National Institute of Public Health

REPORT ON THE DRUG SITUATION 2014 OF THE REPUBLIC OF SLOVENIA

European Monitoring Centre for Drugs and Drug Addiction

National Institute of Public Health

2014 NATIONAL REPORT (2013 DATA) TO THE EMCDDA

by the Reitox National Focal Point

SLOVENIA
NEW DEVELOPMENTS AND TRENDS

REITOX

Editor: Andreja Drev

Design: Andreja Frič

For the content of individual article or chapter is responsible its author

Publisher: National Institute of Public Health, Trubarjeva 2, 1000 Ljubljana

Translation: Optimus Lingua, d.o.o.

Approved by Commision of the Republic of Slovenia for Drugs

Digital production: Gostiša, d.o.o.

Circulation: 60 copies

Publication year: Ljubljana, 2014

Electronic source.

Website: http://www.nijz.si/

ISSN 1855-8003

TABLE OF CONTENTS

SUMMARY

1. In July 2013, 48 new psychoactive substances were added to the Decree on the Scheduling of Illicit Drugs. In late 2013, a group of citizens submitted an initiative to the National Assembly to discuss two acts – a draft of the Cannabis Act and a draft of the Self-medication Act. The National Assembly rejected both drafts, while also appealing to the Government of the Republic of Slovenia to regulate access to cannabis-based medicinal products. This led the Ministry of Health to prepare a new Decree on the Scheduling of Illicit Drugs in June 2014, which recategorised the psychoactive substance THC from the first group of illicit drugs to the second group, i. e. substances for the use in medicine. The Decree also introduced nine new psychoactive substances into the schedule. In April 2014, the National Assembly also passed the new Resolution on the National Programme on Illicit Drugs 2014–2020. The funding for most drug-related programmes continues to be provided by the state budget and the Health Insurance Institute of Slovenia. A portion of the funds is provided by a number of foundations and NGO membership fees, while donations are scarce. Drawing from available data, an estimated minimum of EUR 9,600,691.75 was allocated to the issue of illicit drugs in Slovenia in 2013.

2. No new survey on drug use in the general population or specific target groups was carried out or completed in 2013. According to the Survey on Use of Tobacco, Alcohol and Other Drug carried out among inhabitants aged 15 to 64 in 2011 and 2012, 16.1% of Slovenians in this age group have used an illicit drug at least once in their lifetime, including nearly one fifth of all men and 12.2% of all women. Cannabis was the most common drug of choice. According to the 2011 ESPAD survey, 23% of secondary school students aged 15 to 16 have used cannabis in their lifetime, while the 2010 HBSC study found that 23.2% of 15-year-olds have experimented with marijuana in their lifetime. The latest study on drug use in targeted groups was performed in 2010; it focused on nightlife drug use and showed that respondents most frequently used marijuana, followed by amphetamines and cocaine.

3. Slovenia has introduced no new legislative measures to combat tobacco use or hazardous and harmful alcohol consumption within the past year. However, the tax rate on and the prices of tobacco products have risen, as have excise duties on alcohol and alcoholic beverages. An opinion poll showed that Slovenians largely approve of the new measures on tobacco control and alcohol consumption restrictions. The Youth Association No Excuse and the Slovenian Coalition for Tobacco Control carried out the Mystery Shopper and the Yellow Card campaigns to test whether businesses sold alcohol or tobacco to minors. Minors visited 217 locations and were able to complete the purchase in a large number of cases. Due to poor attendance, the organisers of the Unplugged programme replaced the workshop for parents with EFFEKT, a parent-based prevention programme focused on parents maintaining stricter rules on alcohol drinking for their children. The Youth Association No Excuse carried out 677 workshops on tobacco and alcohol in 2013, reaching 14,457 young people aged 12 to 15. The monitoring of opinions on alcohol held by workshop leaders showed that their opinions on alcohol consumption were more negative after training and the workshops themselves than before the workshops. As part of Click for Support, a European project developing guidelines for online counselling, the

Slovenian partners reviewed online drug-related interventions and organised a workshop at which young drug users evaluated a selection of three online interventions. As part of Take Care, a programme aiming to reduce alcohol consumption, training was carried out for 12 alcohol vendors, 39 young people participated in ro.pe trainings, and 62 parents partook in discussion rounds in 2013 and 2014,. The Koper Svit Society carried out two programmes in the field; as part of the first programme, a variety of safe, high-quality outdoor activities was organised for children of drug users and other school-aged children in an area with a high number of drug users with children, while the second project sought to raise awareness among young people at a number of night-life venues about the consequences of the use of alcohol and other drugs. A training programme for professionals who deal with Roma youth in a professional capacity was carried out as part of an addiction prevention project aimed at the Roma community, and the publication Health, Prevention of Addiction and Roma Youth was published. As part of Fred Goes Net, an early intervention programme, 30 courses involving 352 secondary-school students who came to attention for alcohol or drug consumption were carried out in 2013 and 2014. The After Taxi project, which provides vouchers for a free taxi ride to young people going home from a party, began to distribute the vouchers at locations where young people party and socialise. Evaluation results for 2013 indicated that the majority of respondents preferred using the After Taxi vouchers to drunk driving. Since May 2013, young people can also use the mobile application Driving 0.0, which allows them to calculate the amount of alcohol in exhaled breath. Despite the difficulties in securing financial means for the Strengthening Family programme concerned with the prevention of addiction, the programme will be continued in the Goriška region. The 2013 Substance Abuse Prevention Month slogan was, “What is permitted is not always safe”, and special attention was paid to new psychoactive substances.

4. A prevalence estimate of high-risk opiate use for 2012 was carried out this year by using the capture-recapture method and by obtaining data from the Drug Users' Treatment Records and a survey carried out among users of harm reduction programmes. The 2012 figure estimates there to be 6917 high-risk opiate users aged 15 to 64. A study involving 175 drug users seeking help in harm reduction programmes showed that compared to 2012, the year 2013 saw a decrease in the use of heroin, solvents, substitute medicinal products, synthetic drugs and cannabis, and an increase in cocaine use. Injection remains the preferred route of administration for heroin and cocaine, and continues to be the most common risk behaviour among users of harm reduction programmes. Sexual risk behaviour is also commonplace. Compared to previous years, the year 2013 experienced an increase in needle sharing and overdoses and an increase in the number of homeless drug users. The population of drug users seeking help in harm reduction programmes is ageing.

5. In 2013, 4065 drug users were treated within the network of 18 Centres for the Prevention and Treatment of Illicit Drug Addiction and the Centre for the Treatment of Drug Addiction at Ljubljana University Psychiatric Clinic. The network serves all regions apart from the region of Koroška; currently, there are no wait times in their programmes. In addition, 23 social rehabilitation programmes for addicted persons were carried out in Slovenia in 2013; these programmes are co-funded by the Ministry of Labour, Family, Social Affairs and Equal Opportunities and comprise low-threshold and high-threshold programmes. Local accessibility of social rehabilitation

programmes is unsatisfactory in the regions of Zasavje in Pomurje, which have no high-threshold programme. The counselling and therapy programme aimed at the specific needs of users of club drugs, cocaine and new psychoactive substances reached 48 users within the first eight months of 2014. Since last year, young drug users may also consult Reduser, an online application which allows them control their drug use, either on their own or with the help of an expert. In January 2013, the National Institute of Public Health introduced the new TDI questionnaire to the network of Centres for the Prevention and Treatment of Illicit Drug Addiction; which was filled out by 17 of its centres. Data analysis performed on data obtained from the questionnaire showed that 290 users entered treatment programmes, 95 of whom had never been treated before, while 194 users had a history of treatment, and one case could not be conclusively identified either as a new admission or a readmission. Most of the admitted users were male (80%). The main drug which made them seek out help again or for the first time was once again heroin (73.4%), followed by cannabis (12.4%) and cocaine (3.5%). More than half of those admitted again and for the first time used drugs daily, and 34% injected the drug upon entering the programme. The share of injecting drug users has been in decline over the years, while there has been an increase in users who seek help due to cannabis, in particular among those who entered the programme for the first time.

6. Saliva samples collected in 2013 from persons who inject drugs as part of an unlinked anonymous testing to control HIV infections have not tested positive for HIV antibodies, though two cases of diagnosed HIV infections with a history of drug injection were reported to the National Institute for Public Health. The prevalence of Hepatitis B antibodies among confidentially tested injecting drug users entering or re-entering treatment within the network of Centres for the Prevention and Treatment of Illicit Drug Addiction was 5.6% in 2013, while the prevalence of Hepatitis C antibodies was 32.1%. In the period 2009–2013, the share of those infected with Hepatitis B was the highest in 2011, while the share of those infected with Hepatitis C was the highest in 2013. Medical emergency units in Ljubljana, which serve approximately 600,000 residents of Central Slovenia, treated 83 patients for illicit drug poisoning in 2013, 46 of which were poisoned by a combination of multiple drugs and/or ethanol. The patients suffering from drug poisoning were predominately male and an average age of poisoned patients was 30 years. Over the past three years, the number of phenethylamine and cannabis poisoning cases has been on the rise. In 2013, there has also been a new increase in the number of heroin poisonings, while GHB poisoning was the most common type of poisoning. In 2013, the General Mortality Register recorded 28 deaths caused by drug poisoning in Slovenia; 20 of those were men, while 8 were women. The average age upon death was 36.3 years of age for men and 39.3 years of age for women. Heroin was the leading cause of fatal poisoning, followed by methadone. A ten-year analysis of data on treated drug patients included in the cohort study showed that their average mortality rate is nearly three times as high as other Slovenians in the same age group.

7. The network of Centres for the Prevention and Treatment of Illicit Drug Addiction provides users with access to testing for hepatitis C and to counselling as well as with potential referral to further clinical treatment and potential hepatitis C therapy by specialists. As part of harm reduction programmes, sterile kits are distributed to injecting drug users free of charge and counselling is provided. Needle exchange programmes take place at day centres and in the field. 513,272 needles and syringes were distributed to harm reduction programmes in 2013, and 16,753

contacts with injecting drug users were recorded, 11,247 of which occurred at the stationary needle exchange point, while 5506 were recorded as part of fieldwork. Under the auspices of the Ministry of Health, an interministerial working group of the Early-Warning System for New Psychoactive Substances was founded; the group continuously monitors the emergence of dangerous and new psychoactive substances, to which it alerts the professional public and users. In 2013, the working group detected a significant increase in the number of GHB and GBL poisonings. Information obtained in the field indicated that the use of GHB and GBL had spread from the group of party drug users to young people who were not used to these drugs. The situation became critical in late 2013, when the Centre for Poisoning treated eight extremely severe cases of GHB/GBL poisoning. The members of the Early-Warning System for New Psychoactive Substances responded with rapid measures to prevent additional poisonings.

8. Professional activities for solving social issues related to illicit drug use are carried out by public services (62 Centres for Social Work) and by private and non-governmental organisations carrying out supplementary social care programmes. In 2013, Centres for Social Work handled 275 cases related to illicit drug problems. In the same year about 4900 users participated in social care programmes in the field of drug addiction prevention, which are co-funded by the Ministry of Labour, Family, Social Affairs and Equal Opportunities. The Reintegration Centre programme, which provides assistance to drug users in maintaining long-term abstinence and reintegration into society, has served 79 users over the past ten years, and was successfully completed by more than half of them. In recent years, the duration of participation in the programme has been prolonged due to social hardship faced by the users. The social entrepreneurship project On principle, which provides training in design and social marketing to young people with a history of drug use, has been in operation since 2012 and trained 7 young people and employed 4 persons in 2013.

9. In 2013, the police recorded 2191 criminal offences and 4197 offences related to illicit drugs and investigated 2428 individuals on the suspicion of committing a crime related to illicit drugs and 3898 individuals on the suspicion of committing an offence. The 18% increase in the number of offences and the 12% increase in the number of identified offenders are first and foremost due to increased police efforts. Cannabis has remained the illicit drug most often connected to criminal and minor offences into 2013. In 2013, the police handled 69 suspects who committed a criminal offence under the influence of illicit drugs. Although the majority of these cases are from the area of unlawful manufacture and trade in illicit drugs and rendering opportunity for the consumption of illicit drugs, the police has also recorded other criminal offences such as the neglect and maltreatment of an underage person, manslaughter, murder, an attack on an official, obstruction of an official act and revenge upon an official. The police also ordered 784 professional tests to establish the presence of illicit drugs and other psychoactive substances in drivers; 276 tests came back positive. Drivers were most commonly under the influence of cocaine, cannabinoids and methadone. Judiciary police discovered 93 cases of illicit drugs in prisons; cannabis was the most common drug as well as the drug found in the largest quantity. A total of 4543 individuals were imprisoned in 2013. 1078 of the prisoners had issues with illicit drug use, 649 of which were undergoing substitution therapy. Testing for HIV and hepatitis B and C confirmed 9 individuals had hepatitis B, 25 persons had hepatitis C, and none were HIV

positive. Two persons had tuberculosis. A study involving 58 imprisoned drug users revealed that the most commonly used drugs were heroin, cannabis and tranquilisers, and that almost all of them were smokers. Over 30% reported having overdosed in the past, while 63% said they had been imprisoned before. Over a fifth exhibited symptoms of mild depression, while more than half of them reported having considered suicide.

10. In 2013, the recorded quantities of seized amphetamine, benzodiazepine, methamphetamine, ecstasy and marijuana were significantly larger compared to 2012, while the seized quantities of heroin, cocaine and hashish were smaller than in 2012. The total number of seizures of illicit drugs has risen compared to previous years. The supply and sale of synthetic drugs are also on the rise, and the number of discovered new psychoactive substances has also increased. The traditional Balkan smuggling route remains highly active and bidirectional; the scope of smuggling is estimated to have risen. Heroin and cannabis are transported from Kosovo, north-eastern Albania and Macedonia to the countries of the European Union, while synthetic illicit drugs and, for the most part, cocaine are smuggled in the opposite direction; amphetamine appears to mostly originate in the Netherlands. Criminal organisations engaged in cannabis cultivation are highly active in Slovenia. In 2013, the Slovenian police force discovered and destroyed 70 enclosed spaces modified to grow cannabis. Compared to 2012, the prices of illicit drugs have slightly decreased, which is largely due to increased supply. This is particularly true of amphetamine. Average concentrations of heroin and cannabis in seized samples were similar to previous years, while the average concentration of cocaine and amphetamine in the seized samples was higher, as was the average concentration of THC in seized hashish samples. 12 new psychoactive substances and 19 new types of ecstasy pills were discovered in Slovenia in 2013. 16 types of ecstasy pills contained MDMA, with the average MDMA content in seized samples being 40.2%.

PART A:

NEW DEVELOPMENTS AND TRENDS

1. DRUG POLICY: LEGISLATION, STRATEGIES AND ECONOMIC ANALYSIS

Jože Hren, PhD

In July 2013, 48 new psychoactive substances were added to the Decree on the Scheduling of Illicit Drugs (Official Gazette of the RS, No. 62/2013). In late 2013, a group of citizens submitted an initiative to the National Assembly to discu4ss two acts – a draft of the Cannabis Act and a draft of the Self-medication Act. Following the discussion, the National Assembly rejected both drafts, while also appealing to the Government of the Republic of Slovenia to regulate access to cannabis-based medicinal products. This led the Ministry of Health to prepare a new Decree on the Scheduling of Illicit Drugs (Official Gazette of the RS, No. 45/2014) in June 2014, which rescheduled the psychoactive substance THC from the first group of illicit drugs to the second group, i. e. substances for the use in medicine. The Decree also introduced nine new psychoactive substances into the schedule. In April 2014, the National Assembly also passed the new Resolution on the National Programme on Illicit Drugs 2014–2020 (Official Gazette of the RS, No. 24/2014).

In Slovenia, drug-related programmes are financed via a variety of sources. The funding for most is provided by the state budget and the Health Insurance Institute of Slovenia. A portion of the funds is provided by a number of foundations and NGO membership fees, while donations are scarce. Out of all 212 Slovenian municipalities, only 30 responded to the call for submitting a report on co-funding programmes pertaining to illicit drugs. Drawing from available data, an estimated minimum of EUR 9,600,691.75 was allocated to the issue of illicit drugs in Slovenia in 2013.

1.1 Legal Framework

In Slovenia, illicit drugs are regulated by the following regulations:

- The Criminal Code (Official Gazette of the RS, Nos. 55/08, 66/08 – with amendments and 39/09) regulates two (serious) criminal offences pertaining to illicit drugs in its section on criminal offences against personal health: the unauthorised production of and trade in illicit drugs, prohibited substances in sports and ingredients for the production of illicit drugs, and the facilitation of the use of illicit drugs or prohibited substances in sports.
- The Production of and Trade in Illicit Drugs Act (Official Gazette of the RS, Nos. 108/99, 44/00, 2/04 – ZZdrI-A and 47/04 – ZdZPZ) defines illicit drugs as plants or substances of natural or synthetic origin with psychotropic effects and the ability to affect physical or mental health or pose a threat to the appropriate social standing of individuals. Article 3 of the Act categorises illicit drugs into three categories by the degree of health risks in connection to their abuse and by their use in medicine. The categorisation of illicit drugs was passed in 2000 as part of the Decree on the Scheduling of Illicit Drugs by the Government of Slovenia.
- The Act Regulating the Prevention of the Use of Illicit Drugs and the Treatment of Drug Users (Official Gazette of the RS, No. 98/99) defines the treatment and measures for solving social problems related to the use of illicit drugs, among others.

New Developments in Legislation

In early 2013, the Ministry of Health and the Ministry of the Interior drafted the amendments to the Decree on the Scheduling of Illicit Drugs which aimed to restrict access to new synthetic psychoactive drugs mimicking the effects of illicit drugs of natural origin. The Government Decree regulated 48 new

psychoactive substances. The Decree on the Amendments to the Decree on the Scheduling of Illicit Drugs was published in Official Gazette of the RS, No. 62/13, on 22 July 2013.

In late 2013, a group of citizens submitted an initiative to the National Assembly to discuss two acts pertaining to fields which are the responsibility of the Ministry of Health. Since both the draft of the Cannabis Act and the draft of the Self-medication Act collected a sufficient number of citizen signatures (over 5000 signatures, respectively) in accordance with the Referendum and Popular Initiative Act (Official Gazette of the RS, Nos. 15/94, 26/07), the National Assembly was compelled to put both drafts up for discussion. A draft of the positions on both Acts was prepared by the Ministry of Health along with other competent Ministries, namely the Ministry of Finance, the Ministry of Agriculture and the Environment, the Ministry of the Interior and the Government Office of Legislation for the Cannabis Act, and the Ministry of Agriculture and the Environment for the Self-medication Act. The Ministry of Health recommended that the Government pass the inter-sectoral position that the Government expresses its disapproval of both drafts and that the National Assembly reject them. Following the discussion, the National Assembly rejected both drafts, while also appealing to the Government of the Republic of Slovenia to regulate access to cannabis-based medicinal products in Slovenia by amending the Decree on the Scheduling of Illicit Drugs.

This led the Ministry of Health to prepare a new Decree on the Scheduling of Illicit Drugs, which was published in Official Gazette of the RS, No. 45/2014, on 20 June 2014. The new Decree re-categorised THC, one of the psychoactive substances in the cannabis plant used in medicine, from the first group of illicit drugs to the second group of substances approved for the use in medicine. The Decree also introduced nine new psychoactive substances into the schedule.

In early 2014, the Ministry of Health and other competent Ministries drafted the new Resolution on the National Programme on Illicit Drugs 2014–2020. This document builds upon the previous National Programme pertaining to this field. The Resolution was passed in the National Assembly on 2 April 2014, and was published in Official Gazette of the RS, No. 24/2014, on 11 April 2014.

1.2 National Action Plan, Strategy, Evaluation and Coordination

Strategy

The Resolution on the National Programme on Illicit Drugs 2014–2020 primarily focuses on the comprehensive and balanced future development of all measures, programmes and activities with the purpose of combating the issue of illicit drugs in Slovenia. As the approach to the issue of illicit drugs is predominately inter-sectoral and multidisciplinary, the solutions named in the programme encompass the prevention of the availability of illicit drugs as well as prevention, treatment and social services.

Let us highlight the following goals and objectives in the remainder of the new National Programme on Illicit Drugs 2014–2020:

- We endeavour to advance prevention programmes for illicit drug use to reduce the number of new drug users among youth and the number of minor and major criminal offences in connection to illicit drugs.
- We endeavour to support the development of programmes seeking to maintain or reduce the number of HIV, hepatitis B and hepatitis C infections and fatal overdoses.
- We endeavour to accelerate the development of psychosocial treatment programmes for drug users, therapy communities and reintegration programmes for former individuals with addiction problems.

- We endeavour to develop and advance all drug-related coordination structures on the local and state level.
- We endeavour to bolster the activities combating organised crime, the illegal drug trade, money laundering and other drug-related forms of crime.

The Ministry of Health also coordinated the working group for the first operational action plan and prepared the document for further discussion.

Coordination

The Commission on Narcotic Drugs of the Government of the Republic of Slovenia, the highest coordination body in the field of drugs, is an inter-sectoral governmental body and called three sessions in 2013. Among other topics, it discussed the annual National Report on the Drug Situation and all other pressing drug-related topics in Slovenia, including citizen legislation proposals. The operative part of the work of the Commission on Narcotic Drugs is ensured by the Ministry of Health, which prepared session materials and is responsible for the implementation of Commission session decisions along with other competent sectors and institutions. Measures pertaining to illicit drugs are carried out within a number of ministerial sectors, including that of 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. In addition to the representatives of these ministries, the Commission on Narcotic Drugs includes the representatives of two coalitions of non-governmental organisations.

In Slovenia, November is the month in which organised, concentrated activities aim to influence people's thought processes, experience and behaviours in connection to various types of addiction, focusing on drugs. This period includes the distribution of written materials as well as a number of state-wide and local prevention activities by government and non-governmental institutions involved in the prevention or treatment of addiction to illicit drugs, such as school, preschools, Social Services Centres, Local Action Groups and health care institutions. These prevention activities aim to empower individuals to protect themselves from risk factors in their environment, to reduce demand, as well as to reduce the consequences associated with drug use. These activities were carried out by the Ravne na Koroškem Regional Office of the National Institute of Public Health and the Ministry of Health for the thirteenth time in a row, which also organised a conference on prevention. In 2013, the conference took place in Slovenj Gradec under the slogan “What is permitted is not always safe”. Campaign slogans are customarily derived from the United Nations Office on Drugs and Crime guidelines, which holds the annual International Day against Drug Abuse and Illicit Trafficking on 26 June.

The coordination of the field of drugs on government level is the responsibility of the Commission on Narcotic Drugs of the Government of the Republic of Slovenia and the Ministry of Health. Locally, Local Action Groups remain the principal coordinators within local communities.

1.3 Economic Analysis

In Slovenia, drug-related programmes are financed via a variety of sources. The funding for most is provided by the state budget and the Health Insurance Institute of Slovenia. A portion of the funds is provided by a number of foundations and NGO membership fees, while donations are scarce or not reported.

Budget Appropriations

In 2013 and 2014, the Ministry of Health allocated EUR 200,000 for programmes pertaining to illicit drugs by a call for tender. One half of the sum was paid out to selected programmes in 2013, with the other half paid out in 2014. In 2013, the Ministry also co-funded a proportional share of EUR 100,000 for the operation of the National Focal Point at the National Institute of Public Health.

The Office for Youth of the Republic of Slovenia co-funded activities or types of programmes which could be identified as directly performing activities pertaining to illicit drugs in 2013 within the means of the Office to the sum of EUR 39,784.

In 2013, the Ministry of Labour, Family, Social Affairs and Equal Opportunities distributed EUR 2,808,813.80 for the operation of programmes in the same year in connection to the treatment of users of illicit drugs by a call for tender.

Table 1.1 lists data on the sum of funds allocated by the Ministry of Labour, Family, Social Affairs and Equal Opportunities to social rehabilitation programmes for addicted persons and through those, to social protection programmes pertaining to illicit drugs.

Table 1.1: Ministry of Labour, Family, Social Affairs and Equal Opportunities funds for social care programmes pertaining to illicit drugs, 2008–2013

Ministry of Labour, Family, Social Affairs and Equal Opportunities funds in EUR for: Year:	Social rehabilitation programmes for addicted persons	Therapy community programmes and other community programmes which provide housing for drug users, including the associated networks of admission and day centres, reintegration centres, parallel therapy programmes for the families of drug users and therapy communities of alternative programmes for drug users	Low-threshold programmes for drug users, networks of counselling and social rehabilitation centres of persons addicted to illicit drugs requiring daily treatment
2013	2,808,813.80	1,950,639.20	858,174.60
2012	2,840,897.90		
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

* The piece of data not the sum of Column 3 and 4 of the table, as certain additional social protection programmes (prevention programmes, programmes pertaining to alcoholism and other types of addiction and eating disorders) are funded aside from programmes pertaining to illicit drugs by the "Social rehabilitation programmes for addicted persons" category.

Source: Ministry of Labour, Family, Social Affairs and Equal Opportunities Report[1]

The Ministry of Labour, Family, Social Affairs and Equal Opportunities co-funds 80% of the total cost of the programme, while the programme must obtain the remainder of the funds from other sources.

The role of local communities is especially important, as they help obtain appropriate premises to carry out the programmes.

Of the funds provided by the Ministry of Labour, Family, Social Affairs and Equal Opportunities for co-funding of social rehabilitation programmes, approximately 60% are allocated to high-threshold programmes, approximately 25% are allocated to low-threshold programmes, while approximately 15%

[1] Available from the author.

of funds are allocated to prevention programmes (selective and induced prevention). The funds allocated for the implementation of the programmes are most used to cover the professional staff expenses and urgent material costs.

The Ministry of the Interior selected one substantive network of non-governmental organisations via a call for tender to carry out European cohesion policy projects in the 2012–2014 period in the Republic of Slovenia. The Utrip Institute for Research and Development received EUR 43,987.88 for the purposes of establishing an NGO prevention platform in connection to the prevention of addiction.

The Slovenian Criminal Police spends over half a million euros p. a. to combat organised crime. Specific data for 2013 show that EUR 578,745.75 were spent on covert investigation measures and technical equipment, while EUR 572,163.47 were used for the same purpose in 2012. The majority of the funds were allocated to the fight against illicit drugs. Since crime investigations tend to involve several distinct criminal offences, no specific or precise data on the total sum spent on combating illicit drugs can be provided.

The Health Insurance Institute of the Republic of Slovenia spent EUR 4,954,134 on the operation of Centres for Prevention and Treatment of Illicit Drugs Addiction in 2013. EUR 2,454,134 were used for the operation of the centres (staffing, space, etc.), while EUR 2,500,000 were spent on substitute drugs (methadone and others).

The Health Insurance Institute of the Republic of Slovenia also provided EUR 146,022 for the purchase of sterile material for safe drug injection in 2013, which was distributed to harm reduction programmes by the Koper Regional Office of the National Institute of Public Health.

In 2013, the FIHO foundation provided EUR 283,288.90 to drug-related programmes organised within non-governmental organisations.

This year's report also provides data on co-funding of programmes pertaining to illicit drugs by Slovenian municipalities. There are currently 212 municipalities in Slovenia. Data obtained from 30 municipalities show that these local communities spent a total of EUR 545,915.42 on solving drug-related issues.

Table 1.2: Cumulative data on funds spent on drug-related issues in 2013

	Fund provider	SUM (EUR)
1.	Municipalities	545,915.42
2.	FIHO	283,288.90
3.	Office for Youth	39,784.00
4.	Health Insurance Institute of Slovenia	5,100,156.00
5.	Ministry of Health	200,000.00
6.	Ministry of Labour, Family, Social Affairs and Equal Opportunities	2,808,813.80
7.	Ministry of the Interior	622,733.63
8.	Total	9,600,691.75

Souces: Republic of Slovenia Budget, Health Insurance Institute of Slovenia, FIHO Foundation, municipalities

The report only includes available reports on the funding of various programmes in connection to illicit drugs. The reports by some of the fund providers make it appear that various organisations and projects are funded as a whole, which makes it difficult to ascertain what share of the funds was spent on the implementation on the programme as a whole and how much was actually spent on drug-related issues alone. We estimate that a minimum of EUR 9,600,691.75 was allocated to the issue of illicit drugs in Slovenia in 2013 (Table 1.2).

2. DRUG USE IN THE GENERAL POPULATION AND SPECIFIC TARGETED GROUPS

No new study on drug use in the general population or specific targeted groups was carried out or completed in 2013. The first study on the prevalence of illicit drug use among adult citizens in Slovenia was carried out in 2008; it afforded us a more detailed understanding of the prevalence of the phenomenon. Before the study, the only available data were those obtained in the 2007 EHIS study and the Slovenian Public Opinion surveys of 1994 and 1999. In 2011 and 2012, however, a Survey on the Use of Tobacco, Alcohol and Other Drugs among inhabitants of Slovenia aged 15 to 64 was carried out on a representative sample using EMCDDA methodology. According to this survey, as many as 16.1% of Slovenians in this age group have used an illicit drug at least once in their lifetime; nearly one fifth of all men and 12.2% of all women. Of those who have used an illicit drug in their lifetime, cannabis was the most common drug of choice.

Data on drug use in a the school-aged population are obtained by two international surveys, namely the European School Survey Project on Alcohol and Other Drugs (ESPAD) and Health Behaviour in School-Aged Children survey (HBSC). According to the 2011 ESPAD survey, 23% of secondary school students aged 15 to 16 have used cannabis in their lifetime, while the 2010 HBSC study found that 23.2% of 15-year-olds have used marijuana on at least one occasion in their lifetime.

The latest study on drug use in targeted groups was performed in 2010 by the DrogArt Association; it focused on nightlife drug use.

2.1 Drug Use in the General Population

The first study on the prevalence of illicit drug use among adult inhabitants of Slovenia (18–64 years of age) was carried out in 2008, which afforded us a more detailed understanding of the prevalence of the phenomenon; according to its data, as many as 15.8% of respondents have taken an illicit drug on one or more occasions in their lifetime (Stergar 2010). Prior to the study, the only available data were those obtained in the 2007 EHIS study and the Slovenian Public Opinion surveys of 1994 and 1999. According to the 2007 EHIS study, 2.6% of people over the age of 15 reported last year cannabis use and 0.9% of people reported last year use of other illicit drugs (Krek and Štokelj 2009). According to the data obtained by the Slovenian Public Opinion survey, 4.3% of respondents used an illicit drug on one or more occasions in their lifetime in 1994, while the same was true for 10.6% of respondents in 1999 (Toš et al. 1999; Toš et al. 1994).

In 2011 and 2012, a Survey on the Use of Tobacco, Alcohol and Other Drugs was conducted among inhabitants of Slovenia aged 15–64 using EMCDDA methodology (more in the 2012 and 2013 National Reports). According to survey data, 16.1% of inhabitants of Slovenia aged 15–64 have used an illicit drug in their lifetime; nearly one fifth of all men and 12.2% of all women. Of those who have used an illicit drug in their lifetime, cannabis (15.8%) was the most common drug of choice. 2.1% have used cocaine and ecstasy, respectively, 1.0% have used LSD, 0.9% have used amphetamines, 0.5% have used heroin and 0.6% have used new drugs (Table 2.1). 6.4% of inhabitants have used a combination of drugs on one or more occasions in their lifetime. Data by gender and individual substance showed that lifetime use of every individual drug was higher in men than in women. Data by ten-year age group indicate that lifetime use of cannabis, cocaine, ecstasy, amphetamines and a combination of drugs is

more prevalent in the age groups below 34 years of age than in those above 34 years of age, while heroin and LSD use is more common in the 25–34 and 35–44 age groups than in older age groups. The use of new drugs is most common in the youngest group aged 15–24. In terms of status, lifetime use of cannabis and a combination of drugs is more prevalent in those currently part of the education process (pupils, secondary school and university students), lifetime use of cocaine, ecstasy, amphetamines and new drugs is more common in those currently participating in the education process and the unemployed, while lifetime heroin and LSD use is most common among the unemployed.

Table 2.1: Share of illicit drug use in the general population, by gender, age groups and employment status

Prevalence (%)	Drug	Total	Gender		Age group					Status			
		15–64 years n=7514	Male n=3862	Female n=3652	15–24 years	25–34 years	35–44 years	45–54 years	55–64 years	Employed	Pupils, secondary and university students	Unemployed	Retired
Lifetime	Cannabis	15.8	19.5	11.8	27.3	29.7	14.5	7.5	2.5	15.5	29.3	19.9	1.5
	Cocaine	2.1	2.8	1.2	3.9	4.4	1.7	0.5	0.1	1.7	3.9	4.7	0.0
	Ecstasy	2.1	2.7	1.4	3.5	5.4	1.5	0.2	0.1	1.8	3.5	4.6	0.0
	LSD	1.0	1.4	0.6	0.9	1.6	1.6	0.6	0.3	0.9	1.3	2.4	0.3
	Amphetamine	0.9	1.4	0.5	1.9	2.3	0.5	0.2	0.0	0.7	2.3	2.0	0.0
	Heroin	0.5	0.7	0.3	0.7	0.8	0.7	0.2	0.1	0.3	0.6	1.9	0.1
	New drugs	0.6	0.9	0.3	1.8	1.0	0.4	0.1	0.1	0.3	2.0	1.6	0.0
Last year	Cannabis	4.4	5.9	2.8	15.0	6.8	1.7	0.8	0.2	2.4	16.0	6.9	0.0
	Cocaine	0.5	0.7	0.3	1.9	0.6	0.3	0.1	0.0	0.3	1.5	1.0	0.0
	Ecstasy	0.3	0.4	0.2	1.3	0.4	0.0	0.0	0.0	0.1	1.4	0.3	0.0
	LSD	0.1	0.2	0.1	0.4	0.3	0.0	0.0	0.0	0.0	0.7	0.3	0.0
	Amphetamine	0.3	0.5	0.1	1.1	0.5	0.1	0.0	0.0	0.0	1.4	0.7	0.0
	Heroin	0.1	0.1	0.0	0.3	0.1	0.0	0.0	0.0	0.0	0.1	0.3	0.0
	New drugs	0.3	0.4	0.2	1.2	0.5	0.0	0.0	0.0	0.0	1.4	0.6	0.0
Last month	Cannabis	2.3	3.3	1.2	7.5	3.7	1.0	0.4	0.1	1.3	7.6	4.7	0.0
	Cocaine	0.1	0.2	0.1	0.6	0.2	0.0	0.1	0.0	0.0	0.6	0.2	0.0
	Ecstasy	0.1	0.2	0.1	0.5	0.3	0.0	0.0	0.0	0.0	0.6	0.3	0.0
	LSD	0.0	0.1	0.0	0.2	0.0	0.0	0.0	0.0	0.0	0.2	0.0	0.0
	Amphetamine	0.1	0.2	0.1	0.5	0.3	0.0	0.0	0.0	0.0	0.8	0.3	0.0
	Heroin	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	New drugs	0.1	0.1	0.1	0.3	0.2	0.0	0.0	0.0	0.0	0.5	0.0	0.0

Source: National Institute for Public Health, 2011–2012 Survey on the Use of Tobacco, Alcohol, and Other Drugs

2.2 Drug Use in the School and Youth Population

Data on drug use in a school and youth population are obtained with two international studies, the European School Survey Project on Alcohol and Other Drugs (ESPAD) and Health Behaviour in School-aged Children survey (HBSC).

The European School Survey Project on Alcohol and Other Drugs was carried out in Slovenia for its fifth time in a row in 2011. According to the survey, 24.8% of surveyed secondary school students aged 15 or 16 have used an illicit drug in their lifetime. The trend indicated by the data, i.e. the stabilisation of the prevalence of illicit drug use after 2007, is similar to that of other countries. Compared to the ESPAD average, Slovenia scored above average on the lifetime use of inhalants and cannabis in particular, with 20% of secondary school students reporting lifetime inhalant use and 23% of students reporting lifetime cannabis use (Stergar 2011).

In 2010, the international survey Health Behaviour in School-aged Children was carried out for the third time in Slovenia. The study includes questions on marijuana use among 15-year-olds. According to study data, 23.2% of them have smoked marijuana in their lifetime. 18% reported having smoked marijuana within the last 12 months, while 10% said they used marijuana within the last 30 days (Scagnetti 2011). Following a drop in the share of 15-year-olds who have used marijuana in the 2002–2006 period, the share has been in the rise in the 2006–2010 period (Bajt 2012).

2.3 Drug Use in the Targeted Groups

In 2010, the DrogArt Association performed a study on the use of cocaine and other drugs in nightlife in Slovenia. It found that the most commonly used drug among the respondents was marijuana (80%), followed by amphetamines and cocaine (Sande 2013) (More on the study in the 2013 National Report).

3. PREVENTION

In Slovenia, prevention is regulated by laws, regulations and guidelines across a variety of sectors coordinated by the Ministry of Health in the field of the prevention of psychoactive substance abuse. As an inter-sectoral working group composed of the representatives of nine ministries and two NGO associations focusing on drugs, the Commission of the Government of the Republic of Slovenia on Drugs is responsible for the coordination of government policy, measures and programmes.

Slovenia has introduced no new legislative measures to combat tobacco use within the past year, with legislation regarding the reduction of hazardous and harmful alcohol consumption also remaining unchanged, though the tax rate on and the prices of tobacco products have risen, as have excise duties on alcohol and alcohol beverages. The most recent opinion poll from May 2014 showed that Slovenians of legal age largely approve of the new measures on tobacco control and most measures to combat alcohol consumption. Non-governmental organisations monitored violations of the existing legislation on reducing alcohol and tobacco use, with the Youth Association No Excuse filing 39 complaints on possible violations of law in 2013. As part of the Mystery Shopper campaign in early 2014, the Youth Association No Excuse visited 48 shops selling alcohol and 13 tobacco vendors to test whether the businesses sold alcohol or tobacco to minors. Minors were able to complete the purchase in a majority of cases. The Slovenian Coalition for Tobacco Control carried out the Yellow Card campaign at tobacco vendors and in magazines. In 2013 and early 2014, volunteers approached 156 locations advertising, promoting or selling tobacco products. Under-age customers were able to purchase tobacco products in 25 cases.

Unplugged, a school-based prevention programme was carried out by the Utrip Institute also in 2013 and 2014, with 15 new schools joining the programme since its pilot phase. Due to poor attendance, the year 2014 saw the workshop for parents replaced by EFFEKT, a parent-based prevention programme focused on parents maintaining stricter rules on alcohol drinking for their children. In 2013, the No Excuse Youth Association carried out 677 workshops on tobacco and alcohol, reaching 14,457 young people ages 12 to 15. Monitoring the opinions on alcohol among workshop leaders showed that they were more negative after the completion of the training and the workshops themselves than before it. Despite the difficulties in securing financial means for the Strengthening Family programme concerned with the prevention of addiction, the programme will be continued in the Goriška region.

As part of Click for Support, a European project developing guidelines for effective online counselling services for young drug users, the Slovenian partners reviewed online drug-related interventions and organised a workshop at which young drug users evaluated a selection of three online interventions. After participating in the pilot phase of Take Care, a European programme aiming to reduce alcohol consumption and related harm to adolescents and young adults, Slovenia has continued implementing the project. In 2013, the programme was presented to the key institutions dealing with young adults, promotional materials were created and training was carried out for twelve alcohol vendors. 39 young people participated in ro.pe training, and 62 parents partook in debate parties. In spring of 2013 and 2014, the Koper Svit Society carried out two programmes in the field; as part of their Bouncing Ball programme, a variety of safe, high-quality outdoor activities was organised for children of drug users and other school-aged children in an area with a high number of drug users with children, and counselling was provided to the parents. Their Bat programme, on the other hand, sought to raise awareness among young people at a number of night venues about the consequences of the use of alcohol and other drugs. The addiction prevention programme aimed at the Roma community continued

into 2013. A training programme was carried out for professionals who deal with Roma youth in a professional capacity. Special emphasis was laid on Roma history, culture and inter-cultural communication. The publication Health, Prevention of Addiction and Roma Youth was published; its target audience are those who deal with the Roma community in their professional capacity in connection to drugs and addiction. As part of Fred Goes Net, an early intervention programme for first-time users of alcohol and illicit drugs, 16 courses involving 196 secondary-school students who had consumed drugs or alcohol and 14 courses involving 156 such secondary-school students were carried out in 2013 and 2014, respectively. In 2013 and 2014, the After Taxi project was carried out in Ljubljana, handing out vouchers for a free taxi ride to young people going home from a party. In 2014, vouchers also began to be distributed at locations popular with youth. Evaluation results for 2013 indicated that the majority of respondents preferred using the Free Taxi vouchers to drunk driving. In addition, the DrogArt organisation developed the mobile application Driving 0.0 which allows users to calculate the amount of alcohol in exhaled breath. The application was used by 3285 users in the period from May 2013 and August 2014. In 2014, the Choose Yourself programme seeking to reduce harmful effects of alcohol consumption in youth was expanded through campaigns in the field called Choose Your Own Party, which involves interactive street animation and seeks to present interesting ways of socialising, partying and spending leisure time.

The 2013 Substance Abuse Prevention Month slogan was, “What is permitted is not always safe”, and special attention was paid to new psychoactive substances. A national conference was organised regarding this topic as part of Substance Abuse Prevention Month.

