' among people in the 15-64 age group in one year. This definition was used in estimating the prevalence of problem drug use in Slovenia. Estimates of the prevalence of problem drug use in Slovenia were made using the capture – recapture method on two occasions: the first time for years 2000 and 2001, and the second time for 2004.

This report presents a study on drug users seeking help in harm reduction programmes who are classified as problem drug users according to the above definition. The results of the study, which were obtained using information from anonymous questionnaires completed by 204 harm reduction programme users, show that there was a significant increase in the use of drugs other than heroin in 2011 compared to the previous year. This is probably due to the decreased availability of heroin and its poor quality in 2011. 62% of harm reduction programme users stated that they used cannabis, 61% used heroin, 60% cocaine, 30% synthetic drugs and 69% alcohol. Most of these programme users were in substitution treatment, and more than half of them also used other medications, namely hypnotics and benzodiazepines.

Harm reduction programme users mostly injected heroin and cocaine. In comparison with 2010, intravenous use of heroin decreased in 2011, while intravenous use of cocaine, heroin and cocaine combinations, and medications increased. The most common risk behaviours among harm reduction programme users were: drug injection, simultaneous use of multiple drugs (i.e. polydrug use), unprotected sex, and sharing of joints. Two thirds of users who injected drugs always used sterile materials. Most of them got injection materials from harm reduction programme workers.

#### 4.1 Prevalence and incidence estimates of problem drug use in Slovenia

Estimates of the prevalence of problem drug use in Slovenia were made on two occasions, the first time for 2000 and 2001, and the second time for 2004. The capture – recapture method was used on both occasions, and the data collected was obtained from two sources, namely data on the demand for treatment in the network of centres for the prevention and treatment of drug addiction, and data on drug-related criminal offences obtained from the police. The number of problem drug users in the age group of 15–64 years was estimated at

10,654 in 2004, and at 7,535 and 7,399 in 2000 and 2001, respectively. A more detailed description is available in the 2008 report.

## 4.2 Problem drug use among users of harm reduction programmes in Slovenia

*Ines Kvaternik and Živa Žerjal*

Regional Institute of Public Health Koper (RIPH Koper) conducted a survey between November 2011 and January 2012, using an anonymous questionnaire to obtain information on profiles of drug users who seek help in harm reduction programmes and are considered problem drug users according to different definitions. In accordance with EMCDDA recommendations, the target group of problem drug users included long-term drug users who regularly use heroin, cocaine, amphetamines or methadone, and whose most common route of administration is injection.

The survey covered 204 users of drug-related harm reduction programmes from all over Slovenia (Koper, Izola, Piran, Ilirska Bistrica, Nova Gorica, Sežana, Ljubljana, Celje, Maribor, Velenje and Žalec).

### Survey results

Of 204 survey respondents, 162 were men (80% of respondents) and 40 were women (20% of respondents). The average age of respondents was 33.3 years; the youngest respondent was 20 years old and the oldest respondent was 58. Most respondents, i.e. 34% of all respondents, belonged to the age group of 31-35 years. 11% of respondents belonged to the 20-25 age group; these represented the youngest respondents. One quarter of respondents belonged to the 26-30 age group, and 15% of all respondents were between 36 and 40 years old. 9% of respondents were between 41 and 45 years old, and 4% belonged to the 46-50 age group. There were only 1% of respondents aged 51 and over. Although the data show that people aged 40 or less still represent the largest proportion of programme users (85%), we can see that the average age of programme users is gradually increasing - it increased by 1 year since the last survey.

More than half of all survey respondents had vocational or secondary education (63.5%), 31% had completed primary school and 3% had not completed it; only 2.5% of respondents had university or higher education.

Most respondents were unemployed (66.5%); only 4.9% were employed, 21.2% worked occasionally, and 3.4% of respondents stated that they were retired, received social assistance or worked illegally.

Most surveyed harm reduction programme users lived with their parents (38%), 29% of respondents lived alone, 2% alone with a child, 15% with a partner, 4% with a partner and children, 8% were staying in a shelter or living on the streets (in parks, abandoned buildings, etc.), 1% with their friends or acquaintances, and 3% of respondents lived somewhere else

(with their grandmother, brother, in a motel, in the Kolizej building, etc.). 20% of all respondents had children, most of them only one.

Of all surveyed users of harm reduction programmes, 85% were participating or were treated in other programmes at the same time. More than half of them (57%) were in treatment in centres for the prevention and treatment of drug addiction, 2% in programmes for achieving abstinence, and 4% in hospital detoxification programmes. 34% of respondents stated that they were in combined programmes (i.e. substitution and other programmes) for drug users. 15% of respondents had never been treated in any other programme for drug users.

95% of respondents had basic health insurance and 82% also had supplemental health insurance. Since most respondents were unemployed and depended on social assistance, their health insurance costs were covered by the state. Therefore we can expect that the proportion of those harm reduction programme users who have health insurance will decrease significantly next year due to austerity measures aimed at regulating public spending in 2012, since these measures will limit rights to health and social care of some groups of people.

48% of respondents stated that they had other health problems in addition to drug addiction. Most of them had hepatitis C, followed by mental health problems, stomach problems, asthma, allergies, bad teeth and problems with blood vessels.

Almost 70% of respondents stated they had been subject to different law enforcement procedures.

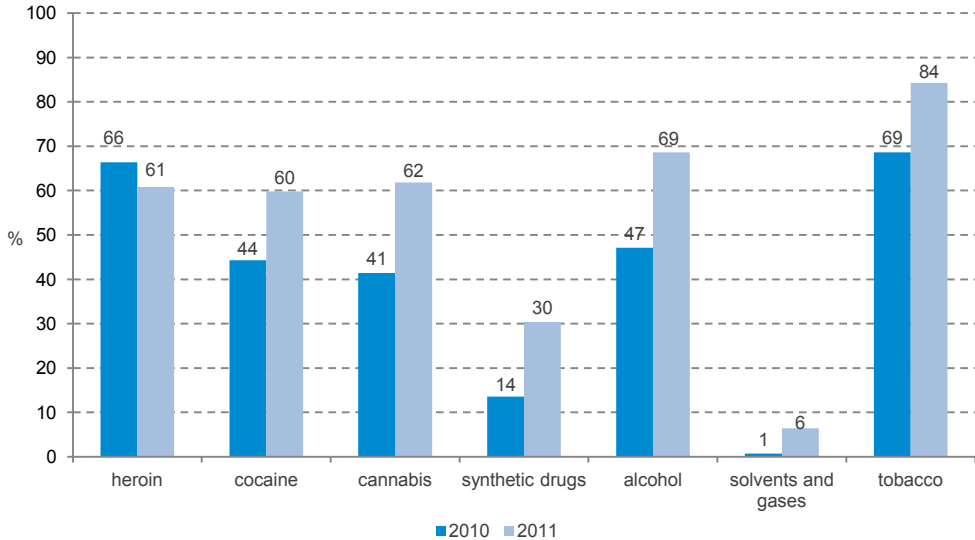
### **Drug use**

Polydrug use is very common among harm reduction programme users. While in 2010 most programme users used heroin (66%), followed by cocaine (44%), marijuana (41%), synthetic drugs (14%) and alcohol (47%) (Drev et al. 2011), the situation changed drastically in 2011. Survey results show that the use of all drugs except heroin increased significantly in 2011. The decrease in heroin use is probably due to the decreased availability of heroin and its poor quality. As in some other countries of the European Union, limited availability of heroin in Slovenia probably reflects in drug users' seeking of substitutes and in an increased use of other drugs such as synthetic drugs and drug combinations (EMCDDA in print). 61% of surveyed harm reduction programme users used heroin, 60% used cocaine, 62% cannabis and 30% synthetic drugs; alcohol abuse increased significantly in 2011 (to 69%) (Figure 4.1). 80.4% of harm reduction programme users used substitute drugs (Methadone, Suboxone, Substitol). 60.8% of respondents also used other drugs, namely hypnotics (Dormicum, Sanval) and benzodiazepines (Apaurin, Xanax, Helex).

Surveyed harm reduction programme users mostly injected heroin and cocaine. In comparison with 2010, intravenous use of heroin decreased in 2011 (61%) and the proportions of intravenous use of cocaine (66%), heroin and cocaine combinations, and medications (benzodiazepines, methadone and other substitute drugs) increased. 3% of

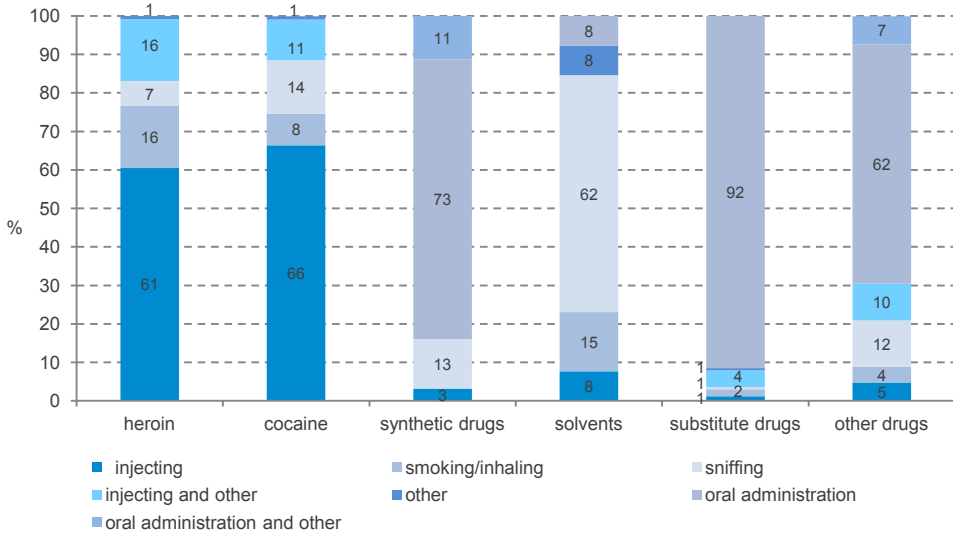
survey respondents injected synthetic drugs and 6% frequently injected substitute drugs. 14% of those who used other medications stated that they injected them (Figure 4.2).

Figure 4.1: Proportions of respondents in drug-related harm reduction programmes by type of drug used, 2010 and 2011



Source: Anonymous survey, RIPH Koper, 2011

Figure 4.2: Proportions of respondents in drug-related harm reduction programmes by type of drug and route of administration, 2011



Source: Anonymous survey, RIPH Koper, 2011

**Risk behaviours**

The most common risk behaviours among harm reduction programme users remain drug injection, inconsistent use of sterile materials or accessories, sharing of needles and other materials, and injuries due to risky administration. These risk behaviours are followed by sexual risk behaviour, as 87% of respondents stated that they occasionally or always had unprotected sex; only about one fifth of respondents always had protected sex (Figure 4.3).

Almost two thirds of those who injected drugs stated that they always used sterile materials; most of them got the materials in harm reduction programmes (73%). 42% of injecting users got sterile materials only from programme workers, 10% from field workers, and 13% from pharmacies. 31% of respondents stated that they got sterile materials elsewhere (they borrowed them from friends or dealers).

Only one fifth of respondents never injected drugs, 38% occasionally injected drugs, and 42% always injected them.

Only about one half of survey respondents (54%) never used the same injection needle twice. 41% of respondents reused needles frequently, and 5% always reused them.

21% of respondents always or sometimes shared needles, and 79% stated that they never shared needles. The situation regarding the sharing of other materials is slightly different: 44% of respondents sometimes or always shared other materials, and 56% never shared them.

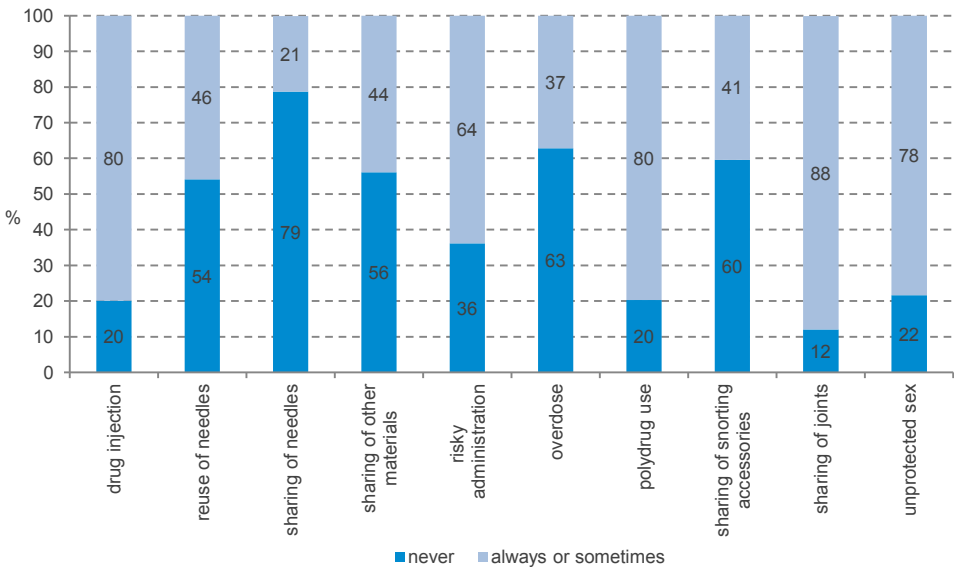
7% of respondents always injected drugs in a risky manner, and 36% had never experienced risky administration. 37% of respondents had experienced a drug overdose.

80% of respondents simultaneously used more than one drug, and almost 8% of them always mixed drugs.

41% of respondents stated that they shared snorting accessories.

88% of respondents smoked cannabis in company and always or sometimes shared joints. This definitely poses a significant risk for the transmission of infectious diseases; in fact, the mentioned target group often has problems with bad teeth and bleeding gums.

Figure 4.3: Proportions of respondents in drug-related harm reduction programmes by risk behaviour, 2011



Source: Anonymous survey, RIPH Koper, 2011

93% of respondents most often used drugs at home, and 81% used drugs at their friends'/acquaintances' places.

5% of respondents always used drugs when at a shelter or a day centre. 5% sometimes and 90% never used drugs at a shelter or day centre.

57% of survey respondents stated that they used drugs in public spaces – 5.5% always and 51% sometimes. 14% of respondents always used drugs outside (in a car, forest, park, abandoned buildings, basements, on trains, outside day centres, in cemeteries). 52% of respondents sometimes and 35% never used drugs outside.

81% of respondents usually returned used needles to programme workers, and 31% of respondents always, 47% sometimes and 22% never threw used needles in garbage cans. Almost 18% of respondents said that they left used materials where they had injected drugs, while others (82%) never did that. 13% of respondents removed used materials in some other way (“I keep them at home and throw them in the trash.”; “We have our own trash can.”; “I destroy them and throw them into the sewers.”; “I burn them.”; “I throw them in the river Ljubljana”).

## **Conclusion**

Survey results show that most harm reduction programme users in Slovenia face many risky situations related to routes of administration, despite a relatively long tradition of implementing harm reduction programmes and their relatively good coverage. This means that programmes also need to focus on other activities aimed at changing the handling of used needles and injection materials and encouraging drug users to use condoms. Given that the population in question is aging and has more and more different needs, health problems and accommodation problems, we will have to consider increasing the number of shelters for homeless drug users and establishing group homes for drug users. The establishment of safe injecting rooms would certainly contribute greatly to achieving harm reduction goals.

## DRUG RELATED TREATMENT: TREATMENT DEMAND AND TREATMENT AVAILABILITY

*Milan Krek*

# 5.

Treatment of illicit drug users is defined in the Resolution on the 2004 - 2009 National Programme in the Field of Drugs (ReNPFĐ) and the laws on drugs, healthcare and social security (see Chapters 1 and 8).

As regards healthcare provision, there is a network of 18 Centres for prevention and treatment of drug addiction (CPTDA) established in Slovenia in addition to the Centre for Treatment of Drug Addiction at the Psychiatric Clinic in Ljubljana (CTDA). Activities carried out in the social security system include those aimed at alleviating social distress of drug users and other forms of assistance provided by centres for social work and non-governmental organizations. The latter implement harm-reduction and day centre programmes, and offer shelters, therapeutic communities, rehabilitation and counselling.

Treatment Demand Indicator data was analysed using completed questionnaires collected from 17 CPTDAs and the CTDA. The analysis shows that the centres recorded 521 persons who sought help in treatment programmes again or for the first time in 2011. 207 of them were admitted for the first time, and 314 were admitted again. The average age of users entering the addiction treatment network again or for the first time was 30.58 years, and most of these users were male (78%). Most programme users (clients) entered a programme on their own initiative. In most cases, the main drug due to which users sought help again or for the first time was heroin (84%), followed by cannabis (8%) and cocaine (3%). Compared to previous years, the proportion of users who sought help due to heroin-related problems decreased, while the proportion of those who sought help due to cannabis-related problems increased. The most common secondary drug was cocaine, followed by alcohol, cannabis and hypnotics. More than half of drug users who entered a programme again or for the first time had already been vaccinated against hepatitis B. Two thirds were unemployed, which means that the proportion of unemployed drug users increased in comparison with previous years. Concerning education levels, the largest proportion of users (50%) had completed primary education.

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### 5.1 General description of treatment and quality assurance

#### Strategy and legislation

Basic laws governing illicit drug addiction treatment in Slovenia include: the Production of and Trade in Illicit Drugs Act (Official Gazette RS, Nos. 108/99, 44/00), the Act Amending the Production of and Trade in Illicit Drugs Act (Official Gazette RS, Nos. 2/04, 47/04) and the

Act Regulating the Prevention of the Use of Illicit Drugs and the Treatment of Drug Users (Official Gazette RS, No. 98/99). The last Act lays down measures to prevent illicit drug use, governs the treatment of illicit drug users, and sets out measures and activities aimed at reducing drug demand.

Treatment programmes for drug users must be approved by the highest relevant professional bodies on the basis of an assessment of efficiency, safety and technical and scientific merit. Funds for treatment and rehabilitation programmes are provided by the state from various sources in accordance with the relevant legislation; in addition, continuous treatment of users is provided at the highest level (Commission on Narcotic Drugs of the Government of the Republic of Slovenia) regardless of funding sources.

Resolution on the 2004–2009 National Programme in the Field of Drugs specifies the scope of drug addiction treatment. Since the new strategy has not been adopted yet, the one set out by the Resolution is still used; it stipulates that assistance programmes must be readily accessible, that human rights must be respected, and that measures must be adaptable to different population groups. The strategy supports programmes that reduce the number of HIV and hepatitis C infections. It sets out measures which improve the quality of addiction treatment programmes by introducing different approaches and upgrading and broadening addiction treatment in prisons, correctional institutions and juvenile detention centres. At the same time, the strategy has ensured the development of social work with drug users in therapeutic communities and harm reduction programmes, and thus contributed significantly to reducing the social exclusion of drug users. The strategy also further specifies the tasks of healthcare and social systems in the field of drug addiction treatment, and sets out the ways of monitoring data on drug addicts in different treatment programmes (Resolution on the National Programme 2004).

Treatment Demand Indicator (TDI) data is collected in the network of CPTDAs and CTDA by using the Record of Treatment of Drug Users forms. Non-governmental organizations (low-threshold programmes) use other forms or questionnaires. Therefore, the possibility of using a uniform questionnaire is being discussed with NGO representatives in the context of implementation of a new questionnaire to be used to collect TDI data. A uniform questionnaire would ensure greater transparency in collecting data on drug users in Slovenia.

### **Treatment systems**

In Slovenia, treatment of drug users is carried out in accordance with the existing legislation, which remained unchanged in 2011. Drug addiction treatment is carried out within the healthcare and social systems and non-governmental organizations.

There is a list of programmes drawn up at the national level, containing relevant information and descriptions of all programmes. The list is available in all programmes and helps drug users decide which programme to enter (Božak et al. 2010).



## **Social protection**

Professional activities aimed at solving drug-related social problems are carried out within the public service sector (62 centres for social work) and by private and non-governmental organizations. In centres for social work, drug-related problems are most often dealt with in the framework of social first aid. Treatment in centres for social work is free of charge, and there are no waiting times. The work of centres for social work is subject to regular supervision and inspections. The inspection service regularly checks whether the operation of centres for social work is in compliance with the existing legislation.

## **Non-governmental organizations**

Complementary social protection programmes are implemented by non-governmental organizations. These programmes include: harm reduction programmes (low-threshold approach), day centres, residential shelters, provision of information, counselling, different forms of high-threshold programmes, reintegration centres, programmes for drug users in prison, vocational training and integration programmes. Programmes receive up to 80% of funds from the Ministry of Labour, Family and Social Affairs (MLFSA), which distributes funds through public tenders to programme providers who meet the requirements for programme implementation. The basic requirements include appropriate premises or facilities, which are usually provided by local communities; expertise (all programme managers must have social work certification); and regular reporting on the development of the programme. Contracts on co-funding of programmes also specify the requirements regarding the quality of work and the conditions under which allocated funding can be withdrawn if a programme is not implemented in accordance with professional guidelines and contractual agreements. The MLFSA regularly evaluates programmes and adjusts programme funding according to evaluation results.

Low-threshold programmes are implemented in large cities and evenly distributed across Slovenia. They offer counselling and provide sterile injection equipment for safe drug injection. They use group work methods and offer education or training to programme users. As regards drug-related harm reduction, these programmes focus mainly on educating drug users about the risks of transmission of HIV and hepatitis C, and about dangerous drug injecting practices.

Rehabilitation programmes are aimed at drug users who have completed one of addiction treatment programmes or therapeutic community programmes. Rehabilitation programmes mainly focus on maintaining abstinence and arranging the social status of individuals who have stopped using illicit drugs. They use counselling and group therapy methods and promote exchange of experience between programme users. Anyone who wants or needs to enter a rehabilitation programme can do so free of charge. The main reason for exclusion from a programme is violent behaviour.

Therapeutic communities are described in more detail in Chapter 11 on residential treatment.

## **Treatment in the healthcare system**

Drug addiction treatment takes place in medical institutions in accordance with the laws governing health care. Addiction treatment is defined in the Recommendations for Doctors on Treatment of Drug Addiction, which were approved by the Slovenian Health Council for the first time in 1994. Medical care of drug users is part of the regular healthcare programme funded by the Health Insurance Institute of Slovenia. The Institute had to cut funding for these programmes in 2012 due to financial difficulties.

The Act Regulating the Prevention of the Use of Illicit Drugs and the Treatment of Drug Users specifies treatment as well as establishment and operation of CPTDAs, which are linked professionally and organizationally in the CPTDA Coordination. The structure and the method of work of the CPTDA Coordination as well as the content and method of supervision of the work of CPTDAs are set out in the Rules on the Structure and Method of Work of Services Co-ordinating the Centres for the Prevention and Treatment of Addiction to Illicit Drugs, and the Rules on Supervising the Work Activity of Centres for the Prevention of and Treatment of Illicit Drug Addiction.

As mentioned, drug users are treated in 18 CPTDAs and the CTDA at the Psychiatric Clinic in Ljubljana. CPTDAs have professional teams consisting of family doctors, psychiatrists, nurses and laboratory technicians. They provide psychosocial therapy and medication therapy. The latter comprises substitution therapy, which is very important and includes the administration of prescribed modern medications or drugs, except heroin. The centres carry out the following activities: counselling for drug users and their families; individual, group and family therapy; preparation for hospital treatment; assistance in rehabilitation and reintegration into society; consultation with healthcare and social services; home care nursing and cooperation with therapeutic communities and self-help groups; ambulatory detoxification; and maintenance programmes.

The Centre for Treatment of Drug Addiction at the Psychiatric Clinic in Ljubljana (CTDA) provides hospital treatment as well as ambulatory care, day hospital treatment and extended hospital treatment with rehabilitation. CTDA also carries out detoxification, emergency treatment and addiction treatment for patients with mental disorders.

Addiction treatment programmes in the CPTDA network follow doctrinal principles and rules on how to treat illicit drug addicts. The National Coordination of CPTDAs regularly monitors changes in drug users' needs and in assistance provided to drug users, and complements the doctrinal principles and rules on CPTDA addiction treatment at its meetings, if necessary. Coordinators meet every month. The Ministry of Health and the multidisciplinary committee responsible for supervising the operation of centres occasionally exercise strict control over the implementation of a programme and request changes where necessary.

## 5.2 Access to treatment

In Slovenia, assistance programmes are available across the whole country, except in the statistical region of Koroška, where there are no CPTDAs or harm reduction programmes. Programmes in the non-governmental sector do not have waiting periods, except for therapeutic communities, which drug users can enter only after completing a preparatory programme, which can last for different periods of time, depending on the individual. Programmes implemented in the healthcare sector do not have waiting periods and are free of charge, and so are harm reduction programmes provided by NGOs, which are accessible to all drug users. However, drug users may be required to pay a fee for entering some other programmes in the non-governmental sector. Such fees do not exceed financial social assistance received by an individual from a centre for social work. The accessibility of treatment has further improved due to the establishment of new programmes, such as programmes for persons with mental disorders, day hospitals and a range of new rehabilitation programmes. A recently opened therapeutic community for drug users with dual diagnosis represents a novelty in the field of social protection programmes.

### Characteristics of treated clients (TDI data included)

#### CPTDA Coordination data for 2011

According to the data from the CPTDA Coordination, 4,178 people entered treatment in 2011, of which 3,557 entered substitution treatment. The following drugs were used in substitution treatment: methadone, Subotex/Suboxone, buprenorphine and morphine SR, as shown in Table 5.1. 3557 people or 85% of all those who entered a programme were admitted into maintenance treatment. 2,446 of them (68.77%) received methadone maintenance treatment, 476 (13.38%) were treated with Subotex, 335 (9.42%) with buprenorphine, and 8.43% with morphine SR. People in methadone maintenance treatment accounted for 59% of all programme users (clients), and those treated with Subotex, buprenorphine and morphine SR accounted for 11%, 8% and 7% of all programme users respectively. Due to the differences in methodologies, the CPTDA Coordination data on the number of people admitted into substitution treatment differs from the number determined using the data from TDI questionnaires.

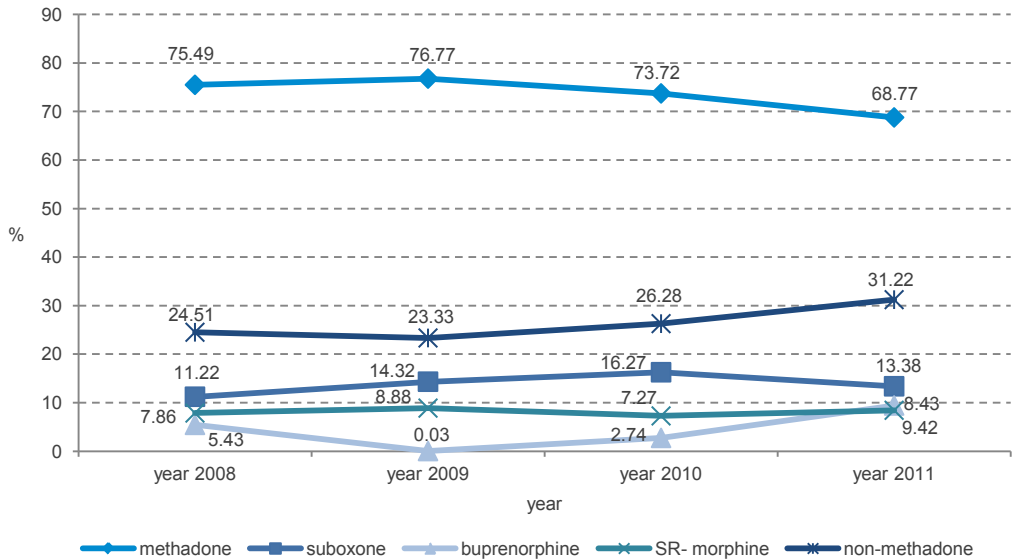
Table 5.1: Number of people treated in Centres for prevention and treatment of drug addiction in 2011

No. of all treated users	No. of participants in substitution treatment	Methadone	Suboxone	Buprenorphine	Morphine SR
4178	3557	2446	476	335	300

Source: CPTDA Coordination, 2012

If we look at the trends over the past four years, we see that the proportion of substitution treatment patients receiving methadone maintenance treatment gradually decreased between 2008 and 2011, and dropped to 68.77% in 2011. The proportion of substitution treatment patients treated with buprenorphine slowly increased after 2008, while the proportion of patients treated with morphine SR remained low and unchanged throughout the period. The proportion of substitution treatment patients treated with Suboxone increased at first, reached 16.27% in 2010, and then decreased to 13.38% in 2011 (Figure 5.1).

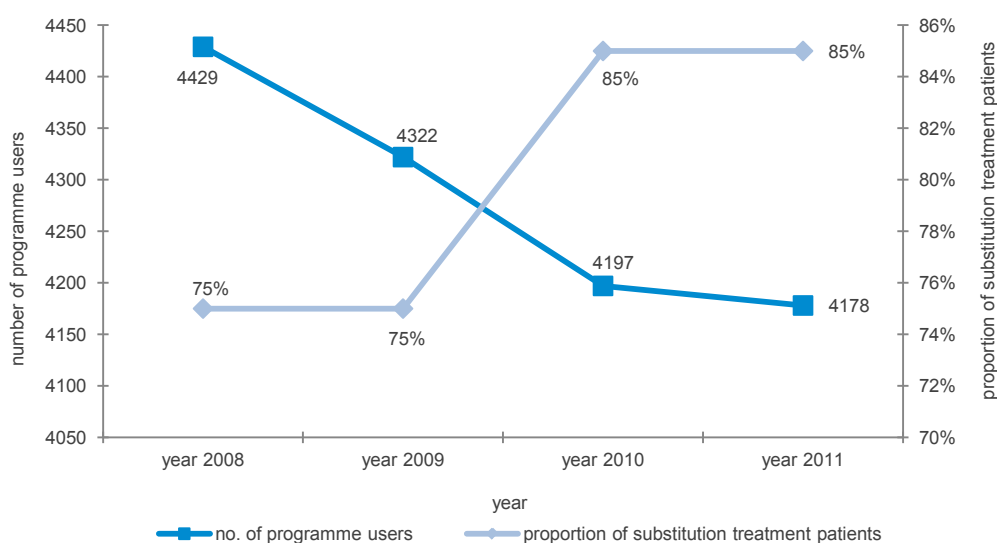
Figure 5.1: Proportions of programme users treated with individual substitute drugs among all users in substitution treatment in the period 2008–2011



Source: CPTDA Coordination, 2012

The percentage of people who underwent maintenance treatment in CPTDAs increased over the years, while the number of all drug users treated in CPTDAs in individual years decreased from 4,429 in 2008 to 4,178 in 2011 (Figure 5.2). However, the ESPAD survey and studies on problem drug users in low-threshold programmes (see Chapters 2 and 4) show that the general number of drug users is not decreasing, but their structure in terms of the drugs they use is changing. Therefore, the adjustment of CPTDA programmes to the current situation in the field of drugs should be accelerated. Data on low-threshold programme users show that the prevalence of cocaine among drug users is increasing, while data on drug users seeking help in CPTDAs do not show such an increase. Furthermore, data on illicit drug poisonings show that the number of opioid poisonings is decreasing, while amphetamine, ecstasy and cannabis poisonings as well as polydrug poisonings are increasing (see Chapter 6).

Figure 5.2: *Number of programme users and the proportion of users in substitution treatment in the period 2008–2011*



Source: CPTDA Coordination, 2012

### Data obtained through TDI questionnaires (see also ST 34)

#### Characteristics of users who entered a treatment programme again or for the first time in 2011

In Slovenia, Treatment Demand Indicator (TDI) data is collected through Record of Treatment of Drug Users forms or questionnaires. In 2011, completed questionnaires were collected from 17 CPTDAs and the CTDA at the Psychiatric Clinic in Ljubljana for the purpose of analysis. One of the centres did not submit data from questionnaires. Given the number of questionnaires collected, we can say that the number of admissions into CPTDA programmes is decreasing. Questionnaires were not used in prisons in 2011. 3,021 drug users were recorded using the TDI questionnaire in 2011; 2,500 of them were admitted into continuous maintenance treatment, and 521 entered a treatment programme in the CPTDA network or the CTDA again or for the first time in 2011.

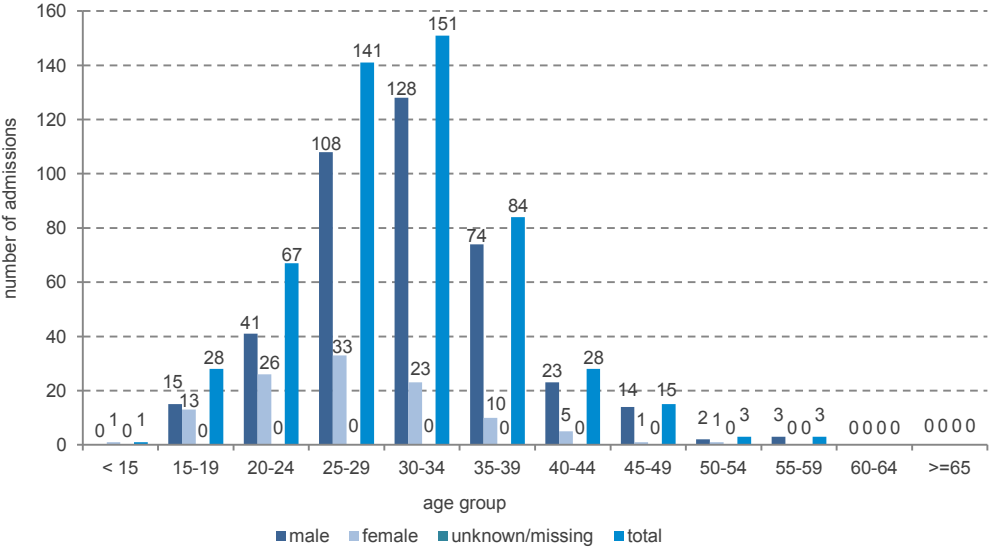
#### Demographic structure of programme users

According to data from TDI questionnaires, 521 drug users entered a CPTDA or CTDA programme again or for the first time in 2011, of which 408 (78.3%) were male, and 113 (21.7%) were female. The average age of all users who entered a programme again or for the first time was 30.58 years; the average age of male programme users was 31.44 years, and the average age of female users was 27.48 years.

Of all 521 programme users, 207 (40%) entered a programme for the first time. 151 (73%) of these first-time programme users were male, and their average age was 28.65 years. The remaining 56 (27%) first-time programme users were female; their average age was 25.77 years.

314 people (60%) entered a programme again in 2011, of which 257 (82%) were male and 57 (18%) were female. In 2011, the proportion of women was significantly lower among drug users who entered a programme again than among first-time programme users (Figure 5.3).

Figure 5.3: Drug users who sought help again or for the first time in 2011, by age group and sex



Source: NIPH, 2012

**Sources of referral**

Of all the people who entered a programme again or for the first time in 2011, 376 (72%) entered on their own initiative, 42 (9%) entered a programme on their parents' initiative, 6% were referred to a programme by other centres, 4% were referred by family doctors, 3% came from a hospital, 5 persons were referred by a court, and one person was referred by social services; the source of referral was unknown in the remaining programme users.

207 people entered a treatment programme for the first time in 2011. 69% of them entered a programme on their own initiative, and 14.5% entered a programme on their relatives' or friends' initiative. 7% were referred to a programme by a general practitioner.

The majority (76.8%) of people who entered a programme again in 2011 entered it on their own initiative, 9% came from other programmes, 4.2% re-entered a programme on their friends' or family's initiative, 3.5% were referred from a hospital or some other institution, and 2.6% were referred by a general practitioner.

**Co-residents of programme users**

47% of drug users who entered a programme again or for the first time lived with their parents, 19.5% lived alone, 15.4% lived with their partner and 7% with their partner and a child.

Of 207 drug users who entered a programme for the first time, 53.1% lived with their parents, 15.5% lived alone, 14.5% lived with a friend, and 6.3% lived with their partner and a child.

42.9% of drug users who re-entered a programme lived with their parents, 22.1% lived alone, 16% with their partner, and 8% with their partner and a child.

The proportion of drug users who lived with their partner and a child was larger among readmitted programme users than among first-time programme users. The proportion of people who lived alone increased compared to previous years and the proportion of drug users living with their parents decreased.

### **Employment status of programme users**

The majority of users who entered a programme again or for the first time in 2011 were unemployed (67.1% or 345 users), while 106 (20.6%) people who sought help in a programme were employed.

