



# Slovenia

## Country Drug Report 2017

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### THE DRUG PROBLEM IN SLOVENIA AT A GLANCE

#### Drug use

in young adults (15-34 years)  
in the last year

##### Cannabis

**10.3 %**



7 % 13.4 %

##### Other drugs

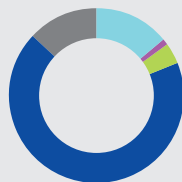
Cocaine	1.2 %
Amphetamines	0.8 %
MDMA	0.8 %

#### High-risk opioid users

**5 172**  
(4 686 - 5 751)

#### Treatment entrants

by primary drug



● Cannabis, 14 %  
● Amphetamines, 1 %  
● Cocaine, 4 %  
● Heroin, 68 %  
● Other, 13 %

#### Opioid substitution treatment clients

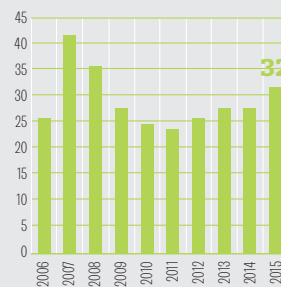
**3 261**

#### Syringes distributed

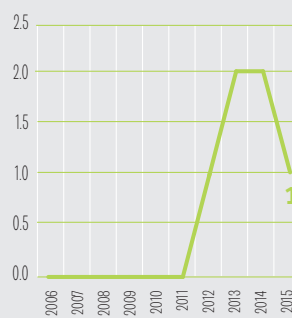
through specialised  
programmes

**500 757**

#### Overdose deaths



#### HIV diagnoses attributed to injecting



Source: ECDC

#### Drug law offences

**4 235**

#### Top 5 drugs seized

ranked according to quantities  
measured in kilograms

1. Herbal cannabis
2. Heroin
3. Cocaine
4. Cannabis resin
5. Amphetamine

#### Population

(15-64 years)

**1 389 178**

Source: EUROSTAT  
Extracted on: 26/03/2017

NB: Data presented here are either national estimates (prevalence of use, opioid drug users) or reported numbers through the EMCDDA indicators (treatment clients, syringes, deaths and HIV diagnosis, drug law offences and seizures). Detailed information on methodology and caveats and comments on the limitations in the information set available can be found in the EMCDDA Statistical Bulletin.

## About this report

This report presents the top-level overview of the drug phenomenon in Slovenia, covering drug supply, use and public health problems as well as drug policy and responses. The statistical data reported relate to 2015 (or most recent year) and are provided to the EMCDDA by the national focal point, unless stated otherwise.

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## National drug strategy and coordination

### National drug strategy

Adopted in 2014, the overarching goal of Slovenia's National Programme on Illicit Drugs (2014-20) is to reduce and contain the harm caused to individuals, families and society from illicit drug use (Figure 1). The National Programme is built around six pillars: (i) information systems; (ii) drug demand reduction; (iii) supply reduction; (iv) international cooperation; (v) coordination; and (vi) evaluation, research and training/education. A series of consecutive two-year action plans specifying priorities, actors and timeframes are being used to implement the programme. In addition, several objectives of the National Crime Prevention and Crime Control Strategy address illicit drug issues, such as demand reduction and prevention.

As in other European countries, Slovenia evaluates its drug policy and strategy through ongoing indicator monitoring and specific research projects. The Ministry of Health

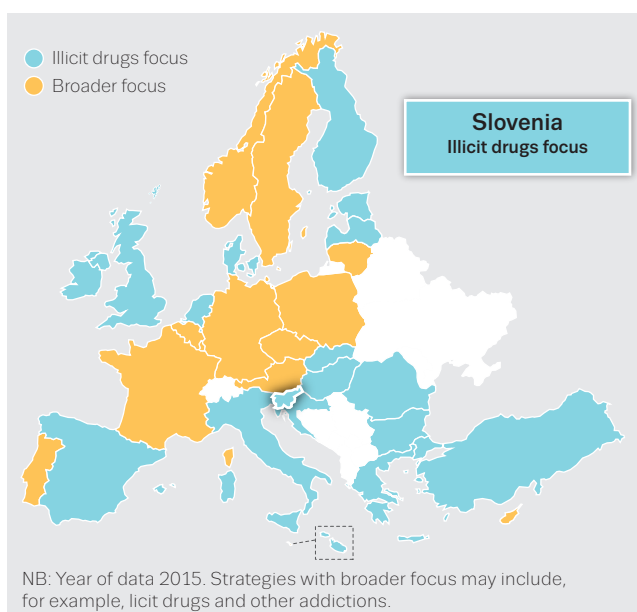
commissioned two external evaluations of the Resolution on the National Programme in the Area of Drugs (2004-09). The evaluations were completed by a research centre in 2008 and a non-governmental organisation (NGO) in 2010 and considered the operation and implementation the programme; the findings were used in the development of its successor for the period 2014-20.

### National coordination mechanisms

The Commission on Narcotic Drugs of the Government of Slovenia is responsible for drug policy at the interministerial level. The Commission promotes and coordinates government policy and programmes, proposes measures and monitors implementation of the provisions of international conventions. It includes representatives from all ministries involved in implementing the programme. The Ministry of Health, which is the Commission's Secretariat, and the Ministry of Interior are responsible for, respectively, the strategic and operational coordination of the programme, in the areas of drug demand and supply reduction. Within the Ministry of Health, the Health Promotion and Healthy Lifestyles Division is responsible for the day-to-day coordination of drug policy. Local Action Groups are tasked with the coordination of drug policy at the local level and 10 regional coordinators were appointed in 2005.

FIGURE 1

Focus of national drug strategy documents: illicit drugs or broader



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of Slovenia's National  
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## Public expenditure

Understanding the costs of drug-related actions is an important aspect of the drug policy. Some of the funds allocated by governments for expenditure to tasks related to drugs are identified as such in the budget ('labelled'). Often, however, the majority of drug-related expenditure is not identified ('unlabelled') and must be estimated using modelling approaches.

In Slovenia, there are no budgets attached to the national drug policy documents. Authorities report their total drug-related expenditure every year, covering both demand and supply reduction activities, but the methodology used is not detailed and data completeness varies every year.

The available data suggest that total drug-related expenditure represented 0.03 % of gross domestic product (GDP) in 2015 and that this proportion varied between 0.02 % and 0.03 % of GDP between 2006 and 2015.

Trend analysis shows that drug-related labelled expenditure increased between 2006 and 2011 in nominal terms. However, after 2008, the pace of growth slowed, which may be a consequence of the public austerity measures that followed the economic recession of 2008. Available data suggest that the total funds available may have been reduced in 2012, following the overall public austerity that was experienced in Slovenia, but remained stable in the following year; however, drug-related funding increased in 2014 and 2015.

**In 2015, total drug-related public expenditure represented 0.03 % of gross domestic product**

## Drug laws and drug law offences

### National drug laws

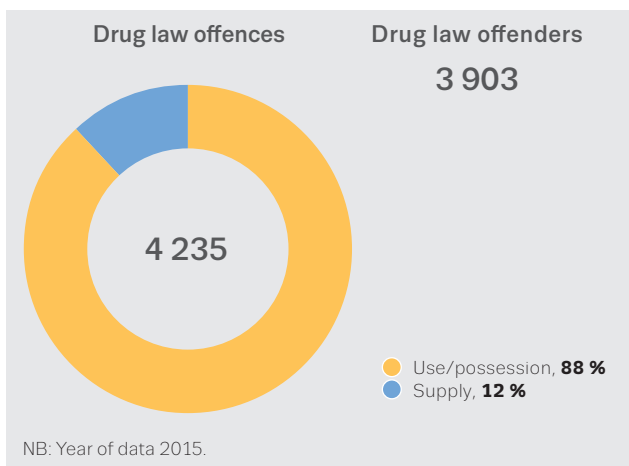
In Slovenia, purchasing drugs for one’s own use and consumption is not considered a criminal offence (Figure 2). Slovenia’s Production and Trade in Illicit Drugs Act has separate definitions for the possession of illicit drugs, the possession of a small quantity for individual use and the possession of a small quantity for individual use by a person who has opted for medical treatment or treatment in a health or social programme. Possession of an illicit drug is considered a minor offence under Article 33 of the Production and Trade in Illicit Drugs Act and is punishable by a fine. For example, possession of small quantities of illicit drugs for one-off personal use might lead to a fine of between EUR 42 and EUR 209. Individuals may be subject to more lenient punishment if they voluntarily enter treatment for illicit drug use or a social security programme approved by the Health Council at the Ministry of Health or by the Council for Drugs at the Ministry of Labour.

The Penal Code, adopted in 2008, defines two criminal offences: the manufacture and trafficking of illicit drugs (Article 186), and facilitating the consumption of illicit drugs (Article 187). Article 186 includes the sale, manufacture and purchase of illicit drugs with the intention of sale, possession with the intent to re-sell, etc., all of which offences are punishable by 1-10 years’ imprisonment or 3-15 years if the offence included defined aggravating circumstances, such as particular locations or the involvement of vulnerable people.

