



NATIONAL INSTITUTE  
OF PUBLIC HEALTH  
*Knowledge for Better Health*



# REPORT ON THE DRUG SITUATION 2013 OF THE REPUBLIC OF SLOVENIA





European Monitoring Centre  
for Drugs and Drug Addiction



NATIONAL INSTITUTE  
OF PUBLIC HEALTH  
*Knowledge for Better Health*

**2013 NATIONAL REPORT (2012 data) TO THE  
EMCDDA  
by the Reitox National Focal Point**

**SLOVENIA**  
**New Development and Trends**

**REITOX**

## REPORT ON THE DRUG SITUATION 2013 OF THE REPUBLIC OF SLOVENIA

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## SUMMARY

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In July 2012, the Government of the RS adopted the National Crime Prevention and Crime Control Strategy for 2012-2016, which also covers the field of illicit drugs. The solutions set out in the Strategy include the prevention of illicit drug supply, drug use prevention, and treatment and social rehabilitation of drug users. In April 2013, the National Assembly of RS adopted the Resolution on the National Social Assistance Programme for 2013–2020, which establishes, inter alia, a network of programmes in the field of addiction, intended also for illicit drug users. In Slovenia, most programmes in the field of illicit drugs are still funded from the national budget and by the Health Insurance Institute of Slovenia. Some financial resources come from various foundations and membership dues paid by members of non-governmental organizations. Based on available data, we estimate that at least EUR 9,790,530.72 was spent on the solution of drug-related problems in Slovenia in 2012. Estimated total expenditure on illicit drugs decreased by EUR 1,337,098.60 compared to the 2011 amount.

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According to the 2011–2012 Survey on the use of tobacco, alcohol and other drugs, 16.2% of inhabitants of Slovenia aged 15–64 have used an illicit drug on one or more occasions in their lifetime. Most of them, i.e. 15.8%, have used cannabis, and the proportion of lifetime cannabis use was higher in men than in women. Less than one percent of the Slovenian population have used new drugs on at least one occasion in their lifetime. Most respondents who have used one of the new drugs stated that they had used methylone or mephedrone. Survey results also show that more than half of inhabitants of Slovenia are low-risk drinkers, 5.8% are risky drinkers and nearly one-fifth were abstinent in the previous year. Data on tobacco use show that 24% of the Slovenian population are smokers, and that there are more smokers among men than women. Most smokers smoke regularly, i.e. every day. According to 2011 ESPAD survey results, 23% of 15- and 16-year-old students have used cannabis in their lifetime, and according to 2010 HBSC survey, 23.2% of 15-year-olds have used marijuana on at least one occasion in their lifetime. The survey on the use of drugs in nightlife conducted in Slovenia and Italy showed that the marijuana was the illicit drug used by the largest proportion of respondents in both countries. In Slovenia, amphetamines were the second and cocaine the third most commonly used drug. The second and third most commonly used drugs among Italian respondents were cocaine and hallucinogens, respectively.

In the context of restricting access to alcohol, nine Slovenian municipalities have banned binge drinking in public places not intended for selling alcoholic beverages. The aim of this measure is to protect public order and prevent binge drinking, particularly among young people. As regards tobacco control, Slovenia did not adopt new measures last year, but it supported the Proposal for a Directive of the European Parliament and of the Council on the approximation of the laws, regulations and administrative provisions of the Member States concerning the manufacture, presentation and sale of tobacco and related products. In 2012, the “Brez izgovora” (No Excuse) Youth Association carried out 845 peer-to-peer tobacco and alcohol prevention workshops in primary and secondary schools. Workshop evaluation showed that most workshop leaders were satisfied with their workshop implementation. In the framework of the early intervention programme FreD goes net, which is aimed at young alcohol and illicit drug users, 8 courses with 53 participants have been implemented in the past two years. 55% of participants entered the programme due to alcohol use, and 45% due to illicit drug use. Assessment of satisfaction with the programme showed that 82% of participants would recommend the course to their friends or other persons. Between 2007 and 2012, the outpatient programme for children and adolescents who experiment with illicit drugs or use them regularly admitted 72 young people and 147 important close persons, of which 31 young people and 75 close persons completed the programme successfully. Two professional publications were issued in 2012, namely a guide for parents entitled Empowerment Strategies for Families and a guide for practitioners entitled Risk Prevention during Adolescence: Strategies Aimed at Parents for Prevention Practitioners and Mediators. Furthermore, a „train-the-trainer“ concept for persons working with socially disadvantaged target groups and three tools for more effective management of nightlife venues were developed. The slogan of the 2012 Addiction Prevention Month was “More resources, more opportunities”.

This year, a preliminary estimate of the prevalence of problem opiate use was made for 2011 using available data sources (drug users' treatment records and survey questionnaires filled out by harm reduction programme users) and the capture – recapture method. The resulting estimated number of problem opiate users in the age group 15–64 is 6,100. A survey covering 160 drug users who have sought help in harm-reduction programmes and are classified as problem drug users showed that, in comparison to 2011, drug use increased in 2012 for all drugs, including heroin, solvents and gases, while the use of substitution medicinal products decreased. Intravenous use remains the most common method of drug use and represents the most common risk behaviour in harm-reduction programme users. Furthermore, one case of HIV was recorded in 2012.



According to the data collected using the Treatment Demand questionnaire 3,154 people were treated in 18 Centres for the Prevention and Treatment of Drug Addiction (CPTDA) and the Centre for Treatment of Drug Addiction at the Psychiatric Clinic Ljubljana in 2012. Of 3,154 treated drug users, 2,635 were in continuous maintenance treatment. 519 persons entered a treatment programme again or for the first time in 2012, and their average age was 30.93 years. Most drug users who sought help in 2012 were male. Data on drug users who were admitted into a programme again or for the first time show that the most common reason why users sought help was heroin, followed by cannabis and cocaine. The most commonly reported secondary drug was cocaine, followed by cannabis and benzodiazepines. In comparison with previous years, the proportion of drug users seeking help due to heroin-related problems decreased in 2012, while the proportion of those seeking help due to cannabis- or cocaine-related problems increased. The proportion of drug users who use black market methadone was also increasing, and the proportion of drug users who injected drugs during the month prior to entering a programme was decreasing. Unemployment among treated drug users has increased compared to previous years.

Of all saliva samples collected from injecting drug users in 2012 in the framework of unlinked anonymous testing for the purposes of HIV infection control, there was one sample positive for HIV antibodies. In 2012, the prevalence of antibodies against hepatitis B virus (HBV; anti-HBC) among confidentially-tested injecting drug users who were in treatment in Centres for the Prevention and Treatment of Drug Addiction (CPTDA) was 2%, and the prevalence of antibodies against hepatitis C virus (HCV) was 27.3%. In both cases, the proportion of infected drug users was the highest in 2011 compared to other years in the period 2008–2012. In 2012, medical emergency units in Ljubljana treated 47 patients for illicit drug poisoning, 27 of which were treated for poisoning with drug combinations and/or ethanol. The average age of persons treated for drug poisoning was 28.5 years, and most of them were male. The number of cases of ecstasy, amphetamine or cannabis poisoning was much higher in 2011 and 2012 than in 2010, when heroin poisoning cases prevailed. There were 26 drug-related deaths recorded in the Mortality Register in Slovenia in 2012. All drug users who died in 2012 were male, and their average and median age at death were 35.9 years. Heroin and methadone were the most common causes of fatal poisoning, followed by cocaine. Analysis of data on treated drug users included in the cohort showed that mortality rate among treated drug users is almost twice as high as the rate among their same-age peers in Slovenia.

Prevention of drug-related poisonings and deaths as well as prevention of infectious diseases are performed in the public health network – in centres for the prevention and

treatment of drug addiction – and by non-governmental organizations. The interministerial working group for Early-warning System on New Psychoactive Substances regularly informs expert public and drug users on the emergence of dangerous or new psychoactive substances. A 24-hour toxicological information-consultation service provides support to all Slovenian doctors who treat patients poisoned with illicit drugs. The non-governmental organization Združenje DrogArt enables drug users to have new psychoactive substances tested. Low-threshold programmes provide counselling and distribute free sterile materials among injecting drug users. In 2012, 553,426 needles and syringes were distributed among harm reduction programmes, which recorded 11,639 contacts with injecting drug users. Six non-governmental organizations carrying out fieldwork via mobile units travelled 148,797 kilometres in total and provided assistance to 1,025 illicit drug users in 2012. The Day Centre for abstinent with dual diagnosis is a high-threshold programme which has been operating since 2005 and is aimed at persons who have mental health problems in addition to drug addiction problems. So far, 40 persons have been admitted to the programme, and most of them suffered from depression or psychosis.

## 8

Professional activities aimed at solving drug-related social problems are carried out in the framework of public service (62 Centres for Social Work) and in private and non-governmental organizations which implement complementary social care programmes. Centres for social work recorded 220 cases of treatment related to drug problems in 2012. In the same year, about 4,500 drug users participated in social care programmes in the field of drug abuse prevention, which are co-funded by the Ministry of Labour, Family, Social Affairs and Equal Opportunities. A survey on the needs of illicit drug users who offer sexual services showed that most of them become involved in such activities due to drug use. There are more women than men among drug users who offer sexual services, and most of them became involved in this activity at a very young age, mostly before 20 years of age. Most of them work independently; they have up to three sexual contacts a day and earn up to EUR 100 or more per day. As regards drug use among such users, most use cocaine, followed by pills and heroin. More than half of them inject drugs. Two thirds of respondents stated they had health problems, and more than half stated that they had already been sentenced to jail time or probation. A social entrepreneurship project was launched in 2012, which provides training in the field of design, programming and web application design to young people who have experienced drug use. The project also offers them employment opportunities.

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In 2012, the police recorded 1,969 criminal offences (according to the Criminal Code) and 3,423 offences (as defined in the Production of and Trade in Illicit Drugs Act) involving illicit drugs, and investigated 2,235 people on suspicion of criminal offence involving illicit drugs. In 2012, cannabis remains the illicit drug that accounts for the largest proportion of criminal and minor offences. In 2011, the police treated 69 suspects who were under the influence of illicit drugs at the time they committed the offence, and recorded 123 criminal offences committed

with the intention of acquiring money to purchase illicit drugs. The police ordered 780 expert examinations to establish the presence of illicit drugs and other psychoactive substances in drivers, 280 of which tested positive for drugs. Most drivers were driving under the influence of methadone, opiates or benzodiazepines. In 2012, there were 116 cases of judicial police officers discovering illicit drugs in prisons, and cannabis accounted for the largest number of finds. There were 5,040 people imprisoned in Slovenian prisons in 2012; of 1,076 prisoners who had drug-related problems, 645 received substitution treatment. According to available data on test results, one prisoner tested positive for HIV virus in 2012, 5 prisoners tested positive for hepatitis B, and 20 for hepatitis C.

In 2012, there was a significant increase in the seized quantities of most illicit drugs in Slovenia compared to 2011, with the exception of methamphetamines and hashish. However, the total number of seizures of illicit drugs remains almost unchanged compared to previous years, while seizure quantities have increased for most illicit drugs. The traditional Balkan Route is still used for smuggling illicit drugs in both directions, and the volume of illicit drug smuggling has increased. The Slovenian police also recorded an increase in cannabis production, and it discovered and destroyed 75 enclosed spaces adapted for cultivation of cannabis under artificially created conditions in 2012. The prices for 1 gram of heroin, cocaine, amphetamine, cannabis and hashish have dropped compared to 2011. The most significant drop has been observed in amphetamine prices, since the supply of amphetamines has increased significantly on the Slovenian market. Average concentrations of cocaine, amphetamine, cannabis and hashish samples were similar as in previous years. The average concentration of seized cocaine samples increased and the average concentration of THC in seized hashish samples decreased in 2012 compared to previous years. 15 new psychoactive substances appeared in Slovenia in 2012, including mainly cathinones and synthetic cannabinoids.

# **PART A:**

## **NEW DEVELOPMENTS AND TRENDS**

# 1. DRUG POLICY: LEGISLATION, STRATEGIES AND ECONOMIC ANALYSIS

Jože Hren, PhD, Mircha Poldrugovac, Jasna Prebil, PhD

In July 2012, the Government of the Republic of Slovenia adopted the National Crime Prevention and Crime Control Strategy, which pays a great deal of attention to drugs. The solutions set out in the Strategy include the prevention of illicit drug supply, drug use prevention, and treatment and social rehabilitation of drug users. As the competent institution responsible for coordination in the field of illicit drugs in Slovenia, the Ministry of Health (jointly with other competent ministries and non-governmental organizations) is responsible for the implementation of the aforementioned strategy, the chapters on illicit drugs in particular.

In April 2013, the National Assembly of the Republic of Slovenia adopted the Resolution on the National Social Assistance Programme for 2013–2020, which establishes, *inter alia*, a network of programmes in the field of addiction intended for illicit drug users as well. The National Social Assistance Programme specifies the scope of the programmes and their accessibility and availability to all citizens.

In June 2013, a proposal for the first National Youth Programme for 2013–2022, which also covers illicit drugs, was submitted for adoption to the National Assembly of the Republic of Slovenia.

Drug-related programmes in Slovenia are funded through various sources. Most of these programmes continue to be funded by the national budget and by the Health Insurance Institute of Slovenia. A share of financial resources comes from various foundations and membership dues paid by members of non-governmental organizations. This year, we also present data on financial resources provided by Slovenian municipalities to combat drug-related problems. Data from the 11 city municipalities were included in last year's report. This year, however, we invited all 212 Slovenian municipalities to report on their co-funding of programmes in the field of illicit drugs. Based on available data, we estimate that at least EUR 9,790,530.72 was spent on the solution of drug-related problems in Slovenia in 2012.

## 1.1 Legal Framework

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

- The Penal Code (Official Gazette RS, Nos. 55/08, 66/08 – amended, and 39/09) regulates two (major) criminal offences related to illicit drugs in the chapter on criminal offences against human health, namely the illicit production of and trafficking in illicit drugs, illicit substances in sports and precursor substances for manufacturing

illicit drugs, and the criminal offence of enabling consumption of illicit drugs or illicit substances in sports.

- The Production of and Trade in Illicit Drugs Act (Official Gazette RS, Nos. 108/99, 44/00, 2/04 – ZZdl-A, and 47/04 – ZdZPZ) defines illicit drugs as plants or substances of natural or synthetic origin which have psychotropic effects and which can influence a person's physical or mental health or threaten a person's rightful social status. Article 3 of the Act classifies illicit drugs into three groups according to the degree of risk to health in the event of their abuse, and according to their use in medicine. The Government of the Republic of Slovenia set out the classification of illicit drugs in the Decree on the Scheduling of Illicit Drugs adopted in 2000.
- The Act Regulating the Prevention of the Use of Illicit Drugs and the Treatment of Drug Users (Official Gazette RS, No. 98/99) defines, *inter alia*, drug-related treatment and measures for solving social problems related to drug use.

### **New Developments in Legislation**

As a regulatory umbrella in the field of youth policy in Slovenia, the Public Interest in Youth Sector Act, adopted in 2010, forms the legal basis for preparing the first National Youth Programme for the period 2013–2022. The Office of the Republic of Slovenia for Youth, which is part of the Ministry of Education, Science and Sport, is responsible for preparing the Programme. Based on various analyses and research, a document was drafted in cooperation with other ministries and youth representatives and approved on 6 June 2013 by the Slovenian Government, which submitted it for adoption to the National Assembly. At the time of preparation of the present National Report, the National Youth Programme was still in the process of adoption.

The National Youth Programme states that the primary objective of prevention in the field of illicit drugs is to create social conditions that give individuals the opportunity to develop a lifestyle that does not involve drug use. At the same time, it stresses the need to develop all measures and activities aimed at reducing illicit drug supply and educating young people about the effects of all kinds of drugs (including licit drugs).

As stated above, the National Assembly of the Republic of Slovenia adopted the Resolution on the National Social Assistance Programme for 2013–2020 in April 2013 (see also Chapter 8). The Resolution establishes, *inter alia*, a network of programmes in the field of addiction, which are also intended for illicit drug users. The aforementioned programmes include: prevention programmes, information and counselling programmes and telephone counselling programmes, coordination programmes, support programmes, assistance and self-help programmes, harm reduction programmes, day centres carrying out fieldwork, housing programmes, therapy programmes, reintegration programmes and activation programmes aimed at increasing employment opportunities. The Resolution states, *inter alia*, that the aim of developing activities in the field of illicit drugs in the aforementioned period is to establish 12 counselling services for various forms of addiction and ensure their operation, and to ensure that low-threshold programmes have the total capacity to admit 2,000 users and that high-threshold programmes are able to admit 300 users.

The purpose of the Slovenian social security system is to ensure social security and social inclusion of all citizens and other residents in the country. In the context of social protection

policies, the Government and local communities have the obligation to create conditions which allow individuals to cooperate in a creative manner with other persons in their family, working and living environment, and to realize their potential for development and, through their activities, achieve the level of quality of life which is comparable to that of other inhabitants of Slovenia and meets the criteria of human dignity. When individuals and families are unable to ensure their own social security, they become eligible for assistance provided by the Government and local communities in the context of active social policy.

## **1.2 National Action Plan, Strategy, Evaluation and Coordination**

### **Strategy**

In July 2012, the Government of the Republic of Slovenia adopted the National Crime Prevention and Crime Control Strategy, which pays a great deal of attention to drugs. The Strategy highlights the following specific objectives in the field of illicit drugs:

- ensure successful detection of criminal acts and offences in the field of illicit drugs;
- reduce the number of all illicit drug users;
- ensure and strengthen universal, selective and indicated prevention activities aimed at preventing drug use and reducing drug-related crime.

The following measures and activities are to be carried out to achieve the aforementioned specific objectives:

The roles of individual organized crime groups, both those active in Slovenia and those operating in larger areas, must be permanently monitored and defined. This requires the strengthening of intelligence activities, establishment of analytics for the field of illicit drugs, measures to direct and plan activities, effective fight against organized crime in the field of illicit drugs, centrally managed approach to working in the field of drugs, fight against cross-border trafficking in drugs and precursors, and more complex treatment of offenders and perpetrators.

Efforts to reduce the demand for illicit drugs involve creating living environments that enable and support decisions against using drugs, and carrying out activities at different levels of prevention, including reducing the negative health and social consequences of drug use, providing treatment, social care and social reintegration of former drug addicts and persons released from prison. Special emphasis should be placed on mental health promotion, provision of care to adolescents and women – especially pregnant drug users – and prevention of HIV infections and other infectious diseases. Comprehensiveness and coordination of various programmes and activities are ensured at the national level.

Universal prevention is broadly targeted and aimed at the whole population or a large group of people. Its aim is to prevent or delay drug use through messaging and programmes. Its advantage is that it targets and reaches out to a large number of people. Selective prevention targets specific populations – vulnerable groups and communities the members of which are at risk for substance abuse due to various risk factors. Focusing intervention efforts on specific groups increases the possibility of meeting the needs of these groups as well as the likelihood that intervention will be successful. Indicated prevention is aimed at

individuals who are at high risk for developing an addiction later in life. The purpose of indicated prevention is to identify individuals with the aforementioned problems and provide them with treatment. Prevention programmes are implemented at the local and national level.

### **Coordination**

Coordination in the field of drugs at the government level is the responsibility of the Commission on Narcotic Drugs of the Slovenian Government and the Ministry of Health. At the local level, local action groups remain the main coordinators of activities in local communities.

The highest coordinating body in the field of drugs is the Commission on Narcotic Drugs of the Slovenian Government, which is an inter-ministerial body at the government level. The Commission held two meetings in 2012. Among other things, it discussed the annual national report on the drug situation, reports on the implementation of harm reduction programmes in Slovenia as well as the report and proposal on the operation of Local Action Groups. The Ministry of Health ensures that the Commission on Narcotic drugs stays operational by preparing materials for its meetings and arranging for the implementation of the Commission decisions. Drug-related measures are implemented within different governmental departments: the Ministry of the Interior, the Ministry of Labour, Family, Social Affairs and Equal Opportunities, the Ministry of Education, Science and Sport, the Ministry of Justice, the Ministry of Finance, the Ministry of Foreign Affairs, the Ministry of Agriculture and Environment, the Ministry of Defence and the Ministry of Health.

## **1.3 Economic Analysis**

Drug-related programmes in Slovenia are funded through various sources. Most of these programmes continue to be funded from the national budget and by the Health Insurance Institute of Slovenia. A share of financial resources comes from various foundations and membership dues paid by members of non-governmental organizations. There are still very few donations or there is no available information thereon.