Of all first-time programme users, 120 (58.8%) were unemployed, 45 (22.1%) were permanently employed, and 32 (15.7%) were students.

The proportion of unemployed persons was larger among users who re-entered a programme (225 or 72.6%) than among first-time programme users, while the proportions of permanently employed people (61 people or 19.7%) and students (10 people or 3.2%) were lower among readmitted users.

### **Current residence of drug users in 2011**

77% of first-time programme users had permanent residence. 17% had a temporary residence, and 1.9% were homeless.

Of those who re-entered a programme, 77.8% had permanent residence, 16.1% lived in a temporary residence, and 3.2% were homeless. The proportion of homeless people among those who re-entered a programme increased almost two-fold in comparison with previous years.

### **Educational levels of programme users**

The majority of users who entered a programme again or for the first time had completed secondary education (260 users or 50.7%). 184 (35.9%) people had primary education, 2.5% had not completed primary education, and 2.7% of users had completed higher education. Educational level was unknown in the remaining users.

Of all first-time programme users, 54.4% had completed secondary education, 32.8% had completed primary education and 3.9% had not completed it. 3.4% users had completed higher education, and the education level was unknown in the remaining users.

149 (48.2%) users who re-entered a programme had completed secondary education, 117 (37.9%) had completed primary education and 1.6% had not completed it. 2.3% of users who re-entered a programme had completed higher education.

## Primary drug due to which users entered a programme

### Primary drug in first-time admissions and readmissions

Most people who sought medical assistance in centres again or for the first time in 2011 reported opiate-related problems. Of 521 recorded programme users, 451 (87%) were treated for opiate addiction. 435 (83.5%) reported heroin as their primary drug, accounting for 96.5% of all users who used opiates as their primary drug. 11 (2.1%) abused non-prescribed methadone, 18 (3%) programme users sought help due to cocaine, and 44 users (8.4%) were treated for cannabis addiction. 4 people entered a treatment programme due to problems with sedatives or hypnotics. It is interesting that primary drugs due to which drug addicts were admitted to treatment programmes do not include inhalants, since the prevalence of inhalants is very high among students aged 15-16 years; 20% of students reported lifetime inhalant use in the 2011 ESPAD survey. It should be noted that the reported proportion of cocaine users who sought help due to cocaine addiction is relatively low, while field research conducted as part of harm reduction programmes shows that the number of cocaine users is increasing and the number of heroin users is decreasing significantly (see Chapter 4).

### Frequency of use of the primary drug at first admission or readmission

Of all 521 admitted and readmitted programme users, 451 (87%) reported opiates as their primary drug due to which they entered a programme. More than half of these opiate users (253 or 55.9%) used opiates every day, 112 (25%) used them occasionally, 53 (12%) used opiates 2-6 times a week, and 26 (5.7%) once a week. 55% of heroin users used heroin every day, 26% used it occasionally, 12% 2-6 times a week, and 6% once a week. The frequency of use was unknown in 1% of heroin users. Of all 521 programme users, 18 (3%) entered a programme due to problems with cocaine. Five of them used cocaine every day, and five used it 2-6 days a week, four users used cocaine occasionally, and two used it every day. Of all users who entered a programme due to marijuana, which was their primary drug, 12 (27%) used marijuana 2-6 times a week, 11 (25%) used it once a week, 10 (23%) used marijuana every day, and 9 (20%) used it occasionally.

### Frequency of use of the primary drug at first admission or readmission by sex

Of 521 first-time or readmitted programme users, 408 were male. Opiates were used by 362 male users, of which 90 (25%) used opiates occasionally, 19 (5%) used them once a week, 41 (11%) used opiates 2-6 days a week, and 206 (57%) used them every day; the frequency of use was unknown in six opiate users. 32 men (7.8% of all male users) used cannabis, of which seven (22%) used cannabis occasionally, 7 (22%) once a week, 9 (28%) 2-6 days a week, and 8 (25%) used cannabis every day. Cocaine was used as the primary drug by 12 (2.9%) men, of which one used cocaine occasionally, five used it once a week, three 2-6 days a week, one used it every day, and data on the frequency of use was not available in two cocaine users.

Of all 521 first-time or readmitted programme users, 113 (22%) were female. Opiates were used by 89 (79%) female users, of which 22 (24.7%) used opiates occasionally, 7 (7.9%)



used opiates once a week, 12 (13.5%) used them 2-6 days a week, and 47 (52.8%) used them every day. Frequency of use was unknown in one female opiate user. 12 female first-time or readmitted programme users (10.6%) used cannabis. Two of them used marijuana occasionally, four once a week, three used it 2-6 times a week, two used marijuana every day, and frequency of use was unknown for one female cannabis user. Cocaine was used as the primary drug by six (5.3%) female programme users. Three of them used cocaine occasionally, two used it 2-6 times a week, and one used it every day.

### **Route of administration of the primary drug at first admission or readmission**

Of 521 users who entered a programme again or for the first time in 2011, 57% injected opiates, 29% smoked them and 12% sniffed them. 44% of programme users injected cocaine, 17% smoked it, and 39% sniffed it. Heroin was used by 435 programme users, of which 59% injected, 30% smoked and 11% sniffed it.

### **Primary drug at first admission into a programme**

207 drug users entered an addiction treatment programme in the CPTDA network in Slovenia for the first time in 2011. 155 (75%) first-time programme users reported opiates as their primary drug and the reason why they sought help. 96% (149) of these opiate users used heroin. 39 (19%) used cannabis as the primary drug, 8 (4%) used cocaine, 2 used hypnotics, and 2 used stimulants. Of all opiate users, 149 (96%) used heroin as their primary drug, and 5 (3%) used methadone as their primary drug.

### **Frequency of use of the primary drug at first admission**

Among those who reported opiates as the primary drug, 95 (61%) used opiates every day, 34 (22%) used them occasionally, 17 (11%) 2-6 times a week, and 6 (4%) once a week. Among those who used cannabis as their primary drug, 11 (28%) used marijuana once a week, 11 (28%) 2-6 times a week, 9 (23%) used it every day, and 7 (18%) occasionally. Of 149 heroin users, 60% used heroin every day, 23% occasionally, 11% 2-6 times a week, and 4% once a week. Frequency of use was unknown in 2% of first-time programme users.

### **Primary drug use at first admission by sex**

151 men and 56 women entered a programme for the first time in 2011. Of 151 men, 117 (77.5%) entered a programme due to problems with opiates, 5 (3.3%) due to cocaine, 1 (0.7%) due to hypnotics, and 28 (18.5%) due to problems with cannabis.

Of 56 women who entered an addiction treatment programme for the first time in 2011, 38 (68%) entered a programme due to opiate-related problems, 3 (5.4%) due to cocaine, 1 (1.8%) due to hypnotics, 11 (19.6%) due to cannabis, and 2 female users (3.6%) were admitted due to problems with stimulants. The proportion of admissions due to cannabis has increased significantly both in men and women as well as in the group of both first-time and readmitted programme users. The proportion of users who entered a programme due to opiate-related problems was much lower among women (68%) than among men (77.5%). 98% of male opiate users who entered a programme for the first time used heroin, while there were only 89% of heroin users among female opiate users.

### Route of administration of the primary drug at first admission

Of 207 people who entered a programme for the first time, 72% used heroin as their primary drug, and 75% used opiates. 50% injected opiates, 32% smoked and 15% sniffed them. Of 149 heroin users, 51% injected, 34% smoked and 15% sniffed it. 25% of cocaine users injected it, 25% smoked and 50% sniffed it. The proportion of drug users with cannabis-related problems increased significantly among first-time programme users, while the proportion of people with opiate-related problems was relatively low.

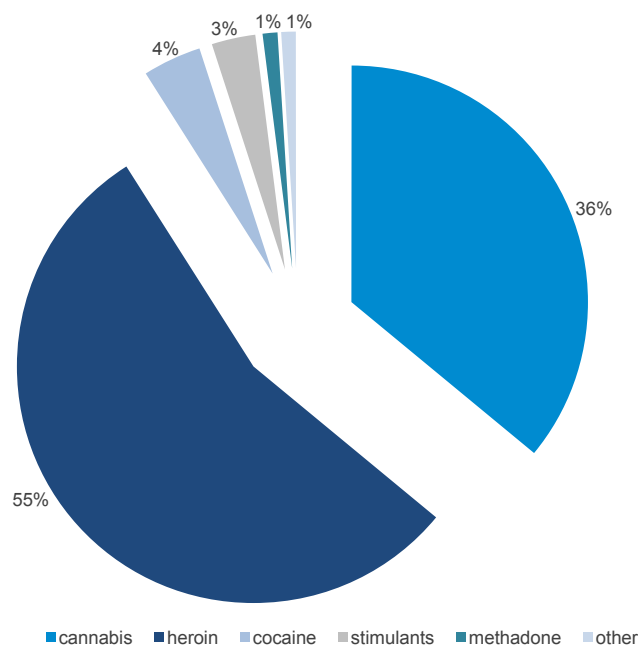
### Route of administration of the primary drug at first admission by sex

Of all women who entered a programme due to opiates for the first time in 2011, 20 (52.6%) injected opiates, 10 (26%) smoked and 3 (7.9%) sniffed them, and 5 (13%) took opiates orally. 56% of female heroin users injected, 29% smoked and 15% sniffed it. Opiates were used by 115 male first-time programme users, of which 57 (49.6%) injected, 40 (34.8%) smoked and 18 (15.6%) sniffed opiates. Of 115 heroin users, 50% injected, 35% smoked and 15% sniffed heroin. The proportion of opiate smokers is significantly larger among men than among women, while women have a significantly higher proportion of users who inject opiates.

### Proportions of first-time programme users by age groups

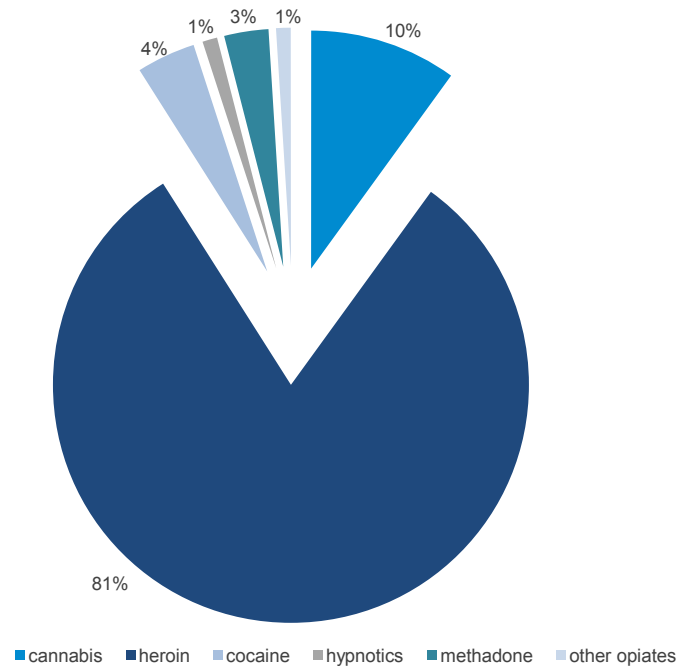
Most users aged 24 years or younger entered a programme for the first time due to heroin-related problems (55%), while 36% of first-time programme users were admitted due to cannabis-related problems, and 4% due to cocaine-related problems (Figure 5.4).

Figure 5.4: *Proportions of users aged 24 or younger by type of drug due to which they entered a programme for the first time in 2011 in Slovenia; N = 69*



The main reason for first-time admission of users aged 25 or older was heroin (81%), followed by cannabis (10%) and cocaine (4%). 3% of users entered a programme for the first time due to methadone abuse problems (Figure 5.5).

Figure 5.5: Proportions of users aged 25 or older by type of drug due to which they entered a programme for the first time in 2011 in Slovenia; N = 138



Source: NIPH, 2012

Reasons for first admission differ significantly across age groups. Younger programme users have a higher percentage of admissions due to cannabis-related problems and a lower percentage of admissions due to heroin-related problems than older users.

### Secondary drug use in users who entered a programme in 2011

#### Secondary drugs in first-time and readmitted programme users

The most common secondary drug in the population of people who entered a CPTDA programme again or for the first time in 2011 (521 people) was cocaine, which was used by 152 (29%) people, followed by cannabis (used by 62 people or 12%), alcohol (used as a secondary drug by 79 people or 15%), hypnotic drugs (46 people or 9%), and opiates (41 people or 8%). The prevalence of cocaine and cannabis as secondary drugs due to which drug users sought help in CPTDAs suggests that cocaine- and cannabis-related problems will probably become more pronounced in Slovenia in the future. In 15% of programme users, the reported secondary drug was alcohol, which is highly accessible in Slovenia. The above data indicate that it is necessary to improve the adjustment of methods and forms of treatment to the needs of drug users.

16% of programme users were participating in at least one other drug addiction treatment programme at the time of first admission or readmission into a CPTDA programme.

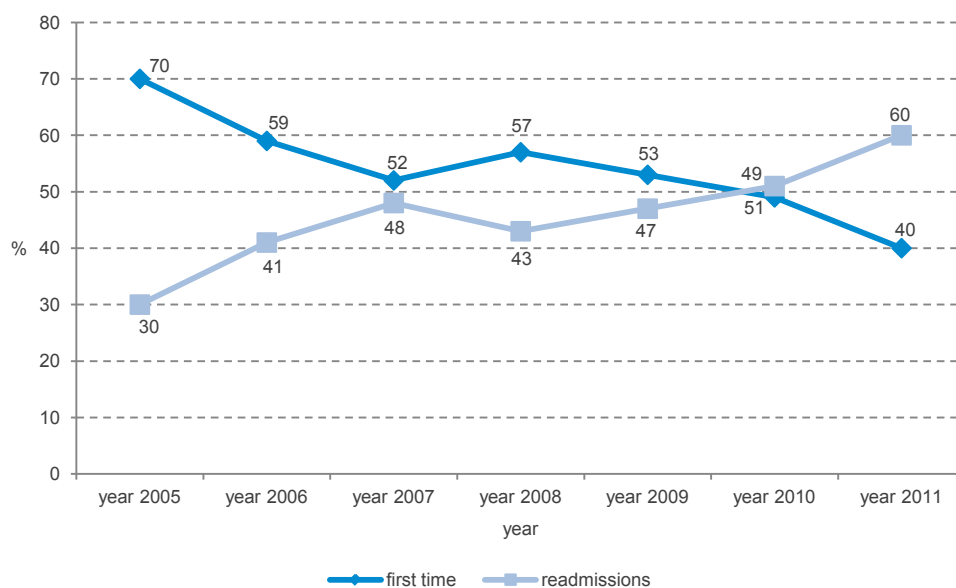
100 (19%) users who entered an addiction treatment programme in the CPTDA network again or for the first time stated that they had children at the time of admission; 63% of them had one, and 34% had two children.

### 5.3 Trends

#### Trends in the proportion of first-time admissions and readmissions into CPTDA programmes in the period 2005–2011

Trends in the proportion of first-time admissions and readmissions into CPTDA programmes have changed over the years. Initially, the proportion of first admissions was very high, but it slowly decreased and reached 40% in 2011. On the other hand, the proportion of readmissions gradually increased and reached 60% of all admissions into a programme in 2011. Therefore, more and more users who seek help in programmes have many health and social problems due to their long drug use ‘career’; as a consequence, it is increasingly difficult to work with these people (Figure 5.6).

Figure 5.6: Proportions of first-time admissions and readmissions into treatment programmes, 2005–2011



Source: NIPH, 2012

#### Evolution of the proportion of drug users admitted again or for the first time, by primary drug

People with problems due to heroin addiction accounted for the largest proportion of those seeking treatment between 2005 and 2011. Proportion of heroin addicts peaked in 2007 (93.6%), decreasing significantly in 2008 and 2009, increasing again to 88% in 2010, after which it dropped to 83.49% in 2011 (Table 5.2). The decrease in 2011 can be accounted for by an increase in the proportion of people who sought help due to cannabis addiction in 2011; the proportion of cannabis addicts was 8.45% in 2011, and 5.4% a year before. It has been increasing significantly since 2007, when it was 3%, peaking in 2009 (6.4%), dropping to 5.4% in 2010 and increasing again to 8.45% in 2011. This trend is in line with the ESPAD

survey results, which show that only a small proportion of young people in Slovenia believe that occasional use of cannabis is dangerous. The proportion of people who entered a programme due to problems with cocaine use also increased in 2011 (3.45%). The proportion of people who sought help due to unprescribed methadone use increased only slightly (Table 5.2). The increase in the proportion of people who entered a programme due to cannabis-related problems is even more pronounced if we only take into account first-time programme users; in this group, the proportion of people with marijuana-related problems was close to 20% in 2011.

Table 5.2: *Proportion of users seeking help again or for the first time, by type of primary drug, 2006–2011*

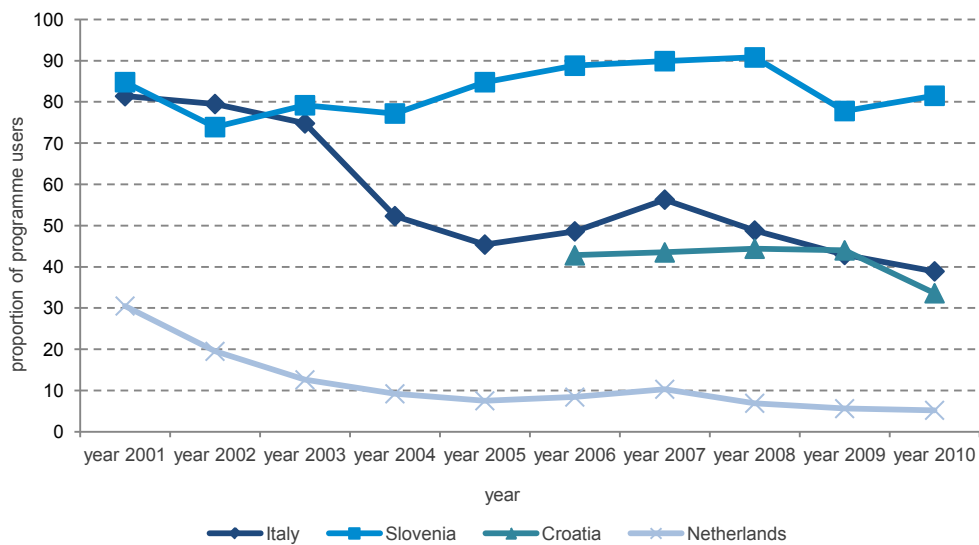
	2005 (%)	2006 (%)	2007 (%)	2008 (%)	2009 (%)	2010 (%)	2011 (%)
<b>Heroin</b>	90.1	92.4	93.6	91.0	84.9	88.0	<b>83.49</b>
<b>Methadone, unprescribed</b>	0.8	0.5	1.5	0.6	1.9	2.0	<b>2.12</b>
<b>Other opioids</b>	0.3	0.2	0.3	0.1	0.3	0.5	<b>0.97</b>
<b>Cocaine</b>	1.4	0.8	0.9	1.3	4.6	2.5	<b>3.45</b>
<b>Amphetamines</b>	0.2	0.2	0.0	0.0	0.4	0.2	<b>0.38</b>
<b>MDMA and other synth. derivatives</b>	0.5	0.2	0.1	0.3	0.1	0.1	<b>0.19</b>
<b>Benzodiazepines, sedatives</b>	0.5	0.2	0.1	0.1	0.9	0.6	<b>0.76</b>
<b>Inhalants</b>	0.0	0.2	0.0	0.0	0.0	0.0	<b>0.00</b>
<b>Cannabis</b>	5.7	5.0	3.0	3.1	6.4	5.4	<b>8.45</b>
<b>Unknown</b>	0.6	0.6	0.4	3.3	0.3	0.4	<b>0.19</b>
<b>Total</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>

Source: NIPH, 2012

### Comparison with other countries

The countries that collect data in a similar way as Slovenia include Croatia, the Netherlands and Italy. A comparison of proportions of first-time admissions due to heroin as the primary drug shows that Slovenia has a very large proportion of such admissions. After 2008, the proportion of drug users admitted for the first time due to heroin has been decreasing slowly in Slovenia, while the proportion of such drug users has been decreasing steadily for several years in the Netherlands and has dropped below 10%. In Italy, the proportion of such users has been declining much faster than in Slovenia, but is still quite large compared to the Netherlands. Epidemiological data on heroin users in Croatia are similar to those in Slovenia. Here the question arises as to why the proportion of people admitted for the first time due to heroin remains high in Slovenia (Figure 5.7).

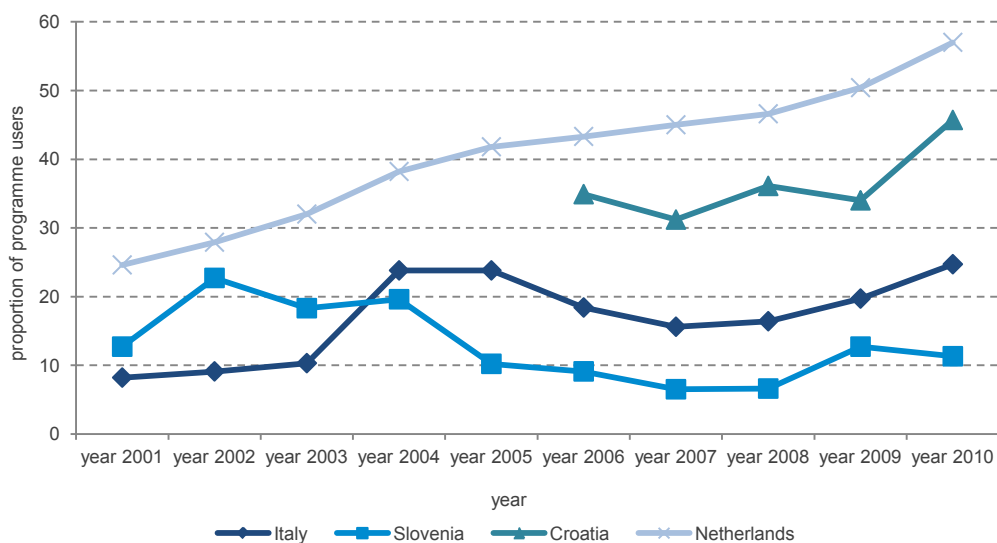
Figure 5.7: *Proportion of programme users who entered a programme for the first time and reported heroin as their primary drug, by country, 2001–2010*



Source: NIPH, 2012

The proportion of people who entered an addiction treatment programme for the first time due to cannabis-related problems has been increasing in the Netherlands since 2001. Also Croatia has recorded a gradual increase of the proportion of such users since 2007. In Slovenia, the proportion of people who sought help in programmes for the first time due to problems with marijuana decreased slowly after 2002, but started increasing again a few years ago. The proportion of such users in Italy shows a similar trend as Slovenia (Figure 5.8).

Figure 5.8: *Proportion of programme users who entered a programme for the first time and reported cannabis as their primary drug, by country, 2001–2010*

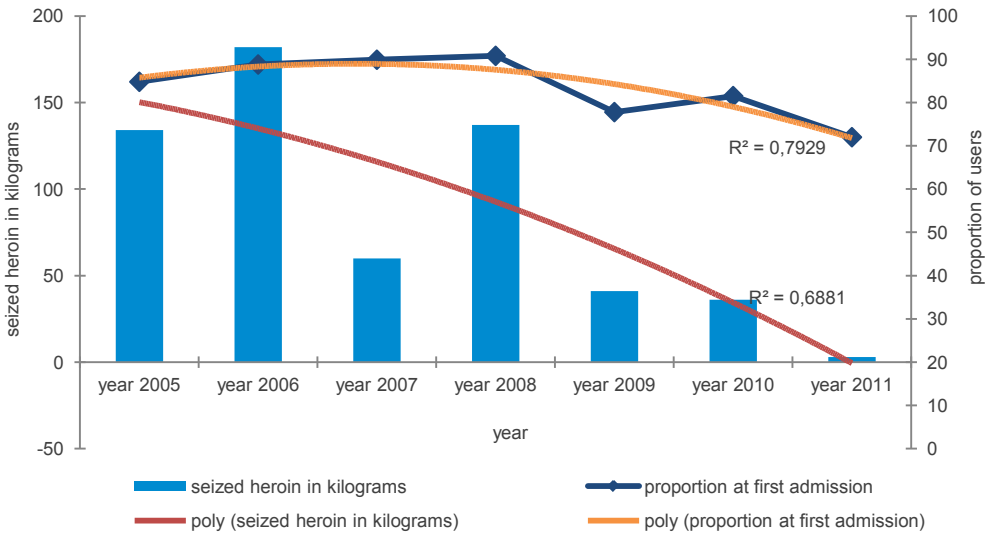


Source: NIPH, 2012

**Correlation between first-time admissions and readmissions due to heroin and heroin seizures in kilograms**

When combining available data on heroin seizures made by the police and data from TDI questionnaires, we noticed a correlation (correlation coefficient 0.75) between seizures and the decrease in the proportion of drug users who entered a programme for the first time due to heroin-related problems. As the quantity of seized heroin decreased, so did the proportion of people who entered a programme again or for the first time due to heroin. This indicates a phenomenon that has been occurring in recent years in some EU countries when there were problems regarding heroin supply on the black market. It also shows a downward trend in the use of heroin in Slovenia, which is similar to trends in some other EU countries (Figure 5.9).

Figure 5.9: Correlation between seized heroin in kilograms and the proportion of users who entered a programme for the first time and reported heroin as their primary drug in the period 2005–2011

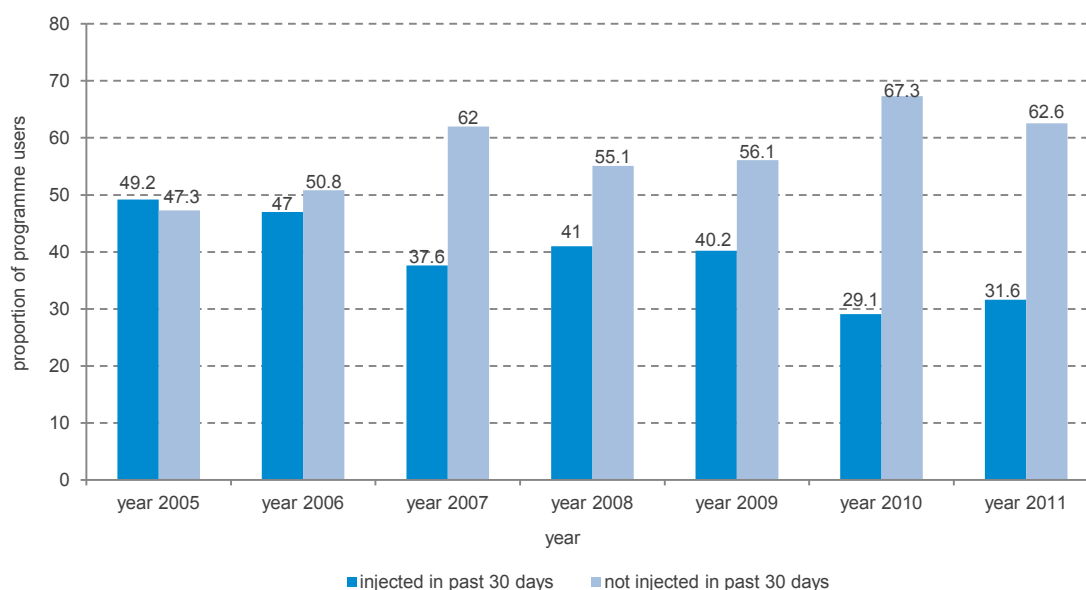


Source: NIPH, 2012

**Risk behaviour – drug injection**

Injection of drugs poses great risks of hepatitis C and B and HIV virus infections in drug users. Between 2005 and 2007, there was a decrease in the proportion of people who sought help again or for the first time and reported intravenous drug use in the past 30 days. This proportion increased to 41% in 2008, and decreased to 31.6% in 2011, which means that there was a significant improvement regarding risk behaviours of drug users (Figure 5.10). However, it should be noted that the proportion of heroin users who smoke heroin is increasing and thus risk behaviour among heroin users is decreasing.

Figure 5.10: Proportion of users who entered a treatment programme again or for the first time by year and route of administration in the past 30 days, 2011



Note: Cases with answers “unknown” have been excluded  
Source: NIPH, 2012

Data on risk behaviours among users who entered a programme for the first time show that the proportion of users who injected drugs in the past 30 days before entering a programme is only 20%. There are fewer such users among women than among men (Table 5.3).

Table 5.3: Risk behaviour in first-time treated patients by sex, 2011

Risk behaviour	Men 2011 (%)	Women 2011 (%)	Total 2011 (%)
Currently injecting: in the past 30 days	22.5	14.18	20
Injected in the past, but not currently	27.8	33.9	29.4
Never injected	47.6	50	48.3

Note: Cases with answers “unknown” have been excluded  
Source: NIPH, 2012

2% of people who entered a programme for the first time and 3.4% of those who re-entered reported past-month needle sharing, while 6% of first-time users and 7.3% of readmitted users shared other drug use equipment in the past month before admission.

9.4% of all first-time and readmitted programme users shared other drug use equipment during 30 days before admission, and 38% reported lifetime equipment sharing.

As regards the risk of hepatitis B infection, it should be pointed out that 52% of people who entered a programme again or for the first time were already vaccinated against hepatitis B. Of all those who entered a programme again in 2011, 86% had already received three doses of vaccine before admission, which is due to the fact that drug addicts are vaccinated against



hepatitis B free of charge in CPTDA programmes in Slovenia. Only 67% of people who entered a programme for the first time in 2011 had received three doses of vaccine, because some of them were older than the first generation of children who underwent systemic vaccination.

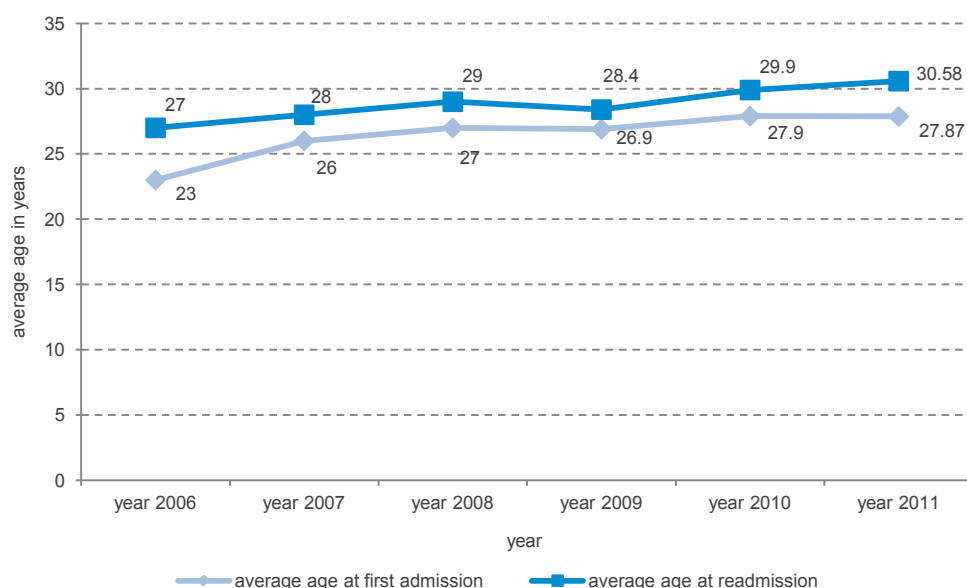
Of all people who entered a programme for the first time in 2011, 61.4% had not been tested for hepatitis C. In the group of readmitted users who had entered a programme at least once before, there were only 42% of people who had not been tested for hepatitis C, which is the result of programme activities aimed at preventing the transmission of hepatitis C among drug users. Another important fact is that 8.7% of those who entered a programme for the first time in 2011 and had been tested for hepatitis C had tested positive, while 37% of readmitted programme users who had been tested for hepatitis C were hepatitis C positive. This suggests that the proportion of hepatitis C positive drug users increases with increased duration of addiction.

Serious communicable diseases such as HIV can be transmitted through sexual intercourse. Data from TDI questionnaires show that 54% of people who entered a programme for the first time in 2011 and 46% of readmitted programme users had had sexual intercourse with people who did not use drugs. Of all first-time and readmitted programme users who had had sexual intercourse, 17% had used condoms; 22% of first-time programme users and only 13% of readmitted programme users had used condoms during sex. Of all people who entered a programme for the first time in 2011, 49% had never been tested for HIV, while only 13% of readmitted programme users had not been tested for HIV. This is due to the fact that HIV testing is voluntary and free of charge for programme users, and due to the fact that professionals working in programmes systematically strive to motivate programme users to undergo HIV tests. These professionals also put a lot of effort into educating programme users about risk behaviours.

### **Trends in the average age at admission of users who sought help again or for the first time in CPTDAs in the current year**

The average age of drug users who entered a programme for the first time increased gradually between 2006 and 2011, except in 2009, when it decreased compared to the year before. The average age of first-time programme users increased from 23 years in 2006 to 27.87 years in 2011. Similarly, the average age of all first-time and readmitted programme users increased over the years, except in 2009, when it decreased slightly compared to 2008. In 2006, the average age at admission of all programme users was 27 years, and by 2011 it increased to 30.58 years (Figure 5.11).

Figure 5.11: Average age at admission (in years) of drug users who entered a programme for the first time and of first-time and readmitted users in the period 2006–2011



Source: NIPH, 2012

### Trends in employment status at admission of users who sought help again or for the first time in CPTDAs in the current year

As shown in Table 5.4, the majority of drug users who entered a treatment programme again or for the first time were unemployed. The proportion of unemployed users decreased slightly between 2007 and 2008 (from 60.6% in 2005 to 54.8% in 2008); however, the trend turned in 2009 (the onset of the financial crisis in the EU and Slovenia), when the proportion started to increase, reaching 62.5% in 2009, 65% in 2010 and 66.3% in 2011. The proportion of students and pupils among programme users decreased between 2005 and 2008 (from 13.9% in 2005 to 6.3% in 2008), but the trend turned in 2009 (9%). The proportion of students and pupils decreased again in 2010 (to 6.4%) and increased to 8% in 2011. There were some fluctuations in the proportion of permanently employed drug users, which increased between 2005 and 2008, dropped to 20.4% in 2009 when the financial crisis started, remained stable in 2010 at 22.3%, and decreased to 20.4% in 2011. This proportion has probably been affected by the economic crisis, which has brought a significant increase in the unemployment rate and made it more difficult for the unemployed to find work. The proportion of economically inactive drug users also increased slightly over the years (Table 5.4).

Table 5.4: Trends in proportions of employed and unemployed people and students in programmes, 2005–2011

	2005 (%)	2006 (%)	2007 (%)	2008 (%)	2009 (%)	2010 (%)	2011 (%)
Permanently employed	20.5	21.8	24.7	25.2	22.5	22.3	20.4
Student, pupil	13.9	11.1	9.3	6.3	9.0	6.4	8
Econ. inactive	0.2	0.6	0.4	0.6	0.6	0.3	1.7
Unemployed/occasional worker	60.6	62.3	56.9	54.8	62.5	65.0	66.3
Other	4.4	3.7	6.5	5.1	2.0	2.5	1.3
Unknown	0.5	0.6	2.2	8.1	3.2	3.4	2.3
<b>Total</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>

Source: NIPH, 2012

The proportion of drug users who had not completed primary education was 3.5% in 2005, decreasing to 1.7% in 2009, and reached 2.5% in 2011. The proportion of drug users who had completed primary school peaked in 2005 (45%) and decreased to 42.2% in 2006 and to 37.2% in 2007. It reached its lowest level in 2010, and then increased again to 35.3% in 2011. The proportion of users who had completed secondary education has been increasing since 2008; it reached its lowest level in 2008 (45.1%) and then increased to 51.7% in 2009, remained stable at 50.7% in 2010, and decreased to 50% in 2011. The proportion of users with higher education was increasing between 2008 and 2010; it also reached its lowest level in 2008 (1.2%), increased to 2.9% in 2009 and to 7.5% in 2010, and then dropped to 2.7% in 2011. A comparison between the data for 2001 and 2005 shows that the proportion of programme users with lower education is decreasing and the proportion of users with secondary and higher education is increasing. This trend is in line with the general trend regarding educational levels, which shows that a growing proportion of young people in Slovenia are well educated (Table 5.5).