Article 187 of the Penal Code considers as offences the offering of illicit drugs for consumption, the offering of premises for

FIGURE 3

Reported drug law offences and offenders in Slovenia

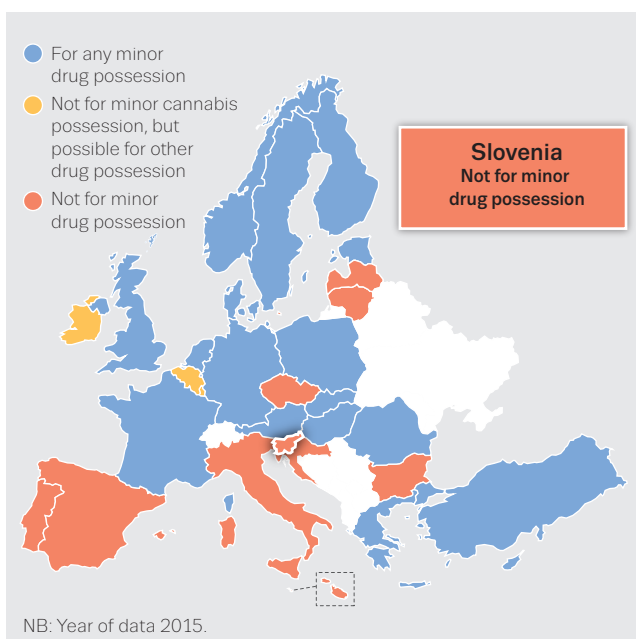


minors to consume illicit drugs, etc., and these offences are punishable by prison sentences of between six months and eight years. Offences that involve vulnerable people or an offender abusing their position are punishable by 1-12 years’ imprisonment. The Penal Code was amended in November 2011 to provide that an action to facilitate illicit drug use is not punishable if it is in the context of a programme of drug treatment or involves the controlled use of drugs that conforms to the relevant law and is implemented within the framework or under the supervision of public health authorities, for example in a drug consumption room. In principle, this new amendment created an enabling legal environment for the establishment of drug consumption rooms in Slovenia.

New psychoactive substances (NPS) are controlled by regular amendments of the list of controlled substances.

FIGURE 2

Legal penalties: the possibility of incarceration for possession of drugs for personal use (minor offence)



### Drug law offences

Drug law offence (DLO) data are the foundation for monitoring drug-related crime and they are also a measure of law enforcement activity and drug market dynamics; they may be used to inform policies on the implementation of drug laws and to improve strategies.

The statistical data on DLOs from Slovenia indicate that the most DLOs are associated with cannabis. In general, offences linked to use/possession dominate DLOs (Figure 3).

## Drug use

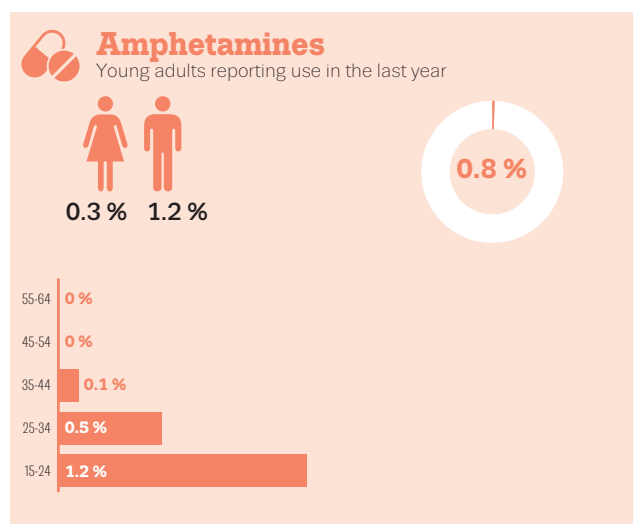
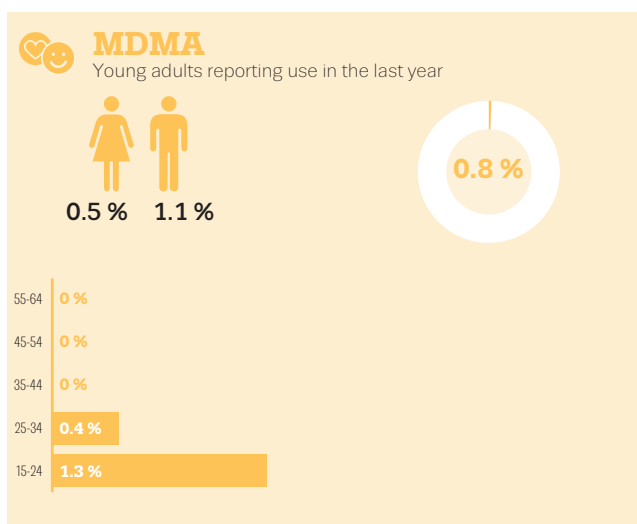
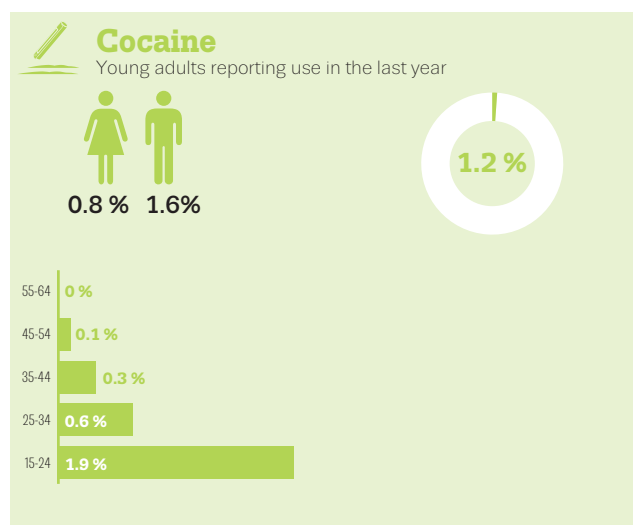
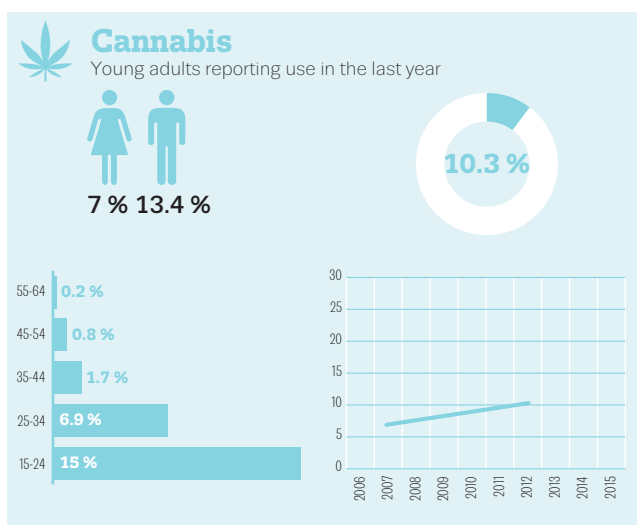
### Prevalence and trends

According to the 2011-12 general population survey, cannabis was the most commonly used drug among the adult population aged 15-64 years in Slovenia. Other illicit substances were less common. Illicit drug use is concentrated among younger age groups and, in particular, among those aged 15-24 years. Use of illicit drugs is generally higher among males than females (Figure 4).

Around 0.6 % of Slovenian adults reported having ever used NPS. Nevertheless, data from other sources, including a recent web-based survey, indicate that the use of NPS alone or in combination with an established illicit substance may be more common among young people in recreational settings.

FIGURE 4

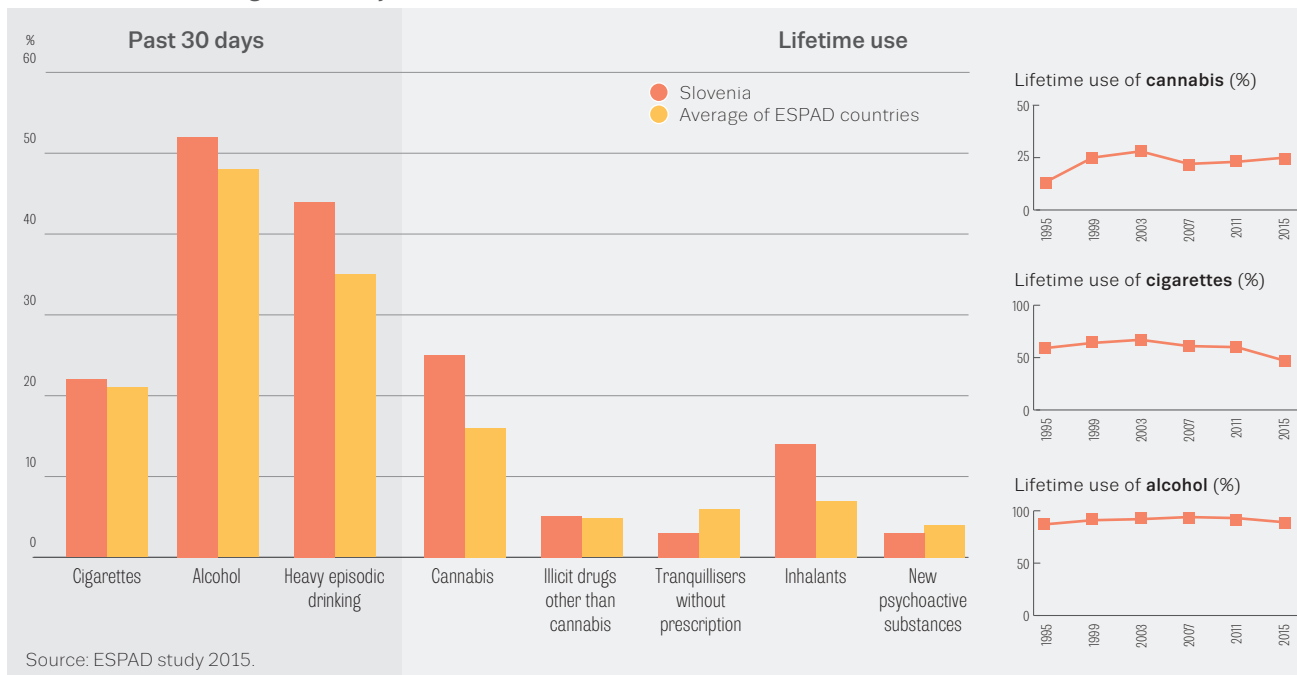
Estimates of last-year drug use among young adults (15-34 years) in Slovenia



NB: Estimated last-year prevalence of drug use in 2015.