### **Budget Appropriations**

Through public tendering, the Ministry of Health dedicated EUR 140,000.00 to drug-related programmes for the 2011–2012 period. Half of this amount was paid to selected programmes in 2012. In the same year, the Ministry also provided a proportional share of financial resources needed for the operation of the Illegal Drugs Unit of the National Institute of Public Health, amounting to EUR 103,173.00. Financial resources allocated by the Ministry of Health to address drug-related problems in 2012 amounted to EUR 173,173.00.

The Office for Youth of the Republic of Slovenia co-funded through its instruments activities or programmes that can be identified as direct implementation of activities in the field of illicit drugs. It provided EUR 45,351.00 for such activities and programmes.

In 2012, the Ministry of Labour, Family, Social Affairs and Equal Opportunities (MLFSAEO) provided EUR 2,840,897.90 for the implementation of drug user treatment programmes for the same year through public tendering.



Table 1.1 presents data on the amount of resources provided by the MLFSAEO to social rehabilitation programmes for addicts, including social security programmes in the field of illicit drugs.

**Table 1.1:** MLFSAEO's financial resources allocated to drug-related social security programmes

Year:	MLFSAEO resources allocated to	Social rehabilitation programmes for addicts (EUR)	Therapeutic community programmes and other programmes that provide housing for drug users, in cooperation with associated networks of reception and day centres, reintegration centres, programmes for parallel therapy support for the families of drug addicts, and other programmes for drug users or alternatives to therapeutic communities (EUR)	Low-threshold programmes for drug users, networks of centres for counselling and social rehabilitation of illicit drug addicts who need daily treatment or assistance(EUR)
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*	1,514,458.00	544,492.50
2008		2,290,728.00*	1,445,691.00	399,013.40

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

Source: Report of the MLFSAEO<sup>1</sup>

The Ministry of Labour, Family, Social Affairs and Equal Opportunities provides programmes with funds amounting up to 80% of their costs; programme providers must obtain the remaining funds from other sources. The role of local communities is of key importance, as they help programme providers acquire suitable premises for the implementation of programmes.

Of all the resources provided by the MLFSAEO for the co-funding of programmes (within the scope of "Social rehabilitation of drug addicts"), about 60% is allocated to high-threshold programmes, about 25% to low-threshold programmes, and about 15% to prevention programmes (selective and indicated prevention). Resources provided for programme implementation are intended primarily for payments to professional workers and basic material costs.

Through a public tender for the implementation of European Cohesion Policy projects for the 2010–2012 period, the Ministry of Public Administration selected two substantive networks of non-governmental organizations. The Utrip Institute for Research and Development received EUR 108,719.35 for the establishment of a prevention platform of NGOs working in the field of addiction prevention. The DrogArt Association received EUR 146,789.90 for the project of empowerment of NGOs working in the field of harm reduction. The purpose of public co-funding is to promote the development of the non-governmental sector and the civil dialogue in relevant thematic areas. Financial resources were allocated for the implementation of all activities carried out over the said two-year period.

<sup>1</sup> Available from the author. Received via e-mail.

The Slovenian Criminal Police uses over half a million euros each year in its fight against organized crime. Data show that financial resources used for the implementation of covert investigative measures and the purchase of technical equipment amounted to EUR 657,254.05 in 2011. Data for 2012 are not available. A large proportion of these resources is allocated to the fight against illicit drugs. Since information on such resources often relates to a number of different offences, we cannot present accurate data on the amount of financial resources devoted to the field of illicit drugs.

The Health Insurance Institute of Slovenia provided EUR 5,214,955.00 for the operation of drug addiction prevention and treatment centres in 2012. EUR 2,555,763.00 was spent on operational costs (personnel, facilities, etc.), and EUR 2,659,192.00 on substitute drugs (methadone and other drugs).

Furthermore, the Health Insurance Institute of Slovenia provided EUR 147,859.04 for the purchase of sterile material for safer drug injection in 2012. The said amount was distributed by the Regional Institute of Public Health Koper among harm reduction programmes.

In 2012, the FIHO foundation dedicated EUR 326,270.54 to drug-related programmes implemented by NGOs.

In this year's report, we report on the co-funding of drug-related programmes in all Slovenian municipalities for the first time. According to current legislation, a municipality is a self-governing local community which ensures: primary education, primary health care, the supply of basic commodities, municipal infrastructure, postal services, financial services by banks or savings banks, access to libraries, and premises for administrative needs of the local community.

Under the national legislation, a municipality must have at least 5,000 inhabitants. (As an exception, for geographical, border, ethnic, historical or economic reasons, a municipality may have less than 5,000 inhabitants.)

For the first time, last year's report presented data on the co-funding of drug-related programmes by the eleven Slovenian city municipalities. The Table 1.2 provides data for both 2011 and 2012 for purposes of comparison.

**Table 1.2:** Financial resources used in the field of drugs by city municipality, 2011 and 2012

	Municipality	Amount in 2011	Amount in 2012
1.	Celje	28,545.63	22,162.35
2.	Koper	45,000.00	25,500.00
3.	Kranj	87,210.00	57,145.42
4.	Ljubljana	342,214.30	322,640.00
5.	Maribor	106,773.00	40,625.00
6.	Murska Sobota	700.00	Not available
7.	Nova Gorica	38,831.00	56,123.43
8.	Novo mesto	30,000.00	Not available

Table 1.2 continues ...

	Municipality	Amount in 2011	Amount in 2012
9.	Ptuj	22,801.93	Not available
10.	Slovenj Gradec	66,786.84	10,818.00
11.	Velenje	8,870.00	Not available

Source: city municipalities

**Table 1.3:** Aggregated data on financial resources used in the field of drugs, 2012

	Funder	Amount
1.	Slovenian municipalities	727,730.18
2.	FIHO	326,270.54
3.	Office for Youth	45,351.00
4.	Health Insurance Institute of Slovenia (ZZZS)	5,572,581.59
5.	Ministry of Health	173,173.00
6.	MLFSAEO	2,840,897.90

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

The present report only contains information from the available reports on the funding of various drug-related programmes. Reports by certain programme co-funders show that they co-fund various organizations and projects in their entirety; therefore, it is difficult to determine the amount used in the implementation of the entire programme and the amount used specifically in the field of drugs. However, we can estimate that the resources used to address drug-related problems in Slovenia amounted to at least EUR 9,790,530.72 in 2012 (Table 1.3).

Estimated total expenditure on illicit drugs is EUR 1,337,098.60 lower compared to the 2011 amount. On this basis, it is not possible to determine the actual reduction in public expenditure in this field, since the basis for estimates varies from year to year. For example, unlike in 2011, we did not receive this year's estimates of costs of investigative measures and police equipment used in carrying out activities in the field of illicit drugs. Furthermore, as mentioned above, we collected data from all Slovenian municipalities for the first time this year, while last year's data refer only to city municipalities. However, some of the municipalities that provided data last year have not responded to the invitation to submit data this year.

This year's data show a significant reduction in the Ministry of Health expenditure (EUR 74,153.67 less in 2012 compared to 2011). Here, it should be noted that the difference is mostly due to singular events in 2011, such as the meeting of Pompidou Group Correspondents and the associated regional ministerial conference. In previous years, co-funding of NGO programmes by the Ministry of Health was arranged on the basis of a call for tenders and has remained unchanged in terms of financial resources (EUR 70,000). In 2012, the Ministry of Public Administration also continued to co-finance programmes according to the arrangement made in 2010 for a three-year period.

The largest single funder of programmes in the field of illicit drugs is the Ministry of Labour, Family, Social Affairs and Equal Opportunities. Its expenditure in this field decreased from EUR 3,001,174.78 to EUR 2,840,897.90, i.e. by 5.3%. The Office for Youth expenditure decreased from EUR 58,994.00 in 2011 to 45,351.00 in 2012. Here, it should be noted that the co-funding of programmes includes, but is not limited to, the field of illicit drugs.

The combined values of the expenditures of all municipalities are not comparable for the reasons mentioned above. Nevertheless, a comparison between 2011 and 2012 amounts spent in individual municipalities (see Table 1.2) shows that expenditure has decreased in six of the seven municipalities for which data are available.

In the field of health care, there has been an increase in expenditure on hospitalizations associated with illicit drug poisoning. It is important to note here that such expenditure depends mainly on the number of cases of poisoning and not on the changes in hospital services funding. The remaining expenses of the Health Insurance Institute of Slovenia (HIIS) are planned in advance and were significantly lower in 2012 compared to 2011. HIIS provided EUR 5,362,814.04 for the operation of centres for the prevention and treatment of drug addiction, for the purchase of drugs used in substitution therapy, and for the purchase of sterile material for safe drug injection in 2012, which is 7.2% less than the year before.

Changes in the volume of funding in the field of illicit drugs should be seen in the context of the economic crisis, which has affected many European countries to a greater or lesser extent in the past five years. According to Eurostat, the total general government expenditure amounted to EUR 17,377 million in 2012, and EUR 18,362.3 million in 2011. Thus, the absolute expenditure decreased by 5.4%. A comparison of main aggregates shows that central government expenditure decreased by 8.27% in 2012 compared to 2011, local government expenditure decreased by 3.34%, and social security funds expenditure by 1.43%. The measures aimed at balancing public finances, which are described in more detail in the 2012 National Report, probably had a significant impact on reducing government spending. It is difficult to estimate the direct impact of these measures on expenditures on illicit drugs; however, the above data show a significant reduction in available resources, irrespective of the source of funding.

## 2. DRUG USE IN GENERAL POPULATION AND SPECIFIC TARGET GROUPS

According to the Survey on the use of tobacco, alcohol and other drugs conducted in 2011 and 2012 by the National Institute of Public Health, 16.2% of inhabitants of Slovenia aged 15–64 have used an illicit drug on one or more occasions in their lifetime. Among those who reported lifetime drug use, most used cannabis (15.8%). The proportion of lifetime cannabis use was higher in men than in women and was highest in respondents under 34 years of age. Less than one percent of the Slovenian population have used new drugs on at least one occasion in their lifetime. Respondents who have already used one of the new drugs mostly stated that they had used methylone or mephedrone. Survey results concerning alcohol use show that more than half of the Slovenian population aged 15–64 years are low-risk drinkers, 5.8% are risky drinkers and nearly one-fifth were abstinent in the previous year. There were more men than women among risky drinkers, and the 15–24 age group had the largest proportion of risky drinkers. As regards tobacco use, survey results show that 24% of Slovenian population aged 15–64 are smokers, and that there are more smokers among men than women. Most smokers smoke regularly, i.e. every day.

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

The survey on the use of drugs in nightlife conducted in Slovenia and Italy showed that marijuana was the illicit drug used by the largest proportion of respondents in both countries. In Slovenia, marijuana was followed by amphetamines and cocaine. The second and third most commonly used drugs among Italian respondents were cocaine and hallucinogens, respectively.

### 2.1 Drug Use in General Population\*

#### Illicit Drug Use in Slovenian Population Aged 15–64

Andreja Drev, Darja Lavtar, Katja Rostohar, PhD

The National Institute of Public Health (NIPH) conducted a Survey on the Use of Tobacco, Alcohol and Other Drugs among the inhabitants of Slovenia aged 15–64 in 2011 and 2012. The survey and methodology used are described in more detail in the Report on the Drug Situation 2012 of the Republic of Slovenia. Presented below are some key survey results.

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\* In articles under this heading only statistically significant results are described

According to the Survey on the Use of Tobacco, Alcohol and Other Drugs, 16.2% of inhabitants of Slovenia aged 15–64 (almost one fifth of men and 12.2% of women) have used an illicit drug on one or more occasions in their lifetime. Most of those who reported lifetime drug use used cannabis. 2.1% of people reported lifetime use of cocaine, and the same proportion of people reported lifetime use of ecstasy. 1.0% reported lifetime use of LSD and 0.9% reported lifetime use of amphetamines. Heroin was used by less than one percent of people (Table 2.1).

### **Cannabis**

Cannabis was the most commonly used illicit drug in Slovenia; 15.8% of the Slovenian population reported lifetime use, 4.4% reported last-year use, and 2.3% reported last-month use of cannabis. The average age of first use of cannabis was 18. The proportion of lifetime cannabis use was higher in men (19.5%) than in women (11.8%) and in inhabitants of Slovenia under 34 years of age than in groups over this age. As regards education and status, lifetime use of cannabis was highest in people with secondary or higher education and in those who were in process of education. The proportion of last-year and last-month use was the highest in young people in the 15–24 age group. 0.4% of the Slovenian population aged 15–64 used cannabis every day or almost every day (i. e. used cannabis 20 or more days in the last month). Daily use estimate by number of people showed that about 6,350 people used cannabis more than 20 times in the month before the survey.

The survey questionnaire also included opinion questions such as “should cannabis use be legalized”. More than half (64.3%) of the Slovenian population aged 15–64 believes that cannabis use should not be legalized, while nearly one fifth (19.2%) thinks that cannabis use should be legalized, and 16.5% of Slovenians are undecided on this issue. Mostly men and groups under 45 years of age were in favour of legalizing cannabis use, while most women and groups over 45 years of age opposed its legalization.

### **New Drugs**

The Survey on the Use of Tobacco, Alcohol and Other Drugs also included questions about the use of new drugs, or, more precisely, about lifetime, last-year and last-month use. It should be noted that, in the survey period, mephedrone was the only new drug already added to the list of illicit drugs under Slovenian law. According to survey results, less than one percent (0.6%) of the Slovenian population aged 15–64 have used new drugs on at least one occasion in their lifetime, 0.3% of people reported last-year use of new drugs and 0.1% reported last-month use. The proportion of lifetime use of new drugs in the 15–24 age group was 1.8%. The average age of first use of a new drug was 21. Respondents who had already used one of the new drugs mostly reported methylone or mephedrone use.

**Table 2.1:** The prevalence of illicit drug use in the general population and selected age groups

Prevalence (%)	Drug	Total	Gender		Age group	
		15–64 years n=7514	Male n=3440	Female n=4074	15–24 years n=1464	15–34 years n=1550
Lifetime use	Any drug	16.2	19.9	12.2	27.7	30.0
	Cannabis	15.8	19.5	11.8	27.3	29.7
	Cocaine	2.1	2.8	1.2	3.9	4.4
	Ecstasy	2.1	2.7	1.4	3.5	5.4
	LDS	1.0	1.4	0.6	0.9	1.6
	Amphetamines	0.9	1.4	0.5	1.9	2.3
	Heroin	0.5	0.7	0.3	0.7	0.8
	New drugs	0.6	0.9	0.3	1.8	1.0
Last year	Any drug	4.5	6.0	2.9	15.4	7.0
	Cannabis	4.4	5.9	2.8	15.0	6.9
	Cocaine	0.5	0.7	0.3	1.9	0.6
	Ecstasy	0.3	0.4	0.2	1.3	0.4
	LDS	0.1	0.2	0.1	0.4	0.3
	Amphetamines	0.3	0.5	0.1	1.1	0.5
	Heroin	0.1	0.1	0.0	0.3	0.1
	New drugs	0.3	0.4	0.2	1.2	0.5
Last month	Any drug	2.4	3.4	1.3	7.7	3.9
	Cannabis	2.3	3.3	1.2	7.5	3.7
	Cocaine	0.1	0.2	0.1	0.6	0.2
	Ecstasy	0.1	0.2	0.1	0.5	0.3
	LDS	0.0	0.1	0.0	0.2	0.0
	Amphetamines	0.1	0.2	0.1	0.5	0.3
	Heroin	0.0	0.0	0.0	0.1	0.0
	New drugs	0.1	0.1	0.1	0.3	0.2

Source: NIPH, 2011–2012 Survey on the Use of Tobacco, Alcohol and Other Drugs

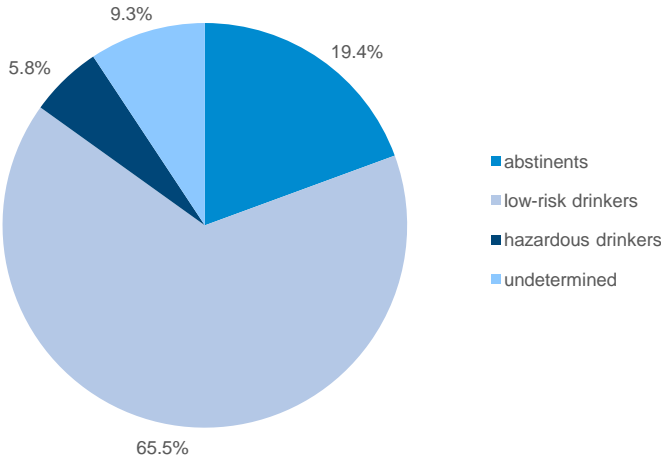
More detailed information on survey results can be found in the “Uporaba prepovedanih drog, tobaka in alkohola 2011–2012” (The Use of Illicit Drugs, Tobacco and Alcohol) publication, which will be published shortly.

### Alcohol Consumption in Slovenia

Maja Zorko, PhD, Darja Lavtar, Katja Rostohar, PhD

The data from the Survey on the Use of Tobacco, Alcohol and Other Drugs conducted in 2011–2012 in Slovenia (Lavtar et al. 2013) show that more than half of the Slovenian population aged 15–64 years are low-risk drinkers, 5.8% are hazardous drinkers and 19.4% were abstinent in the previous year (Figure 2.1). Low-risk drinkers are defined as men who

consume 20 grams or less of pure alcohol a day, and women who consume 10 grams or less of pure alcohol a day<sup>2</sup>. All people who exceed these limits are defined as hazardous drinkers.



Source: NIPH, 2011–2012 Survey on the Use of Tobacco, Alcohol and Other Drugs

**Figure 2.1:** Proportion (%) of abstinent in the previous year, low-risk drinkers and hazardous drinkers among the Slovenian population aged 15–64, and the proportion of persons with undetermined drinking status

There were more men (8.3%) than women (3.2%) among hazardous drinkers. Slovenians in the 15–24 age group had the largest proportion of hazardous drinkers, and the 35–44 age group had the smallest. Furthermore, people with primary or lower education had the largest proportion of hazardous drinkers, while those with higher or tertiary education had the smallest. Unemployed persons and students proved to be particularly vulnerable, since they had a higher proportion of hazardous drinkers than employed persons.

Analysis of the results obtained via the AUDIT-10 questionnaire (Babor et al. 2001, Kolšek 2004) showed that almost one quarter (24.7%) of the Slovenian population aged 15-64 are at increased risk of hazardous drinking, and 2.5% are at increased risk of harmful drinking or even alcohol dependence (Lavtar et al. 2013).

**Prevalence of Tobacco Use in Slovenia between 2007 and 2011/12**

Helena Koprivnikar, Aleš Korošec PhD

The Survey on the Use of Tobacco, Alcohol and Other Drugs, conducted in 2011 and 2012, showed that 24% of Slovenian citizens aged 15–64 are smokers, more men (26.9%) than women (21%). The proportion of smokers is lower among people with tertiary education in comparison with other educational groups (primary school or less, lower or secondary vocational, secondary of professional), among which proportions of smokers do not differ. Proportions of smokers also differ in relation to age (Table 2.2). The vast majority of smokers (79.7%) smoke regularly, every day.

Comparison of data from this survey with those obtained in the 2007 Survey on Health and Health Care, which was conducted for the same age group, shows that the proportion of smokers in the Slovenian population aged 15–64 decreased from 29.3% to 24% between

<sup>2</sup> 10 grams of alcohol (1 unit of alcohol) is found in 3.3 oz of wine or 8.4 oz of beer or 1 oz of spirit drinks (2).



2007 and 2011/12. The proportion decreased in general and for both men and women, in some age groups (25–34 and 34–44 years) as well as among people with vocational education and those with tertiary education (Table 2.2).

Beneficial changes in the proportion of smokers between 2007 and 2011/12 were brought about by the introduction of a complete ban on smoking in all enclosed public and work places in 2007 and regular increases in taxation and prices of tobacco products. Previous research has shown that the proportion of smokers decreased mainly in 2007 in 2008, whereafter it started increasing again (Ministry of Health 2011, Ministry of Health 2010, Ministry of Health 2009, Institute of Public Health 2008). Our data additionally show that the proportion of smokers has not yet reached the baseline level, i.e. the level before the introduction of the ban on smoking in all enclosed public and work places. However, between 2007 and 2011/12 the proportion of smokers did not change among adolescents and young adults (aged 15–24), which is also confirmed by other researches (Koprivnikar 2013, Hibell et al. 2012). All this shows not merely that a significant proportion of the Slovenian population still smokes and that the proportion has been on the rise again in recent years, especially among girls and women (Koprivnikar 2013, IVZ 2013), but also that there is a need to introduce additional effective tobacco control measures as soon as possible.