3.1 Environmental Prevention

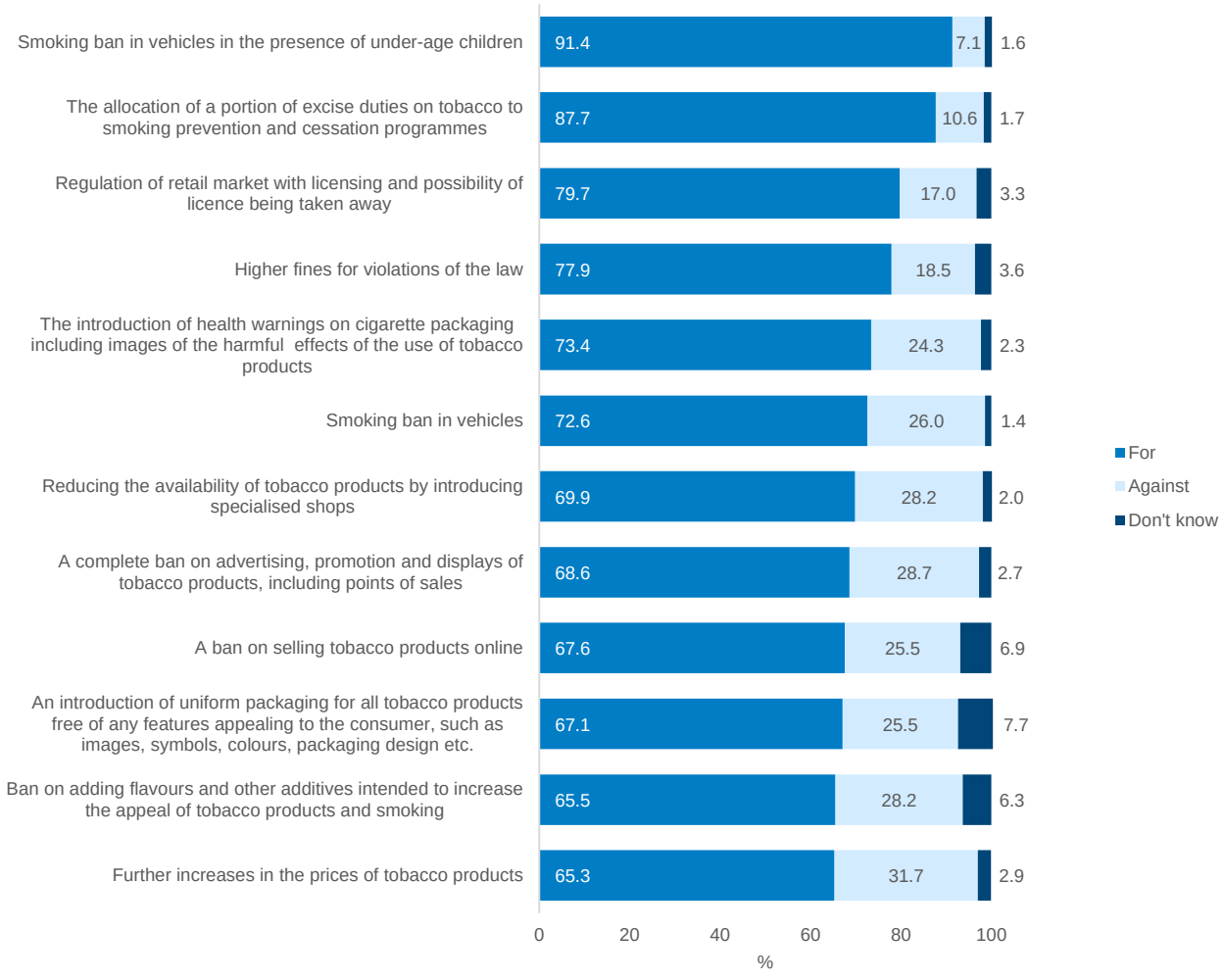
Measures for Reducing Tobacco and Alcohol Use

Helena Koprivnikar, Maja Zorko, PhD, Nataša Blažko

Slovenia has introduced no new legislative measures to combat tobacco use within the past year, but the tax rate on tobacco products and their prices have risen. Between 1 January 2013 and 16 May 2014, the weighted average retail price of a 20-cigarette pack rose from EUR 2.95 to EUR 3.31 according to Ministry of Finance of the Republic of Slovenia data. Following the most recent price increase of 16 May 2014 the prices for a package of cigarettes were in the EUR 2.99 to EUR 4.20 range, according to Customs Administration of the Republic of Slovenia data. Factory-made cigarettes continue to represent the largest share on the tobacco market in Slovenia by far; however, the last two to three years have seen a steep increase in the sales of rolling tobacco, which is most likely primarily due to its lower price compared to factory-made cigarettes. The past year also saw an increase of the taxation and prices of fine-cut tobacco (rolling tobacco), though they remain at least 30% lower than the price of factory-made cigarettes. The calculation assumes that 1g of tobacco equals one factory-made cigarette. However, because 20 g of tobacco may be used to roll more than 20 cigarettes, the price of smoking hand-rolled cigarettes compared to factory-made cigarettes may appear even lower to a smoker. Slovenian tax rates currently exceed the minimum European directive requirements; this is true for tax rates on both factory-made cigarettes as well as fine-cut tobacco.

In 2013, Slovenia was among the most active European Union Member States striving for the introduction of more stringent public health measures during the drafting of the new Directive on the approximation of the laws, regulations and administrative provisions concerning the manufacture, presentation and sale of tobacco and related products. In Slovenia, apart from the measures introduced

by the new Directive, experts and organisations active in reducing the use of tobacco products, support the introduction of additional effective measures for tobacco control , *inter alia*, the complete ban on advertising, promotion and display of tobacco products without exceptions, including points-of-sale; reducing the accessibility of tobacco products by introducing licensing of tobacco product vendors and/or specialised shops; further increases in the price of tobacco products; the allocation of a portion of excise duties on tobacco products to smoking prevention and cessation programmes; and the regulation of electronic cigarettes as soon as possible. According to a public opinion survey from May 2014, the introduction of various measures is supported by the majority of Slovenian inhabitants of legal age, as demonstrated in Figure 3.1 (Ministry of Health 2014).

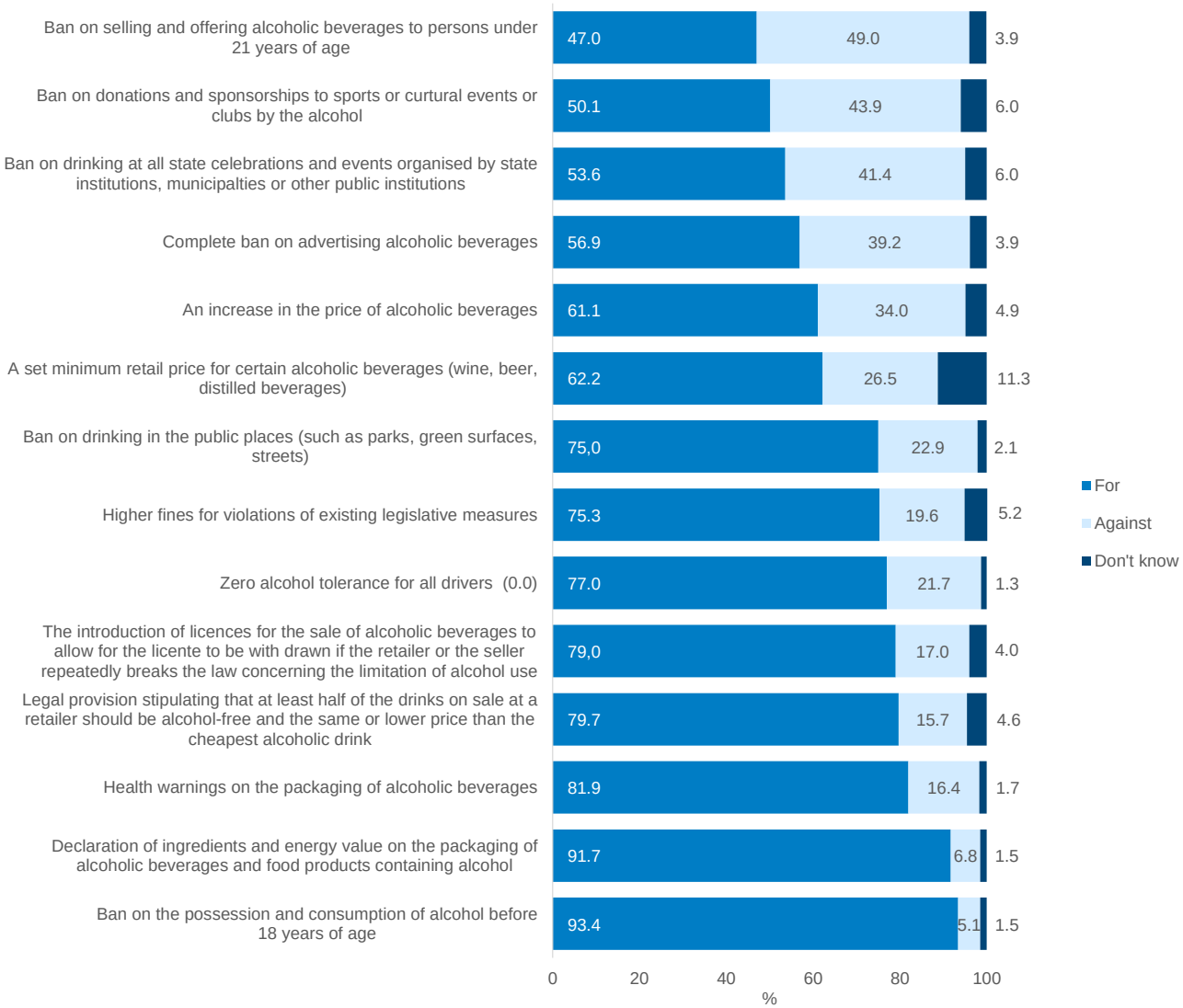


Source: Ministry of Health, 2014 Public Opinion Survey

Figure 3.1: Support for new measures for tobacco control among Slovenian inhabitants, aged 18 or more

The legislation regarding the reduction of hazardous and harmful alcohol consumption also remained unchanged within the past year, with a change in excise duties on alcohol only. In April 2014, the Government of the Republic of Slovenia issued the Decree determining the amount of excise duty on alcohol and alcoholic beverages (Official Gazette of the RS, No. 25/2014). The Decree introduced a 10% increase for the excise duty on beer, intermediate products and ethyl alcohol, resulting in an excise duty of EUR 12.10 for 1% alcohol content by volume for beers, EUR 132 for intermediate products and EUR 1,320 for ethyl alcohol for 100% of alcohol content by volume, all per hectolitre. No excise duties apply to wine or fermented drinks or amount to EUR 0. Excise duties are not adjusted for inflation.

The most recent public opinion survey (Ministry of Health 2014) on the support for some of the measures of alcohol policies showed that Slovenian inhabitants, aged 18 or more, largely support most of the measures for the reduction of alcohol consumption (Figure 3.2). The highest degree of support is enjoyed by the ban on the possession and consumption of alcohol before 18 years of age, the mandatory declaration of ingredients and energy value on the packaging of alcoholic beverages and food products containing alcohol, mandatory health warnings on the packaging of alcoholic beverages, and the rule that at least 50% of the beverages on sale must be alcohol-free and cost the same or less than alcoholic beverages. Over 60% of Slovenian residents, aged 18 or more, also backed the introduction of special permits (licences) for the sale of alcoholic beverages, higher fines for violating existing provisions, 0.0 blood alcohol content for all drivers, the ban on alcohol consumption on public places, the introduction of the minimum price of alcohol and an increase in the price of alcohol. Less than 60% of Slovenian residents, aged 18 or more, support the complete ban on advertising alcoholic beverages, the ban on alcohol consumption on all state celebrations and events, the ban on donations or sponsorships of sports and cultural events or clubs by the alcohol industry, and the ban on selling and offering alcoholic beverages to persons under 21 years of age.



Source: Ministry of Health, 2014 Public Opinion Survey

Figure 3.2: Support for new measures for the reduction of alcohol consumption among Slovenian inhabitants, aged 18 or more

Monitoring Violations of the Current Legislation on the Reduction of Alcohol and Tobacco Use

Youth Association No Excuse: Monitoring Violations of the Legislation on Alcohol and Tobacco

Daša Kokole, Jan Peloza, Nina Rogelj

As part of the Mystery Shopping campaign for tobacco and alcohol products in the first half of 2014, the Youth Association No Excuse visited shops across Slovenia and had under-age shoppers test whether retailers in shops sold alcohol or tobacco to minors.

In connection to alcohol, we visited 48 shops in 4 cities: Ljubljana, Maribor, Kranj and Celje. Under-age shoppers were tasked with attempting to buy a can of beer (under supervision by an adult chaperone). In each city, we visited 12 shops and performed two measurements in each (in the morning and the afternoon). Alcohol was sold to minors in 83% of cases in Ljubljana and in 96% of cases in Kranj, Celje and Maribor.

In connection to tobacco, we visited 13 tobacco vendors, including 3 in Postojna, 5 in Ljubljana and 5 in Koper. Under-age shoppers attempted to purchase a pack of cigarettes (again under supervision by an adult chaperone). Altogether, they were successful in 92% of cases; 100% in Postojna and Koper and 80% of cases in Ljubljana.

In addition to that, we filed reports of violations of the Act Restricting the Use of Tobacco Products (Official Gazette of the RS, No. 93/2007) and Act Restricting the Use of Alcohol (Official Gazette of the RS, No. 15/2003) to various inspectorates (the Trade and Health Inspectorates and the Inspectorate of Education and Sport) in 2013 and first half of 2014. In 2013, we filed 39 reports of potential violations of the law. In 18 cases, the inspectorates started an official inspection and established 7 violations (Table 3.1).

Table 3.1: Statistics on the reports of violations pertaining to alcohol and tobacco, 2013

Field	No. of reports	Violations discovered
Alcohol (total)	9	1
Advertising of alcohol	6	1
Cross-border advertising	1	0
Procurement of alcohol at a sports event	1	0
Text by an advertisement	1	0
Tobacco (total)	30	6
Electronic cigarettes	11	1
Advertising of tobacco	8	2
Smoking room	4	1
Smoking indoors	3	0
Illegal sale	1	1
Cross-border advertising	1	0
Health warnings	1	1
Sponsorship	1	0
Total	39	7

Source: Youth Association No Excuse

The Slovenian Coalition for Tobacco Control: Monitoring Violations of the Legislation on Tobacco

Mihaela Lovše

The Slovenian Coalition for Tobacco Control carried out the Yellow Card campaign for the control of the promotion and sales of tobacco products at tobacco vendors (kiosks, hospitality establishments and shops) across Slovenia and in print media. The campaign involved under-age volunteers who had obtained prior written consent by the parents, undergone training for the campaign and were motivated to respect the Act Restricting the Use of Tobacco Products. In 2013 and first half of 2014, the volunteers visited 156 sites where tobacco products are advertised, promoted and sold. In 25 cases, the under-age shoppers were able to purchase a tobacco product. They placed “The law restricts to protect” flags at the sites where violations were detected listing the articles of the Act that the vendors should have complied with. The Trade Inspectorate of the Republic of Slovenia and the Health Inspectorate of the Republic of Slovenia were notified of the violations. We carried out 14 visits to venues to check the oversight on the adherence to the smoking ban in public spaces and the oversight on advertising and sponsoring events, and detected 6 potential violations, mostly at large public events in the evening.

3.2 Universal Prevention

Reitox Regional Academy

Branka Božank, Marijana Kašnik

On 28–29 April 2014, Ljubljana's City Hotel hosted the two-day Reitox Regional Academy, organised by the European Monitoring Centre for Drugs and Drug Addiction and the National Institute for Public Health. The event was part of the Preparing IPA4 Beneficiaries for Participation in the EMCDDA project. The key goal of the conference was to pave the way to creating a model for the formulation of quality standards for prevention programmes and their successful implementation into common practice.

The Reitox Academy was attended by about 60 experts working in a variety of ways and at various levels connected to addiction: non-governmental organisations, public health institutes, the police, various ministries and faculties. The participants came from 10 countries in the region: Albania, Bosnia and Herzegovina, the Former Yugoslav Republic of Macedonia, Kosovo, Montenegro, Poland, Serbia, Slovenia and Turkey.

The Reitox Regional Academy Evaluation Report by EMCDDA states that the capabilities and activities for the exchange of good practices need to be further developed in the future, both in Slovenia and in IPA4 beneficiary states. Special attention needs to be paid to the content of prevention programmes and their general planning, monitoring and evaluation. Apart from theoretical aspects, the development of capabilities should also involve components such as the exchange of information on the content and results of individual prevention activities being implemented at the basic level.

Unplugged

Matej Košir and Sanela Talić

The school prevention programme Unplugged (Izštekani) was first carried out by Utrip Institute on a pilot basis in the 2010/2011 academic year. The pilot phase included 23 intervention and 22 control primary schools from around Slovenia (more on the project in the 2011 and 2012 National Reports). Following the pilot phase, 15 additional primary schools have joined the programme, and 73 additional teachers

have been trained to carry out the programme in 5 training sessions. The 2014/2015 academic year is a turning point in the future development and expansion of the Unplugged programme, since workshops for parents have been replaced with Effekt, a new Swedish prevention programme, due to low attendance by the parents. The programme focuses on parents maintaining more stringent rules for their children on alcohol consumption, and is carried out at parent-teacher meetings twice a year (i.e. at least five times in the last three-year period of primary school) by trained lecturers. The current situation and trends related to alcohol (Zorko et al. 2013) show that there is a great need for this type of prevention programmes aiming to reduce risk and harmful alcohol consumption among minors. In its pilot phase in the 2014/2015 academic year, the Effekt programme involved 9 intervention and 9 control primary schools from various parts of Slovenia. The programme will be evaluated both in terms of the process as well as in terms of outcomes, notwithstanding the fact that there is much scientific evidence as to its effectiveness already in existence (Koutakis et al. 2008; Koutakis and Ozdemir 2010; Bodin and Strandberg 2011; Ozdemir and Stattin 2012; Koning et al. 2011).

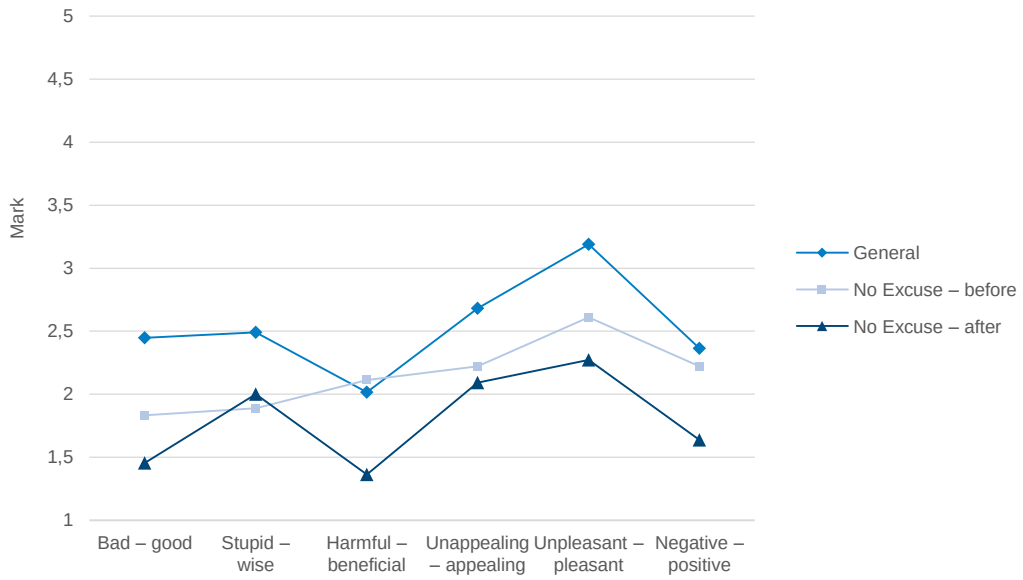
The Slovenian version of the Unplugged programme is one of the most successful such programmes Europe-wide and it has been evaluated in terms of outcomes, as well as demonstrating positive effects, especially in regard to alcohol consumption, intoxication and smoking (Košir et al. 2012).

Peer-to-Peer Prevention Workshops on Tobacco and Alcohol

Daša Kokole

In 2013, Youth Association No Excuse again carried out peer-to-peer prevention workshops in Year 7 of primary school and Year 1 of secondary school as part of the *O_2 belongs to you* project, and workshops on alcohol in Year 9 of primary school as part of the *What about .. no* project. All 12 statistical regions of Slovenia were covered in 2013 and 677 workshops were carried out on the issues of tobacco and alcohol, reaching 14,457 young people between the ages of 12 and 15.

This year, an alcohol-related pilot study of the changes in the opinions of a group of workshop leaders who began holding workshops in 2013 was carried out. The respondents first answered a questionnaire on their opinions on alcohol consumption (where they ranked alcohol consumption on a scale of 1 do 5 with various pairs of adjectives, where a lower mark indicated a more negative opinion, e. g. bad 1, good 5) in April 2013, before training on holding workshops began; they were then trained and participated in running peer-to-peer workshops throughout the year, and responded to the same set of questions in April 2014. The first round (2013) involved 18 activists (16.05 years of age on average), while only 11 activists took part in the second round (2014) due to drop-out (17.18 years of age on average). Due to the low numbers, no statistical analysis was performed; however, Figure 3.3 demonstrates that on average, their opinions shifted towards the negative extreme with nearly all adjective pairs. The change in opinions on harmfulness/benefits of alcohol consumption was the most pronounced.



Source: Youth Association No Excuse

Figure 3.3: A comparison of opinions held by workshop leaders on alcohol consumption before and after the workshops and the opinions of the general population of Slovenian secondary school

The data were also compared to the general population (a convenience sample of 376 secondary school students from around Slovenia) of approximately the same age (15.97 years of age on average) obtained during the measurements in October and November of 2012 as part of data collection for a bachelor thesis[2]. Figure 3.3 demonstrates that the opinions on alcohol consumption held by No Excuse activists had been more negative than those of their peers from the start, with the differences increasing in the second round. Despite the limited data (other potentially significant variables were not monitored, nor was it possible to link the persons and data obtained in both questionnaire rounds) and the small activist sample, the results indicate that carrying out workshops on alcohol is connected to a change in opinions on alcohol.

Strengthening Families Programme

Matej Košir and Sanela Talić

In 2011 and 2012, Utrip Institute carried out the pilot prevention programme The Strengthening Families Programme (Krepitev družin) in the field of addiction prevention; the programme involved 8 families reached out to via school counselling services (more on the project in the 2012 National Report). After a pilot phase, the project unsuccessfully applied for funding for further development and expansion of the programme to multiple tenders by the Ministry of Labour, Family, Social Affairs and Equal Opportunities, Ministry of Health and the City of Ljubljana. In early July 2014, the project was presented in Šempeter pri Gorici to all interested primary and secondary schools as well as dormitories for high school students in the region that are part of the Schools for Health network. In late September 2014, an introductory presentation of the programme was carried out for executives, teachers and parents at the Biotechnical School of the Nova Gorica School Centre, which will be the first school to start carrying out the programme in the 2014/2015 academic year.

[2] Kokole D. (2013) Social skills, susceptibility to peer pressure and alcohol consumption in secondary school students: bachelor thesis.

3.3 Selective Prevention

Click for Support

Jasmina Vrečko and Karmen Osterc Kokotovič

The European project Click for Support, which brings together 13 countries[3] including Slovenia, seeks to develop guidelines for effective online counselling for young drug users and to raise awareness among professionals in drug-related fields about the significance of online technologies in routine work. Digital technology has a significant impact on everyday life of young people, increasing the probability that they would go online to seek help in connection to illicit drugs. Online counselling methods enable easier access to the service, are more cost-effective, reach a wider audience and enable a faster response. Online counselling about illicit drugs is also increasingly important due to the emergence of new psychoactive drugs, such as "legal highs". These substances are inexpensive and readily accessible seeing that they can be purchased online, with websites providing very little information about the substances in question.

In the first phase of the project, the participant states created an overview and an evaluation of online interventions, be it websites, internet forum, chat rooms or applications, as long as they provided expert advice. In Slovenia, three websites were selected for evaluation: Med.over.net, DrogArt (and its application Reduser) and To sem jaz. The evaluation was carried out as a workshop involving 20 invited young users of illicit drugs (11 men and 9 women) between the ages of 15 and 21. They first filled out a prepared questionnaire which involved questions on the use of online interventions in general. They evaluated the three selected web interventions in the second part.

The evaluation results[4] showed that 13 young people have already looked up information in drugs online. They believed that online interventions should include information on drugs (11 respondents), expert help (15 respondents) and the exchange of opinions with other drug users via a forum (11 respondents). Young people wished that such a website included general information about drugs (11 respondents), risks stemming from taking the drug (7 respondents), consequences of use (6 respondents) and the experience of others related to drug use (6 respondents).

All three selected online interventions were known to the majority of the young people in the workshop. 13 respondents would want to use the website Med.over.net, 11 respondents liked the quality provided by this website the most, 15 respondents thought the website design should be changed and ads should be removed, while 6 respondents thought that the website did not provide enough information interesting to young people. 15 respondents would want to use the website DrogArt. What they liked the most was the appearance of the website (11 respondents), but they wished the Reduser application was more easily accessible. 9 respondents would want to use the website To sem jaz. What they liked the most was the website design (10 respondents), but the appearance of the website needed to be improved (8 respondents) and more up-to-date information should be added for users over 16 years of age.

The discussion revealed that the participants felt the appearance of the website was crucial. They mostly wanted a website free of advertisements that was innovative, colourful, creative, and included graphs, quizzes and games. It should include up to five main categories, most importantly: drugs in general, a forum, help/advice and events. They felt that expert advice was very important and that the responses should be clear, age-appropriate and not overly technical, and that they should reach the user within a day. The presentation of the expert should include a photo and personal references. Young people

[3] Slovenia, Luxembourg, Italy, Finland, Netherlands, Germany, Austria, Latvia, Portugal, Cyprus, Belgium, Slovakia and Greece.
[4] Source: 2014 Report of the Maribor Regional Office of the National Institute for Public Health. The report has not been publicly published; it is available with the author.

preferred establishing contact via a forum, which should be moderated and should be read without having to log in. It is also important that counselling can be done via a number of platforms: Facebook, e-mail, forum and Skype. The respondents also felt that conventional counselling was the most effective type of help, and that information on the Internet could only aid someone in realising they had a problem. This is why it is advisable that a website features quizzes which allow young people to realise they need help.

Take Care

Breda Lukavečki Družovec, Karmen Osterc Kokotovič and Karin Mlakar

The Take Care programme aims to reduce alcohol use and associated harm among adolescents and young adults between the ages of 12 and 21 who had previously drawn attention to themselves due to hazardous alcohol consumption. The programme is also aimed at those who serve as role models to these young individuals in terms of behaviour and attitude to alcohol; they may be parents, other significant adult figures or staff selling alcoholic beverages.

The Take Care programme has been shaped to a degree by the experience of SeM (Secondary Prevention of Addition using a Multilevel Approach), a German prevention project, which showed that intervention is the most effective if it is carried out in multiple target groups at once within a certain social setting (Wirth et al. 2013). Methodologically and scientifically, however, it is based on the transtheoretical model, the motivational interview, psychoeducation and learning by doing. It involves the method of using a variety of approaches with a number of target groups with the same objective. It postulates that the various approaches will increase the synergy of everyone involved, thus increasing the effectiveness of the intervention. This allows the programme to influence the social and cultural attitude to alcohol consumption as well.

The programme trains adolescents and young adults to respond competently in risk situations involving alcohol consumption by young people. The purpose of the first informational and motivational interview is to learn more about individual young persons and their issues. They then participate in a 3 to 4-day ro.pe training[5], which includes an adrenaline-filled (sports) event. The purpose of the training is to face risk situations and learn how to act in such situations. Young people in attendance also discuss the effects and dangers of alcohol as well as societal influences, learn about the legislation pertaining to the field, discuss personal experience, their own pattern of drug consumption and find new strategies to handle situations. They are issued a certificate after the completion of the training.

The professionally moderated debate party is intended for parents invited by the host parent as a group to his/her home or the institution premises. The parents discuss alcohol and their attitudes to alcohol as well as any issues they are facing, exchange knowledge about the effects and consequences of alcohol, come up with strategies for specific situations, and most importantly, to strengthen their role as parents. The debate party provides parents with guidelines for formulating a clear position on alcohol, which significantly affects their response to hazardous alcohol use by their adolescent child.

Other significant adult figures are everyone who deals with young people in their line of work and is accepted by them (including counsellors, teachers, staff in youth and secondary school student housing, volunteers, outreach workers, coaches etc.). Members of this group may participate in a two-day workshop, which provides them with information about the issue, the development of addiction and the

[5] Ro.pe training is derived from the first letters of a youth work method **r**isk **o**ptimization, **p**eer **e**ducation. The word also symbolises climbing, ascending.

consequences of alcohol and drug abuse, allows them to reflect on their own attitudes to alcohol and introduces them to motivational interview work methods, which enables us to achieve the motivation needed to make changes.

A short intervention is designed for alcoholic beverage vendors, which provides them with information about legislation pertaining to the sale of alcohol to minors and the consequences of violating the law. Vendors may also opt for longer training where they learn about strategies for handling complex situations involving the sale of alcohol to minors and alternative suggestions for increasing sales without promoting alcoholic beverages.

A pilot of the project involving 10 EU countries[6] was implemented between 2010 and 2012. 1690 participants partook in the evaluation of the pilot project including 440 young people, 474 parents, 176 other significant adult figures and 600 alcoholic beverage vendors. The following indicators were used to evaluate the objectives: the number of young participants involved in the project, their level of satisfaction with the intervention and changes to their opinions and behaviour. The evaluation showed that the consumption of alcohol significantly decreased among the young participants, especially among those who engaged in hazardous alcohol consumption. Of those, 44.4% reduced the amount of consumed alcohol as well as the frequency of consumption, 33.6% remained stabilised on the lower drinking limit, 21.5% consumed more alcohol, 12.8 of those were under 16 years of age and only drank one or two glasses of alcohol over a long period of time leading up to the second interview. The young people participating in the programme attained a better understanding of the law and followed it more closely. Other target groups were also largely in agreement with the law after the intervention. The satisfaction of all target groups with the intervention was graded as high (Kern-Scheffeldt et al. 2012).

The programme continued to be implemented in Slovenia in 2013 and 2014 within the area covered by the Maribor Regional Unit of the National Institute of Public Health. The programme was first presented to institutions dealing with young people (health care centres, hospitals, centres for social work, schools, dormitories for secondary school students, the police, courts of law, sports and other associations, hospitality establishments etc.), which was followed by training for those carrying out the programme and the creation of promotional materials. The short type of training was provided to 12 vendors of alcoholic beverages, 39 young people with a history of risk alcohol consumption participated in 4 ro.pe training sessions and 62 parents partook in 4 debate parties. We also plan to carry out training for other significant adult figures and a final meeting where we will present the programme to the general public.

Outreach to Young People in the Community and at Youth Nightlife Venues

Ingrid Kristančič Šömen

Since carrying on with the Support Programme for Families, Children and Adolescents in its existing form was made impossible after 2011 due to the lack of financial and human resources, we organised volunteer-based creative workshops, additional learning support and organised activities during winter break for children from socially disadvantaged families and children with parents addicted to psychoactive substances.

In accordance with the European strategy which promotes the use and exchange of good prevention practices, the Svit Koper Association carried out street prevention activities in Koper in May 2013. An off-road vehicle, originally used for fieldwork with active drug users, was modified for youth work. The principal purpose of the programme, known as Bouncing Ball (Žoga Skače), is to promote a healthy

[6] Slovenia, Belgium, Cyprus, Denmark, Greece, Ireland, Italy, Germany, Portugal and Slovakia.

lifestyle among youth by creating a positive, safe environment for leisure activities. This is made possible by organising a number of sports, creative, educational and cooking activities as well as a youth discussion round where issues important to young people are discussed (such as sexuality, partying, drugs, and interpersonal relationships). Its target audience are children in primary school, and it also provides information and counselling to parents. The Bouncing Ball project took place twice a week in the afternoon at a permanent location in Markovec near the town of Koper next to the parking garage on Krožna Cesta, which is in immediate proximity to a playground; in 2013, it was held between 7 May and 4 July, and between 6 March and 30 June of 2014. This amounted to 135 hours of outreach in the spring of 2013 and 2014, 270 points of contact with young people in the programme and 47 sessions with parents in the field.

Spring of 2014 also saw the beginning of intergenerational cooperation following a very positive response by the locals. The cooperation developed as the consequence of invitations by residents or passers-by in individual discussions, seeing that residents, parents or grandparents often became involved with some of the activities (hula hooping, brain games, guess the objects in the box, etc.). This was especially true of retired education professionals. We noticed a high number of active pensioners who face insufficient inclusion, but who could substantially contribute to the well-being of the community.

The Bat (Netopir) project is the name of our 2013 programme for working with young people at youth nightlife venues as part of prevention in the local community and in response to the observed excess alcohol consumption among youth (Žabkar 2012). The programme was carried out at a number of venues from Koper to Izola between 4 October 2013 and 5 July 2014. Its purpose was to establish the needs of young people via direct personal contact in the field and to raise awareness among the youth about adverse effects of drug use as well as on safe, responsible sex.

The project vehicle operates on a schedule and is parked at a party venue (open-air car parties, Gavioli etc.) or makes round trips between various less known locations popular among the youth. Young people are provided with information materials, condoms, a chance to talk, get advice or a bottle of water since their car trucks are only filled with alcohol (open-air car parties). We also encourage them to get home safely and raise awareness about the emergence of dangerous NPS.

Young people with issues related to problem use of alcohol or other drugs whom we frequently notice at specific locations (garages, abandoned playgrounds etc.) may benefit from risk and harm reduction measures. The finding that very young individuals (13–15 years of age) also consume alcohol during the week and even in the morning, either to “prepare” for a party or simply because “there is nothing else to do”, is particularly worrisome. We have also observed intolerance and division into groups by ethnic background at larger parties. Young people noted there was a lack of organised activities and pastime activities for them as well as spaces where they could socialise as they wished (at several locations) in a relaxed atmosphere without unnecessary formalities. There is no youth centre in Koper serving the general youth, nor is there a family centre, and the Local Action Group has ceased operations years ago.

Our fieldwork, which also involves parents (via the information and counselling point), has proven to be a good way of reaching out to parents. Because of the non-institutional setting, they do not feel threatened and open up about certain issues and listen to us much more readily. This is particularly true of parents addicted to illicit drugs whose children also partake in our activities. The time slot of the outreach activities (between 1 and 5 pm) has proven to be appropriate, as that is the period between the end of the school day and the arrival of parents home from work, when much of a young individual’s activities, such as alcohol consumption, can be left unnoticed or overlooked by the parents. We hold this to be an unaddressed area in reducing negative influences of the street. Informal socialising with

the youth in the field allows us to pay greater attention and focus more on other types of risk behaviour as well (addiction to computer games, overeating etc.) and detect and respond to distress earlier.

The entirety of our work in the field is performed by a network of volunteers (biopsychology students) and a field worker/information provider (public work placement). Due to personnel and financial limitations, the continuation of the programme is not guaranteed.

The SRAP Project – Preventing Addiction among Roma Youth in Novo Mesto

Tea Sulič and Marjeta Gašperšič

In June 2013, the staff of the Novo Mesto Centre for Development and Education finished working on the international SRAP project (www.srap-project.eu), which began in July 2010 and was dedicated to preventing addiction in Roma communities (a more detailed description of the project can be found in the 2012 National Report).

The activities carried out in 2011 and 2012 showed that young Roma stress their own lack of awareness about the consequences of addiction and poor knowledge about the available forms of help and support in the community, should they develop an addiction. Due to the fact that most prevention campaigns fail owing to the culture gap, we began creating a module training programme for professionals working with Roma youth. The programme puts great emphasis on learning about Roma history, culture and intercultural communication. In 2013, we carried out the pilot modules Special Features of the Roma Community in Slovenia, Intercultural Communication, Prevention Workshops for Roma representatives, and Provision of Information and Raising Awareness among Roma about Forms of Health Care and Social Work Help.

The lecture on special features of the Roma Community in Slovenia held at the Novo Mesto University College for Health Studies received especially wide attention. The event was attended by 75 audience members, mostly students and future health care and other professionals working with Roma. The participants learned about Roma history, culture, some of their traditions and rituals as well as religious convictions affecting the mentality and lifestyle of the Roma which are closely linked to their attitude to health. They also learned about the importance of training Roma for work in health care services. The work of Roma health workers who understand the Romani language and the specifics of patients and their environment in Roma communities has translated into positive outcomes on the European level.

In cooperation with project partners, we also published an e-handbook for health care professionals titled Health, Addiction Prevention and Roma Youth in Europe (Zdravje, preprečevanje zasvojenosti in romska mladina v Evropi); available in Slovenian at http://issuu.com/ricnm/docs/handbook-issuu). The handbook features practical instructions and examples and is intended for anyone whose drug and addiction-related work involves the Roma community.

FreD Goes Net

Karmen Osterc Kokotovič

FreD Goes Net, an early intervention programme in first-time alcohol and illicit drug consumption in young people, has been carried out in Slovenia since 2007 (more on the programme in the 2013 National Report). The programme is based on early short interventions (eight-hour courses), which aim to encourage young drug users to think about their own patterns of drug use and teach them how to handle risk factors which lead to drug use, as well as to take responsibility for their own behaviour, thus

preventing drug addiction. Due to issues with funding, the programme has been scaled back since 2012. In 2013, we carried out 16 eight-hour courses involving 196 under-age high school students who had been picked due to alcohol or illicit drug consumption. In 2014, we carried out 14 courses involving 156 under-age high school students.

After Taxi, Driving 0.0 App and Choose Yourself

Matej Sande, PhD, Špela Dovžan, Anja Mihevc

The After Taxi project, which provides vouchers for a free taxi ride to young people between the ages of 16 and 30 who are attending evening parties and have no safe ride home, has been carried out by DrogArt since 2010 (more on the project in the 2011 National Report). In 2014, the After Taxi vouchers have been available in the field where young people socialise and party: outdoors, in clubs, and at events in the Ljubljana area. The vouchers are given away by our field workers, who also provide information to young people about reducing risks related to the consumption of alcohol and other drugs, and how to organise a safe ride home. The 2013 evaluation results show that as many as 82% of surveyed young people (N = 158) preferred using an After Taxi voucher to drunk driving. In addition, 71% said that after using the After Taxi service, they now choose to leave a party in a taxi more often. 92% of respondents said the After Taxi project was good or very good.

In 2013, DrogArt developed a mobile application Driving 0.0 (Furam 0,0), which allows users to estimate their breath alcohol content (www.furam00.izberisam.org). Between May 2013 and August 2014, the application was used by 3285 users. In 2014, the application was made available to iOS users and is now available to users of the two most popular smartphone operation systems.

The programme Choose Yourself (Izberi sam), which aims to reduce the adverse effects of alcohol consumption among young people and is based on fieldwork and a peer-to-peer approach (more on the programme in the 2011 National Report), was carried out by DrogArt also in 2013 and 2014. Last year, we organised a professional consultation on binge drinking about young people and increased the presence of our field teams at nightlife venues based on the results of the consultation and the detected needs in the field, and enhanced the provision of information with Choose Your Own Party campaigns in the field. These campaigns in the field, which include interactive street animation, and cooperation with various associations seek to present a variety of interesting forms of socialising, partying, active ways of spending free time and developing skills to young people.

3.4 National Media Campaign

Addiction Prevention Month and the 2013 National Conference

Branka Božank

As part of the 2013 Addiction Prevention Month, we formulated an address on the topic as well as the slogan “What is permitted is not always safe” to draw attention to new psychoactive substances (hereinafter: NPS). NPS are new narcotic or psychotropic drugs in pure form or in a formulation, and are as dangerous to individuals and public health as illicit drugs despite not being subject to restrictions. NPS are marketed as legal drugs and claimed to be a safe, acceptable alternative to illicit drugs despite evidence to the contrary. Adverse side effects are similar to and sometimes even more severe than those of illicit drugs. Their ingredients are often unknown. There are also inconsistencies in declaring the psychoactive ingredients of NPS products, meaning that users cannot be sure that two NPS with

the same name and packaging actually contain the exact same substances. The number of studies on the effects of NPS currently available is limited. Unpredictable side effects and the lack of control over the quality of such substances is what constitutes a risk to health. This is why the 2013 Prevention Month was dedicated to raising awareness about NPS and stressing the need for a comprehensive approach in responding to their emergence.

Our website collects and publishes information on current events taking place across Slovenia as part of Addiction Prevention Month, the content of which pertains to prevention, various forms of addiction, rehabilitation, etc.

On 7 November 2013, the Slovenj Gradec Youth Cultural Centre hosted the National Conference Marking Addiction Prevention Month and the accompanying press conference. The event was attended by 159 participants from a number of government and non-governmental organisations, with NGOs, local activist groups, education, police, social work, health care as well as prisons representing the largest share. According to the majority of attendees (96%), the programme was engaging, and most (95%) were also happy with the organisation of the conference.

4. HIGH RISK DRUG USE

Due to the changing drug situation, the EMCDDA revised the epidemiological indicator problem drug use and replaced it with high-risk drug use in 2013. The revised indicator focuses on recurrent drug use which has a harmful or negative impact on the users (addiction, health and social issues, mental health issues, etc.) or places the user at a high risk of negative consequences. According to the EMCDDA definition, high-risk drug use involves any high-risk psychoactive substance use patterns and/or high-risk administration routes for psychoactive substances within the last 12 months.

A prevalence estimate of problem drug use using the capture-recapture method was performed twice in Slovenia, initially for the 2000 and 2001 and again for the year 2004. A trial prevalence estimate of problem opiate use for 2011 was performed last year, and a prevalence estimate of high-risk opiate use for 2012 was carried out this year by using the capture-recapture method and by obtaining data from the Drug Users' Treatment Records and a survey carried out among users of harm reduction programmes. The 2012 figure estimates there to be 6917 high-risk opiate users aged 15 to 64.

A study involving 175 drug users seeking help in harm reduction programmes indicates that a majority is simultaneously treated in other programmes, mostly in Centres for the Prevention and Treatment of Illicit Drug Addiction. According to the data on drug use, 54% use heroin, 64% use cocaine, 59% use cannabis, 35% use synthetic drugs, 8% use solvents, 70% use substitute medicinal products and 64% use other medicinal products (hypnotics or benzodiazepines). 24% of respondents regularly use alcohol, and nearly all of the respondents smoke tobacco. Compared to 2012, the year 2013 saw a decrease in the use of heroin, solvents, substitute medicinal products, synthetic drugs and cannabis, and an increase in cocaine use. Injection remains the preferred route of administration for heroin and cocaine, and continues to be the most common risk behaviour among users of harm reduction programmes. Sexual risk behaviour is also commonplace. Compared to previous years, the year 2013 experienced an increase in needle sharing and overdoses. The population of drug users seeking help in harm reduction programmes is ageing, with the share of the oldest age group on the rise. As many as 40% of respondents suffer from other health issues apart from addiction, with hepatitis C and mental health issues being most commonly reported. The year 2013 also saw an increase in the number of homeless drug users.

4.1 Prevalence Estimate of High Risk Opiate Use

Ines Kvaternik, PhD, Samo Novakovič

Using the capture-recapture method, problem drug use in Slovenia was estimated to involve 7535 high-risk drug users in 2000, 7399 such persons in 2001 and 10,654 high-risk users in 2004. An estimation of problem drug use performed in 2011 identified 6100 such users. Prevalence estimation of opiate use was repeated this year using two data sets, the Drug Users' Treatment Record and a survey conducted among users of harm reduction programmes.

Methodology

To calculate the number of high-risk opiate users (hereinafter: HROU), the capture-recapture method was used by comparing the known HROU population[7] identified via the Drug Users' Treatment Record to the data from an anonymous survey conducted among users of harm reduction programmes (hereinafter: HR programmes). Calculating the prevalence of HROU is dependent on limited data obtained from the Centres for the Prevention and Treatment of Illicit Drug Addiction (hereinafter: CPTDA). Before 2008, data collection by those programmes was insufficient, which constitutes an objective obstacle to monitoring trends in the HROU population. Another reason for insufficient data is underreporting as the database does not include data from prisons and the Murska Sobota CPTDA. While survey data are sufficient for monitoring trends in the HROU population seeking help in HR programmes, a higher proportion of respondents surveyed during fieldwork in particular is needed in order to calculate the HROU population.

The estimate of the total HROU population was based on the relative frequency of respondents in HR programmes who reported current or past treatment in CPTDAs. The share of the hidden population was extrapolated from the share of the remainder of the respondents, thus obtaining the hidden population coefficient. To find the hidden population set, which represents the share of high-risk opiate users, the data on CPTDA user subsets (current and first admissions to the programme as well as readmissions and the number of discharges from the programme), trends in development and the age structure of the individual subsets was used.

Sample

The number of high-risk opiate users conclusively determined to have been admitted to a CPTDA programme in the 2009–2012 period was 4596[8] The crucial part of the calculation was based on the statistical assumption that the frequency of respondents in HR programmes who have never been admitted to a CPTDA was typical for the HROU population in general.