FIGURE 5

Substance use among 15- to 16- year-old school students in Slovenia



Drug use among students aged 15-16 years is reported in the European School Survey Project on Alcohol and Other Drugs (ESPAD). This survey has been carried out in Slovenia since 1995 and the most recent survey was in 2015. Slovenian students reported lifetime cannabis use that is above the ESPAD average (based on data from 35 countries), while lifetime use of illicit drugs other than cannabis and lifetime use of NPS were either very close to or the same as the ESPAD averages. Trend analysis indicates that experimentation with cannabis increased markedly among 15- to 16- year-old students between 1995 and 2003, decreased in 2007 and increased again in 2011 and 2015, according to surveys (Figure 5).

**The estimated number of high-risk opioid users has remained stable in recent years**

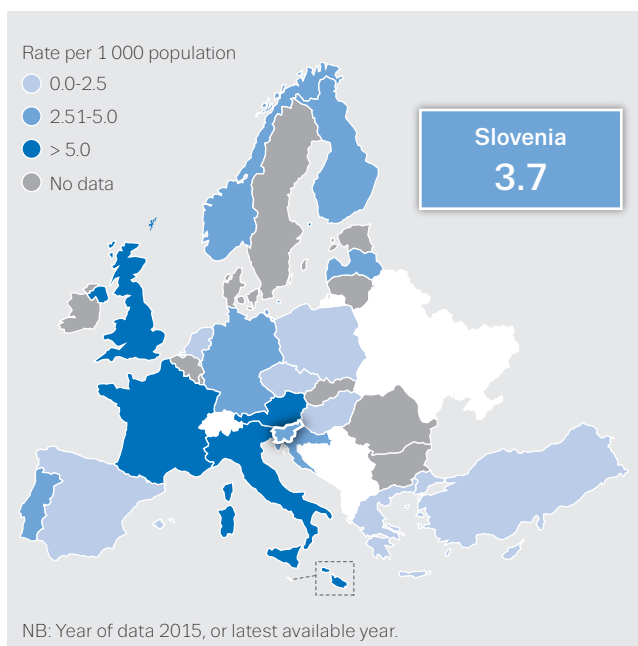
**High-risk drug use and trends**

Studies reporting estimates of high-risk use can help to identify the extent of the more entrenched drug use problems, while data on the first-time entrants to specialised drug treatment centres, when considered alongside other indicators, can inform understanding on the nature and trends in high-risk drug use (Figure 6).

The estimated number of high-risk opioid users has remained stable in recent years; the total number was estimated to be around 5 000 in 2014 (Figure 7).

FIGURE 6

National estimates of last year prevalence of high-risk opioid use

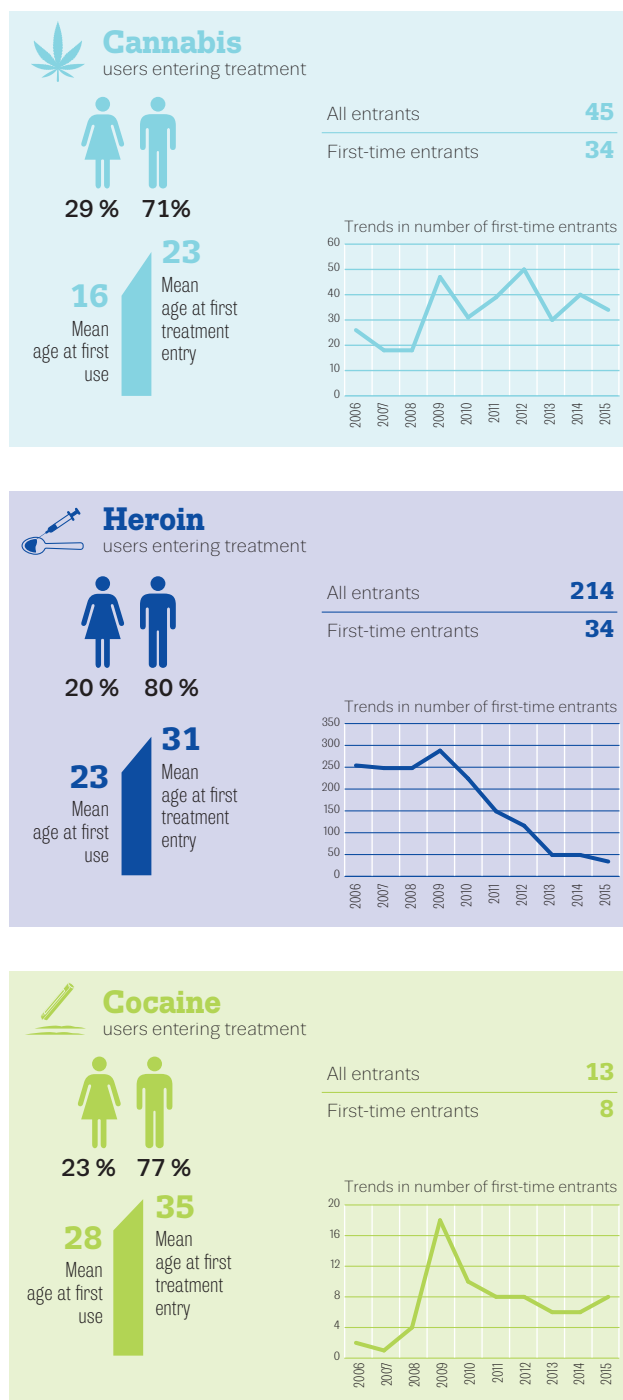


Data from specialised treatment centres in Slovenia indicate that, in 2015, new treatment entries attributable to illicit drug use were reduced. Moreover, new treatment entries attributable to primary heroin use have decreased significantly in the last five years (Figure 6). Although heroin remains the principal opioid drug used in Slovenia, reports from harm reduction programmes indicate some change in the drug use profile among clients, suggesting that heroin has been replaced by other substances, such as stimulants, medicines and NPS, all of which may be injected. However, in general, drug injecting has been declining among treatment clients. Moreover, a shift towards other administration routes, such as sniffing, smoking or oral use of opioids, has been reported. Around 50 % of those new to treatment use drugs by sniffing.

In general, the ageing of the population of drug users is also noted in Slovenia, which presents new issues, such as increased social problems, including homelessness, and a higher frequency of acute and chronic illnesses. The number of females in treatment varies by type of drug and treatment programme (Figure 7).

FIGURE 7

Characteristics and trends of drug users entering specialised drug treatment in Slovenia



NB: Year of data 2015. Data is for first-time entrants, except for gender which is for all treatment entrants.

## Drug harms

### Drug-related infectious diseases

In Slovenia, the National Institute of Public Health (NIPH) collects notifications on drug-related infectious diseases and test results from a convenience sample of treatment clients in Centres for the Prevention and Treatment of Illicit Drug Addiction (CPTDA). In general, the analysis of surveillance information on the prevalence of drug-related infectious diseases among people who inject drugs (PWID) in Slovenia indicates a stable situation in recent years.

The available data indicate that hepatitis C virus (HCV) infection is the most prevalent drug-related infectious disease among PWID. In 2015, the prevalence of HCV infection among PWID who were tested confidentially during treatment was 42.7 %, which is slightly higher than in 2014 (Figure 9).

The number of new cases of human immunodeficiency virus (HIV) infection linked to injecting drug use remains very low, with two new cases detected in 2014 and one in 2015 (Figure 8). In 2015, no positive HIV tests were reported among PWID who were tested confidentially during treatment at CPTDAs.

In 2015, the prevalence of antibodies against HBV among PWID who were tested confidentially during treatment at CPTDAs was 5.9 %, and this proportion has remained stable.

### Drug-related emergencies

Data on drug-related emergencies are reported for the Ljubljana region only and refer to adult patients who are examined and treated at the University Medical Centre Ljubljana.

In 2015, 145 people were treated. Cannabis was the most frequently reported substance in drug-related emergencies (64 cases), while about one third of cases were linked to either heroin or cocaine use. In addition, some emergency cases were attributed to the use of gamma-hydroxybutyric acid/gamma-butyrolactone (GHB/GBL) or amphetamines; a few cases involving NPS, such as 2CI-NBOMe (a derivative of phenethylamine) were also reported.

In general, the trend indicates an increase in the number of illicit drug poisoning cases in the last five years.

FIGURE 8

Newly diagnosed HIV cases attributed to injecting drug use

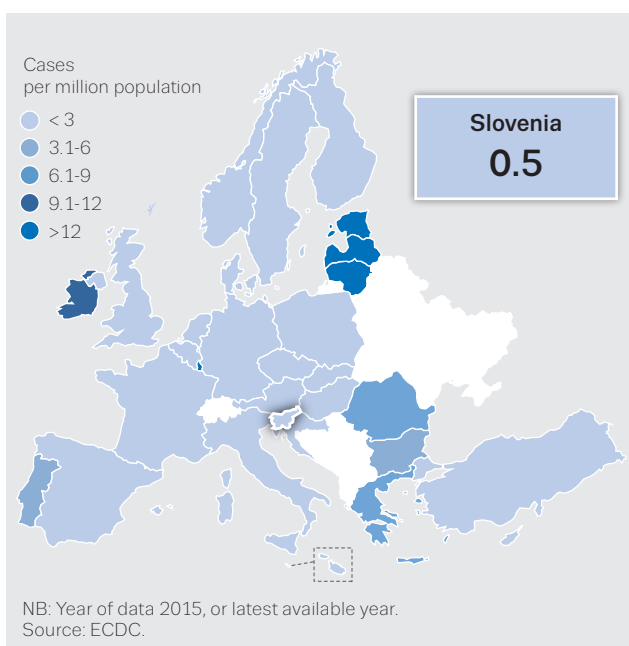
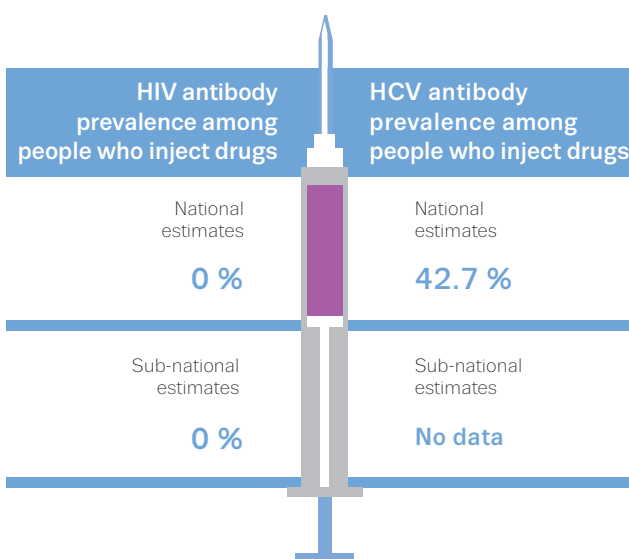