**Table 2.2:** Proportion of smokers among the Slovenian population aged 15–64, in 2007 and 2011/12

Proportion of smokers aged 15–64 (%)		2007*, aged 15–64 (%)	2011/12**, aged 15–64 (%)	Change (statistically significant)
Total		29.3	24.0	↓
Gender	male	31.7	26.9	↓
	female	26.9	21.0	↓
Age	15–24	25.5	25.2	no change
	25–34	36.3	28.0	↓
	35–44	32.4	22.9	↓
	45–54	28.6	25.6	no change
	55–64	21.2	18.4	no change
Education	primary school or less	29.1	27.8	no change
	lower or secondary vocational school	37.1	28.4	↓
	secondary or professional school	26.7	27.3	no change
	tertiary education	23.6	15.1	↓

Source: NIPH, \* 2007 Survey on health and health care \*\*, 2011–2012 Survey on the use of tobacco, alcohol and other drugs

## 2.2 Drug Use in School-aged Population

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

## **ESPAD**

In 2011, the European School Survey Project on Alcohol and Other Drugs was conducted for the fifth time in a row in Slovenia. According to survey results, 24.8% of surveyed 15 and 16-year-old students have used at least one illicit drug in their lifetime. The data also show a trend similar to those in other countries, namely the stabilization of illicit drug use prevalence after 2007. However, Slovenian prevalence rates of lifetime use of inhalants and cannabis stand out in comparison with the ESPAD countries' average rates, as 20% of Slovenian students reported lifetime use of inhalants, and 23% reported lifetime use of cannabis.

## **HBSC**

In 2010, the Health Behaviour in School-aged Children survey was conducted in Slovenia for the third time in a row. The survey includes different questions, including those about marijuana use among 15-year-old students. According to survey results, 23.2% of 15-year-olds have tried marijuana at least once in their lifetime. 18% of 15-year-old respondents reported past-year marijuana use, and 10% reported past month marijuana use. The proportion of 15-year-olds who reported lifetime marijuana use decreased between 2002 and 2006, after which it increased again in the 2006–2010 period.

## **2.3 Drug Use in Targeted Groups/Settings**

### **Cocaine Use in Nightlife in Slovenia and Italy**

Matej Sande, PhD

This section presents some findings from a survey on the use of cocaine and other drugs in nightlife conducted by the DrogArt Association and Etnoblog in 2010. The survey was carried out in parallel in Slovenia and Italy (in the Province of Venice and the Friuli-Venezia Giulia region) because we were interested in both the characteristics of drug use in Slovenia as well as the comparison with Italy, which has one of the highest prevalence rates of cocaine use among young adults in the EU (EMCDDA 2006, EMCDDA 2010). The survey took the form of applied research, thus its main objective was to obtain useful results concerning harm reduction aimed at improving the existing assistance programmes and the provision of new services for cocaine users.

#### **The Purpose of the Survey**

The main purpose of the survey on cocaine use in nightlife was to obtain data on the prevalence and characteristics of cocaine use in bars, clubs and dance clubs in Slovenia and Italy. Furthermore, we were looking to find out what cocaine-related adverse consequences are experienced by the users. We were also interested in the economic aspects of cocaine use, that is to say, monthly consumption, quality assessment and the influence of cocaine prices on its consumption. Other purposes of the survey were to determine users' needs for assistance and additional information concerning cocaine use, and to establish what information provision methods users prefer or which such methods they are most likely to accept.

#### **Sampling Procedure and Survey Sample**

Sampling was carried out in Slovenia and Italy between May and October 2010. In Slovenia, it was carried out in bars and clubs in large cities and at large and small electronic music

events, while a part of the sampling procedure was carried out via an online questionnaire, which is identical to the questionnaire handed out during field work. In Italy, sampling was carried out in clubs and bars, at festivals and electronic music events in the Province of Venice and the Friuli-Venezia Giulia region.

After assessing reliability and validity, the Slovenian survey sample consisted of 607 respondents, of whom 57.2% were male and 42.8% were female. The average age was 25, and the sample age range was 15 to 56. 21.3% of respondents were over 30 years of age.

The final sample in the Italian part of the survey consisted of 446 respondents, of whom 52.9% were male and 47.1% were female. The average age was 26, and the sample age range was 15 to 50. 19.1% of respondents were over 30 years of age.

### Survey Results on Drug Use in Nightlife in Slovenia and Italy

In the survey, we examined the prevalence of drugs which, according to previous research on drugs and alcohol in Slovenia (SAT 2001, SAT 2005, MOND 2007), are most commonly used. Marijuana was the illicit drug used by the largest proportion of respondents (over 80%) in both countries. In Slovenia, marijuana was followed by amphetamines and cocaine. The second and third most commonly used drugs among Italian respondents were cocaine and hallucinogens, respectively (Table 2.3).

In the Slovenian part of the sample, there were statistically significant ( $p = 0.001$ ) differences between men and women as regards drug use, which applies to most illicit and licit drugs, except for mephedrone and 2CB/2CE. There were statistically significant (from  $p = 0.001$  to  $p = 0.05$ ) differences between men and women for most illicit and licit drugs in the Italian sample as well, except for heroin and crack. In the sample used in our survey on cocaine use in nightlife, men in both countries accounted for a significantly higher proportion of persons experimenting with illicit drugs than women.

**Table 2.3:** The prevalence of the use of drugs included in the survey

Drug	ITA (n=446)	ITA (%)	SLO (n=607)	SLO (%)
Marijuana	366	82.1	534	88.0
Poppers	183	41.0	407	67.1
Amphetamines	123	27.6	360	59.3
Cocaine	188	42.2	347	57.2
Ecstasy	143	32.1	329	54.2
Crack	51	11.5	227	37.4
Mephedrone	/	/	126	20.8
Hallucinogens	144	32.3	227	37.4
Ketamine	79	17.7	/	/
Heroin	50	11.2	73	12.0
2CB/2CE	/	/	49	8.1

Source: DrugArt Association and Etnoblog, 2010 Survey on Drug Use in Nightlife in Slovenia and Italy

We examined the frequency of use for the drugs that, according to data from our previous research, were most prevalent in nightlife or that interested us most due to specific characteristics of use in Italy and Slovenia (ketamine, mephedrone). The drug used most commonly in Italy was marijuana, as more than half of respondents tried it on more than forty occasions. Marijuana was followed by cocaine and ecstasy, both with significantly smaller proportions. If we compare these data with those from the Slovenian part of the survey, we can see that the frequency of use is similar for marijuana, cocaine and heroin, while the prevalence of frequent use of amphetamines and ecstasy was significantly higher in Slovenia. It was surprising that Slovenia had a relatively high prevalence of mephedrone (20.8%), which was not yet classified as an illicit drug at the time of the survey. As regards Italy, we examined ketamine (which was allegedly a relatively popular drug in nightlife at that time) instead of mephedrone. Ketamine was used by 17.7% respondents, of which 4.2% used it on more than forty occasions.

## Conclusion

We cannot generalize about the nightlife drug use in Slovenia on the basis of survey data, since the sample was too small and non-representative. Furthermore, the results should not be considered representative for Italy, which is a country with a dynamic nightlife that differs greatly across regions and according to geographical location.

Based on survey results and keeping in mind sampling limitations, it can be concluded that cocaine is the second most commonly used illicit drug (lifetime prevalence) in nightlife in the Province of Venice and the Friuli-Venezia Giulia region (after marijuana), since it was used on at least one occasion by 42.2% of respondents included in the sample. Although a relatively high proportion of respondents tried cocaine, less than half (18.7%) of them used it on a frequent basis (more than forty times) in their life. According to the respondents' answers about the frequency of use, 4.4% of respondents in the sample (n = 436) used cocaine several times a month (but less than once a week), and 5% used it at least once a week. Thus, less than 10% of respondents often used cocaine in nightlife.

Similarly to the Slovenian part of the survey, the Italian results show that cocaine users are poorly informed about the risk of transmission of HIV and hepatitis viruses associated with sharing snorting tools. Snorting or sniffing cocaine is the ingestion method used by most respondents (93%), and 87.6% of respondents who used cocaine stated that they sometimes or always shared snorting tools (bank notes, rolls of paper). An important difference between the two parts of the survey is that the Friuli-Venezia Giulia region had a significantly higher percentage of cocaine users smoking and injecting cocaine. 8% of respondents in the Slovenian part of the survey smoked cocaine, while Italy the share of such respondents was 68.8%. The reason for such a difference probably lies in the fact that smoking cocaine with tobacco is quite popular in the Friuli-Venezia Giulia region, while this method of use is relatively rare or less known in Slovenia.

While the results show that lifetime prevalence of cocaine use in nightlife is relatively high in both countries, only a small proportion of users use it with any degree of regularity. Considering the risky method of cocaine use, various target groups of users should be alerted to the dangers of sharing snorting tools and encouraged to use their own tools. Due

to the similarity of results – and keeping in mind the mentioned sampling limitations – the recommendations set out below apply to both Italy and Slovenia.

Users in both countries consider snorting a safer or less risky method of use with no possibility of addiction and no risk of virus transmission. One possible way to reduce cocaine-related harm and risks is to inform users in bars and clubs about the importance of using one's own tools.

Given that three quarters of Slovenian respondents and almost three quarters of Italian respondents use cocaine in toilet booths in bars and clubs, toilets are a good place to reach out to users with posters/advertisements and thus inform them about cocaine use. 20.1% of Slovenian respondents and 10.8% of Italian respondents chose toilet advertising as the most suitable method of providing information.

Survey results concerning methods of use and tool or equipment sharing showed that there is a need to inform nightlife cocaine users about the risk of virus transmission associated with the sharing of snorting tools. In addition, most users in both countries stated that they wished to receive information about harmful admixtures and cocaine quality or purity. According to the data provided by the Forensic Investigation Centre of the General Police Administration, the average purity of cocaine seized in Slovenia is about 30%, the remaining part consisting of admixtures which may have additional adverse effects on health (most common chemically active substances added to cocaine include levamisole and phenacetin). Thus, providing users with information about harmful admixtures and cocaine purity is the second recommendation concerning the provision of information to users.

More than half of the respondents in both countries stated that they wished to receive information about the effects of cocaine on the body and the long-term psychological and physical effects of cocaine use, and more than a third of respondents wished to receive information about how to reduce adverse effects of cocaine use. Thus, providing information on health complications and harm reduction is the third recommendation for informing drug users.

As regards the provision of information, we must also take into account that more than half of the respondents participating in nightlife in both countries considered themselves quite well-informed about the adverse effects of cocaine use, but stated that they were interested in receiving additional information.

Most cocaine users in both countries consider various media (internet, posters, leaflets) the most suitable way of providing information, while they consider personal discussion and phone counselling less suitable. The fact that respondents wish to receive information and that they would accept information if provided via different media (mostly the Internet) is of key importance for activities in the field of harm reduction.

Cocaine users had the most problems with insomnia and depression, fear and anxiety, as well as a lack of concentration; in addition, respondents stated that they had social problems (with friends, parents and partners). Despite the many problems associated with cocaine use, most users had not sought help. Only a small proportion of respondents (under 6% in both countries) stated that they had sought help. More Italian (11.8%) than Slovenian (3.7%)

cocaine users stated that they had thought about getting help. The largest portion of respondents (just over a third in both countries) stated they would ask their friends or partner for help.

A similar proportion of respondents (between 13% and 17% in both countries) stated they would choose individual counselling outside health institutions<sup>3</sup> or seek help in a non-governmental organization or health institution (e.g. SERT in Italy). More than a tenth (12.7%) of Slovenian cocaine users and 20.9% of Italian cocaine users stated that they would not seek help.

Considering the trends in cocaine use in the EU and research results, we can conclude that both Slovenia and Italy need specialized assistance programmes to address this issue, and that treatment of various groups of cocaine users requires cooperation between the existing programmes of public institutions and non-governmental organizations.

About 60% of nightlife cocaine users in both Slovenian and Italian samples were employed (56.6% in Slovenia and 62.8% in Italy) and about one third of them were students (n = 311 SLO; n = 148 ITA). This means that, when designing assistance programmes in both countries, it should be kept in mind that these cocaine users are socially integrated individuals who need specialized assistance programmes. Such programmes should offer quick access and ensure anonymity, and admission to full-day treatment should not be a prerequisite for admission to the programme.

### **Recommendations for Preventive Activities**

Based on survey results obtained in both countries, the three main recommendations for activities aimed at reducing adverse affects of cocaine use in nightlife are as follows:

- provide users with information about health consequences of cocaine use and inform them how to act in case of complications via carefully designed and optimized web content systems, online counselling and social marketing;
- inform users during fieldwork (in clubs, bars and dance clubs);
- design a specialized assistance programme for socially integrated cocaine users with an emphasis on counselling and therapy, which will allow for a quick and personalized integration of users and ensure a high level of anonymity.

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<sup>3</sup> In Italy, this means an individual meeting with a health care professional.

### 3. PREVENTION

In Slovenia, prevention of psychoactive substance use is regulated by laws, regulations and guidelines within various ministries coordinated by the Ministry of Health. The Slovenian Commission on Narcotic Drugs, in its role as a working group of representatives of nine ministries and two non-governmental umbrella organizations in the field of drugs, coordinates government policies, measures and programmes. Measures in the field of prevention of psychoactive substance use are also set out in regulations of self-governing local communities who adopt them in order to regulate matters within their competence (e. g. decree on the establishment of a Local Action Group for addiction prevention). Furthermore, prevention is regulated via internal acts and rules by some labour organizations (rules on ensuring occupational health and safety) and educational institutions (Rules on the School Order in Secondary Schools, Rules on Elementary School Students' Rights and Duties, etc.). The Act Restricting the Use of Alcohol (Official Gazette RS, No. 15/2003), which was adopted by the Ministry of Health, provides for measures aimed at preventing harmful effects of alcohol use as well as measures and ways to reduce alcohol use. The Restriction of the Use of Tobacco Products Act (Official Gazette RS, No. 93/2007) addresses prevention in the chapter on measures aimed at reducing the use of tobacco products. Road Traffic Safety Act lays down, *inter alia*, the functions of the Slovenian Traffic Safety Agency; these include an important preventative task of providing education and raising awareness about the dangers of driving under the influence of alcohol, drugs, psychoactive medications or other psychoactive substances.

In the context of restricting access to alcohol, nine Slovenian municipalities have banned binge drinking in public places not intended for selling alcoholic beverages. The aim of this measure is to protect public order and prevent binge drinking, particularly among young people. The implementation of the measure is monitored by municipal inspectors and security officers, and individuals who violate the ban may be punished by a fine between EUR 80 and EUR 300. As regards tobacco control, Slovenia did not adopt new measures last year, but it supported the Proposal for a Directive of the European Parliament and of the Council on the approximation of the laws, regulations and administrative provisions of the Member States concerning the manufacture, presentation and sale of tobacco and related products.

In 2012, the “Brez izgovora” (No Excuse) Youth Association carried out 845 peer-to-peer tobacco and alcohol prevention workshops, raising young people's awareness about the negative effects of smoking and marketing approaches used by the tobacco industry to get young people to smoke and become addicted as quickly as possible, as well as about peer pressure and how to resist it. Workshop evaluation showed that most workshop leaders were satisfied with their workshop implementation. In the framework of the early intervention programme Fred Goes net, which is aimed at young alcohol and illicit drug users, 8 courses with 53 participants have been implemented in the past two years. Evaluation showed that

most participants were referred to the programme by schools. 55% entered the programme due to alcohol use, and 45% due to illicit drug use. Assessment of satisfaction with the programme showed that 82% of participants would recommend the course to their friends or other persons. Between 2007 and 2012, the outpatient programme for children and adolescents who experiment with illicit drugs or use them regularly admitted 72 young people and 147 important close persons, of which 31 young people and 75 close persons completed the programme successfully.

Two professional publications were issued in 2012, namely a guide for parents entitled Empowerment Strategies for Families and a guide for practitioners entitled Risk Prevention during Adolescence: Strategies Aimed at Parents for Prevention Practitioners and Mediators. In addition, a „train-the-trainer“ concept for persons working with socially disadvantaged target groups and three tools for more effective management of nightlife venues were developed. The latter include the NightSCOPE online tool, health and safety standards for nightlife venues, and a manual for training staff working at nightlife premises. The slogan of the 2012 Addiction Prevention Month was “More resources, more opportunities”.

### **3.1 Environmental Prevention: Alcohol and Tobacco Policies**

#### **Ban on Binge drinking in Public Places**

Maja Zorko, PhD, Nataša Blažko

A ban on binge drinking in public places not intended for the sale of alcoholic beverages is one of the measures of an alcohol policy that regulates physical availability of alcoholic beverages (Babor et al. 2010). For example, the Slovene town of Kranjska Gora had already adopted such a measure in 1996 to ensure law and order and prevent episodic heavy drinking, particularly among young people. In the following years, this measure was adopted by several other Slovene municipalities, such as Velenje, Krško, Žirovnica, Poljčane, Ptuj, Jesenice, Vransko and Kranj. Municipalities have adopted the measure as part of their Decrees on Public Law and Order, which stipulate that, to ensure law and order in municipalities, it is prohibited to binge drink in shops or other public places (e.g. streets and lawns, parks, in front of shops) which are not intended for the sale of alcoholic beverages, and that this prohibition does not apply to organized events in public places. The implementation of the Decrees is monitored by the competent authorities of municipal administrations (municipal inspectors and municipal security officers). Individuals who violate the provisions of a Decree may be fined between EUR 80 and EUR 300. The aforementioned municipalities do not define the term “episodic heavy drinking” in their Decrees, which we consider a deficiency. The municipality of Kranj introduced the prohibition in 2012 and defined it in more detail. It defined the term “episodic heavy drinking” as consuming more than two units of alcohol on a single occasion, which means more than 2 dl of wine or 0.5 l of beer or 0.6 dl of spirits or 0.5 l of must. Municipal security officers are responsible for monitoring in Kranj as well and have the right to assess the situation and decide how to act. A Slovenia-wide study on the effectiveness of the measure or its effects on alcohol consumption among the population of certain municipalities is yet to be conducted.



## **There are no New Legislative Tobacco Control Measures in Slovenia, but there is Support for the Proposed Changes to the European Directive**

Helena Koprivnikar

In 2012 and in the first half of 2013, no new legislative tobacco control measures were adopted in Slovenia, with the exception of the changes to taxation that were presented in the previous report. However, the Republic of Slovenia has expressed its support for the Proposal for a Directive of the European Parliament and of the Council on the approximation of the laws, regulations and administrative provisions of the Member States concerning the manufacture, presentation and sale of tobacco and related products. We see the proposal as a great opportunity to adopt certain necessary measures in Slovenia, particularly because in recent years there has been an increase in the share of smokers among girls and women and no change in the share of smokers among boys and men. The Republic of Slovenia has expressed specific support for an extension of the scope of the directive to include nicotine-containing products and herbal products for smoking, the introduction of larger combined warnings on cigarettes and roll-your-own tobacco, stricter requirements with regard to reporting the ingredients of tobacco products, prohibition of products with characteristic flavours, prohibition of certain additives in tobacco products and unchanged regulation for tobacco for oral use. The Republic of Slovenia has also expressed its intention to strive for certain stricter solutions in the fields of labelling, ingredients reporting, prohibiting certain flavours and additives, cross-border distance sales of tobacco products and regulating nicotine products, with the aim to ensure the highest-possible level of public health protection, to simplify the implementation and control and to reduce administrative loads. The Republic of Slovenia continues to support the introduction of plain packaging and the prohibition of cross-border distance sales of tobacco products, and it will also endeavour that measures regulate all tobacco products to the same extent.

### **3.2 Universal Prevention**

#### **Prevention in Educational Institutions**

##### **Peer-to-Peer Prevention Workshops in the Field of Tobacco and Alcohol Use**

Daša Kokole

In 2012, the “Youth Association No Excuse Slovenia carried out peer-to-peer tobacco prevention workshops within the framework of the “O2 Belongs to You” project, and workshops on peer pressure and alcohol within the framework of What about ... No. project. The “O2 Belongs to You” project aims at raising young people’s awareness about the negative effects of passive and active smoking and immoral marketing approaches used by the tobacco industry to try to get young people to smoke and become addicted as early as possible. The purpose of the “What about ... No.” project is to teach young people about different forms of peer pressure and how to resist it, and encourage them to form a clearer position on alcohol on the basis of information about alcohol and the influence exercised by the alcohol industry and the media. The joint message of the two projects is, “Think with your own head!” Furthermore, we strive to break the myths about smoking and alcohol use being very widespread, since most young people overestimate the percentage of their peers who smoke and drink alcohol.