The HROU estimate for 2012 is derived from the data obtained from 18 CPTDAs and the Centre for the Treatment of Illicit Drugs Addiction (hereinafter: CTDA), which recorded 3156 individual users, and 160 surveys performed in 7 HR programmes. The regional distribution of individuals who have never been treated in substitution therapy included deviations ranging from 22% in the Notranjsko-Kraška statistical region to 40% in the Central Slovenia statistical region. The total share of those who have never received treatment was 29.37% (20.8% to 37.9% within a 95-percent confidence interval). Due to the low number of surveys, the width of the 95% confidence interval is inversely proportional. This is why only the total hidden population share coefficient was used as a multiple, since the data on former users of the CPTDA programmes are of similar nature and because regional data are insufficient for statistical analysis.

The data on the age structure of HROU taken from the Drug Users' Treatment Record enabled us to review the suitability of the respondent sample. The data showed that the average age of the persons admitted to CPTDAs was 34 years of age (compared to 33 years of age in 2011), which is approximately 4.87 years older than respondents admitted for the first time, whose average age is 28 years. The trend toward lower average age of persons entering the programme has also been a feature in the statistical data from previous years and is likely the consequence of new generations of potential users of

[7] The data on the number of CPTDA users and the share of substitution therapy users (2008–2011) (Drev et al. 2012: 74) and the data on the annual fluctuation of current and first admissions and readmissions as well as withdrawals from the programme (2007–2011 National Reports) were used to estimate the number of known HROU. This group includes users who were undergoing a substitution therapy treatment programme in the specified time period.

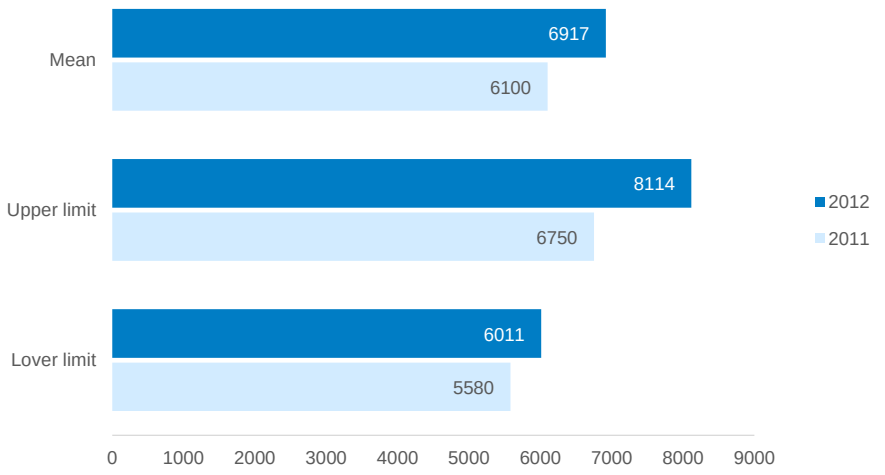
[8] The data indicate the minimum number of users involved in the programmes since 2008. The number of HROU is sourced from the 2009–2012 Reports on the Drug Situation of the Republic of Slovenia.

substitution therapy. The sample distribution of newly admitted persons indicates a likely characteristic of the set they belong to, i.e. the age structure of the hidden HROU population. The subset of readmitted users is characterised by an average age and standard deviation similar to those in the subset of continuously treated persons. Let us stress at this point, however, that the probability of an individual belonging to the hidden population correlates with a number of factors (such as drug administration route, gender, age of first-time drug use, proximity of treatment centres) and is subject to fluctuations. Due to the absence of data which would allow us to classify the interactions between those factors, it shall be assumed that the aggregate data are homogeneous and that their average value is normally distributed.

When assessing the representativeness of the respondent sample, the sum of two sets, of which the hidden population is the one being measured, must be taken into account. Its representation within the sample is connected to the average age, where both subgroups are equally likely to be represented. The average age of respondents was 33. On average, the frequency of the hidden population density is underestimated due to the lower average age in this area, meaning that the survey captured the right tail of the Gaussian curve representing the hidden HROU population. Given the insufficient representation of the hidden population, the survey results needed to be balanced using a log-linear model[9] by setting the dependent parameter to the value obtained with the survey.

Results

The adjustment of the hidden population coefficient to 0.3356 (0.2354 to 0.4336 within the 95-percent confidence interval) was carried out via simulations of setting the parameter to the appropriate value of the hidden population share corresponding to the share of individuals who had never been treated as determined with the survey. While this year's mean is 28% higher, both pieces of data overlap within the 0.24–0.33 area of the hidden population share within the 95-percent confidence interval.



Source: Kvaternik I, Novakovič S. (2013) Prevalence Estimate of Problem Drug Use. In: Drev A. (ed.): Report on the Drug Situation 2013 of the Republic of Slovenia, and personal calculations based on the hidden population coefficient in 2011 and 2012

Figure 4.1: Estimate of high-risk opiate users in 2011 and 2012

[9] A log-linear model, also known as the Poisson regression, is a form of regression used to model numerical values and contingency tables based on the assumption that the values to be determined are distributed according to the Poisson distribution probability function.

Figure 4.1 indicates the difference in the hidden population estimate to 2011. It must be stressed that the lower number of persons surveyed resulted in a higher percentage of probable deviation; however, both calculations overlap within the 5899–6750 area.

The result was checked against the data on prisoners and remand prisoners in 2011, according to which the 958 newly admitted persons with a drug abuse problem[10] included 417, i.e. 43.5% of persons already undergoing substitution therapy (Prison Administration of the Republic of Slovenia 2011: 57). Assuming an even representation of detainees in the hidden population and in the population undergoing substitution therapy, we arrive at the following estimate: 3551/0.435 = 8163. This piece of data serves as additional proof as to the accuracy of our original calculation.

As indicated in Table 4.1, the best estimate of the total HROU population in Slovenia in 2012 is 6917 high-risk opiate users (6011 to 8114 within the 95-percent confidence interval), or a relative share of 4.91 users per 1000 persons aged 15–64.

Table 4.1: Estimated number of high-risk opiate users calculated using the hidden population coefficient from 2011

	Lower limit	Upper limit	Mean
Estimate	6011	8114	6917
All ages / 1000 persons	2.92	3.94	3.36
15–64 / 1000 persons	4.27	5.76	4.91

Source: Calculation based on the data of the Statistical Office of the Republic of Slovenia in: Population by Age and Gender, Cohesion Region, Slovenia, Semi-Annual Data (2013) and the hidden population coefficient from 2011

Although the HROU result for 2012 appears higher than that of 2011, the result does not indicate a statistically significant deviation from the data for the previous year.

Conclusion

The estimate of high-risk opiate use in Slovenia indicates that out of the total of 6917 HROU, 3345 are in substitution treatment (Drev et al. 2013: 52), or 48.35% (41.22% to 55.64% within the 95-percent confidence interval). Accounting for an additional 556 users of substitution therapy serving a prison sentence (Prison Administration of Slovenia 2012 Annual Report) to the number of substitution therapy users, the mean percentage increases for an additional 8%. This indicates that the needs of HROU are served relatively well in Slovenia, this being true to a greater degree in those regions where the upward trend of opiate use first occurred and HR programmes are integrated better and established as a legitimate, socially acceptable response to health and social risks faced by high-risk opiate users. It should be noted, however, that we were unable to calculate the total population of high-risk drug users from the sources used, particularly those who remain unreached by the existing help programmes.

4.2 Characteristics of High-Risk Drug Users in Harm Reduction Programmes

Ines Kvaternik, PhD, Živa Žerjal

Users of illicit drugs seeking help in harm reduction programmes (hereinafter: HR programmes) are generally part of the high-risk subset of drug users. The Koper Regional Unit of the National Institute of Public Health has been systematically collecting data on the profiles of drug users involved in the aforementioned programmes since 2010.

[10] The criteria for determining »persons with a drug abuse problem« are inadequate, likely resulting in a slight overestimation.

The 2013 study involved 175 users of eleven HR programmes in Slovenia (run by the associations Svit Koper, Stigma Ljubljana, Pomoč Sežana, Pot Ilirska Bistrica, Zdrava Pot Maribor, Socio Public Institute in Celje, Šent DC Nova Gorica, Šent DC Velenje, Šent – Shelter for Homeless Drug Users in Ljubljana, DrogArt, and Kralji Ulice). Although differences between 2013 and 2013 data are not statistically significant, they are important in terms of planning responses to risk and understanding everyday problems of high-risk drug users and therefore presented in the article.

Findings

The 175 respondents included 134 men, or 77% of respondents, and 40 women, or 23% of respondents. The average age of respondents was 34, with the youngest and oldest respondents aged 16 and 58, respectively. A plurality of respondents – 34% – belonged to the 31–35 age group. The population of drug users seeking help in harm reduction programmes is ageing, seeing that the share of respondents from the oldest age group (41 or older) in 2013 (17%) was higher for as much as 6%. For the first time, the respondents included two minors, both female.

Nearly 66% of respondents have completed vocational or secondary education, 27% have completed primary school, 2% have not completed primary school, and as few as 5% of respondents have attained college or university education. The majority of respondents is unemployed (65%); nearly 10% reported having permanent employment, 18% engage in occasional work and 3% stated they were either retired, receiving social benefits or working illegally.

The highest share (34.5%) of respondents live with their parents, slightly fewer (28%) live alone, 3% live on their own with children, 15% live with their partners, 7% live with their partners and children, while 7% live in a shelter or outdoors (in parks, streets, abandoned houses, etc.), and 6% live elsewhere (with their grandmother, sister, housing units etc.) Compared to 2012, data indicate an increase in the number of respondents living in a shelter or outdoors. Nearly 26% of respondents are parents, a majority of them of one child.

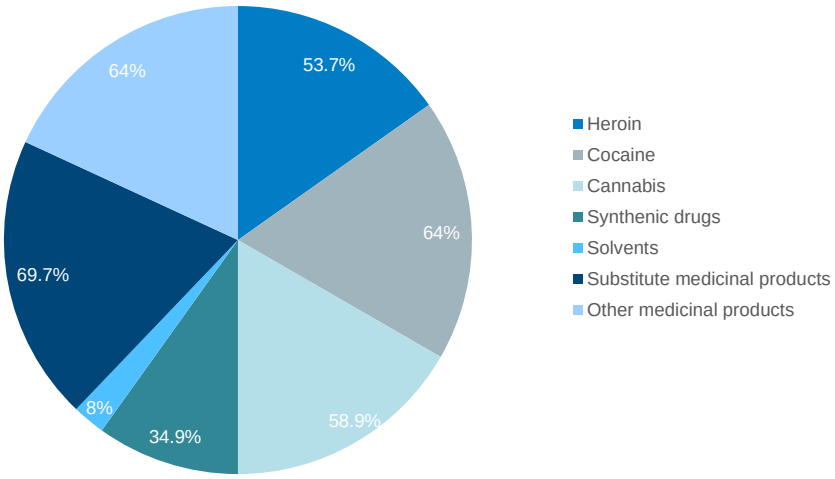
24% of all respondents have only been treated in drug-related harm reduction programmes, while 76% have simultaneously been treated in other treatment programmes for drug users; of those, as many as 79% have been treated by Centres for the Prevention and Treatment of Illicit Drug Addiction, 2.2% have been involved in abstinence-based programmes only, while 3% have only been treated in hospital detoxification programmes, and 11% responded that they were part of a combination of substitution and other programmes for users of illicit drugs.

99% of respondents are covered by basic health insurance, with 85% also having supplementary health insurance. 40% of respondents stated that they had additional health issues apart from addiction, with hepatitis C being the most common, followed by mental health issues, gastric issues, asthma, allergies, poor dental health and an ailing vascular system.

Compared to 2012 (80%), the share of respondents who have had been involved with law enforcement decreased in 2013 (31%).

Drugs and Drug Use

54% of respondents use heroin, 64% use cocaine, 59% use cannabis, 35% use synthetic drugs, 8% use solvents, 70% use substitute medicinal products, and 64% use other medicinal products (hypnotics and benzodiazepines). 24% of respondents regularly consume alcohol, while nearly all of the respondents (90%) smoke tobacco. Compared to 2012, the year 2013 saw a decrease in heroin use (falling from 66% to 54%), solvents, substitute medicinal products, synthetic drugs and cannabis. The only drug which saw an increase in use from 2012 to 2013 was cocaine (Figure 4.2).

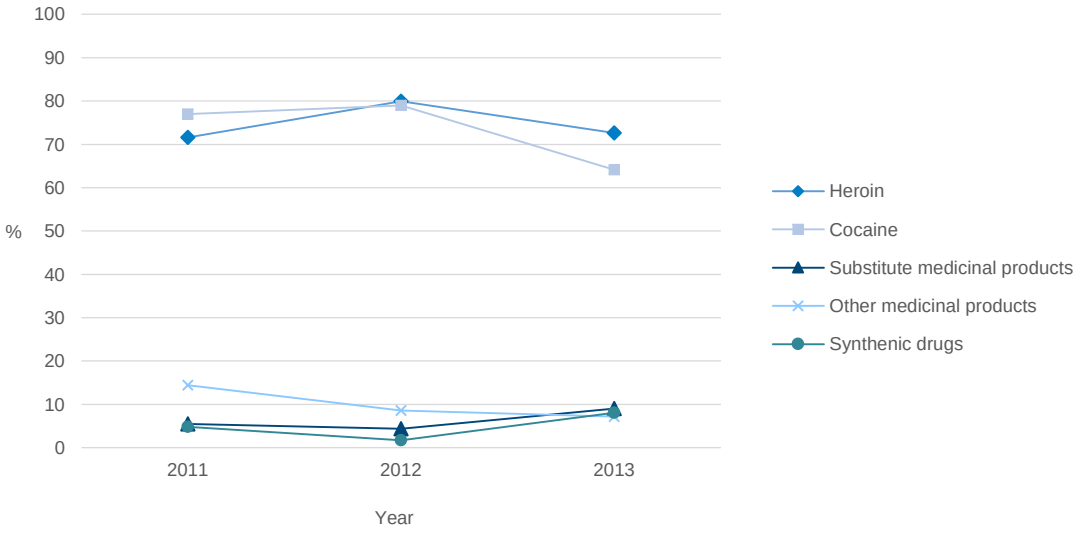


Source: National Institute of Public Health, Koper Regional Unit, An anonymous questionnaire on the profile of users of illicit drugs seeking help in HR programmes

Figure 4.2: Type of drug used by surveyed users of HR programmes, 2013

73% of heroin users administer the drug by injection; the same is true of 64% of cocaine users. Injection of other medicinal products has decreased from 9% to a little over 7%.

Figure 4.3 demonstrates that heroin and cocaine injection has decreased in comparison to previous years. Compared to 2011, cocaine injection has fallen, while heroin injection remains unchanged, leading us to conclude that the rate of heroin injection is relatively stable while cocaine injection is subject to fluctuations. There is a slight reduction in the injection of other medicinal products and an increase in the injection of synthetic drugs and substitute medicinal products.



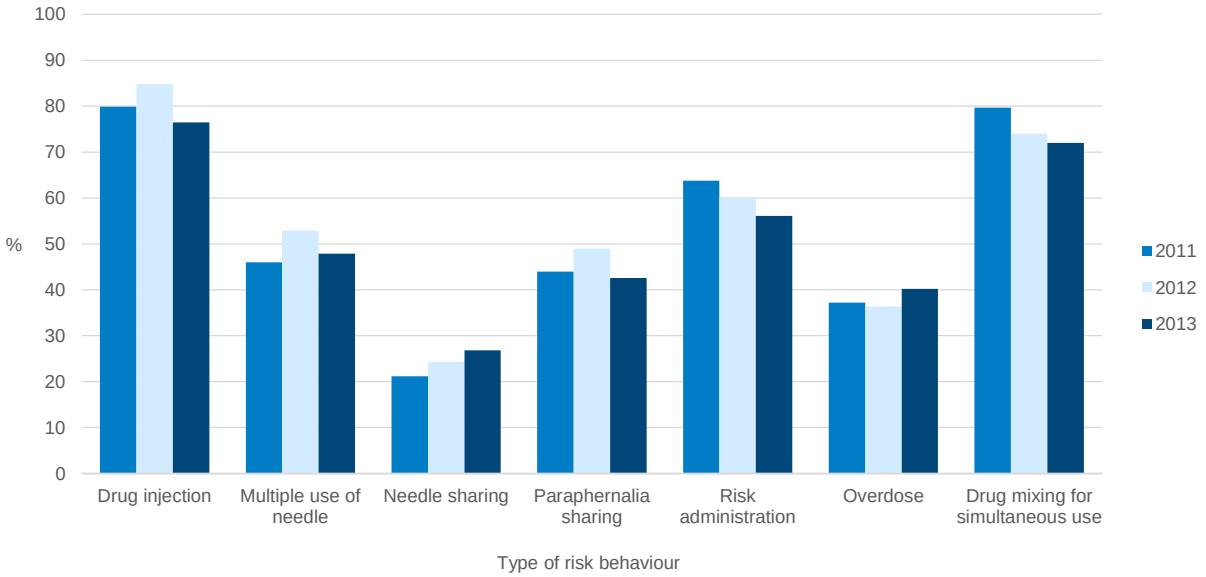
Source: National Institute of Public Health, Koper Regional Unit, An anonymous questionnaire on the profile of users of illicit drugs seeking help in HR programmes

Figure 4.3: Drug injection among surveyed users of HR programmes, 2011–2013

Risk Behaviours

Drug injection is the most common risk behaviour in users of harm reduction programmes. Compared to 2012, however, there has been a decrease in drug injection, falling from 85% to 76.5%. This is followed by mixing drugs for simultaneous use (72%), risk administration (56%), multiple uses of the

same needle (48%), shared use of other paraphernalia (43%), overdose (40%) and needle sharing (27%). These types of risk behaviours are followed by sexual risk behaviour, as 65% of respondents report having unprotected sexual intercourse. Needle sharing and overdosing have increased in comparison to previous years (Figure 4.4).



Source: National Institute of Public Health, Koper Regional Unit, An anonymous questionnaire on the profile of users of illicit drugs seeking help in HR programmes

Figure 4.4: Risk behaviours among HR programme users, 2011–2013

Replacing Paraphernalia

The respondents stated that they usually obtain paraphernalia in their harm reduction programme (nearly 78.5%). Of those, 35% obtain sterile paraphernalia from harm reduction programmes exclusively, 8% receive paraphernalia from fieldwork programmes, and 12% of respondents obtain paraphernalia at the pharmacy.

73% of respondents generally return the needle to the programme, 71% occasionally dispose of the needle in the trash, 11% leave used paraphernalia at the spot of drug injection, 36% of respondents dispose of used paraphernalia in a different way (“I destroy the needle and throw it away with a can”, “I burn it in the central heating furnace”).

Drug Use Location

91% of respondents most frequently use drugs at home, 84% responded that they have also used drugs at their friends' or acquaintances'. 12% of respondents occasionally use drugs in a shelter or a day centre, while 54 % and nearly 65% of respondents use drugs also in public spaces or outdoors (in the car, the forest, parks, abandoned buildings, by the railroad in Tivoli Park) respectively.

Conclusion

The respondents generally obtain injection kits in harm reduction programmes, though 2013 experienced an increase in buying them at the pharmacy and the shared use of the paraphernalia. This is the consequence of the low quality of syringes with an integrated needle given to users in needle exchange programmes.

On one hand, the population of drug users seeking help in harm reduction programmes is ageing as there were 6% more respondents in 2013 (17%) belonging to the oldest age group (41 or over). On the other hand, this is the first time that two minors, both female, were recorded in the survey. There are no developed help programmes for elderly drug users in Slovenia, such as housing units, health care services or modified retirement homes, which contributes to the social impact of drug use, as this makes the lives of such drug users even more difficult and puts a strain on employees in the programme. The increase in demand for treating juveniles with illicit drug use issues is part of the reason why it is of vital importance to develop specialised programmes for that age group and expand the network of such programmes into local communities. The aforementioned programmes would also cover some of the needs of homeless drug users, whose numbers have increased in 2013 according to our data. Compared to 2012 (80%), fewer respondents had run-ins with law enforcement in 2013 (31%). We believe that the number of offences decreased owing to a reduction in the use of illicit drugs and an increase in the use of substitute and other medicinal products.

5. DRUG RELATED TREATMENT: TREATMENT DEMAND AND TREATMENT AVAILABILITY

The treatment of users of illicit drugs is laid out in legislation pertaining to illicit drugs, health care and social care. A network of 18 Centres for the Prevention and Treatment of Illicit Drug Addiction (CPTDA) and the Centre for the Treatment of Drug Addiction (CTDA) at Ljubljana University Psychiatric Clinic is organised as part of the health care system in Slovenia. The network serves all regions apart from the region of Koroška. In 2013, 4065 drug users were treated within the CPTDA and CTDA network. Their health care services are part of the main health care programme funded by the Health Insurance Institute of Slovenia. There are currently no wait times in treatment programmes for addiction to illicit drugs within the health care system.

In 2013, 23 social rehabilitation programmes for addicted persons were carried out in Slovenia; these programmes are co-funded by the Ministry of Labour, Family, Social Affairs and Equal Opportunities and comprise low-threshold and high-threshold programmes. Local accessibility of social rehabilitation programmes is satisfactory, with the exception of the regions of Zasavje in Pomurje, which have no high-threshold programme. The DrogArt Association also carried out a counselling and therapy programmes aimed at the specific needs of users of club drugs, cocaine and new psychoactive substances. The programme reached 48 users in the first eight months of 2014. The DrogArt Association developed Reduser, an online application which allows young drug users to access help over the Internet. The application enables users to control, reduce or stop their drug use or reduce harm associated with drug use, either on their own or with the help of an expert. In 2013, the application was tested by 70 users.

In January 2013, the National Institute of Public Health introduced the new TDI questionnaire to the CPTDA network; 17 of its centres responded to the questionnaire. Data analysis performed on obtained data showed 290 users entered treatment programmes, 95 of whom had never been treated before, while 194 users had a history of treatment, and one case could not be conclusively identified either as a new admission or a readmission. Most of the admitted users were male (80%). The majority entered the programme on their own accord. The main drug which made them seek out help again and for the first time was once again heroin (73.4%), followed by cannabis (12.4%) and cocaine (3.5%). More than half of those admitted again and for the first time used drugs daily, and 34% injected the drug upon entering the programme, which was more common among users who were re-entering the programme. The share of injecting drug users has, however, been in decline over the years, as has heroin injection. The analysis also showed that there was an increase in users who sought help due to cannabis in the period of 2006–2008, in particular among those who entered the programme for the first time.

5.1 General Description, Availability and Quality Assurance

Network of Centres for the Prevention and Treatment of Illicit Drug Addiction: Accessibility and Staffing

Andrej Kastelic, PhD, Prof.

The treatment of addiction to illicit drugs is relatively well organised within Slovenia's public health services network, both on the primary level as part of Centres for the Prevention and Treatment of Illicit Drug Addiction (CPTDA) as well as on the secondary and tertiary level at the Centre for the Treatment

of Drug Addiction (CTDA) at the Ljubljana University Psychiatric Clinic. As shown in Figure 5.1, CPTDAs serve all regions apart from the region of Koroška. The centres are also needed in certain other areas and cities, such as the Bela Krajina area and the towns of Ptuj and Sevnica. The participation of opioid users in the programmes is one of the highest in the world; Slovenia is also one of the few countries using four types of substitute drugs, i.e. methadone, buprenorphine, buprenorphine + naloxone and SR-morphine. These programmes also reach over one-half of all known users of opioid drugs in prisons. In spite of these facts, Slovenia faces a number of challenges and a need for improvement.

Source: CPTDA Coordination

Figure 5.1: The reach of Centres for the Prevention and Treatment of Drug Addiction in Slovenia, 2013

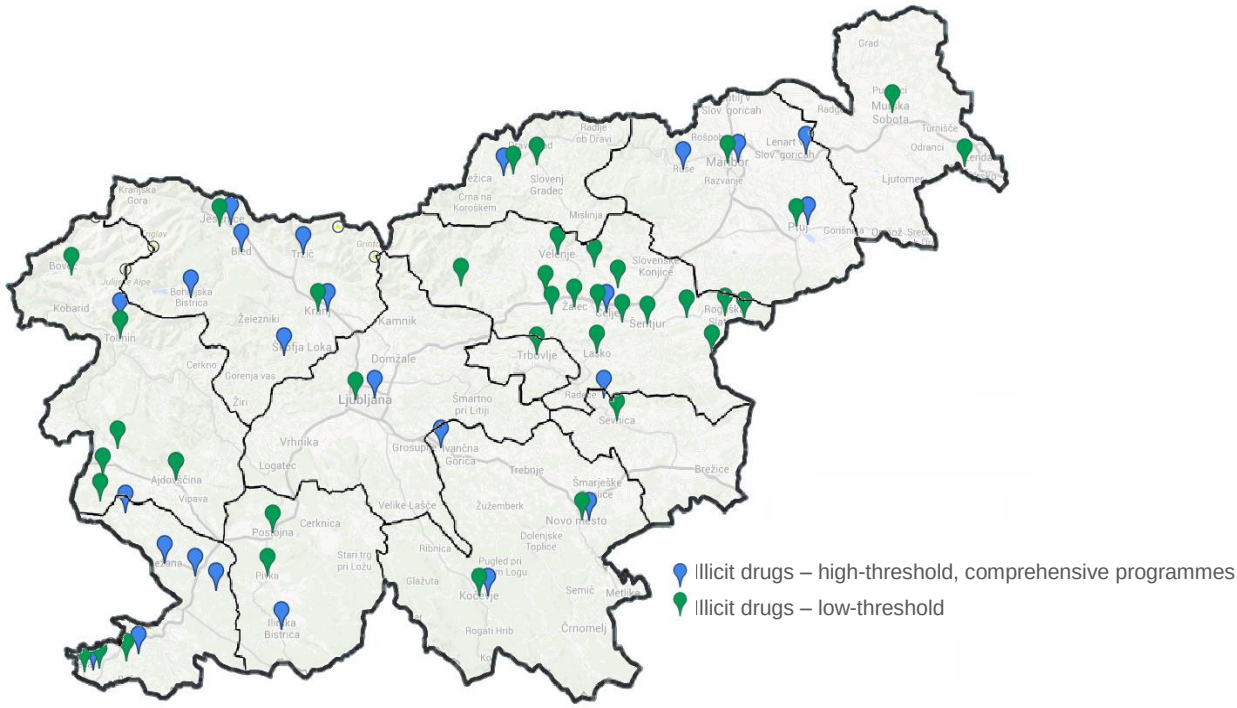
Although generally speaking, the CPTDAs are appropriate and largely follow the recommendations for carrying out stated activities, the premises of some CPTDAs remain in poor condition; some do not have a waiting room, or their waiting room is too small, some do not have adequate space for one-on-one treatment, some lack the space or opportunities for group activities, and the Ljubljana CPTDA serves a disproportionate share of patients. The area around the Ljubljana CPTDA has also turned into a space of open drug use over the past five years. A number of CPTDAs are understaffed, with a shortage of medical practitioners in particular, because no physicians apply for these open job positions for a number of reasons. Prisons also face staffing shortages as per staff standards in prison treatment programmes for drug users, and there needs to be closer cooperation between prisons and CPTDAs as well as uniform standards for the treatment of patients across these institutions. Patients are admitted to Slovenian addiction treatment programmes immediately, there are no wait times and the programmes are funded by the Health Insurance Institute of Slovenia in their entirety. According to our data, the number of people using opioid drugs who are being treated in replacement therapy programmes is no longer on the rise. Due to the increase in the number of people using new drugs, cocaine and other stimulants, cannabinoids and inhalants as well as those with “non-chemical” addictions, prevention and treatment programmes for people affected by these issues need to be expanded and intensified.

Between 50 and 70% of people being treated for addiction to psychoactive substances, suffer from a comorbid mental disorder. Inappropriate treatment of such patients frequently results in relapses both of the mental disorder as well as drug use and an increased risk for a variety of infections and overdose. A day hospital programme is already in place at the Centre for the Treatment of Drug Addiction at the Ljubljana University Psychiatric Clinic already as well as a limited-scope hospital treatment programme for such patients alongside the treatment of other drug users. Because of therapy measures specific to these patients, a special hospital department must be created within the limits of existing capacities to treat them.

Considering the current good practice and the monitoring and evaluation data, we intend to include patients treated for drug use both in the planning a well as the implementation of addiction prevention and treatment programmes. We are also planning to hold occasional meetings of CPTDA staff and patients (at least every three months) in order to involve patients to a greater degree, establish, and cultivate a good relationship with them.

Social Rehabilitation Programmes: Accessibility and Staffing

Simona Smolej, MA, Nadja Kovač



Source: Social Protection Institute of the Republic of Slovenia

Figure 5.2: Regional accessibility of social rehabilitation programmes, 2013

Figure 5.2 shows the regional accessibility of social rehabilitation programmes for addicts by programme type. These include 23 programmes co-funded by the Ministry of Labour, Family, Social Affairs and Equal Opportunities mostly carried at several locations across Slovenia. The blue points are locations with high-threshold programmes or programmes aimed at users of illicit drugs at various stages of drug use. These programmes are accessible in every region apart from the regions of Zasavje and Pomurje. Reintegration programmes (locations also marked blue) are available in the Gorenjska region (town of Tržič) and Central Slovenia (Ljubljana).

Low-threshold programmes (locations are marked green) are more dispersed mainly due to fieldwork and are available in all regions of Slovenia. There is a shelter for homeless drug users in Žalec and Ljubljana, while a safe house for female drug users who are victims of violence only exists in Ljubljana (Smolej et al. 2014).

According to available data, it may be concluded that regional accessibility of social rehabilitation programmes is generally satisfactory, though the regions of Zasavje and Pomurje remain critical areas in this regard. These two regions will need to implement at least one comprehensive programme for users of illicit drugs at various stages of drug use in the future.

Professional Profile of Staff in Social Rehabilitation Programmes for Addicts

Table 5.1: Professional profile of staff in social rehabilitation programmes, 2013

Professional staff profile:	High-threshold, comprehensive programmes	Low-threshold programmes	Total
Social worker	47	24	71
Psychologist	7	1	8
Sociologist	3	0	3
Teologian/marital and family therapy specialist	5	1	6
(Soc.) pedagogue/adult educator/special needs teacher	11	4	15
Economist/manager/organiser	6	2	8
Culturologist/anthropologist/political scientist/journalist/communication scientist	3	4	7
Other arts, humanities and social science fields	4	1	5
Natural science and technology fields	5	5	10
Medicine	0	1	1
Up to V level of education	28	23	51
Total	119	66	185

Source: Social Protection Institute of the Republic of Slovenia

According to the professional profile for the year 2013, the highest share of staff in 23 social rehabilitation programmes for addicts co-funded by the Ministry of Labour, Family, Social Affairs and Equal Opportunities were social workers at 38.4%. There were 32 employees with other professional profiles who can be employed as professional staff in the field of social protection in accordance with Article 69 of the Social Security Act (Official Gazette of the RS, No. 3/2007 *et seq.*). Over a quarter (51 persons or 27.6%) of staff had obtained the V level of education or lower (most were grammar school graduates and graduates of a vocational programme in economics) (Table 5.1). In terms of the number of employees, their share is higher in low-threshold programmes, which have a higher need for “lay staff” than high-threshold programmes due to the type of work.

DrogArt Counselling and Psychotherapy Centre

Mina Paš

The DrogArt Counselling and Psychotherapy Centre is dedicated to people with issues due to the use of club drugs, cocaine and new psychoactive substances (NPS). The programme aims to reduce harm to drug users and to provide psychological rehabilitation to people with a history of addiction. The

programme is anonymous. The first three counselling sessions are free of charge, while any additional counselling sessions require a EUR 10 contribution by the user. The price of psychotherapy depends on the user's monthly income. For school-age children and users with no income, counselling is free of charge, while a psychotherapy session costs EUR 5 per hour.

Programme Structure

We provide single counselling sessions to users in need of information about drugs and their use as well as to the parents of adolescents and to education and other professional staff dealing with drug users in their professional capacity who need information or advice for future action.

The counselling and therapy programme is aimed at users with issues due to drug use. The user attends one-hour sessions once or twice a week, either in person or via Skype. The programme consists of two stages. The first stage comprises ten counselling sessions based on the motivational counselling method and cognitive behavioural therapy. The aim of this stage is to reduce drug-related harm. The user learns to quickly identify drug use triggers and how to use techniques to reduce use or facilitate abstinence. The second stage is more in-depth and seeks to identify and eliminate the causes behind harmful drug use. It utilises psychotherapy methods and techniques. Psychotherapy is also provided to those who have stopped using drugs or use them occasionally as well as those who have experienced a psychedelic crisis and wish to resolve it in therapy. Psychotherapy is carried out by relational psychotherapists.

Counselling and therapy group meetings seek to enable users to identify their behaviour in a group, express themselves and their needs within the group, receive support from other group members and experience the feelings of safety, belonging and being connected to other people. Two counselling and therapy groups are held:

- A harm reduction group (for active drug users),
- A group for achieving and maintaining abstinence (for currently abstinent users or those striving for abstinence).

The Course of the Programme

Upon the user’s initial visit, a counsellor carries out the first counselling session and determines the type of treatment and participation in the different forms of treatment by discussing it with the user. Users typically begin with the first stage comprising 10 counselling and therapy sessions, though some already join group treatment at this stage, which is highly desirable, though optional. After completing the first stage of the programme (after meeting harm reduction objectives), the user enters the second stage (one-on-one psychotherapy sessions). Some users, such as those who have already completely or partially ceased using drugs, begin with one-on-one psychotherapy sessions immediately.

If need be, the relatives or other significant figures in the life of the user are also invited to participate, but only to support the user in achieving or maintaining abstinence. Their participation in the programme is occasional and always involves the user. Typically, they join the user at a limited number of counselling sessions.

Programme Quality Assurance

Those carrying out the programme are trained counsellors and psychotherapists. The programme employs professional staff trained in the field of social care. The former are subject to regular supervision and intervision twice a month. Counselling and therapy are performed in accordance with social care ethical standards and the ethics code of the Slovenian Umbrella Association for Psychotherapy.

Programme Performance Evaluation

The performance of the programme is evaluated in terms of whether the user has met the set objectives upon completion of the first stage and whether the user continues with the programme. Files are kept on each individual user, allowing the psychotherapist or counsellor to evaluate the progress made by the user in the course of the programme.

Between 1 January and 31 August 2014, 48 users participated in the DrogArt Counselling and Psychotherapy Centre programme and completed 296 hours of counselling and psychotherapy.

An Assessment of the Contribution of the Programme to Prevention and Harm Reduction in a Wider Context

The fact that the programme is anonymous is a very important factor for socially integrated users with permanent employment who do not wish to be part of programmes organised within the health care and social care systems for fear of being outed as addicts. Part of the programme specialises in users with issues due to the use of new psychoactive substances. In those cases, it is of extreme importance that the therapist is very familiar with NPS, seeing that the use of those substances carries specific risks which need to be known to the therapist. The programme is priced as to be accessible to the users and provides in-depth individual psychotherapy treatment both to former as well as active drug users. Even though psychotherapy is vital for the long-term rehabilitation of these persons, many psychotherapists refuse to work with drug users as this type of psychotherapy requires special training on addiction. Part of the programme is aimed at juvenile users of NPS or other drugs who have a strong desire to stop using drugs or reduce drug-related harm. The counselling and psychotherapy method for minors is based on a confidential patient-therapist relationship of equals. Our work with minors is focused on teaching them to take responsibility and continue with the programme. Abstinence is not necessarily a requirement; instead, we adapt therapy to allow the minor to stay part of the programme for as long as necessary.

This is a low-threshold programme; the only condition for entry is motivation on part of the user to make harm reduction-related change.

ReDUSER

Matej Sande, PhD

The Reduser application was developed as part of the PASS project aiming to provide online (self) help to minors and young adults facing issues due to drug use. The Reduser application (www.reduser.drogart.org) can be used independently; it can provide the user the help of an expert or serve as a tool in the counselling process. The application is aimed at individuals consuming alcohol or other drugs who wish to stop or reduce its use or associated harm. The application allows the users to record their use and feelings, set goals, record their pastime activities helping them to achieve these goals, and record cravings for drugs. To motivate themselves, they can note the positive and negative consequences of drug use and specific things which may improve or worsen with abstinence or the reduction in drug consumption. The application also links the user to relaxation techniques and methods to control craving for drugs. If users experience strong craving, they can press the “craving button”, which provides them with tips on how to overcome the craving. Users can also access the analysis of their drug use, which allows them to e.g. graphically monitor the effects of specific activities on their craving, the number of times they overcame an instance of craving and refrained from drug use, whether

the craving worsens with their mood etc. The application also allows the users to contact a counsellor and schedule a personal counselling session via Skype or agree to be monitored via the application.

The application is universal and intended for various types of addiction. Its full version can be accessed via the website, but can also be used on smartphones and tablets via a browser.

The application was developed with the help and support of therapists and experts on addiction. Using their therapy experience, a group of therapists created the content and modules for the application that they believed would help users control their drug use and help them reduce or control use in combination with therapy. The application was tested by users in therapy, who pointed out it was overly complicated for use. By the end of 2013, 70 users tested and were using the application. Based on the initial responses, the application was simplified and made more user-friendly, and its design was modified.

The application is currently used as part of the therapy process, while the project itself is ongoing owing to the support of the Ministry of Health, and a modified version of the application will be available to all interested organisations in the future. The application is currently in the phase of being applied to organisations which expressed interest in it, as its design allows its modules to be modified to suit specific needs and organisations.

5.2 Access to Treatment

Milan Krek

Drug Users Treated in Centres for the Prevention and Treatment of Illicit Drug Addiction

CPTDA Coordination Data

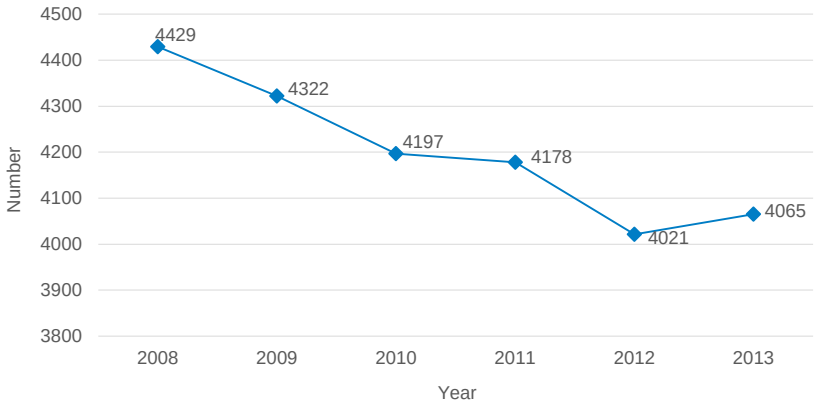
According to CPTDA Coordination data, 4065 individuals entered treatment in 2013. Of those, 3261 (80.23%) were undergoing substitution therapy. Of those 2042 (63%) received methadone, 431 (13%) took Suboxone (buprenorphine and Naloxone), 461 (14%) received buprenorphine and 327 (10%) received SR-morphine (Table 5.2).

Table 5.2: The number of treated users in the CPTDA network and the number of participants in maintenance therapy per substitute drug

Total number of treated persons	Number of patients in substitution therapy	Methadone	Suboxone	Buprenorphine	SR-morphine
4065	3261	2024	431	461	327

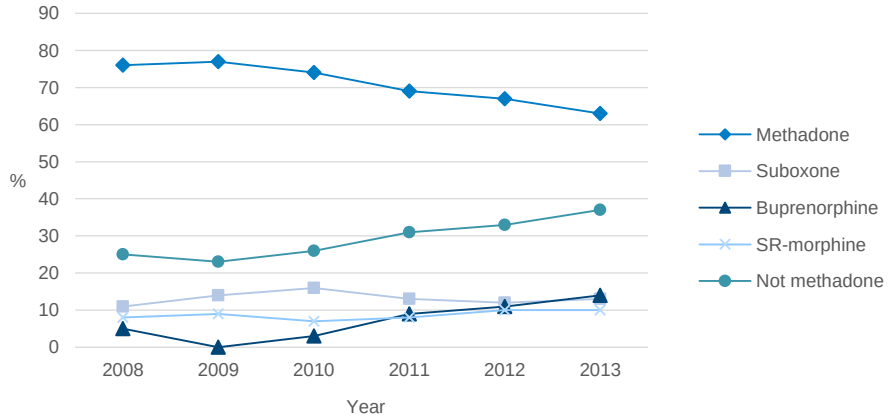
Source: CPTDA Coordination

The number of persons treated in the CPTDA network decreased between 2008 and 2013 (R^2=0.9494), and slightly increased in 2013 compared to 2012 (Figure 5.3). Since 2008, the share of users treated with methadone as a substitute drug has been falling (R^2=0.9617), with new substitute drugs on the rise (Figure 5.4).



Source: CPTDA Coordination

Figure 5.3: Number of users in the CPTDA network, 2008–2013



Source: CPTDA Coordination

Figure 5.4: Share of users in maintenance treatment by substitute drug, 2008–2013

Analysis of TDI Data

On 1 January 2013, the new TDI 3.0 questionnaire was introduced in 18 CPTDAs and the Centre for the Treatment of Drug Addiction (CTDA) at the Ljubljana Psychiatric Clinic; only 17 centres filled it out. The questionnaire was filled out by staff at the centres, who used it to face to face survey every individual who entered or re-entered the programme. This allowed us to prevent individuals being entered into the records twice. In 2013, 290 first-time admissions and readmissions into treatment programmes were recorded.

Number of New Admissions and Readmissions

In 2013, 290 individuals (235 men and 55 women) entered a treatment programme in the centres carrying out the TDI questionnaire. Of those, there were 95 (32.75%) new admissions and 194 (66.89%) readmissions. In the case of one admission or 0.34%, it could not be determined whether it was a new admission or a readmission. The CTDA did not participate in the TDI questionnaire in 2013, but recorded 74 new admissions and 107 readmissions. This means there were 471 admissions in 2013 in total (the CTDA included), comprising 169 new admissions and 301 readmissions. The rest of the paper will only focus on the data collected via the TDI questionnaire, i.e. on the 290 individuals who entered the programme again and for the first time in 2013.[11]

[11] The phrase “again and for the first time” is used to refer to cases which include 290 persons in the analysis; if the categories used in the analysis are distinct, i.e. if new admissions and readmissions are treated as separate, the phrase “again or for the first time” is used and 289 persons are included in total. This is due to the fact that in one case, it could not be established whether the user entered the programme for the first time or re-entered it.

Of those who entered the programme for the first time (95 individuals), 76 (80%) were male and 19 (20%) were female. Of the 194 individuals who were readmitted into the programme, 158 (81.44%) were male and 36 (18.56%) were female.

Primary Drug

Heroin was the primary drug of a large share of users who entered the programme again and for the first time (213 users or 73.44%). Cannabis was listed as the primary drug by 36 persons, i.e. 12.41% of all users (Table 5.3).

Table 5.3: Number of drug users by primary drug upon first admission and readmission into the programme, 2013

Drug	Number	%
Opioids	234	80.68
Cannabis	36	12.41
Cocaine	10	3.45
Hypnotics and sedatives	4	1.37
Missing	3	1.03
Amphetamines	2	0.68
Other	1	0.34
Total	290	100.00

Source: National Institute of Public Health

Among opioid users who entered the programme again and for the first time, the majority used heroin (213 users, or 91.02%). Heroin use was followed by the abuse of medicinal products: methadone (7 users, or 2.99%), buprenorphine (7 users, or 2.99%) and other opioids (7 users, or 2.99%). In 2012, the share of individuals who used other opioids was 2.1%, compared to 1.1% in 2011 and only 0.5% in 2010. There has been an increase in the recorded share of individuals using other opioids among new admissions and readmissions into the programme in recent years.