FIGURE 9

Prevalence of HIV and HCV antibodies among people who inject drugs in Slovenia

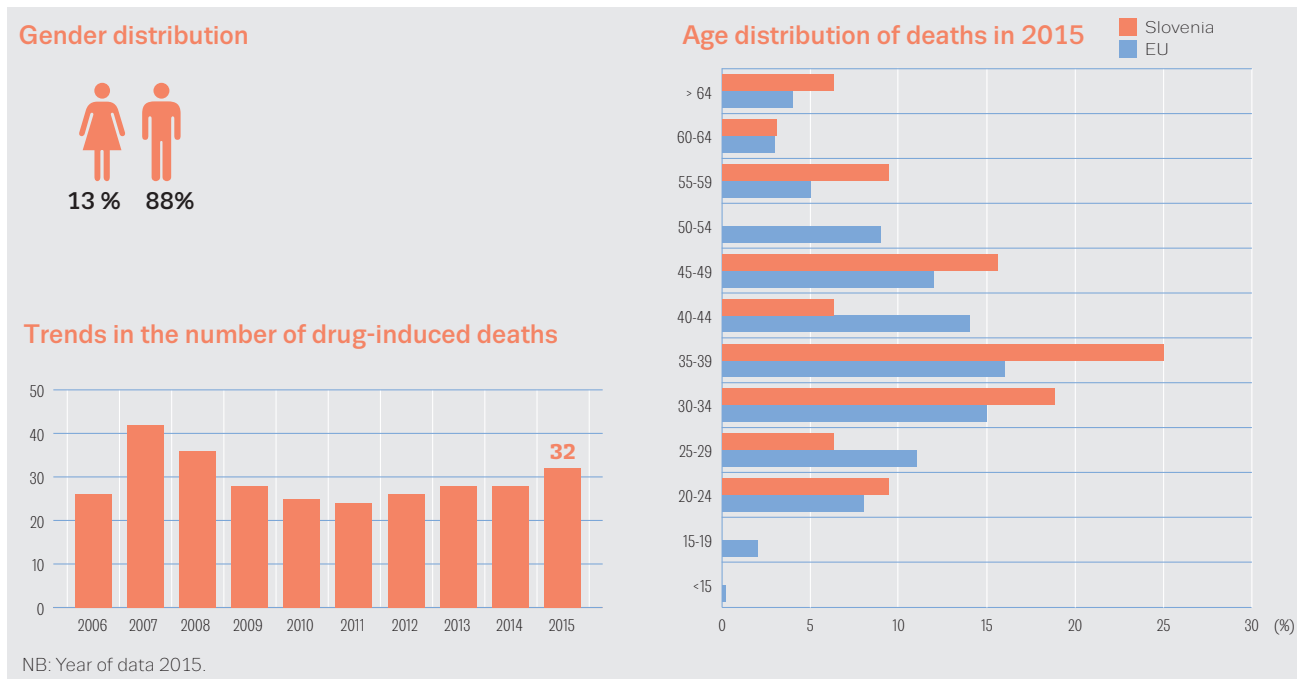


NB: Year of data 2015.



FIGURE 10

## Characteristics of and trends in drug-induced deaths in Slovenia



## Drug-induced deaths and mortality

Drug-induced deaths are deaths directly attributable to the use of illicit drugs (i.e. poisonings and overdoses).

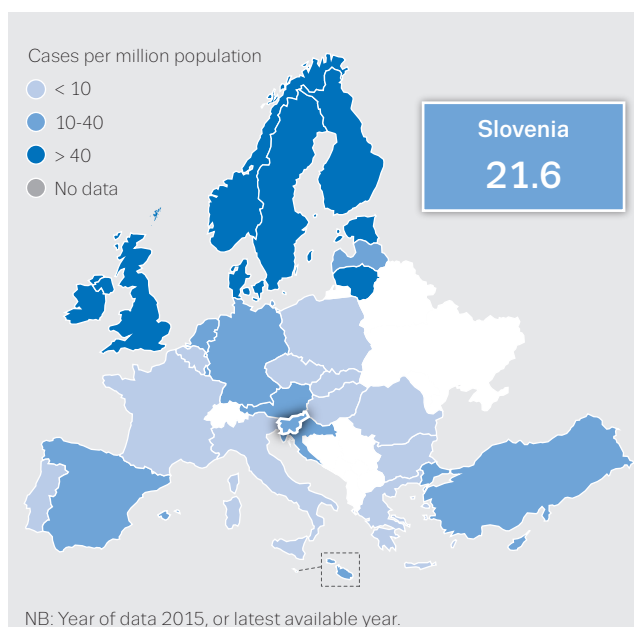
In general, the number of drug-induced deaths in Slovenia has remained stable in recent years. In 2015, the general mortality register reported more deaths than in 2014 (Figure 10). Toxicological testing results showed the involvement of opioids (heroin and methadone) in the majority of reported cases. For the first time, two cannabis-related deaths were registered in 2015. The majority of deaths were among males. The mean age of victims was above 40 years and there has been a continuous trend of increasing age over the last five years.

The drug-induced mortality rate among adults (15-64 years) was 21.6 deaths per million in 2015, which is similar to the most recent European average of 20.3 deaths per million (Figure 11).

A mortality cohort study conducted between 2004 and 2013 among treated drug users found a mortality rate of 5.7 deaths per 1 000 person-years, which is twice that of the general population of the same age. The excess deaths were attributable not only to drugs use directly, but also to suicide, traffic accidents and other violent acts, alcoholic liver cirrhosis and cardiovascular diseases. The excess mortality as a result of suicide was particularly high, being 2.5 times higher for males and almost four times higher for females in the study cohort than in the general population.

FIGURE 11

## Drug-induced mortality rates among adults (15-64 years)



## Prevention

In Slovenia, the current national programme sets out basic principles for drug prevention and prioritises the prevention of drug use among young people. In addition, the prevention of psychoactive substance use is regulated at the national level by laws, regulations and guidelines within various ministries and is coordinated by the Ministry of Health. At the community level, local action groups for drug dependence prevention are tasked with coordinating both these activities and the work of many NGOs under the oversight of the self-governing regions.

### Prevention interventions

Prevention interventions encompass a wide range of approaches, which are complementary. Environmental and universal strategies target entire populations, selective prevention targets vulnerable groups that may be at greater risk of developing drug use problems and indicated prevention focuses on at-risk individuals.

In Slovenia, environmental prevention interventions in recent years have focused mainly on alcohol and tobacco. These are implemented by various governmental organisations and NGOs. Examples of these are the 'watchdog' actions (Mystery Shopping and Yellow Card campaigns), which put formal and informal pressure on policy-makers and decision-makers to ensure the implementation of alcohol and tobacco laws (such as reporting violations of the alcohol/tobacco marketing regulations, which ban the sale of/offering of alcohol or tobacco to minors, etc.).

Universal prevention and selective prevention have been strengthened by the implementation of more evidence-based, evaluated, structured and manual-based prevention interventions, such as Unplugged, FreD goes net, EFTEKT and PUM (Project Learning for Young Adults, which is a selective prevention programme for young people who drop out of school and are at risk). Prevention activities in schools are mainly carried out by the NIPH, local health centres and NGOs or by associations and cover licit and illicit substances. Individual or time-limited structured and semistructured interventions that aim to build self-esteem in children and young people (especially in schools) and to improve their life skills (personal/social) etc., are still common (Figure 12).

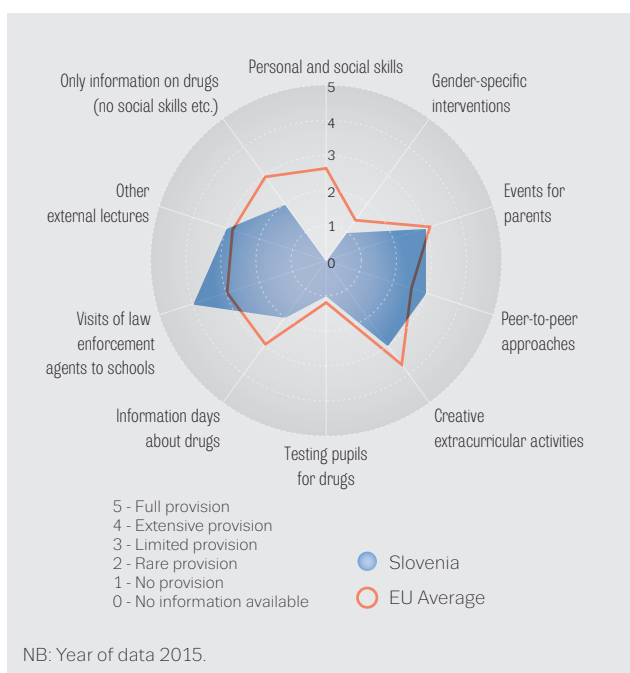
In addition, interventions that aim to provide background support, or individual or time-limited interventions are provided by public and private social services for families that are considered to be at risk (for example, therapeutic meetings involving social workers or therapists and family members). In addition, numerous programmes targeting children with social, developmental and learning problems, as well as those living in deprived neighbourhoods, are provided at local level.