The main part of the programme consists of peer-to-peer workshops carried out in primary and secondary schools by activists aged 15 to 19. First, activists have to undergo training and learn about the relevant theme, workshop implementation methods, public speaking and advocacy. In addition to information provision, the methods used to implement workshops include interactive methods, such as watching short films, role-playing and small group discussions.

In 2012, we visited all 12 statistical regions of Slovenia and carried out 845 workshops on tobacco, peer pressure and alcohol in fifteen “action” days, reaching out to 18,043 children aged 12 to 15.

Due to limited financial resources, only procedural evaluation of workshop leaders was carried out. The first part of the evaluation was carried out via an online survey, and the second part in the form of a group discussion.

31 out of 54 workshop leaders completed the online survey. They evaluated their overall impression for each action day; the resulting average scores on a scale of 1 – “very bad” to 5 – “very good” ranged between 4.25 and 4.8. Furthermore, respondents were to indicate how they felt after each action day by choosing one or more answers: 93.3% of respondents indicated that they were tired, 40% were filled with energy and motivated for further work, 93.5% were happy, and 96.7% were satisfied. 96.7% of respondents considered their participation in the project good or very good, and 80.6% were satisfied or very satisfied with their progress in implementing the workshops.

Of 11 respondents who participated in the implementation of workshops on alcohol use as well, 72.7% stated that they liked the workshop on peer pressure or liked it very much, and 54.5% liked the workshop on alcohol use or liked it very much. 50% of respondents indicated that their attitude towards alcohol changed over the course of the project.

25 workshop leaders took part in the group discussion. They talked mainly about the advantages of participation in the project and about what they had gained by participating. The advantages most commonly reported include improvements in public speaking skills and the ability to overcome stage fright, higher self-confidence, greater responsibility, improved knowledge about the topic and ability to defend their opinion, change in their view of society, and broadening their horizons. Respondents also mentioned the importance of meeting new people and making new friends.

In addition to raising awareness about tobacco, alcohol and possible external influences of both immediate surroundings (peer pressure) and surroundings at large (industry and media) in a wide group of young people, the added value of the programme included the involvement of workshop leaders, as it is presumed that the impact on them was even greater than the impact on workshop participants.

## **Family-based Prevention**

### **Strategies for Cooperation with Parents in the Field of Family Prevention**

Matej Košir, Sanela Talić

Partners of the European Family Empowerment project have issued two professional publications, namely a guide for parents entitled Empowerment Strategies for Families and a guide for practitioners entitled Risk Prevention during Adolescence: Strategies Aimed at Parents for Prevention Practitioners and Mediators. Both publications are available at [www.preventivna-platforma.si](http://www.preventivna-platforma.si).

The guide for parents contains information about the use of alcohol, tobacco and other drugs among adolescents and sets out appropriate prevention strategies and measures for parents, especially regarding effective educational approaches within the family (such as proper oversight over children and the peers they socialize with, clear rules concerning attitudes towards alcohol, tobacco and other drugs) and activities that have a positive or negative effect on drug use.

The guide for practitioners contains information on the logic of drug use among adolescent children and discusses how their families and professionals who work with and for them can better understand and prevent drug use and associated risks. The guide also provides some guidelines and recommendations which can contribute to improving the quality of preventive work with families.

The authors of both publications note that the lack of parental involvement in prevention programmes is often one of the main problems (Alhalabí-Díaz et al. 2006), and that parents are often reluctant to participate in such programmes. This applies in particular to parents whose children have most problems (Hill et al. 2010). These parents are also the ones who most often fail to grasp the truth about their children's risk behaviour. Other parents are not interested in preventive activities because they think that such problems do not concern their children or families. These parents should be informed about the following two facts: (1) the probability that children are using drugs is lower among children of parents who strive to prevent such risks and participate in prevention activities; (2) to find out what their children do, parents usually only need to be familiar with their children's friends. In order to protect and control their children more effectively, parents have to take collective and individual-level measures, both at home and outside their home.

### **3.3 Selective Prevention**

#### **Selective Prevention At-risk Groups**

##### **Early Intervention Programme for Young First-time Alcohol and Illicit Drug Users – FreD Goes Net**

Karmen Osterc Kokotovič, Vesna Šmarčan

The FreD goes net is a programme of early intervention in young first-time alcohol and illicit drug users. It is aimed at preventing addiction and reducing harm that occurs as a result of drug or alcohol use, particularly among young people. The Regional Institute of Public Health

Maribor (RIPH Maribor) started a pilot implementation of the programme in 2007<sup>4</sup>. In Slovenia, the target population of the FreD goes net project comprises young drug or alcohol users aged 13 to 25.

In methodological and scientific terms, FreD goes net is based on the transtheoretical model, motivational interviewing and psychoeducation. The transtheoretical model presently serves as the basis for planning early intervention in addiction prevention. The basic message of this model is that it is possible to achieve effective prevention at a very early stage, more specifically at the stage when the user has not yet developed an interest in receiving help and advice (Wirth and Horre 2010). Motivational interviewing is understood as a direct and client-centered consulting approach aimed at resolving or regulating ambivalence about behavioural changes. The interview process is adjusted so that drug users do not become reluctant about facing their problems, but start solving their own behavioural problems and strengthen their desire to change (Miller and Rollnick 2002).

The FreD goes net programme is based on early short interventions carried out by two agents licensed to carry out such prevention activities and courses. After a person is referred to the programme by an institution which noticed in the course of its work that the person has problems caused by alcohol or illicit drug use, he/she first undergoes an informative interview aimed at determining the problems, motivating the person to change, informing him/her about the stages of the course and establishing whether the person should be admitted to the course or whether it would be more appropriate to refer him/her to a different form of assistance better suited to his/her needs. After the informative interview, the person is admitted to an eight-hour course aimed at encouraging young users to think about their own patterns of drug use and behaviour in general. The course is not intended to criticize or blame users. The basic purpose of the course is to teach young users to face the risk factors leading to drug use and take responsibility for their actions, thus preventing drug addiction. The course can take the form of discussion, experiential exercises, role-playing, etc. Courses are carried out according to a predetermined form of work and consist of four two-hour sessions. The purpose of the first session is to allow the participants to get to know each other, and to create a positive, trusting atmosphere, establish the rules of the group, explain the legal aspects of drug use and increase participants' knowledge about substances (causes, effects and consequences). The second session is devoted to discussing social behaviour related to drug use, learning about different patterns of drug use, and raising participants' awareness about the development of addiction. During the third session, participants reflect on their own patterns of drug use, learn how to identify and assess high-risk situations and assume roles in a group. They also learn about the warning signs of risky drug use and protective factors. The purpose of the fourth session is to promote changes concerning drug use by giving practical advice and rules, by identifying risk factors for re-ingestion and preparing strategies for facing such risks, and by providing information on

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<sup>4</sup> First, the FreD (*Frühintervention bei erstauffällige Drogenkonsumenten*) project outline was designed, tested and evaluated in Germany as an early prevention programme. The purpose of the project was to approach young people who started experimenting with drugs and were convinced that they did not need help because the consequences of drug use were not yet obvious, but were investigated by the police or the court due to drug or alcohol use. Later, the European Commission supported this project as an example of good practice in order to encourage other EU countries to adopt a uniform approach to early intervention in young drug users. As the project spread to other countries, it was named FreD goes net. 12 EU member states (Austria, Germany, Slovenia, Ireland, Romania, Iceland, Poland, Lithuania, Belgium, Cyprus, Sweden and Luxemburg) participated in the pilot project implementation, which lasted from November 2007 to October 2010.

various sources of assistance. After completing the course, participants receive a certificate of attendance, which they can submit to the institution that referred them to the programme.

Throughout the period of pilot implementation of the course, i.e. from November 2008 to January 2010, process evaluation was carried out by the FOGS institute in Germany (Hartmann 2010). 86 informative interviews were carried out during the aforementioned period. There were more boys (68.6%) than girls (31.4 %) among programme users. The average age of users was 16.8 years (the youngest user was 14 and the oldest 21 years of age). Most users were high school students (94%), 4% were university students and 2% were primary school students. Most were referred by schools (59.3%). Others were referred by the police (8.1%), family members (15.1%) and other institutions (16.3% – student residence halls, crisis centre, Maribor University Medical Centre, Maribor Social Work Centre, etc.). 1.2% of users chose to enter the programme by themselves because they learned about the programme through acquaintances, media, etc. Of all 86 users of the programme, 76 participated in the course, and 72 completed it successfully (94.7%). An assessment of satisfaction of course participants showed that 27.8% of participants were highly satisfied, 51.4% satisfied, 16.7% moderately satisfied, 1.4% not very satisfied, and 2.8% were not at all satisfied with the course. 90.3% of participants stated that they would recommend the programme to their friends.

The RIPH Maribor continued to implement the programme for a year after the pilot implementation; however, the implementation of the programme will be limited in the following years, because it was not possible to find a funder who would ensure the existence and further extension of the programme. In 2012, we carried out two courses with 14 participants.

6 courses were carried out between January and December 2011. Based on informative interviews, course participation was recommended to 47 users, and 39 users chose to participate (83%; hereinafter: participants). 26% of users were advised to enter another programme or contact another institution in addition to course participation.

2011 programme evaluation<sup>5</sup> showed that 51 informative interviews were carried out in 2011 (60.8% of interviewees were boys and 39.2% were girls). As during the pilot implementation, the average age of users was 16.8 years. Most users were referred to the programme by schools (82.3%), 9.8% entered the programme at their parents' request, 3.9% were referred by pedopsychiatrists, 2% by the police and 2% by centres for social work. 45.1% of users contacted the FreD goes net project because they had been identified as illicit drug users, and the remaining 54.9% due to their alcohol use. Among 51 users, 5.9% had sought medical or other forms of help before, and 94.1% had never sought help. An assessment of satisfaction of programme users showed that 82.4% of participants would recommend the course to their friends or other people, and 17.6% would not recommend the course. Thus, the course was successful in participants' opinion, since 41.2% of participants stated they were very satisfied with the course, 41.2% were satisfied, 14.7% moderately satisfied and only 2.9% were not very satisfied with the course. None of the participants expressed dissatisfaction with the course.

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<sup>5</sup> Source: Report by the Regional Institute of Public Health Maribor (2011), available from the author. The report is not publicly available.

The early intervention approach for young alcohol or drug users, as implemented under the FreD goes net programme, enables young people who experiment with drugs and alcohol to gain insight into their own patterns of behaviour. Before this programme became available in Slovenia, such users were referred to various centres for addiction prevention where they could not be diagnosed with addiction and, consequently, were not admitted to suitable programmes. Thus, the FreD goes net programme fills the gap between initial experiments, habitual use and, finally, addiction. Therefore, the programme enables greater awareness and sensibility of young people in respect of risk factors of drug use, provides a neutral environment for honest, professionally guided discussions and offers further professional assistance when adolescents decide to change their behaviour.

### **Programme for Children and Adolescents**

Tanja Stanković

The Programme for Children and Adolescents (hereinafter: PCA) is an outpatient programme operating 8 hours per day, from Monday to Friday. It is intended for children and adolescents who experiment with illicit drugs or use them regularly, and for persons close to them. The Programme mostly deals with young people who use marijuana, club drugs, tobacco and alcohol. The aim of the Programme is to prevent addiction in young people, improve their parents' educational approaches, improve family communication and conflict resolution methods, enhance their quality of life and assume responsibility in terms of a high-quality process of growing up.

Most young people enter the Programme on their parents' initiative (70%), and some on the initiative of school or student residence hall counsellors, centres for social work, etc. (22%). Some adolescents entered the Programme on advice of their peers who had a positive experience with the PCA (8%), and only a few sought help on their own accord.

First, adolescents and persons close to them are referred to the PCA reception centre, which arranges the first meeting via telephone or e-mail. The meeting lasts an hour and a half. Some adolescents have to attend several such meetings, where they get to know their personal therapist and receive information about how to solve the problem due to which they sought help. They also get acquainted with the Programme for Children and Adolescents and the manner and conditions of treatment. Reception centre services are free of charge and anonymous.

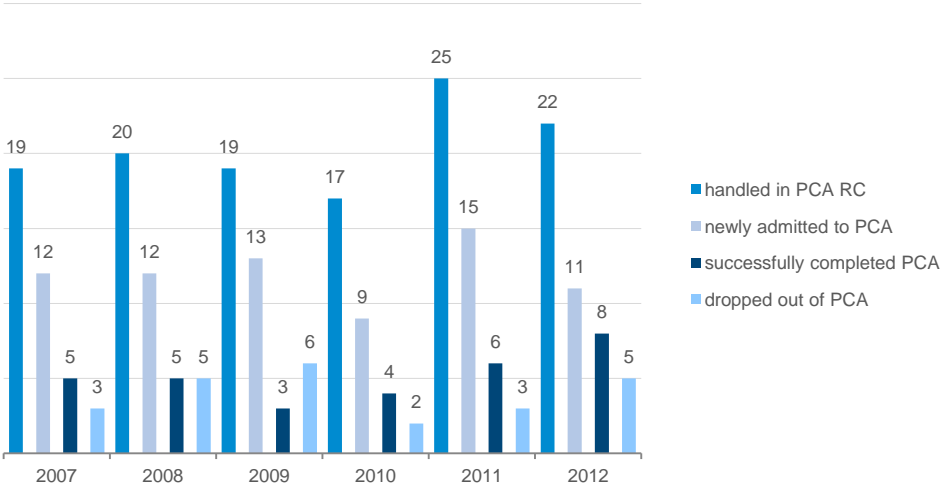
Admission to the programme is voluntary. Conditions of admission are that adolescents only have a minor addiction problem (which is determined through questionnaires and interviews) and that they still attend school. When they decide to enter the PCA, all users (adolescents, parents and personal therapists) sign a therapy cooperation agreement, usually for a duration of 6 months or until the end of the school year. Upon admission into the PCA, an individual plan of work is drawn up in cooperation with the adolescent, clearly determining work objectives. The adolescent's process is evaluated based on that plan. Special emphasis is put on building and maintaining abstinence and participation in society.

Adolescents involved in the PCA participate in a youth group for an hour and a half every week. There, they talk about their current problems and their interests (how they spend their free time, what their roles in the family are, what risk behaviours are, what a healthy lifestyle

is, etc.), explore topics that strengthen their sense of responsibility, independence, self-determination and equality. Through developing social skills, they learn about their role in the group and transfer the obtained experience into their families and the wider environments in which they live. Once a week, they also have an hour to an hour-and-a-half-long individual session with their personal therapist, where, in a secure atmosphere of confidentiality, they explore their emotional world, their desires and needs as well as ways in which they can meet them, and learn about their behavioural patterns, values and attitudes towards drugs. As part of the programme, creative, sport and social activities lasting 2–3 hours are carried out every two weeks, and multi-day camps are organized during school holidays. Urine tests are carried out regularly to check for the presence of psychoactive substances in the urine (abstinence).

The program requires parents to participate in parallel family therapy. Parents may also participate in individual and/or partner counselling and therapy where they can build a trusting relationship with their therapist and solve their personal problems. Counselling sessions last for an hour and a half every two weeks. A parent group meets once a week for 90-minute session. If necessary, we organize family meetings (at least once a month) where we discuss topics relevant to a particular family. We encourage parents to separate their role as a parent from the role as a partner, set clear boundaries and adopt responsible behaviour.

An adolescent successfully completes the Programme when he/she achieves most of the objectives set out in his/her individual plan. Adolescents can extend their participation in the Programme if they wish to or if it is reasonable.



Source: Projekt Človek Association

**Figure 3.1:** Number of adolescents handled in the reception centre and treated in the Programme for Children and Adolescents, 2007–2012

In 2012, the reception centre handled 22 young people and 41 of their relatives or persons close to them. 11 of these young people and 21 of their relatives or persons close to them were admitted to the PCA. In 2012, 8 young people and 15 persons close to them completed the Programme successfully, while 5 young people and 7 close persons dropped out or were excluded. Of these 5 adolescents, one was transferred to a different programme within Projekt Človek (“Project Man”). Between 2007 and 2011, 100 young people and 206

important close persons were handled in reception centres, of which 61 young people and 126 close persons were admitted to the PCA. In the 2007–2011 period, 23 young people and 60 close persons completed the Programme successfully, while 19 young people and 51 close persons dropped out (Figure 3.1).

### **Train-the-Trainer Concept for Persons Working with Socially Disadvantaged Target Groups**

Matej Košir, Sanela Talić

Partners of the ProSkills project have developed the „train-the-trainer“ concept, which can be helpful to persons who carry out training in the fields of working with socially disadvantaged target groups and lifelong learning. The concept comprises training modules in the field of enhancing life skills of socially disadvantaged adults. The basic modules focus on personal, social and self-management skills, and the concept also offers various strategies on how to carry out such training when working with target groups. The concept and different practical exercises to reinforce skills are presented at [www.pro-skills.eu](http://www.pro-skills.eu) in nine European languages, including Slovenian.

### **Selective Prevention in Recreational Settings**

#### **Tools for Effective Management of Nightlife Venues**

Matej Košir, Sanela Talić

Partners of the Club Health project have prepared three tools for more effective management of nightlife venues, including the NightSCOPE online tool, health and safety standards for nightlife venues, and a manual for staff training for nightlife premises.

The NightSCOPE online tool ([www.nightscope.eu](http://www.nightscope.eu)) is used to assess and improve the nightlife at the local level. The tool includes a short online questionnaire which has to be completed by up to ten representatives of different local institutions or organizations. The questionnaire is used to assess four key areas: (1) knowledge of local nightlife issues; (2) commitment to creating safe and healthy nightlife; (3) partnership working between key local agencies; (4) evidence-based practice. NightSCOPE compiles responses from combined questionnaires into a single report. Available results are obtained via an evaluation system which shows in where approaches are well-developed and where they could be strengthened or improved. By using this tool, local partners can identify and determine priority actions for improving approaches to nightlife management.

Health and safety standards for nightlife venues can serve as reference guide for night clubs and other nightlife venues, institutions responsible for issuing licenses or permits for clubs, bars and events, and institutions responsible for the preparation and implementation of measures in this field. The recommended standards include, for example, schemes like ensuring the physical and social conditions of nightlife premises, guaranteeing that staff follows responsible server practices, avoiding marketing strategies that encourage excessive drinking, and developing partnership strategies to reduce alcohol-related incidents.

The manual for training of staff in nightlife premises comprises different training modules, such as basic knowledge about psychoactive substances, communication, conflict resolution



and prevention strategies, first aid and emergency medical care, responsible dispensing of alcoholic beverages, and management of nightlife in terms of safety and security of visitors. The purpose of the manual is to improve staff's knowledge and skills, and help them identify and respond to different risk situations in an appropriate manner.

All tools are available (also in the Slovenian language) free of charge on the project's website at [www.club-health.eu](http://www.club-health.eu).

As part of a European comparative study, we tried to identify effective policy measures. We found that multi-component and multi-disciplinary strategies and policies that focus on several risk behaviours (e.g. alcohol, illicit drugs, violence, road safety, etc.) are the most effective. Measures focused on reducing excessive drinking and alcohol intoxication also have good effects on reducing other nightlife-related risk behaviours, such as violence, risky sex, or driving under the influence of alcohol. Measures that involve regular cooperation between various competent institutions (e.g. local authorities and the police) and the nightlife industry also bring good results. Consistent implementation of policies and legislation, and broad political and social support are also of key importance for the effectiveness of measures (Košir 2012).

### **3.4 National Campaigns**

#### **Addiction Prevention Month 2012**

Branka Božank

In 2012, the Regional Institute of Public Health Ravne as the organizer of Addiction Prevention Month activities prepared a thematic message, a logo and a slogan that read "More resources, more opportunities", thereby emphasizing the importance of various professional, organisational and financial resources in the field of prevention in particular (as well as treatment, rehabilitation and harm reduction programmes). The slogan refers to the fact that there is a wide range of interventions and approaches in the field of universal prevention in Slovenia; however, there are also problems regarding the accessibility of selective and indicated prevention programmes.

As part of the said activities, we collected data on recent events the content of which relates to prevention, various forms of addiction, rehabilitation, etc., and which occurred in Slovenia in the context of Addiction Prevention Month. We published the collected event data online at [www.zzv-ravne.si](http://www.zzv-ravne.si) and reported it via e-mail to governmental and non-governmental organizations across Slovenia.

We organized the Addiction Prevention Month National Conference, which took place on 7 November 2012 and was attended by 96 representatives of various governmental and non-governmental organizations. The participants included representatives from local action groups, police, the Prison Administration of the Republic of Slovenia, kindergartens, primary and secondary schools, residential treatment institutions, health centres, centres for social work, the Employment Service, municipalities and NGOs. Conference events included a press conference.