Of the 95 users who were admitted into a treatment programme for the first time, 49 (52%) reported heroin as the key issue that made them enter the programme, followed by cannabis use (30 individuals, or 31.58%), which is more common in new admissions than readmissions. The data is illustrated in more detail in Tables 5.4 and 5.5.

Table 5.4: Number of new admissions by primary drug, 2013

Drug	Number	%
Opioids	57	60.00
Cannabis	30	31.58
Cocaine	6	6.32
Amphetamines	1	1.05
Missing	1	1.05
Total	95	100.00

Source: National Institute of Public Health

Of the opioid users (57) who first entered the programme in 2013, most were heroin users (49 individuals, or 85.96%), four (4.21%) abused methadone, 2 (2.10%) abused buprenorphine and 2 (2.10%) abused other opioid substances. Men (34%) reported cannabis as their primary drug more often than women (21%) upon initial entry into the programme. Cannabis was reported to be the primary drug of 3% of men and 3% of women re-entering the programme.

194 programme users re-entered a treatment programme in 2013. The majority (163 individuals, or 84%) had a heroin problem, and 6 (3.09%) had a cannabis problem. The data is available in more detail in Table 5.5.

Table 5.5: Number of readmissions into the programme by primary drug, 2013

Drug	Number	%
Opioids	176	90.73
Cannabis	6	3.10
Cocaine	4	2.06
Hypnotics and sedatives	4	2.06
Unknown	2	1.03
Amphetamines	1	0.51
Other	1	0.51
Total	194	100.00

Source: National Institute of Public Health

Age of First Drug Use and Age upon First Entry and Reentry into Treatment Programme

The average age of first drug use was 20 years for users entering the programme for the first time in 2013; the average age upon admission was 28 years of age. The average age of first drug use for users re-entering the programme in 2013 was 20 years of age; on average, they were 33 years old upon re-entering the programme. Men entering the programme for the first time began using drugs earlier (at 19.71 years of age) than women (at 24 years of age). On average, men entered the programme for the first time at a younger age (27.5 years) than women (32.37 years). The average age of individuals re-entering the programme was 33.53 years of age for men and 30.64 years of age for women.

Referrals

Out of the 95 users first entering the programme in 2013, 70 (74%) entered the programme on their own accord. Four sought treatment on the initiative of a health care institution and three did so on the initiative of a school. The majority of drug users re-entering the treatment programme in 2013 also came to the centre on their own accord (159, or 82%), 18 (9.3%) were referred by other treatment programmes in Slovenia and 10 (5.15%) were ordered to enter treatment by a court of law.

Living Accommodations

In Slovenia, a relatively high share of programme users lives with their primary family. Of 290 first admissions and readmissions in 2013, 113 (39%) lived with their families, men (40%) more often than women (35%). A larger share of women (45%) than men (23%) lived with their romantic partner and/or child. Men (19%) lived alone significantly more often than women (9%). 42 (14.48%) – 14.54% (8) of women and 14.46% (34) of men – lived with their children. Precarious living arrangements or homelessness were present in 6.3% of drug users who entered the programme for the first time, and in 12.3% of users re-entering the programme.

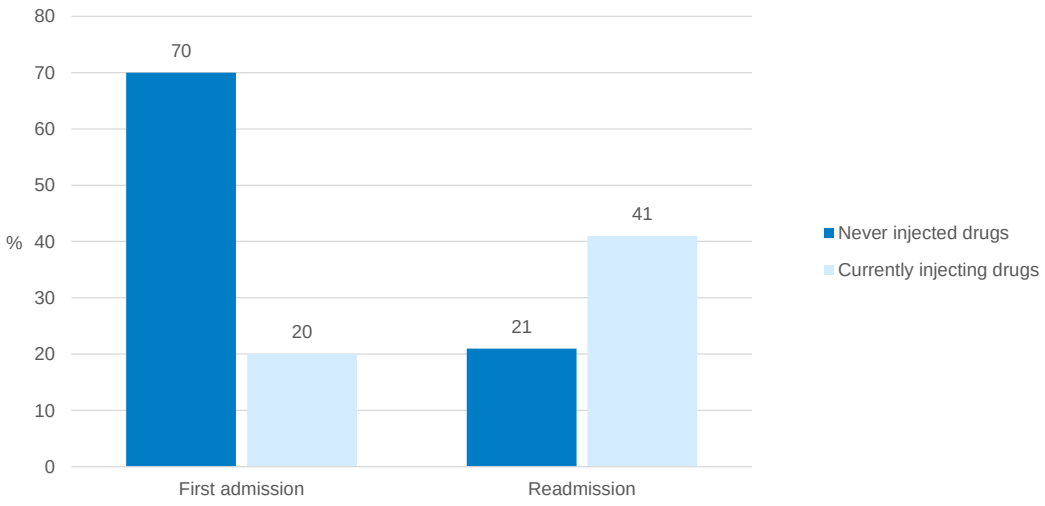
Risk Drug Use

34% of the users who were admitted into a treatment programme again and for the first time in 2013 (290 users) injected drugs. 41% of opioid users (234 users) injected the drug. 40% of cocaine users injected the drug. Amphetamines were not injected. 19% of opioid users sniffed the drug, while 25% smoked opioids. 28% and 20% of heroin users smoked or sniffed the drug, respectively.

Of all users who entered treatment programmes for the first time in 2013 (95 users), 20% injected drugs. 32% of opioid users and 35% of heroin users injected the drugs, respectively, while 17% of cocaine users did. Amphetamines were not injected. 32% of opiate users smoked opiates and 20% sniffed them. 37% of heroin users smoked heroin while 22% sniffed it.

Of the users who re-entered treatment programmes in 2013, 41% injected drugs. 43% of opioid users injected opioids. There were 163 heroin users, 44% of which injected the drugs upon admission to the programme. The majority of cocaine users (75%) injected cocaine. Amphetamines were not injected by this group, either. 23% smoked opioids.

The share of drug users who injected drugs was higher among those re-entering the programme (41%) than among those being admitted for the first time (20%). In addition, the share of individuals who have never injected drugs decreased to 21% among readmitted users, while the share of such users was relatively high among new admissions (70%), (Figure 5.5).

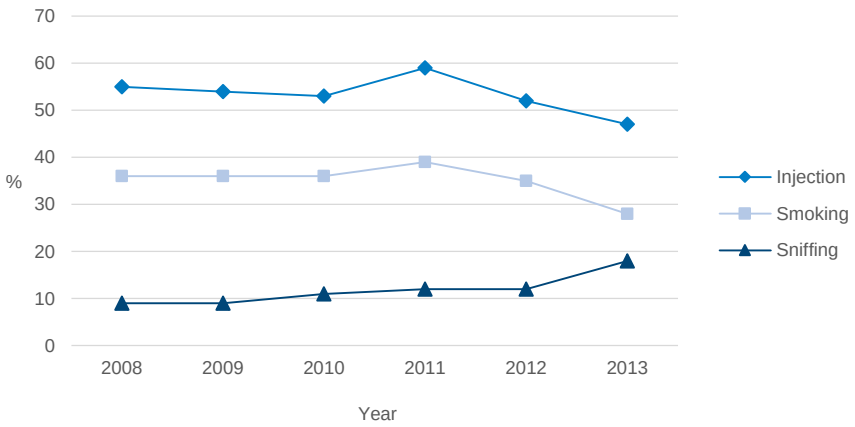


Source: National Institute of Public Health

Figure 5.5: Share of users entering or re-entering the programme who injected drugs, 2013

Heroin Smoking and Sniffing

In recent years, the share of users injecting heroin upon first admission and readmission decreased (R^2=0.5936) in Slovenia, but not significantly. In 2008, they accounted for 55% of heroin users and 47% in 2013. In the period 2008-2013 also the share of those who smoked heroin as their primary drug decreased (R^2=0.7915). The share of users who sniffed heroin, however, increased (R^2=0.8932) from 9% in 2008 to as many as 18% in 2013 (Figure 5.6).



Source: National Institute of Public Health

Figure 5.6: Share of users entering and re-entering treatment programmes by type of heroin use, 2008–2013

Drug Injection Paraphernalia Sharing

Of a total of 290 individuals who entered treatment programmes again and for the first time in 2013, 98 (34%) have never shared injection paraphernalia. 58 (20%) have shared injection paraphernalia, but not within the past year. 23 (8%) have shared injection paraphernalia within the past year. In total, 81 individuals (28%) have a history of sharing injection paraphernalia.

Frequency of Primary Drug Use

Of the users entering treatment programmes for the first time in 2013, 5 (5.32%) had not used drugs within the preceding 30 days. 53 (56%) used drugs daily, 8 (8.4%) 4 to 6 times per week, 17 (17.64%) 2 to 3 times a week and 10 (10.53%) used drugs once a week or less frequently.

Of the users re-entering treatment programmes in 2013, 105 (54.14%) used drugs on a daily basis, while 29 (14.95%) had not used drugs within the preceding 30 days. 22 (11.34%) used drugs 4 to 6 times per week, 24 (12.37%) used drugs 2 to 3 times a week and 8 (4.1%) used drugs once a week or less frequently.

Of the users entering treatment programmes for the first time in 2013, 75% of drug users used opioids daily, while the same was true for 52% of users re-entering treatment programmes.

HIV Testing

There were 95 individuals who entered the programme for the first time. 68 of them (71.58%) have never undergone HIV testing. 8 (8.43%) have been tested, but not within the past year. Only 13 (13.69%) have been tested for HIV in the past year. Of the 21 individuals (22.11%) who have injected drugs within the past year, only 4 (19.5%) have been tested for HIV.

In the group of users re-entering treatment programmes (194 individuals), 28 (14.44%) have never been tested for HIV. 96 (49.49%) have undergone HIV testing, but not in the past 12 months, while 54 (27.84%) have been tested within the past year. Although 98 (50.52%) have injected drugs within the past year, only 27 (28%) have been tested for HIV in the same time period.

Hepatitis C Testing

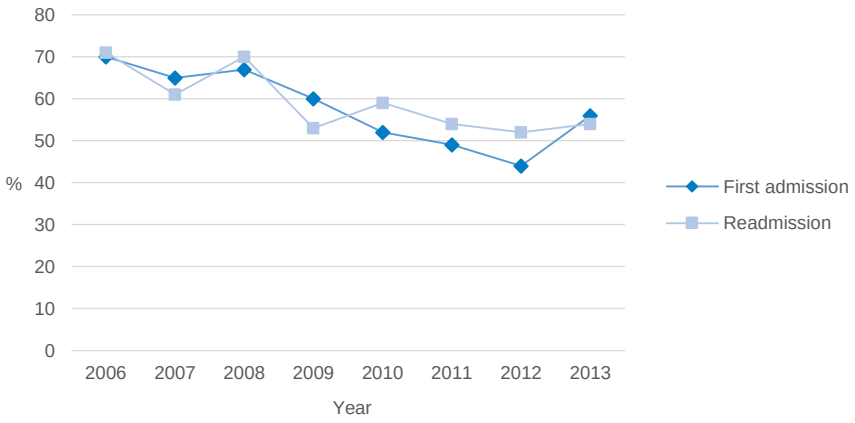
Of the 95 individuals who entered the programme for the first time, 69 (72.64%) have never undergone HCV antibody testing. 7 (7.37%) have been tested, but not within the past year. Only 13 (13.69%) have

been tested within the past year. Of the 21 individuals (22.11%) who have injected drugs within the past year, only 12 (57%) have been tested with the same period.

There were 194 individuals who re-entered the programme. 28 (14.44%) of them have never been tested, while 93 (47.94%) have undergone HCV antibody testing, but not within the past 12 months. 57 (29.39%) have been tested for HCV antibodies within the past year. 98 (50.52%) of readmitted users have injected drugs within the past year, but only 30 (31%) of them were tested for HCV antibodies within the same period.

Trends

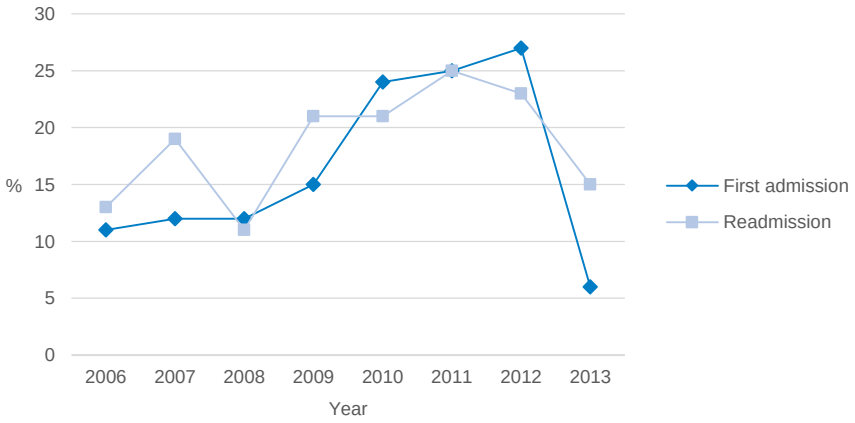
Trends must be interpreted with a great deal of caution, seeing that the new TDI 3.0 questionnaire was introduced in January 2013. The share of users being admitted to the programme for the first time who used their primary drug daily had been in decline for a number of years (R^2=0.7716), but rose from 44% in 2012 to 56% in 2013. A slight increase in the share of readmitted users who used drugs daily also occurred in 2013. The year 2013 was the first year after a seven-year period when the share of daily drug use was higher both among the users re-entering the programme and those entering the programme for the first time (Figure 5.7).



Source: National Institute of Public Health

Figure 5.7: Share of users entering or re-entering the programme who engaged in daily drug use, 2006–2013

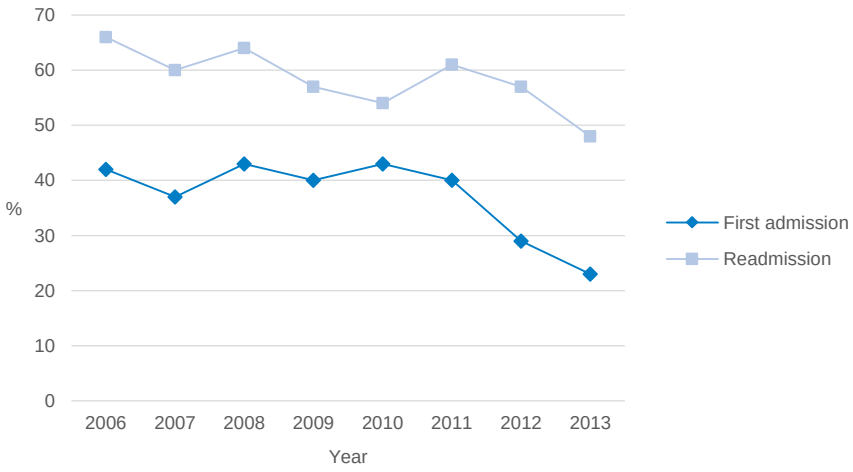
In comparison to previous years, we also recorded a lower share of users who had not engaged in primary drug use 30 days prior to entering or re-entering the programme in 2013 (Figure 5.8).



Source: National Institute of Public Health

Figure 5.8: Share of users entering or re-entering the programmes who had not used their primary drugs within the past month, 2006–2013

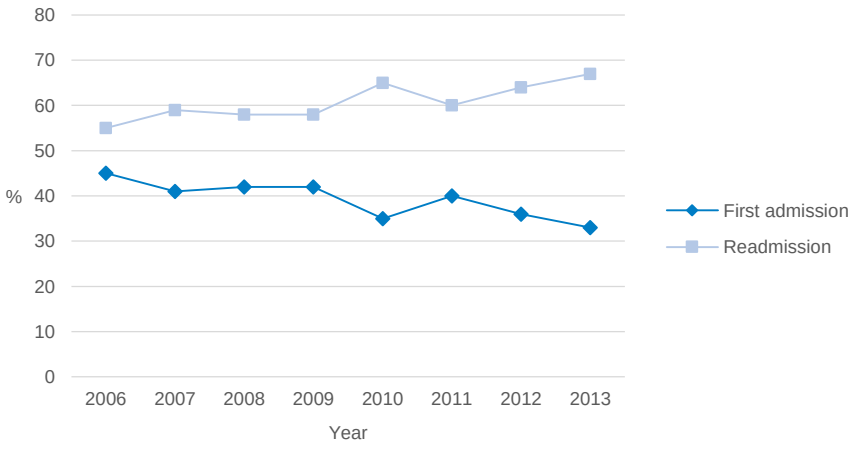
The share of users who injected drug upon first admission (R^2=0.8335) or readmission (R^2=0.612) to the programme has been gradually decreasing over the years (Figure 5.9). This is a positive indicator in terms of the effect of harm reduction.



Source: National Institute of Public Health

Figure 5.9: Share of users entering or re-entering the programme who injected drugs, 2006–2013

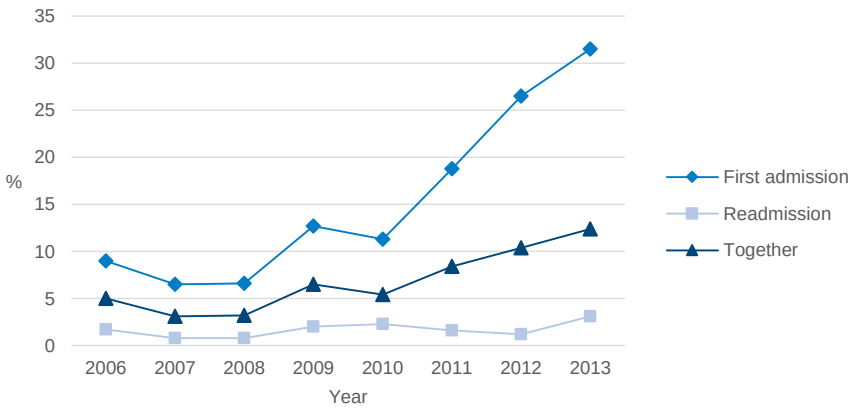
In 2008, the share of drug users re-entering the programme began to increase and reached 67% in 2013. The share of first admissions, however, was in decline between 2006 and 2013 (R^2=0.7446) and reached 33% in 2013 (Figure 5.10).



Source: National Institute of Public Health

Figure 5.10: Share of users entering or re-entering the treatment programme, 2006–2013

In the period of 2006-2013 there was an increase in the share of users entering treatment programme again and for the first time due to cannabis use as their primary drug. This phenomenon is especially present among users who are entering the programme for the first time (R^2=0.828), while the corresponding share among readmitted users has been increasing more gradually (Figure 5.11).



Source: National Institute of Public Health

Figure 5.11: The share of users entering treatment programme again and/or for the first time due to cannabis as their primary drug, 2006–2013

Conclusion

The Centres for the Prevention and treatment of Drug Addiction network reached 4065 drug users in 2013; however, a trend of decreasing numbers of admissions has been observed in recent years. 3261 drug users underwent substitution treatment, with over half of them receiving methadone. The share of methadone recipients has been in decline since 2008, with the share of other substitute drug on the rise.

This paper used data obtained by the TDI 3.0 questionnaire for the first time. According to the data obtained, 290 users were admitted to treatment programme for the first time or were readmitted to them in 2013, which is fewer than last year, when there were 519 such users. The lower number of recorded admissions is likely due to the introduction of the new questionnaire. The share of admissions due to the use of opioids as the primary drug, however, remains high, reaching up to 80% among first admissions and readmissions. Most opioid users use heroin. The share of those injecting or smoking heroin has decreased, while there has been an increase in the share of those sniffing heroin. There has also been an increase in the share of drug users who entered the programme due to cannabis, especially among new admissions. As yet, no increase of synthetic drug use has been recorded despite the increased supply. There has, however, been a recorded increase in users with issues due to synthetic opioid use. The share of users who were tested for HIV and hepatitis C in 2013 has also been unsatisfactory.

The share of users entering the programme who inject drugs has been in decline over the years, which is a testament to the quality of the network of help programmes. The share of users entering treatment who share injection paraphernalia is relatively low, which is due to highly developed harm reduction programmes. It is necessary to initiate a safe house and a prescription heroin programme to further reduce the number of people sharing paraphernalia, the share of infections and the number of deaths.

Homelessness is an increasingly serious issue among drug users in treatment. Homelessness is associated with the ageing of drug users and leads to increased social hardship and a higher frequency of acute and chronic illnesses.

6. HEALTH CORRELATES AND CONSEQUENCES

The prevalence of HIV, Hepatitis C virus (HCV) and Hepatitis B virus (HBV) infections is monitored by collecting data on voluntary diagnostic tests for HIV, HCV and HBV infections among persons who inject drugs and who enter or re-enter treatment within the national network of Centres for the preventions and treatment of illicit drug addiction, which covers the whole country. In addition, unlinked anonymous HIV testing of persons who inject drugs at first treatment demand is carried out for the purposes of HIV infection control. Furthermore, the National Institute for Public Health collects data on newly diagnosed cases of HIV, HBV and HCV infections, including data on transmission route. All diagnoses of infection with these viruses must be reported in accordance to the Infectious Diseases Act (Official Gazette of the RS, No. 33/06). Saliva samples collected in 2013 from persons who inject drugs as part of an unlinked anonymous testing to control HIV infections have not tested positive for HIV antibodies, though two cases of diagnosed HIV infections with a history of drug injection were reported to the National Institute for Public Health. The prevalence of antibodies against hepatitis B virus among confidentially tested injecting drug users entering or re-entering treatment within the network of Centres for the prevention and treatment of illicit drug addiction was 5.6% in 2013 and the prevalence of antibodies against hepatitis C virus was 32.1%. In the period 2009–2013, the share of those infected with Hepatitis B was the highest in 2011, while the share of those infected with Hepatitis C was the highest in 2013.

Medical emergency units receive patients of illicit drug poisoning who require a minimum of several hours of treatment and/or hospitalisation. Medical emergency units at Ljubljana, which serve approximately 600,000 residents of Central Slovenia, treated 83 patients for illicit drug poisoning in 2013, 46 of which were poisoned by a combination of drugs and/or ethanol. The patients were predominately male and the average age of poisoned patients was 30 years. Over the past three years, the number of phenethylamine and cannabis poisoning cases has been on the rise. In 2013, there has also been a new increase in the number of heroin poisonings, while GHB poisoning was the most common type of poisoning.

Drug-related deaths in Slovenia have been monitored in accordance to European Monitoring Centre for Drugs and Drug Addiction recommendations since 2003. Monitoring data includes direct deaths, i. e. the deaths directly caused by the effects of illicit drugs on the body. These data, also known as the underlying cause of death, are obtained from the General Mortality Register of the National Institute for Public Health. In addition, data on indirect deaths are also monitored using cohort analysis. Data on indirect deaths involve data on persons who died due to an indirect effect of illicit drugs on health, i. e. where the effects of drugs were the associated cause of death. In 2013, the General Mortality Register recorded 28 deaths caused by drug poisoning in Slovenia; 20 of those were men, while 8 were women. The average age at death was 36.3 years of age for men and 39.3 years of age for women. Heroin was the leading cause of fatal poisoning, followed by methadone. A ten-year analysis of data on treated drug patients included in the cohort study showed that their average mortality rate is nearly three times as high as other Slovenians in the same age group.

6.1 Drug Related Infectious Diseases

Irena Klavs, PhD, Assoc. Prof., Tanja Kustec

Drug-related infectious diseases among persons who inject drugs (PWIDs[12]) are an important challenge to public health. Such diseases include HIV, hepatitis C virus (HCV) and hepatitis B virus (HBV). HIV, HBV and to a much lesser extent also HCV infections are transmitted through sexual intercourse. Thus, these infections can be spread through unprotected sexual intercourse to the partners of PWIDs 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. In contrast, vaccination against HIV and HCV infection 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 PWIDs in Slovenia for the period from 2009 to 2013 are presented in this chapter.

Methods

The prevalence of HIV, HCV and HBV infections is monitored by collecting data about voluntary diagnostic HIV, HCV and HBV testing among PWIDs who enter or re-enter treatment 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 PWIDs 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 PWIDs 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 Act (Official Gazette of the RS, No. 33/06). Nearly all of the newly diagnosed HIV infection cases reports also contain information on the transmission route. In contrast, information on the transmission route (e.g. PWIDs) is only available for a minority of reported HBV and HCV cases. Surveillance reports that include information on HIV, HBV and HCV newly diagnosed cases reporting are published annually (Klavs et al. 2014; NIPH 2014).

HIV Infection

According to all available surveillance information, extensive spread of HIV infection has not started yet among PWIDs in Slovenia.

During the period from 2009 to 2013, HIV prevalence among confidentially tested PWIDs entering or re-entering treatment within the network of Centres for the Prevention and Treatment of Illicit Drug Addiction ranged from the highest 1.9% in 2011 to the lowest 0% in 2012 and was 1.4% in 2013. During

[12] Previously used injecting drug users (IDUs).

the same period, among a total of 885 saliva specimens collected for unlinked anonymous testing for surveillance purposes at three or four different sentinel sites, three specimens were positive for HIV antibodies in 2010, 2011 and 2012 (Table 6.1).

Table 6.1: Proportion of HIV infected persons among persons who inject drugs, 2009–2013

	Year	Number of sentinel sites	Number of tested		Number of HIV infected		% HIV infected	
			Male	Female	Male	Female	Male	Female
PWID	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
	2012	4	132	41	1	0	0.8	0
	2013	3	84	30	0	0	0	0

Source: Unlinked anonymous testing for HIV for surveillance purposes, 2009-2013.

During the last five years (2009–2013), three cases of a new HIV diagnosis in individuals with a history of injecting drug use were reported to the NIPH, one in 2012 and two in 2013. Before that, the last HIV infection in a PWID 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 16 new HIV diagnoses were reported among PWIDs. Majority of these individuals had a history of injecting illegal drugs abroad.

In Europe, the latest figures show that the long-term decline in the number of new HIV diagnoses might be interrupted as a result of outbreaks among PWIDs in Greece and Romania. In other countries such as Spain and Portugal, which have experienced periods with high rates of infection among PWIDs in the past, trends in rates of newly reported diagnoses continue to decline. The situation is less positive, in Estonia, where the rate of new diagnoses remains high, and in Latvia, where annual rates have been increasing since 2009. In 2012, the average rate of newly reported HIV diagnoses attributed to injecting drug use was 3.09 per million population (EMCDDA 2014).

HBV

The prevalence of antibodies against hepatitis B virus (HBV; anti-HBc) among confidentially tested PWIDs entering or re-entering treatment within the network of Centres for the Prevention and Treatment of Illicit Drug Addiction was 5.6% in 2013. During the period from 2009 to 2013, the prevalence ranged between the highest 8.1% in 2011 and the lowest 2.0% in 2012.

The reported acute and chronic HBV infection incidence rate in the Slovenian population in 2013 was 2.5/100,000 inhabitants. During the period from 2009 to 2013, the reported incidence rate ranged from the highest 3.4/100,000 inhabitants in 2011 to the lowest 2.0/100,000 inhabitants in 2010. Due to underascertainment and underreporting, HBV reported incidence rates greatly underestimate the burden of this infection.

In Europe, PWIDs represent 9% of all hepatitis B diagnoses and 21% of acute diagnoses notified (EMCDDA 2014).

HCV

The prevalence of antibodies against hepatitis C virus (HCV) among confidentially tested PWIDs entering or re-entering treatment within the network of Centres for the Prevention and Treatment of Illicit

Drug Addiction was 32.1% in 2013. During the period from 2009 to 2013, the prevalence ranged from the highest 32.1% in 2013 to the lowest 21.5% in 2010.

The reported acute and chronic HCV infection incidence rate in the Slovenian population in 2013 was 4.3/100,000 inhabitants. During the period from 2009 to 2013, the reported incidence rate ranged from the highest 5.4/100,000 inhabitants in 2009 to the lowest 4.2/100,000 inhabitants in 2010. Due to underascertainment and underreporting, HCV reported incidence rates greatly underestimate the burden of this infection.

Viral hepatitis, and in particular infection caused by the hepatitis C virus (HCV), is highly prevalent among PWIDs across Europe. HCV antibody levels among national samples of injecting drug users in 2011–12 varied from 19% to 84%, with seven of the 11 countries with national data reporting a prevalence rate in excess of 50% (Portugal, Latvia, Greece, Norway, Cyprus, Austria, Turkey). Among countries with national trend data for the period 2007–12, declining HCV prevalence in injecting drug users was reported in Norway, while seven others observed an increase. Averaged across the 18 countries for which data are available for the period 2011–12, PWID accounts for 64% of all HCV diagnoses and 50% of the acute diagnoses notified (where the risk category is known) (EMCDDA 2014).

Discussion

The strengths of prevalence monitoring of HIV, HCV and HBV infection among PWIDs entering or re-entering treatment 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 PWIDs cannot reliably reflect HIV incidence. However, the notification of diagnosed HIV cases is believed to be complete and HIV incidence among PWIDs 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 PWIDs is only due to possible late diagnosis. In contrast, due to underascertainment and 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. PWIDs) 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, PhD, Assist. Prof.

Medical emergency units at Ljubljana University Medical Centre serve approximately 600,000 residents of Central Slovenia and performed medical examinations on 23,334 patients in 2013. Statistical data on those examined and treated for illicit drug poisoning are presented below.

Medical emergency units admit illicit drug poisoning patients who require a minimum of several hours of treatment and/or hospitalisation. The most common causes for referral to a medical emergency unit are loss of consciousness, respiratory failure, low blood pressure, cardiac arrhythmia, chest pain, epileptic seizures, aggressive behaviour etc.

Methods

Two methods were used to determine the frequency of illicit drug poisoning. First, the number of drug poisoning cases was determined using the hospital computer system, where diagnoses are coded in accordance with ICD-10. Unfortunately, in the cases in which treatment was only provided in emergency units, medical records in the hospital computer system only include the code for the underlying or primary diagnosis, whereas secondary diagnoses are only recorded as notes. Furthermore, ICD-10 coding of illicit drug poisoning is highly complicated and inadequate. For example, amphetamines are included in the large and non-transparent group of "Psychostimulants with abuse potential", while coding poisonings involving new drugs such as GHB is practically impossible. Therefore, to determine the frequency of illicit drug poisoning, we also reviewed the record of examined patients, which includes data on all examined patients, including referral and discharge diagnoses (one or more).

Cases of Illicit Drug Poisoning

The analysis of computer system data on underlying diagnoses coded in accordance with ICD-10 and the review of non-coded referral and discharge diagnoses of all patients manually recorded in the record of examined patients in 2013 showed that there were 83 patients treated for illicit drug poisoning in medical emergency units in Ljubljana (Table 6.2), which is nearly twice the number of cases over the previous years. There were only 51 such patients in 2010, 43 in 2011 and 47 in 2012. Cases of illicit drug poisoning accounted for 0.36% of all medical emergency unit patients in 2013, while the share was 0.24%, 0.19% and 0.20% in 2010, 2011 and 2012, respectively. Similarly to the last three years, the average age of the patients treated for illicit drug poisoning in 2013 was around 30 years of age, and 75% of the patients were male.

By reviewing all descriptive diagnoses, we also identified combined drug poisoning cases, that is poisoning cases involving combinations of known drugs and drugs which could not be coded using ICD-10 (Table 6.2). The number of illicit drugs used between 2010 and 2013 is recorded in Table 6.3, which includes ecstasy, speed, mephedrone, 3-MMC and 2-Cl under phenethylamines (2013). Individual patients may have taken two or more kinds of phenethylamines, e. g. ecstasy and mephedrone.

Table 6.2: Patients suffering from illicit drug poisoning who were treated in emergency medical units at Ljubljana University Medical Centre, 2010–2013

Illicit drugs and combinations thereof	No. of patients in 2010 (n = 51)	No. of patients in 2011 (n = 43)	No. of patients in 2012 (n = 47)	No. of patients in 2013 (n = 83)
Heroin	25	5	4	6
Heroin + ethanol	2	3	1	3
Heroin + phenethylamine	1	0	0	0
Heroin + cocaine	6	2	0	2
Heroin + cocaine + ethanol	1	0	1	0
Heroin + cannabis	0	0	0	1
Heroin + cannabis + ethanol	0	0	1	0
Heroin + cocaine + cannabis	0	0	1	1
Cocaine	5	6	5	3

Table 6.2 continues …

Illicit drugs and combinations thereof	No. of patients in 2010 (n = 51)	No. of patients in 2011 (n = 43)	No. of patients in 2012 (n = 47)	No. of patients in 2013 (n = 83)
Cocaine + ethanol	0	0	3	1
Cocaine + phenethylamine + cannabis	0	0	0	2
Cocaine + phenethylamine + cannabis + ethanol	0	1	1	0
Cocaine + phenethylamine + phenethylamine + ethanol	0	1	1	0
Cocaine + cannabis	0	0	0	2
Cocaine + cannabis + methadone	0	1	0	0
Phenethylamine	1	1	1	3
Phenethylamine + phenethylamine	1	0	1	2
Phenethylamine + ethanol	1	6	3	4
Phenethylamine + phenethylamine + ethanol	0	2	0	1
Phenethylamine + cannabis	0	1	0	1
Phenethylamine + phenethylamine + phenethylamine + cannabis	0	1	0	0
Phenethylamine + cannabis + ethanol	0	0	0	1
LSD	0	0	0	1
LSD + cannabis	0	0	1	0
GHB	1	1	1	10
GHB + phenethylamine	1	0	1	0
GHB + cocaine	0	0	0	1
GHB + cocaine + heroin	0	0	0	1
GHB + ethanol	0	1	0	11
GHB + cannabis + ethanol	0	0	0	3
GHB + cocaine + ethanol	0	0	0	0
GHB + phenethylamine + ethanol	0	0	0	1
GHB + phenethylamine + cannabis + ethanol	0	0	1	0
GHB + phenethylamine + phenethylamine + cannabis + ethanol	0	0	1	0
GBL	0	0	0	2
GBL + ethanol	0	0	1	0
1,4 BD	0	0	0	1
1,4 BD + ethanol	0	0	0	1
Cannabis	6	11	7	11
Cannabis + ethanol	0	1	9	5
Psylocybin	0	0	1	0
Ibogaine	0	0	1	0
Unknown substance	0	0	0	2

Source: Ljubljana University Medical Centre databases

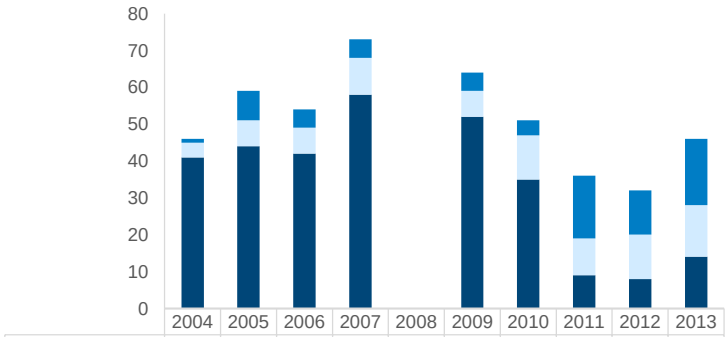
Table 6.3: Number of illicit drugs used by poisoning patients treated in medical emergency units at Ljubljana University Medical Centre, 2010–2013

Illicit drugs	No. of drugs in 2010 (n = 61)	No. of drugs in 2011 (n = 55)	No. of drugs in 2012 (n = 61)	No. of drugs in 2013 (n = 107)
Heroin	35	9	8	14
Cocaine	12	10	12	14
Phenethylamines	6	18	12	18
Tryptamines	0	0	1	1
GHB, GBL, BD	2	2	5	31
Cannabis	6	16	23	27
Ibogaine	0	0	1	0
Unknown substance	0	0	0	2

Source: Ljubljana University Medical Centre databases

As expected, the number of taken illicit drugs (Table 6.3) exceeds the number of patients suffering from illicit drug poisoning (Table 6.2), seeing that drug users commonly consume several different drugs as well as ethanol. In 2013, only 37 patients (45%) had taken a single drug, while the remainder had also consumed other drugs or ethanol, including 25 patients (30%) who had consumed a drug as well as ethanol and 21 patients (25%) who had taken two types of drugs or more, 6 of whom had also drunk ethanol. This is in line with data from the last three years, when more than a half of drug poisoning cases were also due to a combination of drugs (Table 6.2).

Ljubljana University Medical Centre has monitored the frequency of illicit drug poisoning for a number of years. Figure 6.1 illustrates the number of heroin, cocaine and phenethylamine poisonings over the past ten years.



	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Phenetylamines	1	8	5	5		5	4	17	12	18
Cocaine	4	7	7	10		7	12	10	12	14
Heroin	41	44	42	58		52	35	9	8	14

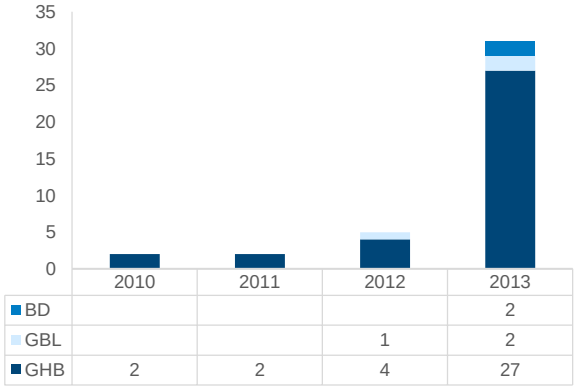
Source: Ljubljana University Medical Centre databases

Figure 6.1: Number of illicit drugs used by poisoning patients treated in medical emergency units at Ljubljana University Medical Centre, 2004–2013

Figure 6.1 shows that the number of heroin poisonings had been gradually declining between 2007 and 2012, when it unexpectedly began to rise in 2013. Of the patients who only suffered heroin poisoning, 75% were male, with an average age of 37 years, which is approximately 10 years older than in 2011 and 2012. There is no known cause behind the increase in heroin poisoning cases and the higher average age of patients. The number of cocaine poisonings was similar across the 2010–2013 period. It is a matter of some interest that there was a high number of poisonings from a combination of heroin

and cocaine in 2010, while there has only been one such case in 2011 and 2012, respectively, and two such cases in 2013.

The last three years of a decade-long monitoring of illicit drug poisonings in medical emergency units in Ljubljana reveal an increase in the number of phenethylamine poisonings, such as ecstasy, amphetamines and cathinones. The year 2013 saw the highest numbers of phenethylamine poisonings in the past ten years. The number of cannabis poisoning cases has been steadily increasing for the past three years, and was the most common type of poisoning diagnosed in medical emergency unit patients in 2012. In 2013 GHB poisoning unexpectedly replaced it as the most common type of poisoning, with as many as 27 cases of GHB poisoning, 2 cases of GBL poisoning and 2 cases of BD poisoning (Figure 6.2). The average age of GHB poisoning patients was 28, with 84% of them being male. 88% of GHB poisoning patients were comatose (21) or somnolent (6) upon examination in the medical emergency unit.



Source: Ljubljana University Medical Centre databases

Figure 6.2: Number of GHB, GBL and BD poisoning cases in medical emergency units at Ljubljana University Medical Centre, 2010–2013

Conclusion

We have found that emergency examinations of patients poisoned with illicit drugs constituted at least 0.35% of all patient examinations at emergency units in Ljubljana in 2013, which is nearly twice the number of such examinations in previous years. The year 2013 has seen a new increase in heroin poisonings, a continuation of the increase in cannabis poisonings and a pronounced rise in GHB poisonings. The number of cocaine and phenethylamine (ecstasy, amphetamines, cathinones etc.) poisonings has, however, remained relatively steady in comparison to previous years.

6.3 Drug Related Deaths and Mortality among Drug Users

Jožica Šelb Šemerl, PhD

Method

Drug-related deaths in Slovenia have been monitored in accordance to EMCDDA recommendations since 2003. The following data are monitored:

– Direct deaths, i. e. the deaths induced by a fatal illicit drug poisoning. The poisoning may be intentional (suicide), accidental (overdose), or there is not known or determined intent of death (undetermined intent). One of the above mentioned types of poisoning is the underlying cause of death. Underlying causes of death are listed in the General Mortality Register of the National Institute for Public Health 46: Medical Report on the Deceased Person.

– Indirect deaths, i. e. the deaths of drug users whose underlying cause of death is any illness or other condition causing the death rather than any of the aforementioned types of poisoning, where the effect of drugs is an associated cause of death. In Slovenia, these data are obtained by a cohort study; up until 2007, a special registry was also use as a source of the data.

For direct deaths, the demographic and other data collected on the Medical Death Certificate and Report on the Causes of Death (death certificate) and the DEM-2 form[13] are analyzed. The basic epidemiological indicators[14] are used, while mortality rates are calculated per 1000 or 100,000 person years (persons/year) of the corresponding population group. For ten-year denominator, the 2009 population is used, multiplied by ten. For standardized death rates, the total population and the number of deceased in Slovenia in 2007 and the old European standard population are used. Due to the significant changes in the number of deaths among drug users per year in individual regions, the regional comparison was calculated from a ten-year total of deaths in a specific region per the tenth factor of the population between the ages of 15 and 65. In those cases, mortality rates are expressed per 100,000 populations.

Direct Deaths

In 2013, the General Mortality Register recorded 28 deaths caused by drug poisoning in Slovenia (Table 6.4). 20 of those were men, while 8 were women; the average age at death was 36.3 years of age for men and 39.3 years of age for women, and the majority of the deaths were between the ages of 30 and 34. The youngest deceased woman was 26, while the youngest deceased man was not yet 29. Four fifths of all deceased were single, two persons were divorced, two were widowed and one was married. Of the 28 direct poisonings, 20 were proven by toxicological testing. The number of deaths in 2013 was on the lower confidence interval limit of the ten-year average.

Table 6.4: Number of direct drug-related deaths by external cause and type of drug used, 2013

External cause/ Type of drug	Addiction	Accidental overdose	Undetermined intent	Total
Opioid addiction	4	0	0	4
Addiction to multiple drugs	1	0	0	1
Heroin	0	9	4	13
Other opioids	0	1	0	1
Methadone	0	7	0	7
Cocaine	0	1	1	2
Total	5	18	5	28

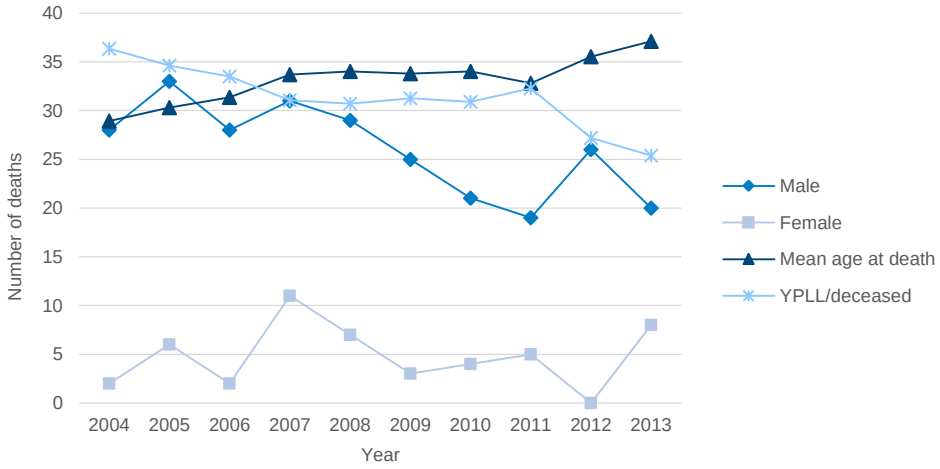
Source: National Institute for Public Health, Medical Report on the Deceased Person – NIJZ 46

In 2013, nearly half of the deaths were due to heroin, seven were caused by methadone, two by cocaine, four of the deceased were opioid addicts, and the death of one addict was caused by several drugs. In 2013, nearly two thirds of all poisonings were accidental, while the remaining one third of cases could not be confirmed either as intentional (suicide) or accidental (overdose).