Prevention work in recreational settings is primarily organised by the NGO DrogArt, which offers activities at electronic music events, at youth nightlife venues and in club settings in central Slovenia, while some local projects aim to ensure safer nightlife through the distribution of information, condoms and, occasionally, drinking water.

Indicated prevention programmes that target children with mental health, behavioural and learning problems are provided within the public health system.

FIGURE 12

### Provision of interventions in schools in Slovenia (expert ratings)



## Harm reduction

In Slovenia, the reduction of drug-related harm has been one of the main objectives of several consecutive national strategies on drugs, the latest of which covers the period from 2014 to 2020. The harm reduction programmes are partly financed by the Ministry of Labour, Family, Social Affairs and Equal Opportunities. In addition, the Slovenian Health Insurance Institute provides funding for the centralised purchase of injecting equipment, which is distributed by the Koper Regional Unit of the NIPH to harm reduction programmes.

### Harm reduction interventions

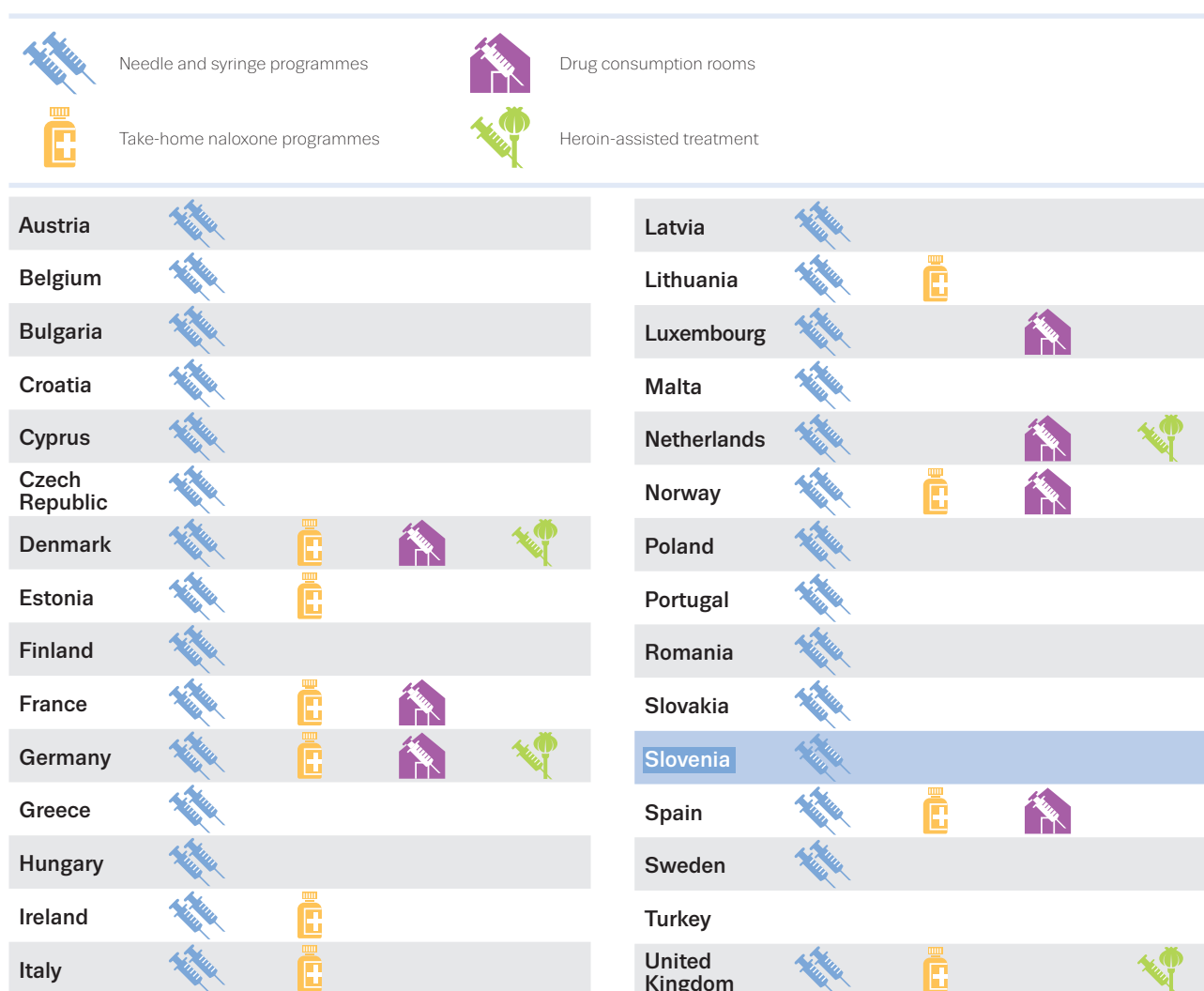
In 2015, 10 harm reduction programmes operated across Slovenia, providing sterile injecting equipment, information and counselling at fixed sites and at various outreach locations (Figure 13).

These services are provided in the capital city of Ljubljana and other major regions and cities (the Maribor region, the Koper region, the cities of Celje, Ilirska Bistrica, etc.). Syringes and other injecting paraphernalia (alcohol wipes and ascorbic acid) are usually made available through day-care centres and outreach and mobile services, and are also available at five pharmacy-based exchange sites. In 2015, about half a million syringes were distributed nationwide, which indicates an increase in the distribution of sterile injecting material when compared with 2014.

In recent years, new programmes have been developed at the local level, mainly aimed at PWID and drug users in recreational settings. As an example, in response to the emerging use of NPS, the NGO DrogArt provides a drug testing and counselling service for users of NPS. Within the framework of a national early warning system, a network of information points for the anonymous collection and testing of substance samples was established.

FIGURE 13

#### Availability of selected harm reduction responses



NB: Year of data 2016.

In addition, free vaccination against hepatitis B virus and free testing for hepatitis and HIV infection are available to all drug users in contact with CPTDAs. These centres also provide training on overdose prevention. Treatment of HCV infection is free of charge in Slovenia. In 2015, an NGO obtained funding to prepare and operate a safe consumption facility in Ljubljana; however, the facility has not yet been opened.

**Free vaccination against HBV and free testing for hepatitis and HIV infection are available to all drug users in contact with drug treatment services**

## Treatment

### The treatment system

In Slovenia, the current national drug strategy stipulates that drug treatment must be comprehensive, ensure continuity of care and be accessible to all drug users. Responsibility for implementing treatment lies predominantly at the national level, and drug treatment is provided by different systems of health, social support and civil society NGOs.

The Health Insurance Institute of Slovenia funds drug treatment in the health sector, and treatment is free of charge to the client. The treatment programmes delivered through the social care system are mainly funded by the Ministry of Labour, Family, Social Affairs and Equal Opportunities and the municipalities, or by other external resources, and may include a co-payment from clients.

Drug-related outpatient treatment is available through the national network of public CPTDAs and from the Centre for the Treatment of Drug Addiction at the Ljubljana

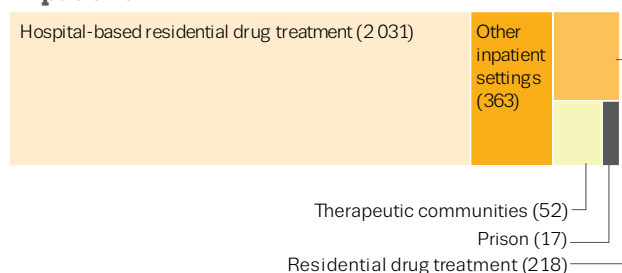
FIGURE 14

### Drug treatment in Slovenia: settings and number treated

#### Outpatient



#### Inpatient



NB: Year of data 2015.

FIGURE 15

Trends in percentage of clients entering specialised drug treatment, by primary drug in Slovenia

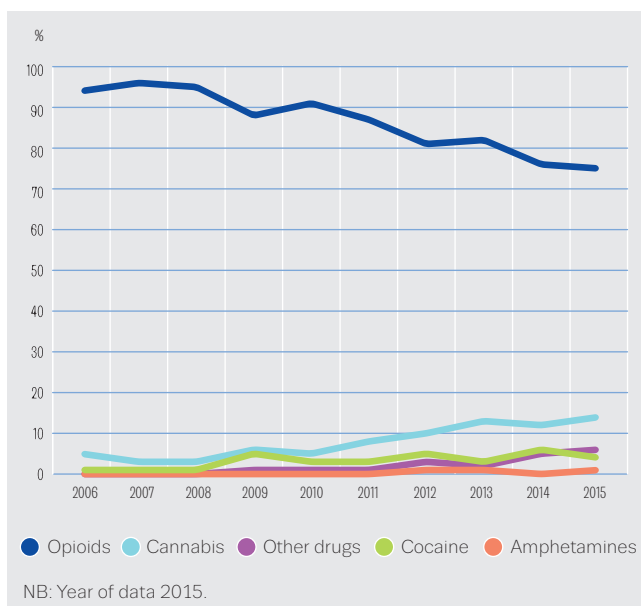
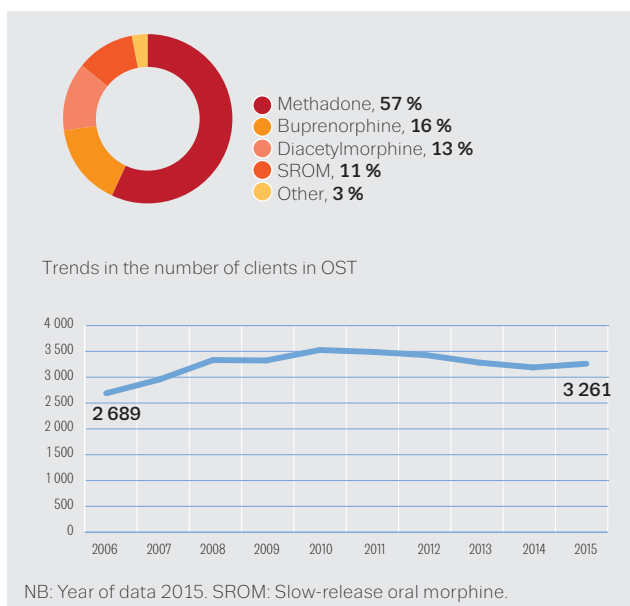


FIGURE 16

Opioid substitution treatment in Slovenia: proportions of clients in OST by medication and trends of the total number of clients



Psychiatric Hospital. The latter also provides inpatient treatment. Other psychiatric hospitals and psychiatric outpatient units within the primary healthcare system can also provide drug treatment. NGOs within the framework and funding of social welfare programmes are involved mainly in the provision of treatment communities and non-hospital-based residential treatment programmes.