Table 5.5: Proportions of first-time and readmitted programme users by educational level, 2005–2011

	2005 (%)	2006 (%)	2007 (%)	2008 (%)	2009 (%)	2010 (%)	2011 (%)
Incomplete primary school	3.5	3.7	3.0	1.9	1.7	2.6	2.5
Primary school	45.0	42.2	37.2	35.1	35.7	34.6	35.3
Secondary school	47.0	51.4	55.6	45.1	51.7	50.7	50
College, faculty or academy	1.7	2.1	1.7	1.2	2.9	4.5	2.7
Unknown	1.4	nd	nd	7.5	7.8	7.5	9.5
<b>Total</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>

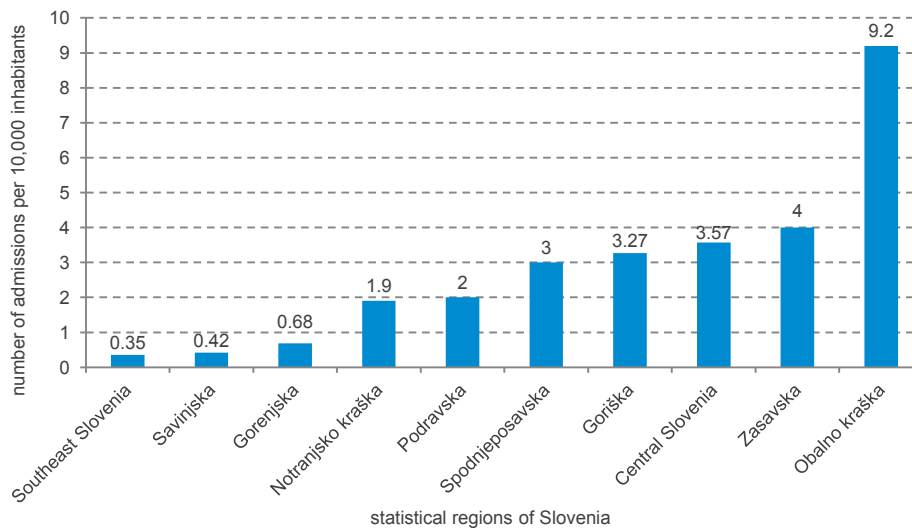
Nd: no data

Source: NIPH, 2012

### Number of first admissions and readmissions per 10,000 inhabitants in individual regions

It has been noted from the very beginning of the drug abuse epidemic in Slovenia that the statistical regions in the western part of the country, i.e. those that border Italy, have the highest burden of diseases associated with illicit drug addiction. Thus, the Obalno kraška (Coastal-Karst) region, which borders Italy, has the highest number of users who entered CPTDA programmes in 2011 per 10,000 of inhabitants (9.2/10,000 inhabitants) (Figure 5.12). There are four CPTDAs operating in this region, therefore the accessibility to treatment programmes is high. The region has a highly developed tourism industry. The port of Koper is located in the region, and the Italian port of Trieste is located nearby. The neighbouring Italian region is also burdened by drug abuse and has a longer history of drug use and assistance for drug users than the Obalno kraška (Coastal-Karst) region. Historically speaking, the majority of drugs intended to be sold in Northern Italy have been trafficked to Italy along the route crossing the Coastal-Karst region and the Italy–Slovenia border.

Figure 5.12: Number of first-time admissions and readmissions per 10,000 inhabitants in individual regions in 2011

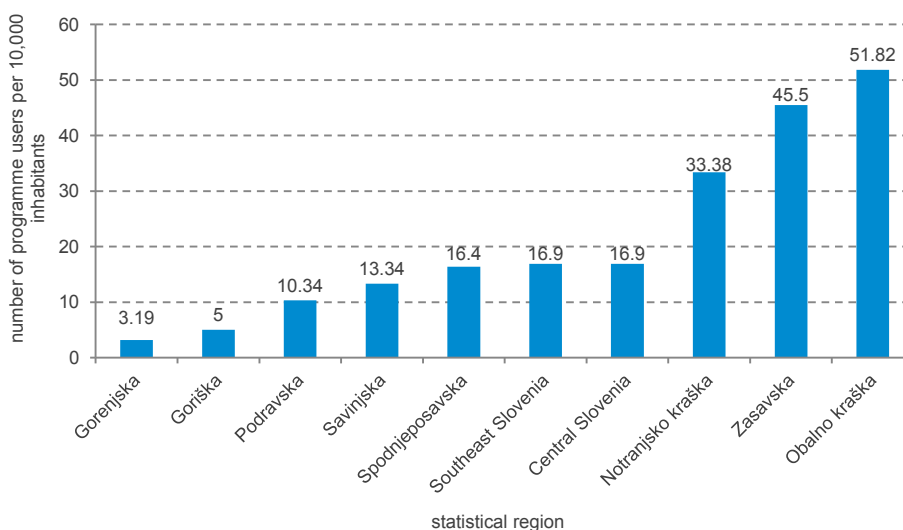


Source: NIPH, 2012

### Number of all programme users per 10,000 inhabitants in individual regions

In 2011, there were 2,500 drug users in Slovenia who had been participating in a treatment programme for more than a year. Their average age was 33.7 years. If we add the number of all first-time and readmitted users, we get 3,021 people who were admitted into a programme on the basis of a completed and submitted questionnaire. In 2011, the Obalno kraška region had the largest number of CPTDA programme users per 10,000 inhabitants (51.82 users per 10,000 inhabitants) among all statistical regions in Slovenia. As regards the burden of drug addiction, the mentioned region is followed by the Zasavska and the Notranjsko kraška (Inner Carniola-Karst) regions, while other regions have lower burdens (Figure 5.13). It should be noted that data for two regions (Koroška and Pomurska) were not available. The above data show that programme development policies and approaches to solving drug-related problems in Slovenia should be adjusted to regional needs.

Figure 5.13: Number of users per 10,000 inhabitants in individual regions, 2011

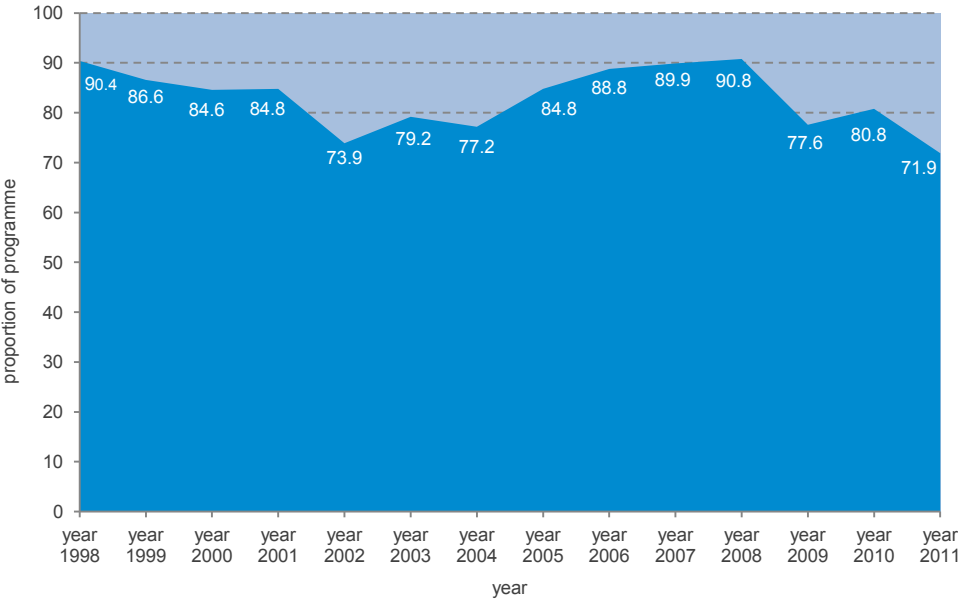


Source: NIPH, 2012

**Trends in the proportion of users who reported heroin or cocaine or cannabis as their primary drug at first admission into a programme**

The proportion of programme users who entered a programme for the first time and reported heroin as their primary drug was 90.4% in 1998. It decreased gradually after 1998, dropping to 73.9% in 2002. It gradually increased between 2002 and 2008, reached 90.8% in 2008 and then decreased again between 2009 and 2011, when it dropped to 71.9%. Occasional lack of heroin was noted in 2011, when users had to replace heroin with illegally obtained medications and substitute drugs such as methadone, among others. Hence, the prevalence of illegally obtained methadone increased among users who entered a CPTDA programme again or for the first time in 2011. The increase in the use of heroin between 2005 and 2008 coincides with the increase in global heroin production, which resulted in an increased supply of heroin to the Slovenian market. Similarly, the recent decrease in heroin use is associated with the decrease in the global production of heroin in recent years (UNODC 2012) (Figure 5.14).

Figure 5.14: *Proportion of people who used heroin as their primary drug at the time of first admission into a treatment programme, 1998–2011*

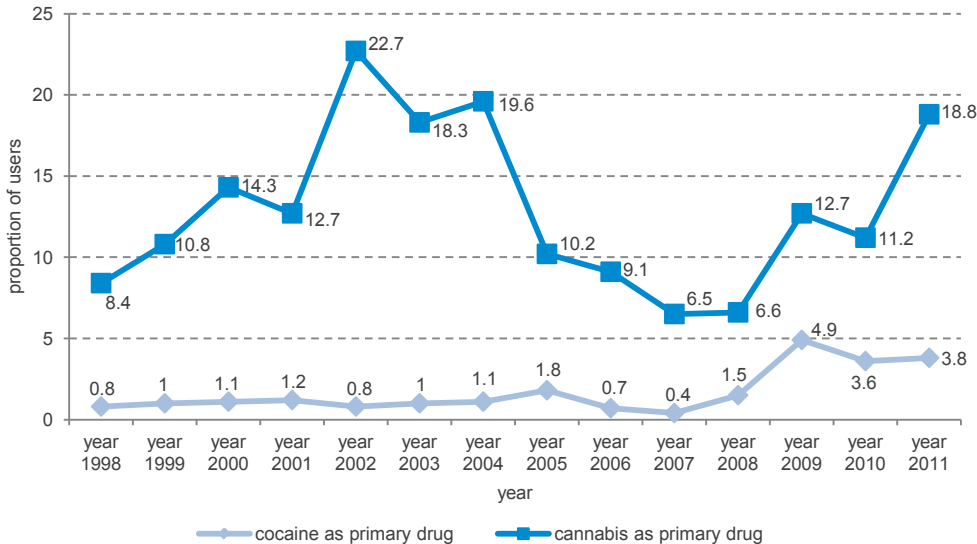


Source: NIPH, 2012

The proportion of programme users who sought help due to cannabis used as their primary drug increased from 8.4% in 1998 to 22.7% in 2002. After that the proportion decreased and reached its lowest level in 2007 (6.4%), and then increased again, reaching 18.8% in 2011. This is probably due to young people’s attitude towards marijuana use, since only 58% of Slovenian adolescents who participated in the 2011 ESPAD survey stated that regular use of marijuana is harmful, 32% stated that occasional marijuana use is harmful, and only 28% of adolescents stated that it is harmful to use marijuana once or twice (Hibell et al. 2011). The proportion of first-time programme users who entered a programme due to cocaine-related problems was very low in 1998 (0.8%). It increased to 1.2% in 2001, decreased in the following years and gradually increased again to 1.8% in 2005. After that it decreased and

reached 0.4% in 2007, then increased to 4.9% in 2009 and finally decreased to 3.8% in 2011. Increases in the proportion of cocaine users in Slovenia coincide with increases in the proportion of cocaine users in some other EU countries (UNODCP 2012) (Figure 5.15).

Figure 5.15: *Proportion of users who entered a treatment programme for the first time and reported cocaine or cannabis as their primary drug, 1998–2011*



Source: NIPH, 2012

### 5.4 Conclusion

Drug use in Slovenia had its own characteristics and its own development, which is specific to this country. Recent field research findings show that the number of users of new drugs and inhalants is increasing; however, this is not reflected in the data obtained from the existing illicit drug addiction treatment network. Compared to other EU countries, Slovenia is still a country where most people seek help in centres due to problems with opiate use. The structure of drug users who seek help in programmes also varies according to age; the proportion of opiate users is lower and the proportion of cannabis users is higher among young people who seek help than among older programme users.

The following trends have been observed:

1. In the past seven years, the main drug due to which patients entered a programme was heroin; however, the proportion of people entering a programme due to heroin slowly decreased from 90.1% in 2005 to 83.49% in 2011. A relatively high proportion of men (29%) and women (30%) smoke heroin, which poses less risks than intravenous use. The proportion of people who seek help in a programme again or for the first time due to cannabis use is increasing. This proportion was 5.7% in 2005 and increased to 8.45% by 2011. The proportion of cocaine users is also growing slowly in Slovenia; it increased from 1.4% in 2005 to 3.45% in 2011.

2. The decrease in the proportion of heroin users is connected with the decrease in the quantity of seized heroin, which in turn is probably related to reduced trafficking of heroin to Slovenia due to decreased global heroin production. Thus, heroin users seek other drugs to replace heroin.
3. The proportion of heroin addicts is lower and the proportion of cannabis addicts higher among young people admitted into treatment than among other programme users.
4. The proportion of people who injected drugs during 30 days before admission is decreasing – from 49.2% in 2005 to 31.6% in 2011. There were only 20% of such drug users among the people who entered a programme for the first time in 2011. Drug users who shared needles accounted for only 2% of people who entered a programme for the first time and 3.45% of people who were admitted again in 2011.
5. The average age of drug users who seek help in a programme again or for the first time increased gradually between 2005 and 2011. Thus, the average age of first-time programme users increased from 23 years in 2005 to 27.87 years in 2011, and the average age of readmitted programme users increased from 27 years in 2005 to 30.58 years in 2011.
6. The proportion of permanently employed drug users who seek help in a programme again or for the first time has been decreasing in recent years, reaching 20.45% in 2011. This is partly due to the complex economic situation in the EU and Slovenia. The proportion of unemployed drug users increased from 60.6% in 2005 to 66.3% in 2011.
7. In Slovenia, the proportion of drug users with low education has decreased over the years, while the proportion of drug users with secondary or higher education has been increasing among people who entered a treatment programme again or for the first time. This trend is in line with the general increase in the proportion of better educated young people in Slovenia.
8. The proportion of people receiving maintenance treatment in CPTDAs is increasing. Among people in maintenance programmes, the proportion of those receiving methadone maintenance treatment is decreasing, while the proportion of people receiving other forms of maintenance treatment is increasing.
9. The ratio between first-time admissions and readmissions into programmes has changed over the years. At first the proportion of first-time admissions was much higher, but in 2011 the proportion of readmissions (60%) was significantly higher than the proportion of first admissions (40%).
10. As regards the number of first-time and readmitted users per 10,000 inhabitants in individual regions, the Obalno kraška (Coastal-Karst) region stands out with 9.2 admissions per 10,000 inhabitants. The same region stands out also as regards the number of all users in CPTDA programmes per 10,000 inhabitants. Both regions that border Northern Italy have significantly higher numbers of programme users per 10,000 inhabitants than other regions.
11. Addiction treatment programmes in Slovenia will have to be adjusted to the situation in the field of drugs and become more accessible also to people using other drugs, such as cocaine, cannabis, etc. Furthermore, programmes more adaptable to new drug use trends in Slovenia should be introduced. Data regarding the primary drug in people who

were admitted into a programme for the first time show a relatively high proportion of users with cannabis-related problems (19%). Programmes need more public support and more money.



The prevalence of HIV, hepatitis C virus (HCV) and hepatitis B virus (HBV) infections is monitored by collecting data on voluntary diagnostic testing for the detection of HIV, HCV and HBV infections carried out in the national network of Centres for Prevention and Treatment of Drug Addiction (CPTDA), which covers the whole country. In addition, unlinked anonymous testing for HIV infection is carried out for the purposes of HIV infection control among injecting drug users who apply for treatment for the first time. Furthermore, the National Institute of Public Health (NIPH) collects data on diagnosed cases of HIV, HBV and HCV infections, including data on routes of transmission. All diagnosed cases of the above mentioned virus infections must be reported under the Contagious Diseases Act.

Of all saliva samples collected from injecting drug users in 2011 in the framework of unlinked anonymous testing for the purposes of HIV infection control, there was one sample positive for HIV antibodies.

The prevalence of antibodies against hepatitis B virus (HBV; anti-HBc) among anonymously tested injecting drug users who were in treatment in CPTDAs was 8.1% in 2011, and the prevalence of antibodies against hepatitis C virus (HCV) was 28.5%. In both cases, the proportions of infected drug users were the highest in 2011 compared to other years in the period 2007–2011.

Medical emergency units in Ljubljana treated 43 patients for illicit drug poisoning in 2011. The number of cases of ecstasy, amphetamine or cannabis poisoning was much higher in 2011 than in 2010, when heroin poisoning cases prevailed.

Drug-related deaths have been monitored in Slovenia in accordance with recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) since 2003. Monitoring data includes direct drug-related deaths, i.e. deaths caused by direct effects of illicit drugs on the body. Such data on underlying causes of death is obtained from the Mortality Database of the NIPH. Furthermore, indirect drug-related deaths are also monitored using cohort analyses. Indirect drug-related deaths are deaths caused by indirect effects of illicit drugs on health, where drug use is a secondary cause of death.

There were 24 direct drug-related deaths recorded in the Mortality Database in Slovenia in 2011. These death cases included 19 men and 5 women, which means that the ratio of men to women was 4:1. Heroin was the most common cause of fatal poisoning, followed by methadone and cocaine.

## 6.1 Drug related infectious diseases

*Irena Klavs and Tanja Kustec*

Drug-related infectious diseases among injecting drug users (IDUs) are an important challenge to public health. Such diseases include HIV, hepatitis C virus (HCV) and hepatitis B virus (HBV) as well as other serious diseases. HIV, HBV and to a lesser extent also HCV infections are transmitted through sexual intercourse. Thus, the infections can be spread through unprotected sexual intercourse to the partners of IDUs and also to the general sexually active population, which does not use illicit drugs intravenously. All three infections are also transmitted vertically (from mother to child) and, in addition, represent a risk for nosocomial transmission (infections in hospital environment, if preventive safety measures are not taken). Hepatitis B infection can be prevented by vaccination. The potential vaccination population includes injecting drug users and other groups who may be at risk of infection through contact with infected blood or other bodily fluids, as well as other groups at high risk of infection through unprotected sexual intercourse, or even the entire general population. In contrast, vaccination against HIV and HCV infection is unknown and is unlikely to be available in the near future. Thus, prevention mostly depends on preventing risky behaviour and encouraging behavioural change.

Available data on HIV, HBV and HCV infections among IUDs in Slovenia for the period from 2007 to 2011 is presented in this chapter.

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### Methods

The prevalence of HIV, HCV and HBV infections is monitored by collecting data about voluntary diagnostic HIV, HCV and HBV testing within the national network of Centres for the Prevention and Treatment of Illicit Drug Addiction whose coverage is nationwide. In addition, unlinked anonymous HIV testing of IUDs at first treatment demand is conducted for HIV surveillance purposes in the largest Centre for the Prevention and Treatment of Illicit Drug Addiction in Ljubljana since 1995. Since 2002, four non-governmental harm reduction programmes have also been included in the system. These programmes are needle exchange programmes: AIDS Foundation Robert (only in 2003 in Ljubljana), Stigma (in Ljubljana since 2005), Svit (in Koper since 2004) and Zdrava pot (in Maribor since 2010). Detailed descriptions of methods have already been published (Klavs and Poljak 2003). Saliva specimens for unlinked anonymous HIV testing are voluntarily provided by IDUs entering the treatment at the Centre for Prevention and Treatment of Illicit Drug Addiction in Ljubljana, and by injecting drug users already involved in the aforementioned needle-exchange programmes.

In addition, the National Institute of Public Health (NIPH) collects information on newly diagnosed cases of HIV, HBV and HCV infections, which may include information on the transmission routes. All three diagnoses must be reported according to the Infectious Diseases Law. Nearly all of the newly diagnosed HIV infection cases reported also contain information on the transmission route. In contrast, information on the transmission route (e.g. IDUs) is only available for a minority of reported HBV and HCV cases. Surveillance reports

on the prevalence of infections that include information on infectious diseases case reporting are published annually (Klavs et al. 2012, IVZ 2012).

### HIV infection

According to all available surveillance information, the rapid spread of HIV infection has not started yet among IDUs in Slovenia.

During the period from 2007 to 2011, HIV prevalence among confidentially-tested IDUs treated in the network of Centres for the Prevention and Treatment of Illicit Drug Addiction consistently remained under 1%, but rose to 1.3% in 2009 and to 1.9% in 2011. During the same period, among a total of 948 saliva specimens collected for unlinked anonymous testing for surveillance purposes at three or four different sentinel sites, two specimens were positive for HIV antibodies in 2010 and 2011 (Table 6.1, see also ST9).

Table 6.1: *Share of HIV infected persons among injecting drug users in the period 2007–2011*

	Year	Number of sentinel sites	Number of tested		Number of HIV infected		% HIV infected	
			Male	Female	Male	Female	Male	Female
<b>IDU</b>	2007	3	130	44	0	0	0	0
	2008	3	142	34	0	0	0	0
	2009	3	127	32	0	0	0	0
	2010	4	179	74	1	0	0.6	0
	2011	4	136	50	1	0	0.7	0

Source: Unlinked anonymous testing for epidemiological surveillance of HIV infection, Slovenia, 2007-2011

In the last five years, from 2007 and 2011, there was not a single reported case of a new HIV diagnosis with a history of IDU. The last HIV infection in an IDU was reported to the NIPH in 2001. However, since 1986, when the national HIV surveillance, based on mandatory notification of all diagnosed HIV infection cases was initiated, a cumulative total of 13 new HIV diagnoses were reported among IDUs.

The comparison of EU trends in newly diagnosed infections related to injecting drugs with trends in the prevalence of HIV infection among IDUs shows that the incidence of HIV infection among IDUs has been decreasing on a national level (EMCDDA 2010).

### HBV

The prevalence of antibodies against hepatitis B virus (HBV; anti-HBc) among confidentially-tested IDUs treated within the network of Centres for the Prevention and Treatment of Illicit Drug Addiction was 8.1% in 2011. During the period from 2007 to 2011, the prevalence ranged between the highest 8.1% in 2011 and the lowest 3.6% in 2007 (see also ST9).

In EU, four of nine countries that issued reports on anti-HBc infections among IDUs, reported the prevalence rates of over 40% in the period from 2007 to 2008 (EMCDDA 2011a).

The reported acute and chronic HBV infection incidence rate in the Slovenian population in 2011 was 3.4/100,000 inhabitants. During the period from 2007 to 2011, the reported incidence rate ranged from the highest 3.4/100,000 inhabitants in 2011 to the lowest 2.0/100,000 inhabitants in 2007 and 2010. Due to underreporting, HBV reported incidence rates greatly underestimate the burden of this infection.

## **HCV**

The prevalence of antibodies against hepatitis C virus (HCV) among confidentially-tested IDUs treated within the network of Centres for the Prevention and Treatment of Illicit Drug Addiction was 28.5% in 2011. During the period from 2007 to 2011, the prevalence ranged from the highest 28.5% in 2011 to the lowest 21.5% in 2010 (see also ST9).

In EU member states, HCV antibody levels among national samples of IDUs in 2008-2009 varied from 22% to 83%, with eight of the twelve countries reporting levels of over 40%. Three countries, including Slovenia, reported of prevalence under 25% in national samples of IDUs, however such infection rates still constitute a significant public health problem (EMCDDA 2011a).

The reported acute and chronic HCV infection incidence rate in the Slovenian population in 2011 was 4.6/100,000 inhabitants. During the period from 2007 to 2011, the reported incidence rate ranged from the highest 5.5/100,000 inhabitants in 2007 to the lowest 4.1/100,000 inhabitants in 2008. Due to underreporting, HCV reported incidence rates greatly underestimate the burden of this infection.

## **Discussion**

The strengths of prevalence monitoring of HIV, HCV and HBV infection among IDUs treated in the Centres for Prevention and Treatment of Illicit Drug Users are the nationwide coverage and sustainability of such a surveillance system.

The strength of HIV, HBV, and HCV reported incidence monitoring is its nationwide coverage. In contrast to relatively reliable AIDS reported incidence data, the information about reported newly diagnosed HIV infection cases among IDUs cannot reliably reflect HIV incidence. However, the notification of diagnosed HIV cases is believed to be complete and HIV incidence among IDUs to be very low. Also, almost 100% of HIV infection cases reported to the NIPH contains information on probable transmission route. Thus, any underestimation of HIV infection incidence among IDUs is only due to possible late diagnosis. In contrast, due to underreporting of diagnosed cases, HBV and HCV reported incidence rates are much less reliable and underestimate the true burden of diagnosed infections in this population. Also, information on transmission routes (e.g. IDUs) is only available for a minority of reported HBV and HCV cases.

## 6.2 Other drug-related health correlates and consequences

### Non-fatal overdoses and drug related emergencies

*Miran Brvar*

This chapter presents an overview of drug poisoning patients treated in medical emergency units at the University Medical Centre in Ljubljana (hospital first aid) in 2011.

Medical emergency units at the University Medical Centre in Ljubljana provide emergency care to approximately 600,000 people living in central Slovenia. 22,937 patients were treated in medical emergency units in Ljubljana in 2011; below we present the number of people examined and treated for illicit drug poisoning.

Medical emergency units admit illicit drug poisoning patients who need at least a few hours of treatment and/or hospitalization. The most common reasons for referral of these patients to medical emergency units are disorders of consciousness, respiratory failure, low blood pressure, cardiac arrhythmias, chest pain, epileptic seizures, aggressive behaviour, etc.

The frequency of poisoning with illicit drugs treated at the medical emergency units at the University Medical Centre in Ljubljana was determined using two methods. First, the number of drug poisoning cases was determined using the hospital computer system, where diagnoses are coded according to ICD-10. Unfortunately, in cases where patients are treated only in emergency units, medical records in the hospital computer system include only the code for the underlying or primary diagnosis, whereas secondary diagnoses are recorded only in a descriptive manner. Furthermore, coding of illicit drug poisonings using ICD-10 codes is very complicated and inadequate. For example, amphetamines are included in the large and non-transparent group of "Psychostimulants with abuse potential". Coding of poisonings with newer drugs, e.g. GHB, is practically impossible. Therefore, to determine the frequency of illicit drug poisoning, we also examined the book of examined patients, which includes data on all examined patients, including referral and discharge diagnoses (one or more).

By using the mentioned computer system and data on underlying diagnoses coded according to ICD-10, and by examining non-coded referral and discharge diagnoses of all patients recorded manually in the book of examined patients in 2011, we determined that there were 43 patients treated for illicit drug poisoning in medical emergency units in Ljubljana (Table 6.2). There were 51 such patients in 2010. By reviewing all descriptive diagnoses, we also identified combined drug poisoning cases and drug poisoning cases that could not be coded using ICD-10 codes.

Table 6.2: *Patients poisoned with illicit drugs and treated in medical emergency units at the University Medical Centre in Ljubljana in 2010 and 2011*

Illicit drugs and their combinations	No. of patients in 2010 (n=51)	No. of patients in 2011 (n=42)
Heroin	24	3
Heroin + ethanol	2	2
Heroin + methadone	1	2
Heroin + methadone + ethanol		1
Heroin + amphetamine	1	
Heroin + cocaine	6	1
Heroin + cocaine + ethanol	1	
Cocaine	5	4
Cocaine + ecstasy + cannabis + ethanol		1
Cocaine + ecstasy + amphetamine + ethanol		1
Cocaine + cannabis + methadone		1
Cocaine + methadone		1
Cocaine + morphine		1
Ecstasy + ethanol		4
Ecstasy + amphetamine + ethanol		2
Ecstasy + mephedrone	1	
Ecstasy + amphetamine + mephedrone + cannabis		1
Amphetamine		1
Amphetamine + ethanol		2
Amphetamine + THC		1
Mephedrone + ethanol	1	
2C-I	1	
GHB	1	1
GHB + amphetamine	1	
GHB + ethanol		1
Cannabis	6	8
Cannabis + ethanol		1
Cannabis + methadone		2
Cannabis + methadone + buprenorphine		1

Source: University Medical Centre Ljubljana

Table 6.3 shows the number of illicit drugs used by poisoned patients. As expected, the number of used drugs is higher than the number of poisoned patients (Table 6.2), since there were 13 patients (25%) treated for poisoning caused by multiple drug use in 2010, and 26 such patients, i.e. 60% of all drug poisoning patients, in 2011.

Table 6.3: *The number of illicit drugs used by poisoned patients treated in medical emergency units at the University Medical Centre in Ljubljana in 2010 and 2011*

Illicit drugs	Number of drugs in 2010	Number of drugs in 2011
Heroin	35	9
Cocaine	12	10
Cannabis	6	16
Mephedrone	2	1
Amphetamines	2	8
GHB	2	2
Ecstasy	1	9
2C-I	1	0

Source: University Medical Centre Ljubljana

The average age of patients poisoned with illicit drugs was approximately 29 years in 2011, and 29.5 in 2010. Most poisoned patients were male (79% in 2010 and 67% in 2011).

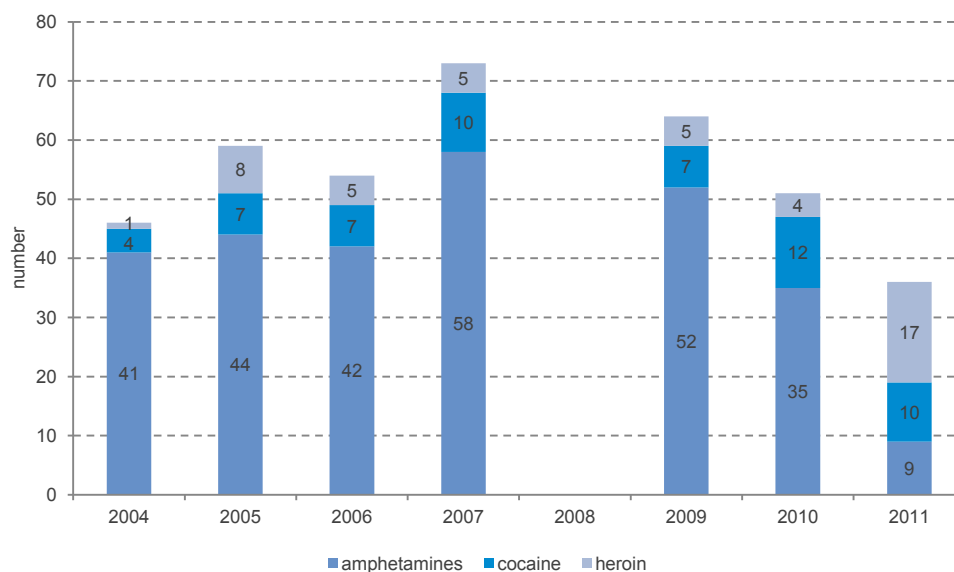
In 2010, 83% of all patients poisoned only with heroin were male and their average age was 31.5 years. All heroin poisoning patients treated in 2011 were male (100%), and their average age was 25 years.

It is interesting that there were many cases of poisoning caused by a combination of heroin and cocaine in 2010, while there was only one such case in 2011.

There were many more patients treated for ecstasy, amphetamine or cannabis poisoning in 2011 than in 2010, when heroin poisoning cases prevailed. In 2011, the number of cocaine poisoning cases remained almost unchanged from the previous year. In 2011, the number of combined drug poisonings with multiple drugs was significantly higher than the year before.

The number of amphetamine poisoning cases increased in 2011 in comparison with previous years (2004-2010), while the number of heroin poisoning cases has been decreasing for the past three years (Figure 6.1).

Figure 6.1: *The number of illicit drugs used by poisoned patients treated in medical emergency units at the University Medical Centre in Ljubljana in the period 2004–2011*



Source: University Medical Centre Ljubljana

Drug poisoning cases accounted for 0.19% of all cases treated in medical emergency units in 2011, while in 2010 they accounted for 0.24% of all cases.

104 The actual number of drug poisoning cases in observed years is probably higher, since poisoning diagnoses are often incorrectly coded with ICD-10 codes and often manually recorded incorrectly or incompletely in the book of examined patients.

We could determine the actual number of drug poisoning cases only if we reviewed medical records of all patients examined in emergency units as well as medical records of hospitalized patients, as sometimes poisoning is not diagnosed before a patient is in treatment in the hospital. Unfortunately, it is practically impossible to carry out such an extensive review of medical records of all patients referred to medical emergency units; to this end, the Slovenian Register of Intoxications was established in 2001, which is kept in accordance with the Rules on Reporting, Collecting and Arranging of Data on Poisonings in Slovenia (Official Gazette RS, No. 38/2000). According to the mentioned Rules, all natural and legal persons engaged in healthcare activities are required to regularly report on poisoning cases, including cases of poisoning with illicit drugs, to the Poison Control Centre at the University Medical Centre in Ljubljana using the “Poisoning Report Form”, which was published in the Official Gazette of the Republic of Slovenia. The form must contain the patient’s sex, age, education level, bad habits, medical conditions, etc., and information on the poisoning (name and quantity of the medication/poison/drug, place and circumstances of poisoning, clinical picture and treatment of the poisoning, etc.). Unfortunately, Slovenian medical professionals often avoid this obligation, despite repeated encouragement and warnings.



In conclusion, we can say that emergency examinations of persons poisoned with illicit drugs account for at least 0.20% of all patients examined in medical emergency units in Ljubljana, and that the number of combined poisonings, especially with amphetamines, is increasing, while the number of heroine poisonings is decreasing.

### 6.3 Drug-related deaths and mortality of drug users

*Jožica Šelb Šemerl*

Drug-related deaths are a phenomenon that belongs, like other addictions, in the field of public health; it concerns young people starting an independent life, that means people who have not yet started or have just started to live their own lives. In theory, the mentioned phenomenon could be prevented completely, or at least decreased through preventive actions.

Because death and causes of death are only final consequences of the effects of internal and external factors which lead to death at a certain age, we have to pay attention to as many those factors as possible, namely factors that are involved in the process of illicit drug use and the occurrence of drug-related health problems. On the basis of causes of death we can retrospectively determine the risk factors for diseases or health problems which finally led to death. In order to be able to prevent drug related deaths, we have to determine how many of them in a certain population group are involved in drug use, and learn about the basic epidemiological characteristics and time trends of the phenomena.

This chapter presents mortality due to direct effects of drugs in the body in Slovenia in 2011, the evolution of direct drug-related deaths in the period 2004–2011, and mortality in a cohort of patients in treatment for illicit drug addiction, which were followed up during the period 2004–2011.

Drug-related deaths have been monitored in Slovenia in accordance with the EMCDDA recommendations since 2003. Monitoring data includes:

- direct drug-related deaths, i.e. deaths of people who died due to direct effects of illicit drugs in the body: such data, i.e. data on the underlying cause of death, are obtained from the Mortality Database (IVZ 46: Medical Report on the Deceased Person);
- indirect drug-related deaths, i.e. data on those people who died due to indirect effects of illicit drugs on their health, where drug effects were a secondary cause of death; such data are cohort study data.

To determine the number of indirect drug-related deaths, we analysed demographic and other data collected at the Death Certificate and Civil Report on the Cause of Death - the DEM-2 form. Deaths were analysed according to basic epidemiological indicators, and mortality rates were calculated as deaths per 1,000 person years in an individual population group. To calculate the mortality rate in the Slovenian population, we used the number of deaths and the number of inhabitants in 2007; for age standardization, the European standard population was used. We also calculated excess mortality in drug users compared

to other inhabitants of Slovenia, and the correlation between mortality rates in 17 CPTDAs and socio-economic parameters in corresponding statistical regions. The limit for statistical significance of the correlation coefficient was set at 0.400 ( $R^2 > 0.399$ ).

People included in the cohort study were drug users registered in one of seventeen CPTDAs (out of eighteen; at that time CPTDA Koper was not sending data to NIPH where central data base was located) in Slovenia for the first time or repeatedly between 2004 and 2006. Drug users' data are recorded on the Evidence of Drug Users Treatment forms (hereinafter: drug-related data). The data used in the study were reported by Treatment Demand Centres during the mentioned period and included all types of treatment: first-time treatment, re-treatment and long-term treatment. Medical records of persons treated at the Clinical Department for Mental Health (hospital unit) were excluded from the study and were not monitored (i.e. records of 382 persons), because the type of treatment was different for these patients.

The study connected data from the register of treated drug users for 2004, 2005 and 2006 with data obtained from the mortality database on persons deceased between 2004 and 2011. The process of data linkage is described in detail in the chapter on drug-related mortality in the 2010 National Report on the Drug Situation in Slovenia, under the heading "Cohort study".