[13] The form form contains additional data on the circumstances of death and the deceased.
[14] The basic epidemiological indicators are: the number of deaths, specific mortality rates, standardized mortality rates, the age median of the deceased and the years of potential life lost.

Trends in Drug Related Deaths and Mortality of Illicit Drug Users in the Period 2004–2013

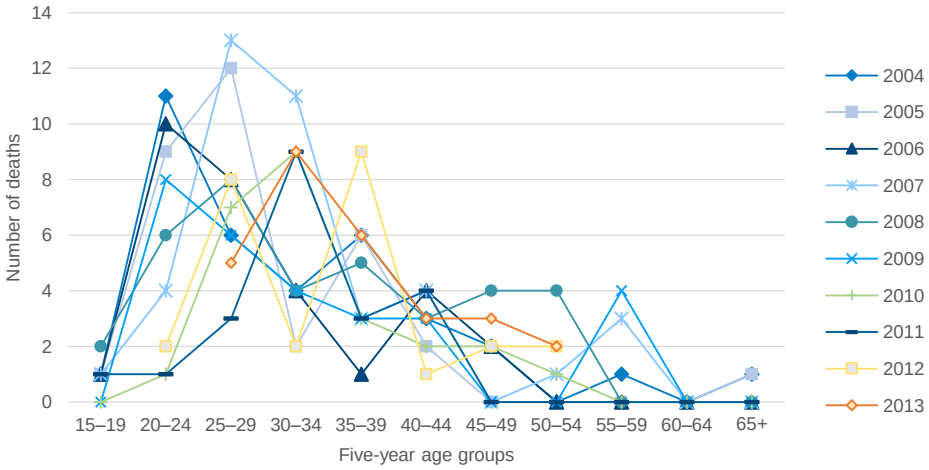
Between 2004 and 2013, the number of direct deaths from a drug overdose (intentional, accidental or undetermined intent) was five times higher in men than in women (Figure 6.3), while age-standardized mortality rates per individual year were 2 to 12-times higher in men than in women. The number of death decreased between 2007 and 2011, then rose again among men in 2012 and among women in 2013, though neither case exceeded the confidence interval of the ten-year average. Age-standardized mortality rates significantly decreased in men ($R^2 = 0.6062$), but not in women.



Source: National Institute for Public Health, Medical Report on the Deceased Person – NIJZ 46

Figure 6.3: Trends in the number of deaths by gender, 2004–2013

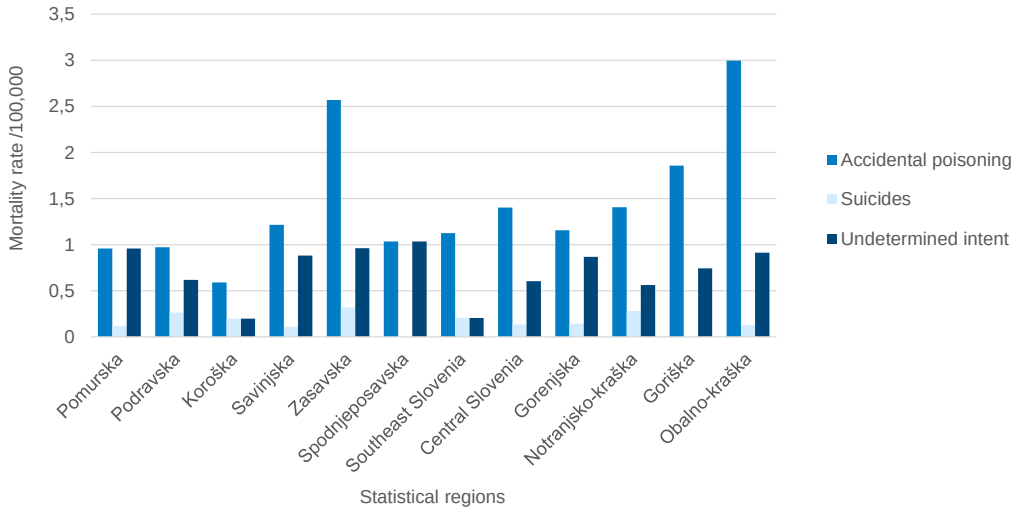
During ten years we have been using the EMCDDA methodology to collect the causes of direct deaths of illicit drug users, the number of years of potential life lost (YPLL), a cumulative indicator of the number of deaths and the mean age at death, has experienced a drop due to the increasing mean age at death and the decrease in the number of deaths (Figure 6.3). The increasing mean age at death and the drop in YPLL indicate that addicts die at an increasingly older age.



Source: National Institute for Public Health, Medical Report on the Deceased Person – NIJZ 46

Figure 6.4: Trends in the number of direct drug-related deaths among the population aged 15–64, per five-year age groups, 2004–2013

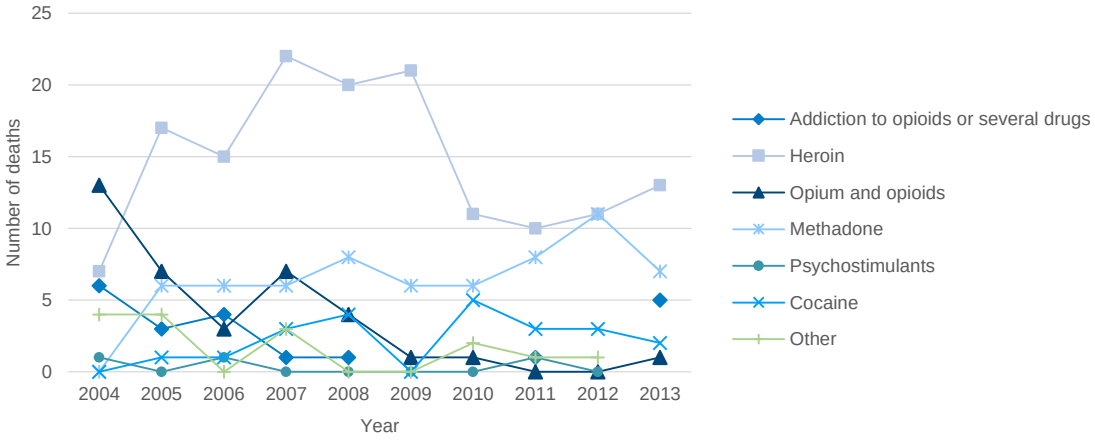
The number of deceased within a single age group was the highest in 2007 for the 25–29 age group (Figure 6.4). The figure dropped in the following years and shifted towards older age groups. In 2012, the largest number of deceased belonged to the 35–39 age group, and the 30–34 age group in 2013.



Source: National Institute for Public Health, Medical Report on the Deceased Person – NIJZ 46

Figure 6.5: Ten-year mortality rates of direct illicit drug poisonings in the 15–64 age group, per region, 2004–2013

The mortality rate due to direct poisoning of drug users was the highest in the Obalno-Kraška and the Zasavje statistical regions, that is three or slightly fewer than three deaths per 100,000 population higher than in the Koroško region, which had the lowest mortality rate (Figure 6.5). All regions experienced more deaths due to accidental drug poisoning than deaths due to suicide or undetermined intent poisonings. The large number of undetermined intent poisonings has obscured the data on deaths due to intentional and accidental poisoning, though the former number dropped substantially in 2012 and 2013. Judging by this decrease and a large increase of deaths from acute accidental poisoning, the share of acute accidental poisoning was likely larger than the share of suicides in the previous years as well. To test this hypothesis, accidental acute poisonings and suicides and acute poisonings of undetermined intent will need to be monitored for several more years or a study will need to be carried out and complete existing data with data from autopsy reports pertaining to individual cases will be on disposal.



Source: National Institute for Public Health, Medical Report on the Deceased Person – NIJZ 46

Figure 6.6: Trends in the number of fatal drug poisonings – intentional, accidental and undetermined intent – by type of drug, 2004–2013

The highest number of fatal poisonings was due to heroin during the entire 2004–2013 period, with only methadone reaching the same number in 2012 (Figure 6.6). The number of methadone-related deaths, which is the second most common cause of poisoning and has been on the rise since 2010, experienced a slight drop in 2013. The number of cocaine-related deaths has generally fallen in the 3–5 range since 2007, with the exception of 2009, when there were no such deaths. There were no opium or opioid poisoning within the last two years, with deaths caused by other drugs occurring occasionally. The year 2013 saw the re-emergence of deaths due to addiction to opioids or several drugs without data on the principal drug causing death.

Conclusion

In 2013, 28 people, mostly men, died of drug poisoning in Slovenia. The majority of the deceased were between the ages of 30 and 34. The number of deaths in 2013 did not significantly differ from the number of deaths in the previous years. Heroin remains the illicit drug behind the majority of deaths, followed by methadone. There are significant differences in mortality rates per region, with the Obalno-Kraška and the Zasavska region being at most risk. The median age at death and the number of years of potential life lost indicated that the age at death increased in the 2004–2013 period among drug users. The quality of data has been improving with the recent years due to the higher number of data obtained from autopsies. This is likely also the cause behind the increase of deaths due to accidental poisonings and the corresponding decrease in deaths with no determined intent. In terms of the mortality rate directly attributable to illicit drugs, Slovenia ranks on the line between the first and second third of the 30 states reporting to the EMCDDA.

A Cohort Study: Ten-Year Observation of Treated Drug Users

Jožica Šelb Šemerl, PhD

Method

The data on the treatment conditions of drug users included in the cohort and the methods of calculating results have already been published in previous National Reports in the sections on the key indicator “Drug-related Deaths and Mortality among Drug Users in Slovenia” (Drev et al. 2011:86). Similarly, the differences in demographic, social and other factors monitored by the Treatment Record of Drug Users form have also been presented (Šelb Šemerl in Drev et al. 2012:101). For this reason, the 2004–2006 cohort observed up to 2011 was only amended with data on deceased cohort members in 2012 and 2013.

Both the age-standardized mortality rate and the mortality ratio were calculated for groups by cause of death in the same way as they were for all cohort members and those who listed opioid abuse as the reason for entering treatment. Cohort mortality rates were calculated for people between the ages of 15 and 59 and were compared to male and female mortality rates for Slovenia in 2008, the median year of cohort observation. Age-standardized mortality rates (using the old European standard population and the Slovenian mortality in 2007) and specific per 1,000 were calculated using person-years (PY) as the denominator. Cumulative mortality for specific years was calculated using the number of deaths in previous years up to the specified year per 1,000 person-years of follow-up. Years of potential life lost (YPLL) were calculated up to 65 years of age and were shown for the entire observation period and calculated per one deceased person. In terms of the trends of mortality indicators, we focused on comparing the trends in the shapes of the curves, which is why Figure 6.7 shows a tenth of the real value for the average age at death.

The observed group included those treated for the first time and old patients. Those treated for the first time were defined as those who entered treatment for the first time in the years of entering the cohort,

i.e. between 2004 and 2006, and old patients were defined as those who had already been in treatment but suspended treatment for at least three months or those who had already been treated at a different centre, and those undergoing continuous long-term treatment. In 2005 and 2006, old patients also included those persons who first entered treatment in 2004 or 2005 along with those who had already been treated in the years before the beginning of the study and between 2004 and 2006 or were undergoing long-term continuous treatment. Unless otherwise stated, the calculations pertaining to first-time treated patients only encompass the 2004–2006 period.

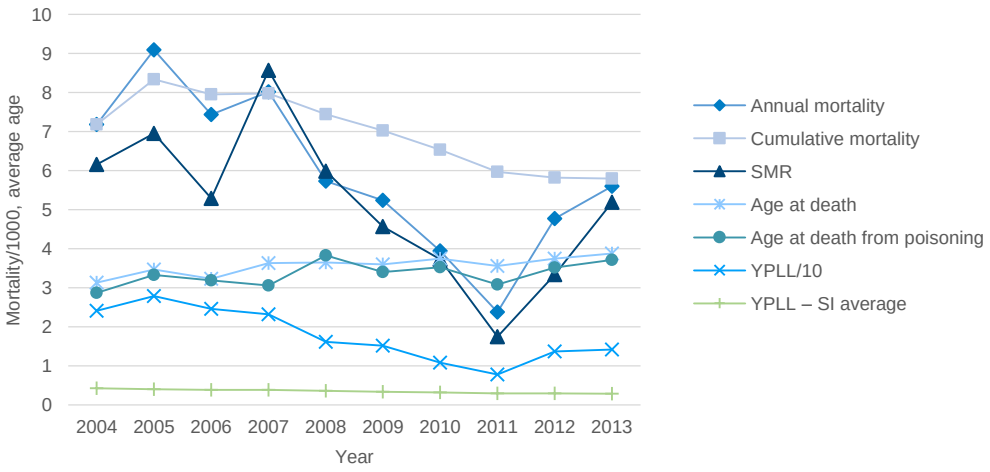
To compare age-standardized mortality rates (ASMR) among centres for the prevention and treatment of illicit drug addiction (CPTDA), the study only used the data on those who entered treatment in 2004, and illustrated the ASMR of the entire cohort by centre that treated them. This was done due to the differences in the number of drug users entering treatment in the period of 2004–2006 at various centres.

Results

In the 2004–2013 period, 206 persons, or 5.2% of the 3945 treated drug users who participated in the 2004–2006 study, passed away, including 5.9% of men and 3.2% of women. All persons, both alive and deceased, were observed for 35,082.7 person years, which is 5.7 deceased persons/1000 person years of cohort members between the ages of 15 and 59. Men's mortality rate was twice as high as the general mortality of Slovenians of the same age (relative risk RR = 2.04), while women's mortality rate was almost 2.5 times as high (RR = 2.44); however, age-standardized mortality was almost 3.5 times as high in treated male drug users and 2.5 times as high in treated female drug users compared to Slovenian men and women of the same age. The ten-year ASMR average was twice as high in men compared to the corresponding mortality rates for women.

Between 2005 and 2011, mortality rates in men significantly (R2 = 0.8033) decreased, but rose again in 2012 and 2013. Women's mortality rates also rose in 2013 after a period of decreasing after 2007.

The mortality of drug users is affected by the type of drug used, the ageing of users as well as the environment and lifestyle. As opposed to annual mortality, cumulative mortality designates the mortality over a certain period lasting from the beginning to the end of the observed period. Years of potential life lost is an indicator which stresses the deaths of young people as well as indicates the economic losses for the state.



SMR – standardised mortality rate, YPLL – years of potential life lost

Source: National Institute of Public Health, Medical Report on the Deceased Person – NIJZ 46, Record of Treatment of Drug Users – NIJZ 14

Figure 6.7: Trends in cohort member mortality rates and the average age at death and years of potential life lost for cohort members and Slovenians of the same age, 2004–2013

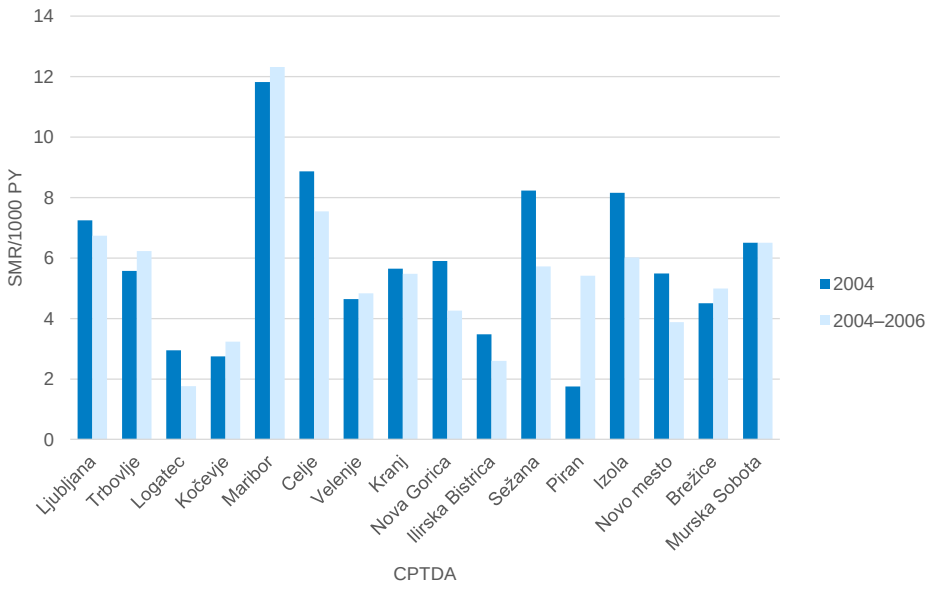
The figure, which has been adjusted due to better comparison of the curves, shows that the initial fluctuations in mortality, caused by the entries of first-time treated and old patients into the cohort between 2004 and 2006, were followed by a decrease in mortality. This is due to the fact that those undergoing long-term treatment between 2004 and 2006 or beforehand had already survived the initial risk associated with entering treatment, which later on made their risk of death approximate the cumulative risk of the cohort. In 2004, 56% of persons who entered treatment had never been treated, which increased the total mortality rate. This corresponds to the fact that more patients up to 34 years of age died than those older than 34 years of age in the first three years. After the pre-2011 decrease, all three parameters (mortality, SMR and YPLL) increased again in 2012 and 2013. Cumulative mortality stopped decreasing after 2011 due to the fact that the risk of death of cohort members was in decline with the duration of observation since 2005 for men and since 2008 for women; at the same time, the risk of death increased with age of the cohort members (Figure 6.7). The average age at death in the cohort increased for 7.5 years between 2004 and 2013; the increase was due to the increased age of death due to illness. The average age of death caused by drug poisoning did not differ between those who were treated and those who were not, and was on the rise on both groups.

The highest number of years of potential life lost due to premature death happened after the cohort had been formed, i.e. between 2005 and 2007. Years of potential life lost decreased with the drop in mortality between 2008 and 2011, in part due to the increase in age at death. Over the past two years, they returned to the 2009 level due to the increase in the number of deaths. Compared to the Slovenian population of the same age, treated drug users who died lost between 2.5 (2011) and 7 times (2005) as many years of potential life, calculated up to 65 years of age.

A course similar to the total mortality rate is also present in specific mortality rates for men and women; they were in decline during the observation period, and have increased over the past two years for men and over the past year for women.

Mortality rates among first-time patients were higher (11.98/1000 PY) for the year of entering treatment (2004, 2005 and 2006) than the rates of those who had already been in treatment or were undergoing long-term treatment (7.07/1000 PY). The average age at entering the study and the average age at death for drug users treated for the first time were lower (24 and 30.5 years of age, respectively) than the average ages of drug users who had already been in treatment or were undergoing long-term treatment (27.9 and 36.7 years of age, respectively). The number of years of life after entering the study was also lower for those in treatment for the first time than for those who had already been treated. Causes of death for first-time patients included heroin and ethanol poisoning, addiction to opioids and unspecified drugs as well as cancer and polytrauma due to a fall. Those who had already been treated and those undergoing treatment died from heroin or methadone poisoning, suicide and traffic accidents.

The mortality rates of treated drug users were also compared by CPTDAs which treated them. The differences were pronounced. The size of mortality rates may also be affected by the small number of observed years at individual CPTDAs.



Source: National Institute of Public Health, Medical Report on the Deceased Person – NIJZ 46, Record of Treatment of Drug Users – NIJZ 14

Figure 6.8: SMR of those who entered treatment between 2004 and 2006 and those who did so in 2004, by CPTDA, 2004–2013

Mortality rates were the lowest for those who entered treatment in 2004 (1.75 deaths/1000 PY) at the Piran CPTDA and the highest (11.83) at the Maribor CPTDA, which amount to a difference of 10.1 deaths/1000 observed PY (Figure 6.8). The large discrepancy in mortality rates may be caused by the difference in the number of deaths and the small number of those recorded to be in treatment at individual centres. The second column is the total mortality of those who entered treatment in 2004, 2005 and 2006; there is a strong correlation between both mortality rates ($R^2 = 0.8293$).

Source: National Institute of Public Health, Medical Report on the Deceased Person – NIJZ 46, Record of Treatment of Drug Users – NIJZ 14

Figure 6.9: ASMR of treated drug users and opioid users, by gender, 2004–2013

Age-Standardized Mortality Rates

Most years, the mortality rates of those who used opioids when entered into treatment were higher than the mortality rates of all treated drug users due to lower numbers of years in observation for those who used opioids when entering treatment, and the deceased in both groups were mostly opioid addicts. In 2013, the mortality rates for women being treated for opioid addiction surpassed the mortality rate of the total cohort of women, while the rates for men were equal (Figure 6.9).

In terms of living arrangements, mortality was highest in those who lived alone or on their own with a child (8.9 deaths/1000 PY). For slightly over 3 deaths per 1000 PY was lower the mortality of those living with a partner, with a partner and child/children, with friends or in any other community, those two lived with their parents had the lowest mortality. Mortality was over twice as high (7.54/1000 PY) in the unemployed and economically inactive compared to the employed or high school or university students (3.65/1000 PY). The need for an early start of drug addiction treatment is indicated by the fact that on average, the deceased treated drug users were older (31.6 years of age) when entering survey than those who survived to the end of the study (26.6 years of age).

Causes of Death

Table 6.5: Causes of death and external causes of death in cohort members, 2004–2013

External / ICD Chapter	Diseases	Vehicle and traffic injuries	Poisoning	Suicides	Undetermined intent	Other accidents	Total	Rate/1000 PY
Infectious dis.	5	0	1	0	0	0	6	0.17
Neoplasms	6	0	0	0	0	0	6	0.17
Endocrine dis.	1	0	0	0	0	0	1	0.03
Mental disorders	5	0	0	2	1	0	8	0.22
Dis. of the cardiovascular system	9	0	0	0	0	1	10	0.35
Dis. of the respiratory system	2	0	0	0	0	0	2	0.06
Dis. of the digestive system	15	0	0	0	0	0	15	0.42
Congenital malf.	1	0	0	0	0	0	1	0.03
Unknown cause	2	0	0	0	0	0	2	0.06
Injury and poisoning	0	13	64	33	34	11	155	4.33
Total	46	13	65	35	35	12	206	5.75
Rate/1000 PY	1.28	0.36	1.82	0.98	0.98	0.36	5.75	

Source: National Institute of Public Health, Medical Report on the Deceased Person – NIJZ 46, Record of Treatment of Drug Users – NIJZ 14

Among treated drug users, over three quarters of all deaths were of a violent nature, and less than a quarter of deaths were natural; of violent deaths, poisoning was the most common cause of death. 32% of all deaths were due to accidental poisoning, followed by deaths of unidentified intent (17%) and suicides (17%), diseases of the digestive system (7%), traffic and vehicle accidents (6%) and diseases of the cardio-vascular system (5%), all other causes of death had smaller shares (Table 6.5). Mortality rates were distributed similarly to the shares of causes of death.

Between 2004 and 2013, 183 men and 30 women died; in both genders, most deaths were violent, and deaths from natural causes were in the minority. Most violent deaths were due to overdoses and suicides.

Table 6.6: Types of poisoning, suicides and deaths by undetermined intent among cohort members, 2004–2013

Type of violent death/ Cause of violent death	Poisoning	Suicides	Undetermined intent	Total	Rate/1000PY
Heroin	27	3	21	51	1.42
Other opioids	7	1	0	8	0.22
Methadone	20	1	5	26	0.73
Cocaine	5	0	0	5	0.14
Unspecified narcotics	0	0	4	4	0.11
Benzodiazepines	2	0	0	2	0.06
Unspecified drugs	1	0	1	2	0.06
Alcohol toxicity	2	0	1	3	0.08
CO poisoning	0	8	0	8	0.22
Suicide by hanging	0	11	0	11	0.31
Other causes	1	11	3	15	0.42
Total	65	35	35	135	3.81

Source: National Institute of Public Health, Medical Report on the Deceased Person – NIJZ 46, Record of Treatment of Drug Users – NIJZ 14

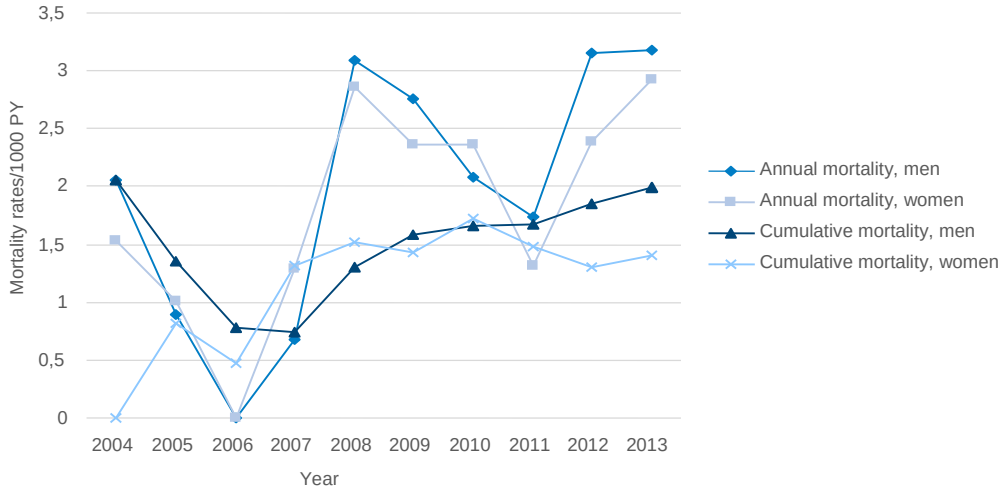
By type of illicit drug, half of the poisonings (intentional, accidental and of undetermined intent) was caused by heroin, followed by methadone with half as many cases, other drugs accounted for less than 10% of drug poisonings (Table 6.6). The most common way of suicide was death by hanging, while CO poisoning was the cause of death in a fifth of suicides, 14% were due to illicit drug poisoning, and the remaining one-third committed suicide using other methods. Considering that 7% of poisonings with determined intent were suicides, 2 of the 31 poisonings with undetermined intent may have been intentional, and the other 29 accidental.

When coding the leading cause of death, more additional information from autopsy reports and toxicology tests after 2007 have been obtained to code for poisonings without a clear intent, which may have resulted in a decrease in the number of the deaths which could not be conclusively determined to have been caused by intentional or accidental poisoning.

As the age of the cohort increases, so does the number of natural deaths. Diseases of the digestive system were predominant both in new and old patients, followed by diseases of the cardiovascular system and mental disorders, infectious diseases and neoplasms.

Accidental Poisoning

During the ten-year follow-up period, 65 persons out of 3945 cohort members died of accidental poisoning; 53 accidental poisonings in men accounted for over a third of all violent deaths. The 12 accidental poisonings in women amounted to over half of all female violent deaths. The ten-year rate of accidental poisoning was 1.99/1000 PY in men and 1.4/1000 PY among women. The average age of men who died from accidental poisoning was 35.7 years, with the youngest victim being 20.9 years of age. The average age of women was two years lower, with the youngest victim being 18 years of age.

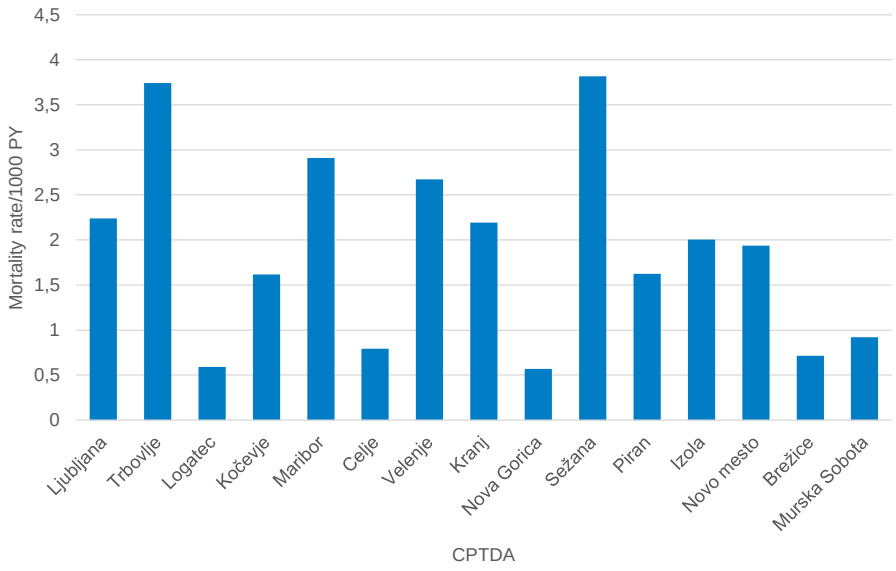


Source: National Institute of Public Health, Medical Report on the Deceased Person – NIJZ 46, Record of Treatment of Drug Users – NIJZ 14

Figure 6.10: Trends in the annual and cumulative mortality from acute poisoning by gender, 2004–2013

Mortality due to accidental poisoning was somewhat lower in women than in men and increased in the observation period; the increase was, however, uneven and similarly shaped for both genders. The average annual mortality was 1.96/1000 PY for men and 1.8/1000 PY: for women.

During the initial phase and the final years of observation, cumulative mortality was higher in men than in women. Both types of mortality were on the rise for both genders, though the increase in cumulative mortality was steadier. Cumulative mortality for women decreased in the past two years, as no women died from poisoning in 2011 and 2012 (Figure 6.10).



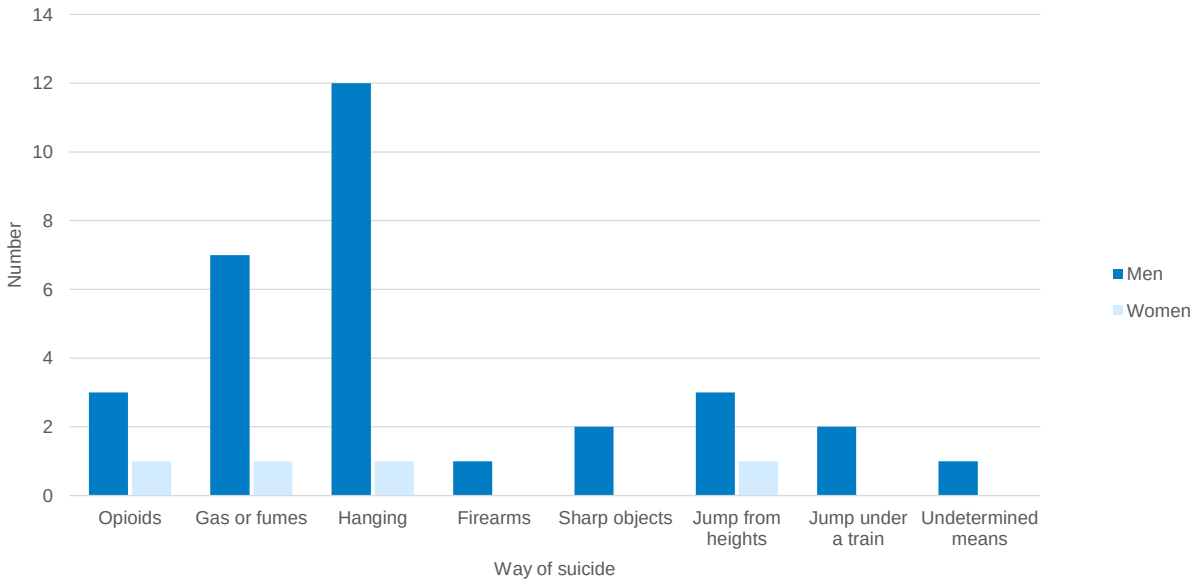
Source: National Institute of Public Health, Medical Report on the Deceased Person – NIJZ 46, Record of Treatment of Drug Users – NIJZ 14

Figure 6.11: Mortality rates due to accidental poisoning by CPTDA, 2004–2013

By the end of the ten-year observation period, mortality rates due to accidental poisoning were the lowest (0.57 deaths/1000 PY) at the CPTDAs in Logatec and Nova Gorica and the highest (3.82 deaths/1000 PY) in Sežana, which is a difference of over three death per 1000 treated drug users in a year (Figure 6.11). The highest mortality rate (2.11 deaths per 1000 PY) was recorded among the drug users who repeatedly suspended treatment or switched between centres, while those in continuous treatment had the lowest mortality rate (0.53 deaths/1000).

Suicides

35 cohort members – 31 men and 4 women – died of suicide in the ten-year period, which amounts to 0.99 deaths per 1000 PY or 1.16/1000 PY for men and 0.47/1000 PY for women. For men, this was 2.5 times as many suicides compared to Slovenian men of the same age in 2008, while suicide among these women was 3.6 times as common compared to Slovenian women of the same age in 2008. Men and women were most often victims of accidental poisoning than due to suicide. The annual mortality rate for male drug users in treatment was decreasing up to 2011 and then returned to 2008 values. One death by suicide was recorded among female drug users in treatment every year up to 2008, except for 2006, and no suicides have been recorded after 2009.



Source: National Institute of Public Health, Medical Report on the Deceased Person – NIJZ 46, Record of Treatment of Drug Users – NIJZ 14

Figure 6.12: Number of suicides among cohort members by way of suicide and gender, 2004–2013

Hanging was the method of suicide in one third of cases, one fifth of suicide victims suffered poisoning by CO or other fumes or gases, one tenth committed suicide by heroin, other opioid or methadone overdose, an additional tenth died of multiple injuries resulting from a jump from heights. Other methods of suicide accounted for a smaller share (Figure 6.12). The average age of men upon committing suicide was 32.8 years, with the youngest victim being 23.8 years of age. The average age for women was 5 years lower, with the youngest female victim being 22.1 years of age. All deceased women and a strong majority of deceased men had a history of treatment for illicit drug addiction or had been undergoing long-term treatment.

A larger share of those who committed suicide had a history of treatment or had been undergoing long-term treatment compared to victims of accidental poisoning. Suicide victims also consisted of larger shares of those who lived with their parents and those who never injected drugs.

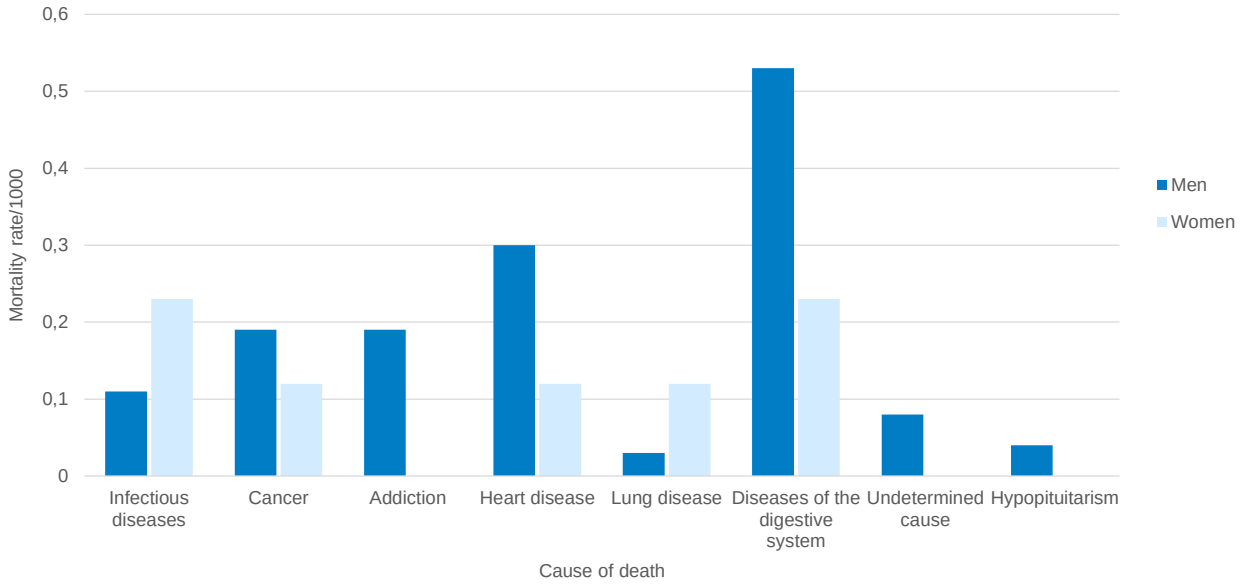
Other Violent Deaths

Of 160 violent deaths, 13 were traffic or vehicle accidents, the largest share were car passengers and car drivers, followed by motorcyclists or motorcycle passengers and pedestrians. Four persons died in an assault, and eight violent deaths were due to fall, drowning or other accidents, and 35 deaths had no determined intent.

Natural Causes of Death

In the ten-year period of observation, 39 men and 7 women out of 3945 treated drug users died of disease or other natural causes, which amounts to 1.47 men and 0.82 women per 1000 PY. The men who died due to disease were 42.7 years old on average, while the women were 45.3 years old. The majority had begun treatment several times or had been undergoing long-term treatment. Due to the low number of deaths per individual year, no difference between the effect of freshly started or long-term treatment on the number of deaths in the cohort could be established.

The highest share of men who died of illness was between 2005 and 2007, and the same was true for women between 2007 and 2009; for men, the number of deaths increased in 2013 compared to 2011 and 2012 (3.9 deaths/year on average; confidence interval of 3.1–4.7). No female drug user in treatment has died of natural causes in the last four years.



Source: National Institute of Public Health, Medical Report on the Deceased Person – NIJZ 46, Record of Treatment of Drug Users – NIJZ 14

Figure 6.13: Mortality rates due to natural causes among cohort members by type of disease and gender, 2004–2013

Alcoholic liver cirrhosis was the most common disease that caused deaths among drug users. Most of them had been in treatment before or were undergoing long-term treatment due to heroin. Their average age at death was 47.8 years, while the youngest and the oldest victim of alcoholic liver cirrhosis were 31.6 and 59 years old, respectively. Those who died of diseases of the cardiovascular system, which was the second most common illness, were between 23.7 and 56 years of age at death, with an average of 40.4 years, and they all entered treatment due to heroin use. Half of them used cocaine or MDMA as a second drug upon entering treatment. The third leading cause of death was chronic viral hepatitis C or HIV (AIDS); the deceased were between 28.9 and 44.2 years old at death. All used heroin upon

entering treatment. None of them were first-time patients. All were drug injectors and the majority of them did not have a steady romantic partnership upon entering treatment.

Conclusion

Over the ten-year observation period, key indicators allow us to estimate that the health of male and female treated drug users is 3.5 times and 2.5 times worse than the health of Slovenian men and women of the same age, respectively. Although the male mortality rate was higher than the female mortality rate, a comparison to the Slovenian population of the same age showed that the health of female treated drug users is at significantly more risk than women in general, while the difference is not as pronounced in men. The mortality of treated drug users was decreasing between 2004 and 2011 in both genders, while 2012 and 2013 saw a new increase in mortality. The average age at death and the years of potential life lost increased in this period, meaning that users die older, but that there are more deaths. It was also confirmed that the first year of entering treatment poses more risk of death for first-time patients than those with a history of treatment. Mortality rates are also affected by the living arrangement and employment status. The leading causes of death were accidental poisonings, diseases and suicides.

Joint Conclusion

The share of deceased women was smaller compared to men in the group of treated and untreated drug users. Poisoning posed the largest risk to untreated women. It turns out that there was no difference between the average ages of treated and untreated users who died of drug overdose. Mortality is also affected by the season, which, however, has little effect on treated drug users. Interestingly, there are fewer deaths among untreated drug users in the summer. Untreated users have a higher share of divorcees compared to treated users. Accidental heroin overdose is the leading cause of death in both groups. The share of accidental overdoses was higher in those who first entered treatment; however, suicide was more common in those with a history of long-term treatment. The most common fatal diseases in treated drug users were alcoholic liver cirrhosis and diseases of the cardiovascular system. Half of the deceased due to diseases of the cardiovascular system had reported taking cocaine or MDMA upon entering treatment. A higher risk of death, a lower average age at death and a lower number of years of life after entering the study as well as the causes of death point to the vulnerability of the group of first-time treated patients and to the need for early start of treatment of drug users.

7. RESPONSES TO HEALTH CORRELATES AND CONSEQUENCES

The prevention of drug-related poisonings and deaths and the prevention of infectious diseases are carried out as part of the public health care system – at Centres for the Prevention and Treatment of Illicit Drug Addiction (CPTDA) – and by non-governmental organisations; this issue is addressed by low-threshold harm reduction programmes in particular. The CPTDA network provides users with access to testing for hepatitis C and to counselling as well as with potential referral to further clinical treatment and potential hepatitis C therapy by hepatitis specialists, i.e. infectologists. In 2007, the National Guidelines for the Management of Hepatitis C Viral Infections in Drug Users in Slovenia within the public health care system (the CPTDA network) were published. As part of harm reduction programmes, sterile kits are distributed to injecting drug users and counselling is provided. Needle exchange programmes take place at day centres and in the field, carried out by NGO staff at locations known to be frequented by drug users. In addition to needle exchange and the distribution of other injection paraphernalia (alcohol wipes, ascorbic acid), field workers also distribute information materials on infectious diseases and low-risk injection. 513,272 needles and syringes were distributed to harm reduction programmes in 2013, and 16,753 contacts with drug users were recorded, 11,247 of which occurred at the stationary needle exchange point, while 5506 were recorded as part of fieldwork.

Under the auspices of the Ministry of Health, an interministerial working group of the Early-Warning System for New Psychoactive Substances is operating; the group continuously monitors the emergence of dangerous and new psychoactive substances, to which it alerts the professional public and users. In 2013, the working group detected a significant increase in the number of GHB and GBL poisonings. Information obtained in the field indicated that the use of GHB and GBL had spread from the group of "party drug" users to young people who were not used to these drugs and used them as an inexpensive alternative to alcohol. The situation became critical in late September and early October, when the Centre for Poisoning treated eight extremely severe cases of GHB/GBL poisoning. The members of the Early-Warning System for New Psychoactive Substances responded with rapid measures to prevent additional poisonings.

7.1 Prevention of Drug Related Emergencies and Reduction of Drug Related Deaths

GHB and GBL Poisonings and the Response of the Early-Warning System on New Psychoactive Substances

Andreja Drev, Matej Sande, PhD, Simona Šabić

Under the auspices of the Ministry of Health, an interministerial working group of the Early-Warning System for New Psychoactive Substances is operating. The working group is composed of the representatives of the National Institute of Public Health, the National Forensic Laboratory, the Centre for Poisoning, the Institute of Forensic Medicine, the General Police Directorate, the DrogArt and Stigma non-governmental organisations and the Ministry of Health. One of the group's missions is to provide up-to-date information about the emergence of new and dangerous psychoactive substances and their consequences to the professionals and drug users.