The available treatment modalities include detoxification; psychosocial interventions; opioid substitution treatment (OST) and other medically assisted treatments; individual or group counselling with a sociotherapy or psychotherapy component, including assistance with rehabilitation and social reintegration; and links to home nursing, therapeutic communities and self-help groups. An integrated treatment programme for drug users with mental comorbidities is available at the Ljubljana Psychiatric Hospital.

OST is provided only by the CPTDAs and is free of charge to clients. Methadone was first introduced in 1990, while buprenorphine was registered in 2004, slow-release morphine in 2005 and buprenorphine/naloxone combination in 2007.

## Treatment provision

In Slovenia, the majority of clients who received drug treatment in 2015 were treated in outpatient settings, with low-threshold facilities playing an important role as a first point of access to more specialised treatment services for high-risk drugs users (Figure 14).

Treatment demand data are provided only by the specialised treatment centres. The majority clients admitted to treatment in 2015 did so as a result of opioid, mainly heroin, use, although treatment requests linked to opioid use have more than halved in the last decade. However, in 2015, the proportion of those who entered treatment who did so because of cannabis use increased among both new treatment clients and all treatment clients (Figure 15).

Opioid users remain the main clients of the Slovenian treatment system and, in 2015, many of them received OST; methadone remains the most commonly used OST medication (Figure 16).

## Drug use and responses in prison

According to a 2015 survey that was carried out in all Slovenian prisons, lifetime illicit drug use was reported by 38 % of prisoners. Cannabis was the illicit drug most likely to have been used regularly, followed by cocaine and heroin. One in four inmates reported having ever used drugs in prison, with cannabis being the most commonly used, although heroin is more commonly used than cocaine in prisons. About 2.3 % of prisoners reported regular use and 1.9 % reported injecting use of illicit substances during imprisonment. The level of NPS use was low, although there has been an increase in seizures and poisonings involving these substances in recent years.

Health and psychological disorders are common among prisoners. Based on a small study, 30 % of prisoners had an overdose prior to imprisonment and more than 20 % showed signs of social problems and mental health disorders, especially depression.

Since 2009, medical services in prisons in Slovenia have been provided by healthcare service providers under the authority of the Ministry of Health. Healthcare services for prisoners are provided by the primary healthcare centres that operate in the areas where prisons are located, based on agreements signed between prisons and healthcare centres. In general, drug treatment in prison follows the general guidance for drug treatment in the country, although internal guidelines are also applied.

If a medical examination confirms that a new inmate has drug use problems, a physician determines whether or not OST should be administered. In 2015, around three quarters of prisoners who were diagnosed with drug dependence received OST.

Apart from OST, drug treatment also includes individual and group counselling and psychosocial support programmes led by qualified professionals working in prisons. Prisoners with a drug problem may enrol in low-threshold, medium-threshold and high-threshold programmes during their prison term.

All inmates have access to free, voluntary and anonymous testing and treatment for hepatitis and HIV infections. Before release from prison, prisoners are provided with information on overdose risk, and community treatment centres are contacted to ensure continuity of care.

**Lifetime illicit drug use  
is reported by 38 %  
of prisoners in 2015**

## Quality assurance

The National Programme on Illicit Drugs 2014-20 and the National Social Care Programme 2013-20 are the key documents regulating the areas of drugs and social welfare, which provide for quality drug use prevention programmes, drug treatment programmes and social care programmes. The provision of quality programmes is also stipulated by individual laws in the areas of drugs, social welfare and the organisation of the healthcare system; these laws prescribe courses of action for the management and supervision of treatment programmes and for the treatment of those enrolled in social care programmes.

Drug use assessment and treatment programmes must meet regulatory requirements to be recognised as quality programmes and to be eligible to receive public funding. Major requirements include the programmes' professional relevance, which is evaluated on an ongoing basis. In the area of drug dependence treatment, methods for ensuring the professional relevance of the programmes are proposed and evaluated by the CPTDAs, the Medical Chamber of Slovenia, expanded professional boards and the Health Council. There is also a commission in place that oversees the CPTDAs. This commission is appointed by the Minister of Health and checks the documentation, human resources and equipment of the centres, the scope of work performed, methadone maintenance treatment programmes and other forms of treatment.

The implementation of social care programmes is monitored by the Social Protection Institute of the Republic of Slovenia. All verified public social care programmes are part of a uniform system for evaluating the achievement of the programmes' goals, which ensures that they are comparable to related programmes.

In the field of prevention, a number of activities have been implemented to increase the quality of evidence-based programme provision. In 2012, recommendations were issued for school-based prevention by one NGO, based on literature reviews and the evaluation of the Unplugged programme; however, these recommendations have not been accepted at the national level. In addition, an initiative was taken to set up a nationwide model for the evaluation of drug prevention activities. In 2014, Slovenia started to work actively on developing and implementing a quality assurance system for drug prevention programmes and began setting quality standards for drug prevention programmes, which were finalised and released in a publication in 2016.

## Drug-related research

The current national programme includes a chapter on research, evaluation and education, in which priority research areas are listed. These include descriptive studies; interpretive (ethnographic) studies on drug use; studies into the dangers of individual drugs, with a focus on synthetic drugs, methods of drug use and the harm caused by drugs; studies of social experiments, for example, the introduction of new programmes (heroin maintenance programmes, safe injection rooms, etc.); assessment studies of various programmes, approaches and procedures; epidemiological studies; studies to assess the harm to the economy and broader society caused by drug-related issues; and research into the effectiveness of new approaches and active substances in treating drug dependence and other medical conditions and dysfunctions.

The NIPH is one of the agencies involved in drug-related research and also plays an important role in collecting and disseminating research findings at the national level. The main focus of drug-related research is on population surveys, although applied research in the area of treatment and pharmacological research projects are also undertaken.

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## Drug markets

The illicit drug market in Slovenia is determined by the country's geographical position on the Balkan route, which is the main pathway for the illicit trafficking of heroin (from Turkey) and cannabis (from Western Balkan countries) into Western Europe; in addition, more recently, the use of south-east Europe as an entry point for cocaine has increased. Illicit drugs are trafficked through the country mainly by land. A growing number of investigations have revealed evidence of criminal groups establishing transport businesses in Slovenia, registering heavy goods vehicles and recruiting drivers to smuggle large quantities of a range of illicit drugs. Typically, the illegal cargo is not intended for the Slovenian consumer market.

Cannabis is the most important illicit substance locally produced and it is considered that cultivation is sufficient to meet domestic demand. Recent data indicate increased cultivation, mainly indoor, with some of the yield intended for neighbouring markets (Austria, Croatia and Italy).

The number of heroin seizures was stable between 2001 (552) and 2012 (439) and declined to 273 in 2015. The quantities seized have declined from a maximum of 393 kg in 2000 to 6.5 kg in 2015. The number of cocaine seizures has risen since 2002, to a maximum in 2010, before decreasing in 2015 (Figure 17).

Slovenia is increasingly seen as a country that provides logistical support to members of criminal groups across Europe and beyond. To prevent and counteract this, law enforcement agencies are engaging in joint investigation teams. In addition, focus is maintained on operations to dismantle illicit cannabis plantations and illicit synthetic drug production facilities.

Retail price and purity data of the main illicit substances seized are shown in Figure 18.

FIGURE 17

Drug seizures in Slovenia: trends in number of seizures (left) and quantities seized (right)