Causes of death were coded according to the International Statistical Classification of Diseases and Related Health Problems – 10th revision (ICD-10). As in the period 2002–2011, underlying causes of death were selected according to the codes requested by the EMCDDA; thus, we took into account only codes that have a value '1' on Filter B.

### Direct drug-related deaths in Slovenia in 2011

The number of deaths in different groups of drug users

There were 24 direct drug-related deaths recorded in the mortality database in Slovenia in 2011. 19 men and 5 women died due to direct effects of drugs, which means that the male to female deaths ratio was 4:1 (Table 6.4) (see also ST6).

Table 6.4: *The number of direct drug-related deaths by age group and sex, 2011*

Sex/Age group	Sex		Total
	Male	Female	
15-19	0	2	2
20-24	1	0	1
25-29	4	0	4
30-34	9	0	9
35-39	1	2	3
40-44	4	1	5
<b>Total</b>	<b>19</b>	<b>5</b>	<b>24</b>

Source: NIPH (Medical Report on the Deceased Person – IVZ 46)

In all observed years, the number of male deaths caused by the direct effects of drugs was higher than the number of female deaths. Fifty percent of men and the same percentage of women who died of drug poisoning were younger than 31.4 years when they died. The youngest man was 22.7 and the oldest 52.6 years old at the time of death; the youngest woman was 29.2 and the oldest was 42.9 years old at the time of death.

Table 6.5: *The number of direct drug-related deaths by type of drug and sex, 2011*

Sex/ Type of drug	Sex		Total
	Male	Female	
F192 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances; dependence syndrome	1	0	1
T401 Heroin	9	1	10
T403 Methadone	5	3	8
T405 Cocaine	3	0	3
T407 Cannabis (derivatives)	1	0	1
T436 Psychostimulants with abuse potential	0	1	1
<b>Total</b>	<b>19</b>	<b>5</b>	<b>24</b>

Source: NIPH (Medical Report on the Deceased Person – IVZ 46)

As in 2010, heroin was the cause of fatal poisoning in almost one half of drug poisoning cases in 2011. Compared to 2010, the number of deaths due to methadone and other opioids remained almost unchanged, but the number of deaths caused by cocaine decreased (Table 6.5) (see also ST5).

Table 6.6: *The number of direct drug-related deaths by external cause and type of drug, 2011*

External cause/ Type of drug	Accidental poisoning X410-X429		Intentional self-poisoning X610-X629		Poisoning, undetermined intent Y110-Y129		Total	
	Male	Female	Male	Female	Male	Female	Male	Female
T401 Heroin	7	0	1	0	1	1	9	1
T403 Methadone	4	2	0	0	1	1	5	3
T405 Cocaine	3	0	0	0	0	0	3	0
T407 Cannabis (derivatives)	1	0	0	0	0	0	1	0
T436 Psychostimulants with abuse potential	0	1	0	0	0	0	0	1
<b>Total</b>	<b>15</b>	<b>3</b>	<b>1</b>	<b>0</b>	<b>2</b>	<b>2</b>	<b>18</b>	<b>5</b>

Note: F-diagnoses are excluded

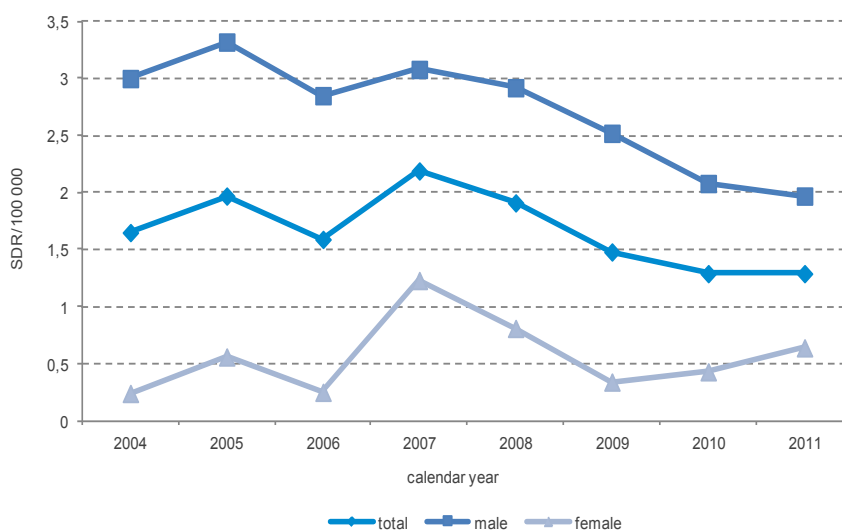
Source: NIPH (Medical Report on the Deceased Person – IVZ 46)

In all but two poisoning cases, the overdose was accidental. Of the remaining two poisoning cases, one was a suicide by overdose of a synthetic narcotic which was not opium, heroin or an opiate of another kind or methadone, and the other case was a heroin poisoning of undetermined intent.

According to data from the Slovenian Mortality Register, 231 people died due to direct effects of illicit drugs between 2004 and 2011, which means there were 7,508 years of potential life lost due to premature death (death before the age of 65) in the period 2004–2011, and an average of 938,5 years of potential life lost in one year.

### Trends of direct drug-related deaths in the period 2004–2011

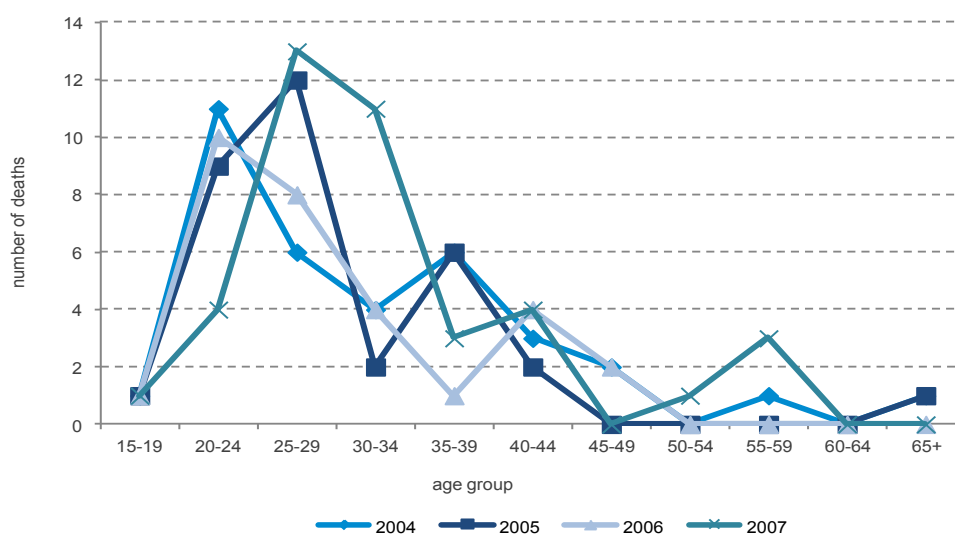
Figure 6.2: Trends of age-standardized direct drug-related mortality by sex, 2004–2011



Source: NIPH, Mortality Database 2004–2011

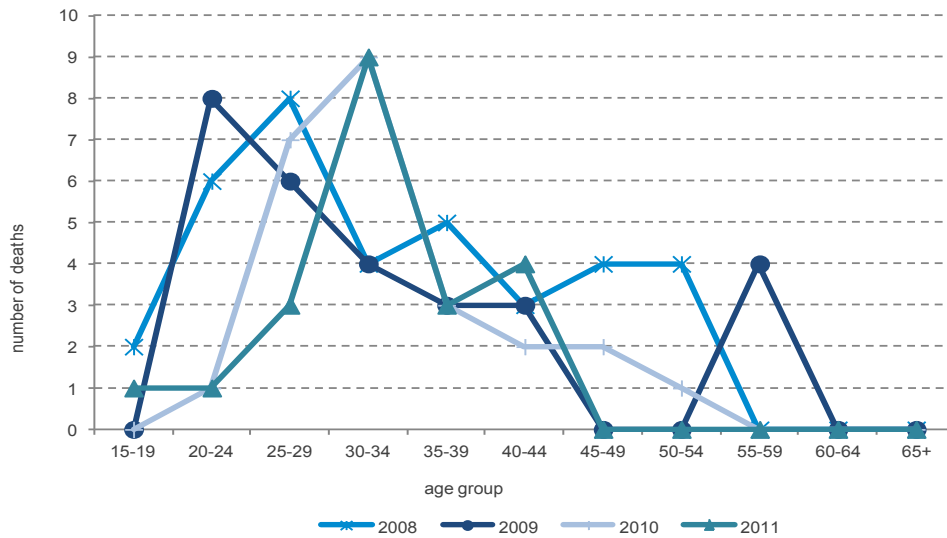
In the observed period, the direct drug-related mortality increased until 2007, peaking in 2007 and then declining: the whole trend was atypical, as was the trend of drug-related mortality in women, while drug-related mortality in men typically decreased in this period ( $R^2 = 0.576$ ) (Figure 6.2).

Figure 6.3: Trends in the number of direct drug-related deaths caused by opioids and cocaine (T400–T406), by 5-year age groups, 2004–2007



Source: NIPH (Medical Report on the Deceased Person – IVZ 46)

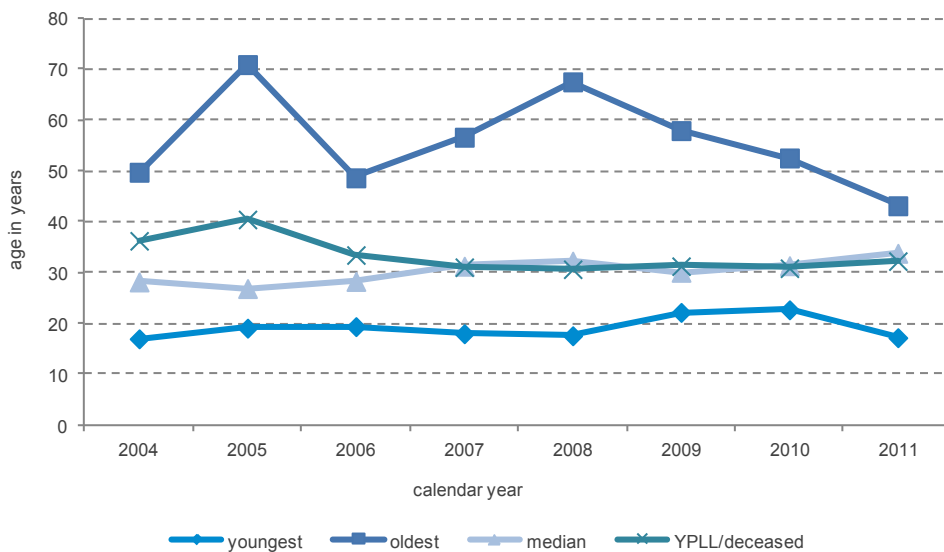
Figure 6.4: Trends in the number of direct drug-related deaths caused by opioids and cocaine (T400–T406), by 5-year age groups, 2008–2011



Source: NIPH (Medical Report on the Deceased Person – IVZ 46)

The number of deaths caused by opioids and cocaine increased until 2007, then began to decrease. Throughout the observed period, most direct drug-related deaths occurred among people aged 20–29; however, in 2010 most deaths occurred in the 30–34 age group (Figure 6.3, Figure 6.4).

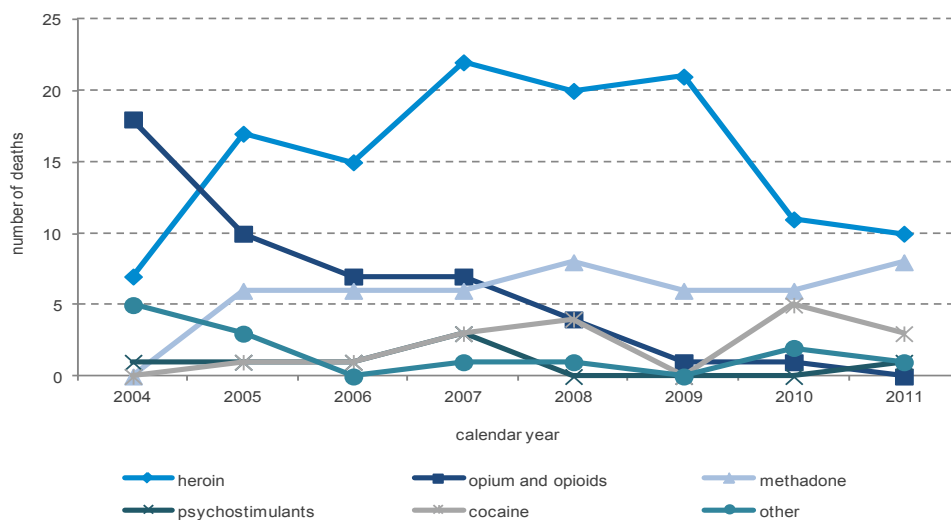
Figure 6 5: Changes in the highest and the lowest age at death, median age at death of drug users and the average number of years of potential life lost per deceased, 2004–2011



Source: NIPH (Medical Report on the Deceased Person – IVZ 46)

The highest age at death ranged from 49 to 71 years, and the median age increased slightly from 27 to 32 years ( $R^2 = 0.5862$ ) while the youngest deceased persons were between 17 and 22 years old. The number of years of potential life lost per 1,000 inhabitants decreased between 2005 and 2007, and remained constant after 2007 (Figure 6.5).

Figure 6.6: Trends in the number of poisoning cases by type of drug, 2004–2011

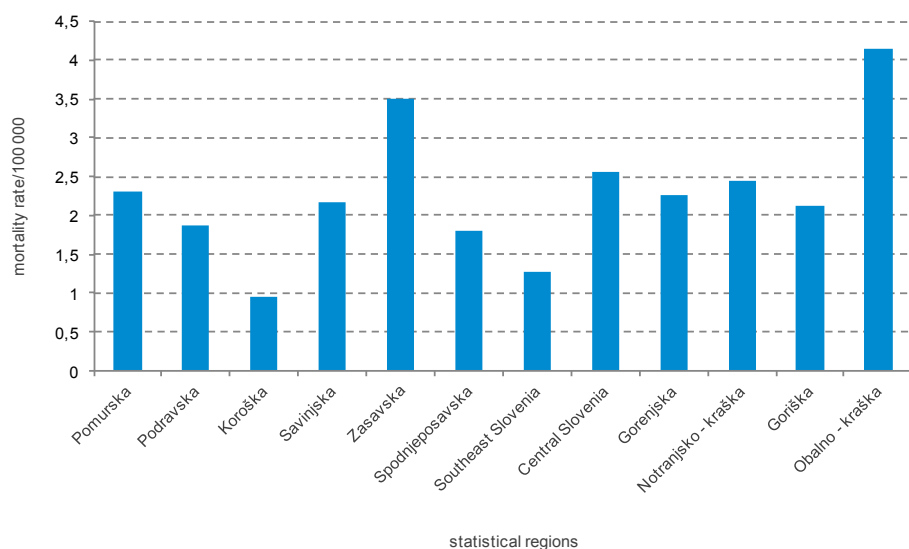


Source: NIPH (Medical Report on the Deceased Person – IVZ 46)

In the observed period, 41.7% of deaths were caused by heroin poisoning, 33.3% by methadone, 12.5% by cocaine, 4.2% by cannabis, 4.2% by other psychostimulants with abuse potential, and 4.2% by multiple drug intoxication. The number of deaths due to methadone and cocaine increased in the observed period ( $R^2=0.4603$ ;  $R^2=0.364$ ) while deaths due to opium and opioids decreased ( $R^2=0.8725$ ) (Figure 6.6).

**Mortality rates and proportions of certain variables in the period 2004–2011, by region**

Figure 6.7: Average annual drug-related mortality rates in the 15–64 age group by region, 2004–2011



Source: NIPH (Medical Report on the Deceased Person – IVZ 46)

The Obalno-kraška and the Zasavska regions had the highest mortality rates; the mortality rate in the former was 87% higher and the rate in the latter 56% higher than the Slovenian average mortality rate. The Koroška region and the Southeast Slovenia had the lowest mortality rates; their respective mortality rates were 58% and 42% lower than the average rate (Figure 6.7).

### **Some common personal characteristics of people who died due to direct effects of drugs in the period 2004–2011**

A large majority of people who died due to illicit drugs were single, one tenth was divorced, and there were very few married and widowed deceased drug users. Just over two fifths of drug-related deaths occurred outside the place of residence, and the same proportion of deaths occurred at home. According to NIPH's Mortality Database, 16% of drug-related deaths occurred in healthcare institutions where drug users were treated before death for the underlying or direct cause of death. It is not completely clear what it means that a deceased drug user was treated before death; perhaps it means that he or she was treated in a CPTDA. Most death certificates and reports on the cause of death were completed by doctors who performed the autopsy, and not the doctors who performed an examination immediately after death.

### **Discussion**

Data on direct drug-related deaths were obtained from the Mortality Database, which represents the National Register of Deaths. It contains data stored electronically together with the underlying causes of death. The remaining data on causes of death, which are also recorded on death certificates and which could show us that the deceased person was a drug user, is kept only in paper form. The procedure for obtaining such data is time consuming and is not carried out routinely due to the lack of staff.

The quality of data on the causes of death of illicit drug users was not assessed in Slovenia, but there are some professional publications about the quality of data on the causes of death per se issued for the purpose of improving the practice of recording the causes of death and consequently of determining the true underlying cause of death. When determining and coding the underlying cause of death of drug users, medical professionals should follow the recommendations of the Anamort project, which was coordinated by the French Institut de veille sanitaire (Sanitary Surveillance Institute) (source: Institut de veille sanitaire website). Three main recommendations warn that the person who chooses or determines and codes the underlying cause of death of a drug user should always take into account the toxicological analysis of body fluids of the deceased; that, in case of drug poisoning, it is necessary to determine the intent of poisoning as well as identify and code the substance that caused the poisoning; and finally, that, in cases where young people die due to sudden cardiac arrests or unclear cause of death, the possibility of drug poisoning should also be considered. Until recently, the intent was undetermined in almost half of drug poisoning cases in Slovenia. The coding of the underlying cause of death has improved, thus the number of such cases decreased significantly in 2011, while the number of accidental poisoning increased.

The results of the presented analysis show that the total number of direct drug-related deaths has been decreasing since 2007; however, the number of female drug-related deaths has increased, while the number of male deaths has decreased. There were 1.7 direct drug-related deaths per 100,000 population in 2011 in Slovenia. As the median age at death increased, the highest number of deaths moved from the 20–30 age group to the 30–40 age group. The number of deaths due to methadone and cocaine has been increasing, and deaths due to heroin, opium and other opioids have been decreasing. Mortality rates in statistical regions differ by up to 3 deaths per 100,000 person years. Most deceased drug users were single, and many of them did not die at home but outside their place of permanent residence.

There were three and a half direct drug-related deaths per 200,000 population (1.7 /100,000) in the 15–64 age group in Slovenia, which, keeping in mind the 95% confidence interval (10.7–24.5), places Slovenia in the same group as Germany, Lithuania, Malta, Greece, Spain and Belgium, and at the 15th place among 30 countries that report to EMCDDA; Slovenia's drug-related mortality rate is very close to the average of the mentioned countries (2.0/100 000) (source: EMCDDA website). The ratio of male to female deaths is in favour of women in all countries. In Slovenia this ratio is 4:1 in favour of women, which is better than the average in the mentioned countries (5:1). Among the thirteen countries that report using the 'Selection B' method for general mortality registries and whose average ages at death range between 44 in Denmark and 25.7 in Latvia, Slovenia holds the 9th place with its average age at death (34 years), which places it between Belgium and Croatia.

The fact that 48% of deceased drug users had opioids present in their bodies at the time of death places Slovenia in the top fifth of the above mentioned countries. The fact that the number of direct deaths caused by heroin decreased in the early observed period might be due to incorrect diagnoses of poisonings caused by opium or opioids and heroin, since deaths due to heroin increased when those due to opium and opioids decreased (source: EMCDDA website).

The age-standardized mortality in men has been decreasing since 2005, while there was no significant trend in the mortality in women until 2009, when the number of female direct drug-related deaths started increasing. It has not been determined why the mortality of women increased four-fold in 2007 compared to 2006, and then decreased again; undoubtedly, such sudden increases are partly due to low absolute numbers of female deaths in individual years. Future studies will need to determine why mortality rates in different regions differ by 3 deaths per 100,000 population; also this phenomenon is partly due to low numbers of deaths.

According to the Australian Bureau of Statistics, unmarried persons represent the largest proportion of drug poisoning victims, followed by divorced persons; the proportion of married victims is much smaller (Bureau of Statistic 2002). Some interpretations say that those who live alone receive help later or do not receive it at all; it is also believed that drug use, especially heroin, is less common among married people than among single and divorced (Bureau of Statistic 2002).



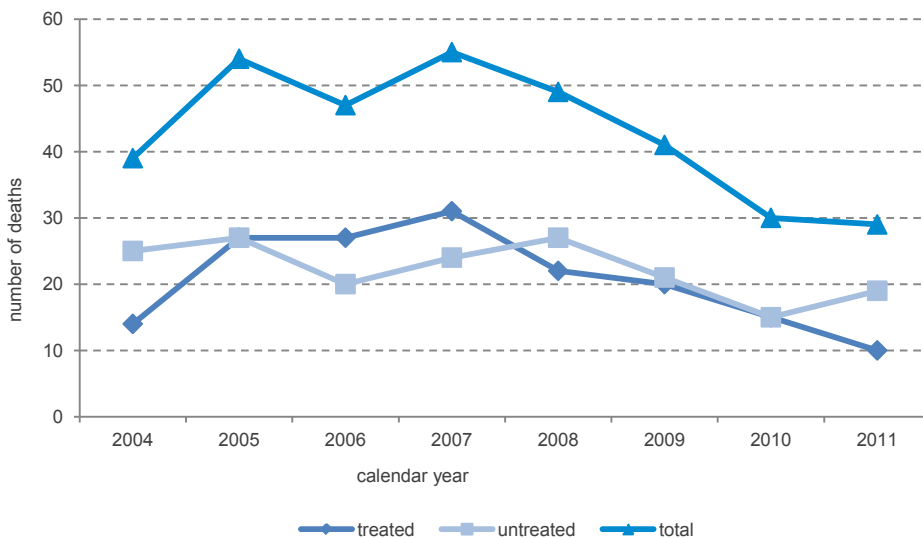
## Cohort study

### Mortality

Only drug users who died due to direct effects of illicit drugs are recorded in the NIPH's Mortality Database. Data on other drug users who died due to other causes, such as violent deaths (suicides, traffic accidents, etc.) or diseases, are not recorded in the electronic database, therefore we could not use it to determine which deceased persons were addicted to drugs. Data on indirect causes of death of drug users can be obtained only from special registers or cohort studies.

In Slovenia between 2004 and 2006, 6,482 records of persons who had been treated in CPTDAs were identified. The cohort study included 3,944 persons from these records; 166 of them died in 27,659.9 observation years in the period from 2004 to 2011 (Figure 6.8).

Figure 6.8: *The number of drug-related death cases included in the cohort, and fatal poisonings among untreated users, 2004–2011*



Source: NIPH (Medical Report on the Deceased Person – IVZ 46)  
NIPH (Record of Treatment of Drug Users – IVZ 14)

178 persons who had not been treated also died due to direct effects of illicit drugs in the mentioned period. 2007 had the largest number of deaths of people in treatment, while the number of deaths of people who had not been treated peaked in 2005 and 2008. The number of deaths in both mentioned groups decreased after 2008, but increased in the group of untreated patients in 2010 and 2011. The presented data on deaths does not include indirect drug-related deaths of persons who had not been treated.

Table 6.7: Mortality rates in drug users per 1,000 observation years for persons included in the cohort aged 15–59 years in the period 2004–2011, in comparison with mortality rates of their peers

Sex/Age	Males		Females		Total	
	Drug users	All males	Drug users	All females	All drug users	Total population
Mortality/1,000	6.69	3.36	3.87	1.69	6	2.69
Mortality, standardized per European standard population	15.29	3.4	34.23	1.52	32.35	2.47
Excess mortality of drug users, RR(relative risk)*.	1.99	4.5	2.29	22.52	2.23	13.1

\*Excess mortality of drug users compared to their peers (of the same age) in Slovenia

Source: NIPH (Medical Report on the Deceased Person – IVZ 46)

The mortality of persons treated in CPTDAs was one-fold higher among men and two-fold higher among women than among their peers (of the same age and sex). The age-standardized mortality rate of drug users was 8.8-fold higher than the age-standardized mortality rate of their peers (Table 6.7).

Table 6.8: Individual personal characteristics of drug users by 16 addiction treatment centres, Slovenia, 2004–2011

Centre	Number of deaths	Years of observation	Mortality rate	Median age at death	% opioids	% other drugs	Violent deaths		
							Rates/1000 py		
							Pois.	Suic.	Undet.
	Total	Total	Total						
Ljubljana	53	7391	7.2	37.5	92.4	3.8	1.89	1.49	1.08
Trbovlje	7	1265	5.5	28.9	100	0	3.16	0.79	0
Logatec	3	1327	2.3	27	100	0	0.75	0	0
Kočevje	3	964	3.1	30.6	66.7	33.3	2.07	0	0
Maribor	25	1921	13	40.7	68	0	3.12	1.04	2.601
Celje	17	1974	8.6	27.3	82.4	0	0.51	3.55	3.04
Velenje	6	1168	5.1	36.2	100	0	2.57	0.86	0
Kranj	5	720	6.9	26.5	100	0	2.78	2.78	0
Nova Gorica	13	2753	4.7	29.6	84.6	7.7	0.36	0.73	2.18
Ilirska Bistrica	2	605	3.3	22.6	100	0	0	1.65	1.65
Sežana	5	822	6.1	29.7	80	20	4.87	0	0
Piran	8	1450	5.5	34.6	75	0	2.07	0.69	1.38
Izola	4	783	5.1	42.4	75	25	1.28	2.55	0
Novo mesto	2	802	2.5	30.9	50	50	1.25	0	0
Brežice	3	1096	2.7	38.7	66.7	33.3	0	0.91	0.91
Murska Sobota	10	1735	5.8	30.2	90	10	1.15	0	1.73
<b>Total</b>	<b>166</b>	<b>26776</b>	<b>6.23</b>	<b>33.1</b>	<b>84.9</b>	<b>5.5</b>	<b>1.68</b>	<b>1.16</b>	<b>1.2</b>

Pois.: poisonings, Suic.: suicides, Undet.: undetermined intent

The missing percent (out of 100%) of primary drugs represent unknown

Source: NIPH (Medical Report on the Deceased Person – IVZ 46)

CPTDAs covering the three largest Slovenian cities had the highest numbers of drug-related deaths; however, mortality rates did not follow the order of cities from highest to lowest number of inhabitants, since the mortality rate was the highest in Maribor and Celje, followed by Ljubljana and Kranj. The median age at death ranged from 22.6 years in Ilirska Bistrica, where only two persons died, to 42.4 years in Izola, where four persons died (Table 6.8).

Most deceased drug users who had been treated had problems mainly due to opioids; there were only few persons who entered treatment due to cocaine or cannabis addiction.

Accidental poisonings represented the largest proportion of violent deaths, followed by poisonings of undetermined intent and suicides (these two accounted for approximately the same number of deaths); and far from them traffic accidents. In some CPTDAs, all drug users died due to accidental poisoning. In CPTDA Celje, suicides and deaths of undetermined intent prevailed. In CPTDA Kranj, the number of suicides and the number of accidental poisonings were the same.

Calculations of correlation between mortality rates of treated drug users (classified by CPTDAs in corresponding statistical regions) and the selected indicators of education, employment, social security, gross domestic product and business entities show a typically positive correlation between mortality in an individual CPTDA and the number of unemployed persons with secondary education and persons receiving financial social assistance per 1,000 population, as well as the number of business entities that stopped operating and were without successors. In regions with higher numbers of unemployed people with primary education and college or university students the mortality rate was significantly lower than in regions with lower numbers of people with such education levels.

When we calculated the correlation between mortality due to suicides (by regions) and the above indicators, we found that mortality due to suicides was positively correlated to the number of people with primary education registered as unemployed, and negatively correlated to the number of unemployed people with higher education, and to average net income per employee and the proportion of adults with public library membership. Gross domestic product per capita and the proportion of college and university students in an individual region were also important.

## Demographic information about deceased and living persons included in the cohort

Table 6.9: Characteristics that differ significantly between deceased treated drug users and treated drug users alive at the end of 2011 in the period 2004–2011

Variables	Categorical variables	Number		Proportion (%)		Probability of error (P)
		Dead	Alive	Dead	Alive	
Sex	Men	140	2863	84.3	75.7	0.011
	Women	26	918	15.7	24.3	
Type of treatment upon admission	First-time	23	962	13.9	25.4	0.002
	Re-treatment	137	2611	82.5	69	
Employment status	Permanently employed	25	759	18.6	22.5	0.001
	Pupil, student	9	553	6	16.4	
	Unemployed, occasionally	110	1912	66.3	50.5	
Primary drug	Opioids	141	3066	84.9	81	0.041
	Cocaine, stimul.	4	32	2.4	0.8	
	Cannabis	5	250	3	6.6	
	Other	16	435	9.6	11.5	
Route of administration (primary drug)	Injecting	113	2091	75.3	62.1	0.001
	Smoking/sniffing	20	947	13.3	28.1	
	Oral	1	32	0.7	1	
	Sniffing	16	296	10.7	8.8	
Ever injected	Yes	134	2544	90.5	76.4	0.001
	No	14	784	9.5	23.6	
Testing for anti-HIV before 2006	Positive	3	3	2.2	0.1	0.001
	Negative	131	2500	97.8	99.9	
Testing for anti-HBC before 2006	Positive	11	81	6.6	2.1	0.001
	Negative	94	1659	56.6	43.9	
Testing for anti-HCV before 2006	Positive	44	488	39.3	25.3	0.001
	Negative	68	1441	60.7	74.7	
Type of treatment centre	Local h.c.	33	985	19.9	26	0.025
	Other non-residential specialized	63	1089	38	28.8	
	Ambulatory care centre for ment. health	41	882	24.7	23.3	
	General practitioners	28	822	16.9	21.7	

H.c.: health centre, ment.: mental

Source: NIPH (Medical Report on the Deceased Person – IVZ 46)

NIPH (Record of Treatment of Drug Users – IVZ 14)

The proportion of men was higher among deceased drug users than among survived ones. The proportions of re-treated drug users, unemployed persons or occasional workers, persons who had at any point in life used drugs intravenously, and persons tested positive for HIV, HBC and/or HCV antibodies between 2004 and 2006 were also larger among deceased drug users (Table 6.9). More dead drug users than living drug users had been treated in other non-residential specialized centres, and more living drug users than dead

drug users had been treated in other centres. The differences between the proportions of dead and alive drug users were statistically significant for all above variables.

Table 6.10: *Average values for characteristics which typically differ between deceased treated drug users and treated drug users alive at the end of 2011 in the period 2004–2011*

Variables	Vital status	Number	Average age	Probability of error (P)
Age at death at the end of observation period	dead	149	35	0.025
	alive	3361	33.8	
Age at entry into the study	dead	166	31.9	0.001
	alive	3781	26.7	
Age at first drug use (any drug)	dead	150	16.6	0.012
	alive	3364	15.9	
Age at first use of primary drug	dead	149	20.3	0.001
	alive	3361	19.1	

Source: NIPH (Medical Report on the Deceased Person – IVZ 46)

NIPH (Record of Treatment of Drug Users – IVZ 14)

The average age of deceased drug users, both male and female, was higher than the average age of alive drug users. The average ages of deceased drug users upon the entry into the study, at first use of any drug, and at first use of primary drug were also higher than among survived drug users (Table 6.10).

## Causes of death

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Table 6.11: *Mortality rates in the cohort of drug users aged between 15 and 59, compared to mortality rates in the Slovenian population, by cause of death, 2004–2011*

Cause of death	No. of deaths of drug users	Proportion of deceased drug users 2004–2011	Proportion of deaths in Slovenia in 2007	Mortality of drug users 2004–2011	Mortality in the Slovenian population in 2007	RR
Infectious and parasitic diseases	6	3.6	0.7	0.217	0.016	13.6
Neoplasms	4	2.4	35.2	0.145	0.841	0.2
Diabetes	1	0.6	1.4	0.036	0.132	2.3
Mental disorders	6	3.6	1.05	0.217	0.025	8.7
Diseases of the circulatory system	9	5.4	17.6	0.325	0.419	0.8
Diseases of the respiratory system	2	1.2	1.8	0.072	0.043	1.7
Gastrointestinal disorders	12	7.2	11.8	0.434	0.281	1.5
Congenital anomalies	1	0.6	0.4	0.036	0.011	3.3
Unknown cause of death	1	0.6	3	0.036	0.072	0.5
External causes	124	74.7	24.6	4.483	0.588	7.6
Total	166	100.0	95.1	6.001	2.386	2.5

RR: relative risk of death in treated drug users in comparison with their peers

Source: NIPH (Medical Report on the Deceased Person – IVZ 46)

More than three quarters of deaths among cohort members who died between 2004 and 2011 represented violent deaths. Mortality rates of drug users due to infectious diseases, mental disorders, respiratory and gastrointestinal diseases and violent deaths were higher than mortality rates of their peers in Slovenia. Relative risk of death was 1.5-fold higher among drug users with gastrointestinal diseases, and up to 13.5-fold higher among drug users with infectious diseases than among their peers in Slovenia (Table 6.11).

#### Infectious diseases (A00.0 - B99.9)

Infectious diseases were the cause of death in six drug users aged between 29 and 44 years; all of them were treated in CPTDAs before entering the cohort. Their average age at entry into the study was just under 35 years. Heroin was the primary drug upon entry into the cohort for five of them, and one used cocaine as the primary drug. All of them died in the first two months of the winter. In four cases, the cause of death was chronic viral hepatitis C (B182), and the remaining two drug users died due to a disease caused by HIV (B240).

#### Malignant neoplasms (C00.0-C99.9)

Cancer was the cause of death in five drug users aged between 25 and 58. Three of them died of lung cancer (aged 29 and 58 years), and one (25 years old) died of soft-tissue sarcoma. Of the three drug users who died of lung cancer, two used heroin as their primary drug upon entry into the study, and there was no information on primary drug available for the third drug user. One of these three drug users used cannabis and alcohol as secondary drugs, and one was hepatitis C virus positive.

#### Cardiovascular diseases (I00.0 – I99.9)

Nine drug users aged between 23 and 53 died of cardiovascular diseases. All but one had been treated for a long time, and all of them used heroin as their primary drug upon entry into the study. Four treated drug users aged between 27 and 40 died of acute myocardial infarction. The oldest drug user and the youngest one died of endocarditis, one drug user died due to unspecified heart failure, and two due to brain haemorrhage.

#### Gastrointestinal disorders (K00.0 – K99.9)

In all twelve cases of gastrointestinal disease, the cause of death was alcoholic liver disease in drug users aged between 31 and 59. In eight out of eleven cases, the primary drug upon entry into the cohort was heroin, and in one case other opioids; the primary drug was unknown in three cases. Of the twelve drug users, three used cocaine and alcohol as their secondary drugs, two only used alcohol as the secondary drug, one used a combination of alcohol and heroin, and one a combination of alcohol and cannabis. Of nine drug users tested for hepatitis B and C antibodies, two were positive for hepatitis B and seven were positive for hepatitis C. One of eleven drug users tested for HIV was positive.

Violent deaths (V01.0 – Y98.9, F11.2 and F19.2)

Table 6.12: *Violence-related mortality rates among cohort members in comparison with violence-related mortality rates among other deceased people aged 15-59, 2004–2011*

Cause of death	No. of deaths of drug users	Mortality of drug users	Mortality rate in the Slovenian population	RR
Transport accidents	12	<b>0.43</b>	0.18	2.36
Falls	1	0.04	0.05	0.68
Drownings	1	0.04	0.01	3.28
Other accidents	2	<b>0.07</b>	0.04	2.06
Accidental poisoning	45	<b>1.63</b>	0.02	77.43
Suicides	31	<b>1.12</b>	0.2	5.52
Assault	3	<b>0.11</b>	0.01	9.00
Undetermined intent	32	<b>1.16</b>	0.05	25.71
Complications of medical care	1	0.04	0.09	4.50
Late effects	1	0.04	0	18.00
<b>Total</b>	129	4.66	0.59	7.93

RR: relative risk of death in treated drug users in comparison with their peers

Source: NIPH (Medical Report on the Deceased Person – IVZ 46)

Accidental poisonings and poisonings of undetermined intent represented the largest proportion of violent deaths, closely followed by suicides. The proportion of transport accidents was much smaller. In addition to these cases, where mortality rates were higher among drug users than among other members of the population, the numbers of other accidents and assaults were also higher among drug users; however, these absolute numbers were low. If we exclude those causes of death which are very rare in the general population, but not among drug users (these are accidental poisonings and poisonings of undetermined intent), the risk of death in drug users, compared to the general population, is the highest in suicide cases, followed by traffic accidents. As absolute numbers of other causes of death are very low, it has no sense to calculate the corresponding relative risk.