In 2013, Early-Warning System on New Psychoactive Substances members recorded a significant increase in the number of GHB and GBL poisonings (cf. Chapter 6, Non-fatal overdoses and drug-related emergencies). The situation became critical in late September, when the Centre for Poisoning

treated four extremely severe cases of GHB poisoning; all four patients had consumed the drug at a party or in a night club. It was not immediately clear whether the poisoning was caused by GHB or GBL because only the analysis of body fluids was available rather the analysis of the substance itself. As is known, GBL is converted to GHB in the body. The members of the interministerial working group immediately reported known information about the substance to the Early-Warning System on New Psychoactive Substances and discovered that the police had already handled 16 cases of GHB poisoning. According to reports by the DrogArt Association, the use of GHB spread from the group using party drugs to nightclub goers who had not used such drugs. The reason was that GHB or GBL was an inexpensive alternative to alcohol does to its similar effects. GBL was also easily accessible and could be purchased online as a cleaning agent.

Due to the severity of the poisoning, two alerts were immediately released to target groups, one to professional staff dealing with drug users and one for young party goers. Despite the prompt warning, the Centre for Poisoning treated four additional extremely severe poisoning the following weekend. Due to the severity of the situation, members of the interministerial working group held a crisis meeting and came to an agreement about taking rapid action to prevent future poisonings. Thus, the Ministry of Health notified all emergency health services and all centres for the prevention and treatment of illicit drug addiction in the country of the poisonings and the correct course of action in such cases; the General Police Directorate alerted police departments and increased control, and the National Institute of Public Health provided information to local communities, low-threshold programmes and professional staff working with young people in the field. The non-governmental organisation DrogArt was responsible for the provision of information to nightclubs and dance party organisers as well as to users of new drugs; they also increased their presence in the field. Locally, other non-governmental organisations active in the field of reducing drug-related harm, such as SVIT Koper Association and SOCIO Celje Public Institute, also helped disseminate information. In total, 59 clubs and pubs across Slovenia were reached. DrogArt was also present at over 20 events at which users of new drugs were informed about the risks associated with the use of GHB and GBL, and were provided non-professional first aid if necessary.

Several materials were created as part of the campaign, such as an information for nightclub staff describing the symptoms of overdose and basic first aid techniques, a poster for club goers on visible places in clubs detailing information about risk minimisation, and a website notice listing cautionary measures to prevent involuntary GHB/GBL consumption as well as instructions on how to proceed in the case of poisoning. DrogArt also prepared a package for the reduction of risks associated with the use of GHB/GBL. The package contained an information leaflet with information on GHB/GBL, a syringe (1 ml) and a simple timetable to keep track of the last use of GHB/GBL. Users thought the syringe was useful, while they found the timetable difficult to use given the club setting.

The campaign proved to be effective, as no new cases of GHB or GBL poisoning were recorded in 2013 and the early months of 2014. The analysis performed by the National Forensic Laboratory showed that some poisonings were caused by GBL and some by GHB. While GHB is listed as an illicit drug, GBL is not banned in Slovenia due to its industrial use as a solvent.

7.2 Prevention and Treatment of Drug Related Infectious Diseases

Management of Hepatitis C in People Who Inject Drugs

Mojca Matičič, PhD, Prof.

In Slovenia complex management of hepatitis B and C is driven by the multidisciplinary team of experts from various public medical institutions, the National Viral Hepatitis Expert Group which was founded by a self-initiative in 1997 considering as much as possible the best practice and standard of care regarding HCV infection including people who inject drugs (PWID) (Matičič et. al 1999).

In 1995, 18 Centres for the Prevention and Treatment of Illicit Drug Addiction (CPTDA) were established in Slovenia providing HCV testing by entering the programme followed by 6-12 months test offer for HCV-negatives (Kastelic and Kostnapfel 2010). To increase the proportion of PWID treated for HCV and gain satisfactory treatment adherence, efficacy and safety, Slovenian national consensus guidelines for the management of HCV infection in drug users were set up in 2007 (Matičič and Kastelic 2009). They provide complex management of HCV-infected PWID including improvement in screening for HCV treatment eligible PWID, providing them with highly qualified education and counselling and performing treatment of HCV in close cooperation between the viral hepatitis specialists and addiction therapists.

Accordingly, under the a multidisciplinary national healthcare network for the treatment of HCV infection in PWID was established combining already existing facilities of all the 18 CPTDA and all the five clinical settings for treatment of viral hepatitis being located at two university clinical centres and three general hospitals around the country, Clinic for Infectious Diseases and Febrile Illnesses in Ljubljana representing the referential institution. The network consists of clinical care providers (addiction therapists, viral hepatitis specialists: infectologists, hepatologists), psychiatrists and councillors (nurses, social workers) that gained additional medical education and supportive training, as well as peers (former HCV-positive PWID) and other supportive system (family, friends, co-workers, etc.). Close collaboration of all the involved health professionals is crucial and includes not only the exchange of patients' medical information but also joint national conferences on HCV in PWID that have been held yearly since 2006. The safety and efficacy of HCV treatment in PWID has been monitored regularly.

Exchange of Sterile Kits for Drug Injection

Ines Kvaternik, PhD

As part of harm reduction programmes, injecting drug users are provided with free sterile kits and counselling. Needle exchange programmes are carried out by professional NGO staff at day centres and in the field in the areas where drug users are known to frequent. In addition to needle exchange and the distribution of other paraphernalia for injection (alcohol pads, ascorbic acid), information materials on infectious diseases and low-risk injection are distributed at day centres and in the field.

In Slovenia, there were 10 harm reduction programmes[15] carried out in 2013 which participated in sterile kit exchange. They are carried out at 178 locations in 91 cities and villages across Slovenia.

The purchase and distribution of sterile kits for safe drug injection are performed by the Koper Regional Unit of the National Institute for Public Health. In 2013, the kits were provided to 10 harm reduction programmes and four mobile units for sterile kit exchange in the field. The kits and operation of the programme are funded by the Health Insurance Institute of Slovenia. In 2013, the programmes involved

[15] The network of harm reduction programmes comprises of 11 programmes. One of them, carried out by the DrogArt Association, is aimed at the users of synthetic drugs and cocaine and as such, does not participate in the sterile needle exchange programme.

1792 injecting drug users (1449 men, 343 women), 70 (58 men, 12 women) of those were recorded for the first time. Harm reduction programmes recorded 16,753 contacts with injecting drug users, 11,247 of those at on-site kit exchange and 5506 in the field. In 2013, the Koper Regional Unit of the National Institute for Public Health provided drug-related harm reduction programmes with 402,000 syringes with an integrated needle and 47,400 syringes of various sizes.

The collection of used kits was organised as part of seven programmes and using four vans. The used material is collected on the premises of the programmes and in mobile vans, where it is stored in safe packaging protecting staff from injuring themselves with a used needle or other paraphernalia. The paraphernalia are disposed of and destroyed by a specialised company. Expert disposal of used needles was provided to all harm reduction programmes. In 2013, the National Institute for Public Health distributed 513,272 needles and syringes to harm reduction programmes. 187,786 were returned, representing 44% of the distributed needles. In 2013, 40,154 needles and syringes fewer were distributed in comparison to 2012.

Koper Regional Unit of the National Institute for Public Health carried out a 65-hour course titled Professional Work in the Field of Drugs in cooperation with harm reduction programmes, which was accredited by the Social Chamber of Slovenia with four credit points.

8. DRUG-RELATED SOCIAL ISSUES AND REINTEGRATION

The legal framework for the operation of the social care system is provided by the Social Security Act (Official Gazette of the RS, No. 3/2007 et seq.), while the field of financial social assistance is regulated in particular by the Financial Social Assistance Act ([Official Gazette of the RS, No. 61/2010 et seq.), the Exercise of Rights to Public Funds Act (Official Gazette of the RS, No. 62/2010 et seq.) and the Fiscal Balance Act (Official Gazette of the RS, No. 40/2012). The latter three Acts entered into force in 2012 and substantially cut into the social assistance system. Some of the solutions brought about by the new social legislation proved to be inappropriate, which led to minor modifications and amendments to legislation in 2013. In April 2013, the National Assembly passed the Resolution on the National Programme of Social Care 2013–2020 (Official Gazette of the RS, No. 39/2013), which defines the core principles for the development of the social care system, goals and strategies, outlines the public service network for social care services and programmes and defines their operation and monitoring as well as the responsibilities of individual agents on various levels.

Social issues pertaining to illicit drug use are the responsibility of the Ministry of Labour, Family, Social Affairs and Equal Opportunities. Professional activities for solving these social issues are carried out by public services (62 Centres for Social Work) and by private persons and non-governmental organisations carrying out supplementary social care programmes. In 2013, Centres for Social Work handled 275 cases involving illicit drugs, and about 4900 users participated in social care programmes for the prevention of addiction to illicit drugs co-funded by the Ministry of Labour, Family, Social Affairs and Equal Opportunities. Nation-wide data on social care programmes are collected by the Social Protection Institute of the Republic of Slovenia, while data on cases handled by Centres for Social Work are collected in the social database. These data are compiled and processed by the Social Protection Institute for the purposes of the National Report.

The Reintegration Centre programme, which provides assistance to drug users in maintaining long-term abstinence and reintegration into society, has been carried out by the Projekt Človek Association for a decade. Over these ten years, 79 users have participated in the programme, which was successfully completed by more than a half of them. The social entrepreneurship project On Principle, which provides training in design and social marketing to young people with a history of drug use, has been in operation since 2012 and trained 7 young people and employed 4 persons in 2013.

8.1 Social Treatment and Social Reintegration

Simona Smolej, MA

The legal framework for the operation of the social security system is provided by the Social Security Act (Official Gazette of the RS, No. 3/2007 et seq.), while the field of financial social assistance is regulated in particular by the Financial Social Assistance Act (Official Gazette of the RS, No. 61/2010 et seq.), the Exercise of Rights to Public Funds Act (Official Gazette of the RS, No. 62/2010 et seq.) and the Fiscal Balance Act (Official Gazette of the RS, No. 40/2012). The latter three Acts entered into force in 2012 and substantially cut into the social assistance system. Some of the solutions brought about by the new social legislation proved to be inappropriate, which led to minor modifications and amendments to legislation in 2013. A number of those were general amendments pertaining to income and assets to be calculated for the determination of entitlements, while some pertain to individual entitlements. For example, a grant for secondary school students below the age of 18 is being reintroduced, while the special child benefit sum for secondary school students is to be terminated; funeral and bereavement

payments, once entitlements from compulsory health insurance, are now being reclassified as social care benefits and are to be special types of extraordinary financial social assistance. They will cease to be universal entitlements, and will instead depend on entitlement to financial social assistance or supplementary allowance or the income of the applicant. These amendments seek to improve the status of the most vulnerable groups while also upholding the core principles of social legislation. The effects of the amendments are not yet known.

The core substantive and normative principles for the course of action with cases of social need and problems of individuals are laid out in the National Programme of Social Care passed by the government for a multi-year period. In April 2013, the National Assembly passed the Resolution on the National Programme of Social Care 2013–2020 (hereinafter: the Resolution) (Official Gazette of the RS, No. 39/2013), which is the core programme document in Slovenia pertaining to social assistance up to the year 2020. The Resolution defines the core principles for the development of the system, social assistance objectives and development strategies, the public service network of social assistance services and programmes and the course of their implementation and monitoring, as well as the responsibility of individual agents on several levels.

As regards the public service network of social care programmes, the Resolution also lays out the framework for the development of a network of addiction-related programmes aimed at users of illicit drugs or individuals in social need due to alcoholism or other types of addiction (eating disorders, gambling, etc.). The Resolution also provides for the establishment of prevention, information, counselling, helpline, coordination, support and activation programmes, harm reduction programmes, day centres, field work, therapeutic and reintegration programmes in this field (Resolution on the National Programme of Social Care 2013–2020; Official Gazette of the RS, No. 39/2013).

Professional activities for adressing social issues in connection to the use of illicit drugs are carried out as part of public services (62 Centres for Social Work) and by individuals and non-governmental institutions carrying out supplementary programmes of social care.

Social Care Programmes

Performed tasks, services and public powers carried out at Centres for Social Work are recorded in the Social Database, which is part of the Centre for Social Work Information System. Social Database data in Table 8.1 are assembled by issue of the performed task, service or public authorisation, meaning that professional staff members at the Centre who perform a public authorisation or a social care service for a particular individual or family also record the reason why the task was performed; this is referred to as issue(s). Let us use this occasion to stress, however, that the data are issue-specific, rather than person-specific.

At Centres for Social Work, the issue of illicit drugs is largely (in 62% of cases) dealt with as part of first social aid. Evidently, the issue of illicit drugs is not very common at Centres for Social Work. Between 2009 and 2013, there were between 220 and 365 cases per annum. In 2013, the number of cases was the same as in 2009, that is 275 (Table 8.1).

Table 8.1: Number of cases pertaining to the issue of illicit drugs at Centres for Social Work 2009–2013

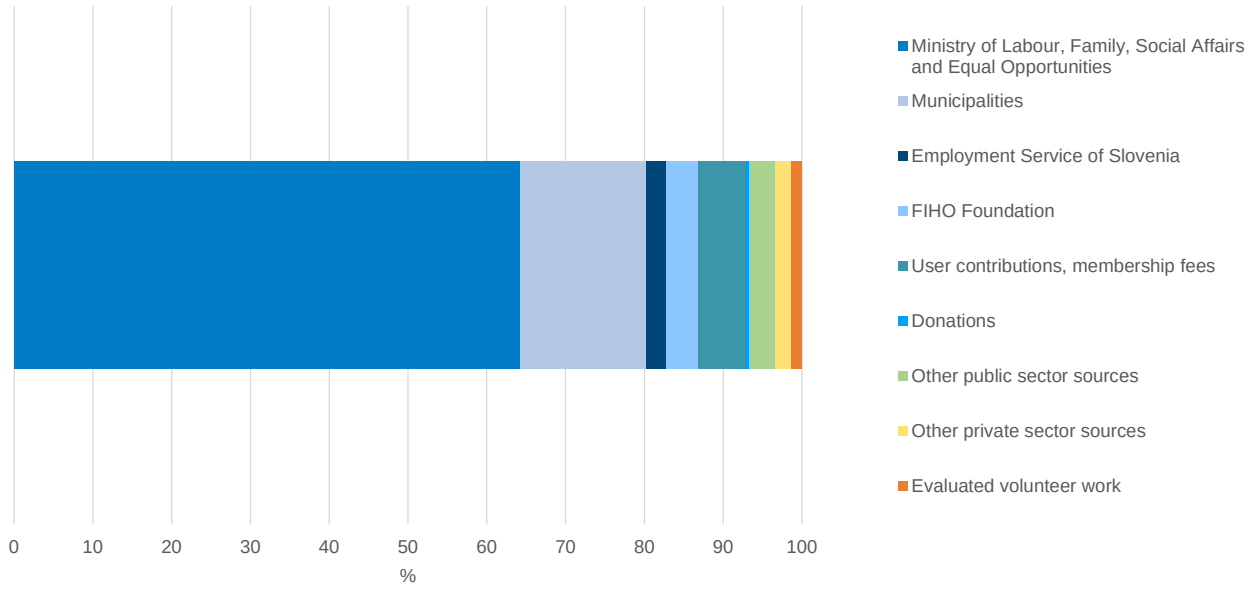
Issue	2009	2010	2011	2012	2013
Illicit drugs	275	365	298	220	275

Source: Ministry of Labour, Family, Social Affairs and Equal Opportunities, Social Database data

There is a number of social care programmes available to persons in need with issues in connection to illicit drug use. The Social Protection Institute of the Republic of Slovenia aggregates final (annual) programme implementation reports and use them as the basis to catalogue and analyse the social care programmes co-funded by the MLFSA. As the data are collected state-wide, they are a reliable indicator of the situation pertaining to the implementation of social care programmes. However, they only pertain to the programmes which have received funding from the MLFSA, while the programmes which fail to obtain funds via the MLFSA tender are not included in the data. Such programmes, however, are believed to be rare in the field of social care.

The MLFSA co-funded 23 social care programmes pertaining to the prevention of addiction to illicit drugs in 2013. Of those, 13 were high-threshold programmes and programmes providing a wide range of services and activities for users at various stages of drug use. Three programmes also seek to reintegrate former drug users. High-threshold programmes and programmes aimed at users at various stages of drug addiction are available in all regions apart from the regions of Zasavje and Pomurje, while reintegration programmes are only carried out in the regions of Gorenjska and Central Slovenia. There are ten low-threshold programmes providing help to active drug users, including two shelters for homeless drug users and a safe house for female drug users who have been victims of violence. Low-threshold programmes are carried out in all regions (Smolej et al. 2014).

The programmes received the total of EUR 4,377,776.8 in funding. The majority of funds – nearly two thirds, or 64.2% – was obtained from the MLFSA. Other major fund providers were municipalities (16% of funding) and programme users, who contributed 6% of funds (Figure 8.1) (Smolej et al. 2014).



Source: Social Protection Institute of the Republic of Slovenia, own calculations

Figure 8.1: Sources of funding for social care programmes for the prevention of addiction to illicit drugs, 2013

According to data of Social Protection Institute of the Republic of Slovenia, approximately 4900 users participated in social care programmes pertaining to illicit drugs co-funded by the MLFSA in 2013, not including the users of various online forums, helpline and online counselling services and general prevention campaigns (such as those by the DrogArt Association, which included an additional 3000 users). Social care programmes in connection to illicit drugs provided 173 beds for the accommodation of users, most as part of high-threshold programmes (Smolej et al. 2014).

Social reintegration of addicted persons was performed as part of three social care programmes co-funded by the MLFSA in 2013. Users could enter those programmes at the Kranj Centre for Social Work, the UP Association for the Support of Addicts and their Families and the Projekt Človek Association. The Centre for Support, Social Rehabilitation and Reintegration of Addicts programme (Kranj Centre for Social Work) involved 93 users, 19 of those used the provided accommodation, while 74 were outpatients. UP Association housed 16 persons, while the Projekt Človek Association housed 14; the latter also involved 23 key persons close to the users (Smolej et al. 2014).

Projekt Človek Association – Reintegration Centre

Roman Koštal, MA, Helena Hercog

The Reintegration Centre (RC) is the final phase of the Projekt Človek programme[16]. The programme provides the user with help and support in maintaining long-term abstinence and reintegration into society and comprises of three consecutive phases, each lasting at least six months, or approximately 18 months in total. The programme takes place in Ljubljana; its participants are persons abstaining from alcohol or drugs who have developed a (self-)support system in the rehabilitation process that is sufficient for the process of reintegration into society (job seeking, education, establishing and working on healthy interpersonal relations, romantic relationships), but still require professional help in the process. The RC programme is comprised of work, therapy, sports and cultural activities.

The Process and Structure of the Reintegration Programme

Once the user enters the RC programme, an individual therapy plan is designed in cooperation with the user, who also sets out specific personal goals before each of the three phases. After completing the phase, the user composes an evaluation, looking at core areas of life and assessing whether the goals have been met and with which points he/she is or is not satisfied as well as describing his/her desires for the future. The written evaluation is presented before his/her group, which allows the user to receive feedback from the group as well as a team of professionals.

The initial RC phase may be inpatient or outpatient. Inpatient users are independent in taking care of themselves as well as the house and its surroundings while receiving support by the staff. The programme includes both morning, afternoon and on-call night staff. The programme takes place from Sunday afternoon to Friday afternoon, while the weekends are spent at home or with people who can provide a supportive environment. If the users do not have access to a supportive environment over the weekend, they can stay at the Škofja Loka Therapeutic Community. Inpatient RC programme can house up to six people. Outpatient users stay at home or at people who can provide a supportive environment during the initial phase and come to the RC for therapy activities. The initial phase aims to stabilise the users in general society, help them establish relationships with supportive people and actively prepare to enter the employment market or education. Monday begins with a meeting at which users plan their week, tasks and shopping for food and other supplies with the help of professional staff. Other topics of discussion include the atmosphere in the group, interpersonal relations and potential sources of conflict. This is followed by a group session in which the weekly plan is formulated regarding the user's activities in the course of the week and how much time should be allocated to each activity. This helps the user

[16] The Projekt Človek programme is aimed at those who require comprehensive help due to drug addiction. The programme comprises of several phases. It begins at the Admission Centre, where motivational interviews and preparation to enter the Prius programme are of key importance. The Prius programme involves work, sports, cultural and therapy activities in the form of discussions and a variety of group work. The core purpose of the programme is to maintain abstinence and involve the entire family of the user. The Therapeutic Community organises day-to-day life in a way that allows users to work on being independent, problem solving and spending their free time creatively. The final phase of the programme is the Rehabilitation Centre.

to balance core areas of life, such as work, leisure, exercise, socialising, hobbies and finances. Next is a group session for in-depth emotion processing, where the users can reflect on their current events in life. Lunch cooked by the users is followed by leisure and hobby time. The users are encouraged to pick their own hobbies in the general social environment. On Tuesdays and Thursdays, users partake in external volunteer work. This allows them to feel included in the "employment reality" awaiting them as well as allowing them to perform good deeds for other people. The users can also become mentors to users who are new to the rehabilitation process. Wednesdays are reserved for employment training or group sessions for attaining and developing social skills. Friday activities are evaluation versions of Monday activities. Each user also participates in at least one weekly session with a personal therapist.

The second and third phase of the RC programme are outpatient phases, each including up to 15 users. The users usually first find employment, as they need financial resources for everyday expenses. There is a group session for in-depth emotion processing scheduled each week, where the users can reflect on their current events in life. At this stage, the topics are typically related to inclusion in a work setting. Each user also participates in at least one weekly session with a personal therapist. A topical group called Attitude to Alcohol is held every two months, where users present their essays before the group. The aim of the group is to empower users to maintain long-term abstinence, including abstinence from alcohol. In general, the goal of the second and third phase is for the user to win greater independence, enter employment or education and complete rehabilitation.

Upon completion of the RC programme, the user writes an overview of the course of the rehabilitation and presents it before a group of fellow users and persons invited by him/her for the occasion. Aside from the evaluation, the event is also of celebratory nature, signifying the end of the rehabilitation process, which is an important achievement for the user. Although the RC rehabilitation is supposed to last approximately 18 months, the users typically remain included in the programme for another six to twelve months. Lately, this is due to poor employment outlook in particular.

After completion of the traditional programme, most users opt for entering the Intera programme, which provides them with continuous support as part of weekly individual therapy sessions with a personal therapist. It may also be carried out as a less in-depth two-week programme. Should the users relapse, we motivate them to enter the Replay programme, in which an individual abstinence plan and a plan for reintegration in life and the rehabilitation process is designed for them.

The Rehabilitation Centre permanently employs four staff members: an integral therapy therapist with an MA in social pedagogy, a gestalt therapist, a systemic family therapy therapist and a social worker for night on-call shifts, as well as volunteers. In terms of quality assurance, our organisation was awarded the SIQ-NVO quality certificate for non-governmental organisations and prepared two documents: Quality Standard – NGO Requirements is based on the ISO 9001:2008 standard, while the Quality Rules of Procedure were created as part of the qualification process for the Quality Certificate for Non-governmental Organisations.

Data on Programme Attendance

79 users entered the RC programme over the last 10 years (Table 8.2), 55 of which (70%) were male and 24 (30%) were female. The programme also involved 110 key significant persons, mostly the parents of the users. The average age of the participants was 29 years of age. Over one half of them (56.9%) successfully completed the programme, while 23.6% relapsed (Figure 8.2). The majority (85%) of users who successfully complete the programme remains abstinent and gets their life in order. It has, however, been observed that many of them consume alcohol at least occasionally.

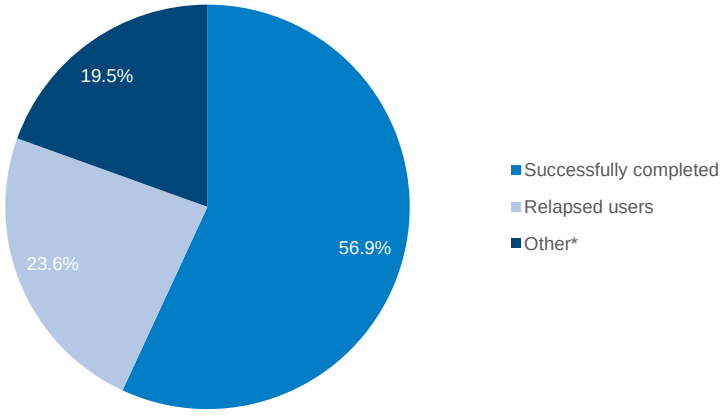
In the past, data on the life of users after the programme were collected at meetings with them; this was recently replaced with a systematic follow-up procedure after the completion of the programme.

Table 8.2: Number of users upon entering the programme, programme completion and relapses, 2004–2014

Year	Users who entered the programme	Users who completed the programme	Relapsed users
2004	10	7	3
2005	6	3	1
2006	3	2	0
2007	8	5	3
2008	8	5	3
2009	9	7	0
2010	9	2	1
2011	12	5	5
2012	6	1	2
2013	4	*	1
(data up to June) 2014	4	*	0

* Users of an ongoing programme.

Source: Projekt Človek Association records



* "Other" refers to users for which no data on their life after leaving the programme are available, users who left the programme before completion, are abstinent and socially integrated, and users who left the programme before completion, are not abstinent, but are socially integrated.

Source: Projekt Človek Association records

Figure 8.2: Share of users successfully completing the programme and relapsed users, 2004–2014

Key Changes over the Ten-Year Period

Due to increasing numbers of users who were unable to return home owing to a poor support network and users who entered the programme following the opening of regional admission centres and were unable to commute between their place of residence and Ljubljana, the outpatient programme was expanded into an inpatient programme. Currently, the inpatient RC programme can accommodate all users.

There has been an evident increase of users with comorbid issues apart from addiction (personality disorders, eating disorders, diminished cognitive abilities). We believe this is the consequence of the use of new drugs and a higher average age of users entering the programme, meaning the duration of

drug use is longer. This has led us to modify our work methods from a therapy-based to a more education-reliant model. Therapy is usually the preferred method for high-functioning users in the individual therapy programme Intera who enter the programme after completing the RC programme. This shift may be behind the recent decrease in the number of users entering the programme. Because the traditional programme, including the RC programme is relatively difficult, it may be said that weak users cannot handle the programme and leave the programme before the RC phase.

Changes have also been observed in terms of job seeking: there is an increasing number of users who have difficulty finding employment in a time in which a typical day of work often exceeds eight hours due to issues such as concentration and attention deficits as well as poor impulse control. Compared to other vulnerable groups, addicted persons continue to face worse employment rates. Although we are working with the Ministry of Labour, Family, Social Affairs and Equal Opportunities to make legislative changes which would afford better chances of employment to this vulnerable group, the situation is unfavourable due to a shortage of job positions. This leads to long-term frustration in persons actively looking for work without success; there have also been cases in which users have found work, which was, however, paid so poorly that it did not cover the monthly costs of rent and other expenses. Some therefore work two jobs or do overtime, which raises the chance of a relapse. It is necessary to establish a network of employers who are aware of the needs of those abstaining from drugs and would provide them employment with a greater understanding of their individual needs (such as various types of social entrepreneurship).

An additional issue is the limited accommodation capacity of the programme, as the number of users who cannot enter the outpatient RC programme due to distance or a lack of a support network. Additional accommodation capacities and maintenance funds would allow us to expand programmes for addicts, minors, persons with comorbid issues, addicted parents with children and abstaining persons who have been out of work for a sustained period of time.

Social Entrepreneurship: On Principle

Matej Sande, PhD

The social entrepreneurship project On Principle (Iz principa), which provides design and social marketing services, has been carried out by the DrogArt Association since 2012. The project is co-funded by the European Social Fund (ESF). The principal objective of the project is to create new creative jobs and provide employment to unemployed youth and young people with fewer opportunities, who are part of a vulnerable target group, through developing design and social marketing services. Participating in the project are adolescents and young adults with a history of drug use or addiction, as well as young people up to 25 years of age with little to no formal education (more available in the 2013 National Report).

In 2013, the activities of the project focused on providing training and employment to a vulnerable target group of adolescents and young adults; seven persons were provided training and four persons were employed, three of which have remained employed into 2014. In 2013, the focus was on providing services to small clients (small businesses and non-governmental organisations) and obtaining experience and references; in 2014, the focus was shifted to bigger clients (public organisations, large enterprises) and to providing comprehensive services in design and social marketing campaigns. Due to the fact that the ESF will cease co-funding the project next year, attracting clients and strengthening competitiveness on the market are of vital importance for the remainder of the year, and will play a key role in ensuring smooth independent operation of the social entrepreneurship project.

9. DRUG RELATED CRIME, PREVENTION OF DRUG RELATED CRIME AND PRISON

The core legislative framework for law enforcement activities by the police in the field of illicit drugs is set out in the Criminal Code of the Republic of Slovenia (Official Gazette of the RS, Nos. 55/2008, 66/2008 – amended and 39/2009) and the Production of and Trade in Illicit Drugs Act (Official Gazette of the RS, Nos. 108/1999, 44/2000, 2/2004 and 47/2004). Article 186 of the Criminal Code prohibits and sanctions the unlawful manufacture and trade with illicit drugs, while Article 187 bans rendering opportunity for the consumption of illicit drugs. Article 33 of the Production of and Trade in Illicit Drugs Act imposes a fine for the possession of minor quantities of illicit drugs for one-time personal use. The Ministry of the Interior has been collecting data on crime using a central computer system which records police data on the national, regional and local level. In 2013, the police recorded 2191 criminal offences (as per the Criminal Code) and 4197 offences (as per the Production of and Trade in Illicit Drugs Act) related to illicit drugs and investigated 2428 individuals on the suspicion of committing a criminal offence related to illicit drugs and 3898 individuals on the suspicion of committing an offence. The 18% increase in the number of offences and the 12% increase in the number of identified offenders is first and foremost due to increased police efforts. Cannabis has remained the illicit drug most often connected to criminal and minor offences into 2013. In 2013, the police handled 69 suspects who committed a criminal offence under the influence of illicit drugs. Although the majority of these cases are from the area of unlawful manufacture and trade in illicit drugs and rendering opportunity for the consumption of illicit drugs, the police has also recorded other criminal offences such as the neglect and maltreatment of an underage person, manslaughter, murder, an attack on an official, obstruction of an official act and revenge upon an official. The police also ordered 784 professional tests to establish the presence of illicit drugs and other psychoactive substances in drivers; 276 tests came back positive. Drivers were most commonly under the influence of cocaine, cannabinoids and methadone.

The Prison Administration of the Republic of Slovenia is the body of the Ministry of Justice of the Republic of Slovenia responsible for implementing sentences and organising and managing prisons and the juvenile correctional centre. Slovenia has six prisons and one juvenile correctional centre. Every three months on a specific day, the Prison Administration records the number of prisoners with drug problems and the number of prisoners with HIV, hepatitis or tuberculosis. The data on the prison system and prisoners are published in the annual report, which is a key source of data on drug use in prisons for the National Report. In 2013, slightly less than a quarter (23.7%) of imprisoned persons had a drug problem, 60% of which were undergoing substitution therapy. Judiciary police discovered 93 cases of illicit drugs in prisons; cannabis was the most common drug as well as the drug found in the largest quantity. A study involving 58 imprisoned drug users revealed that the most commonly used drugs were heroin, cannabis and tranquilisers, and that almost all of them were smokers. Over 30% reported having overdosed in the past. 63% have been imprisoned before. Over a fifth exhibited symptoms of mild depression, while more than half of them reported having considered suicide. Social issues were also extremely common and compared to the general population imprisoned drug users are more asocial, disorganised, emotionally unstable and anxious, and find it more difficult to conform to social norms.

9.1 Drug Related Crime

Staša Šavelj

Crimes and Minor Offences

In 2013, the Slovenian police force increased its activities pertaining to uncovering crime related to illicit drugs and violations of the Production of and Trade in Illicit Drugs Act. The increase in activity and the focus of police work on illicit drugs resulted in a rise in the number of identified violations and criminal offences, a trend that continues into 2014.

In 2013, 2191 criminal offences were recorded in the field of illicit drugs, which is a 10.1% increase in detected criminal offences compared to 2012. Consequently, there was a 7.9% rise in people suspected of committing drug-related criminal offences.

Table 9.1 shows criminal offences in the field of illicit drugs between 2009 and 2013 as defined in Articles 186 and 187 of the Criminal Code of the Republic of Slovenia[17]. As many as two thirds of all recorded criminal offences pertain to illicit manufacture of and trade in illicit drugs (Article 186), with the purchase, manufacture, offering for sale and sale being most common offences.

Table 9.1: Criminal and minor offences pertaining to illicit drugs, 2009–2013

	2009	2010	2011	2012	2013
Total number of criminal offences	87,463	89,489	88,722	91,430	93,833
Number of drug related criminal offences	2231	1969	1925	1969	2191
Number of suspects in drug related criminal offences	2570	2240	2229	2235	2428
Number of minor offences as per the Production of and Trade in Illicit Drugs Act	3338	3328	3691	3423	4197
Number of offenders violating the Production of and Trade in Illicit Drugs Act	3336	3327	3690	3421	3898

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

In 2013, the police recorded as many as 18.4% more minor defences and 12.2% more offenders as per the provisions of the Production of and Trade in Illicit Drugs Act, or 4197 in absolute numbers (compared to 3423 in 2012), which is the highest figure in recent years (Table 9.1). The increase in identified minor offences and the consequent rise in the number of offenders of the Production of and Trade in Illicit Drugs Act is primarily due to increased police efforts in uncovering minor offences and crimes.

As in 2012, cannabis continues to be the drug most commonly involved in the crimes and minor offences in this field into 2013, followed by heroin, amphetamine and cocaine (Table 9.2). The table is limited to the most common illicit drugs as the cause of the offence.

[17] Article 186 of the Criminal Code of the Republic of Slovenia – “Unlawful manufacture and trade with illicit drugs, unlawful substances in sports and precursors to manufacture illicit drugs” and Article 187 of the Criminal Code of the Republic of Slovenia – “Rendering Opportunity for consumption or illicit drugs or illicit substances in sports.”

Table 9.2: The number of violations of the Production of and Trade in Illicit Drugs Act by individual illicit drug, where one offence may have involved several types of drug, 2013

Type of illicit drug	No. of offences
Cannabis marijuana	2958
Heroin	182
Amphetamine	167
Cannabis plant	103
Cocaine	100
Benzodiazepines	62
Cannabis hashish	56
Ecstasy	37
Methamphetamine	11

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

Criminal Offences Committed under the Influence of Alcohol or Illicit Drugs

As part of the pre-trial procedure, the police may be granted legal authorisation to order the suspect to undergo a professional blood and urine test. The test is used to determine whether the suspect was under the influence of alcohol and/or illicit drugs when the offence was committed. The blood and urine samples are drawn and analysed by a competent health care institution.

In 2013, the police handled 225 (386 in 2012) suspects who had been under the influence of alcohol upon committing the offence, while 69 were under the influence of illicit drugs (Table 9.3). This means that the number of suspects (compared to 2012) under the influence of alcohol upon committing a criminal offence decreased by 41.7%, while the number of suspects under the influence of illicit drugs upon committing a criminal offence remained unchanged. The latter comprised 61 male and only 8 female suspects.

Table 9.3: The number of suspects who committed a criminal offence under the influence of alcohol or illicit drugs, 2009–2012

	2009	2010	2011	2012	2013
Number of suspects who committed a CO under the influence of alcohol	625	535	463	386	225
Number of suspects who committed a CO under the influence of illicit drugs	137	94	128	69	69
Total number of suspects under the influence of alcohol or illicit drugs	762	629	537	437	271

CO – criminal offence

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

As in 2012, most criminal offences committed under the influence of illicit drugs continue to be from the field of unlawful manufacture and trade in illicit drugs and rendering opportunity for their consumption. However, the structure of other criminal offences committed under the influence of illicit drugs (e.g. rape, neglect and maltreatment of an underage person, sexual abuse of a defenceless person, murder, audacious driving in road traffic) was found to be wildly different, indicating that in a majority of cases, criminal suspects have no financial motive. The number of manslaughter suspects is alarming (five suspects, two of which are suspects in completed criminal offences, while three are suspected of a manslaughter attempt). Obstructing the performance of official acts or exacting revenge upon an official

was restricted to an attempt in two cases, while the obstruction of an official act was committed three times and twice an attack on an official exercising security tasks. The aforementioned data also indicate increased risks to officials (police officers) handling suspects under the influence of illicit drugs (Table 9.4).

Table 9.4: Number of suspects who committed a criminal offence under the influence of illicit drugs by select types of criminal offences as per the Criminal Code, 2009–2013

Criminal offence as per the CC	2009	2010	2011	2012	2013
Larceny, Art. 204	7	18	19	1	0
Grand larceny, Art. 205	11	10	21	4	4
Unlawful manufacture and trade with narcotic drugs, illicit substances in sport and precursors to manufacture narcotic drugs, Art. 186	36	11	11	14	17
Rendering opportunity for consumption of narcotic drugs or illicit substances in sport, Art. 187	5	-	7	5	15
Violent conduct, Art. 296	3	10	8	4	1
Robbery, Art. 206	1	2	2	1	0
Obstructing the performance of official acts or revenge upon an official, Art. 299	7	2	4	4	5
Actual bodily harm, Art. 122	6	3	11	1	1
Manslaughter, Art. 115	2	3	2	3	5
Damaging another's object, Art. 220	1	5	4	1	0
Family violence, Art. 191	-	-	9	6	2
Murder, Art. 116	-	-	-	-	1
Rape, Art. 170	-	-	-	-	1
Sexual abuse of defenceless person, Art. 191	-	-	-	-	1
Aggravated bodily harm, Art. 123	-	-	-	-	1
Presentation, manufacture, possession and distribution of pornographic material Art. 176	-	-	-	-	1
Attack on an official exercising security tasks, Art. 300	-	-	-	-	2
Illegal manufacture of and trade in weapons or explosive materials, Art. 307	-	-	-	-	1
Causing public danger, Art. 314	-	-	-	-	2
Audacious driving in road traffic, Art. 324	-	-	-	-	2
Neglect and maltreatment of an underage person, Art. 192	-	-	-	-	5

- no data available, CC – Criminal Code

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

Secondary Crime

In recent years, the Slovenian police force has recorded a trend of a decreasing number of criminal offences committed in order to acquire funds to purchase illicit drugs. In 2013, there was a further reduction in the number of crimes where at least one suspect of a criminal offence sought to acquire funds to purchase illicit drugs. The police handled 40.6% fewer cases committed in order to acquire funds to purchase illicit drugs in comparison to 2012 (when there were 123 in total); there were 73 such cases in total (compared to 210 in 2011), and their composition changed in comparison to previous years (Table 9.5).

Table 9.5: Number of criminal offences committed with the intent of acquiring funds to purchase illicit drugs (cases involving at least one suspect sought to do so), 2011–2013

	2011	2012	2013
Total number of criminal offences	210	123	73

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

The majority of criminal offences were crimes against property (larceny, grand larceny), followed by criminal offences of unlawful manufacture and trade with illicit drugs which were committed with the intent of acquiring funds to purchase new illicit drugs, and criminal offences of family violence and the forgery of documents (Table 9.6).

Table 9.6: Number of criminal offences (by type) committed with the intent of acquiring funds to purchase illicit drugs (cases involving at least one suspect sought to do so), 2013

	2013
Unlawful manufacture and trade with narcotic drugs, illicit substances in sport and precursors to manufacture narcotic drugs, Art. 186	22
Rendering opportunity for consumption of narcotic drugs or illicit substances in sport, Art. 187	1
Family violence, Art. 191	2
Larceny, Art. 204	10
Grand larceny, Art. 205	36
Forging documents, Art. 251	2

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

Driving under the Influence of Illicit Drugs, Psychoactive Medication or Other Psychoactive Substances

Compared to 2012, the police ordered approximately the same number of professional tests in 2013 (784) to determine the presence of illicit drugs, psychoactive medication or other psychoactive substances in drivers. The share of drivers tested positive for psychoactive substances in 2013 (276 positive tests) was similar to 2012 (280 positive tests) (Table 9.7). However, there has been a large increase of 40.4% in declined professional tests, which amounted to 89 in 2012, but rose to 125 in 2013. Declining a professional test results in the same sanction as evidence of the presence of illicit drugs, psychoactive medication or other psychoactive substances in the bloodstream and/or saliva or urine. Those in violation of the Rules in Road Traffic Act face a fine of EUR 1200 and 18 infraction points against their licence. The driver shall be barred from continuing to drive and shall have his/her driving licence temporarily taken away (for 24 hours). If no intoxication is proven, but the urine test comes back positive for these substances, the driver shall be referred to a control medical examination. There are no fines or other punitive measures laid out for such drivers. The driver shall be barred from continuing to drive and shall have his/her driving licence temporarily taken away (for 24 hours).

Table 9.7: Number of ordered professional tests to determine the presence of illicit drugs and other psychoactive substances, and the number of positive blood/saliva or urine tests, 2010–2013

	2010	2011	2012	2013
Ordered tests	1501	1162	780	784
Positive tests	870	648	280	276

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

Owing to the high standard of proof and conclusively proving diminished driving capacity, the number of issued orders for professional tests remains low, as does the number of cases where the presence of psychoactive substances in drivers was proven as a consequence. This makes the current procedure of proving the presence of illicit drugs, psychoactive medication or other psychoactive substances considerably more complex and costly.

Table 9.8: Illicit drugs, psychoactive medication or other psychoactive substances detected in positive test results, 2010–2013

	2010	2011	2012	2013
Amphetamines	48	50	16	22
Benzodiazepines	173	103	37	44
Cannabinoids	115	72	58	52
Cocaine	210	88	43	54
Methadone	239	142	68	45
Opiates	309	134	47	40
Antidepressants	2	0	4	5
Antipsychotics	1	0	1	0
Hypnotics/sedatives	1	3	1	1
Opioids	18	10	7	6
Other	614	409	204	202

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

The results of positive blood/saliva and/or urine analyses in professional tests in 2013 showed that drivers most commonly drove under the influence of cocaine and cannabinoids, followed by driving under the influence of methadone, benzodiazepines and opiates. Compared to 2012, the results may indicate a slight increase in the use of cocaine and cannabinoids among drug users in Slovenia (Table 9.8).

9.2 Prevention of Drug Related Crime

Staša Šavelj

Police prevention activities against crimes involving illicit drugs are based on cooperation with competent institutions primarily dedicated to raising awareness among target groups about the adverse effects of the use of illicit drugs and self-protection measures. To this end, the police force cooperates with non-governmental institutions, municipal panels, education institutions and all other stakeholders active in the field of reducing drug-related issues on the state, regional and local level. Prevention activities are carried out by participating at lectures, consulting state institutions, presenting police force activities at a variety of events and creating prevention materials such as leaflets.

9.3 Interventions in the Criminal and Justice System

Justice System and Criminal Offences

Igor Kovačič

The Justice System

The powers of the Republic of Slovenia are divided into the legislative, executive and judicial power. Judicial power is vested to judges at courts established by the Courts Act (Official Gazette of the RS, Nos.94/07, 45/08, 96/09, 86/10 - ZJNepS, 33/11, 75/12 - ZSPDSLS-A and 63/13) or another Act of Parliament. There are courts of general and specialised jurisdiction.

Courts of general jurisdiction are divided into local courts (44) – these are generally the organisational units of district courts; district courts (11), higher (appellate) courts (4) and the Supreme Court of the Republic of Slovenia, the highest court in the country.[18]There are three courts of specialised jurisdiction in Slovenia: the Administrative Court, the Labour and Social Court and the Higher Labour and Social Court.