## 4. PROBLEM DRUG USE

According to the definition used by the EMCDDA, problem drug use is defined as injecting drug use or long-duration/regular use of opioids, cocaine and/or amphetamines in the 15–64 age group during a one-year period. This definition was used also in estimating the prevalence of problem drug use in Slovenia. Prevalence estimates of problem drug use in Slovenia were made using the capture – recapture method on two occasions: the first time for 2000 and 2001, and the second time for 2004. This year, a preliminary estimate of the prevalence of problem drug use was made for 2011 using available data sources (drug users' treatment records and survey questionnaires filled out by harm reduction programme users) and the capture – recapture method, which covered only problem opiate use. For 2011, the estimated number of problem opiate users in the age group 15–64 is 6,100.

A survey covering 160 drug users who have sought help in harm-reduction programmes and are classified as problem drug users showed that 66% of respondents use heroin, 65% use cannabis, 62% use cocaine, 36% use synthetic drugs, 77% substitution medicinal products and 9% solvents or gases. 68% of all respondents also use alcohol, and almost all use more than one drug. Compared to 2011, drug use increased in 2012 for all drugs, including heroin, solvents and gases, while the use of substitution medicinal products decreased. Intravenous use remains the most common method of drug use and represents the most common risk behaviour in harm-reduction programme users. 82% of harm-reduction programme users are simultaneously treated in other programmes, most of them in centres for the prevention and treatment of drug addiction. More than half of respondents indicated that they had other health problems, mostly hepatitis C, in addition to drug addiction. Furthermore, one case of HIV was recorded in 2012.

### 4.1 Prevalence Estimate of Problem Drug Use

Ines Kvaternik, PhD, Samo Novakovič

According to the definition used by the EMCDDA, problem drug use is defined as injecting drug use or long-duration/regular use of opioids, cocaine and/or amphetamines in the 15–64 age group over a one-year period. This definition was used in estimating the prevalence of problem drug use in Slovenia. Prevalence estimates of problem drug use in Slovenia were made using the capture-recapture method on two occasions: the first time for the years 2000 and 2001 (7,535 and 7,399 problem drug users, respectively), and the second time for the year 2004 (10,654 problem drug users).

This year, we made a preliminary estimate of the prevalence of problem drug use using available data sources (drug users' treatment records and survey questionnaires filled out by harm reduction programme users) and the capture-recapture method. It should be noted here that the said estimate only covers problem opiate use (hereinafter: POU).

## Methods used

When calculating the POU, we used the capture-recapture method by comparing the known POU population<sup>6</sup>, identified via drug users' treatment records, with data from an anonymous survey conducted among users of harm reduction programmes (hereinafter: HR programmes). The manner of calculating the prevalence of problem opiate use depends on limited data obtained from Centres for the Prevention and Treatment of Drug Addiction (hereinafter: CPTDA). Before 2008, data collection was insufficient, which constitutes an objective obstacle to monitoring trends among problem drug users. Another reason why data are insufficient is under-reporting, since the relevant database does not include data from prisons, detention centres and CPTDAs in Murska Sobota. While survey data are sufficient for monitoring trends among the POU population seeking help in HR programmes, a higher proportion of respondents surveyed during fieldwork is needed in particular to calculate problem drug use prevalence.

The POU population size was calculated on the basis of relative frequency of respondents in harm reduction programmes who reported current or past treatment in CPTDAs. From the remaining proportion of respondents, we extrapolated the hidden population<sup>7</sup> proportion, thus obtaining the hidden population coefficient. To find the hidden population set, which represents a certain proportion of problem opiate users, we used data on subsets of CPTDA users (currently participating in a programme, admitted for the first time/again, and the number of discharges from programmes), its variation trends and age structure of the individual subsets.

## Sample

The number of problem drug users who were undoubtedly admitted to a CPTDA programme in the period from 2009 to 2011 is 4,500<sup>8</sup>. The most important part of the calculation was based on the statistical assumption that the frequency of surveyed users in HR programmes who have never been admitted to CPTDA is typical of the entire POU population.

The POU hidden population coefficient was obtained via a survey conducted among HR programme users. 78.11% of respondents reported current or past participation in CPTDA programmes. It may be noted that regional differences in the hidden population coefficient are statistically relevant. However, we only used the total coefficient of the hidden population share as a multiple, since the data on past CPTDA programme users are of such nature, and because regional numerical data are limited. Furthermore, the result does not significantly change when taking into account regional differences.

On the basis of the data on the POU age group obtained from drug users' treatment records, we examined the adequacy of the sample of respondents. Data show that the average age of respondents admitted to CPTDAs is 33.22 years, which is approximately 5.35 years older than respondents admitted for the first time; the average age of the latter is 27.87 years

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<sup>6</sup> Data on the number of CPTDA users and the proportion of substitution treatment programme users (2008–2011) (Drev et al. 2012: 74) and data on the annual fluctuation in the number of current programme participants, first-time admitted and readmitted persons and programme discharges (National Reports 2007–2011) were used to estimate the size of known POU population. This group comprises users admitted to a substitution treatment programme in the said period. The data offer insight into the minimum number of users admitted to programmes from 2008 onwards.

<sup>7</sup> Individuals who have never been included in the CPTDA.

<sup>8</sup> Sources of data on the number of POU include National Reports on the Drug Situation 2009–2011.

(Drev et al. 2012: 87), and their standard deviation is 0.6 years lower (the corresponding age range is narrower). The trend toward lower average age of persons entering programmes is already present in statistical data from previous years, and is probably due to new generations of potential users of substitution treatment. 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 POU population. The subset of re-admitted persons is characterized by an average age and standard deviation similar to those of the subset of continuously treated persons. It should be noted at this point that the probability of belonging to the hidden population correlates with many factors (e.g. drug administration route, gender, age of first drug use, proximity to treatment centres) and is subject to fluctuations. Due to absence of data concerning the relationship between these factors, which is the data required to classify mutual correlations, we have to assume that the data in the aggregate are homogeneous and that their average value is normally distributed.

In assessing the representativeness of the sample of respondents, we must take into account the sum of two sets, of which the hidden population is the one we wish to measure. Its representation in the sample is connected to the average age, where both subsets have equal probability of being represented. The average age of respondents was 33.31 years. On average, the hidden population frequency density is underestimated due to the lower average age in this area, which means that the survey covered the right tail of the Gaussian curve representing the hidden POU population. Given the insufficient representation of the hidden population, it was necessary to balance the results of the survey using the log-linear model<sup>9</sup> with the dependent parameter set at the value obtained in the survey.

**Results**

We obtained the adjusted hidden population coefficient of 0.2607 (within the 95-percent confidence interval of 0.1920–0.3313) via simulations of adjusting the parameter to the appropriate size of the hidden population share corresponding to the proportion of persons who had never been treated, which was calculated using survey results.

As shown in Table 4.1, the best estimate of the entire population of problem opiate users in Slovenia in 2011 is 6,100 (within the 95-percent confidence interval of 5,580–6,770), which is, expressed as a relative share, 4.37 users per 1,000 population aged between 15 and 64.

**Table 4.1:** Estimated number of problem opiate users calculated using the hidden population coefficient, 2011

	Lower limit	Upper limit	Best estimate
Estimate	5,580	6,750	6,100
All ages / 1,000 population	2.71	3.28	2.97
15–64 / 1,000 population	4.00	4.84	4.37

Source: Calculation based on data from the Statistical Office of the Republic of Slovenia for basic groups by gender (2012) and the hidden population coefficient in 2011

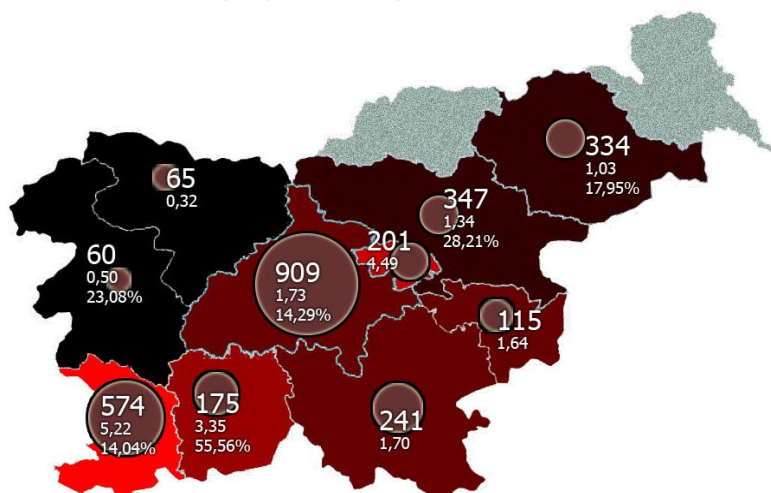
<sup>9</sup> Log-linear model or Poisson regression is a form of regression used to model numerical values and contingency tables, based on the assumption that the values to be determined are distributed according to Poisson distribution probability function.

**Table 4.2:** Number and proportion of CPTDA programme users by statistical regions, and the number and proportion of never-admitted respondents in HR programmes in 2011

Region	No. of recorded in substitution treatment	Proportion of recorded in substitution treatment per 1,000	No. of respondents in HR programmes	No. of persons never treated in substitution programme	Proportion of persons never treated in substitution programme
Gorenjska	65	0.32	/	/	/
Goriška	60	0.50	13	3	23.08
Southeast Slovenia	241	1.70	/	/	/
Koroška	0	/	/	/	/
Notranjsko - kraška	175	3.35	18	10	55.56
Obalno - kraška	574	5.22	57	8	14.04
Central Slovenia	909	1.73	35	5	14.29
Podravska	334	1.03	39	7	17.95
Pomurska	0	/	/	/	/
Savinjska	347	1.34	39	11	28.21
Spodnjeoposavska	115	1.64	/	/	/
Zasavska	201	4.49	/	/	/
<b>Total</b>	<b>3,021</b>	<b>1.48</b>	<b>201</b>	<b>44</b>	<b>21.89</b>

Source: Treatment records of drug users (2011), NIPH; Survey conducted in harm reduction programmes (2011), RIPH Koper

As shown in Table 4.2 and Figure 4.1, Koroška region is not covered by substitution treatment programme and for Pomurska region treatment data for 2011 are not available. HR programme users survey results reveal an average of 21.89% of persons who have never been admitted to a CPTDA. Regional differences in the group of never-admitted respondents ranged from 55.55% in the Notranjsko-kraška region to 14.04% in the Obalno-kraška region. Relatively speaking, the latter region has the highest burden in terms of the number of problem opiate users; however, HR programme users survey results show that this region has the smallest proportion of persons in CPTDAs who have never been treated.



Source: Treatment records of drug users (2011), NIPH; Survey conducted in harm reduction programmes (2011), RIPH Koper

**Figure 4.1:** Number of persons treated in CPTDAs, number of persons treated per 1,000 population, and percentage of HR programme users who have never been treated, statistical regions, 2011

As shown in Figure 4.1, the most problem opiate users participating in substitution treatment programmes are in the Central Slovenia and the Obalno-kraška regions. These two regions also have the lowest proportions of never-admitted respondents, since they are covered by treatment and harm reduction programmes. There are insufficient data for the Koroška and Pomurska regions, either due to under-reporting (the Pomurska region) or due to the lack of assistance programs for drug users.

## Conclusion

Preliminary assessment of problem opiate use in Slovenia shows that 3,557 out of 6,100 POU are in substitution treatment (Drev et al. 2012: 73), which is 58.31% (within the 95-percent confidence interval of 52.54 %–64.09 %) of all POUs. This indicates that the needs of problem opiate users in Slovenia are relatively well-covered, which is the case in regions where the upward trend of opiate use first occurred and HR programmes are better integrated and established as a legitimate and socially acceptable way of responding to health and social risks faced by problem opiate users. Since the data from drug users' treatment records and HR programme survey results were insufficient to calculate the estimated number of problem cocaine and amphetamine users, the methodological tools will have to be improved and the HR programme users survey conducted in a manner adapted to attributes of other data sources.

## 4.2 Problem Drug Use Among Participants in Harm Reduction Programmes in Slovenia

Ines Kvaternik, PhD, Živa Žerjal

In the period from November 2012 to January 2013, the Regional Institute of Public Health Koper (RIPH Koper) carried out a study by means of an anonymous questionnaire to acquire data on the profile of drug users seeking help in harm reduction programmes in Slovenia. Due to the prevailing method of use (injection) and type of drug (heroin, cocaine and medicinal products), the users of such programmes are considered problem drug users.

The study involved 160 users of harm reduction programmes (users of programmes run by associations SVIT Koper, Stigma Ljubljana, Pomoč Sežana, Pot Ilirska Bistrica, Zdrava Pot Maribor, Želva Žalec and Socio Celje Public Institute).

### Findings

Among 160 respondents, 121 were men and 39 were women, which constitutes 76% and 24% of respondents respectively. The average age of respondents was 33 years, the youngest one being aged 19 and the oldest 52. The majority of respondents, a total of 35%, belonged to the 31–35 age group. The 26–30 age group comprised a quarter of respondents (25%) and a bit less than a fifth belong to the 36–40 group. The 20–25 age group included 8% of respondents. In 2012, the oldest respondent group of over 41 comprised 11%, which is less than in the preceding survey year. This time, the respondents included one person below 20.

More than a half (61%) of all respondents have completed vocational or intermediate education, whereas 31% have only attained primary education, 5% have incomplete primary education, and only 3% have higher education or a university diploma. The majority of

respondents are unemployed (61%); slightly under 7% have permanent employment, a good quarter (26%) work occasionally and slightly under 5% stated to be retired, receiving social assistance or moonlighting.

The highest rate (37%) of interviewed participants in harm reduction programmes live with their parents, a somewhat smaller share (24%) lives on their own, 3% live on their own with children, 17% live with their partner, 6% live with their partner and children, 4% reside in a shelter or outdoors (in parks, streets, abandoned houses), nearly 4% live with their friends or acquaintances, and nearly 4% reside elsewhere (with their grandmother, sister, in a housing unit, in a boarding house...). Almost 24% of respondents have children, the majority of them one.

82% of interviewed participants in drug harm reduction programmes also participate in other programmes – a good half of them (53%) only in programmes run by Centres for the Prevention and Treatment of Drug Addiction, 4.7% only participated in abstinence programmes and nearly 5% only in hospital detoxification programmes. 35% reported to have been included in a combination of substitution and other programmes for illicit drug users. Among the respondents, only 18% have never been treated in any other programme for illicit drug users.

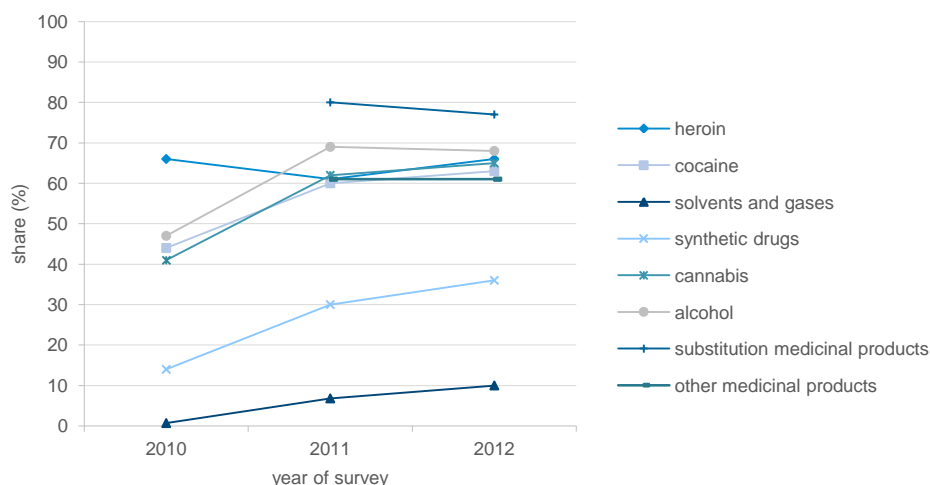
97% of respondents are covered by basic health insurance, and 86% are covered by supplemental health insurance. 55% respondents stated to be experiencing other health problems alongside their drug addiction. They most often listed hepatitis C, followed by mental health problems, gastric problems, asthma, allergies as well as poor dental health and vascular system. In 2012, an incidence of HIV was also recorded.

Nearly 80% of respondents have been involved with law enforcement because of drugs.

### **Drug use**

More than half of the respondents use heroin (66%), 62.5% cocaine, 36% synthetic drugs, 65% cannabis, 9% use solvents and gases, 77% substitution medicinal products (methadone, suboxone, subtitol), and 66% other medicinal products, i.e. hypnotics (Dormicum, Ambien) and benzodiazepines (Valium, Xanax, Helex). A staggering 68% of the respondents also consume alcohol. Almost all of the participants in harm reduction programmes (94%) use more than one drug at a time, most often heroin, cocaine, cannabis and substitution medicinal products.

In comparison to 2011, the use of all illicit drugs was on the increase in 2012, with a notable increase in the use of heroin. There was also a rise in the use of cocaine, synthetic and club drugs as well as solvents and gasses. Data on the use of substitution and other medicinal products can only be compared to 2011 and 2012, whereby lower use of substitution medicinal products was recorded in 2012, and the use of other medicinal products remained the same (Figure 4.2).

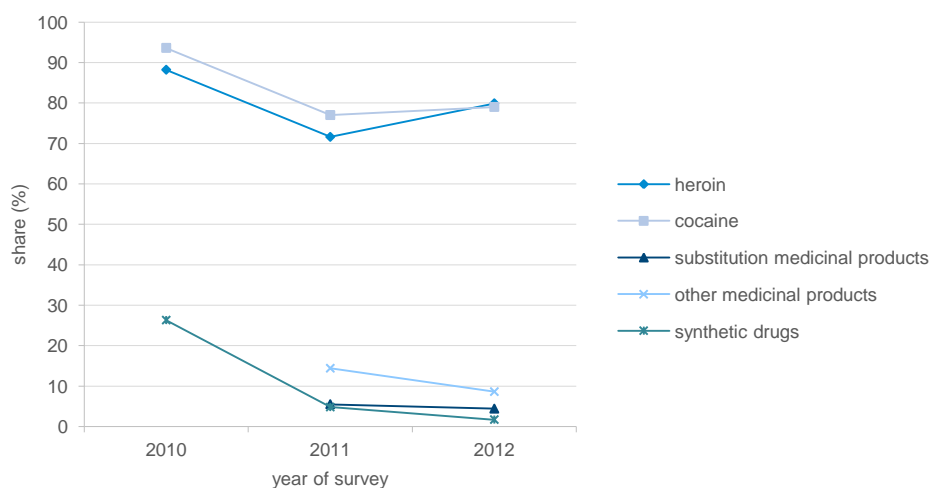


Source: Anonymous questionnaire, RIPH Koper, 2010–2012

Figure 4.2: Drug use among participants in harm reduction programmes, 2010–2012

### The most common way of drug use remains injection

Heroin and cocaine are mostly being injected by participants in drug-related harm reduction programmes. 80% of heroin users inject it (the percentage includes those who only inject heroin and those who inject it and use it in another way), which is 8% more than in 2011. Cocaine injection rate (comprising those who only inject cocaine and those who inject it and use it in another way) increased by 2% in comparison to the preceding year, reaching 79% in 2012. However, injection of other medicinal products decreased from 14% to slightly over 9% (again, the data is only available for the years 2011 and 2012). (Figure 4.3)



Source: Anonymous questionnaire, RIPH Koper, 2010–2012

Figure 4.3: Share of participants in harm reduction programmes by type of drug and injection, 2010–2012

### Risk Behaviour

The most common risk behaviour among users harm reduction programmes is drug injection (85%). This is followed by mixing drugs used at once (73%), risk use (60%), repeated use of the same needle (53%), shared use of other paraphernalia (49%), overdose (36%) and shared use of needles (24%). 90% of respondents reported to be sharing joints on every or



some occasions when smoking cannabis, which poses a high risk for the spread of contagious diseases due to poor oral health in this target group. 42% of respondents share sniffing paraphernalia. These types of risk behaviour are followed by sexual risk behaviour, as 78% of respondents report to have unprotected intercourse either on some or every occasion, and only slightly over a fifth of the respondents always use protection when having sex.

### **Sharing Paraphernalia**

Respondents stated that they mostly receive the paraphernalia in the harm reduction programme (nearly 88%), of which 39% get sterile paraphernalia from the programme exclusively, 9% of respondents receive the paraphernalia in fieldwork programmes, and 7% get the paraphernalia from a pharmacy. 3% reported to be borrowing sterile paraphernalia from friends or acquaintances.