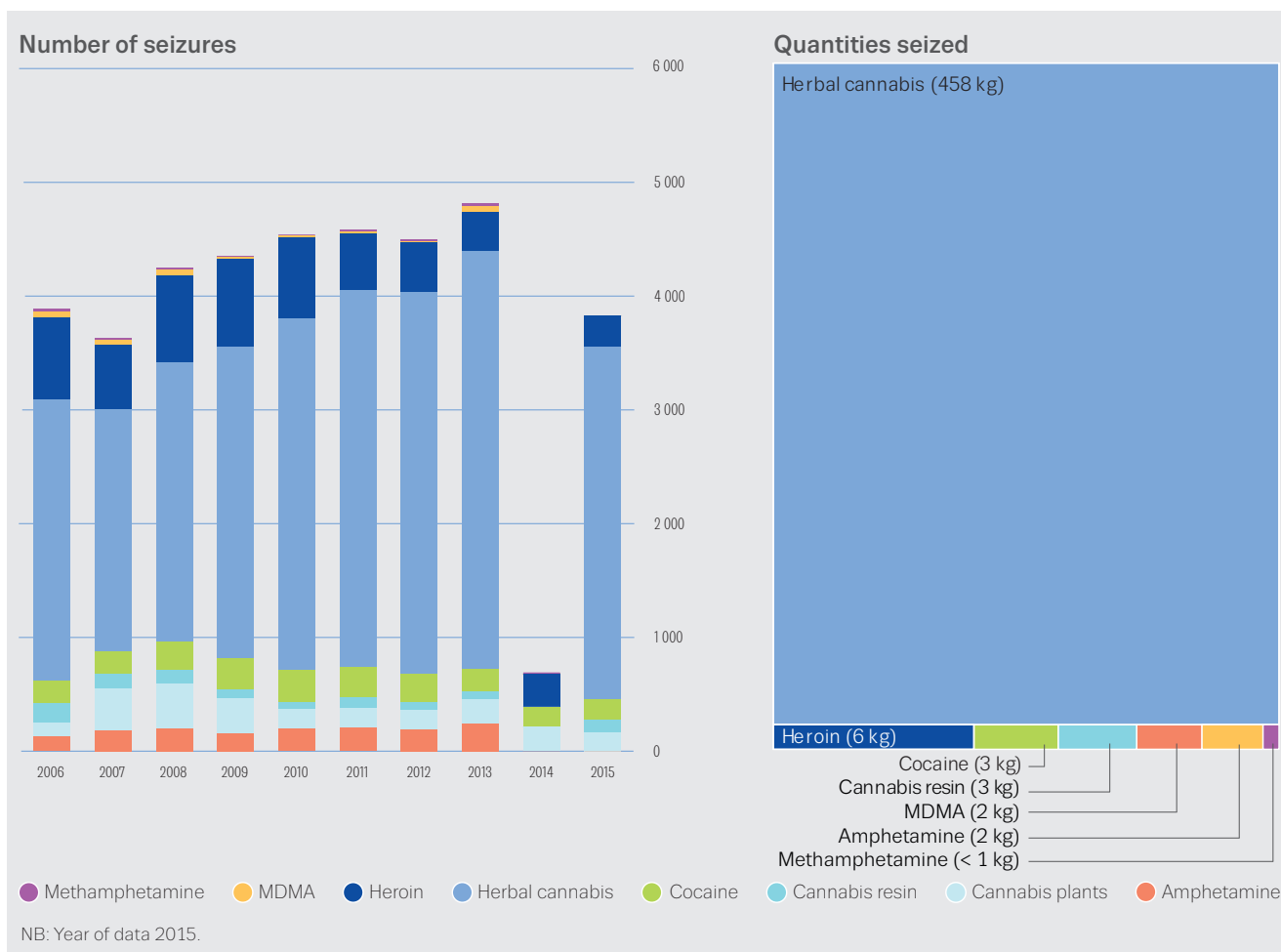
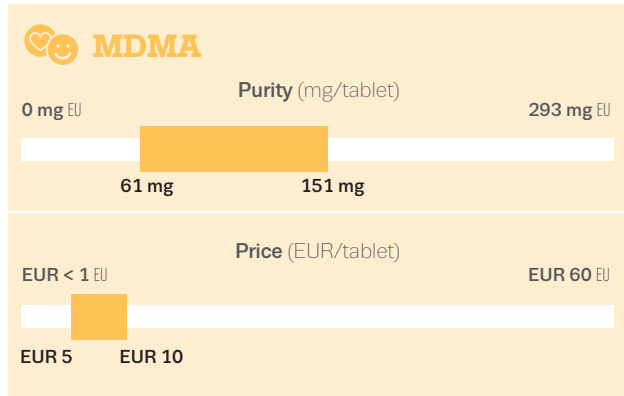
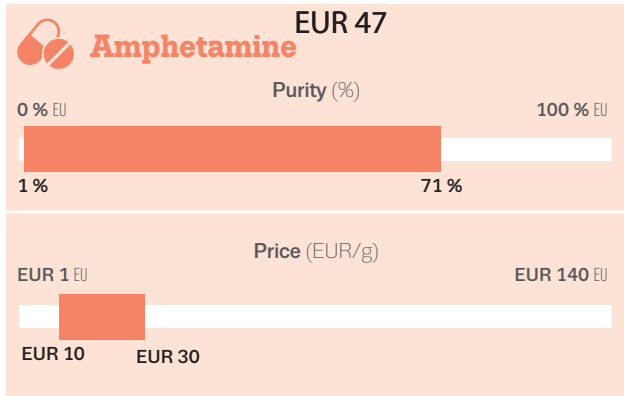
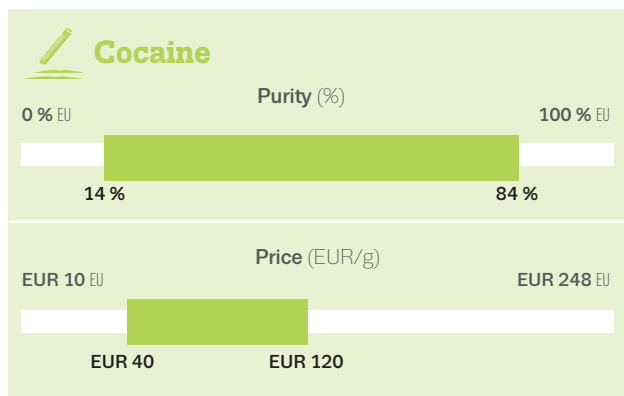
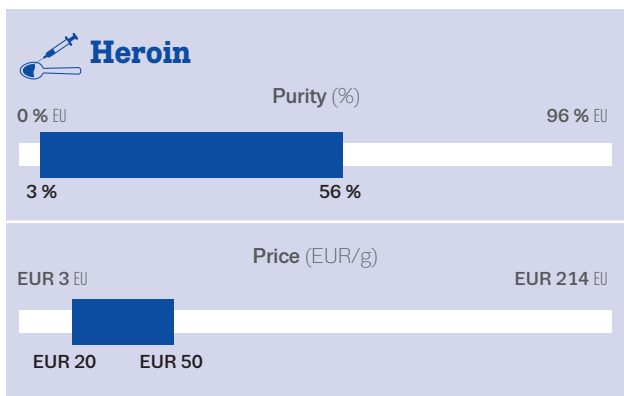
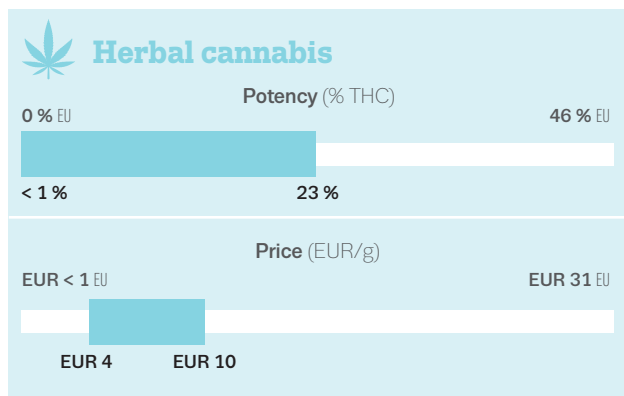
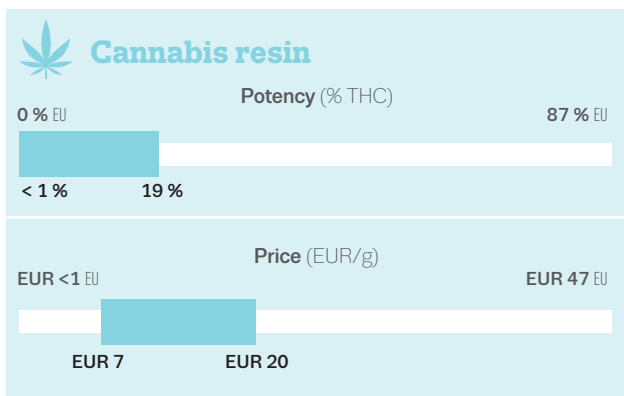




FIGURE 18

Price and potency/purity ranges of illicit drugs reported in Slovenia



NB: Price and potency/purity ranges: EU and national mean values: minimum and maximum. Year of data 2015.