On the first instance, adjudication on criminal offences is within the competence of local and district courts; however, due to the seriousness of the offence, drug-related offences fall under the sole jurisdiction of district courts, which usually decide cases in panels consisting of three judges. An investigation usually takes place before the indictment, which is carried out at by an individual judge (the investigating judge) at district courts, and it is generally obligatory to have a defence attorney in these cases. The indicted person may choose his/her own legal counsel for such criminal proceedings; otherwise, the presiding judge assigns them an attorney ex officio upon the delivery of the indictment. In some cases, the person charged must also have legal representation at the first hearing (e. g. if the indicted person is mute, deaf or otherwise unable of defending himself/herself, or if he/she is brought before the investigating judge in accordance with Article 157 of the Criminal Procedure Act) (Official Gazette of the RS, Nos. 32/12 and 47/13).

The prosecution of criminal offenders is the principal right and duty of state prosecutors. State prosecutor's offices in Slovenia are organised as laid out in the following scheme (Article 185 of the State Prosecutor's Office Act (Official Gazette of the RS, No. 58/11, 21/12 - ZDU-1F, 47/12, 15/13 - ZODPol, 47/13 - ZDU-1G and 48/13 - ZSKZDČEU-1)):

- District State Prosecutor's Offices (11) – based in the district of individual district courts;
- The Specialised State Prosecutor's Office – holds the status of the 12th District State Prosecutor's Office and handles the most complex criminal offences requiring special prosecution – different organisation and training and the highest level of efficiency (the list of criminal offences for which the Specialised State Prosecutor's Office is competent is laid out in Article 192 of the State Prosecutor's Office Act; among them is the prosecution of criminal organisations committing the criminal offence of unauthorised production of and trade with illicit drugs, substances prohibited in sports and precursors for the production of illicit drugs);
- The Supreme State Prosecutor's Office of the Republic of Slovenia.

Upon assuming office, the State Prosecutor General adopts a policy on prosecution.[19] In particular, the policy states the State Prosecutor General's position on the types of cases taking precedence, the sentencing policy for specific criminal offences and categories of criminal offenders which the State Prosecutor's Office shall submit in proposals for sentencing and appeals against the pronounced sentence, etc.

In terms of substantive law, state prosecutors prosecute two criminal offences in connection with illicit drugs in accordance with the Criminal Code (Official Gazette of the RS, No. 50/12) (hereinafter: CC-1) under the section Criminal Offences against Public Health: Article 186 of the CC-1 – Unlawful Manufacture and Trade of Narcotic Drugs, Illicit Substances in Sport and Precursors to Manufacture Narcotic Drugs; Article 187 of the CC-1 – Rendering Opportunity for Consumption of Narcotic Drugs or Illicit Substances in Sport.

[18] Paragraph 1 of Article 127 of the Constitution of the Republic of Slovenia.
[19] The file is available at http://www.dt-rs.si/uploads/documents/politika_pregona.pdf.

Criminal Offences Involving Illicit Drugs

In 2013, District State Prosecutor's Offices and the Specialised State Prosecutor's Office received criminal complaints against 966 persons above the age of majority (989 in 2012) and, given the unresolved criminal complaints against 281 persons from the previous period, handled criminal complaints against 1247 persons above the age of majority (1347 in 2012). The figure includes complaints involving criminal offences committed by criminal organisations.

State prosecutors dismissed complaints against 134 persons above the age of majority (116 in 2012), requested an investigation against 778 such persons (820 persons in 2012), withdrew from the prosecution of 79 such persons following the completion of the investigation (119 in 2012) and filed an action against 1036 persons (601 in 2012) and a direct indictment against 65 adults (47 in 2012).

In 2013, courts issued their decisions on 1326 defendants (683 in 2012), while 1844 defendants (1101 in 2012) await the ruling on the first instance. 1151 defendants (622 in 2012) were convicted, while 80 (34 in 2012) were acquitted, and 75 cases (27 in 2012) were rejected. Convictions thus represent 88.5% of cases (91% in 2012), while the share of rejections rose from 4% in 2012 to 6% in 2013; the share of acquittals also increased from 5% in 2012 to 6.5% in 2013.

In the report period, state prosecutors also handled criminal complaints against 114 juvenile offenders, of which 93 were new and 21 originated from the preceding period. Compared to the preceding year, when state prosecutors decided on the criminal complaints against 109 juvenile offenders, the number of cases is on the rise. Complaints against nine juvenile offenders were dismissed (the number was identical in 2012), while preliminary proceedings were requested for 77 juvenile offenders (65 in 2012). Upon completion of the preliminary proceedings, the criminal proceedings against 11 juvenile offenders (19 in 2012) were stopped, while state prosecutors recommended the juvenile departments of District Courts pronounce a correctional measure in 54 cases (42 in 2012). In 2013, there were no cases of juveniles participating in the trade in illicit drugs as members of a criminal organisation.

In 36 cases involving juvenile offenders, the courts have yet to issue their judgments on the first instance, a decision on the cessation of proceedings was pronounced in two cases (18 in 2012), and a sentence was pronounced in 22 cases (38 in 2012). All cases of sentencing but one involved a correctional measure. Prosecutors objected to the decision of the courts in two cases; both objections were dismissed.

In 2013, District State Prosecutor's Offices handled several criminal organisations involved in illicit drug trade. A request to begin an investigation was submitted against 53 persons, two persons were indicted directly, and 192 persons were indicted after the completion of the investigation. 90 persons were convicted, 15 were acquitted and three cases were rejected.

According to the data of the Statistical Office of the Republic of Slovenia, the number of convictions increased by 34% in 2013 compared to 2012, mainly due to the changes to the Criminal Procedure Act (the Agreement on the Confession of Guilt and the introduction of a pre-trial hearing); in addition, there were 68% more convictions for the criminal offence of Unlawful manufacture and trade of narcotic drugs, illicit substances in sport and precursors to manufacture narcotic drugs (Article 186 of the CC-1).

Alternative Methods of Enforcing Criminal Sanctions

Eva Salecl Božič

The Enforcement of Criminal Sanctions Act (Official Gazette of the RS, Nos. 110/06, 76/08, 40/09, 9/11-ZP-1G, 96/12-ZPIZ-2 and 109/12) foresees a number of less severe forms of serving a sentence, i. e. weekend imprisonment, house detention and the alternative sentence of performing community service.

– "Weekend imprisonment" (Article 12 of the Enforcement of Criminal Sanctions Act): The enforcement of weekend imprisonment is imposed with an order by the court based on a proposal lodged after the judgment has become final. Enforcement of weekend imprisonment can also be allowed based on a request lodged by a convict already serving a prison sentence and following the opinion of the director of the institution. In such a case, the enforcement of weekend imprisonment is also imposed by a court order.

– Home detention (Article of 12a the Enforcement of Criminal Sanctions Act): The court may allow enforcement of imprisonment in the form of home detention with a judgment or special decision and order or change its enforcement method. The court shall submit the judgment or special decision on the method of enforcing home detention and the decision on the modified method of enforcement to the convict, the prison to which the convict would otherwise be referred, and the police department competent for the area in which home detention is being served. The enforcement of home detention is overseen either by the court or by the police.

– Alternative sentence of performing community service (Article of 13 the Enforcement of Criminal Sanctions Act): Community service, with which the court replaces a prison sentence of up to two years, is arranged, run and overseen by a Centre for Social Work. The agreement on the commencement of community service between the convict, the organisation where the service will be performed, and the competent Centre shall be considered an order to begin serving the sentence.

Alternative Sentencing

The Prison Administration of the Republic of Slovenia does not have official figures on the enforcement of two types of alternative sentencing, namely homedetention and community service.

Weekend imprisonment may be granted to convicts with sufficient personal integrity who can be trusted not to abuse this form of sentencing. This allows them to continue to work or attend education programmes and live at home except on work-free days (usually weekends), which they need to spend in prison. 122 convicts were subject to weekend imprisonment in accordance with Article 12 of the Enforcement of Criminal Sanctions Act (Table 9.9). All had full-time employment and remained employed, while 7 convicts pursued full-time education.

Table 9.9: Number of convicts serving their prison sentence on weekends[20]

Year	2011	2012	2013
Article 12 of the Enforcement of Criminal Sanctions Act	60	86	122

Source: Prison Administration, 2013 Annual Report

Persons in Compliance Detention

In 2013, 1123 persons were kept in compliance detention in Slovenian prisons[21]. Compared to the preceding year, their numbers decreased for 542 persons, or 32.5%. 23.9% served the entire duration of the sentence (one month). Due to a change to the Minor Offences Act (Official Gazette of the RS, No. 29/11) which entered into force on 14 March 2011, stipulating that an individual may only propose to the court to substitute the payment of the fine by performing a specific service for the public good or to the benefit of a locally governed community before the commencement of compliance detention, a total of

[20] The data apply to all prisoners regardless of drug-related problems.
[21] The data apply to all persons in compliance detention regardless of drug-related problems.

five persons were recorded for 2013 to whom courts granted the option of performing a specific community service instead of paying the fine while in compliance detention.

Pursuant to the Enforcement of Criminal Sanctions Act, the termination of compliance detention is decided upon by the director of the institution based on the opinion of the prison physician, whereas the suspension of compliance detention is decided upon by the court. The decision on the non-enforcement of compliance detention shall be issued within 24 hours of receiving the opinion. Opinions are mostly related to poor health and poor social conditions of the person brought in to serve compliance detention. In 2013, 30.8% of persons in compliance detention were discharged based on the director's proposal.

If individuals in compliance detention have a substance abuse problem, the following practice has been established: if the prison determines that the individual in question is not capable of serving the compliance detention sentence due to health problems and does not have the means to settle the fine, a proposal against placement in compliance detention is lodged. Health-related proposals are approved in most cases. The procedure involves a medical examination in the prison surgery by a doctor from the competent health centre, who assesses whether there are valid health concerns for the prison to petition the court not to enforce the imprisonment.

Of those in compliance detention in prisons in 2013, 78 persons, or 6.9% of all such detainees, were determined to have alcohol addiction issues, and 110 were determined to have drug addiction issues, which is 9.8% of all persons in compliance detention.

9.4 Drug Use and Illegal Drug Market in Prison

Eva Salecl Božič

The Prison Administration of the Republic of Slovenia regularly monitors the drug situation in prisons via data capture for the purposes of the annual report. On a certain date every three months, it asks prisons to report the number of imprisoned persons with issues due to addiction to psychoactive substances (drugs, alcohol) and the number of HIV, hepatitis and tuberculosis cases as an electronic table. The Administration also daily communicates with the prisons, thus monitoring any extraordinary events in connection to these issues.

Imprisoned individuals with issues due to the use of illicit drugs are treated in compliance with a clearly formulated strategy on treating drug addiction, comprising medical attendance, an educational programme and a motivation process, the aim of which is to enable prisoners to commence and maintain abstinence, enter psychosocial assistance programmes and gradually transform their lifestyle from passive to active. They are treated in compliance with the Instructions on Treatment of Imprisoned Drug Users (The Prison Administration of the Republic of Slovenia, 2010), and the Instructions on Collecting Urine Samples and Performing Control Tests (The Prison Administration of the Republic of Slovenia, 2010).

In 2013, 1078 of 4543 imprisoned persons were identified as having a drug problem (Table 9.10). A statistically significant increase of 3.4% was detected in comparison to the preceding year. Of those, six persons were subjected to compulsory drug addiction treatment.

Table 9.10: Number of persons with drug use related problems in comparison to the total number of all prisoners, 2005–2013

Year	2005	2006	2007	2008	2009	2010	2011	2012	2013
Number of all imprisoned persons	3097	3572	4311	4383	4730	4592	4975	5040	4543
Persons with a drug problem	868	948	1090	1210	1209	1215	1073	1076	1078
Share in %	28.0	26.5	25.3	27.6	25.6	26.5	21.6	21.3	23.7

Source: Prison Administration, 2013 Annual Report

Prison Drug Trafficking

Imprisoned persons introduce drugs into prisons in a variety of ways, always seeking new concealment methods. Common techniques include hiding them on the body (by gluing) or in clothing (by sewing them into hems, etc.), throwing them over the fence and entry inside parcels, especially in food in original packaging (Photo 9.1). It is thought that imprisoned persons most commonly hide drugs inside their bodies, which causes additional problems in detection as any invasive exams of the human body are prohibited. However, in all discovered cases, only small amounts of drugs were brought into prisons.

Source: Prison Administration

Photo 9.1: A discovered instance of drug concealment in a chocolate bar in original packaging

More thorough controls upon entry into the prison, regular inspections of the facility and prisoners, cooperation with police investigations and the use of sniffer dogs to discover drugs all lead prisoners to be more creative in finding new ways of bringing drugs into prisons; that is why we also remain alert to any efforts by prisoners to take advantage of the staff. If any such suspicion arises, police become involved in investigating the incident.

In 2013, drugs were found in 93 cases, with 261 finds/events in total (paraphernalia, pills, alcohol etc.) (Table 9.11). In 2013, the most common type of drug discovered by judicial police was cannabis 420.72 g), followed by heroin (166.98 g), hashish (158.57 g) and cocaine (27.2 g). In addition, 50 ecstasy pills, 3 ml of methadone, 38.6 l of alcohol and 4969.5 pills were also discovered (Table 9.12).

Table 9.11: Number of finds of illicit drugs and psychoactive substances by type*

Prison	Heroin	Cannabis	Cocaine	Ecstasy	Hashish	Alcohol	Methadone	Pills	Para-phernalia	All finds	All drugs
Dob	3	9	0	1	0	5	1	17	12	48	13
Slov. vas	0	0	0	0	0	0	0	0	0	0	0
Puščava	0	0	0	0	0	0	0	0	0	0	0
Ig	1	0	0	0	0	0	0	3	5	9	1
Celje	0	8	0	0	0	0	0	7	1	16	8
Koper	8	21	2	0	2	3	0	36	6	78	33
N. Gorica	0	1	0	0	0	0	0	5	0	6	1
Ljubljana	5	13	0	0	1	10	0	20	4	53	19
N. mesto	0	2	0	0	0	0	0	4	0	6	2
Ig Open Prison	0	0	0	0	0	0	0	0	0	0	0
Maribor	1	8	4	0	0	0	0	21	5	39	13
M. Sobota	0	1	0	0	0	0	0	0	0	1	1
Rogoza	0	0	0	0	0	1	0	0	0	1	0
Radeče	0	2	0	0	0	1	0	0	0	3	2
Total	18	65	6	1	3	20	1	113	33	260	93

* Note: The total number of finds (events) was 244, since the judicial police discovered several types of drug in a number of cases.
Source: Prison Administration, 2013 Annual Report

Table 9.12: The quantity of discovered illicit drugs and psychoactive substances by type*

Prison	Heroin/g	Cannabis/g	Cocaine/g	Ecstasy/tab	Hashish/g	Alcohol/l	Methadone/ml	Pills/tab
Dob	60.36	98.5	0	50	0	16.2	3	1713.75
Slov. vas	0	0	0	0	0	0	0	0
Puščava	0	0	0	0	0	0	0	0
Ig	1	0	0	0	0	0	0	23
Celje	0	31.9	0	0	0	0	0	192
Koper	84.5	147.8	18.7	0	95.9	11.5	0	436
N. Gorica	0	2	0	0	0	0	0	48
Ljubljana	20.42	113.37	0	0	62.67	8.74	0	1460
N. mesto	0	7.55	0	0	0	0	0	17
Ig Open Prison	0	0	0	0	0	0	0	0
Maribor	0.7	12.1	8.5	0	0	0	0	1079.75
M. Sobota	0	5	0	0	0	0	0	0
Rogoza	0	0	0	0	0	1.5	0	0
Radeče	0	2,5	0	0	0	0.7	0	0
Total	166.98	420.72	27.2	50	158.57	38.64	3	4969.5

* Note: The weight of the discovered drugs is gross weight (expressed in g), i.e. together with the wrapping handed over to the police as a whole.
Source: Prison Administration, 2013 Annual Report

Select Characteristics of Convicted Persons Addicted to Illicit Drugs

Tanja Madjar, MA

The following piece is restricted to presenting a limited scope of the outcomes of a broader study performed on a sample of addicted convicts and employees of the company Talum d.d.[22] The focus shall be on the issue of addiction to psychoactive substances (PAS) in the context of various personality traits (depression, self-esteem, suicidal ideation) and criminal behaviour (type of criminal offence, age upon earliest arrest, recidivism). The risk of drug addiction with certain personality traits and behavioural characteristics shall be presented.

Methodology

The collection of data was carried out by a group survey in small groups in early 2012. The respondents were informed about the purpose of the study, and its anonymity and voluntary basis were stressed. The group of convicted persons was composed of 58 males, all of them recorded as illicit drug addicts in prison. They had an average age of 31.6 years (MD = 5.8). The majority (N=29, or 61.7%) said they were single. Approximately one half of them had been living with their parents upon being imprisoned (N=24; 51.1%), followed by those without a permanent residence (N=9; 19.1%), 5 convicted persons had their own apartment (10.6%), while the rest lived with relatives, partners or in rented apartments. The majority (N=41; 87.2%) were unemployed prior to being imprisoned. More than half (N=24; 51.1%) have completed lower professional secondary education or professional secondary education, 38.3% (N=18) have only completed primary school, four (8.5%) did not finish primary school, and one has obtained V level of education. The study also included a pseudo-control group (N=52), composed of Talum d.d. employees.

To determine the status of addiction to chemical PAS (alcohol and illicit drugs), we used the SASSI (The Substance Abuse Subtle Screening Inventory) and various items determining the relationship to various psychoactive substances. The items were grouped into the following sections: cigarette smoking, alcohol consumption, the consumption of psychiatric medication therapy, the consumption of illicit psychoactive substances (the type of drug used, duration of use, any overdoses during the period of drug consumption). To determine their psychological state, the Rosenberg self-esteem scale, the Zung self-rating depression scale, the Eysenck personality questionnaire (EPQ-R) and items to assess auto-aggressive behaviour were used. Only statistically relevant results shall be presented below.

Results

The SASSI questionnaire was used to identify those with a high probability of problem drug use or addiction out of the whole sample of prisoners. One of the benefits of the questionnaire is that it comprises of direct and indirect scales, which detect addiction in those who deny having this issue on direct scales. This makes it particularly well-suited to determine addiction among the prison population, who generally deny having an addiction or do not yet have a realistic perception of it. Out of 42 respondents, 36 (85.7) reached the chemical dependency criterion, or a high probability of problem drug use. Regardless of the type of responses regarding their own addiction by the respondents (denial, minimalisation), the SASSI questionnaire accurately detected addicted individuals. Rogers et al. (1997) also reached similar conclusions. Addicted convicts were relatively open about their addiction and did not deny it: significant positive correlation between direct and indirect scales and a low score on defensiveness scales were demonstrated. Our hypothesis is that the use of direct scales or a structured

[22] The complete study is available in Madjar T. (2012) Psihične motnje pri zapornikih (Mental Disorders in Prisoners), Master's Thesis.

interview would be an appropriate method for assessing the state of addiction. On the other hand, the sincerity of responses may have been affected by their anonymity in the survey.

Correlation procedure results showed higher scores on scales measuring elements of addict behaviour (EPQ-R addiction (A), self-assessment of alcohol use (FVA SASSI), self-assessment of the use of other drugs (FVOD SASSI), obvious attributes of addict behaviour (OAT SASSI), subtle attributes of addict behaviour (SAT SASSI) significantly correlated to poorer mental health: lower self-esteem, higher rates of depression, lower defensiveness, higher incidence in auto-aggressive behaviour (thoughts, attempts and intent), and a lower opinion on their mental state and their outlook, meaning that the descent into addiction worsens the mental state of individuals.

Compared to the pseudo-control group, addicted convicts exhibit more signs of depression, more frequently engage in PAS consumption (marijuana, heroin, cocaine, ecstasy, LSD) and exhibit a higher incidence of auto-aggressive behaviour (suicide ideation, attempts and intent of taking their own lives, but backing out in the last minute). Addicts are more sensitive to stress, with frequent depression and depressive disorders (Auer 2001; Benedik 2003; Donovan and Marlatt 2005). This was also true of our sample, although mainly mild symptoms of depression were present. Minimal to mild depression was observed in 9 convicts (23.08%), while the rest did not exhibits depression symptoms according to the criterion. Mild depression symptoms are more difficult to detect and require no hospitalisation, yet still significantly affect the subjective well-being of individuals. Over half (54.54%) of addicted convicts thought about committing suicide, over one third of them (35.71%) have attempted suicide on at least one occasion, and 28.57% had the intention of committing suicide on at least one occasion. Addiction disorders are closely linked to suicide, and early substance abuse is connected to an increased risk of suicide (Gossop 2010, in Towl and Crighton 2010). Individuals with a depressive disorder who also abuse alcohol or illicit drugs or are addicted to them are at an especially high risk (Dernovšek 2003). This makes the assessment of suicide risk a key diagnostic step in working with addicted convicts, who are a pronounced risk group in terms of suicidal behaviour. The data above confirm the hypothesis that the treatment of addiction should include parallel issues in addition to addiction (auto-aggressive behaviour, depression). This is an issue of internalising behaviours, which is often forgotten due to the higher visibility of externalised behaviour in prisons (aggressive episodes, arguments, conflicts, etc.).

As in foreign works on the topic (Gossop and Eysenck 1980, in the Eysenck Personality Scale manual), the addicted convicts from our sample also scored higher on psychoticism (P) and neuroticism, lower extraversion and lower scores on the sincerity scale, meaning that in comparison to the general population, they are generally more introverted, less social, unsystematic, highly emotional, emotionally unstable, plagued by fears and worries, non-conformist (find it more difficult to adapt to cultural norms), and experience a higher degree of depression and mood swings. Compared to the general Slovenian sample of drug addicts, addicted convicts from our sample also scored significantly higher on psychoticism scale, which encompasses hostility, manipulativeness and a lack of empathy and compassion, meaning that in interpreting EPQ-R results of addicted convicts, special attention should be paid to the P scale as an expression of an additional burden of criminal offenders.

In terms of PAS use, heroin and marijuana consumption, mostly on a daily basis, were most frequently reported. Within the prison system, heroin addicts are most common, since heroin is the drug most frequently leading to criminal behaviour. The consumption of sedatives was also common (81.8%) of the total sample. The convicts who consumed sedatives had a significantly higher incidence of heroin and cocaine consumption as well as depression compared to convicts who did not consume sedatives, and scored significantly higher on the FVOD SASSI scale. Nearly all convicts in our sample were smokers (93%). A comparison of smokers and non-smokers showed that smokers had a higher

incidence of heroin use. Those who smoke more cigarettes per day act out more frequently (COR SASSI) and score higher on the N scale of the EPQ-R. Cigarettes are used to regulate their emotional state as a calming mechanism. Therefore, it may be wise to touch upon nicotine and sedative addiction when treating addiction. Active overdose prevention measures also need to be introduced to work with addicted convicts. 31.5% of our sample reported an overdose with illicit PAS in the past. According to studies, the majority of heroin addicts have experienced an overdose (50–60 %). An overdose experience increases the chances of dying of overdose (Stoové et al. 2009). Overdoses in PAS users typically occur due to relapsing into drug use, which is a frequent occurrence upon being released from prison, where users typically consumed lower amounts of drugs, as well as a serious risk (Marlowe 2011). It is especially important to discuss this topic before releasing an individual at risk from prison, as such individuals frequently have no interest in maintaining abstinence and are relatively ambivalent about their addiction.

A highly important finding of the study is that addicted convicts rated some aspects of their mental condition more positively than expected: in general, they have a positive self-image, most exhibit no signs of depression, they rate the family atmosphere as positive and their physical health as very good, they also consider their mental state to be good and are optimistic about the future. This deviated from our expectations as well as the findings of other studies, which report low self-esteem in young individuals experimenting with drugs as well as persons already suffering from addiction (Auer 2001; Kastelic and Mikulan 2004). The results lead us to conclude that the respondents of our sample experience deviations in self-perception and a lack of meta-perspective. These individuals have a poor self-reflection capacity, find it difficult to assess their personal psychological and biological state and compare it to others. This is naturally the consequence of inappropriate primary socialisation as well as the long-term addict lifestyle, which ostracised them from conventional social groups. Such individuals are also less defensive (decreasing with the degree of addiction and ailing mental state), meaning that they do not possess enough constructive defensive mechanisms to protect their person.

Considering the aforementioned, the treatment of addiction in Slovenian prisons should primarily focus on identity formation and a gradual realistic perception of the self rather than solely on abstinence and resulting punitive measures for breaking abstinence. The reality is that not all addicted convicts are motivated to abstain from drugs, with many being ambivalent to abstinence. For this reason, programmes employing duress and punitive measures are not very appropriate, as individuals have yet to develop sufficient defence mechanisms and personal strength to protect themselves from addiction treatment measures as “aggressive” as this. Such methods increase defensiveness and aggressive behaviour already present in prisons. Convicts utilise manipulation and denial, with no progress in terms of gaining insight into their own personal psychological and biological state.

Social issues are also very present in the addicted convict sample: on average they are poorly educated, nearly a half do not have a vocation, a job, work experience, or a permanent residence. In addition to increased mental vulnerability and stigmatisation, these variables contribute to the continued social isolation of addicted convicts and their failed reintegration into society after their release from prison. If these issues are not resolved, even the most brilliantly designed addiction treatment cannot significantly help comprehensively solve life issues of these individuals.

Let us conclude with some statistics on criminal behaviour of addicted convicts. There is a significant link between addiction to PAS and criminal behaviour, leading many persons addicted to illicit drugs to break the law. The core of this link is the need to sustain the addiction, which is a large expense for the addict, which usually cannot be covered with work or social assistance. For this reason, crime, drug dealing and other other criminal offences as well as prostitution are the main ways to sustain the

addiction. 63.6% (N=28) of the addicted convicts of our sample have been sentenced to prison before, 2.63 times on average. The age of first arrest falls in the 18–29 age group, 22 being the average. In accordance with foreign works on the topic (Loeber et al. 2008; Packer et al. 2009; Towl and Crighton 2010; Wojtowicz, Liu and Hedgpeth 2007), property crime is the most prevalent type of criminal offences of addicted convicts (44.07%). These are most commonly thefts, while robberies and fraud are less common. This piece of data confirms our hypothesis about the financial motive behind criminal offences with the objective of obtaining funds to purchase drugs. Following are criminal offences against human health (32.2%), which are drug-related criminal offences such as the unauthorised production of and trade in illicit drugs and the facilitation of drug consumption. Only 8 persons (17%) committed a criminal offence with elements of violence. Other studies also reinforce the hypothesis that the use of illicit drugs is closely connected to property crime and criminal drug possession, and less so to violent crimes, which correlate more closely to alcohol consumption (Raskin White, Loeber and Farrington in Loeber et al. 2008).

Conclusion

Chemical dependency among prisoners is one of the significant issues in Slovenian prisons. The percentage of prisoners in Slovenian prisons with a PAS addiction is high, and the issue of addiction affects the prison dynamic as a whole. This makes the need for in-depth research into the topic and the introduction of effective measures all the more pressing. The results of the study have provided us with useful data on the state of addiction, personal characteristics and criminal behaviour in a sample of convicts with a PAS addiction. In addition, the results provide useful data to formulate guidelines for the treatment of these convicts. The results of the study confirmed their high psychosocial vulnerability. As their addiction worsens, so does their mental state; they usually do not deny having an addiction, but they do experience distortions in the perception of their own psychobiological states. The improvement in the state of addiction would likely result in a decrease in associated criminal offences, making treatment the key to breaking the link to crime

9.5 Responses to Treatment Related Drug Issues

Eva Salecl Božič

Since 1 January 2009, health care services in prisons are provided by health care providers in the Republic of Slovenia. Prisoners receive health care from regional health centres serving the area in which the prison is located by means of an agreement between the prison and the health centre. Health centres provide sufficient access to physicians and other medical staff at general practices and a psychiatry practice, physicians in the centre for prevention and treatment of illicit drugs addiction, a dentist practice for adults and a gynaecologist.

Imprisoned persons with a drug addiction are provided with the same access and quality of health services as outside of prison. Upon admission into prison, each prisoner is examined in the prison surgery. If they have an addiction[23], the doctor makes a decision about the necessity of providing medication therapy to alleviate the effects of drug withdrawal or prescribes substitution therapy to the

[23] The syndrome, i.e. the diagnosis of addiction is determined by a physician. Apart from the diagnosis, the assessment of the issues due to the consumption of psychoactive substances also involves the information from the judgment (the type of criminal offence committed under the influence of psychoactive substances), the expert witness opinion, the Centre for Social Work report, the findings of a professional during meetings with the prisoner and from the prisoner's statements as well as the event of the prisoner commencing his sentence under the influence of alcohol and the finding that the prisoner is using psychoactive drugs which are not part of a medical treatment.

prisoner. The Instructions on the Treatment of Imprisoned Drug Users, developed in cooperation with centres for the prevention and treatment of illicit drugs addiction, lay out a uniform doctrine of substitution therapy in prisons.

Substitution drugs are taken under supervision. In the case of methadone, the substance is administered as a solution mixed with fruit juice. Of 1078 prisoners with issues due to illicit drug use, 649 prisoners (60% of the all prisoners with an addiction) were undergoing substitution therapy, of which 187 were remand prisoners, 394 were convicts (Table 9.13) and 68 were prisoners in compliance detention.

Table 9.13: Number of prisoners undergoing substitution therapy by category, 2007–2013

Category	2007	2008	2009	2010	2011	2012	2013
Remand prisoners	234	196	219	219	182	190	187
Convicts	352	346	328	319	378	366	394
Total	586	542	547	538	560	556	581

Source: Prison Administration, 2013 Annual Report

Testing

According to available data on test results[24] from surgeries organised by competent regional health centres, 196 prisoners opted to be tested for HIV and hepatitis in 2013. None were HIV-positive. Hepatitis A was discovered in one prisoner, nine prisoners were diagnosed with hepatitis B, and twenty-five were found to have hepatitis C (Table 9.14). Two persons had tuberculosis, and one of them had already been treated in Golnik Hospital prior to imprisonment. Testing is anonymous and voluntary. Patients also sought help and counselling at AIDS treatment practices.

Table 9.14: The results of voluntary confidential testing for hepatitis and HIV, 2005–2013

Year	2005	2006	2007	2008	2009	2010	2011	2012	2013
Persons tested for HIV and hepatitis	608	564	675	561	473	481	326	222	196
HIV	0	2	1	1	2	1	0	1	0
Hepatitis A	2	1	2	0	0	0	0	1	1
Hepatitis B	7	12	15	7	13	11	15	5	9
Hepatitis C	85	87	97	75	47	60	55	20	25
Total	94	102	115	83	62	72	70	27	35

Source: Prison Administration, 2013 Annual Report

Medical staff has implemented the recommendations of medical professionals regarding the timely discovery of patients as well as treatment and care as instructed by specialist doctors. All imprisoned persons are to be provided counsel and information on the dangers of HIV and hepatitis infections, and be encouraged to get tested and receive hepatitis B vaccination and treatment. Prisoners are provided with disinfectants, cleaning agents, latex gloves and condoms.

Upon release, imprisoned drug users are advised on their significantly lowered drug tolerance, which could result in relatively small amounts of drugs or a combination of drugs, alcohol and medication being fatal. In compliance with the Instructions for Treatment of Imprisoned Drug Users, the centre for prevention and treatment of illicit drug addiction or another institution overseeing future treatment of the

[24] The data apply to all prisoners regardless of drug-related problems.

released person is to be informed a week before release (if possible) of the type of drug treatment prescribed to the prisoner, administration times and the last received amount for a specified time period, as well as whether they were issued a sufficient prescription for medicinal products.

9.6 Treatment Programmes and Reintegration

Eva Salecl Božič

Work with imprisoned persons in Slovenian prisons is organised and focused on preventing recidivism and facilitating reintegration of prisoners into society. Upon commencement of imprisonment, prison professionals create a personal plan for each imprisoned person outlining the prisoner's needs and the objectives of serving a sentence. Prisoners are then directed to the type of treatment they require (e.g. treatment of drug or alcohol addiction). The personal treatment plan is supplemented, assessed and coordinated depending on the convict's prison term, needs, opportunities and changes in conditions.

While serving the sentence, persons with issues due to drug use may join low-threshold, higher-threshold and high-threshold drug addiction treatment programmes (Table 9.15).

Table 9.15: The number prisoners with issues due to illicit drugs involved in treatment programmes, 2013

Low-threshold programmes	Higher-threshold programmes	High-threshold programmes
566	235	110

Source: Prison Administration, 2013 Annual Report

Compared to 2012, a higher number of imprisoned persons involved in treatment programmes was recorded last year. To ensure a higher number of participants in such programmes, it is of key importance for prison professional staff to motivate prisoners to enter the programmes, to use an individual approach to creating a personal prison term plan according to the prisoner’s needs, and to provide a team-based interdisciplinary approach that involves both prison professionals as well as prison medical staff and other external experts. Persons participating in various treatment programmes during their prison term are also provided individual and group treatment within the prison. They may also be treated at health care institutions outside the prison and be included in NGO-run programmes (psychiatric hospitals, Centres for the Prevention and Treatment of Illicit Drug Addiction, Up Association, Srečanje Community, Karitas – Pelikan Institute, Vir Institute, Projekt Človek Association, Stigma Association, Križišče Association, etc.). In 2013, 91 prisoners opted for this form of help. Upon completion of service, 143 prisoners continued the treatment in institutions outside the prison.

Meetings may be organised within or outside the prison, depending on the effectiveness of treatment during service, the prison regime (closed, semi-open, open) and formal reasons (ongoing criminal trial, pending sentence, etc.). External organisations adapt their programmes to prisoners. Basic work methods are counselling and the provision of information, mostly concerning addiction-related issues: support in unpacking the phenomenon and identification of the complexity of the problem with regard to age, gender, social status or role, personal traits and family circumstances. These organisations provide assistance with interpreting and assessing the problem as well as solution planning. Prisoners commonly seek out information on the dangers of drug use, harm reduction and prevention. As well as providing information and counselling, the programmes also include practical assistance (with writing applications, requests and complaints, support and advocacy with various services and institutions, gathering specific information required to solve problems, initiating contact and making arrangements,

etc.). An important part of the programme is the prisoner escort service on their special day leaves, which enables them to manage their lives, settle current affairs and lay the foundations for successful reintegration after the completion of service.

While serving a sentence, every prisoner (either with or without drug issues) may participate in a number of activities. Various prison professional staff (educators, social workers, psychologists, etc.) encourages prisoners to follow a daily routine comprising work, education and active leisure time, and help them reconnect with close family members. They also seek to initiate change on a personal level via individual and group sessions. They aim for change in the prisoners' way of thinking and overcoming difficulties, the attitude to self and others, resolving conflict situations, self-esteem, managing impulsive behaviour as well as setting and reaching life goals during and after the prison term. The realisation of personal plans and the reintegration of individuals into society would be impossible were it not for cooperation between prison professional services and external institutions. Before release, treatment as a whole focuses on the specific arrangements for release: employment, accommodation, material circumstances and the preparation of the immediate family circle for the return of the convict. For this reason, pre-release arrangements are made in prisons as part of individual and group treatment, and prison professionals carry out post-penal cooperation with centres for social work, the Employment Office, housing funds, etc. The cooperation with centre for social work s is both the most defined content-wise and the most common (48%) form of cooperation, followed by educational and humanitarian organisations in terms of the number of contacts established (39%).

10. DRUG MARKETS

According to Slovenian legislation, the police are the sole body responsible for the seizure of items which may serve as evidence in a criminal procedure. As such, the Customs Administration of the Republic of Slovenia alerts the police upon discovering illicit drugs; the latter than carry out the seizure. The Slovenian police systematically collect and process data on seized illicit drugs and their prices. Based on these data, an estimate on the availability of individual drugs on the Slovenian market can be made. Data on drug quality and purity are only available for certain commonly seized drugs. The 2013 sampling, analysis and processing of the results was once again carried out by the National Forensic Laboratory, which has carried out annual monitoring since 2006.

In 2013, the recorded quantities of seized amphetamine, benzodiazepine, methamphetamine, ecstasy and cannabis in the form of marijuana were significantly larger compared to 2012, while the seized quantities of heroin, cocaine and hashish were smaller. The total number of seizures of illicit drugs has risen compared to preceding years. The supply and sale of synthetic drugs are also on the rise, and the number of discovered new psychoactive substances has also increased. Slovenia is considered a drug consumer country and a transit state for drug smuggling, with certain quantities of specific drugs staying within Slovenian territory. The traditional Balkan smuggling route remains highly active and bidirectional; the scope of smuggling is estimated to have risen. Heroin and cannabis are transported from Kosovo, north-eastern Albania and Macedonia to the countries of the European Union, while synthetic illicit drugs and, for the most part, cocaine are smuggled in the opposite direction. International crime syndicates are active in Slovenia; their Slovenian members are primarily responsible for the organisation, logistical support and supply of illicit drugs to the European market. Criminal organisations engaged in cannabis cultivation are also highly active. In 2013, the Slovenian police discovered and destroyed 70 enclosed spaces modified to grow cannabis. Compared to 2012, the prices of illicit drugs have slightly decreased, which is largely due to increased supply. This is particularly true of amphetamine.

In 2013, monitoring involved 715 samples of heroin mixtures, 490 samples of cocaine mixtures, 1150 cannabis samples and 3 hashish samples, 235 amphetamine samples and 18 MDMA samples. All heroin samples contained heroin in base form; its average concentration was 9% and thus similar to preceding years. All cocaine samples contained cocaine in hydrochloride form and contained 51.4% of cocaine on average, which is higher than in previous years. The average concentration of THC in cannabis plants was similar to previous years, while the average concentration of THC in hashish was higher than previously at 5.8%. The average concentration of amphetamine was also higher, at 8.7%, while the average MDMA content in analysed samples was 40.2%. 12 new psychoactive substances were discovered in Slovenia in 2013.

10.1 Supply and Seizures

Staša Šavelj

The Slovenian police systematically collect and process data on seized illicit drugs as well as data on prices of individual illicit drugs. Based on these data and operational findings, an estimate of the availability of individual drugs in the Slovenian market can be made.

In 2013, a significant increase in the seized quantities of amphetamine, benzodiazepine, methamphetamine, ecstasy (powder) and cannabis in the form of marijuana was recorded. Similarly to 2012, there was a significant decrease in the seizures of heroin, cocaine and hashish (Table 10.1).

Table 10.1: Total quantity of seized illicit drugs by type of illicit drug, 2009–2013

Type of illicit drug	Unit	2009	2010	2011	2012	2013
Heroin	Kg	41.787	36.203	4.394	20.34	7.65
Cocaine	Kg	2.867	2.012	1.697	26.82	3.31
Ecstasy	Tabs	16.872	399	33.5	960	922
	Kg	0.0361	0.003	0.007	0	0.85
Amphetamine	Tabs	778	7,524	150	80	307
	Kg	3.214	2.831	0.724	9.28	15.12
Cannabis plant	Pcs	9,373	9,278	12,836	11,166	9,515
Cannabis marijuana	Kg	242.025	188.760	613.045	706.06	809.59
Cannabis resin – hashish	Kg	0.689	0.224	4.240	2.56	0.52
Benzodiazepines	Tabs	5,116	1,927	5,012	3,251	14,620
Methadone	Ml	5,111.4	3,654.1	926.92	2,670.00	2,093.7
Methamphetamine	Kg	0.003	0	0.124	0.05	0.54
	Tabs	0	0	61	43	110

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

The total number of seizures of illicit drugs in criminal and minor offences has increased in comparison to previous years (Table 10.2), owing to greater police efforts in the field of illicit drugs. Due to an increase in seizures of amphetamine, methamphetamine, ecstasy and benzodiazepine, higher quantities of these illicit drugs were seized. It was found that a very vibrant illicit drug market has developed in Slovenia and that the supply and sale of synthetic illicit drugs are on the rise. On the other hand, a considerable decrease in heroin and cocaine seizures was recorded once again. The trend of slight increases in cannabis seizures continues, partly due to the larger supply on the market.

Table 10.2: Number of seizures by type of illicit drug, categorised by minor and criminal offences, 2009–2013

	2009			2010			2011			2012			2013		
	MO	CO	Total	MO	CO	Total	MO	CO	Total	MO	CO	Total	MO	CO	Total
Heroin	487	285	772	441	279	720	285	218	503	245	194	439	174	165	339
Cocaine	158	113	271	145	133	278	167	105	272	142	109	251	102	94	196
Ecstasy	8	8	16	4	5	9	9	5	14	12	4	16	37	16	53
Amphetamine	111	46	157	135	62	197	166	38	204	146	44	190	167	74	241
Cannabis plant	219	83	302	85	93	178	87	91	178	80	94	174	97	115	212
Cannabis marijuana	2,285	460	2,745	2,600	490	3,090	2,790	516	3,306	2,697	653	3,350	3,000	673	3,673
Cannabis resin – hashish	74	9	83	48	9	57	67	22	89	51	15	66	58	15	73
Benzodiazepines	67	49	116	56	40	96	92	42	134	54	32	86	84	52	136
Methadone	62	23	85	50	14	64	29	11	40	38	9	47	38	17	55
Methamphetamine	1	1	2	0	0	0	8	10	18	5	8	13	11	21	32
Total			4,549			4,689			4,758			4,632			5,010

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

Based on available data, Slovenia is considered a drug consumer country, and a transit or intermediate country for the smuggling of illicit drugs, with certain quantities of illicit drugs staying within Slovenian

territory. The amount of illicit drug seizures at border crossings has decreased both quantity-wise as well as in terms of the number of seizures.

The traditional Balkan Route still sees high activity in illicit drug smuggling in both directions, and it is estimated that the scope of smuggling has increased. Heroin and cannabis are transported from Kosovo, north-eastern Albania and Macedonia to the countries of the European Union, while synthetic illicit drugs as well as, for the most part, cocaine are transported in the opposite direction. Amphetamine appears to arrive mainly from the Netherlands.

International organised criminal syndicates are active on Slovenian territory; their Slovenian members as criminal offenders primarily engage in the organisation, logistic support and the supply of illicit drugs to the European market. These are mostly minor organisations the members of which seek out connections with other crime syndicates from other Western Balkan and EU states. International organised crime syndicates adapt fully to the trends in supply and demand of illicit drugs.

No active laboratory for the production of synthetic drugs or cocaine and heroin has been discovered in Slovenia. However, there is still an upward trend in the activity of criminal groups engaged in the cultivation of cannabis in enclosed spaces modified for the purpose. Listed below are data on such discovered spaces in Slovenia over the last 4 years (Table 10.3). Although the upward trend in discovered spaces stabilised in 2013, that is only the current situation, as there has been a further increase in the number of discovered and destroyed spaces modified for cannabis cultivation in 2014. It is still assumed that the reasons behind the large number of such spaces are primarily financial. Individual criminal groups or individuals are able to acquire disproportionate financial gain from a very small, legal investment. Based on the available data, it is believed the sale of cannabis grown in this manner is limited to the Slovenian territory.

Table 10.3: Number of discovered spaces modified for cannabis cultivation, 2010–2013

	2010	2011	2012	2013
Number of spaces modified for cannabis cultivation	42	52	75	70

Source: Ministry of the Interior, General Police Directorate

New discoveries of new psychoactive substances available on the Slovenian market are still increasingly common. It is often discovered that a seized drug thought to be amphetamine is actually a new psychoactive substance. Such substances are most commonly first discovered by customs authorities, particularly during the control of shipments, or samples of new psychoactive substances are obtained by non-governmental organisations. The Decree on the Scheduling of Illicit Drugs is amended as new psychoactive substances are discovered.