#### Transport accidents

Twelve drug users aged between 20 and 43 years died due to transport accidents. Upon entry into the cohort, ten of them stated that their primary drug was heroin, and one used cannabis as the primary drug; there was no such information available for the last one. Two drug users were fatally injured as pedestrians and died due to head injuries. Three drug users were killed while driving a motorcycle, three while driving a car, and two while driving in a car as passengers. For the remaining two, the role in the accident was not specified. All of them died due to head injuries or severe multiple injuries. All persons for whom such data was available (9 persons) had been treated in CPTDAs for a long time.

### Accidental poisonings

Death due to accidental poisoning occurred in 45 drug users aged between 18 and 58. Ten of them were in treatment for the first time, and others were re-treated or treated for a long time. 8/39 of these deceased drug users lived alone; marital status of four persons was unknown. Seven persons were permanently employed, and six were school pupils or students; others were unemployed or economically inactive. Education level of 39 out of 40 persons was two- or three-year vocational school or lower.

For 38 out of 45 persons, the primary drug upon entry into treatment was heroin; 35 of them injected heroin, and the others snorted or inhaled it. Of three persons who used cocaine, two injected it, and one inhaled it. One person used methadone as the primary drug upon entry into treatment, and one used cannabis. Of those persons who used heroin as the primary drug, 21 also used cannabis, 12 cocaine, 4 benzodiazepines, and 5 alcohol, 4 MDMA or amphetamines, and 2 also used methadone.

Among heroin addicts, the causes of accidental poisonings were heroin (ten cases), other opioids (seven cases), methadone (six cases), benzodiazepines (one case) and alcohol (one case). Of 45 persons who died due to poisoning, 15 persons used one secondary drug in addition to the primary drug, most of them cannabis or MDMA, followed by cocaine, alcohol, heroin and methadone. 15 persons used two secondary drugs, most of them a combination of cannabis and cocaine (6 persons), cocaine and MDMA or amphetamines (4 persons), cannabis and benzodiazepines (2 persons), cocaine and alcohol or benzodiazepines (1 person) and benzodiazepines and methadone (1 person).

All thirty-nine people who were tested for HIV were negative. Two out of 29 persons tested for hepatitis B were positive. Of 36 persons tested for HCV, 15 were positive, and results were unknown for 4 persons.

The following statistically significant differences were found between the group of drug users who died due to accidental poisoning and the group of drug users who died due to other kinds of violent causes ( $P < 0.100$ ): the proportion of female deaths among deaths due to accidental poisoning was significantly larger than among other violent deaths; the proportion of pupils and students, the proportion of those who injected drugs upon the entry into treatment, and the proportion of persons positive for hepatitis C virus were also larger among deaths caused by accidental poisoning. People who died due to accidental poisoning were older at the time of death, and they had been treated or monitored for a longer time than persons who died due to other kinds of violent death. The proportion of persons who had received substitution treatment in an institution before, but not continuously, was larger among people who died due to accidental poisoning than among other violent deaths.

### Suicides

Of 3944 treated drug users, 31 persons aged between 22 and 50 committed suicide in the period 2004–2011. 25 of these persons used heroin as their primary drug upon entry into treatment, and two used cannabis; information on the primary drug was not available for four deceased. Most suicide victims used cannabis as their secondary drug, followed by cocaine



and benzodiazepines. Three quarters of suicide victims lived with their parents; 9/10 of them were single, and only 8 out of 27 had had a permanent sexual partner for over a year. Two persons were hepatitis B, and four hepatitis C positive. One quarter of suicide victims were permanently employed. Most suicide victims had completed 2- or 3-year vocational school or had lower education, and most of them entered treatment voluntarily.

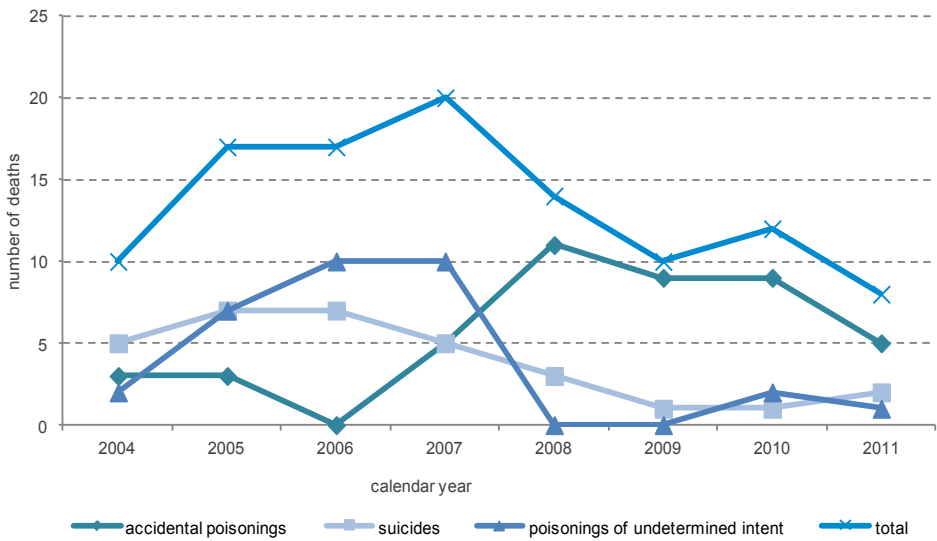
Of four cases of intentional illicit drug poisoning, two were suicides by heroin, one was suicide by opioids, and one by methadone. There were seven carbon monoxide poisoning cases and ten suicides by hanging, four suicides by jumping from a height, two suicides by cutting with a sharp object, two by jumping in front of a train, and one firearm suicide; in one case, the method of suicide had not been recorded.

Among drug users who committed suicide, the proportion of those who were re-treated or in long-term treatment was larger than the proportion of those who entered treatment for the first time during the period of recruiting people for the study. Most suicide victims lived with their parents, and most smoked or inhaled their primary drug. The proportion of drug users who had been treated in local CPTDAs was larger among suicide victims than among other treated drug users who had died a violent death.

Deaths of undetermined intent

32 deaths of undetermined intent occurred among drug users aged between 19 and 48 in the observation period. In 26 cases, the primary drug upon entry into treatment was heroin, in one case it was cannabis, and in one case the primary drug was unknown. One death occurred due to a fall from a height, but it is unclear whether it was an accident, homicide or suicide.

Figure 6.9: The number of deaths in three categories of violent deaths among treated drug users, 2004–2011



Source: NIPH (Medical Report on the Deceased Person – IVZ 46)  
NIPH (Record of Treatment of Drug Users – IVZ 14)

Keeping in mind that there were only four deaths of undetermined intent recorded between 2008 and 2011, and that there were 34 accidental poisonings which mostly included opioid poisonings, we can conclude that most poisonings of undetermined intent were probably accidental poisonings.

## **Discussion**

In order to determine the indirect causes of death of drug users, we monitored drug users in treatment, and recoded their deaths, demographic and social indicators, behavioural indicators, infection indicators and causes of death throughout a period of eight years. Data were available from 17 of 18 CPTDAs in Slovenia. There were no studies on the proportion of coverage or the quality of data, thus the study covered all people registered in the 17 CPTDAs in three years. Their vital status was monitored by connecting the data on treated drug users and the data from the mortality databases in the period 2004–2011. Even though data on the same drug user were not registered under the same identification code in the two databases, we estimated that, using further procedures (e.g. by excluding one or two cases if two or three had the same identification number), we finally collected high-quality data on individual deceased.. It was assumed that all drug users included in the study were monitored until death or until the end of the study. It has not been investigated whether any cohort members died abroad.

An analysis of mortality monitoring of treated drug users in Slovenia showed that the mortality among them was more than two times higher than among their peers (of the same age). The range of mortality rates of persons treated in individual CPTDAs was wide, and mortality was higher in regions where indirect indicators showed a low socio-economic status. Regarding deaths due to suicide, it has been determined that the mortality was lower in regions where indicators of economic status were better, and in regions where education levels were higher.

There were more drug users in long-term treatment, more those with low socio-economic status, more injecting drug users and more drug users with infections caused by drug use among deceased than among survived drug users. The average age of deceased was also higher than the average age of survived ones.

A large majority of treated drug users died a violent death, followed by gastrointestinal diseases, cardiovascular and infectious diseases. Most violent deaths were due to heroin, opium or other opioids and methadone overdoses. Most suicides were committed by hanging and by carbon monoxide or other exhaust gases self-poisonings. The proportions of people in long-term treatment and people who lived with their parents were larger among suicide victims than among other violent death cases.

The high coefficient between the mortality of drug users and the mortality of their peers might be partly due to the low number of deaths and person years in individual age groups of drug users in the cohort in comparison with the number of observation years in the Slovenian population, and due to the fact that the majority of deaths of drug users occur much earlier in

life than deaths of their peers (the median age at death of drug users was 32.7 years, and the median age of their peers in Slovenia was 51.1 years). It is estimated that the differences between mortality rates, especially the mortality of female drug users and the age-standardized mortality, are due to the difference between the actual number of years of follow up and the number of years in individual categories of the EU standard population; the latter difference is quite large especially in the youngest and the oldest age groups. It would make sense to have a single standard population for all observation years, composed of all cohorts to be compared, or choose one population as a standard and use it for standardized rates of other populations.

According to unpublished data from a pooled analysis of eight cohort studies carried out by EMCDDA's partners, Slovenia holds the sixth place with its 5.7 deaths of treated drug users per 1,000 person years, which places it one place behind Croatia and one place before Romania. Slovenia also holds the sixth place for the number of male deaths, and the fifth place for female deaths. Compared to the rates of all eight countries, Slovenia had significantly higher mortality due to suicides, traffic accidents, deaths of undetermined intent, and gastrointestinal diseases (EMCDDA 2012). The Oslo Mortality Study showed that childhood living conditions are associated with deaths due to psychiatric disorders, especially due to alcohol and drug addiction among adults (Claussen et al. 2003). The prevalence of excessive alcohol consumption is high in Slovenia, and all mentioned causes of death except deaths of undetermined intent belong to the category of alcohol-related causes of death.

## Conclusions

- Like male deaths in the cohort, the number of male deaths due to direct effects of drugs on the body typically decreased between 2004 and 2011. Female direct drug-related deaths decreased between 2007 and 2009, but have been increasing in the last two years. The mortality rate in the cohort has been decreasing in woman since 2007.
- The male to female death ratio is 4:1 in favour of women; however, the number of female deaths increased during the eight-year period, while the number of male deaths decreased. The male to female deaths ratio in the cohort in individual year ranges from just under one in favour of men to eight-fold higher in favour of women. This wide range is mainly due to the small number of deaths of women in comparison with men in individual years.
- As the age of drug users increased, the largest proportions of direct drug-related deaths and deaths of treated drug users moved from the under-30 into the over-30 age group. In addition, the median age at death also increased in both groups (direct drug-related deaths and deaths of treated drug users), while the number of premature deaths in both groups did not significantly change after 2007. The numbers of years of potential life lost per deceased were also almost the same in both groups.
- The fact that the number of deaths due to heroin increased while the number of deaths due to opium and other opioids decreased among direct deaths in the initial period of data collection might be due to inaccurate determination of the cause of death in deaths due to heroin, opium and other opioids. The mortality of treated opium and opioid users also decreased; however, after 2008 it was lower than the fatal poisonings among

untreated drug users. After 2005, the number of deaths due to methadone ranged between 6 and 8 direct deaths per year, and between 1 and 3 treated drug users per year, but increased to 5 in 2011. The number of direct deaths due to cocaine gradually increased throughout the observed period. There were four deaths due to cocaine among treated drug users in 2010.

- Direct mortality rates in individual statistical regions differed by up to 3 deaths per 1,000 person years in 2011; among drug users treated in individual treatment centres, direct mortality rates differed by 2.3–13.0 deaths per 1,000 treated drug users. The significant differences between mortality rates in seventeen CPTDAs were partly due to low numbers of deaths in individual CPTDAs (the lowest number of deaths was 2); other reasons for such differences have yet to be determined. It has been found that mortality rates among drug users treated in individual CPTDAs were associated with indirect socio-economic indicators in their environment, and, as regards suicides, also with education levels. While most drug users who died due to direct drug poisoning were single or divorced, only ten percent of deceased treated drug users had lived alone.
- In the last two years of the study, the number of deaths of undetermined intent decreased, and the number of accidental poisonings increased. Since the number of suicides did not change significantly, we can conclude that a large proportion of deaths of undetermined intent can be considered accidental poisonings.

## RESPONSES TO HEALTH CORRELATES AND CONSEQUENCES

# 7.

*Andreja Drev, Milan Krek, Mina Paš*

Prevention of drug-related emergencies and deaths as well as prevention of infectious diseases are performed in the public health network – in centres for the prevention and treatment of drug addiction – and by nongovernmental organisations, primarily through low-threshold harm-reduction programmes. Furthermore, the Ministry of Health RS has founded interministerial working group for Early-warning System on new Psychoactive Substances which informs expert public as well as drug users of the emergence of dangerous or new psychoactive substances. The Poison Control Centre of the University Medical Centre Ljubljana also includes a 24-hour toxicological information-consultation service providing support to all Slovenian doctors treating patients poisoned with illicit drugs. The nongovernmental organisation Združenje DrogArt enables users of psychoactive substances to have new psychoactive substances tested if they suspect that they contain unusual substances or have effects different than expected.

Programmes for the prevention and treatment of drug addiction provide all drug users in treatment with basic knowledge on drug-related risks and methods to prevent drug-related overdose and death. Drug users have the possibility of free hepatitis B vaccination as well as free HIV and hepatitis C testing. Any drug user that might test positive is ensured HIV and hepatitis C treatment free of charge.

Low-threshold programmes include free distribution of sterile materials among injecting drug users as well as counselling. Needle exchange programmes are executed in daily centres and as part of field work performed by employees of nongovernmental organisations at locations where users frequently stay. The so-called mobile needle exchange is performed in specifically adapted vans. In 2011, there were 632,462 needles and syringes distributed within low-threshold programmes.

### 7.1 Prevention of drug-related emergencies and reduction of drug-related deaths

There is an interministerial working group, the Early-warning System on new Psychoactive Substances, operating under the auspices of the Ministry of Health RS. Among the functions of the group is to inform expert public as well as drug users promptly of the emergence of new and dangerous psychoactive substances and of their consequences. Informing is carried out by sending information via electronic mail to institutions and nongovernmental organisations operating in the field of illicit drugs, and also through mass media in cases of greater threat to the health of users. For users of illicit drugs undergoing treatment, centres

for the prevention and treatment of drug addiction (CPTDA) provide overdose trainings that teach users how to identify an overdose as well as the basic measures to deal with a suspected overdose. At electronic music events, field workers provide information on how to reduce the risks associated with stimulants, and distribute isotonic beverages, sniffing papers (to reduce the risk of transferring hepatitis and HIV in shared use of sniffing tools) and condoms. They also provide first aid for users with health complications caused by stimulants. The Poison Control Centre operates in the University Medical Centre Ljubljana, functioning as a hospital ward with 12 beds. The Unit treats all types of acute and chronic poisonings and provides a 24-hour information-consultation service for the field of toxicology, which includes support to all Slovenian doctors treating patients poisoned with illicit drugs. The Poison Control Centre also holds a depot of all major antidotes that can be used to help doctors from across Slovenia when they encounter a rare poisoning and have no appropriate medicine. (Detailed descriptions are available in the 2011 National Report on the Drug Situation in Slovenia).

The Združenje DrogArt nongovernmental organisation, which aims to reduce recreational-drugs-related harm, enables the users of psychoactive substances to have new psychoactive substances tested if they suspect that they contain unusual substances or have effects different than expected. Users can bring a sample to the DrogArt info point, where a quick colour test is performed immediately using Marquis' and Mandelin reagent and Cobalt thiocyanate. This method makes it easy to establish whether the substance contains cocaine, MDMA, amphetamine or some other substances. If the presence of an expected substance is confirmed by the test, the sample is returned to the user. If, however, the colour reaction is incompatible with the expected substance, or if the colour reaction is untypical, or if the user reports "weird" effects, the substance is submitted to the National Forensic Laboratory for further tests upon user's consent. If it turns out that the detected substance poses health risks, DrogArt informs users of the emergence of the substance through their webpage, Facebook, and their web forum ([www.drogart.org/forum](http://www.drogart.org/forum)), and in some cases also on location. For example, when a series of ecstasy tablets that also contained mCPP emerged, DrogArt agreed with organizers to give each visitor to a music event a note with a warning on mCPP content in ecstasy tablets when purchasing a ticket.

## 7.2 Prevention and treatment of drug-related infectious diseases

Prevention of infectious diseases is being implemented in all CPTDAs. Drug users have the possibility of free hepatitis B vaccination as well as free HIV and hepatitis C testing. Any drug user that tests positive is ensured HIV and hepatitis C treatment free of charge. The Slovenian national guidelines for the treatment of hepatitis C in drug users in substitution therapy programmes were drawn up in 2007. An anonymous hepatitis C testing campaign is held once a year. Tests are executed at the Department of Infectious Diseases, Ljubljana and at mobile points where users can submit blood samples in adapted ambulances located at certain spots where mobile needle exchange is usually performed. Health insurance is not required for such tests. (Detailed descriptions are available in the 2011 National Report on the Drug Situation in Slovenia.)

Low-threshold programmes include free distribution of sterile materials among injecting drug users, as well as counselling. Needle exchange programmes are executed in daily centres and as part of field work performed by employees of nongovernmental organisations at locations where users frequently stay. The so-called mobile needle exchange is performed in specifically adapted vans. In addition to exchanging needles and distributing other injecting tools (alcohol wipes, ascorbic acid), mobile staff and daily centre staff also distribute informative materials on infectious diseases and injecting with lesser risk.

Purchase and distribution of sterile materials for safer injection of drugs are organized by the Regional Institute of Public Health Koper (RIPH Koper), which in 2011 provided regular supply to ten low-threshold programmes as well as four mobile units (vans) that carry out exchange of sterile accessories at specific sites. Together with sterile materials for injection of drugs, the following is also distributed: ascorbic acid, gauze, bandages, condoms, disinfectants for hands, floor and other working surfaces. Materials and work carried out within the programme are funded by the Health Insurance Institute of Slovenia.

Collection of infected materials was organised in ten programmes and four vans. Used materials are collected at locations where programmes are held and in mobile vans, and stored in safe packaging protecting the staff from getting injured with used needles or accessories. Materials are disposed of by a competent company, which also ensures their appropriate destruction. Expert used-needle disposal and destruction services were provided to 12 low-threshold programmes.

In 2011, RIPH Koper distributed 632,462 needles and syringes among low-threshold programmes. 220,549 needles and syringes were returned, which represents 35 % of all needles and syringes distributed within low-threshold programmes. Compared to 2010, the number of distributed needles and syringes decreased by 173,611 in 2011. However, there was an increase in the use of large syringes (a 20ml), which are used to prepare substances based on a special medicine filtering procedure using cotton wool. This is consistent with data, which show an increase in the abuse of diverse psychoactive drugs. There were 13,851 contacts with the drug users who sought help in low-threshold programmes in 2011, which included exchange of sterile materials; 11,480 were male and 2,443 female, and their average age was 30.25 and 29.25, respectively.

RIPH Koper's measures to reduce the number of needles discarded in parks and other locations include the establishment of a special training programme for municipal utility staff who often come into contact with discarded needles. 60 people were trained in Ljubljana. The seminar covered the basics of addiction, injection methods, injection materials, methods of picking up infected materials and the use protective equipment, as well as collection of contaminated materials and final destruction of materials thus collected. The training also comprised a practical demonstration of collecting and disinfecting needles while wearing special protective equipment, as well as a presentation of methods of collecting materials wearing special protective equipment and storage of materials in specifically adapted protective packaging.

The legal framework governing the operation of the social security system is set out in the Social Security Act (Official Gazette RS, No. 3/2007 and following), and the field of financial social assistance is governed by the Financial Social Assistance Act (Official Gazette RS, No. 61/2010 and following), Exercise of Rights to Public Funds Act (Official Gazette RS, No. 62/2010 and following) and the Fiscal Balance Act (Official Gazette RS, No. 40/2012). All three acts came into effect this year, the first two in January and the third one in May. The new social legislation introduced some important innovations and changes in the field of financial social assistance and subsidies, such as: a uniform method for determining the financial status of an individual or a family, the order of enforcement of rights, a single entry point for all cases of financial social assistance, subsidies and payments, the establishment of new classes or categories of beneficiaries of financial social assistance, etc. These changes significantly altered the financial social assistance system, and the reactions from users and professionals vary, but most of them are negative. However, it is difficult to say anything about the real effects of the implementation of the mentioned legislation at this point.

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The basic substantive and normative starting points for dealing with individuals in social distress are specified in the National Social Assistance Programme, which is adopted by the state for the period of five or ten years. The National Social Assistance Programme sets out basic guidelines for the development of a system, specifies the objectives and strategies for the development of a social security system, establishes the public services network of social security services and programmes, and defines the method of its implementation and monitoring as well as the responsibilities of different stakeholders at different levels.

The basic starting points for dealing with users who have drug-related problems in the social security system are set out in the Resolution on the National Programme of Social Care 2006–2010 (Official Gazette RS, No. 39/2006). The period of implementation of the mentioned Resolution ended in 2010. Slovenia has not adopted a new strategic document for the field of social security at the national level yet. The new National Programme for the period until 2020 is currently being developed.

Professional activities aimed at solving social problems related to illicit drug use are carried out in the framework of public service (62 Centres for Social Work) and in private and non-governmental organizations which implement complementary social care programmes.

Centres for Social Work recorded 298 cases of treatment related to drug problems in 2011. In the same year, more than 6,400 users participated in drug-related social care programmes co-funded by the Ministry of Labour, Family and Social Affairs (MLFSA).



## 8.1 Social exclusion and drug use

Tasks and services carried out in centres for social work as well as public authorization information are recorded in the social database, which is part of the Information System for Social Work Centres (ISCSD). Data from the social database, which are presented in the Table 8.1, are recorded and arranged according to the type or problem of the public authorization, task or service carried out. This means that a professional worker at the centre, where a public authorization process or a social care service has been carried out, records information and indicates the reason for which the service was carried out (referred to as the problem). Here it should be noted that such information does not refer to individuals, but to the identified problem.

In centres for social work most drug-related problems, more specifically about half of all cases (in 2009 even 70%), are dealt with in the framework of social first aid. It may be noted that centres for social work do not deal with drug-related problems often. Between 2009 and 2011 there were between 275 and 365 such cases dealt with every year, and the number of cases was the highest in 2010 in the period of last three years. In 2011 the number of cases fell below 300 again (Table 8.1).

Table 8.1: *Number of drug-related treatment cases in centres for social work, 2009–2011*

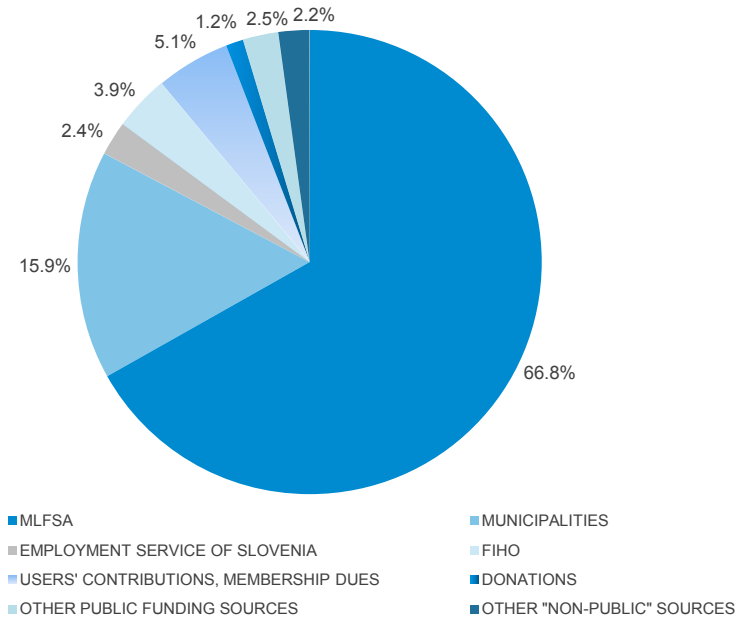
Problem	2009	2010	2011
Illicit drugs	275	365	298

Source: Social database extract, Ministry of Labour, Family and Social Affairs of the RS

In the social security system there are various social care programmes available to users who are in distress and have drug-related problems. The Social Protection Institute of the Republic of Slovenia (IRSSV) collects annual reports on the implementation of programmes every year; based on these reports, the Institute prepares an inventory and conducts an analysis of social care programmes, which were co-funded by the Ministry of Labour, Family and Social Affairs of the RS the year before. Data are collected at the national level, and provide a reliable picture of the situation in the field of social care programme implementation. However, their shortcoming is that they only refer to programmes that are partly funded by the MLFSA, while they do not cover programmes which were unsuccessful in bidding for MLFSA's public tender. We estimate that there are only a small percentage of such programmes in the field of social care.

In 2011 the MLFSA co-funded 36 drug-related social care programmes, which received financial resources totalling EUR 4,490,697.60. A large proportion of the resources, namely more than two thirds, were provided by the MLFSA. Major funders included municipalities (15.91% of resources) and programme users, who provided 5.14% of resources (Figure 8.1).

Figure 8.1: Sources of funding for drug-related social care programmes, 2011



Source: IRSSV, own calculations

According to IRSSV data, more than 6,400 users participated in drug-related social care programmes co-funded by MLFSA in 2011, excluding users of various Internet forums, telephone and Internet-based counselling and wider preventive actions. Most users (more than 4,000) participated in low-threshold programmes. There were 174 beds available for the housing of users in social care programmes in 2011. Most beds were available in high-threshold programmes (Table 8.2).

Among drug-addiction-related social care programmes co-funded by the MLFSA in 2011, there was only one programme entirely dedicated to reintegration, namely the Reintegration Centre, which is operated by the Centre for Social Work in Kranj. There were 12 users housed in the Reintegration Centre, and there were 66 more users involved in sub-programmes (out-patient treatment, reintegration group, medical first aid users, introductory interviews – information required for enrolment). Reintegration was also carried out as part of a programme implemented by the “UP” Association for addicts and their families, which had 14 users, and a programme implemented by the Društvo Projekt Človek (Project Man Association), which had 75 people undergoing reintegration.

Table 8.2: *Users and capacities in drug-related social care programmes, 2011*

Programmes	Number of users	Number of beds
Low-threshold programmes	4,491	28
“Middle” threshold programmes	890 (R:14)	41 (R:14)
High-threshold programmes	1,048 (R:75)	95 (R: 6)
Reintegration programmes	12	10
<b>Total</b>	<b>6,441</b>	<b>174</b>

(R:): Reintegration is carried out as part of some “middle” and high-threshold programmes. Data connected with such programmes is presented in (R:)

Source: Smolej et al. 2012

The fundamental legal basis for the Police to implement repressive action regarding illicit drugs is set out in the Criminal Code of the Republic of Slovenia (Official Gazette RS, Nos. 55/2008, 66/2008 – amended and 39/2009) and in the Production of and Trade in Illicit Drugs Act (Official Gazette RS, Nos. 108/1999, 44/2000, 2/2004 and 47/2004). The Criminal Code specifies two criminal offences involving illicit drugs, i.e. in Article 186 it prohibits and sanctions unlawful manufacture of and trade in illicit drugs, and in article 187 it incriminates rendering opportunity for consumption of narcotic drugs. Article 33 of the Production of and Trade in Illicit Drugs Act sets out a penalty for possessing small quantities of illicit drugs for single personal use.

The Ministry of the Interior RS has been collecting data on criminality with the help of the central computer, into which the data from the national, regional and local police levels are entered. In 2011, the police recorded 1,925 criminal offences (according to the Criminal Code) and 3,691 offences (as defined in the Production of and Trade in Illicit Drugs Act) involving illicit drugs, and investigated 2,229 people on suspicion of criminal offence involving illicit drugs. In 2011, cannabis remains the illicit drug that accounts for the largest proportion of criminal and minor offences.

In 2011, the police treated 128 suspects who upon committing a criminal offence were under the influence of illicit drugs, as well as 210 criminal offences committed with the intention of acquiring money to purchase illicit drugs. The police also ordered 1,162 expert examinations to establish the presence of illicit drugs and other psychoactive substances in drivers, 648 of which tested positive for drugs. Most drivers were driving under the influence of methadone, opiates and benzodiazepines.

The Prison Administration of the Republic of Slovenia is a body of the Ministry of Justice and Public Administration that provides for prison administration and organises and manages prisons and the juvenile correctional facility. In Slovenia, there are six prisons and one juvenile correctional facility. On a specific day, every three months, The Prison Administration of the Republic of Slovenia determines the number of imprisoned persons having problems with illicit drugs as well as the number of those infected with HIV, hepatitis or tuberculosis. In 2011, more than a fifth of all prisoners had problems with illicit drugs, of which 58 % were in substitution therapy. Judicial police officers found illicit drugs in prisons in 81 cases, cannabis accounting for the majority of finds and the largest share of total amount.

In 2011, no specific surveys on drug use and problem drug use in prison were made. The Survey on risky behaviour data were presented in 2010 National Report on Drug Situation.

## 9.1 Drug-related crime

Staša Šavelj

### Criminal and minor offences

In 2011, the Slovenian police recorded 88,722 criminal offences, of which 1,925 were criminal offences involving illicit drugs, amounting to 2.2 % of all criminal offences recorded (Table 9.1). The number of recorded criminal offences involving illicit drugs in 2011 remains largely the same as in 2010, meaning that in Slovenia, the situation has not worsened. Also, the number of people suspected of committing criminal offences involving illicit drugs did not change significantly compared to 2010. There was a slight increase, though, in the number of minor offences as well as the number of offenders according to Production of and Trade in Illicit Drugs Act.

The data shown in Table 9.1 relates to criminal offences as defined in Articles 186 and 187 of the Criminal Code of the Republic of Slovenia<sup>15</sup>, and does not include the so-called secondary crimes (committing another criminal offence in order to acquire money to purchase illicit drugs). As much as two thirds of all recorded criminal offences relate to unlawful manufacture and trade of illicit drugs (Article 186), which most commonly includes purchase of illicit drugs, production, offering for sale or sale of illicit drugs.

Table 9.1: Total number of recorded criminal offences, the number of criminal offences involving illicit drugs, the number of people suspected of committing criminal offences, the number of minor offences involving illicit drugs and the number of offenders according to the Production of and Trade in Illicit Drugs Act, 2009–2011

	2009	2010	2011
Total number of criminal offences	87,463	89,489	88,722
Number of criminal offences involving illicit drugs	2,231	1,969	1,925
Number of suspects due to committing criminal offences involving illicit drugs	2,570	2,240	2,229
Number of minor offences against the Production of and Trade in Illicit Drugs Act	3,338	3,328	3,691
Number of offenders according to the Production of and Trade in Illicit Drugs Act	3,336	3,327	3,690

Source: Frozen database from the electronic computer centre, Ministry of the Interior RS

In the middle of 2011, the police in Slovenia was reorganised, with regional police directorates being merged, therefore a comparison of criminal offences or minor offences involving illicit drugs recorded by individual police directorates with records from previous years is not sensible.

Apart from criminal offences, the police also recorded 3,691 minor offences in 2011 involving illicit drugs as defined in the Production of and Trade in Illicit Drugs Act. Cannabis still accounts for the largest proportions of criminal and minor offences, followed by heroin and cocaine.

<sup>15</sup>Article 186 of the Penal Code of the Republic of Slovenia – “Unlawful Manufacture and Trade of Narcotic Drugs, Illicit Substances in Sport and Precursors to Manufacture Narcotic Drugs” and Article 187 of the Penal Code of the Republic of Slovenia – “Rendering Opportunity for Consumption of Narcotic Drugs or Illicit Substances in Sport”

### Criminal offences committed under the influence of alcohol or illicit drugs

Based on a legal authorisation, the police may as part of pre-trial proceedings order an expert examination of blood and urine of a person suspected of committing a criminal offence. This is to check whether at the time of committing the criminal offence the suspect was under the influence of alcohol and/or illicit drugs. Blood and urine sampling and analysis are carried out by a competent health care institution.

In 2011, the police investigated 463 suspects who, upon committing the criminal offence, were under the influence of alcohol, and 128 suspects who were under the influence of illicit drugs (Table 9.2). This means that the number of suspects who were under the influence of alcohol upon committing the criminal offence decreased, whereas the proportion of suspects who committed the offence under the influence of illicit drugs increased in comparison with 2010.

Table 9.2: *Number of suspects who committed the criminal offence under the influence of alcohol or illicit drugs, 2009–2011*

	2009	2010	2011
Number of CO suspects who committed the act under the influence of alcohol	625	535	463
Number of CO suspects who committed the act under the influence of illicit drugs	137	94	128
Total No of suspects under the influence of alcohol or illicit drugs	762	629	537

CO: criminal offence

Source: Frozen database from the electronic computer centre, Ministry of the Interior RS

Table 9.3: *Number of suspects who committed the criminal offence under the influence of illicit drugs, by types of criminal offences specified in the Criminal Code, 2009–2011*

Criminal offence as defined in CC	2009	2010	2011
Larceny, Art 204 CC	7	18	19
Grand larceny, Art 205 CC	11	10	21
Unlawful Manufacture and Trade of Narcotic Drugs, Illicit Substances in Sport and Precursors to Manufacture Narcotic Drugs, Art 186 CC	36	11	11
Rendering Opportunity for Consumption of Narcotic Drugs or Illicit Substances in Sport, Art 187 CC	5		7
Violent Conduct, Art 296 CC	3	10	8
Robbery, Art 206	1	2	2
Obstructing the Performance of Official Acts or Revenge upon an Official, Art 299 CC	7	2	4
Actual Bodily Harm, Art 122	6	3	11
Manslaughter, Art 115	2	3	2
Damaging Another's Object, Art 220 CC	1	5	4
Family Violence, Art 191	-	-	9

CC: Criminal Code

Source: Frozen database from the electronic computer centre, Ministry of the Interior RS

## Secondary crime

Compared to 2010, the proportion of secondary criminal offences investigated by the police decreased by 33.5% in 2011, thus there were 210 such cases (316 such criminal offences were investigated in 2010) committed for the purpose of acquiring money to purchase illicit drugs. The majority of criminal offences committed in order to get money to purchase illicit drugs are delicts against property (larceny, grand larceny, robbery, misappropriation, fraud) as well as criminal offences of extortion and blackmail, and of threatening the security of another person.

## Driving under the influence of illicit drugs, psychoactive medications or other psychoactive substances

Compared to 2010 (1,501 examinations), the police ordered a substantially lower number of expert examinations in 2011, i.e. 1,162, to establish the presence of illicit drugs, psychoactive medicinal products or other psychoactive substances in drivers. The proportion of expert examinations to establish the presence of illicit substances thus decreased by 22.6 % in comparison with the previous year, and the proportion of drivers tested positive for the mentioned substances decreased by 25.5 %. Among the expert examinations ordered, blood/saliva or urine analysis results indicated the presence of illicit substances in 648 cases (Table 9.4). The Slovenian police have been recording a decrease in the presence of psychoactive substances among road users ever since 2010. Increased awareness of drivers and partly also higher fines could be listed as possible reasons.

Table 9.4: *Number of ordered expert examinations to establish the presence of illicit drugs and other psychoactive substances, and the number of positive results of blood/saliva or urine analysis, 2010–2011*

	2010	2011
Ordered examinations	1,501	1,162
Positive tests	870	648

Source: Frozen database from the electronic computer centre, Ministry of the Interior RS

Positive blood and urine tests carried out during expert examinations ordered in 2011 showed that most drivers were under the influence of methadone, which was followed by driving under the influence of opiates and benzodiazepines (Table 9.5).