## KEY DRUG STATISTICS FOR SLOVENIA

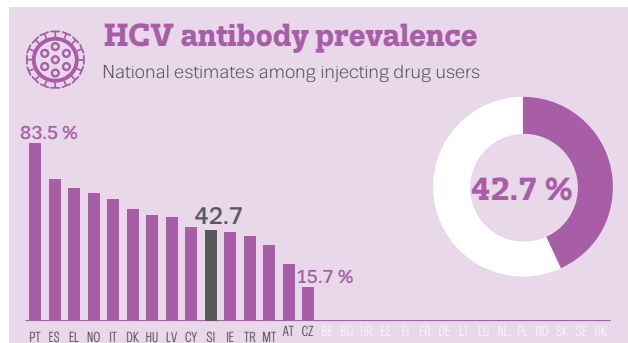
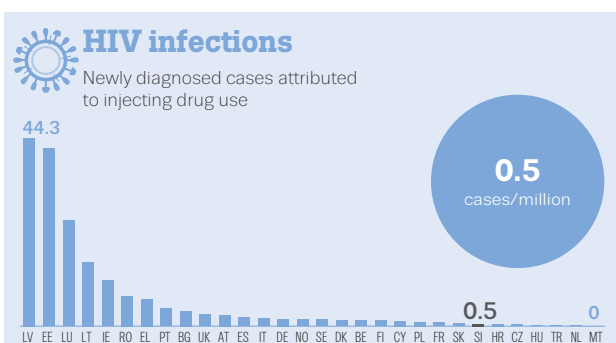
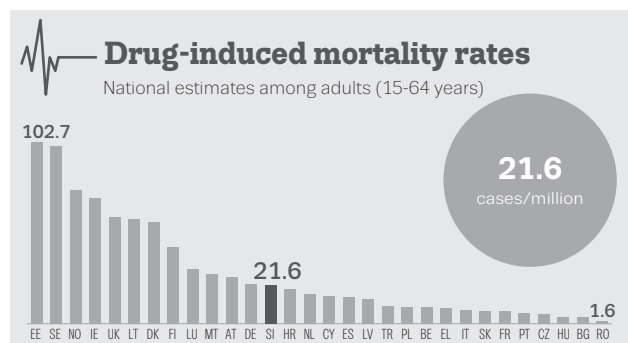
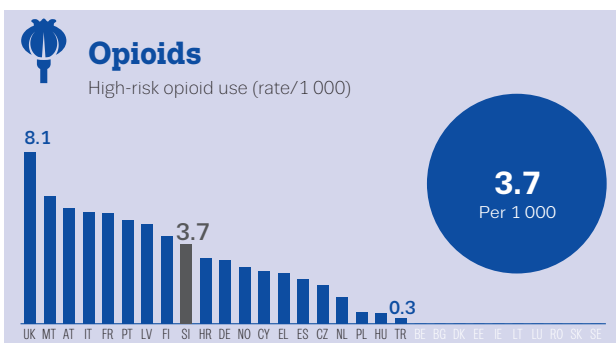
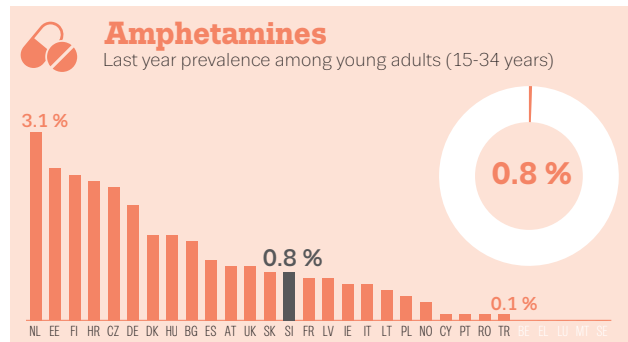
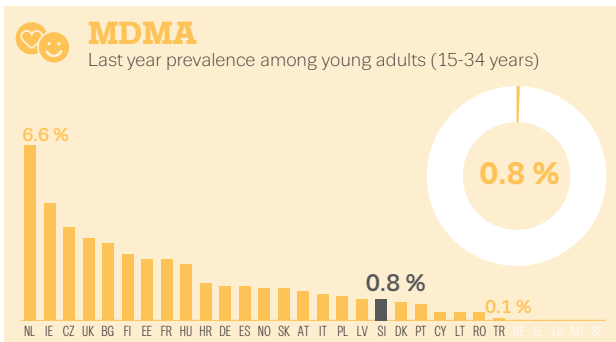
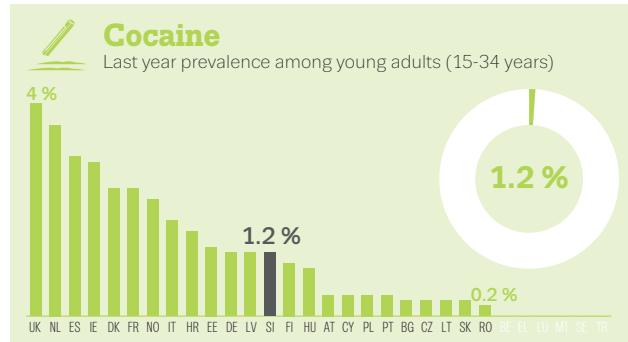
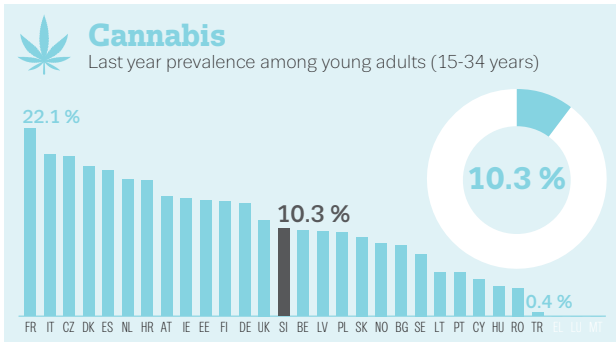
## Most recent estimates and data reported

	Year	Country data	EU range	
			Minimum	Maximum
<b>Cannabis</b>				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	24.9	6.5	36.8
Last year prevalence of use — young adults (%)	2012	10.3	0.4	22.1
Last year prevalence of drug use — all adults (%)	2012	4.4	0.3	11.1
All treatment entrants (%)	2015	14	3	71
First-time treatment entrants (%)	2015	39	8	79
Quantity of herbal cannabis seized (kg)	2015	457.5	4	45 816
Number of herbal cannabis seizures	2015	3 103	106	156 984
Quantity of cannabis resin seized (kg)	2015	2.5	1	380 361
Number of cannabis resin seizures	2015	109	14	164 760
Potency — herbal (% THC) (minimum and maximum values registered)	2015	0.1-23.1	0	46
Potency — resin (% THC) (minimum and maximum values registered)	2015	0.3-19.4	0	87.4
Price per gram — herbal (EUR) (minimum and maximum values registered)	2015	4-10	0.6	31.1
Price per gram — resin (EUR) (minimum and maximum values registered)	2015	7-20	0.9	46.6
<b>Cocaine</b>				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	2.2	0.9	4.9
Last year prevalence of use — young adults (%)	2012	1.2	0.2	4
Last year prevalence of drug use — all adults (%)	2012	0.5	0.1	2.3
All treatment entrants (%)	2015	4	0	37
First-time treatment entrants (%)	2015	9	0	40
Quantity of cocaine seized (kg)	2015	2.8	2	21 621
Number of cocaine seizures	2015	178	16	38 273
Purity (%) (minimum and maximum values registered)	2015	14.1-84	0	100
Price per gram (EUR) (minimum and maximum values registered)	2015	40-120	10	248.5
<b>Amphetamines</b>				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	0.9	0.8	6.5
Last year prevalence of use — young adults (%)	2012	0.8	0.1	3.1
Last year prevalence of drug use — all adults (%)	2012	0.3	0	1.6
All treatment entrants (%)	2015	1	0	70
First-time treatment entrants (%)	2015	5	0	75
Quantity of amphetamine seized (kg)	2015	2	0	3 796
Number of amphetamine seizures	2013	241	1	10 388
Purity — amphetamine (%) (minimum and maximum values registered)	2015	1.3-71.1	0	100
Price per gram — amphetamine (EUR) (minimum and maximum values registered)	2015	10-30	1	139.8

	Year	Country data	EU range	
			Minimum	Maximum
<b>MDMA</b>				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	2.2	0.5	5.2
Last year prevalence of use — young adults (%)	2012	0.8	0.1	6.6
Last year prevalence of drug use — all adults (%)	2012	0.3	0.1	3.4
All treatment entrants (%)	2015	0	0	2
First-time treatment entrants (%)	2015	1	0	2
Quantity of MDMA seized (tablets)	2015	2 908	54	5 673 901
Number of MDMA seizures	2013	53	3	5 012
Purity (mg of MDMA base per unit) (minimum and maximum values registered)	2015	60.5-150.7	0	293
Price per tablet (EUR) (minimum and maximum values registered)	2015	5-10	0.5	60
<b>Opioids</b>				
High-risk opioid use (rate/1 000)	2015	3.7	0.3	8.1
All treatment entrants (%)	2015	75	4	93
First-time treatment entrants (%)	2015	42	2	87
Quantity of heroin seized (kg)	2015	6	0	8 294
Number of heroin seizures	2015	273	2	12 271
Purity — heroin (%) (minimum and maximum values registered)	2015	3.4-55.7	0	96
Price per gram — heroin (EUR) (minimum and maximum values registered)	2015	20-50	3.1	214
<b>Drug-related infectious diseases/injecting/deaths</b>				
Newly diagnosed HIV cases related to injecting drug use (cases/million population, Source: ECDC)	2015	0.5	0	44
HIV prevalence among PWID* (%)	2015	0	0	30.9
HCV prevalence among PWID* (%)	2015	42.7	15.7	83.5
Injecting drug use (cases rate/1 000 population)	No data	No data	0.2	9.2
Drug-induced deaths — all adults (cases/million population)	2015	21.6	1.6	102.7
<b>Health and social responses</b>				
Syringes distributed through specialised programmes	2015	500 757	164	12 314 781
Clients in substitution treatment	2015	3 261	252	168 840
<b>Treatment demand</b>				
All clients	2015	316	282	124 234
First-time clients	2015	88	24	40 390
<b>Drug law offences</b>				
Number of reports of offences	2015	4 235	472	411 157
Offences for use/possession	2015	3 730	359	390 843

\* PWID — People who inject drugs.

## EU Dashboard



NB: Caution is required in interpreting data when countries are compared using any single measure, as, for example, differences may be due to reporting practices. Detailed information on methodology, qualifications on analysis and comments on the limitations of the information available can be found in the EMCDDA Statistical Bulletin. Countries with no data available are marked in white.

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## About the EMCDDA

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is the central source and confirmed authority on drug-related issues in Europe. For over 20 years, it has been collecting, analysing and disseminating scientifically sound information on drugs and drug addiction and their consequences, providing its audiences with an evidence-based picture of the drug phenomenon at European level.

The EMCDDA's publications are a prime source of information for a wide range of audiences including: policymakers and their advisors; professionals and researchers working in the drugs field; and, more broadly, the media and general public. Based in Lisbon, the EMCDDA is one of the decentralised agencies of the European Union.



### About our partner in Slovenia

The Slovenian national focal point is a part of the Information Unit for Illicit Drugs (IUID), which is located at the National Institute of Public Health of the Republic of Slovenia (NIPH). The NIPH collects, organises and analyses health-related statistical data in the fields of diagnoses, attendance, staff and visiting hours in outpatient facilities, outpatient specialist services and hospitals. The legal basis for the establishment of the Slovenian national focal point is the Prevention of Illicit Drug Abuse and Treatment of Drug Addictions Act (1999).

### National Institute of Public Health

Trubarjeva 2  
SLO-1000 Ljubljana  
Slovenia  
Tel. +386 15202776  
Fax +386 15205778  
Head of national focal point: Mr Milan  
Krek — Milan.Krek@nijz.si

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EMCDDA, Praça Europa 1, Cais do Sodré, 1249-289 Lisbon, Portugal  
Tel. +351 211210200 | [info@emcdda.europa.eu](mailto:info@emcdda.europa.eu)  
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