84% of respondents mostly return the used needle to the programme, 26% always throw it in the trash, 60% do that occasionally, 13% never. Nearly 16% of respondents leave the used paraphernalia at the spot of drug injection, whereas the rest (84%) never do that. 36% dispose of the used paraphernalia in another way (“destroy the needle and throw it away with a can,” “burn it in the central heating furnace”).

### **Location of Drug Use**

98% of respondents most often use drugs at home, but 90% replied to be using drugs at their friends' or acquaintances' as well. 1% of respondents always use drugs in a shelter or day centre, 11% use them occasionally, 88% never. As many as 62% use drugs in public spaces, and nearly 57% always take drugs outdoors (in cars, forests, parks, deserted buildings, alongside the railway in Tivoli Park), some of them always, others occasionally.

### **Conclusion**

Based on the data acquired, it can be established that in 2012, the use of heroin among the examined participants in harm reduction programmes increased in comparison to 2011. Despite the general trend of decreasing use on heroin in Europe, the data acquired show that in Slovenia, the use of heroin within the target group is quite stable. Increased use of cocaine and synthetic drugs as well as increased use of solvents and gases has been recorded among the questioned drug users.

The prevailing approach to drug users in Slovenia still focuses on addiction to narcotics, but according to data available, such programmes fail to include adolescents and young adults – which is partly due to the fear of stigmatisation and partly because the programmes are not suited to their needs (i.e. synthetic drug addicts require drug treatment and hospital detoxification programmes that are suited to their needs, whereas such programmes in Slovenia have mostly been developed for addiction to narcotics).

Concerning risk behaviour, no major changes were detected in comparison to surveys from previous years. The most common risk remains drug injection.

## 5. DRUG-RELATED TREATMENT: TREATMENT DEMAND AND TREATMENT AVAILABILITY

Milan Krek

Treatment of drug users is defined in the legislation regulating the fields of illicit drugs, health care and social security. In Slovenia, a network consisting of 18 Centres for the Prevention and Treatment of Drug Addiction (CPTDA) and the Centre for Treatment of Drug Addiction at the University Psychiatric Clinic (CTDA) has been established within the healthcare system. Medical treatment of drug users is part of the regular healthcare programme financed from the resources of the Health Insurance Institute of Slovenia. Currently, there are no waiting times for treatment of illicit drug addiction within the healthcare system.

In 2012, preparations were made for the introduction of a new questionnaire “treatment demand” (TDI 3.0); the preparations included translating the questionnaire, adding questions covering the needs of the national health statistics, and developing methodological instructions for filling out the questionnaire. A workshop was also executed in collaboration with the European Monitoring Centre for Drugs and Drug Addiction to familiarise the professionals from CPTDAs with the contents of the new questionnaire, which has been used for data collection since January this year.

This chapter presents an analysis of data on the “treatment demand” indicator (TDI), which was performed on the basis of completed forms submitted by 18 CPTDAs and CTDA.

In 2012, there were 519 users recorded as seeking assistance in treatment programmes, either for the first time or again. 189 (36.4%) of them sought assistance for the first time, and 330 (63.6%) again. The average age of users upon their first admission or readmission to the treatment system was 30.93 years. There were more men (78.4%) than women (21.6%) among users who sought assistance. Most of them entered a programme on their own initiative. In most cases, the main drug due to which users sought assistance again or for the first time was heroin (77.6%), followed by cannabis (10.4%) and cocaine (4.8%). In comparison to previous years, the proportion of users seeking assistance due to heroin-related problems decreased, and the proportion of those seeking assistance due to cannabis- and cocaine-related problems increased. There has also been an increase in the proportion of persons using black market methadone. The most common secondary drug was cocaine (41.8%), followed by cannabis (22.2%) and benzodiazepines (13.1%). The proportion of users who entered a programme the first time or again and were using at least one secondary drug has been decreasing in recent years. The proportion of drug users who injected drugs in the month prior to entering a programme has also been decreasing. However, there has been an increase in unemployment as compared to previous years.

## 5.1 General Description, Availability and Quality Assurance

### Strategy/Policy and Treatment System

The basic laws governing illicit drug addiction treatment in Slovenia comprise: Production of and Trade in Illicit Drugs Act (Official Gazette of the Republic of Slovenia, Nos. 108/99, 44/00), the Act Amending the Production of and Trade in Illicit Drugs Act (Official Gazette RS, Nos. 2/04, 47/04) and Act Regulating the Prevention of the Use of Illicit Drugs and the Treatment of Drug Users (Official Gazette RS, No. 98/99). The last Act lays down measures to prevent illicit drug use, governs the treatment of illicit drug users, and sets out measures and activities aimed at reducing drug demand.

Treatment programmes for drug users must be approved by the highest competent professional bodies on the basis of an assessment of efficiency, safety and technical and scientific merit. State resources for treatment and rehabilitation programmes are provided from various sources – in compliance with applicable legislation. At all times, continuous user treatment is ensured at the highest level (Commission on Narcotic Drugs of the Government of the Republic of Slovenia), regardless of the source of financing. Such treatment comprises:

- Treatment within the healthcare system;
- Treatment within the social security system (see Chapter 8);
- Treatment in non-governmental organizations (see Chapter 7 and 8).

Medical treatment of drug users is implemented in public healthcare institutions, either as outpatient or inpatient treatment. The CPTDA network has been established since 1995, and currently comprises 19 centres. These feature professional teams, each composed of a family doctor, psychiatrist, nurse and laboratory technician. The highly specialised CTDA at the Ljubljana University Psychiatric Clinic has been operating since 2003, providing inpatient as well as outpatient treatment, day hospital treatment as well as extended hospital treatment with rehabilitation (a detailed description is available in 2012 and 2011 reports).

In the CPTDA and CTDA network, the treatment demand questionnaire (TDI) is used to collect data on drug users admitted to medical care or treatment.

## 5.2 Access to Treatment

Access to social security programmes is ensured across Slovenia with no waiting periods. The only exception is admission to therapeutic communities, which requires prior participation in a preparatory programme, the length of which varies depending on the individual. Some programmes run by non-governmental organizations are free of charge, i.e. harm-reduction programmes, and some are subject to fees, either equal to or lower than the amount of financial social assistance received by an individual from a centre for social work.

Programmes offered within the public health network have no waiting periods and no fees. Following the introduction of treatment programmes run by local health centres, and programmes run by non-governmental organisations into prisons, the accessibility of appropriate treatment of drug users in such institutions has improved (Uprava za izvrševanje kazenskih sankcij 2012).

# Characteristics of Treated Clients, Some Trends of Treated Population and Treatment Provision

## CPTDA Coordination Data

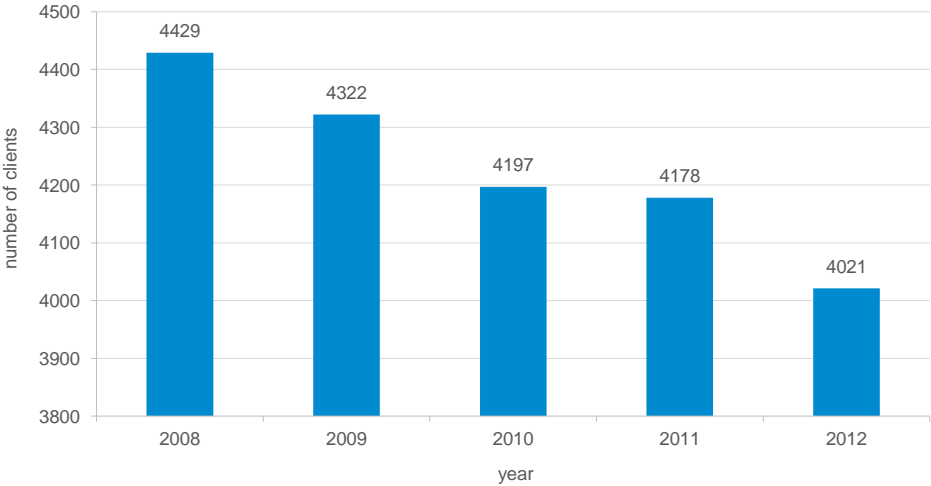
According to the data of the CPTDA Coordination, 4,021 persons entered treatment in 2012, of which 3,345 (83.15%) were admitted to substitution treatment. The substitute drugs used were methadone, Suboxone, Buprenorphine and Morphine SR (Table 5.1). Of all users in maintenance therapy, 2,237 (66.89%) were in methadone maintenance treatment, 411 (12.28%) were treated with Suboxone, 359 (10.73%) with Buprenorphine and 338 (10.1%) with Morphine SR. The persons in methadone maintenance treatment represent 55.63% of the total programme user population, whereas users of Suboxone represent 10.22%, users of Buprenorphine 8.4% and users of Morphine SR 8.4%. Due to various types of methodology applied, the number of users in substitution treatment as reported by the body responsible for the coordination of Centres for the Prevention and Treatment of Drug Addiction differs from the number obtained via the treatment demand questionnaire.

**Table 5.1:** Number of people treated in Centres for prevention and treatment of drug addiction, 2012

Total No. of persons treated	No. of persons in substitution treatment	Methadone	Suboxone	Buprenorphine	Morphine SR
4021	3345	2237	411	359	338

Source: CPTDA Coordination

The proportion of users in substitution treatment in CPTDAs has been growing over the years. However, there has been a decrease in the number of drug users participating in CPTDA programmes, i.e. from 4,429 in 2008 to 4,021 in 2012 (Figure 5.1). As the structure of drug users changes with regard to the type of drug they use, it would be sensible to consider a quicker adaptation of CPTDA programmes, particularly now that problems related to the use of new drugs are growing more severe.



Source: CPTDA Coordination

**Figure 5.1:** Number of users of the CPTDA network programmes, 2008–2012

## **Pregnant Women and Births by Drug Users in Substitution Treatment**

According to the CPTDA Coordination data, 26 users gave birth in 2012, of which 17 were in methadone maintenance treatment, 4 in Buprenorphine maintenance treatment, and 1 in Suboxone maintenance treatment. One of them was admitted to Suboxone maintenance treatment at first, which was then replaced with methadone maintenance treatment. One pregnant woman did not undergo maintenance treatment, and for two of them there is no data on the treatment they underwent during pregnancy and giving birth.

## **Data Acquired Using the Questionnaire for Drug Users' Treatment Records**

### **Characteristics of Users Who entered a Treatment Programme for the First Time in 2012 or Again**

The Drug Users Treatment Records questionnaire (TDI – Treatment Demand Indicator) is used in Slovenia to collect data on treatment demand; it is used to monitor and study the prevalence and characteristics of problem drug use among users of CPTDA programmes. In 2012, completed questionnaires from 18 CPTDAs and the CTDA at the Ljubljana University Psychiatric Clinic were used for the purposes of analysis. One centre did not provide complete data, which, according to our estimations, could have reduced the total number of people treated, as stated in the report, by approximately 180 persons. In 2012, we received no reports from prisons.

In 2012, completed questionnaires covered 3,154 persons, 2,635 of which were admitted to continuous maintenance treatment, and 519 persons were admitted to treatment programmes within the CPTDA and CTDA network, either for the first time or again.

### **Demographic Data**

- First admission or readmission to a programme

The Drug Users Treatment Records questionnaire covered 519 users treated who in 2012 entered a CPTDA or CTDA programme, either for the first time or again. 407 of them were male (78.4%) and 112 were female (21.6%). The average age of all users who were admitted to a programme for the first time or again was 30.93 years, the average age of men being 31.47 years, and of women 28.97 years.

- First admission to a programme

Of 519 users, 189 (36.4%) entered a programme for the first time in 2012. Of 189 users recorded for the first time, 145 (76.7%) were male. Their average age was 28.52 years. The number of women entering for the first time was 44 (23.3%), and their average age was 27.77 years.

- Readmission to a programme

In 2012, 330 persons (63.5%) entered a programme again, of which 262 (79.4%) were male and 68 (20.6%) were female. The average age of men was 32.61 years, and of women 29.38 years.

### **Referral to Treatment**

- First admission or readmission to a programme

Of all persons entering a programme again or for the first time in 2012 (519 persons), 352 (67.8%) entered on their own initiative, 35 (6.7%) entered on the initiative of their

parents and friends, 5.2% were referred to the treatment programme from another centre, 2.3% were referred by their family doctor, 4.8% came from a hospital, 1.7% were referred by the court and 1.6% by the social service, and for others the source of referral was unknown.

- First admission to a programme

In 2012, 189 persons entered a treatment programme for the first time. Among these, 54.5% made the decision by themselves, 13.8% entered a programme on the initiative of their family and friends, and 2.6% were referred from other treatment centres. 4.8% were referred to treatment by a general practitioner, 6.9% from a hospital and other healthcare institutions, 2.6% by the social service and 1% by the police and courts.

- Readmission to a programme

Among the persons readmitted to a programme in 2012, the majority entered on their own initiative (78.3%), and 6.9% were referred to treatment from other programmes. 2.8% came on the initiative of friends and family, 3.8% were referred from a hospital or another healthcare institution, and 0.9% were referred by a general practitioner.

### **Co-residents of Programme Users**

- First admission or readmission to a programme

Upon first admission or readmission to a programme, the majority of users (42.1%) lived with their parents (in 2011 the percentage was 47%), 16.7% lived alone, 14.0% with their partner, and 13% with their partner and child (in 2011 the percentage was 7.3%).

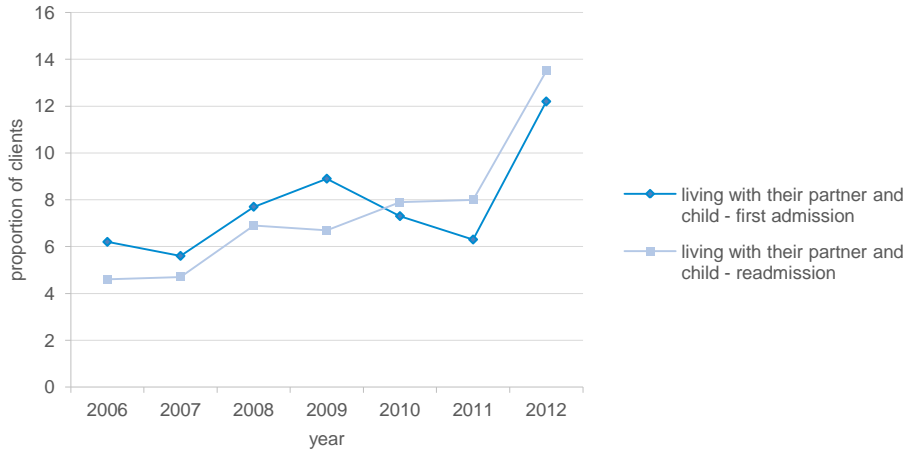
- First admission to a programme

Upon first admission to a programme, 45.0% (53.1% in 2011) lived with their parents, 12.7% lived alone, 12.2% with their partner, and 12.2% (6.3% in 2011) with their partner and child.

- Readmission to a programme

Upon readmission to a programme, 40.4% persons lived with their parents, 19.0% lived alone, 15.0% with their partner (16% in 2011), and 13.5% (8% in 2011) with their partner and child.

In the period 2006–2012, there was an increase in the number of drug users living with their partner and child and entering the programme either for the first time ( $R^2=0.47$ ) or again ( $R^2=0.86$ ) (Figure 5.2). This also shows an increased need for providing assistance to children living in such communities, and the need for a special approach to such marital or extra-marital unions.

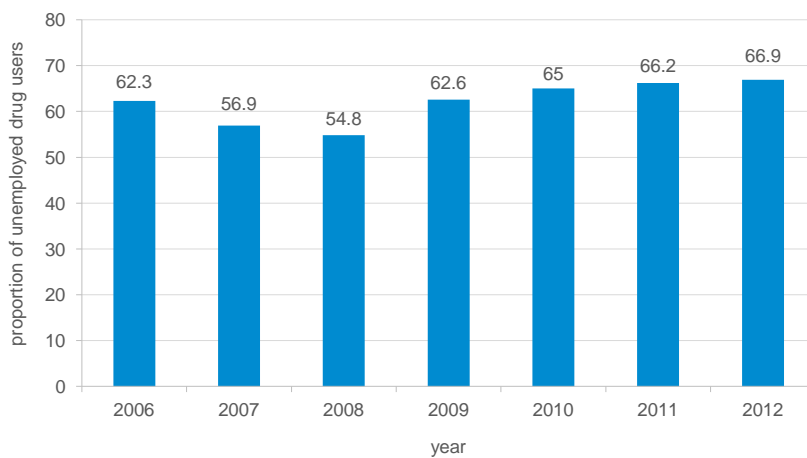


Source: NIPH

**Figure 5.2:** Proportion of users living with their partner and child upon first admission or readmission to a programme, 2006–2012

### Employment Status

- First admission or readmission to a programme  
Of all users who participated in a programme for the first time or again (all treatments) in 2012, 66.9% (347 people) were unemployed, and 18.5% (96 people) were employed. In the period 2006–2012, an increase in the proportion of unemployed was recorded in the group of first-time admitted or readmitted persons ( $R^2 = 0.62$ ) (Figure 5.3).
- First admission to a programme  
Of all users who entered the programme for the first time, 104 (55%) were unemployed and 41 (21.7%) were permanently employed. 29 were still studying (15.3%).
- Readmission to a programme  
Among the users who entered the programme again, the proportion of unemployed (73.6%) was higher than among those entering the programme for the first time. There were less permanently employed persons (16.7%) and less students (2.7%).



Source: NIPH

**Figure 5.3:** Proportion of unemployed drug users who entered the CPTDA network programme for the first time or again, 2006–2012

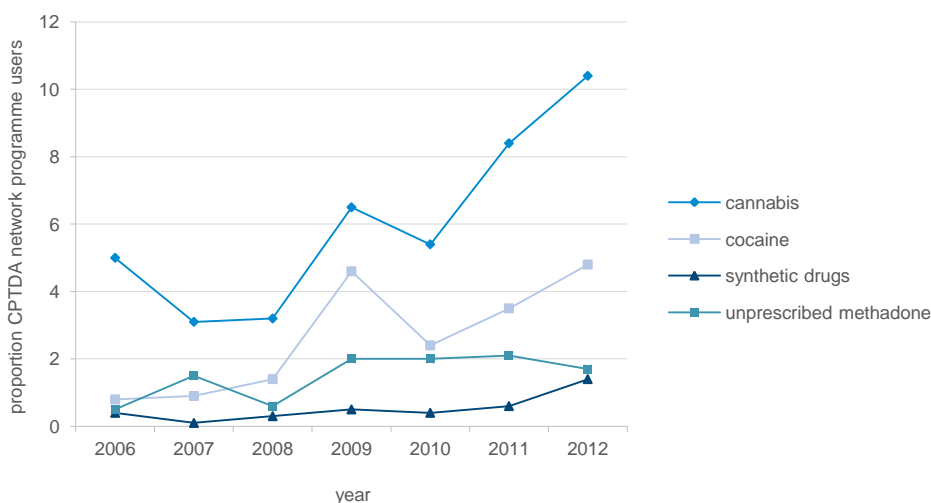
## Residency Status

Upon first entry into a programme, 76.4% users had permanent residence, 17.6% had temporary residence and 0.5% were homeless. Among the users who entered a programme again, 75.1% had permanent residence, 20.0% had temporary residence and 4.0% were homeless. In the group of readmitted programme users, the proportion of the homeless persons has risen almost eightfold.

## Primary Drug Due to Which Users Entered a Programme for the First Time or Again

Among 519 recorded users who sought assistance in a CPTDA again or for the first time, 421 (81%) sought help due to opiate-related problems, which is less than in 2011 (87%). Of 421 persons using opiates as their primary drug, 403 persons (95.7%) were using heroin, 9 persons (2.1%) methadone and 9 persons (2.1%) other opiates. 25 people sought help due to cocaine, accounting for 4.8% of all first-time and readmitted programme users. 54 people (10.4%) entered treatment due to cannabis addiction. 6 person was admitted to a treatment programme because of sedatives or hypnotics. 5 persons (1%) entered treatment because of amphetamines, and 2 persons (0.4%) because of MDMA.

While the proportion of people using heroin upon first admission or readmission decreased, the proportions of those using cannabis ( $R^2= 0.69$ ), cocaine ( $R^2= 0.68$ ), synthetic drugs ( $R^2= 0.58$ ) and black market methadone ( $R^2=0.50$ ) as their primary drug increased in the period 2006–2012 (Figure 5.4).