Table 9.5: *Illicit drugs, psychoactive medications or other psychoactive substances found in positive analysed samples, 2010–2011*

	2010	2011
<b>Amphetamines</b>	48	50
<b>Benzodiazepines</b>	173	103
<b>Cannabinoids</b>	115	72
<b>Cocaine</b>	210	88
<b>Methadone</b>	239	142
<b>Opiates</b>	309	134
<b>Antidepressants</b>	2	0
<b>Antipsychotics</b>	1	0
<b>Hypnotics/sedatives</b>	1	3
<b>Opioids</b>	18	10
<b>Other</b>	614	409

Source: Frozen database from the electronic computer centre, Ministry of the Interior RS

On 1st July 2011, the Act of Rules in Road Transport entered into force (Official Gazette RS, Nos. 109/2010, 57/2012), which sets out the manner of determining the driving capacity or impairment among individuals driving under the influence of illicit drugs, psychoactive medications or other psychoactive substances. Previous legislation only required a confirmation of the presence of such a substance in the body, but it did not require an assessment of whether the substance had a direct impact on the driver's ability to drive safely.

Under the new legislation, a driver is considered to be under the influence of an illicit drug, psychoactive medicinal product or other psychoactive substance when the presence of such substances in his or her blood and/or saliva or urine is detected using special means, devices or an expert examination. Based on a higher standard of proof and the influence on driving capacity being proven beyond any doubt, the foreseen fine for offenders is EUR 1,200 and 18 penalty points. The driver will be temporarily banned from driving and have the driving licence suspended (for 24 hours). If impaired driving is not proven, yet the presence of such substances in urine is detected, the driver will be referred to a control medical examination. Fines or other sanctions are not foreseen for such offenders. The driver will be temporarily banned from driving and have the driving licence suspended (for 24 hours).



## 9.2 Prevention of drug-related crime

*Staša Šavelj*

Preventive action by the police against crimes involving illicit drugs is mostly aimed at raising awareness among target groups of adverse effects of using illicit drugs, and of self-defence conduct. To this end, the police have been cooperating with non-governmental organisations, municipal panels, educational institutions and all other players working towards a decline in the issue of illicit drugs at the national, regional and local level. Preventive action is being implemented as targeted lectures, providing advice to public authorities and developing various preventive materials, such as brochures.

## 9.3 Interventions in the criminal justice system

### Alternatives to prison

*Eva Salecl*

The Enforcement of Criminal Sanctions Act (Official Gazette RS, No. 22/2000) allows for some milder forms of serving a sentence, i.e. serving a prison sentence at weekends, house arrest and alternative sentence by performing community work. In 2011, 60 convicts served weekend prison sentences. All of them were permanently employed, and thus they didn't have to terminate their employment relationships. Two convicts were placed under house arrest by the competent court in 2011, and community work was performed by 9 convicts (Table 9.6)<sup>16</sup>.

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Table 9.6: Number of convicts serving alternative sentences, 2009–2011

Year	2009	2010	2011
Weekend prison sentence	25	63	60
House arrest	3	2	2
Community work	26	12	9

Source: Prison Administration of the Republic of Slovenia, Annual report 2011

Following an amendment to the Minor Offences Act (Official Gazette RS, No. 9-318/2011), a person serving imprisonment for unpaid fines is no longer entitled to propose that the fine be substituted with community work. The increase in the number of people imprisoned for unpaid fines in 2011 is supposedly due to the amendment of the act mentioned. To compare: In 2011, there were 1,816 people imprisoned in Slovenia for unpaid fines, thus the number of such sentences increased by 40.4 % in comparison with 2010, when 1,293 people were imprisoned for unpaid fines.

According to the Enforcement of Criminal Sanctions Act (Official Gazette RS, No. 22/2000), imprisonment for unpaid fines may be suspended or delayed due to medical reasons. In

<sup>16</sup> The data refers to all convicts (with and without addiction problems)

practice, the following procedure has been adopted in the execution of fine enforcement by imprisonment for people having problems with illicit drug addiction: if an institution finds out that a person is not able to serve imprisonment for unpaid fines for medical reasons, and has no funds to settle the fine, the institution submits a termination proposal. Proposals based on health conditions are mostly granted. This particularly relates to people having issues with addiction (alcohol, drugs...). During the procedure, the person is examined by an outpatient doctor from the competent health-care centre, who examines whether there are any medical reasons due to which the institution could appeal to the court not to enforce the imprisonment for unpaid fines.

Data on addiction among people imprisoned for unpaid fines is being collected in prisons based on medical reports/opinions, or the person's statements. In 2011, the number of persons imprisoned for unpaid fines who had alcohol addiction related problems was 151, i.e. 8.3 % of all prisoners, and 135 such prisoners had drug-related problems, i.e. 7.4 % of all prisoners.

## 9.4 Drug use in prison

*Eva Salecl*

The Prison Administration of the Republic of Slovenia regularly monitors drug situation in prisons by collecting data for the annual report. On a specific day, each three months, the Prison Administration determines the number of imprisoned persons having problems with illicit drugs as well as the number of those infected with HIV, hepatitis or tuberculosis. Based on daily communication with prisons they also monitor any exceptional events related to this issue.

Prisoners addicted to illicit drugs are treated in compliance with a perfected strategy defining the medical support, the education programme and the motivational process that must be provided to the prisoner with the aim helping him or her establish and maintain abstinence, join psychosocial support programmes and gradually transform his or her lifestyle from passive to active. Prisoners are treated based on the Expert Rules for the Treatment of Prisoners Drug Users and the Rules on Submitting Urine and Implementing Control Tests (Prison Administration of the Republic of Slovenia April 2010).

Upon reception into prison, the prisoner is examined in the prison infirmary. The doctor determines whether the prisoner needs a medication therapy to alleviate withdrawal symptoms, or prescribes substitution therapy. Medical staff is obliged to make people aware of various communicable diseases, to encourage them to take tests and vaccinations against hepatitis B and to refer those infected with hepatitis C to specialist doctors.

Table 9.7: Number of persons having problems with illicit drugs in proportion to the total number of prisoners<sup>17</sup> on a specific day, 2003–2011

Year	2003	2004	2005	2006	2007	2008	2009	2010	2011
Number of all prisoners	4,725	4,344	3,097	3,572	4,311	4,383	4,730	4,592	4,975
Persons having problems with drugs	727	944	868	948	1,090	1,210	1,209	1,215	1,073
Proportion in %	15.38	21.73	28.03	26.5	25.3	27.6	25.6	26.5	21.6

Source: Prison Administration of the Republic of Slovenia, Annual report 2011

In 2011, 1073 prisoners were identified as having problems due to illicit drug use (Table 9.7), including 12 persons whose sentences included mandatory drug addiction treatment.

In comparison with the previous year the number of persons having problems with illicit drugs decreased by 178 persons in 2011, i.e. from 26.5% to 21.6% of all prisoners (Table 9.7). Possible reasons for the decrease could include imposition of alternative sentences on drug users (community service, mandatory drug addiction treatment and alike), possible decrease in the proportion of heroin users in the wider society, and an increase in the number of users of other substances, who are more difficult to identify in prisons.

### Illicit drugs trade in prisons

Prisoners use various ways to bring drugs into prison. A common way is to hide it in the body or clothing (sewn into hems, etc.), throw it over the fence or bring in packages, particularly factory packed foods. It is presumed that prisoners most often hide drugs in their bodies, which makes discovery even more difficult, since no intervention in the human body is allowed. In virtually all cases, the amounts of drugs smuggled into prisons are small.

Due to increased scrutiny upon entry, regular inspections of rooms and people, collaboration with police to gather information, and drug searches with detection dogs, the prisoners are forced to be increasingly inventive in bringing drugs into prison. When suspicion arises, the prison staff collaborates with the police to investigate the events.

#### Example:

Executing their regular tour of inspection, judicial police officers noticed a quite long rod projecting (sticking) out of a prisoner's room through the net covering the window. A prisoner was trying to use the rod, approximately 8 m in length and made of broom handles and wooden window mouldings, its joints bound by copper threads taken from an electric cable, to "catch" a drug package located on the wall surrounding the recreation yard, as an unknown person had tried unsuccessfully to throw it into the prison recreation yard.

<sup>17</sup> Prisoners are classified by category as follows: Convict: a person who has been found by a final judgment to be criminally responsible. Remand prisoner: a person deprived of liberty due to a criminal procedure. Imprisoned for unpaid fines: persons who failed to settle fines before the set deadline, partly or in total, and are forced to pay by serving imprisonment for unpaid fines. Detainee: a person deprived of liberty for legal reasons. Detention may not last longer than 24 hours. Young offender: a person aged under 18 who has been found by a final judgment to be criminally responsible. Youth in detention centre: younger minors (aged 14 to 16) who have been imposed the corrective measure of placement in a detention centre

Photo 9.1: A rod made by prisoner and used for catching a drug package



Photograph published with the permission of The Prison Administration of the Republic of Slovenia

In 2011, there were 81 cases of drug discovery, with all finds amounting to 241 (Table 9.8). As regards the total amount of drugs discovered in 2011, cannabis accounted for the largest amount of illicit drugs discovered by the judicial police (155.85 g), followed by heroin (61.02 g), cocaine (38.38 g) and hashish (2.9 g). The judicial police also discovered 79.4 ml of methadone, 11.05 l of alcohol and 2585.5 tablets (Table 9.9).

Table 9.8: Number of finds of illicit drugs and other psychoactive substances by type, 2011

	No. of heroin finds	No. of cannabis finds	No. of cocaine finds	No. of hashish finds	No. of alcohol finds	No. of methadone finds	No. of tablet finds	No. of drug paraph. finds	Total No. of finds	Total No. of drug finds
<b>Total</b>	<b>19</b>	<b>50</b>	<b>9</b>	<b>3</b>	<b>11</b>	<b>3</b>	<b>138</b>	<b>8</b>	<b>241</b>	<b>81</b>

Note: Total number of finds (events) was 241; in many cases the judicial police found several types of drugs at once

Source: Prison Administration of the Republic of Slovenia, Annual report 2011

Table 9.9: Amount of illicit drugs and other psychoactive substances by type, 2011

	Total amount of heroin /g	Total amount of cannabis /g	Total amount of cocaine /g	Total amount of hashish /g	Total amount of alcohol /l	Total amount of methadone /ml	Total amount of tablets /items
<b>Total</b>	<b>61.02</b>	<b>155.85</b>	<b>38.38</b>	<b>2.9</b>	<b>11.05</b>	<b>79.4</b>	<b>2585.5</b>

Note: The drug discovered is weighed as a gross amount, i.e. together with the package, as is turned over to the police

Source: Prison Administration of the Republic of Slovenia, Annual report 2011

## 9.5 Responses to drug-related health issues in prisons

*Eva Salecl*

### Substitution therapy

Substitution therapy is prescribed by specialist doctors in the outpatient addiction service operating within the institution, under the authority of the regional health centre. In cooperation with centres for the treatment of drug addiction, the Expert Rules for the Treatment of Prisoners Drug Users have been drawn up, comprising a uniform doctrine of substitution treatment in institutions.

Patients take substitute medicine under supervision. In cases when the substitute medicine is methadone, it is given to patients as a solution mixed with fruit juice. Overdoses rarely occur in prisons, and if they do, they are usually due to undercover medication trade among prisoners. Each dose in excess of what is prescribed is considered overdose, yet it does not necessarily lead to any additional treatment proceedings. Such data is normally not recorded.

Of 1,073 prisoners either addicted to illicit drugs or having problems due to drug use, 623 (58%) underwent substitution therapy in 2011 (the number also includes 63 persons imprisoned for unpaid fines and receiving substitution therapy). In comparison to 2010, the number of persons receiving substitution therapy grew by 13.8% (Table 9.10).

Table 9.10: *The number of prisoners receiving substitution therapy (without those imprisoned for unpaid fines), 2005–2011*

Year	2005	2006	2007	2008	2009	2010	2011
Number	382	532	586	542	547	538	560

Source: Prison Administration of the Republic of Slovenia, Annual report 2011

**Tests**

Immunochemical urine tests were performed on prisoners who entered the programme of illicit drug addiction treatment and confirmed in writing their agreement with treatment programme providers with the aim of self-affirmation and abstinence control. Tests were mostly used to establish the presence of opiates, cannabis and benzodiazepines. All the prisoners receiving substitution therapy also underwent urine testing. 3,774 urine tests were carried out in 2011.

Compared to 2010, a lower number of prisoners decided to take a test for HIV and hepatitis (A, B, C). Patients also sought help and advice in AIDS treatment centres.

According to available data on test results, nobody was positive for HIV virus in 2011. Hepatitis B was confirmed in 15 prisoners, and hepatitis C in 55 (Table 9.11)<sup>18</sup>. Also in 2011, activities were implemented in prisons to prevent morbidity from the diseases mentioned.

<sup>18</sup> The data refers to all prisoners (with and without addiction problems)

Table 9.11: *Results of voluntary and confidential hepatitis and HIV tests, 2003–2011*

Year	2003	2004	2005	2006	2007	2008	2009	2010	2011
Number of tested for HIV	134	179	305	242	297	235	202	197	134
Number of tested for hepatitis	183	269	303	322	378	326	271	284	192
HIV	0	0	0	2	1	1	2	1	0
Hepatitis A	3	3	2	1	2	0	0	0	0
Hepatitis B	14	10	7	12	15	7	13	11	15
Hepatitis C	63	90	85	87	97	75	47	60	55
<b>Total</b>	<b>80</b>	<b>103</b>	<b>94</b>	<b>102</b>	<b>115</b>	<b>83</b>	<b>62</b>	<b>72</b>	<b>70</b>

Source: Prison Administration of the Republic of Slovenia, Annual report 2011

### Support programmes

Persons having problems due to illicit drugs may enter low-, higher-, or high-threshold treatment programmes. In 2011, 546 persons having drug-related problems entered such programmes (Table 9.12).

Table 9.12: *Number of prisoners in treatment programmes by category, 2011*

Low-threshold programmes	Higher-threshold programmes	High-threshold programmes
248	181	117

Source: Prison Administration of the Republic of Slovenia, Annual report 2011

Prisoners who successfully abstain from drugs and express a wish for upgraded treatment while serving a prison sentence are allowed to enter such treatment in external healthcare institutions and within programmes of nongovernmental organisations (Centres for the Prevention and Treatment of Drug Addiction, mental hospitals, associations: Društvo Up, Skupnost Srečanje, Karitas – Zavod Pelikan, Zavod Vir, Društvo Projekt Človek, Društvo Stigma, Društvo Križišče, etc.). Treatments begin while prisoners are serving their prison sentence, with meetings organised in prison as well as treatments organised outside the institution. 94 prisoners opted for such treatment in 2011. Upon completion of sentence, 30 prisoners continued treatment in institutions outside prison.

External organisations implement their programmes adjusted to prisoners. The basic methods of work are counselling and informing. They mostly address addiction related problems: support in learning about the phenomenon, definition of problem complexity based on pharmacology, age, sex, social position or role, personal traits, family matters. They provide support in interpretation and assessment of the problem, in planning how to solve it, and in practical execution. Usually, the most needed information includes addresses of support services and entry conditions, facts, dangers and other drug-related data, harm reduction and preventive actions. Apart from providing information and counselling, the programme also includes practical help (support in writing requests, applications, and complaints, escorting and advocacy in various services and institutions, gathering specific

information required for solving problems, making first contacts and arrangements...). Another important part of the programme is the possibility to escort convicts on their specific leaves intended for arranging their lives and solving current problems as well as building the foundations for successful reintegration upon completion of sentence. Counselling talks may last about an hour, up to an hour and a half, and are held at varying frequency, in some institutions once or twice per week, and in some (smaller) institutions once per month.

Cooperation of prisoners addicted to illicit drugs with governmental and non-governmental organisations as well as individual experts can be organised in different ways, sometimes inside the institution, sometimes outside as well. This depends on the performance in the treatment acquired while serving the sentence, the regime of serving the sentence (closed, semi-open, open) and on formal reasons (unsettled criminal procedure, pending penalty, etc.).

### **Reintegration**

In Slovenian prisons, work with prisoners is directed and organised with a view to prevent them from becoming persistent offenders and help them integrate into the society. Upon admission to prison, an individual personal treatment plan is prepared for each individual, giving special attention to treatment that they will receive while they serve their prison sentence (e.g. treatment of drug or alcohol addiction...).

Serving a prison sentence is a process that enables each prisoner to participate in active spending of time. Expert staff of diverse profiles (pedagogues, social workers, psychologists) encourage prisoners to establish their daily rhythm comprising work, education, and active leisure time, and help them re-establish their contacts with close relatives.

They also work towards a change at the personal level, i.e. through individual discussions and group sessions related to the way of thinking and value system, the way of overcoming life problems, attitudes towards oneself and towards others, solving difficult situations, development of self-respect, management of impulsive behaviour as well as setting and reaching life goals while serving a sentence and upon its completion.

Social work centres play an important role in solving individuals' problems outside prisons. Institutions' expert employees make visits, alone or together with prisoners, to social work centres, prisoners' homes, employment services, places of work as well as employers and other institutions. Execution of personal plans and reintegration of individuals in the society could not be possible without the collaboration of prisons' expert departments with external institutions. Prisons mainly collaborate with centres for social work, and the content of such collaboration is clearly defined; in addition, prisons also collaborate with charity and labour organisations. Slovenian post-penal treatment is characterized by its counselling services. In some centres for social work, expert social workers themselves carry out such support activities, and in others such activities are performed by volunteers, mostly students of social sciences.

According to Slovenian legislation, the police has the sole authority to confiscate items that may be used as evidence of the offence charged. In cases when Customs Administration of the Republic of Slovenia discovers illicit drugs, it informs the police accordingly, who then start the seizure or confiscation procedure. In prosecution of criminal groups trafficking in illicit drugs and drug precursors, the Slovenian police thus collaborate with the Slovenian customs administration as well as authorities from other countries. Since 2004, the police have been monitoring and analysing systematically retail and wholesale prices of illicit drugs. The methodology of monitoring has changed due to the fact that the number of regional police directorates was reduced from 11 in 2010 to 8 in 2011. Because of the lower number of police directorates, which now cover wider areas of Slovenia than before, the scope or level of monitoring was reduced. Therefore, in certain cases even the prices submitted by individual police stations are considered. Data on prices is obtained through operative activities both by criminal and uniformed police, and during the implementation of undercover investigative measures based on decrees by competent public prosecutors and investigating judges.

In comparison with the year before, the quantity of illicit drugs seized in Slovenia decreased in 2011. The only exceptions were cannabis and hashish, in the case of which the police noted an evident increase both in smuggling over the Slovenian territory to other EU member countries as well as in the quantity intended for sale in the Slovenian market. It is true that the total number of seizures of illicit drugs remained almost unchanged in comparison with previous years, but there are differences in the number of seizures of individual drugs. There has been a decrease in the number of heroin seizures, whereas in the case of cannabis, the number of seizures continues to rise. The number of seizures of amphetamine, methamphetamine and benzodiazepines grew with regard to 2010, and the number of seizures of cocaine remains stable. In general, Slovenia is considered a transit country and a country with a significant rate of illicit drug use, but it is not a manufacturer of illicit drugs, as police has not yet detected any production of heroine, cocaine or synthetic drugs. The only exception is production of cannabis, which has been on the increase in recent years. In 2010, the Slovenian police recorded 42 spaces adapted for cultivation of cannabis under artificially created conditions, whereas in 2011 it recorded 52 such spaces, and in the first half of 2012 it already recorded 43. Also, the police have been recording an increase in the occurrence of new psychoactive substances in the Slovenian market.

In Slovenia there are active organised criminal groups that mostly engage in the organisation, logistic support and execution of criminal operations aimed at providing the European market with illicit drugs. The groups are small in size, and connected with criminal



groups from other countries. Most of them do not specialise in smuggling a single kind of illicit drug. They act in accordance with the demand and supply on the black market.

Regular annual monitoring of the quality and purity of seized illicit drugs in Slovenia has been carried out by the National Forensic Laboratory (NFL) since 2006.

Average prices of heroin, cocaine, amphetamine, cannabis and hashish rose slightly in 2011 in comparison with the year before, particularly because of greater access to particular illicit drugs of higher purity.

In 2011, average concentrations of illicit drugs, such as cocaine, amphetamine, cannabis and hashish, were similar as in previous years, only the average concentration of heroine was much lower in 2011 compared to previous years.

## 10.1 Availability and seizures of illicit drugs

*Stasa Šavelj*

Slovenian police has been systematically gathering and processing both the data on seized illicit drugs as well as the data on prices of particular illicit drugs. Based on such data, an estimate of availability of individual drugs in the Slovenian market can be made, provided, of course, that the estimate includes the above mentioned data obtained from prosecution authorities.

Slovenia still records a decrease in seized quantities of most illicit drugs. In 2011, the exceptions were cannabis and hashish. In the case of these two, the police recorded a significant increase both in smuggling across the Slovenian territory to other EU member states and in quantities of illicit drugs intended for sale in the Slovenian market. This trend still continues in 2012. Here we should mention the biggest seizure of cannabis in 2011, which was made at Gruškovje border crossing and amounted to 300 kg. Cannabis was hidden in the double bottom of a lorry trailer with Albanian licence plates. The smuggling trail ran along the classic Balkan route from Albania through Montenegro, Bosnia and Herzegovina, Croatia, Slovenia and onwards through EU member states to the end customer in the Netherlands.

The police also monitor the quantities of illicit drugs seized from Slovenian citizens abroad. In the past, most illicit drugs seizures included heroin and cocaine, whereas recently there have been many cases where amphetamines as well as larger amounts of benzodiazepines were seized from Slovenian citizens in EU member states such as Sweden, Germany and Belgium. Based on this data, we can conclude that there is a smuggling path for these illicit drugs leading from the above mentioned countries to Slovenia.

The total number of seizures of illicit drugs in criminal and minor offences remains approximately the same as in previous years. However, the number of seizures of individual illicit drugs has been on the increase or decrease in comparison with the total quantity of

seized illicit drugs. A large decrease in the number of seizures of heroin could be attributed to a decreased supply or demand for it. The growing trend of seizures of cannabis still continues, which is partly due to the increased supply on our market. The number of seizures of amphetamines, methamphetamine and benzodiazepines has grown in comparison with 2010, whereas the demand for and supply of cocaine remains stable.

Based on available data, Slovenia is labelled as a country with a significant rate of illicit drug use, and a transit or intermediate country for smuggling most types of illicit drugs to target markets in EU member countries. Small amounts of individual illicit drugs also stay in Slovenia. There are organised criminal groups in Slovenia that mostly engage in the organisation, logistic support and execution of criminal operations related to supplying the European market with illicit drugs. Most of them are small in size, and their members establish connections with criminal groups from other countries. Members of organised criminal groups are primarily Slovenian citizens, mostly Slovenian by origin, but some came to Slovenia from the countries of Western Balkans (Albania, Kosovo, Serbia, Montenegro, Croatia, Bosnia and Herzegovina, etc.), and some are still citizens of Western Balkan countries, which enables them to have connections with people coming from countries of their origin. Organised criminal groups are mainly not specialised for smuggling a single type of illicit drugs. Rather, they operate in accordance with available opportunities as well as the demand and supply at the black market.

According to the data available, Slovenia cannot be labelled as a producer of illicit drugs. Not a single laboratory for producing synthetic drugs, cocaine or heroin has been found in recent years. What has been detected in the territory of Slovenia, though, is an increase in the activity of criminal groups engaged in the manufacture of hydroponically cultivated cannabis in especially adapted enclosed spaces. In 2009, the police recorded 11 such spaces, and they discovered 42 such spaces in 2010 and 52 in 2011. The growing trend in discovering enclosed spaces for hydroponical cultivation of cannabis continues in 2012, as there were already 43 such spaces discovered and destroyed in the first six months. Some of them were particularly large, expertly furnished and profitable. It is estimated that the reason for such a large number of enclosed spaces for hydroponical cultivation of cannabis could be that, as the necessary investments are quite small, the required materials readily available (cannabis seeds, lamps, heaters, fans, fertilisers, etc.) and electricity can be used in an ingenuous manner, individual criminal groups or individuals can generate disproportionately large profits. Cannabis cultivated in such a manner is harvested 4 times a year. It is estimated that the sale of cannabis thus cultivated is still limited to the Slovenian territory, whereas in the future Slovenia could turn into a country producing hydroponically cultivated cannabis.

An increase in the occurrence of new psychoactive substances has also been recorded on the Slovenian market. Such substances are most often first discovered by customs authorities, particularly during control of shipments. In Slovenia, new psychoactive substances are not regulated appropriately and not included automatically in the list of illicit drugs.

Table 10.1: Total amounts of seized illicit drugs by type of drug, 2009–2011

Problem	Unit	2009	2010	2011
Heroin	Kg	41.787	36.203	4.394
Cocaine	Kg	2.867	2.012	1.697
Ecstasy	Tabs	16,872	399	33.5
	Kg	0.0361	0.003	0.007
Amphetamine	Tabs	778	7,524	150
	Kg	3.214	2.831	0.724
Cannabis plant	Pcs	9,373	9,278	12,836
Cannabis marijuana	Kg	242.025	188.760	613.045
Cannabis resin-hashish	Kg	0.689	0.224	4.240
Benzodiazepines	Tabs	5,116	1,927	5,012
Methadone	ml	5,111.4	3,654.1	926.92
Methamphetamine	kg	0.003	0	0.124
	Tabs	0	0	61

Source: Frozen database from the electronic computer centre, Ministry of the Interior RS

Table 10.2: Number of seizures of individual illicit drugs, divided by minor offences and criminal offences, and as a total amount, 2009–2011

	2009			2010			2011		
	MO	CO	T	MO	CO	T	MO	CO	T
Heroin	487	285	772	441	279	720	285	218	503
Cocaine	158	113	271	145	133	278	167	105	272
Ecstasy	8	8	16	4	5	9	9	5	14
Amphetamine	111	46	157	135	62	197	166	38	204
Cannabis plant	219	83	302	85	93	178	87	91	178
Cannabis marijuana	2.285	460	2.745	2.600	490	3.090	2.790	516	3.306
Cannabis resin-hashish	74	9	83	48	9	57	67	22	89
Benzodiazepines	67	49	116	56	40	96	92	42	134
Methadone	62	23	85	50	14	64	29	11	40
Methamphetamine	1	1	2	0	0	0	8	10	18
			4.549			4.689			4.758

MO: minor offence, CO: criminal offence, T: total amount

Source: Frozen database from the electronic computer centre, Ministry of the Interior RS

## 10.2 Prices of illicit drugs

Staša Šavelj

Slovenian police has been systematically collecting and analysing data on the prices of illicit drugs available on the market. The data collection methodology has changed, as the number of regional police directorates was reduced from 11 in 2010 to 8 in 2011. Because of the lower number of police directorates, which now cover wider areas of Slovenia than before, the level of collection or monitoring was reduced; therefore, in certain cases the prices considered include those submitted by individual police stations in the region. Data on prices are obtained through operative activities both by criminal and uniformed police, and during the implementation of undercover investigative measures based on decrees by competent public prosecutors and investigating judges.

The table 10.3 shows prices of illicit drugs most commonly sold on the black market in Slovenia. The lowest and the highest values are shown, as well as the average price; the price usually depends on the purity of an illicit drug and its supply on the market.

In comparison with 2010, average prices of heroin, cocaine, amphetamine, cannabis and hashish increased slightly, particularly due to the greater access to individual drugs of higher purity.

Table 10.3: *Prices of illicit drugs in Slovenia, in EUR, 2011*

Type of illicit drug		1 gram	1 kg	1 tab	1000 tabs
Heroin	Min.	20			
	Max.	70			
	typical	50			
Cocaine	Min.	30			
	Max.	120			
	typical	80			
Ecstasy	Min.			3	
	Max.			10	
	typical			6	
Amphetamine	Min.	10			
	Max.	40			
	typical	30			
Cannabis marijuana	Min.	3	1.000		
	Max.	15	3.500		
	typical	10	2.500		
Cannabis resin-hashish	Min.	7	2.500		
	Max.	30	5.000		
	typical	15	3.500		

Source: Ministry of the Interior RS, General Police Directorate

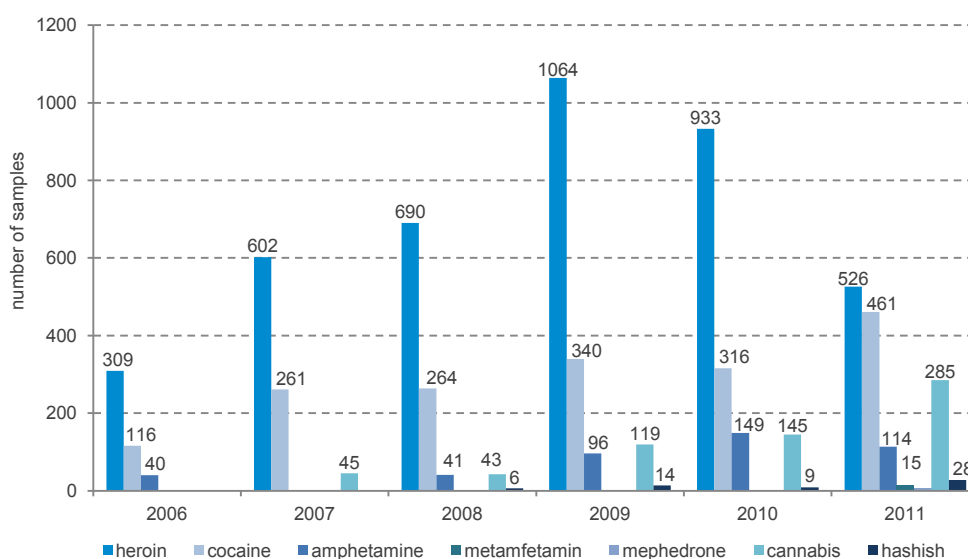
### 10.3 Quality and purity of illicit drugs

Mojca Janežič, Katja Benčina, Tomaž Gostič, Andreja Vidic, Sonja Klemenc

Regular annual monitoring of the quality and purity of seized illicit drugs in Slovenia has been carried out by the National Forensic Laboratory (NFL) since 2006. To this end, samples are collected throughout the year according to pre-set criteria. Qualitative and quantitative chemical tests are done using various analytical methods (GC-MS, HPLC). Results concerning illegal substance concentrations in samples are always presented in terms of base forms. They are reported to domestic (National Institute of Public Health) and international institutions (UNODC and EMCDDA).

The number of analysed samples of heroin, cocaine, amphetamine, cannabis and hashish (in years 2006–2011) by the type of illicit drug is shown in Figure 10.1. The presented data have been taken from the 2010 National Report on the Drugs Situation in Slovenia, and complemented with 2011 data. The lower number of samples taken in 2011 is due to changed criteria of selecting samples for quantitative analysis.

Figure 10.1: Number of samples of illicit drugs for quantitative analysis, 2006–2011

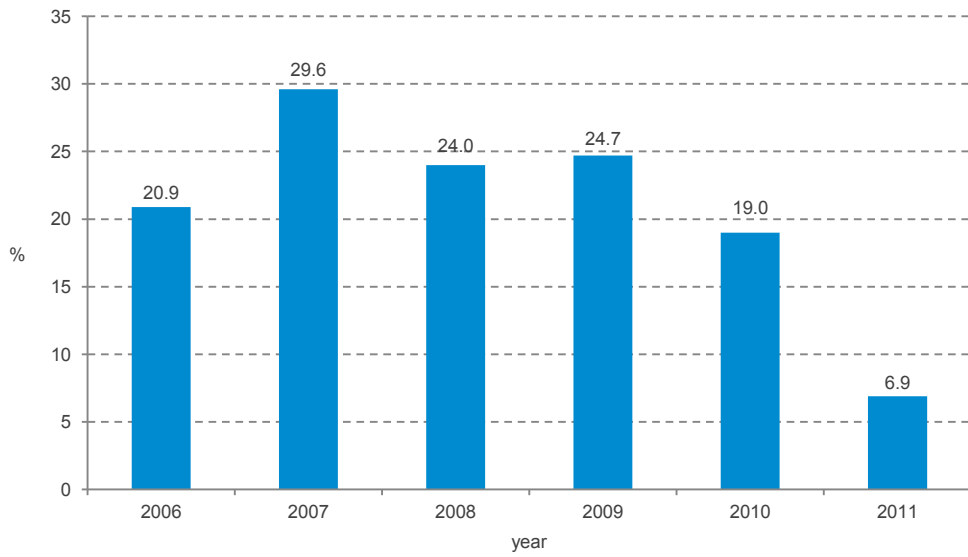


Source: NFL

#### Heroin

In 2011 the average recorded heroin concentration in the samples of seized drugs was 6.9%, which is considerably lower than in previous years (Figure 10.2). Lower average concentrations are most likely due to the lack of heroin on the black market because of a poor harvest (UNODC 2011). All heroin samples were in base form, and they contained the usual additives paracetamol and caffeine (Klemenc 2003). The highest recorded value for heroin in 2011 was 47.8% (Table 10.5).

Figure 10.2: Average concentrations of heroin base in samples seized in years 2006–2011

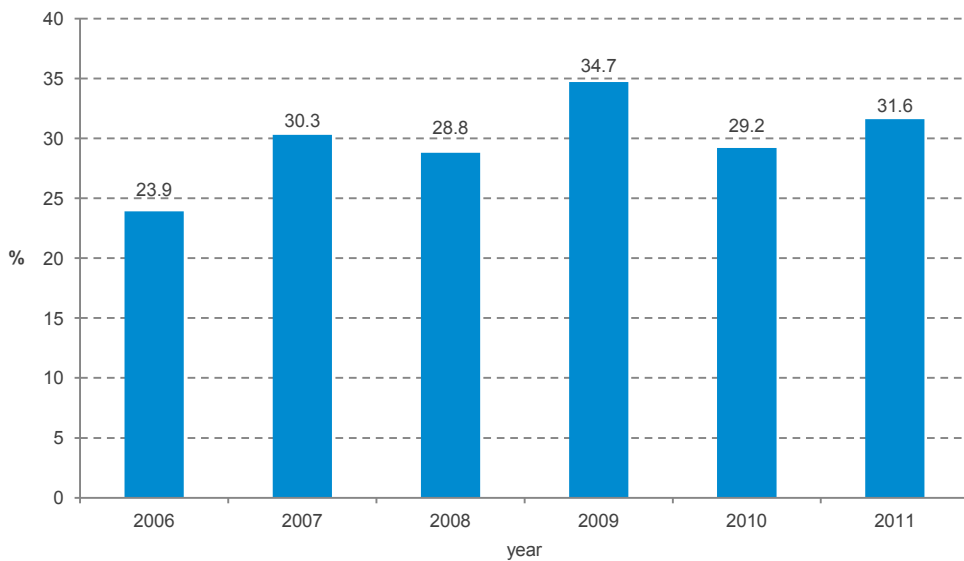


Source: NFL

### Cocaine

The average recorded cocaine concentration in the samples seized in 2011 was 31.6%, and is thus similar to cocaine concentrations in the samples seized in the period 2007–2010 (Figure 10.3). The most common additives in cocaine were levamisole and lidocaine. The highest recorded cocaine concentration in samples seized in 2011 was 86.8%. This practically equals almost pure cocaine hydrochloride, which is the typical form of cocaine in illegal samples.