10.2 Availability

Prices of Illicit Drugs

Staša Šavelj

The Slovenian police systematically collect and analyse data on the prices of illicit drugs available on the market. Data on prices are obtained through operative activities carried out both by criminal and uniformed police, and during the implementation of undercover investigative measures based on the decrees by competent public prosecutors and investigating judges.

Table 10.4 shows the prices of illicit drugs most commonly sold in Slovenia. The table lists minimum and maximum prices as well as the average price. The price is most commonly determined by the purity of the drug, supply on the market and the region in which it is sold.

According to our data, the prices of amphetamine continue to drop; this is believed to be due to the high increase in the supply of the drug on the Slovenian market. The fall in value was also affected by the increase in the supply of other illicit drugs. The reason behind the decrease in the price of the cannabis plant is still believed to be due to the increasing supply of high-quality cannabis grown in modified enclosed spaces.

Table 10.4: Prices of illicit drugs in Slovenia in EUR, 2013

Type of illicit drug		1 gram	1 kg	1 tab	1000 tabs
Heroin	Min.	20	10,000		
	Max.	50	25,000		
	Typical	40	16,000		
Cocaine	Min.	35	20,000		
	Max.	120	55,000		
	Typical	60	42,000		
Ecstasy	Min.			3	1,500
	Max.			10	5,000
	Typical			5	3,000
Amphetamine	Min.	5	1,500		
	Max.	30	3,500		
	Typical	10	3,000		
Cannabis marijuana	Min.	4	1,300		
	Max.	10	4,000		
	Typical	5	2,500		

Source: Ministry of the Interior, General Police Directorate

Quality and Purity of Illicit Drugs

Sonja Klemenc, PhD, Mojca Janežič, Katja Benčina, PhD, Rajko Koren, Nemec Brigita, Bojana Koštrun

Data on the quality and purity of drugs are only available on certain seized drugs. The National Forensic Laboratory, which has carried out regular annual monitoring since 2006 (since 1995 for heroin mixtures), also carried out the sampling, analysis and processing of results in 2013. NFL performs qualitative (identification) and, to a limited extent, quantitative (concentration of active compounds) analyses of all drug samples in connection to criminal investigations. It also analyses precursors used in illicit drug production, new psychoactive substances (NPS) and samples brought to NGOs by drug users who suspect that samples may contain unusual substances and/or experience unexpected effects with drug use.

Quantitative analysis is carried out primarily for monitoring purposes, and less frequently at the request of clients (the police, prosecution, courts of law). Samples are collected in accordance with pre-set criteria as part of routine inspections of the material received. Quantitative analysis is only performed

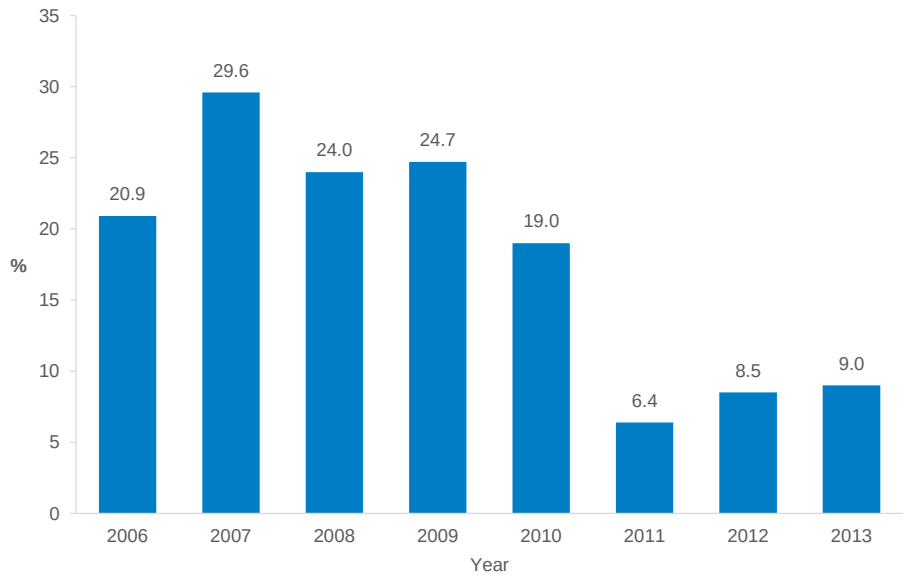
on samples the weight of which exceeds a certain lower limit (in 2013: over 0.1 g of heroin, cocaine, amphetamine or other amphetamine-type compounds; and over 10 g of cannabis or hashish). The number of samples for analysis may be reduced in individual cases, namely in the cases in which populations of many similar samples were seized. In such cases, the number of samples for analysis is determined statistically by using the hypergeometric sampling tool (ENFSI 2012). Similarity assessment is based on the weight of the seized material, its texture, colour, type of drug and the results of preliminary testing and qualitative analysis.

Qualitative and quantitative chemical tests are performed using a number of analytical methods, mainly GC-MS and HPLC. Illegal substance concentrations in samples are always expressed as base forms. For cannabis, the total concentration of THC (tetrahydrocannabinol) is given, i.e. the sum concentrations of delta-9-THC and THCA. The proportion of total THC content is always determined in dried plant material.

NFL reports the results to domestic (National Institute of Public Health) and international institutions (UNODC and EMCDDA).

Heroin Mixtures

In 2013, 715 samples seized in 179 cases with a total net weight of approximately 10 kg were analysed as part of the monitoring (some samples with a total weight of approximately 3 kg were seized in 2012 but analysed in 2013). All samples contained heroin in base form, the typical accompanying opium-derived heroin compounds, as well as added paracetamol and caffeine. The average concentration of heroin (calculated for a population of 715 samples) was 9%, which is comparable to 2012 data (Figure 10.1). The highest and the lowest measured concentrations in 2013 were 50.9% and 1.2%, respectively. The low average concentration of heroin (compared to the pre-2011 period) is most likely due to the lack of heroin resulting from the low opium yield in Afghanistan (UNODC 2011, UNODC 2012).

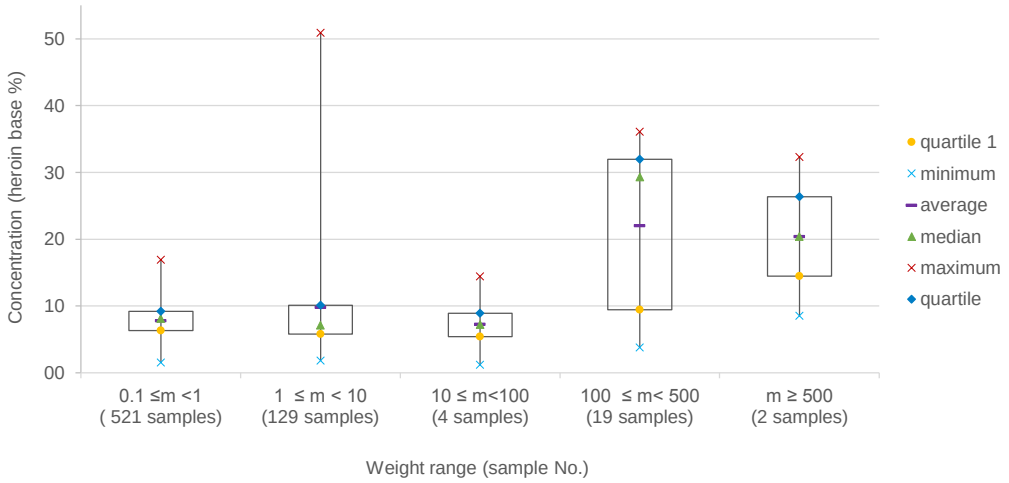


Source: National Forensic Laboratory

Figure 10.1: Average heroin concentrations, 2006–2013

Figure 10.2 shows the relationship between the concentration of heroin and the net weight of seized samples in more detail. As can be seen, the largest group of the tested samples consisted of “street heroin samples” weighing up to 1 g (521 samples). 70% of this group contained between approximately

6% and 17% of heroin (Figure 10.2). The group of samples with net weights exceeding 100 g (21 samples), which may be labelled “wholesale samples”, has a slightly different concentration profile (Figure 10.2). Approximately 50% of samples from this group contain approximately 30% of heroin. The average content of heroin is about 22%. Although this population is small, the above data suggest that heroin mixtures are further diluted with other substances (most commonly with additional quantities of paracetamol and caffeine) at the local distribution level.

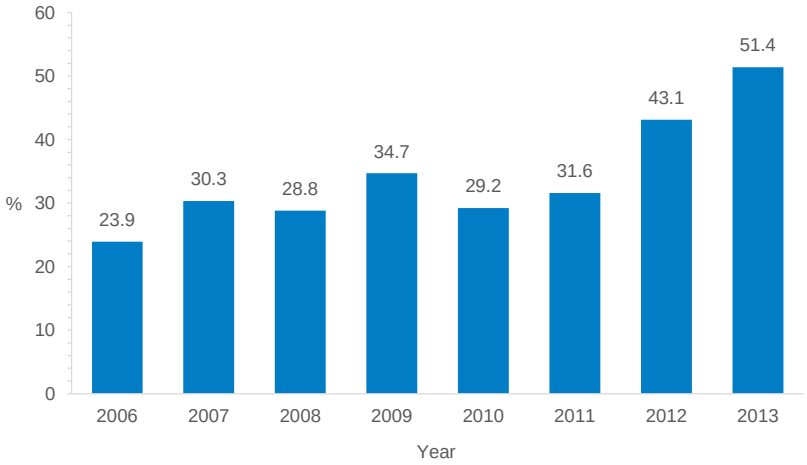


Source: National Forensic Laboratory

Figure 10.2: Heroin concentration in relationship to the net sample weight, 2013

Cocaine Mixtures

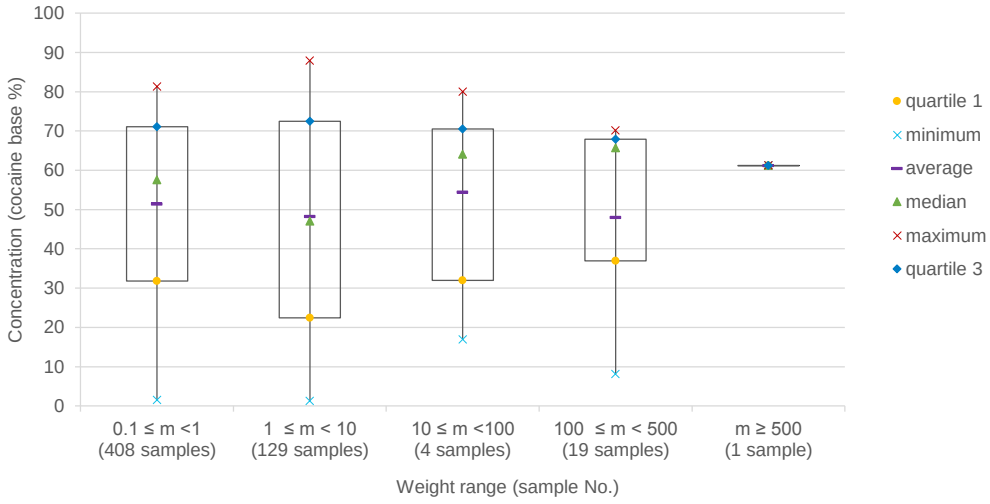
490 samples from 90 seizures were analysed as part of the monitoring. All samples contained cocaine in a hydrochloride form. Compared to previous years, the established average cocaine content was slightly higher, amounting to 51.4% (Figure 10.3). The lowest and the highest cocaine content was 1.3% and 87.9%, respectively. The total net weight of monitored samples was approximately 3.3 kg. Most common cutting agents detected in cocaine were levamisole and lidocaine, which is similar to the data from previous years.



Source: National Forensic Laboratory

Figure 10.3: Average cocaine concentration, 2006–2013

Figure 10.4 shows the relationship between the concentration of cocaine and the net weight of seized samples in more detail. As can be seen, the largest group of the tested samples consisted of “street cocaine samples” weighing up to 1 g (408 samples). 80% of this group contained between approximately 1.5% and 81% of cocaine.

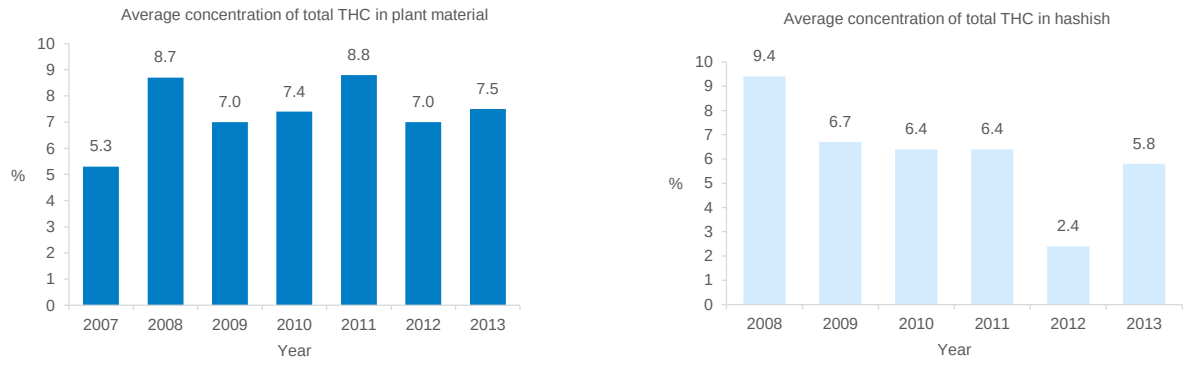


Source: National Forensic Laboratory

Figure 10.4: Cocaine concentration in relation to the net sample weight, 2013

Cannabis and Cannabis Products

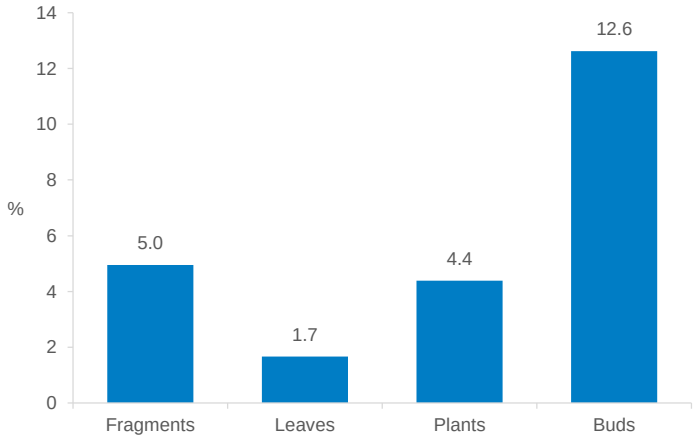
A population of 1150 samples of cannabis seized in 238 cases and 3 samples of hashish seized in 3 cases were analysed as part of the monitoring. The average concentration (Figure 10.5) of total THC in plant material was similar to those from previous years (average 7.5%; minimum 0.1%; maximum 26.8%), while the average concentration of total THC in hashish samples was higher than in 2012 and similar to those between 2009 and 2011 (average 5.8%; minimum 0.6%; maximum 9%).



Source: National Forensic Laboratory

Figure 10.5: Average concentration of total THC in seized cannabis samples (marijuana and hashish), 2006–2013

Average total THC content by type of material (crushed plant fragments; cannabis leaf only; whole plants, where both leaves and buds were sampled for analysis; cannabis buds only) is shown in Figure 10.6.

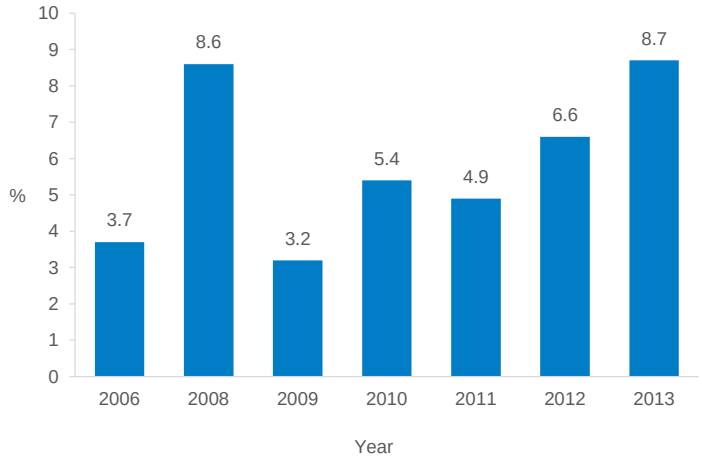


Source: National Forensic Laboratory

Figure 10.6: Average concentration of total THC by sample type, 2013

Amphetamine-Type Stimulants and New Psychoactive Substances

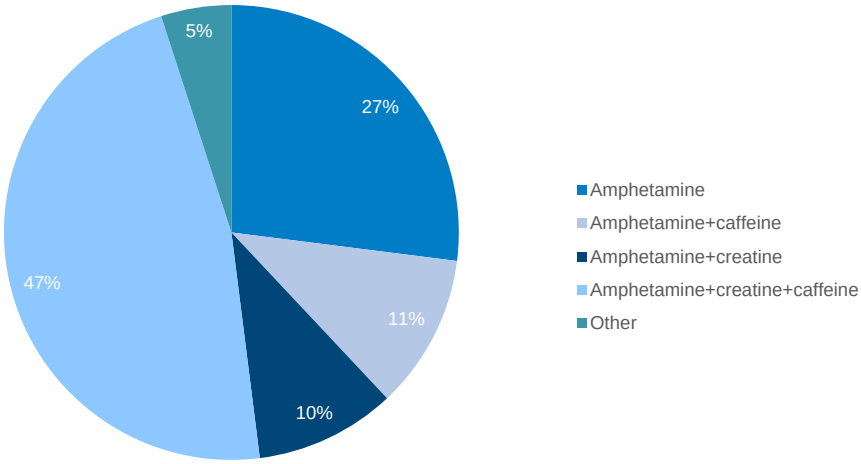
The majority of samples seized in 2013 contained amphetamine. 3,4-methylenedioxy-N-methamphetamine (MDMA) and methamphetamine seizures were rarer. The average concentration of amphetamine in a population of 235 samples from 52 cases was slightly higher than in 2012, i. e. 8.7% (Figure 10.7). The lowest and highest concentrations were 0.5% and 73%, respectively. The average MDMA content determined in the 18 samples seized in 8 cases was 40.2%, with the lowest and the highest concentrations being 2.5% and 83%, respectively.



Source: National Forensic Laboratory

Figure 10.7: Average amphetamine concentration, 2006–2013 (no data for 2007)

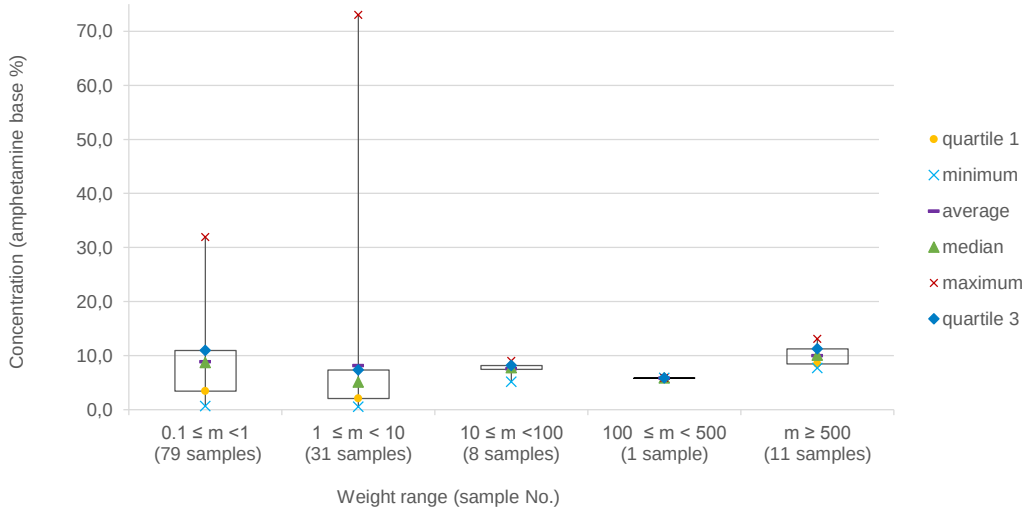
The National Forensic Laboratory also detected certain cutting agents in amphetamine samples (e.g. creatine, caffeine), but it did not test the samples for sugars. The composition of samples with respect to cutting agents is presented in Figure 10.8. 47% of amphetamine samples contained creatine and caffeine. Caffeine was the only cutting agent in 12% of the samples, creatine was the only proven cutting agent in 10% of the samples, while 27% of the samples only contained amphetamine, with no active cutting agents.



Source: National Forensic Laboratory

Figure 10.8: Share of amphetamine samples by cutting agent, 2013

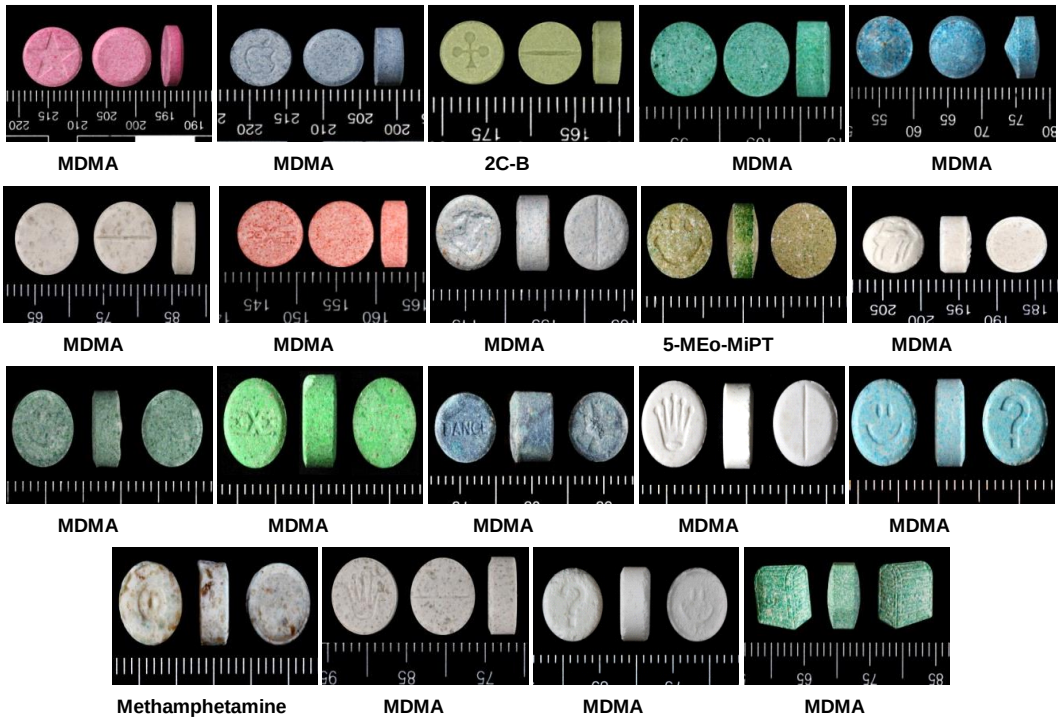
Figure 10.9 shows the relationship between the concentration of amphetamine and the net weight of seized samples in more detail. As can be seen, the average concentration is of approximately of the same order of magnitude regardless of the weight of the seized sample. Higher concentrations were only detected in a few individual samples.



Source: National Forensic Laboratory

Figure 10.9: Amphetamine concentration in relation to the net sample weight, 2013

In 2013, the Slovenian police seized 19 new types of ecstasy pills. 84% of new types of ecstasy pills contained MDMA, while the remainder contained other substances (Figure 10.10). The approximate average weight of MDMA in the pills was assessed to be 80 mg per pill. No other active components were subject to quantitative analysis.



Source: National Forensic Laboratory

Figure 10.10: Types of pills seized in Slovenia, 2013

In 2013, the National Forensic Laboratory analysed 24 cases in which it proved the presence of 12 new psychoactive substances (Table 10.5). In July 2013, the Republic of Slovenia included 48 new psychoactive substances in the Decree on the Scheduling of Illicit Drugs (Official Gazette of the RS, No. 62/13; cf. Chapter 1).

Table 10.5: Seized new psychoactive substances, 2013

Substance	No. of seizures	Total quantity seized
JWH-122	4	1.80 g
MPA/methiopropamine MPA	1	0.14 g
25C-NBOMe	1	1 pc. of blotting paper
Methylone/ bk-MDMA	4	7.87 g
AM-2201	2	28.66 g
5-MeO-MiPT	4	3.89 g
5F-AKB48 (AKB-48F, 5F-APINACA)	2	0.75 g
Methoxetamine	1	0.04 g
3-MMC	2	0.64 g
Pentedrone	2	270.71 g
4-chloro-2,5-dimethoxyamphetamine(DOC)	1	0.01 g
DMT-fumatrate*	1	0.04 g

* The compound was inconclusively confirmed by GC-MS on the basis of mass spectrum only – reference material was not available.

Source: National Forensic Laboratory

PART B:

BIBLIOGRAPHY, ANNEXES

BIBLIOGRAPHY

List of References

Auer, V. (2001). Droge in odvisnost. Ormož: Samozaložba Ibidem.

Bajt, M. (2012). Trendi v uporabi marihuane. In: Jeriček Klanšček, H., Koprivnikar, H., Zupanič, T., Pucelj, V., Bajt, M. (eds.) Spremembe v vedenjih, povezanih z zdravjem mladostnikov v Sloveniji v obdobju 2002–2010. Ljubljana: Inštitut za varovanje zdravja Republike Slovenije.

Benedik, E. (2003). Antisocialne značilnosti osebnosti uživalcev opiatnih drog. Revija za kriminalistiko in kriminologijo, 54, 25, 172 - 178.

Boben, D. (ed.) (1997). Eysenckove osebnostne lestvice. Priročnik. Ljubljana: Produktivnost, d.o.o., Center za psihodiagnostična sredstva.

Bodin, M.C. and Strandberg, A.K. (2011). The Orebro prevention programme revisited: A cluster-randomized effectiveness trail of programme effects on youth drinking. Addiction, 106, 2134-2143.

Dernovšek, Z. M. (2003). Preprečevanje samomora v primernem zdravstvu. Slovenija s samomorom ali brez. Ljubljana: DZS.

Donovan, D. M., and Marlatt, G. A. (2005). Assessment od addictive behaviors. 2nd ed. New York, London: The Guilford press.

Drev, A. (ed.) (2013). Report on the Drug Situation 2013 of the Republic of Slovenia. Ljubljana: National Institute of Public Health of the Republic of Slovenia.

Drev, A., Štokelj, R., Krek, M. (eds.) (2012). Report on the Drug Situation 2012 of the Republic of Slovenia. Ljubljana: Institute of Public Health of the Republic of Slovenia.

Drev, A., Štokelj, R., Krek, M. (eds) (2011). Report on the Drug Situation 2011 of the Republic of Slovenia. Ljubljana: Institute of Public Health of the Republic of Slovenia.

Društvo Projekt Človek. (1995 – 2014). Interno gradivo in evidence Društva projekt Človek. Ljubljana: Društvo Projekt Človek.

IRSSV (2014). Končna poročila o izvajanju programov socialnega varstva v obdobju od 1. 1. 2013 do 31. 12. 2013. Arhiv IRSSV. Ljubljana: IRSSV.

Kastelic, A. and Kostnapfel, T. (2010). Opioid substitution treatment programs in Slovenia. Zdrav Vestn; 79: 575-81.

Kastelic, A. and Mikulan, M. (2004). Mladostnik in droga. Ljubljana: Prohealth.

Kern-Scheffeldt, W. et al. (2012). Evaluation Take care: Strategies towards Responsible Alcohol Consumption for Adolescents in Europe. Zürich: Zürich University of Teacher Education.

Klavs, I. and Poljak, M. (2003). Unlinked anonymous monitoring of human immunodeficiency virus prevalence in high and low risk groups in Slovenia, 1993–2002. Croat Med J; 44 (5): 545–9.

Kokole, D. (2013) Socialne spretnosti, dovzetnost za vrstniški pritisk in uživanje alkohola pri srednješolcih. Diplomsko delo (bachelor thesis). Ljubljana: Univerza v Ljubljani.

Koning, I.M., van der Eijnden, R.J., Verdurmen, J.E., Engels, R.C., Vollebergh, W.A. (2011). Long-term effects of a parent and student intervention on alcohol use in adolescents: A cluster randomized controlled trial. American Journal of Preventive Medicine, 40(5): 541-547.

Koutakis, N. and Ozdemir, M. (2010). Latent growth curve analysis taking clustered data into account on a quasi-experimental parent targeted intervention trial: The Orebro Prevention Program. Centre for Development at the Research School of Law, Psychology, and Social Work, Orebro University, Orebro, Sweden.

Koutakis, N., Stattin, H. and Kerr, M. (2008). Reducing youth alcohol drinking through a parent-targeted intervention: the Örebro Prevention Program. Addiction, 103, 1629-1637.

Krek, M. and Drev, A. (eds) (2010). Report on the Drug Situation 2010 of the Republic of Slovenia. Ljubljana: Institute of Public Health of the Republic of Slovenia.

Krek, M., Drev, A., Cerar, M., Štokelj, R (eds.) (2009). Report on the Drug Situation 2009 of the Republic of Slovenia. Ljubljana: Institute of Public Health of the Republic of Slovenia.

Krek, M. and Štokelj, R. (2009). Drug use in the general population. In: Krek, M., Drev, A., Cerar, M., Štokelj, R. (eds.). National Report on the Drug Situation 2009 of the Republic of Slovenia. Ljubljana: Institute of Public Health of the Republic of Slovenia.

Kvaternik, I. and Novakovič, S. (2013). Prevalence Estimate of Problem Drug Use. In: Drev, A. (ed.): Report on the Drug Situation 2013 of the Republic of Slovenia. Ljubljana: Institute of Public Health of the Republic of Slovenia.

Loeber, R., Farrington, D. P., Stouthamer-Loeber, M., Raskin White, H. (2008). Violence and serious theft. New York: Routledge.

Marlowe, D. B. (2011). Evidence-based policies and practices for drug-involved offenders. The Prison Journal, 91 (3), 27 - 47.

Maticic, M., Brinovec, V., Lešničar, G., Vidmar, L., Meglič-Volkar, J. (1999). Hepatitis C in Slovenia. ISIS; 8: 49–51.

Maticic, M. and Kastelic, A. (2009). National guidelines for the management of hepatitis C virus infection in drug users in Slovenia. Zdrav Vestn; 78: 529-39.

Miller, W. R. and Rollnick, S. (2002). Motivational Interviewing. The Guilford Press, New York.

Ministrstvo za delo, družino, socialne zadeve in enake možnosti. (2014). Izpis iz BSP. Neobjavljeni podatki. Ljubljana: Ministrstvo za delo, družino, socialne zadeve in enake možnosti. (unpublished)

Ministrstvo za zdravje. (2014) Raziskava javnega mnenja o podpori ukrepom na področju tobaka in alkohola. Ljubljana: Ministrstvo za zdravje. (unpublished)

NIJZ (2014). Epidemiološko spremljanje nalezljivih bolezni v Sloveniji v 2013. Ljubljana: Nacionalni inštitut za javno zdravje.

NIJZ, OE Maribor (2014). Poročilo Nacionalnega inštituta za javno zdravje, območne enote Maribor. Maribor: Nacionalni inštitut za javno zdravje, OE Maribor. (unpublished)

NIJZ, OE Koper (2013). Baza podatkov o izmenjavi sterilnega pribora. Koper: Nacionalni inštitut za javno zdravje, OE Koper.

Ozdemir, M. and Stattin, H. (2012). Does the Orebro Prevention Programme prevent youth drinking? Addiction, 107, 1705-1706.

Packer, G., Best, D., Day, E., Wood, K. (2009). Criminal thinking and self-control among drug users in court mandated treatment. Criminology and Criminal Justice, 9(1), 93 - 110.

Raskin White, H., Loeber, R., Farrington, D. P. (2008). Substance use, drug dealing, gang membership, and gun carrying and their predictive associations with serious violence and serious theft. In: Loeber, R., Farrington, D. P., Stouthamer-Loeber, M., in Raskin White, H. (2008). Violence and serious theft. New York: Routledge.

Rogers, R., Cashel, M. L., Johansen, J., Sewell, K. W., Gonzalez, C. (1997). Evaluation of adolescent offenders with substance abuse: validation of the SASSI with conduct-disordered youth. Criminal Justice and Behavior, 24 (1), 114 - 128.

Sande, M. (2013). Uporaba kokaina v nočnem življenju v Sloveniji in Italiji. In: Drev, A. (ed). Nacionalno poročilo 2013 o stanju na področju prepovedanih drog v Republiki Sloveniji, Ljubljana: Inštitut za varovanje zdravja Republike Slovenije.

Scagnetti, N. (2011). Kajenje marihuane. In: Jeriček Klanšček, H., Roškar, S., Koprivnikar, H., Pucelj, V., Bajt, M., Zupanič, T. (eds.) Neenakosti v zdravju in z zdravjem povezanih vedenjih slovenskih mladostnikov. Ljubljana: Inštitut za varovanje zdravja Republike Slovenije..

Smolej, S., Žiberna, V., Kovač, N. (2014). Spremljanje izvajanja programov socialnega varstva: poročilo o izvajanju programov v letu 2013: končno poročilo. Ljubljana: Inštitut Republike Slovenije za socialno varstvo.

Stergar, E. (2011). ESPAD. In: Drev, A., Štokelj, R., Krek, M. (eds.) Nacionalno poročilo 2012 o stanju na področju prepovedanih drog v Republiki Sloveniji, Ljubljana: Inštitut za varovanje zdravja Republike Slovenije.

Stergar, E. (2010). Razširjenost uporabe prepovedanih psihoaktivnih snovi v splošni populaciji 18–65 let v Sloveniji. In: Krek, M., Drev, A. (eds.) Nacionalno poročilo 2010 o stanju na področju prepovedanih drog v Republiki Sloveniji. Ljubljana: Inštitut za varovanje zdravja Republike Slovenije.

Stoové, M.A., Dietze, P.M., Jolley, D. (2009), Overdose deaths following previous non-fatal heroin overdose: record linkage of ambulance attendance and death registry data. Drug and Alcohol Review; 28: 347 – 52.

Toš, N. and group (1999). Stališča o zdravju in zdravstvu III. Slovensko javno mnenje 1999/2; Mednarodna raziskava o kakovosti življenja. Ljubljana: Fakulteta za družbene vede, CJMMK.

Toš, N., Mlinar, Z. and group (1994). Slovensko javno mnenje 1994/1. Ljubljana: Fakulteta za družbene vede, CJMMK.

Towl, G. J. and Crighton, D. A. (2010). Forensic Psychology. West Sussex, UK: Blackwell Publishing Ltd.

UNODC (2011). The opium/heroin market. In: UNODC World drug report 2011. Vienna: UNODC.

UNODC (2012). Illicit opiate market. In: UNODC World drug report 2012. Vienna: UNODC.

Uprava RS za izvrševanje kazenskih sankcij (2010). Strokovna navodila za obravnavo zaprtih oseb uživalcev drog. Interno gradivo. (Non-published material)

Uprava RS za izvrševanje kazenskih sankcij (2010). Navodila o oddajanju urina in izvedbi kontrolnega preizkusa. Interno gradivo. (Non-published material)

Wirth, N. et al. (2013). Take care Manual: Strategies towards responsible alcohol consumption for adolescents in Europe. Münster: LWL.

Wojtowicz, J. P., Liu, T., Hedgpeth, G. W., (2007). Factors of Addiction. Crime & Delinquency, 53 (3), 471 - 501.

Zorko, M. et al. (2013). Alkohol v Sloveniji: trendi v načinu pitja, zdravstvene posledice škodljivega pitja, mnenja akterjev in predlogi ukrepov za učinkovitejšo alkoholno politiko. Ljubljana: Inštitut za varovanje zdravja Republike Slovenije.

Žabkar A. (2012) Poročilo o terenskem delu. Hitri posnetek stanja na področju uživanja in odnosa do PAS med mladostniki v Kopru. Koper: Društvo Svit Koper. E-publication.

Internet Sources

Aftertaxi. Available at: www.aftertaxi.si

EMCDDA (2014). Evropsko poročilo o drogah 2014: Trendi in razvoj. Lizbona, Portugalska, 2014. Available at: http://www.emcdda.europa.eu/attachements.cfm/att_228272_EN_TDAT14001ENN.pdf.

ENFSI (2012). Hypergeometric sampling tool, background of calculation and validation, version 2012, Available at: http://www.enfsi.eu/sites/default/files/documents/external_publications/dwg-sgl-002-vers001_hypgergeometric_calculationbackground_and_validation_2012-12-07.pdf

Furam 0,0. Available at: www.furam00.izberisam.org

Izberi sam. Available at: www.izberisam.org

Klavs, I. et. al (2014) Okužba s HIV v Sloveniji v 2013. Ljubljana: Nacionalni inštitut za javno zdravje, 2014. Available at: http://www.ivz.si/hiv_spo

Košir, M., Talić, S. in Jelen, V. (2012). Analiza stanja v preventivi. Preventivna platforma. Bilten št. 20 (avgust 2012). Vsebinska mreža »Preventivna platforma«. Ljubljana. Available at: http://www.preventivna-platforma.si/docs/Preventivna_platforma_e-novice_20.pdf.

REDUSER. Available at: www.reduser.drogart.org

Skupno poročilo o delu državnih tožilstev za leto 2013. Available at: http://www.dt-rs.si/uploads/documents/letno%20porocilo/porocilo-2013.pdf

SRAP project. Available at: www.srap-project.eu

Statistični urad Republike Slovenije. (2012). Osnovne skupine prebivalstva po spolu, Slovenija, četrtletno. Available at: http://www.stat.si/ (25. 8. 2014).

Uprava za izvrševanje kazenskih sankcij. (2012). Letno poročilo MPJU 2011. Available at: http://www.mp.gov.si/fileadmin/mp.gov.si/pageuploads/UIKS/Letna_porocila/LP_2012.pdf (1.7.2014)

Zdravje, preprečevanje zasvojenosti in romska mladina v Evropi. Available at: http://issuu.com/ricnm/docs/handbook-issuu).

List of Laws

Kazenski zakonik. Uradni list RS, št. 55/08, 66/08 - popr., 39/09, 91/2011 in 50/2012. / Criminal Code. Official Gazette RS, No. 55/08, 66/08 - amended, 39/09, 91/2011 and 50/2012.

Pravilnik o izvrševanju kazni zapora. Uradni list RS, št. 102/2000. / Rules on the Implementation of Prison Sentences. Official Gazette RS, No. 102/2000.

Resolucija o nacionalnem programu na področju drog 2014–2020. Uradni list RS št. 24/2014. / Resolution on the National Programme on Illicit Drugs 2014–2020. Official Gazette of the RS, No. 24/2014.

Resolucija o nacionalnem programu socialnega varstva za obdobje 2013–2020. Uradni list RS, št. 39/2013. / Resolution on the National Programme of Social Care 2013–2020. Official Gazette RS, No. 39/2013.

Uredba o dopolnitvi Uredbe o razvrstitvi prepovedanih drog. Uradni list RS, št. 62/2013, 45/2014. / Decree Amending the Decree on the scheduling of Illicit Drugs. Official Gazette RS, No. 62/2013, 45/2014.

Uredba o spremembah Uredbe o določitvi zneska trošarine za alkohol in alkoholne pijače. Uradni list RS št. 25/2014. / Decree determining the amount of excise duty on alcohol and alcoholic beverages. Official Gazette RS, No. 25/2014.

Zakona o državnem tožilstvu. Uradni list RS, št. 58/11, 21/12 - ZDU-1F, 47/12, 15/13 - ZODPol, 47/13 - ZDU-1G in 48/13 - ZSKZDČEU-1. / Prosecutor's Office Act. Official Gazette RS, No. 58/11, 21/12 - ZDU-1F, 47/12, 15/13 - ZODPol, 47/13 - ZDU-1G and 48/13 - ZSKZDČEU-1.

Zakon o izvrševanju kazenskih sankcij. Uradni list RS, št. 109/2012. / Enforcement of Criminal Sanctions Act. Official Gazette RS, No. 109/2012.

Zakon o kazenskem postopku. Uradni list RS, št. 32/12 in 47/13. / Criminal Procedure Act. Official Gazette RS, Nos. 32/12 and 47/13.

Zakon o omejevanju porabe alkohola – ZOPA. Uradni list RS, št.15/2003. / Act Restricting the Use of Alcohol - ZOPA Official Gazette RS, No. 15/2003.

Zakon o omejevanju uporabe tobačnih izdelkov, uradno prečiščeno besedilo (ZOUTI). Uradni list RS, št. 93/2007. / Restriction of the Use of Tobacco Products Act (ZOUTI). Official Gazette RS, No. 93/2007.

Zakon o pravilih cestnega prometa. Uradni list RS, št. 109/2010, 57/2012. / Act of Rules in Road Transport entered into force. Official Gazette RS, Nos. 109/2010, 57/2012.

Zakon o prekrških. Uradni list RS, št. 9-318/2011. / Minor Offences Act. Official Gazette RS, No. 9-318/2011.

Zakon o preprečevanju uporabe prepovedanih drog in obravnavi uživalcev prepovedanih drog. Uradni list RS. 98/1999. / Act Regulating the Prevention of the Use of Illicit Drugs and the Treatment of Drug Users. Official Gazette RS, No. 98/1999.

Zakon o proizvodnji in prometu s prepovedanimi drogami. Uradni list RS, št. 108/1999, 44/2000, 2/2004 in 47/2004. / Production of and Trade in Illicit Drugs Act. Official Gazette RS, Nos. 108/1999, 44/2000, 2/2004 and 47/2004.

Zakon o referendumu in ljudski iniciativi. Uradni list RS, št. 15/94, 26/07. / Referendum and Popular Initiative Act. Official Gazette of the RS, Nos. 15/94, 26/07.

Zakon o socialnem varstvu. Uradni list RS, št. 3/2007 in naslednji. / Social Security Act. Official Gazette RS, No. 3/2007 and following.

Zakon o socialnovarstvenih prejemkih. Uradni list RS, št. 61/2010 in naslednji. / Financial Social Assistance Act. Official Gazette RS, No. 61/2010 and following.

Zakon o sodiščih. Uradni list RS, št. 94/07, 45/08, 96/09, 86/10 - ZJNepS, 33/11, 75/12 - ZSPDSLS-A in 63/13. / Courts Act. Official Gazette RS, Nos.94/07, 45/08, 96/09, 86/10 - ZJNepS, 33/11, 75/12 - ZSPDSLS-A and 63/13.

Zakon za uravnoteženje javnih financ. Uradni list RS, št. 40/2012. / Fiscal Balance Act. Official Gazette RS, No. 40/2012.

Zakon o uveljavljanju pravic iz javnih sredstev. Uradni list RS, št. 62/2010 in naslednji. / Exercise of Rights to Public Funds Act. Official Gazette RS, No. 62/2010 and following.

ANNEXES

List of Tables of the Text

List of Figures in the Text