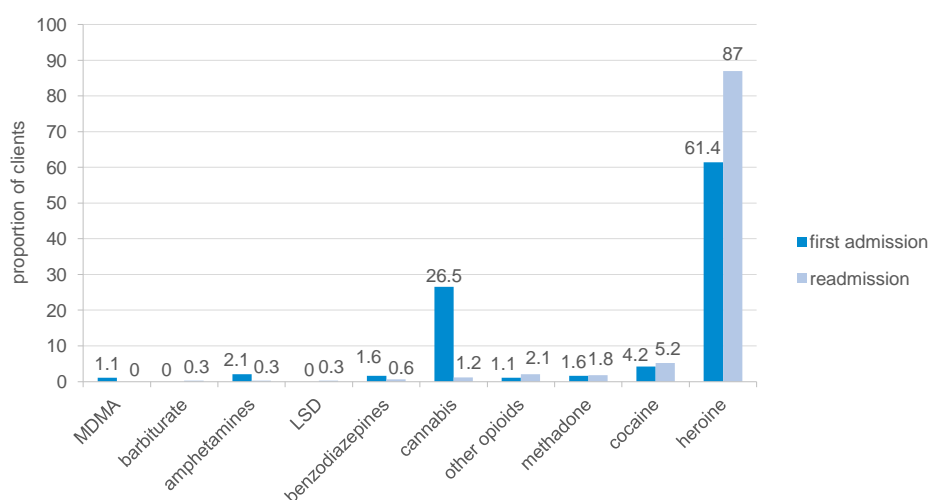
Source: NIPH

**Figure 5.4:** Proportion of CPTDA network programme users who reported cannabis, cocaine, synthetic drugs or unprescribed methadone as their primary drug upon first admission or readmission to a programme, 2006–2012

## Proportion of First-Time and Readmitted Programme Users by Primary Drug

Among persons readmitted to a programme in 2012, the majority (87%) were using heroin as their primary or main drug, while this proportion was lower in users entering a programme for the first time (61%). The proportion of cannabis users is higher among users entering a treatment programme for the first time (26.5%) than among readmitted users (1.2%) (Figure 5.5).





Source: NIPH, 2012

**Figure 5.5:** Proportion of users by their primary drug upon first admission (n = 189) and readmission (n = 330) to a programme, 2012

Drug use by age groups shows that the most common primary drug due to which users in the 15–24 age group entered a programme for the first time or again was cannabis (45.9%), while the most common primary drug in users over 25 years of age was heroin (84.6%) (Table 5.2). Data show that the type of drug due to which users seek assistance in CPTDA programmes changes with age.

**Table 5.2:** Proportion of drug users by type of drug due to which they first entered a programme, by age groups, 2012

Primary drug	Age group	15–24 years (%)	25 years and older (%)
Heroin		42.4	84.6
Methadone		0	2.1
Other opiates		0	2.1
Cocaine		7.1	4.4
Amphetamines		2.4	0.7
MDMA		0	0.5
Cannabis		45.9	3.5
Other stimulants		1.2	0
Barbiturates		0	0.2
Benzodiazepines		1.2	0.9
LSD		0	0.2

Source: NIPH, 2012

### First Admissions or Readmissions, by Sex and Primary Drug

In 2012, 407 men were admitted to programmes for the first time or again, of which 330 (81%) were using opiates and 18 (4.4%) cocaine. Cannabis was used as the primary drug by 45 (11.1%) men, methadone by 6 (1.5%) and benzodiazepines by 5 (1.2%). There were 112 women admitted to programmes for the first time or again. 91 (81.2%) used opiates as their

primary drug, 9 (8%) used cannabis, 7 (6.3%) used cocaine, and 3 women (2.7%) used amphetamines as their primary drug.

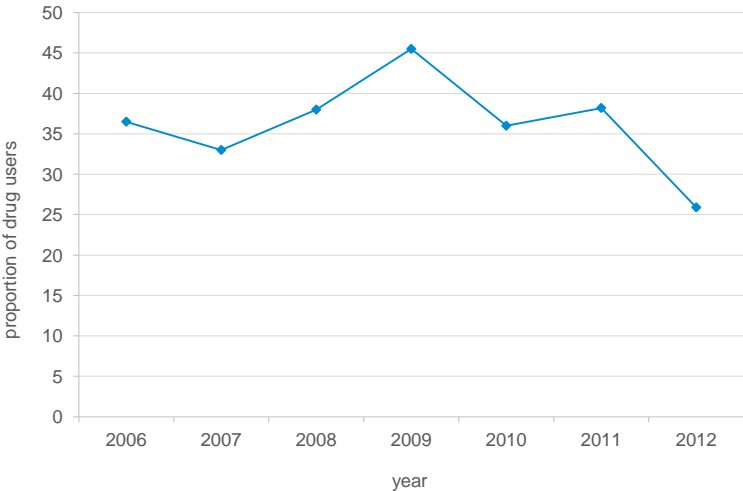
**Frequency of Use of the Primary Drug at First Admission and Readmission**

Among the users admitted for the first time (189), 43.3% used drugs every day before entering the programme, 19% used them two to six times a week, and 9% once a week or less. Of 330 persons who entered the programme again, 50.8% used their primary drug daily, 15.8% two to six times a week, and 7% once a week or less.

**Route of Administration of the Primary Drug at First Admission or Readmission**

Of 519 users who entered a programme in 2012 for the first time or again, 52% injected heroine in the past month, 35.2% smoked it, and 12% snorted it. In case of cocaine users, 40% injected cocaine, 8% smoked it, and 52% snorted it. Among drug users who entered a programme for the first time in 2012 (189 persons), 25.9% injected their primary drug, 51% either smoked or inhaled it, 16 % snorted it, and 6.3% used it orally. Of 329 drug users who entered a programme again, 52.6% injected their primary drug in the past month, 31,3% smoked it, 10,9% snorted it and 4.6% used it orally.

In the period 2006–2012, there was a decrease in the number of injecting drug users, who entered a programme for the first time ( $R^2= 0.57$ ) (Figure 5.6).



Source: NIPH

**Figure 5.6:** Proportion of drug users who entered a programme for the first time and injected drugs in the month before entry, 2006–2012

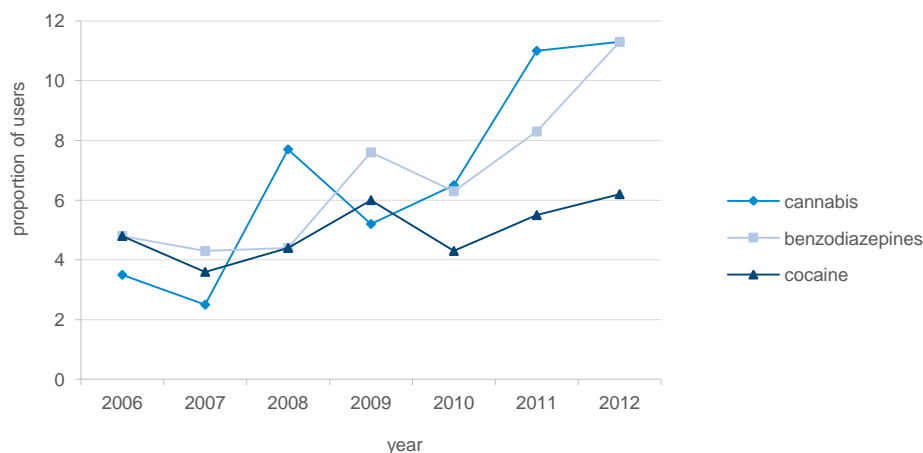
**Secondary Drug**

The most common secondary or additional drug among users (519 persons) who entered a CPTDA programme again or for the first time in 2012 was cocaine (23.9%), followed by cannabis (12,7%), benzodiazepines (7,5%) and opiates (10,2 %). Of 60 programme users aged 15 to 24 who entered a programme for the first time, 19 (31.7%) used a secondary drug; 8 of them used cocaine, accounting for 42.1% of all persons using a secondary drug in this group. 30.2% of users in this age group who entered a programme again used cocaine as their secondary drug. Benzodiazepines were used as a secondary drug by 5.3% newly admitted users aged 15–24, and by 12% of readmitted users.

Upon first admission or readmission to a CPTDA programme, 16.7% users were participating in at least one other treatment programme for drug users. This is due to high transitivity between various drug treatment programmes in Slovenia, high programme accessibility, and close cooperation between various programmes as well as due to the fact that drug users are well informed about such programmes. In the period 2006–2012, the average length of time between the completion of treatment and readmission increased from 21.75 months to 31.5 months. This might indicate that the length of abstinence period has increased, or that other programmes are used in the meantime.

### Trends among Drug Users who participated in a CPTDA Programme for More Than a Year

In addition to data collected using the treatment demand questionnaire (TDI), a special questionnaire is used to monitor all the users who, in the year of observation, had been participating in a programme for more than a year. The data for the period 2006–2012 show an increase in the average age of such users, i.e. from 29.65 years in 2006 to 34.73 years in 2012. In the same period, the highest age of programme users increased as well, namely from 63 years in 2006 to 74 years in 2012, while the proportion of users with heroin as the primary drug decreased from 86.2% in 2006 to 69.7% in 2012. There was an increase in the proportion of users who used cocaine ( $R^2= 0.45$ ), cannabis ( $R^2= 0.79$ ) or benzodiazepines ( $R^2= 0.88$ ) as their primary drug (Figure 5.7).

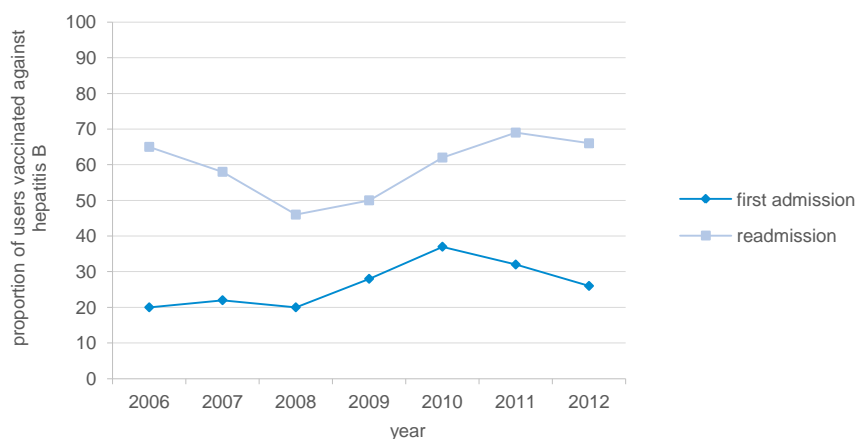


Source: NIPH

**Figure 5.7:** Proportion of users who had participated in a programme for more than a year, by primary drug, 2006–2012

### Hepatitis B Immunization among Drug Users in the Period 2006–2012

Between 2006 and 2012, the vaccination coverage rate among drug users who entered a programme of CPTDA the first time was lower than among users who entered a programme again. This is due to an active approach to hepatitis B immunization of drug users during their first addiction treatment. Thus, the vaccination rate among readmitted users has increased over the years (Figure 5.8).



Source: NIPH

**Figure 5.8:** Proportion of users vaccinated against hepatitis B upon first admission and readmission to a CPTDA programme, 2006–2012

## Conclusion

Analysis of the data obtained via the treatment demand questionnaire (TDI) shows that the structure of drug users has changed in recent years. Among younger users particularly, there have been less problems due to heroin use, and like elsewhere in the EU, the proportion of drug users with heroin as their primary drug has decreased. However, there has been an increase in the proportion of users having problems due to cannabis, cocaine, synthetic drugs and black market methadone. The proportion of persons using more than one drug at a time has decreased, but it remains high, requiring serious efforts to raise awareness and decrease multiple drug use, since poisonings with combinations of drugs are a major risk factor for premature death among drug users. Among users entering treatment programmes for the first time, an increase in the use of medical opiate products has also been detected, which is probably due to occasional lack of heroin. Among the users who had participated in a programme for more than a year, there was an increase of those using benzodiazepines.

Among drug users undergoing maintenance therapy, the number of those receiving methadone as a substitute drug has decreased, while the number of those treated with other substitute drugs has increased. Special attention in such programmes is given to pregnant women who are being treated with substitute drugs. There has also been an increase in the number of users who live with a partner and have a child. Thus, new sub-programmes should be developed within the existing programmes to provide assistance to pregnant women, children and families, be it during pregnancy, upon giving birth or when children are growing up.

The average age of programme users has been increasing over the years, indicating that the population of drug users is aging, and that their health-related and social problems are growing. There is a higher share of unemployed and homeless persons, which is probably partly due to the financial crisis. Therefore, new shelters and housing communities will have to be established, and helpless aging drug users will have to be provided with proper care.

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

Of all saliva samples collected from injecting drug users in 2012 in the framework of unlinked anonymous testing for the purposes of HIV infection control, there was one sample positive for HIV antibodies.

The prevalence of antibodies against hepatitis B virus (HBV; anti-HBc) among anonymously tested injecting drug users who were in treatment in CPTDAs was 2.0% in 2012, and the prevalence of antibodies against hepatitis C virus (HCV) was 27.3%. In both cases, the proportions of infected drug users were the highest in 2011 compared to other years in the period 2008–2012.

In 2012, medical emergency units in Ljubljana treated 47 patients for illicit drug poisoning, 27 of which were treated for poisoning with multiple drugs and/or ethanol. Most poisoned patients were male and the average age of poisoned patients was approximately 28.5 years. The number of patients treated for ecstasy, amphetamine or cannabis poisoning was significantly higher in 2011 and 2012 compared to 2010, when heroin poisoning cases prevailed.

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

In 2012, 26 deaths due to drug poisoning were recorded in the Slovenian General Mortality Register. All deceased were male, and their average and median age at death was 35.9 years. Heroin and methadone were the most common cause for fatal poisoning, followed by cocaine. The analyses of cohort data shows that the mortality rate of treated drug users is a little less than twice as high as the mortality rate of their Slovenian peers.

## 6.1 Drug-related Infectious Diseases

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

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

Available data on HIV, HBV and HCV infections among IUDs in Slovenia for the period from 2008 to 2012 is 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 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 IDUs at first treatment demand is conducted for HIV surveillance purposes in the largest Centre for the Prevention and Treatment of Illicit Drug Addiction in Ljubljana since 1995. Since 2002, four non-governmental harm reduction programmes have also been included in the system. These programmes are needle exchange programmes: AIDS Foundation Robert (only in 2003 in Ljubljana), Stigma (in Ljubljana since 2005), Svit (in Koper since 2004) and Zdrava pot (in Maribor since 2010). Detailed descriptions of methods have already been published (Klavs and Poljak 2003). Saliva specimens for unlinked anonymous HIV testing are voluntarily provided by IDUs entering the treatment at the Centre for Prevention and Treatment of Illicit Drug Addiction in Ljubljana, and by injecting drug users already involved in the aforementioned needle-exchange programmes.

In addition, the National Institute of Public Health (NIPH) collects information on newly diagnosed cases of HIV, HBV and HCV infections, which may include information on the transmission routes. All three diagnoses must be reported according to the Infectious Diseases Law. Nearly all of the newly diagnosed HIV infection cases reported also contain information on the transmission route. In contrast, information on the transmission route (e.g. IDUs) is only available for a minority of reported HBV and HCV cases. Surveillance reports on the prevalence of infections that include information on infectious diseases case reporting are published annually (Klavs et al. 2013, IVZ 2013).

## HIV Infection

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

During the period from 2008 to 2012, HIV prevalence among confidentially-tested IDUs treated in the network of Centres for the Prevention and Treatment of Illicit Drug Addiction consistently remained under 1%, but rose to 1.3% in 2009 and to 1.9% in 2011. During the same period, among a total of 947 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:** HIV infected persons among injecting drug users, sentinel sites, 2008–2012

Year	Number of sentinel sites	Number of tested		Number of HIV infected		% HIV infected	
		Male	Female	Male	Female	Male	Female
2008	3	142	34	0	0	0	0
2009	3	127	32	0	0	0	0
2010	4	179	74	1	0	0.6	0
2011	4	136	50	1	0	0.7	0
2012	4	132	41	1	0	0.8	0

Source: Unlinked anonymous testing for epidemiological surveillance of HIV infection, Slovenia, 2008–2012

In the last five years (2008–2012), there was one single reported case of a new HIV diagnosis with a history of IDU. Before that the last HIV infection in an IDU was reported to the NIPH in 2001. However, since 1986, when the national HIV surveillance, based on mandatory notification of all diagnosed HIV infection cases was initiated, a cumulative total of 14 new HIV diagnoses were reported among IDUs.

The comparison of EU trends in newly diagnosed infections related to injecting drugs with trends in the prevalence of HIV infection among IDUs shows that the incidence of HIV infection among IDUs has been decreasing on a national level (EMCDDA 2012).

## HBV

The prevalence of antibodies against hepatitis B virus (HBV; anti-HBc) among confidentially-tested IDUs treated within the network of Centres for the Prevention and Treatment of Illicit Drug Addiction was 2.0% in 2012. During the period from 2008 to 2012, 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 2012 was 2.1/100,000 inhabitants. During the period from 2008 to 2012, 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 underreporting, HBV reported incidence rates greatly underestimate the burden of this infection.

In EU for hepatitis B, IDUs represent 6% of all notified cases and 12% of acute cases (EMCDDA 2012).

## HCV

The prevalence of antibodies against hepatitis C virus (HCV) among confidentially-tested IDUs treated within the network of Centres for the Prevention and Treatment of Illicit Drug Addiction was 27.3% in 2012. During the period from 2008 to 2012, the prevalence ranged from the highest 28.5% in 2011 to the lowest 21.5% in 2010.

The reported acute and chronic HCV infection incidence rate in the Slovenian population in 2012 was 5.0/100,000 inhabitants. During the period from 2008 to 2012, the reported incidence rate ranged from the highest 5.4/100,000 inhabitants in 2009 to the lowest 4.1/100,000 inhabitants in 2008. Due to underreporting, HCV reported incidence rates greatly underestimate the burden of this infection.

In EU member states, HCV antibody levels among national samples of IDUs in 2009–2010 varied from 14% to 70%, with seven of the 11 countries with national data, reporting prevalence over 40%. The Czech Republic, Hungary and Slovenia report HCV prevalence of under 25% (5–24%), although infection rates at this level still constitute a significant public health problem (EMCDDA 2012).

## Discussion

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

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

## 6.2 Other Drug Related Health Correlates and Consequences: Non-fatal Overdoses and Drug-related Emergencies

Miran Brvar, PhD

This chapter presents an overview of drug poisoning patients treated in medical emergency units at the University Medical Centre in Ljubljana (hospital first aid) in 2012.

Medical emergency units at the University Medical Centre in Ljubljana provide emergency care to approximately 600,000 people living in Central Slovenia. In 2012, 23,086 patients were treated in medical emergency units in Ljubljana; below we present the number of people examined and treated for illicit drug poisoning.



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

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

By using the computer system and data on underlying diagnoses coded according to ICD-10, and by examining non-coded referral and discharge diagnoses of all patients recorded manually in the book of examined patients in 2012, we determined that there were 47 patients treated for illicit drug poisoning in medical emergency units in Ljubljana (Table 6.2). There were 51 such patients in 2010 and 43 in 2011. By reviewing all descriptive diagnoses, we also identified combined drug poisoning cases (involving combinations of known drugs) and drug poisoning cases that could not be coded using ICD-10 codes.

**Table 6.2:** Patients poisoned with illicit drugs and treated in medical emergency units at the University Medical Centre in Ljubljana, 2010–2012

Illicit drugs and their combinations	No. of patients in 2010 (n = 51)	No. of patients in 2011 (n = 43)	No. of patients in 2012 (n = 47)
Heroin	24	3	4
Heroin + ethanol	2	2	1
Heroin + methadone	1	2	
Heroin + methadone + ethanol		1	
Heroin + amphetamine	1		
Heroin + cocaine	6	1	
Heroin + cocaine + ethanol	1		1
Heroin + cannabis + ethanol			1
Heroin + cocaine + cannabis			1
Cocaine	5	4	5
Cocaine + ethanol			3
Cocaine + ecstasy + cannabis + ethanol		1	1
Cocaine + ecstasy + amphetamine + ethanol		1	1
Cocaine + cannabis + methadone		1	
Cocaine + methadone		1	
Cocaine + morphine		1	

Table 6.2 continues ...