Figure 10.3: Average concentrations of cocaine base in samples seized in years 2006–2011



Source: NFL

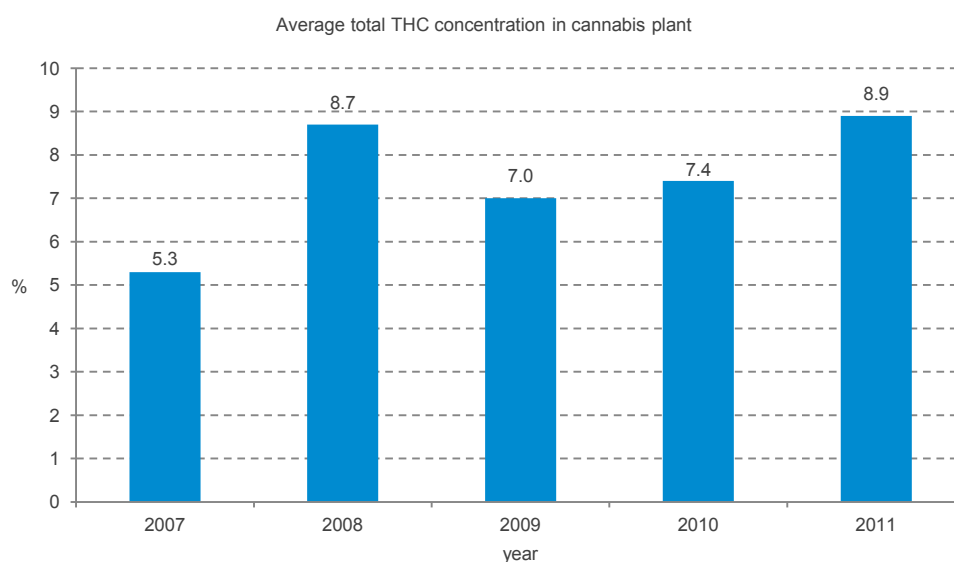
## Cannabis

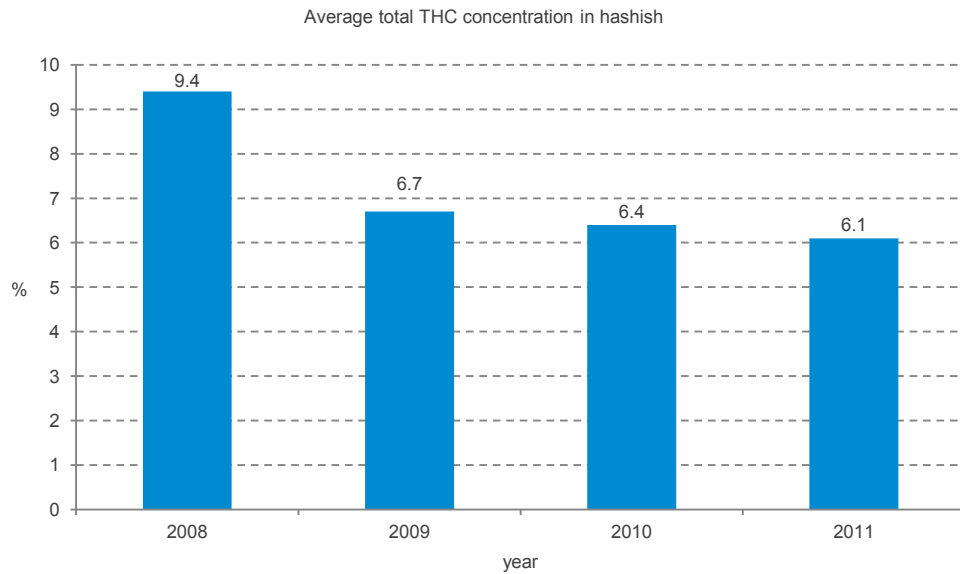
The most common type of cannabis vegetable matter seized is marijuana, which consists of plant tips and leaves. Hashish, compressed resin of cannabis female flowers, is not particularly common in Slovenia, and is smuggled from elsewhere, whereas the majority of marijuana samples come from illegal indoor and outdoor cultivation places in Slovenia. The cultivation of hemp is permitted in Slovenia under conditions set out in the Rules on the Conditions for Cultivation of Hemp and Poppy (Official Gazette RS, No. 40/2011). One of the conditions for hemp cultivation is that THC concentration in dried plants stays below 0.2%.

THC is also present in these plants in the form of THC acid (THCA), which has weak psychophysical effects and, when exposed to higher temperatures (e.g. when smoked, baked, etc.), decomposes into THC (Grotenhermen 2003). Using the HPLC method, the NFL measured concentrations of THC and THCA in samples of marijuana and hashish, and the sum of concentration values represents the total THC content.

Total THC concentrations in marijuana in the samples seized in 2011 ranged between 0.3% and 22.6%, and averaged at 8.8% (Figure 10.4). The differences in the total content of THC are due to different genetic heritage of the cannabis plant and different growth conditions, and can differ even within the same plant (the level of THC is higher in tips of female plants). Figure 10.5 shows the composition of total THC in samples of cannabis plant and hashish seized in 2011. A large part of total THC (almost 90%) in marijuana is present in the form of THCA.

Figure 10.4: Average concentrations of total THC in samples of cannabis (marijuana and hashish) seized in years 2007–2011

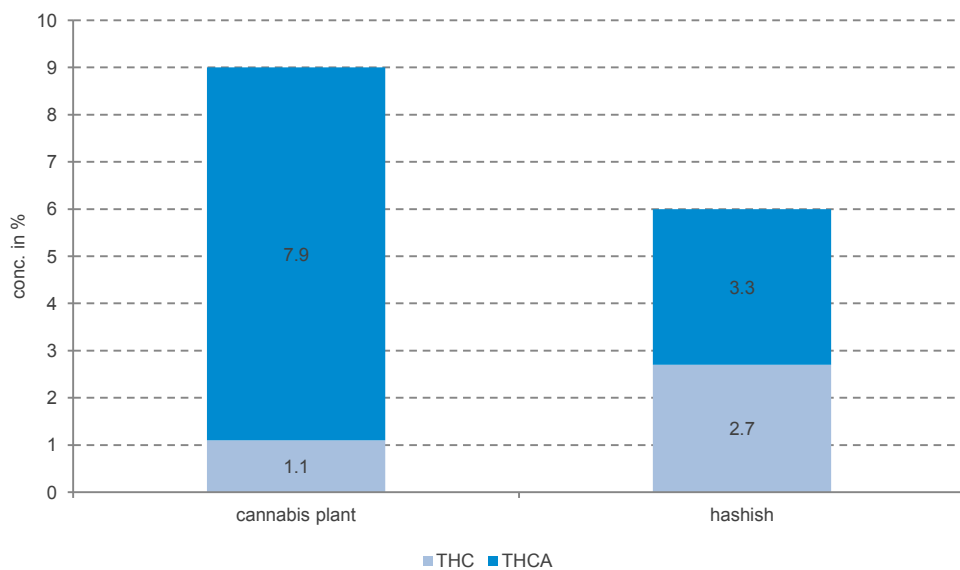




Source: NFL

Recorded total THC concentrations in samples of hashish seized in 2011 ranged between 1.2 and 16.1%, and averaged at 6.4% (Figure 10.4). The proportion of THCA in total THC was around 55%, which is lower than in marijuana.

Figure 10.5: Composition of total THC in cannabis plant and in hashish in samples seized in 2011



Source: NFL

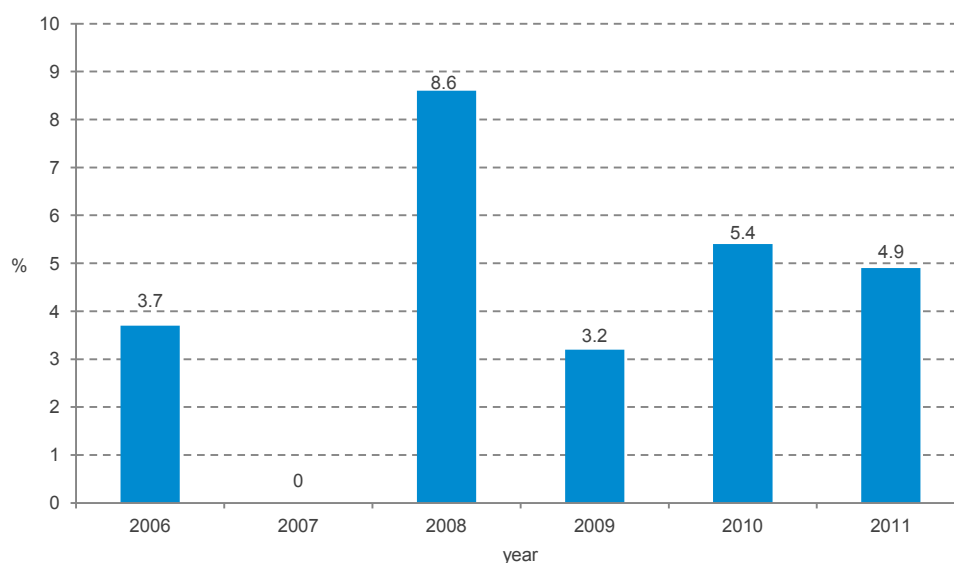
### Amphetamine-type stimulants and “legal highs”

Recorded average amphetamine concentration in samples seized in 2011 was 4.9%, which is similar to average amphetamine concentration from previous years (Figure 10.6). A common additive found in all samples was caffeine; another common cutting agent was creatine, as 75% of the samples were diluted with it. Low concentrations of mephedrone were found in 3% of the samples as well. Compositions of amphetamine samples, i.e. the



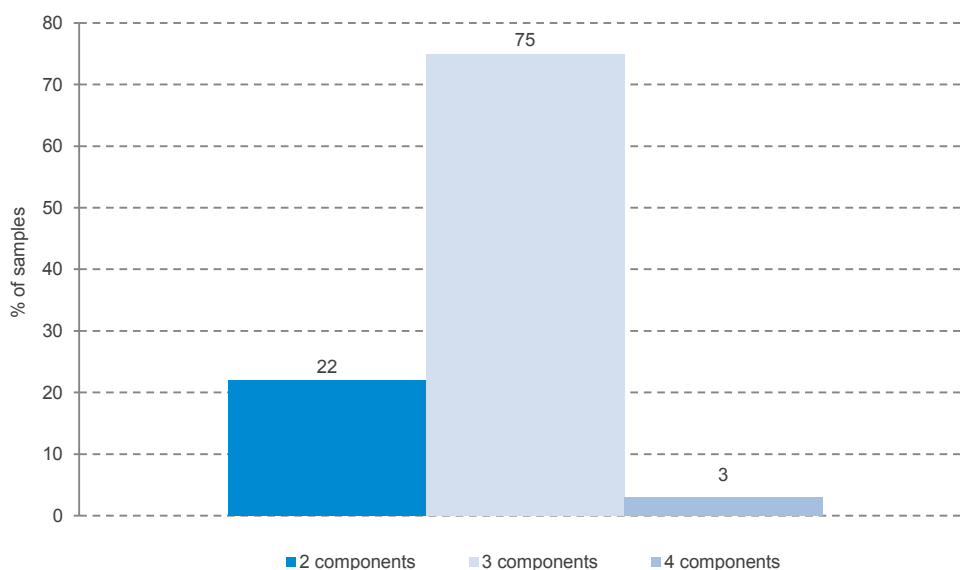
amounts of active components and additives (excluding sugars) present in these samples, are shown in Figure 10.7.

Figure 10.6: Average amphetamine base concentrations in samples seized in years 2006–2011



Source: NFL

Figure 10.7: Composition of amphetamine samples by the number of components (excluding sugars)



Source: NFL

In comparison with previous years, the number of methamphetamine seizures increased in 2011. The concentration of methamphetamine in 15 analysed samples ranged between 1.3 and 21.4%, and averaged at 10.1%. Active additives were not found in methamphetamine samples.

In 2011, 11 different types of ecstasy tablets were seized in Slovenia (with different logotypes and other physical features), of which 7 types contained MDMA as the only active

component, three types contained chlorophenylpiperazine, and one type contained 2C-B (Figure 10.8). Concentrations of these components in tablets seized in 2011 were not determined by NFL.

In 2011, the customs authorities and the police seized many new legal psychoactive drugs also called “legal highs”. Data on the type and weight of seized drugs and the number of seizures are shown in Table 10.4.

Table 10.4: Type, form, number of seizures and total weight of “legal highs”, 2011

Substance	Form	No. of seizures	Total seized weight in g
4-methylmethcathinone (mephedrone, 4-MMC)*	white crystals	4	2477.41
4-methylethylcathinone (4-MEC)	white crystals	2	1.27
Fluoroamphetamine	white powder	2	3.54
TFMPP	white powder	1	20.48
Mitragynine (kratom)	brown solid substance	1	1.06
Methylone	white powder	3	101.18
4-MEC + methylenedioxypropylvalerone (MDPV)	white powder	1	1.01
JWH-122	brown powder	3	8.98
Chlorophenylpiperazine	tablets	4	25.60

\*Mephedrone was classified as illegal drug in Slovenia in August 2011. (Decree Amending the Decree on the Scheduling of Illicit Drugs. Official Gazette RS, No. 58/2011)

Source: the Police

Among the drugs from the “legal highs” group, the NFZ determined concentrations of active components in 7 samples of mephedrone (from 4 cases). The recorded mephedrone concentrations ranged between 0.1 and 33.0%, and averaged at 16.4%.

Photo 10.1: Illegal tablets seized in 2011 and containing “legal highs”



Note: The top left and right tablets and the bottom left tablets contain chlorophenylpiperazine, and bottom right tablets (mushroom logo) contain 2C-B

Source: NFL

Data on the purity of various illicit drugs at the level of street dealing for years 2010 and 2011 are shown in Table 10.5.

Table 10.5: Purity of various illegal drugs at the level of street dealing, 2010 and 2011

		Cannabis		Hashish		Heroin		Cocaine		Amphetamine		Ecstasy	
		2011	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011	2010
Purity in %	Min	0.3	0.1	1.2	1.0	1.0	10	3.7	4.1	0.2	0.3	-	-
	Max	22.6	23.6	16.1	11.6	47.8	30	86.8	86.5	21.4	22.3	-	-
	Average	8.8	7.4	6.4	6.4	6.9	17	31.6	29.2	4.9	5	-	-

Source: NFL

**PART B:**

**SELECTED ISSUES**

### 11.1 Introduction

Experience in the field of residential treatment (therapeutic communities) was introduced in Slovenia in the 1960s by doctors who underwent training in Great Britain and brought new experience to Slovenia. During the epidemic of heroin use at the beginning of the 1990s there was a significant increase in the demand for addiction treatment programmes and therapeutic communities; however, therapeutic communities in Slovenia were not developed enough to satisfy all needs. Therefore, experts turned to Italian colleagues for help and later brought different forms of therapeutic communities from Italy to Slovenia. As the epidemic of illicit drug use spread, the number of therapeutic communities grew. Today, these communities represent an important part of the comprehensive approach to treating and preventing addiction in Slovenia. By adopting current rules in this field, which are in line with the norms of the European Union, Slovenia has set up the legal framework governing the operation of therapeutic communities. The network of therapeutic communities is funded by the Ministry of Labour, Family and Social Affairs (MLFSA), which also controls the implementation of programmes in therapeutic communities that are co-funded by the Ministry. Therapeutic communities are part of Slovenia's comprehensive approach to the treatment and prevention of addiction, and are defined in the Resolution on the 2004 - 2009 National Programme in the Field of Drugs as well as in the current legislation.

### 11.2 Therapeutic communities in Slovenia: History and policy frameworks

The first knowledge of therapeutic communities was brought to Slovenia by doctors who underwent training in London. They brought such knowledge to the University Psychiatric Clinic Ljubljana Polje already in the 1960s. In 1969 the mentioned clinic started systematically introducing the therapeutic community method and using it in all hospital departments (Paš 1982). When talking about therapeutic communities in Slovenia, we cannot overlook dr. Janez Rugelj's alternative therapeutic community. It was a dynamic community which had no actual treatment facility where people could stay 24 hours a day. This alternative therapeutic group had about 120 members who could join and leave the programme freely. The programme was based on a social-andragogical method developed by dr. Janez Rugelj on the basis of literary sources and Rugelj's own professional knowledge and findings. People who entered the community were in distress due to alcoholism, drug addiction, obesity, gambling addiction, etc. (Bagon 2000). The first club or programme for the treatment of drug addiction was established by prof. dr. Kopal and prof. dr. Milčinski in 1974

in Ljubljana and named Vsemirje (Universe). At the beginning of 1990s, an epidemic of heroin use broke out in Slovenia. The then existing network of mostly psychiatrically oriented institutions could not offer drug users enough suitable assistance programmes. In addition to the network of Centres for Prevention and Treatment of Drug Addiction (CPTDA), which began to develop in 1991, the non-governmental sector started introducing initiatives for establishing therapeutic communities, especially according to Italian therapeutic community models. In 1991 the Social Forum for Addictions and Intoxications (Socialni forum za zasvojenosti in omane), comprising of a large number of experts in the field of addictology, contacted the Italian Ce.I.S centre (Centro Italiano di Solidarieta), which was then implementing its Progetto Uomo (Project Human) in more than 42 countries. The Forum's experts decided to transfer Ce.I.S's practice in the field of addiction treatment to Slovenia and adjust it to the situation in Slovenia. Thus, they launched the Slovenian Projekt Človek (Project Human) programme, which gradually evolved into a comprehensive programme which now encompasses, in its basic form, a reception centre, a therapeutic community and a rehabilitation programme designed to help those who have completed the therapeutic community programme return to their everyday life.

In addition to these basic programmes, Projekt Človek also includes programmes for parents and other programmes such as:

- the Infotel programme, which provides information to drug users over the phone;
- the Alfa programme, which provides assistance to drug users undergoing substitution treatment;
- a day centre for drug users, which operates in accordance with therapeutic community methods and allows drug users to participate for up to 3 years;
- a programme for children and adolescents who experiment with drugs;
- a programme of individual and partner therapies for people abstinent from drugs;
- a therapeutic community for addicted parents and their children. Addicted parents and their children join the therapeutic community and live there for at least two years, 24 hours a day (Social Forum for Addictions and Intoxications 1995).

Another such programme also started in 1991 under the auspices of Caritas Slovenia, which was in contact with the Comunita Incontro programme from Italy. Even though this programme did not have any therapeutic communities in Slovenia, it started admitting drug addicts to therapeutic communities in Italy and other countries through a preparatory centre in Italy. The first drug users to be sent from Slovenia to Italy were those who entered the Srečanje (Meeting) programme (Caritas Slovenia 1995).

Photo 11.1: *The old school which was transformed into a therapeutic community facility by the members of the Srečanje therapeutic community at Čadrg in the Tolmin region*



Photo: Neva Volarič

The community was and still is primarily self-help oriented. Later Caritas Slovenia developed the Pelikan programme as a unit for the preparation of drug users for entry into therapeutic community programmes in Slovenia and Italy. It also established therapeutic groups in Slovenia. Today they also offer the following programmes for drug users:

- an S.O.S. phone line which provides callers with information on addictions, drugs and programmes;
- informative conversations;
- a programme for juvenile drug users;
- a preparatory centre;
- a support group for parents of drug addicts;
- a reintegration programme;
- prevention activities in local communities (source: Pelikan Karitas website).

Caritas's programmes also include a therapeutic community for addicts with associated mental health problems (Social Protection Institute 2012).

Photo 11.2: *Reception centre of the Srečanje therapeutic community in Bertoki near Koper*



Photo: Milan Krek

Association for Help to Addicts and Their Families (Društvo za pomoč zasvojenecem in njihovim svojcem Slovenije) was established in 1993. It is a non-governmental non-profit and non-partisan charitable organization. Initially, it was connected with the DIANOVA therapeutic community; if drug users decided to enter treatment in a therapeutic community the Association prepared them and arranged for them to join one of the therapeutic groups in the DIANOVA network. Later the Association started cooperating with the Gruppa Valdinievole from Italy; today it mostly cooperates with the latter and also with DIANOVA. The Association monitors the progress of an individual who is in treatment abroad. After a year and a half abroad, the individual is admitted to a rehabilitation programme in Slovenia. This rehabilitation programme is based on the principle of residential communities and also admits people who have completed a detoxification programme or any programme in some other therapeutic community (Caritas Slovenia 1995).

The mentioned reintegration programme includes the following programmes or activities:

- abstinence from all drugs and alcohol;
- taking care of the house and later of own apartment or house;
- organized therapeutic groups where participants solve their problems;
- learning how to clearly express one's thoughts, feelings and needs;
- thematic discussions;
- learning how to be more creative;
- spending time with volunteers;
- recreation and sports;
- learning computing skills;
- trying out new ways of spending free time; hiking, spending time in camps, going to concerts, cinemas, theatres, etc.;
- obtaining or completing education;
- preparing for employment and searching for jobs;
- learning how to communicate well with relatives, since programme users usually spend weekends at home with their families;
- learning how to live without drugs (source: the UP Association website).

Today, this programme provides programme users with a number of support programmes for various target groups. Support programmes include a school for relatives, a therapy group for relatives, a support group for juveniles who have achieved abstinence, prevention workshops for high-school students, counselling in prisons, and court advocacy.

The mentioned three early initiatives in the field of therapeutic communities were followed by others. The TAV therapeutic community at Stari trg on the Kolpa River is a self-help community based on four foundations: fellowship, order or tidiness, work and prayer. Its parent therapeutic community is based in Međugorje in Bosnia and Herzegovina. In 2004, the CENACOLO therapeutic group was established at Škocjan in the Dolenjska region. Drug users usually spend 3 – 5 years in this therapeutic group. It is a self-help community and is completely self-sufficient. Its parent therapeutic community is also based in Međugorje



(source: Terapevtska skupnost Cenacolo, Šentjošt website). The SVIT Koper non-governmental organization is professionally connected with the Lautari therapeutic community, which is based in Italy. SVIT has taken over the preparation of drug users and their referral to the Lautari therapeutic community. It also monitors programme users in the community and organizes a support group for the parents of drug users treated in the Lautari community (source: SVIT Koper website). The non-governmental organization Drevo življenja (the Tree of Life) also established a therapeutic community in 2003. During the period of preparation for entry into the therapeutic community the organization also carried out detoxification using medications. A doctor was regularly present in this therapeutic community who monitored and examined drug addicts and prescribed appropriate medications (Office on Drugs 2004). The therapeutic community Žarek (Ray) in Jesenice, which was established by the Žarek non-governmental organization, opened its doors in 2006. Its programme lasts for two years, and its users are encouraged to become more responsible through following daily schedules and through work therapy, mutual acceptance, group and individual conversations, therapeutic monitoring, recreation in nature and by gradually assuming more responsibility (source: Žarek Association website).

### **Strategy and policy frameworks for residential treatment**

The legal basis for the operation of therapeutic communities in Slovenia was provided by the Act Regulating the Prevention of the Use of Illicit Drugs and the Treatment of Drug Users (Official Gazette RS, No. 98/1999). This Act specifies that social-security services aimed at preventing and eliminating social distress and problems associated with illicit drug use and performed in the framework of the public service include in particular: social prevention, social first aid, personal assistance, and support for families. These services or tasks are mostly carried out by centres for social work; there are 62 centres for social work in Slovenia. Services are carried out in accordance with the Social Security Act (Official Gazette RS, No. 36/2004) and with norms and standards laid down by the minister responsible for social affairs. The Act also stipulates that programmes for solving drug-related social problems which are implemented outside the public service should be professionally defined sets of professional social-security practices or services intended for individuals, families and population groups to help them eliminate social distress and problems associated with illicit drug use. The Act provides that organized forms of mutual help groups consisting of illicit drug users, their relatives or other interested persons can also be considered as drug-related social-problem-solving programmes implemented outside the public service. Thus, the Act also defines therapeutic communities and rehabilitation programmes. However, in another article referring to non-governmental organizations, the Act defines therapeutic communities and rehabilitation programmes even more precisely by providing that the activities of non-governmental organizations may include programmes for achieving or maintaining abstinence, social rehabilitation and reintegration programmes and other types of treatment and help for illicit drug users and their relatives. NGOs can perform these tasks within residential communities or as non-residential programmes or other forms of work in accordance with the national programme. As specified in the Act, residential groups also include therapeutic communities that implement professional therapeutic and rehabilitation

programmes, communes offering programmes based mainly on mutual help, and asylums offering programmes based mainly on cohabitation and group work. According to the Act, non-residential programmes include day centres offering organized assistance programmes in which drug users and their loved ones participate while continuing with their everyday lives, and centres which implement programmes designed to reduce the harmful effects of illicit drug use. In addition, the Social Security Act (Official Gazette RS, No. 36/2004) further provides for the establishment of programmes for people in need outside the public service. The Resolution on the 2004 - 2009 National Programme on Drugs Control (Official Gazette RS, No. 28/2004) ensured the establishment and support of therapeutic communities in Slovenia in accordance with a comprehensive and balanced approach in the field of drugs. The Resolution classifies therapeutic communities among social programmes that are MLFSA's responsibility. One of the objectives set by the MLFSA in the field of social security is to develop new approaches to addressing social distress of drug users. NGOs have played an important role in this respect, as they continue to develop new programmes tailored to users' needs. Providers of these programmes should mainly include NGOs which, due to their position in the civil society, can more easily identify specific needs of individuals and population groups. In its relationship with NGOs, MLFSA acts as a facilitator of their development, arranges legal options for their operation and defines the role of the non-governmental sector in performing social security services, provides and redistributes financial resources allocated for NGOs' operation, issues tenders for co-funding of programmes, grants work authorizations and ensures high-quality performance of activities. The Ministry has been supporting NGOs by co-funding programmes in the field of social security since 1993 (source: MLFSA website). In the field of social security in Slovenia, the task of spreading various types of professional assistance has been continuously transferred to NGOs for more than a decade. NGOs often start initiatives to provide various services, and the government usually provides the necessary funds if it determines that such services are in public interest. As some programmes and their providers have proved themselves in the past years by working in a professional manner and achieving good results, the Ministry introduced multi-annual co-funding of programmes in 1998. It continued to award multi-annual contracts in the following years. Through a public tender, the Ministry has extended the co-funding period by five years for those programmes whose five-year co-funding period expired, if these programmes still met the requirements (source: MLFSA website). The Ministry provides programmes with funds amounting up to 80% of the cost of their project; programme providers must ensure that the remaining funds are provided by local communities, through donations, participants' contributions and from other sources. Evaluation of programmes is becoming a regular task for more and more providers. MLFSA requires programme providers to draw up partial and final reports on the implementation of programmes. If a contract administrator finds that a programme is not being implemented in accordance with the contract, he or she may suggest professional or financial supervision of implementation, and, based on the findings, request that the contract be terminated and the resources returned. Furthermore, if programme providers do not spend all allocated resources and fail to request in time for the remaining part to be transferred to the following year, unused financial resources will be withdrawn (source: MLFSA website). The funding of

social assistance networks is of highest priority. These networks include the network of therapeutic communities and other programmes that provide drug users with housing, as well as their associated networks of reception and day centres, centres for the reintegration of abstinent people into society, and programmes for parallel therapeutic assistance for drug users' relatives (source: MLFSA website). The Resolution on the National Social Assistance Programme 2006 – 2010 (Official Gazette RS, No. 39/2006) defines the network of therapeutic communities and other residential programmes, which has a total capacity of 280 places or beds, and includes in the definition the associated networks of reception and day centres (which ensure motivation and preparation of drug users before joining therapeutic communities), centres for the reintegration of abstinent people into the society, programmes for parallel therapeutic assistance for drug users' relatives, programmes for drug users as alternatives to therapeutic communities, and a network of reception centres and shelters for homeless drug users, which offer at least 80 places in all statistical regions.

#### Funding of therapeutic communities

Therapeutic communities are funded from various sources:

1. Ministry of Labour, Family and Social Affairs: it issues a public tender every year, calling on all therapeutic communities to submit applications for funding. Each therapeutic community can receive funds from this source; allocated funds amount up to 80% of the cost of community's operation.
2. Donations: therapeutic communities get donations from different donors. However, it should be noted that the practice of donating money is not developed enough in Slovenia to represent an important source of funding for therapeutic communities.
3. Programme users' contributions account for a modest part of funds, but in some cases they cover up to 20% of costs of a programme.
4. Therapeutic communities get financial contributions from local communities through calls for tenders issued by the latter.
5. Funds for facilities: therapeutic communities usually rent facilities free of charge from local or religious communities.

### 11.3 Availability and characteristics

#### National overall availability

The Srečanje community has two preparatory centres in Ljubljana and Koper. There are 8 beds in the preparatory centre in Ljubljana, and 4 in Koper. The Srečanje community also has five therapeutic communities for men and one for women, and one community for persons with dual diagnoses. Up to 50 persons can be admitted to these communities every year. The Žarek therapeutic community has seven beds. The CENACCOLO therapeutic community has eight places, and TAV in Stari Trg on the river Kolpa has seven. The Svit non-governmental organization in Koper has 25 people in average in treatment in therapeutic communities in Italy. The UP NGO collaborates with the Gruppo Valdinievole programme in Italy, where it sends up to 10 persons a year to be treated in a therapeutic community. The Reto Centre programme at Dobrova near Ljubljana has 20 places, and it sends up to 15 people to its treatment centres abroad. Projekt Človek has 24 beds in its therapeutic

community. Altogether, there are 116 beds available in therapeutic communities in Slovenia. In addition, there are many beds in foreign therapeutic communities, but these are used in exceptional circumstances and at the request of a programme user, since some programmes are implemented as parts of broader programmes and may send drug addicts to treatment in other countries. It is difficult to determine the number of beds available abroad.

Anyone who decides to enter a therapeutic community in Slovenia may do so. Usually he or she has to undergo a preparation period before entering the community, which may last for different lengths of time. Candidates sometimes confuse this period with a waiting period; however, it is not a waiting period, but a period of preparation during which drug users stop taking drugs, attend preparatory meetings and undergo all medical examinations required for the admission into a community; they also have to arrange their social security status and health insurance. Drug users can stay in a community for up to 3 years. An individual may stay in a community longer at his or her request. Some stay for long periods of time and may become employed as leaders or managers of individual communities.

### **Types and characteristics of residential treatment units**

Firstly, we should point out that most therapeutic communities in Slovenia are self-help communities based on mutual help between their members. Some therapeutic communities (Srečanje, Reto centre, Cinaccolo, TAV at Stari Trg on the Kolpa River, and Žarek) are based on mutual help between former drug users and do not normally use psychopharmacological agents (medications) in the process of treatment. Furthermore, they do not normally have various professionals to help with the treatment; they only provide help in programmes where necessary. The Srečanje therapeutic community cooperates more intensively with health care providers in managing its therapeutic community for persons with dual diagnoses, who receive appropriate medication therapy. The Projekt Človek therapeutic community is well supported by professional staff, and its programme users may use medications prescribed by a doctor, but only under supervision of the staff. The Centre for Treatment of Drug Addiction at the Psychiatric Clinic in Ljubljana is preparing a therapeutic community programme for persons with associated mental disorders. The programme staff will include a strong healthcare team as well as other professionals.

The Srečanje therapeutic community is primarily a self-help community with clear rules and contents. It uses the group's influence to achieve changes in the behaviour of an individual and his or her acceptance of the environment. Occasionally, external professionals help in the process of treatment of addicts in this therapeutic community, but, apart from that, programme users live by themselves and take care of their daily living needs independently. Drug users enter the therapeutic community through preparatory centres in Ljubljana and Koper.

The commune of the Društvo Žarek association has drawn up the House Rules of the Žarek Community, which govern the users' stay in the commune and set out basic indications for arranging daily schedules and other rights and obligations. The programme normally lasts for two years. Its users are encouraged to become more responsible through following daily

schedules and through work therapy, mutual acceptance, group and individual conversations, therapeutic monitoring, recreation in nature and by gradually assuming more responsibility. The programme also enables users to complete education, depending on the decision and abilities of an individual. It provides support in court procedures and takes care of individuals' health needs (with the help of a dentist, infectious diseases clinic, physiotherapy, etc.) (source: Društvo Žarek website). The Reto Center therapeutic community was established by former drug users, who also manage it. It is primarily self-help oriented and is not funded by government sources. Their work is their only source of income. The community does not employ professionals. It has clear rules to be observed by all members of the community. The Cinaccolo community is also primarily self-help oriented and does not receive financial resources from the local community or the government; it is self-sufficient and covers its own expenses. It does not employ professionals. The TAV therapeutic community is another self-help community managed by former drug users. It is self-sufficient and does not receive financial resources from the government.

### **Typical mix/integration of services**

Of all programmes, Projekt Človek is integrated into the system to the greatest extent. It admits to its Alfa programme patients who had previously been or are still in substitution treatment. While in the Alfa programme, these patients gradually stop substitution treatment and join a therapeutic community. All therapeutic community programmes are also connected with the network of Centres for the Prevention and Treatment of Drug Addiction (CPTDA), which carry out medical examinations before drug users enter a therapeutic community, vaccinate them against hepatitis B and test them for HIV and hepatitis C. When users are in treatment, self-help programmes use public healthcare services only when necessary. The programme of the Srečanje project, which provides help to drug addicts with associated mental disorders, has established good cooperation relations with healthcare programmes which provide appropriate medical care to persons with associated mental disorders in one of the project's programmes. All therapeutic communities offer the possibility to complete or obtain education, develop new skills or learn about positive personal experience of former drug users who became programme managers; they also help individuals gradually become independent of therapeutic programmes and go back to school. In its therapeutic group, Projekt Človek also uses more complex methods of work such as: diagnostics (psychological testing and medical history, urine testing) and various forms of assistance such as education assistance, help in carrying out work activities, obtaining education, a special programme to ease the transition from a therapeutic community to everyday life, educational and preventive activities (information on HIV, hepatitis C, etc.), motivation, education and counselling, individual and group therapies according to different principles (integrative, Gestalt, "bonding" behaviour therapy, systemic family therapy, psychodrama, transactional analysis) (Stojanov et al. 2012).

Therapeutic communities normally connect with CPTDAs and the Centre for Treatment of Drug Addiction at the Psychiatric Clinic Ljubljana (CTDA). However, only the Projekt Človek therapeutic community offers the users of its special Alfa programme the possibility to enter a substitution programme. The programme is a form of transitional programme between

substitution treatment and an abstinence programme. CPTDA patients in substitution treatment enter the Alfa programme, where they gradually prepare themselves for entering a therapeutic community. Drug users can enter all other therapeutic communities by completing a preparatory programme of an individual community, during which they achieve a certain degree of abstinence with the help of CTDA; in the worst case, drug users undergo detoxification immediately after entering a therapeutic community. All programmes work towards HIV and hepatitis C prevention as well as relapse prevention. They also educate users on drug overdose and teach them how to perform first aid and how to react in case of overdose. All programmes try to improve programme users' employment opportunities, thus they encourage users to complete or continue their education during their time in a programme. Some programmes have also developed reintegration programmes; those who have no such programmes use reintegration programmes provided by governmental and non-governmental organizations such as the Centre for Social Work Kranj, which has designed different social reintegration programmes for persons who have completed a detoxification program or a therapeutic community programme.

### **Typical levels of collaboration and networking**

#### **Level 1: Information provided**

There is an information brochure on all programmes available in Slovenia. It is the third brochure containing such information issued by the government in the last 15 years. These brochures are available in all programmes; thus, when a person enters any programme, he or she gets the same information on all addiction treatment programmes in Slovenia. Then the person can decide which programme to enter. Individual local action groups regularly prepare lists of drug addiction treatment programmes in their area (Božank et al. 2010). All programmes have their own websites where the conditions for admission and the programmes themselves are described in detail.

#### **Level 2: Nominative referrals and meetings between agencies**

The Union of Associations and Non-Governmental Organisations in the Field of Drugs (Zveza društev na področju drog) regularly coordinates activities of non-governmental programmes in Slovenia (source: Zveza društev na področju drog website). It also provides education or training for people employed in therapeutic communities. Occasionally, individual therapeutic communities organize presentations and seminars that address different aspects of treatment of drug addicts in therapeutic communities. Information meetings are also held from time to time at the Ministry of Health, where various programme providers meet and exchange information on any changes or innovations. The drug addiction conference is normally held every two years in Slovenia, and brings together all experts in this field.

#### **Level 3: Formal joint working**

Therapeutic communities collaborate with each other and allow for drug users to move from one therapeutic community to another. Furthermore, a very good collaboration has been established between the CPTDA network and therapeutic communities. The CPTDA network

provides drug users with medical care services and performs all medical examinations before an individual enters a therapeutic community; it also offers assistance when the individual is staying in a therapeutic community. When examining drug users, CPTDA employees pay particular attention to HIV and hepatitis C infections. They also inform each programme user about all treatment options in Slovenia, including therapeutic communities. If the person being treated in the CPTDA network decides to enter addiction treatment in a therapeutic community, CPTDA employees help him or her contact the community and with the transition from the centre to the therapeutic community. Therapeutic communities use professional detoxification services provided by CPTDAs and also refer users of their programmes to CPTDAs.

#### **Level 4: Integrated treatment**

Addiction treatment programmes in Slovenia operate as parts of a single assistance network. Each programme is an entry point into the network. At each entry point, professional workers decide which programme is most suitable for a drug addict, and advise him or her to enter it. People in treatment can move freely from one programme to another. Therapists exchange important information about an individual, but only with the individual's prior consent. They also discuss the type and manner of treatment and transition of the individual between programmes; such transitions are usually agreed upon and organized by therapists.

For example, when a drug user enters a low-threshold programme of needle exchange and counselling, programme workers may refer him or her to different programmes. If they refer the drug user to a CPTDA, the CPTDA will make arrangements for a detoxification process on the basis of the drug user's wishes. Detoxification can be carried out professionally in only one centre in Ljubljana. When the drug user is admitted to the centre, it has already been decided which therapeutic community the user will enter after detoxification, since a doctor working at the centre has already discussed all options with the user and contacted the chosen therapeutic community with the user's consent. After discharge from the detoxification centre, the person enters the therapeutic community. If he or she leaves the therapeutic community before completing the programme, he or she can return to the CPTDA or the low-threshold programme. However, if the person stays in the therapeutic community and if the community does not offer a rehabilitation programme, it connects with those that do offer rehabilitation programmes and refers the person to one of them. Of course, everything is done with the voluntary consent of the said person. If the disease reappears the person can re-enter the low-threshold programme and the CPTDA, which again chooses the best option for the person in collaboration with other programmes. In the meantime, the person can participate in HIV- and other prevention programmes, etc.

## 11.4 Quality management

### Availability of guidelines and service standards for residential treatment

Information on all therapeutic communities, i.e. information on programmes and requirements for admission to a therapeutic community, is publicly available. Each programme has its own rules of conduct and its own methods of work, information on which is also publicly available – this makes it easier for drug users to choose a programme. Internal evaluations of programmes and goal attainment are carried out in all programmes. External evaluation is occasionally carried out by the MLFSA, which can evaluate programmes in accordance with contractual terms and check whether financial resources have been used in accordance with the mutual agreement. The last such evaluation was made in 2011 (Social Protection Institute of the Republic of Slovenia 2012a).

A large-scale evaluation of social programmes funded by the MLFSA was carried out in Slovenia in 2011. It included the evaluation of the Žarek, UP, Srečanje and Projekt Človek therapeutic communities. Evaluators found that the target group of programmes for illicit drug users mostly included:

- persons who use drugs (some programmes are intended only for illicit drug users, and other for users of various psychoactive substances) or persons who are in different stages of development or severity of drug addiction (e.g. persons who experiment; persons whose addiction is not severe enough to require them to leave their home environment; persons who inject drugs and are not in contact with other institutions; active drug users; persons who want to abandon such lifestyle; at-risk drug users);
- persons in various stages of addiction management (e.g. persons who have achieved abstinence by themselves or with the help of others; persons in medication therapy; persons who have been abstinent for at least three months; former drug users after completing a therapeutic programme or coming from a commune);
- drug users with associated mental health problems;
- drug users who have been suspended, reprimanded or sentenced (by courts, centres for social work, schools, employees);
- individuals (high school students, juveniles) and families from an unfavourable environment (preventive activities);
- close relatives and loved ones (parents, partners, children, etc.);
- interested professional and lay public (counselling, educational, informative activities) (Smolej et al. 2012).

Programmes funded by MLFSA have to report on their work every year by completing an extensive form. Reports must include the following information: programme goals; methods used in the programme when treating drug addicts; description of the programme, including its work processes and key elements specific to the programme; environment in which the programme is implemented; description of the quality certificate; the users in the programme's target group, population groups; the number of users in an individual programme per month; age of users; programme in which users are participating (day, night programme, etc.); they also have to report which population group was included in the



programme, and draw up a report on programme employees, including name and surname, education level and the number of hours worked by an individual employee in the programme; and a report on volunteer work and the method of rewarding volunteers (Stojanov et al. 2012).

Each report is carefully examined annually by professionals, and if it does not meet the requirements set out in the agreement, MLFSA can decrease funding by a certain percentage or terminate the cooperation with the programme. A programme must be managed by a professional with higher education who has passed a professional social work examination. Also other people working in a therapeutic community must have specific competencies. The Code of Ethics of Social Workers also in a way ensures the quality of work; it requires strict adherence to human rights and the right to assistance regardless of biological, personal, social status, national, religious, ideological and political differences. It also requires programme workers to respect individual's decisions and act with respect for human dignity and the uniqueness of the individual (Code of Ethics of Social Workers, Official Gazette RS, No. 59/2002).

## 11.5 Discussion and outlook

Therapeutic communities began to emerge in Slovenia due to a major demand of drug users for appropriate treatment of drug addiction at the beginning of the 1990s, when illicit drug use reached epidemic levels in Slovenia. In the following years, therapeutic communities played an important role in implementing a comprehensive approach to managing the consequences of drug use in Slovenia. These communities were established mainly on the initiative of drug users, their parents and professionals who formed associations and other forms of non-governmental organizations and sought solutions on how to achieve greater success in drug addiction treatment. At first, Slovenian drug users used services provided by large therapeutic communities in Italy. On the basis of knowledge and experience gained through cooperation with foreign therapeutic communities, such communities were later also established in Slovenia. Today, only few Slovenian drug users enter treatment in therapeutic communities abroad, as therapeutic communities in Slovenia offer sufficient capacities. According to observations of therapeutic community managers, the interest in entering a therapeutic community has been declining in recent years.

Since the very beginning, therapeutic communities have been collaborating with the CPTDA network. CPTDAs thoroughly examine drug users before they enter a therapeutic community. Initially, drug users had to go to Italy to undergo preparation, but later this service was also set up in Slovenia. Collaboration between low-threshold programmes and therapeutic communities is also important, as there have also been some referrals or transitions to therapeutic communities directly from harm-reduction programmes. Effective collaboration between different programmes has created a single assistance network which enables drug users to enter directly into the network of programmes, whatever the entry point; this enables drug users to move freely from one programme to another.

Funding from the state was modest at the beginning, but then it gradually increased as the state found on the basis of epidemiological data and pressure from the non-governmental sector that the demand for treatment programmes in therapeutic communities was growing. Today, most Slovenian therapeutic communities receive funds amounting up to 80% of their costs from the state. They get the remaining funds from donors, local communities, and contributions from relatives of drug addicts. Each drug user who decides to enter a therapeutic community receives monthly social support to pay for his or her stay in a therapeutic community and take care of his or her personal needs. The facilities and premises of therapeutic communities are properly arranged. Therapeutic communities have internal rules which have to be observed by all persons admitted. Evaluation of work is carried out in all programmes. Such evaluations are primarily internal in nature, and therapeutic communities are rarely evaluated by external professionals. Professional workers employed in programmes must have appropriate qualifications and professional competencies. MLFSA most commonly acts as an external evaluator of programmes; it is allowed and obligated to evaluate a programme under the provisions of the programme funding agreement. However, therapeutic communities should be evaluated in a more systematic manner in order to further improve the quality of work and the efficiency of therapeutic communities.

In recent years, there has been a decrease in the drug users' interest in entering a therapeutic community, thus it would be reasonable to consider programme changes in this field to make programmes more attractive to drug users. When searching for professional literature and articles, one notices that only few such publications exist in this field in Slovenia, therefore it would also make sense to encourage research and consequently promote publishing in this field.

By using different approaches, we have to continue promoting at the national level the collaboration between different programmes that complement each other and constitute a whole that enables each individual to find appropriate assistance and solutions to his or her problems. It is also necessary to maintain good mutual partnerships and complementarities of programmes, and thus maintain a wide range of addiction treatment options in Slovenia. Epidemiological studies in the field of harm reduction programmes and the demand for treatment show that new forms of addiction are emerging. These new forms of addiction, such as cocaine, synthetic drug addiction, etc. will come into the fore in the future; therefore, the whole assistance system will have to be changed to meet the needs of drug users. In addition, professionals will have to be further trained in a systematic manner and new approaches to treatment developed to make treatment more attractive to users of new drugs. Without such changes we will find ourselves stuck in the past and unable to satisfy present and future needs, and more and more drug users will be left on the streets without anyone to help them.

In addition to the need for a successful medication therapy for new forms of addiction, the need for new forms of therapeutic communities will probably come to the fore again. These new therapeutic communities will have to use cognitive behavioural therapy techniques and be more adjusted to the needs of users of different new drugs in terms of timing and location.

It seems that we will have to devote a great deal of effort to the analysis of needs of individuals who seek help, and take into account these needs when developing new and transforming existing programmes. However, this is a new and demanding task which requires a multidisciplinary approach and the help of all currently running programs and systems of programme planning, evaluation and funding.

# 12.

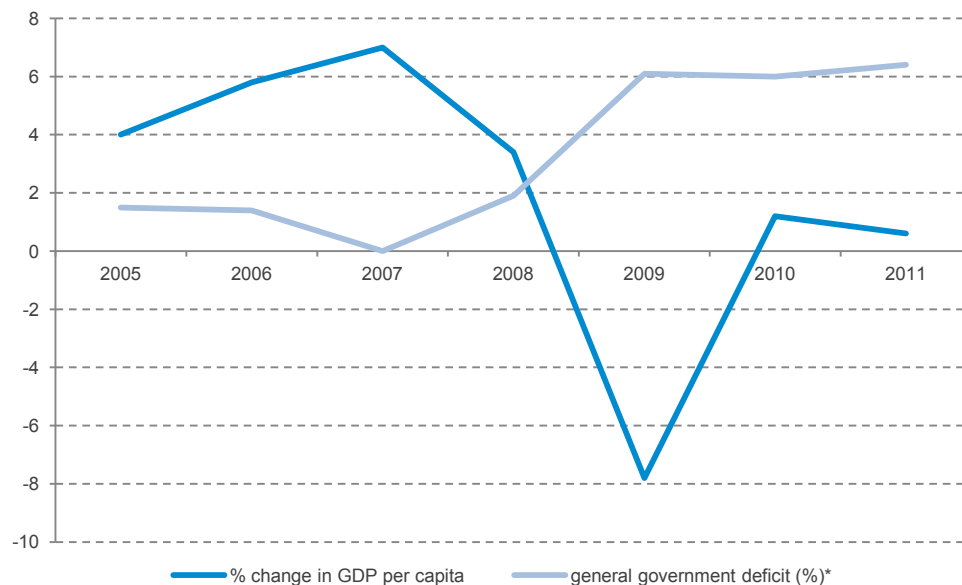
## RECENT TRENDS OF DRUG-RELATED PUBLIC EXPENDITURES AND DRUG SERVICES

Mircha Poldrugovac

### 12.1 Economic situation in Slovenia during the period 2005-2011

Slovenia's gross domestic product (GDP) per capita adjusted for purchasing power was 27.545 USD in 2010 (OECD 2012a). The economic crisis that started in 2008 has also affected Slovenia. As a small open economy, Slovenia is relatively susceptible to external factors such as economic situation of foreign countries, especially those in the euro area. According to OECD, the decline in real GDP in Slovenia was second largest among OECD countries in 2009. The same year, the convergence of GDP per capita turned away from the EU15 countries' average GDP per capita (OECD 2011). Figure 12.1 shows the changes in GDP in Slovenia and the general government deficit in the period from 2005 to 2011.

Figure 12.1: Changes in GDP and general government deficit in the period 2005–2011



\*Net lending/net borrowing under the EDP (Excessive Deficit Procedure)

Sources: Percentage change in GDP per capita: Statistical Office of the Republic of Slovenia; government deficit: Eurostat

The first year of negative growth was 2009. The General government deficit since then has only increased, which indicates that there were no radical cuts in government spending until 2011. The government's reform programme, the most prominent part of which is the pension system reform, was not implemented in 2010 and 2011 as was originally planned. After early election the new government took office in the beginning of 2012. In May 2012 the National Assembly adopted the Fiscal Balance Act, which is the first step of the current government towards reducing the government deficit to 3% GDP by 2013 (OECD 2012b).

Despite the absence of radical measures to reduce government spending in the period examined, i.e. until 2011, a number of activities aimed at achieving such reduction have been carried out in the last few years. For example, the Government's decision which provides that a special approval from the Ministry of Finance must be obtained for all pending financial obligations of ministries, except for direct obligations arising under the existing rules, entered into force in June 2011. Applications were approved only if the Ministry of Finance recognized the expenses as necessary.

It should also be noted that the majority of health care services in Slovenia are funded by the Health Insurance Institute of Slovenia (HIIS). HIIS is responsible for balancing its own financial plan, which includes funds for hospitals, health centres and other healthcare providers in the public healthcare network. HIIS has been facing the problem of ensuring the long-term sustainability of the healthcare budget for some time, as do most healthcare systems in Europe. The economic crisis has highlighted the need to adopt certain measures and shifted the focus to the current issues of financial sustainability. In this context, several measures have been adopted to rationalize healthcare expenditure. In relation to the ongoing crisis, it is important to point out that acute hospital inpatient care costs have decreased by 2.5%. This decrease refers to agreed and recognized costs which are reimbursed by the HIIS to hospitals in accordance with the "diagnosis related groups" model. The value of the entire programme in Euros has been reduced, which means that the providers of acute hospital care are expected to save 2.5% of costs through internal reorganization and rationalization while providing the same volume of services. This measure reflects the desire to decrease expenditure while maintaining healthcare service levels.

## 12.2 Drug-related public expenditure

The table below shows data on drug-related public expenditure in Slovenia for the period 2005–2011. The sources of data for previous years are past annual Reports on the drug situation in the Republic of Slovenia. Data has been supplemented in cases where additional data was acquired. Among the data added, it is worth mentioning those on acute hospital care related to illicit drug poisoning.

Table 12.1: *Drug-related public expenditure in the period 2005–2011*

Purpose	Funder	Year	Amount (EUR)	Cofog	Reuters	Labelled or not
Empowerment of NGO in the harm reduction sector	MPA	2011	52,142.00	10.7	H	non-labelled
Co-funding of NGOs' activities in the field of drug addiction prevention	MPA	2011	53,333.33	10.7	P	non-labelled
Call for tender for funding of drug-related programmes	MH	2011	70,000.00	7.4	UK	non-labelled
Other activities funded by the Ministry of Health	MH	2011	177,326.67		UK	non-labelled
Therapeutic community programmes and related programmes	MLFSA	2011	1,915,586.46	10.9	T	labelled

Table 12.1 continues

Purpose	Funder	Year	Amount (EUR)	Cofog	Reuters	Labelled or not
Low-threshold programmes	MLFSA	2011	1,085,588.32	10.9	H	labelled
Co-funding of programmes in the field of drugs	Office for Youth	2011	58,994.00	10.7	UK	non-labelled
Investigative activities and technological equipment and material used by the Police	MI - Police	2011	657,254.05	3.1	E	non-labelled
Operation of centres for the prevention and treatment of drug addiction	HIIS	2011	2,709,098.00	7.2	T	labelled
Substitute drugs	HIIS	2011	2,914,437.27	7.2	T	labelled
Sterile material for safer drug injection	HIIS	2011	152,850.00	7.4	H	labelled
Hospitalization due to drug poisoning (acute hospital care)	HIIS	2011	160,294.55	7.3	T	non-labelled
Co-funding of programmes in the field of drugs	Municipalities	2011	777,732.70	10.7	UK	labelled
Programmes in the field of drugs, organized as NGOs	FIHO foundation	2011	342,991.97	10.7	UK	non-labelled
<b>TOTAL</b>			<b>11,127,629.32</b>			
Empowerment of NGO in the harm reduction sector	MPA	2010	52,142.00	10.7	H	non-labelled
Co-funding of NGOs' activities in the field of drug addiction prevention	MPA	2010	53,333.33	10.7	P	non-labelled
Call for tender for funding of drug-related programmes	MH	2010	60,707.00	7.4	UK	non-labelled
Therapeutic community programmes and related programmes	MLFSA	2010	1,575,993.26	10.9	T	labelled
Low-threshold programmes	MLFSA	2010	587,876.52	10.9	H	labelled
Other MLFSA programmes of social rehabilitation of addicts	MLFSA	2010	549,259.59	10.9	P	labelled
Renovation of a property	MLFSA	2010	21,156.00	10.9	T	labelled
Investigative activities and technological equipment and material used by the Police	MI - Police	2010	576,040.00	3.1	E	non-labelled
Purchases of materials and training and education of professionals	MJ - PA	2010	18,794.19	3.4	UK	non-labelled
Operation of centres for the prevention and treatment of drug addiction	HIIS	2010	2,700,000.00	7.2	T	labelled
Substitute drugs	HIIS	2010	2,900,000.00	7.2	T	labelled
Sterile material for safer drug injection	HIIS	2010	146,000.00	7.4	H	labelled
Hospitalization due to drug poisoning (acute hospital care)	HIIS	2010	168,731.19	7.3	T	non-labelled
Programmes in the field of drugs, organized as NGOs	FIHO foundation	2010	268,186.45	10.7	UK	non-labelled
<b>TOTAL</b>			<b>9,678,219.53</b>			
Therapeutic community programmes and related programmes	MLFSA	2009	1,514,458.00	10.9	T	labelled
Low-threshold programmes	MLFSA	2009	544,492.50	10.9	H	labelled
Other MLFSA programmes of social rehabilitation of addicts	MLFSA	2009	499,847.50	10.9	P	labelled
Purchase of a property to be used for the implementation of programmes for addicts	MLFSA	2009	4,993.00	10.9	T	labelled
Investigative activities and technological equipment and material used by the Police	MI - Police	2009	546,513.00	3.1	E	non-labelled
Sterile material for safer drug injection	MH	2009	145,100.00	7.4	H	labelled
Other tasks in the field of drugs	MH	2009	99,167.00	1.1	Admin	non-labelled
Co-funding of various programmes	Office for Youth	2009	49,350.00	10.7	UK	non-labelled
NGOs' programmes (European Structural Funds)	MPA	2009	419,388.98	10.7	UK	non-labelled
Operation of centres for the prevention and treatment of drug addiction	HIIS	2009	2,605,338.00	7.2	T	labelled
Substitute drugs	HIIS	2009	3,168,324.00	7.2	T	labelled

Table 12.1 continues

Purpose	Funder	Year	Amount (EUR)	Cofog	Reuters	Labelled or not
Hospitalization due to drug poisoning (acute hospital care)	HIIS	2009	218,130.63	7.3	T	labelled
Programmes in the field of drugs, organized as NGOs	FIHO foundation	2009	240,156.00	10.7	UK	non-labelled
<b>TOTAL</b>			<b>10,115,965.61</b>			
Therapeutic community programmes and related programmes	MLFSA	2008	1,445,691.00	10.9	T	labelled
Low-threshold programmes	MLFSA	2008	399,013.40	10.9	H	labelled
Other MLFSA programmes of social rehabilitation of addicts	MLFSA	2008	446,023.60	10.9	P	labelled
Purchase of a property to be used for the implementation of programmes for addicts	MLFSA	2008	110,868.00	10.9	T	labelled
Co-funding of various programmes	Office for Youth	2008	42,632.00	10.7	UK	non-labelled
Substitute drugs	HIIS	2008	3,178,047.00	7.2	T	labelled
Operation of centres for the prevention and treatment of drug addiction	HIIS	2008	2,373,053.00	7.2	T	labelled
Investigative activities and technological equipment and material used by the Police	MI - Police	2008	534,434.36	3.1	E	non-labelled
Sterile material for safer drug injection	MH	2008	100,000.00	7.4	H	labelled
Public tender in the field of drugs	MH	2008	100,000.00	7.4	UK	non-labelled
Hospitalization due to drug poisoning (acute hospital care)	HIIS	2008	249,987.74	7.3	T	non-labelled
Printing of publications	MH	2008	10,000.00	1.1	UK	non-labelled
Donation to the United Nations	MH	2008	10,000.00	1.1	UK	non-labelled
<b>TOTAL</b>			<b>8,999,750.10</b>			
Therapeutic community programmes and related programmes	MLFSA	2007	464,549.10	10.9	H	labelled
Low-threshold programmes	MLFSA	2007	1,090,398.40	10.9	T	labelled
Other MLFSA programmes of social rehabilitation of addicts	MLFSA	2007	346,005.50	10.9	P	labelled
Purchase of a property to be used for the implementation of programmes for addicts	MLFSA	2007	200,000.00	10.9	T	labelled
Co-funding of various programmes	Office for Youth	2007	18,550.00	10.7	UK	non-labelled
Centres and substitute drugs together	HIIS	2007	5,280,223.00	7.2	T	labelled
Investigative activities and technological equipment and material used by the Police	MI - Police	2007	397,617.49	3.1	E	non-labelled
Evaluation of substitution programmes	MH	2007	40,000.00	7.5	T	non-labelled
Hospitalization due to drug poisoning (acute hospital care)	HIIS	2007	168,759.56	7.3	T	non-labelled
Sterile material for safer drug injection	MH	2007	150,000.00	7.4	H	labelled
<b>TOTAL</b>			<b>8,156,103.05</b>			
Funding of MLFSA programmes	MLFSA	2006	1,502,600.00	10.9	UK	labelled
Co-funding of various programmes	Office for Youth	2006	31,105.00	10.7	UK	non-labelled
Centres and substitute drugs together	HIIS	2006	4,975,070.00	7.2	T	labelled
Investigative activities and technological equipment and material used by the Police	MI - Police	2006	506,505.53	3.1	E	non-labelled
Prevention programmes	MH	2006	22,980.30	7.4	P	non-labelled
Studies and expertise	MH	2006	2,944.42	7.5	UK	non-labelled
International cooperation	MH	2006	11,018.67	1.1	Admin	non-labelled
Low-threshold programmes	MH	2006	92,757.38	7.4	H	labelled

Table 12.1 continues

Purpose	Funder	Year	Amount (EUR)	Cofog	Reuters	Labelled or not
Hospitalization due to drug poisoning (acute hospital care)	HIIS	2006	188,523.70	7.3	T	non-labelled
State contributions to various projects	MH	2006	310,585.56	7.4	UK	non-labelled
Co-financing of purchases of vehicles for low-threshold programmes	EC	2006	162,944.80	7.4	H	non-labelled
<b>TOTAL</b>			<b>7,807,035.36</b>			
Funding of MLFSA programmes	MLFSA	2005	1,469,800.00	10.9	UK	labelled
Training and equipment for customs officers	MF	2005	37,600.00	3.6	E	non-labelled
Prevention programmes	MH	2005	70,073.00	7.4	P	non-labelled
Studies and expertise	MH	2005	11,778.00	7.5	UK	non-labelled
International cooperation	MH	2005	851.00	1.1	Admin	non-labelled
Low-threshold programmes	MH	2005	101,450.00	7.4	H	labelled
State contributions to various projects	MH	2005	18,553.00	7.4	UK	non-labelled
Substitute drugs	HIIS	2005	2,519,232.00	7.2	T	labelled
Operation of centres for the prevention and treatment of drug addiction	HIIS	2005	2,181,367.00	7.2	T	labelled
Hospitalization due to drug poisoning (acute hospital care)	HIIS	2005	206,204.00	7.3	T	non-labelled
Investigative activities and technological equipment and material used by the Police	MI - Police	2005	387,799.49	3.1	E	non-labelled
Co-funding of various programmes	Office for Youth	2005	26,161.00	10.7	UK	non-labelled
Co-funding of various programmes	Office for Youth	2005	21,884.00	10.7	UK	non-labelled
<b>TOTAL</b>			<b>7,052,752.49</b>			

Sources: National reports on the drug situation in the Republic of Slovenia, from 2006 to 2011, Ministry of the Interior, National Institute of Public Health (NIPH), Smolej et al. 2012

Explanation of abbreviations: MLFSA – Ministry of Labour, Family and Social Affairs, MH – Ministry of Health, MF – Ministry of Finance, MPA – Ministry of Public Administration, MI – Ministry of the Interior, HIIS – Health Insurance Institute of Slovenia, EC – European Commission, NGO – non-governmental organization, MJ - PA – Ministry of Justice - Prison Administration

Reuters classification: P – addiction prevention programmes; T – treatment programmes; E – law enforcement programs; H – low-threshold programmes; UK – classification not possible, according to Reuter's classification resources are associated with various kinds of programmes; Admin – classification not possible, expenses are related to the coordination of activities, including different categories according to Reuters

## 12.3 Limitations

The author of this chapter categorized expenditure according to Reuters and Cofog classifications and according to the purpose of appropriations in the budget (EMCDDA 2008) on the basis of available information. It was especially difficult to determine government budget appropriations expressly intended to cover drug-related expenditure (described as “labelled” or “non-labelled” in Table 12.1). In a typical case, the government budget, which sets out estimated expenditures by their purpose, is not accurate enough to specify the amount of resources allocated to the prevention and treatment of drug-related problems. Such resources are usually described as “non-labelled” expenditure of the Ministry of Health, the Ministry of Public Administration, the FIHO foundation and the Office for Youth. These organisations co-fund the activities of NGOs, usually through public tenders the purpose of which extends beyond the field of illicit drugs. Thus, in such cases, NGOs working in this field compete with other NGOs for limited resources. However, data for the last five years show



that co-funding is relatively stable. In the case of tenders issued by the Ministry of Labour, Family and Social Affairs (MLFSA), the expenditure is marked as “labelled”. The resources in the corresponding budget line are allocated to the treatment and prevention of illicit drug addiction, alcoholism and other addictions as well as eating disorders. It is evident that annual funding dedicated to drug-related programs represents a large part of the resources in the mentioned budget line and constitutes permanent and important expenditure in the budget.

HIIS is funded mainly by contributions from employers and employees, and manages its own finances relatively independently. Therefore, HIIS's expenditure is not included in the budget, but it is considered as public expenditure according to international standards. Resources provided by HIIS to health service providers are generally subject to annual negotiations with representatives of service providers and the Ministry of Health. The scope of programmes funded in the previous year (or previous years) is usually the starting point for negotiations. Also in this case, the data show that the funding of centres for the prevention and treatment of illicit drug addiction is stable; therefore the related expenditure is described as “labelled”.

The HIIS's system of reimbursement of acute hospital care costs does not determine which hospital services must be provided to meet the agreed reimbursement requirements or so called weights (with some exceptions). At the same time, each hospital is responsible to provide necessary services to citizens. Therefore, expenditure on acute hospital care associated with drug poisoning is not pre-determined, but depends on the demand or specific cases treated by service providers. Such expenditure is marked as “non-labelled”.

It is important to clarify some of the data limitations which were identified in this and previous years and most of which were already described in the economic analysis in the first chapter of this report:

- Resources of the Ministry of the Interior – Police are earmarked for material costs and equipment for investigative activities. The Police estimate that a large part of these resources (80–90%) is dedicated to the fight against illicit drugs. The mentioned part or amount does not include labour costs, i.e. salaries paid to serving police officers, detectives and other employees working in this field. Labour cost data are not available.
- Funding of multiannual projects was divided into equal annual periods, provided that the projects timeframe was known. For example, financial resources allocated to some of the MPA's projects implemented between 2010 and 2012 were divided into three equal parts, each of which was taken into account in the calculation of corresponding annual expenditures.
- It is very difficult to estimate drug-related acute hospital care costs. As explained in last year's report (Drev et al. 2011) the identification of cases of drug-related acute hospital care is difficult due to frequent errors in diagnostic coding in inpatient care databases. Frequent treatments in emergency departments, which do not lead to hospitalization, represent events that are not included in hospital statistics. The estimates of the number and cost of hospitalizations due to acute illicit drug poisoning outside psychiatric institutions were made using the “diagnosis related group” (SPP) database, which

includes all providers of acute hospital inpatient care. We identified all cases of hospitalization in which diagnoses included poisoning with narcotics and psychodisruptants (codified with T40 in accordance with the International Classification of Diseases – ICD-10). In some cases there were other primary reasons for hospitalization (e.g. childbirth). In many cases, even when illicit drug poisoning was not the main diagnosis, it appears that the main reasons for hospitalization were complications directly related to drug use.

- In the economic analysis in the first chapter herein the MPA's expenditure is estimated at EUR 0, because financial resources were allocated by the Ministry in previous years. In the multi-annual review of expenditure above on the other hand, the Ministry's resources are divided into equal annual amounts, taking into account the duration of projects, so expenditure from multiannual projects allocated in previous years are included in the table containing 2011 data.

#### **12.4 Variations in drug-related expenditure over time and the impact of the crisis**

Totals of all identified drug-related expenditures incurred in individual years in the period from 2005 to 2011 show a constant moderate increase in the total amount of financial resources. However, an in-depth review of expenditure titles reveals that the increase in the total sum is often due to the fact that new data was acquired and funding sources were added which were probably already present in the past, but for which data was not available. For example, this year's report includes for the first time the data on co-funding of drug-related programmes by Slovenian city municipalities, although the municipalities had provided funding for such programmes before.

In view of the above, it is reasonable to examine the changes in the volume of drug-related expenditure, but only if we compare those amounts that we were able to determine for each year of the period 2005-2011. Individual amounts from Table 12.1 have been grouped according to funding sources and presented in Table 12.2.

Table 12.2: *Drug-related expenditure covered by sources that were subject to monitoring throughout the period 2005–2011*

Expenditure title	Funder	Year						
		2005	2006	2007	2008	2009	2010	2011
MLFSA's funding of programmes	MLFSA*	1,469,800.00	1,502,600.00	1,554,947.40	2,290,728.00	2,558,798.00	2,713,129.37	3,213,519.00
Drug-related expenditure covered by MH (other than the purchase of sterile material)	MH	101,255.00	347,528.95	40,000.00	120,000.00	99,167.00	60,707.00	247,326.67
Sterile material for safer drug injection	MH, ZZS	101,450.00	92,757.38	150,000.00	100,000.00	145,100.00	146,000.00	152,850.00
Operation of CPTDAs and substitute drugs	ZZS	4,700,599.00	4,975,070.00	5,280,223.00	5,551,100.00	5,773,662.00	5,600,000.00	5,623,535.27
Acute hospitalization	ZZS	206,204.00	188,523.70	168,759.56	249,987.74	218,130.63	168,731.19	160,294.55
Investigative activities and technological equipment and material used by the Police	MI - Police	387,799.49	506,505.53	397,617.49	534,434.36	546,513.00	576,040.00	657,254.05
<b>TOTAL</b>		<b>6,967,107.49</b>	<b>7,612,985.56</b>	<b>7,591,547.45</b>	<b>8,846,250.10</b>	<b>9,341,370.63</b>	<b>9,264,607.56</b>	<b>10,054,779.54</b>

\*Data for 2011 does not represent the sum of MLFSA's expenditures listed in Table 12.1 In this case, the data on MLFSA's expenditure in Table 12.2 is comparable to data for previous years. However, Table 12.1 shows data which are more accurate due to changes in the method of monitoring drug-related expenditure

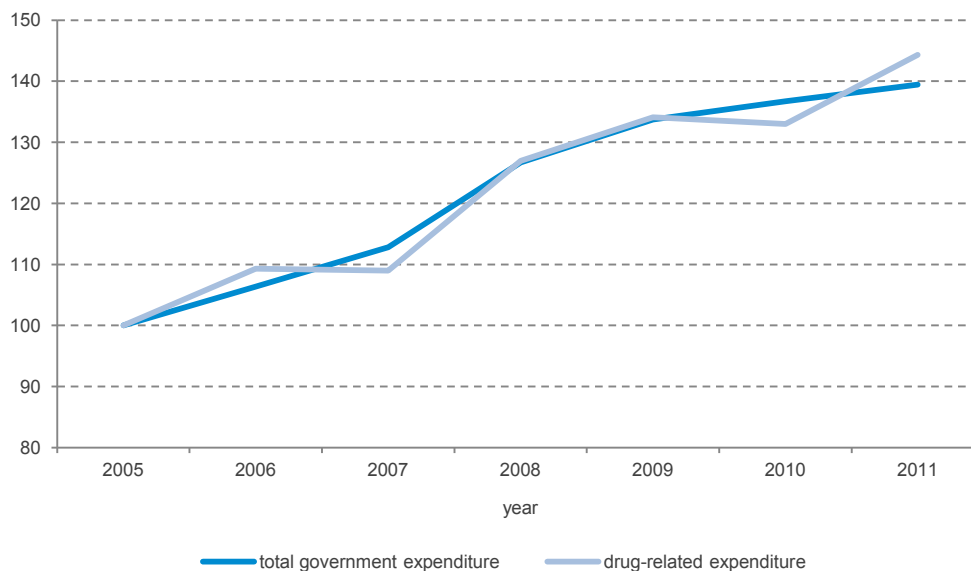
Explanation of abbreviations: MLFSA – Ministry of Labour, Family and Social Affairs, MH – Ministry of Health, MI – Ministry of the Interior, ZZS – Health Insurance Institute of Slovenia, CPTDA – Centres for the Prevention and Treatment of Drug Addiction

With the aim of examining the effects of the economic crisis on drug-related public expenditure, we compared such expenditure to total government expenditure. Given that drug-related expenditures are expressed in absolute values in Euros, we have taken into account the absolute value of total government expenditure. According to Eurostat, the total government expenditure amounted to EUR 13,015.30 million in 2005. After that it gradually increased and reached EUR 18,148.60 million in 2011. The comparison between total government expenditure and drug-related expenditure has been made starting from 2005 values, which were normalised to 100.

Most individual expenditures in the examined period increased moderately, which means that resources from all the funders listed in the above table increased. The changes in the expenditure of the Ministry of Health stand out. These relatively large changes in expenditure are primarily due to two factors: occasional important role in international activities such as the meeting of the Pompidou Group in Ljubljana in 2011, and public tenders for the co-funding of NGO programmes issued by the Ministry every two years. As regards HIIS's funding of centres for the prevention and treatment of drug addiction and the cost of drugs used in substitution treatments, we can notice a decrease in HIIS's expenditure in 2010 and a moderate increase in 2011. Expenditure in the field of acute hospital care due to illicit drug poisoning is not pre-determined. In this case, the variability of expenditure is due to

unpredictability or expected variability of such cases, changes in cost weights in acute hospital care, and especially due to unreliability of data on diagnoses related to illicit drug poisoning recorded in the inpatient care monitoring system.

Figure 12.2: Comparison of changes in general government expenditure and drug-related expenditure (value in 2005 = 100)



Sources: Total government expenditure: Eurostat; drug-related expenditure: calculated by author

Using available data, we determined the number of drug-related programme or service users. There are no significant variations in the number of users, with the exception of the number of acute hospital care cases, which shows a decreasing trend. It is difficult to explain the reason for this decrease. As mentioned above, it is reasonable to expect a certain degree of variability; however, the main unknown factor is the accuracy of diagnostic coding in the hospital inpatient care database, which was used in calculating the number of users.

Table 12.3: Number of users of drug-related programmes or services, 2005-2011

Programme/Service	Year						
	2011	2010	2009	2008	2007	2006	2005
High-threshold programmes co-funded by the MLFSA*	4640	4591					
Low-threshold programmes (only main programmes), co-funded by the MLFSA*	4155	3870					
Hospitalizations in CPTDAs, total**	187	177	178	174		175	185
Cases of acute hospital inpatient care due to drug poisoning***	84	103	137	121	152	124	140
All persons treated in CPTDAs****		4197	4322	4429			
Persons who underwent substitution treatment****		3547	3324	3332			

Sources: \*Smolej et al. 2012, Jakob Krejan et al. 2011, \*\*Psychiatric Clinic Ljubljana, \*\*\*NIPH, \*\*\*\*Coordination of CPTDA

## 12.5 Conclusions

By 2011, the effects of the economic crisis had not yet led to significant cuts in public expenditure. There was also no apparent decrease in drug-related public expenditure; quite the opposite: the total amount of financial resources allocated to drug-related problems gradually increased from the beginning of the crisis to 2011. In view of the above and in accordance with expectations, there was no significant decrease in the number of users of drug-related services and programmes. The question of the effects of the recession on the illicit drugs issue is much more complex. In order to study such a broad question, one would have to obtain information on the health status of illicit drug users and changes in their health status over the years, to take into account the number of persons who sought help from health service providers or other programmes again or for the first time, etc. Different results or outcomes related to illicit drug use would have to be examined in the context of different factors such as drug price changes, changes in unemployment rates, and socioeconomic status. However, such analysis extends beyond the scope of this chapter. It should be noted that this analysis does not determine the effects of the recession on the use of illicit drugs in a comprehensive manner.

More radical austerity measures aimed at prompt balancing of public finances were first adopted in 2012. The need to stabilize public finances and the Slovenian Government's reform program forecast further implementation of such measures. We can only speculate if and how austerity measures will reflect in a possible decrease in drug-related expenditure and how they will affect the scope or number of services and programmes aimed at illicit drug users. There is significant variation in the amount of financial resources earmarked to cover "non-labelled" expenditure. It is relatively easy to reduce resources in these areas. Only time will tell if such reduction will actually take place.

## **PART C:**

### **BIBLIOGRAPHY, ANNEXES**

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