Illicit drugs and their combinations	No. of patients in 2010 (n = 51)	No. of patients in 2011 (n = 43)	No. of patients in 2012 (n = 47)
Ecstasy+ ethanol		4	3
Ecstasy + amphetamine			1
Ecstasy + amphetamine + ethanol		2	
Ecstasy + mephedrone	1		
Ecstasy + amphetamine + mephedrone + cannabis		1	
Amphetamine		1	1
Amphetamine + ethanol		2	
Amphetamine + THC		1	
Mephedrone + ethanol	1		
2-Cl	1		
LSD + cannabis			1
Psilocybe			1
Ibogaine			1
GHB	1	1	1
GHB + amphetamine	1		
GHB + ecstasy			1
GHB + ethanol		1	
GHB + amphetamine + cannabis + ethanol			1
GHB + amphetamine + ecstasy + cannabis + ethanol			1
GBL + ethanol			1
Cannabis	6	8	7
Cannabis + ethanol		1	9
Cannabis + methadone		2	
Cannabis + methadone + buprenorphine		1	

Source: University Medical Centre Ljubljana

Table 6.3 shows the number of illicit drugs used by poisoned patients. As expected, the number of drugs used is higher than the number of poisoned patients (Table 6.2), since there were 14 patients (27%) treated for poisoning caused by use of multiple drugs combined with ethanol in 2010, and as many as 25 such patients, i.e. 62% of all drug poisoning patients, in 2011. Similar numbers were recorded in 2012, when there were 27 patients (67%) treated for poisoning with multiple drugs and/or ethanol, 10 of which used several illicit drugs and 22 (46%) used one or more drugs combined with ethanol.

**Table 6.3:** The number of illicit drugs used by poisoned patients treated in medical emergency units at the University Medical Centre in Ljubljana, 2010–2012

Illicit drugs	Number of drugs in 2010 (n=61)	Number of drugs in 2011 (n=55)	Number of drugs in 2012 (n=61)
Heroin	35	9	8
Cocaine	12	10	12
Cannabis	6	16	23
Mephedrone	2	1	0

Table 6.3 continues ...

Illicit drugs	Number of drugs in 2010 (n=61)	Number of drugs in 2011 (n=55)	Number of drugs in 2012 (n=61)
Amphetamines	2	8	4
GHB	2	2	4
Ecstasy	1	9	8
GBL	0	0	1
Ibogaine	0	0	1
2-CI	1	0	0

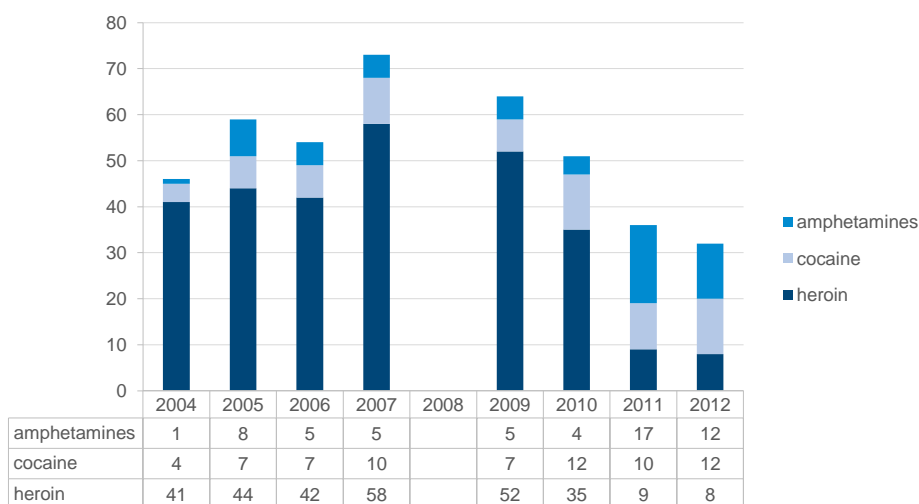
Source: University Medical Centre Ljubljana

The average age of patients poisoned with illicit drugs was approximately 28.5 years in 2012, 29.5 in 2010, and 29 in 2011. Most poisoned patients were male (79% in 2010, 67% in 2011, and 86% in 2012).

In 2010, 83% of all patients poisoned with heroin only were male and their average age was 31.5 years. All patients poisoned only with heroin treated in 2011 were male (100%), and their average age was 25 years, while in 2012, 87% of patients poisoned only with heroin were male and their average age was 27.

It is interesting that there were many cases of poisoning with a combination of heroin and cocaine in 2010, while there was only one such case in 2011 and two in 2012. However, the number of patients treated for ecstasy, amphetamine or cannabis poisoning was significantly higher in 2011 and 2012 compared to 2010, when heroin poisoning cases prevailed. The number of cocaine poisoning cases was similar in 2010, 2011 and 2012.

The number of amphetamine poisoning cases increased in 2011 and 2012 in comparison with previous years (2004–2010), while the number of heroin poisoning cases has been decreasing for the past three years (Figure 6.1).



Source: University Medical Centre Ljubljana

**Figure 6.1:** The number of illicit drugs used by poisoned patients treated in medical emergency units at the University Medical Centre in Ljubljana, 2004–2012

Drug poisoning cases accounted for 0.2% of all cases treated in medical emergency units in 2012, while they accounted for 0.24% and 0.19% of all cases in 2010 and 2011, respectively.

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

The only way we could determine the actual number of drug poisoning cases would be if we were to review all medical records of all patients examined in emergency units as well as medical records of hospitalized patients, as sometimes poisoning is diagnosed no sooner than during treatment in a hospital, especially in cases of poisoning with new synthetic drugs, which require a complex toxicological analysis. Unfortunately, it is practically impossible to carry out such an extensive review of medical records of all patients referred to medical emergency units; to this end, the Slovenian Register of Intoxications was established in 2001, which is kept in accordance with the Rules on Reporting, Collecting and Arranging of Data on Poisonings in Slovenia. According to the Rules mentioned, all natural and legal persons engaged in healthcare activities are required to regularly report poisoning cases, including cases of poisoning with illicit drugs, to the Poison Control Centre at the University Medical Centre in Ljubljana using the "Poisoning Report Form", which was published in the Official Gazette of the Republic of Slovenia. The form must contain information about the patient (gender, age, education level, bad habits, medical conditions, etc.) and information about the poisoning (name and quantity of the medication/poison/drug, place and circumstances of poisoning, clinical picture and treatment of the poisoning, etc.). Unfortunately, Slovenian medical professionals often avoid this obligation despite repeated encouragement and warnings.

It may be concluded that emergency examinations of persons poisoned with illicit drugs account for at least 0.2% of all patients examined in medical emergency units in Ljubljana, and that the number of combined poisonings, especially involving amphetamines and cannabis, is increasing, while the number of heroine poisonings is decreasing.

### **6.3 Drug Related Deaths and Mortality among Drug Users**

Jožica Šelb Šemerl, PhD, Chief Physician

#### **Introduction and Methodology**

In Slovenia, data on health effects of drug use are collected from several medical statistics databases. The General Mortality Register (GMR) remains the most used and most reliable data source. Data obtained from the Mortality Register include the number of deceased drug users in Slovenia, regions, age and sex distribution of them, and data on the most dangerous drugs in use.

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

- direct drug-related deaths, i.e. deaths of people who died due to a direct effect of illicit drug in the body; such data, i.e. data on the underlying cause of death, are obtained from the General Mortality Register (NIPH 46: Medical Report on the Deceased Person);

- indirect drug-related deaths, i.e. data on people who died due to indirect effects of illicit drugs on their health, where drug effects produce an indirect cause of death; such information is from cohort study data.

To determine the number of direct drug-related deaths, we analysed demographic and other data collected via the Medical and Civil Death Certificate, named also DEM-2 form (Drev et al. 2011). Deaths were analysed according to basic epidemiological indicators, and mortality rates were calculated as deaths per 1,000 person years in an appurtenant population group. To calculate the mortality rate in the Slovenian population, we used the number of deaths and the number of inhabitants in 2007; for age standardization, the old European standard population was used. 95% Confidence Interval for statistical significance was obtained on the base of Poisson distribution for the number of occurrences.

## Results

In 2012, 26 deaths due to drug poisoning were recorded in the Slovenian General Mortality Register. All drug users who died due to drug poisoning in 2012 were male, and their average and median age at death were 35.9 years; most of them were 29 years old, and the youngest one was 24.7 years. Most deaths occurred in the 25–29 and 35–39 age groups (ST 6). Of 26 poisoning cases, 24 were determined by a toxicological analysis (ST 6). The number of deaths in 2012 was significantly lower than the average for the last seven years.

**Table 6.4:** The number of direct drug-related deaths, by external cause and type of drug used, 2012

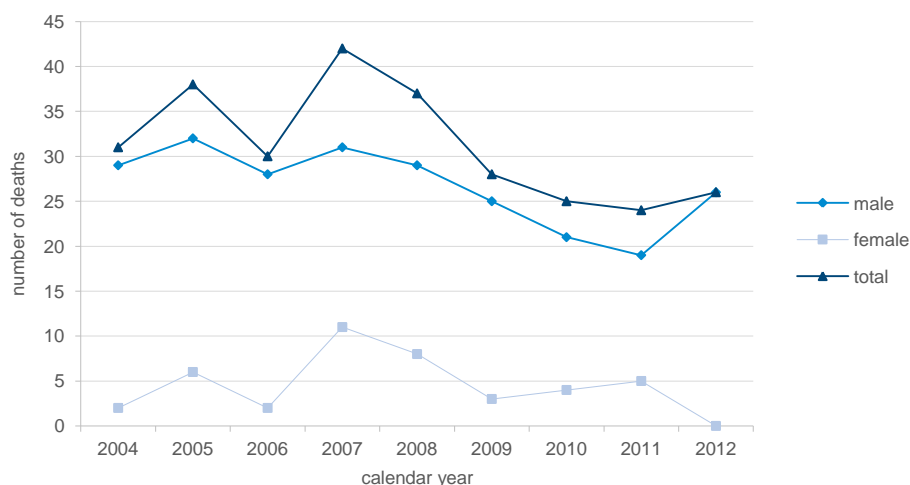
Type of drug	Accidental poisoning	Intentional self-poisoning	Undetermined intent	Total
Heroin	10	0	1	11
Methadone	7	1	3	11
Other synthetic narcotics	0	1	0	1
Cocaine	2	0	1	3
Total	19	2	5	26

Source: Medical Report on the Deceased Person – NIPH 46

In 2012, the majority of deaths were due to heroin or methadone poisoning. Methadone and heroin caused the same number of drug-related deaths, while one-tenth of deaths were due to cocaine. Almost three-quarters of poisonings were accidental, two deaths were intentional, and for the remaining five ones it remains undetermined whether the poisoning was intentional (suicide) or accidental (overdose) (Table 6.4) (ST 5).

## Trends in Drug-related Deaths and Mortality among Illicit Drug Users in Slovenia in the Period 2004–2012

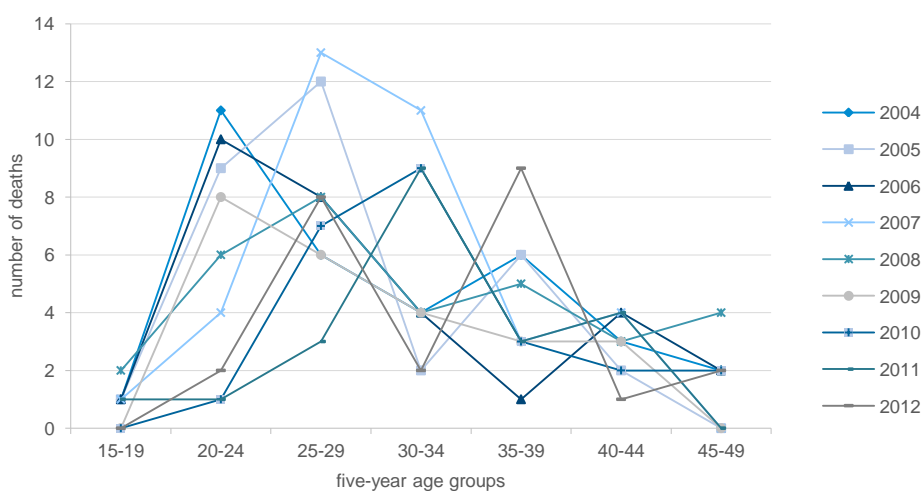
The number of direct deaths due to drug overdose (intentional, accidental or of undetermined intent) has been decreasing since 2007 in Slovenia. On average, the number of deaths in the period 2004–2012 was almost six times higher among men than among women. The number of deaths among men stopped decreasing in 2012, when it increased by 6 deaths compared to 2011 (Figure 6.2).



Source: Medical Report on the Deceased Person – NIPH 46

Figure 6.2: Trends in the number of drug-related deaths by sex, 2004–2012

The highest number of deaths in one age group was in 2007 in the 25–29 age group. In the following years, the number of deaths decreased and the highest proportion moved towards older age groups; thus in 2012 the largest proportion of deaths occurred in the 35–39 age group (Figure 6.3).



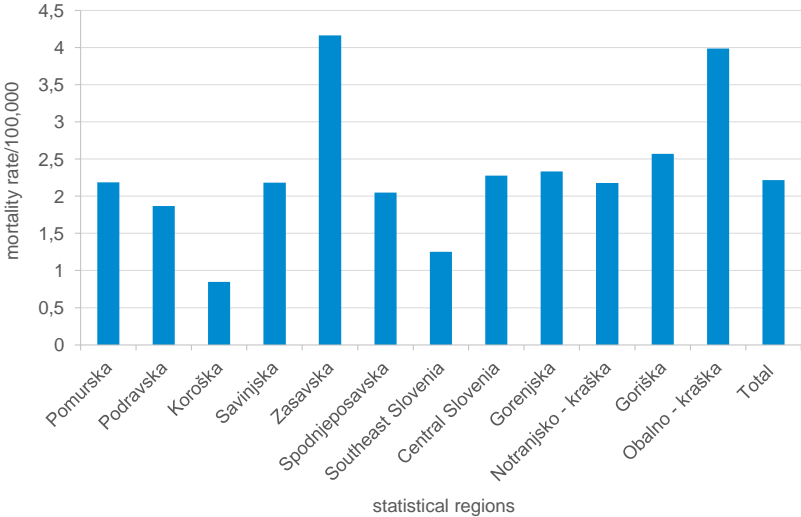
Source: Medical Report on the Deceased Person – NIPH 46

Figure 6.3: Trends in the number of direct drug-related deaths among people aged 15–49 years, by five-year age groups, 2004–2012

In the nine years of collecting data according to the EMCDDA methodology, on causes of death in drug users, we recorded a decline in the maximum age at death and a decrease in years of potential life lost (YPLL) in parallel with an increase in the minimum age at death and an increase in the median age at death. The decrease in YPLL in parallel with the increase of median age shows that the age at death of drug users is increasing.

In seven out of twelve statistical regions, mortality rate was near the average of the Slovenian population. The Zasavje and the Obalno-kraška statistical regions (the latter also called the Koper region) had by far the highest percentage of accidental poisonings in

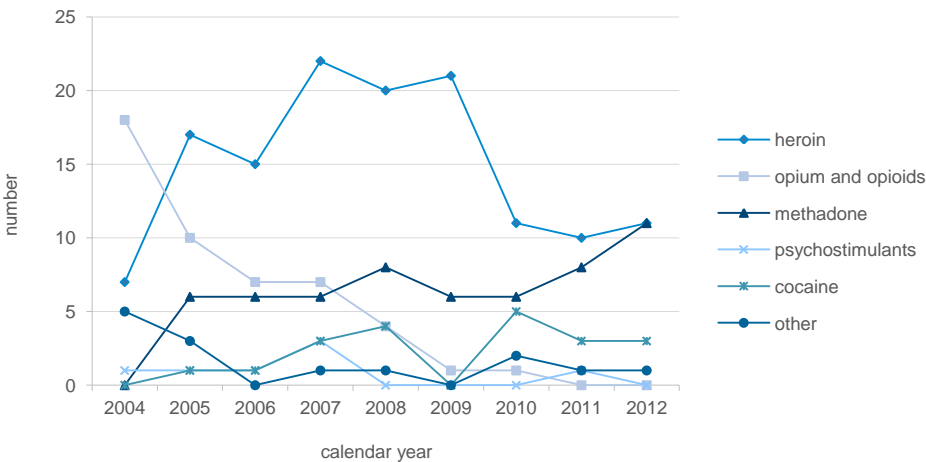
relation to the number of inhabitants (Figure 6.4). In the observed period, compared to Slovenia as a whole, these two regions had, on average, two more drug-related deaths per 100,000 population aged 15–64, while the Koroška and the Southeast Slovenia regions had the lowest mortality rates. As regards fatal poisonings, all regions had more deaths due to accidental drug poisoning than deaths by suicide. Due to the high number of deaths with undetermined intent, it was impossible to form a clearer picture of mortality rates related to intentional and accidental poisonings.



Source: Medical Report on the Deceased Person – NIPH 46

Figure 6.4: Drug-related mortality rates among people aged 15–64 by region, 2004–2012

In 2012, the number of deaths due to heroin poisoning, which was the leading cause of death in all previous years, was equal to the number of deaths due to methadone, which was the second most common cause of death and has been increasing since 2010. The number of deaths due to cocaine has ranged between 3 and 5 since 2007, except in 2009, when there were no such deaths. There have been no opium or opioid poisonings in the last two years, and few deaths due to other drugs, if any, occurred during single years of the period (Figure 6.5).



Source: Medical Report on the Deceased Person – NIPH 46

Figure 6.5: Trends in the number of fatal drug poisonings (intentional, accidental and with undetermined intent) by type of drug, 2004–2012

Three-quarters of people who died due to illicit drugs were single, some were divorced and the rest were married or widowed. In the last four years, most victims of acute drug poisoning died at home, while prior to that period there were more deaths outside the home. About 16% of victims of acute drug poisoning died in healthcare institutions. In recent years, the amount of data provided by pathologists has been increasing, thus the quality of data on the manner of death and an intention of poisoning has improved.

### **Factors Associated With Drug-Related Mortality Trends**

Trends in drug-related mortality can be influenced by various factors, some of which are described below.

For the Zasavje and Koper regions, where the drug-related mortality rate was the highest, the following indicators were used to estimate some of the possible reasons for the highest mortality: population, education, labour market, social protection, health and economic situation (the data of the Statistical Office of the Republic of Slovenia compiled in the 2013 Slovene Regions in Figures publication - Slovenske regije v številkah 2013). A combination of these indicators could suggest that people of Zasavje region are trapped in an environment that does not offer a promising perspective. For example, Zasavje has the most significant negative population growth in the country, a high number of immigrants and the least educated inhabitants compared to other regions. Two socio-economic indicators stand out in this region: the second lowest GDP per capita and a high rate and long term unemployment. In contrast, the above mentioned indicators are exceedingly favourable in the Koper region, which is the second richest region in the country and has the lowest percentage of families with three or more children and the lowest percentage of students per 1000 inhabitants despite the relatively high percentage of educated parents.

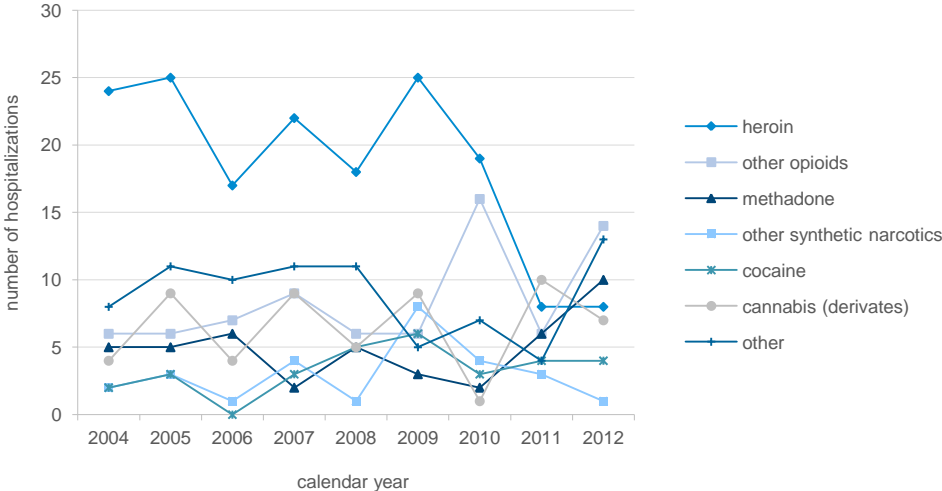
These conflicting data on the socio-economic situation in the two regions suggest that the low socio-economic status on a regional level is not the only reason for the high drug-related mortality, and thus further reasons must be sought elsewhere. The Koper region has a well-developed tourism industry. Furthermore, the Koper harbour is located in the region, and the Italian harbour of Trieste is located nearby. The neighbouring Friuli - Venezia Giulia region in Italy is also burdened by drug abuse and has a longer history of dealing with this issue. The majority of drugs intended to be sold in Northern Italy are trafficked to Italy along the route crossing the Koper region and the Italy–Slovenia border. Therefore, there are more drugs available in the Koper region than in other regions (Drev et al. 2012:96), which might have influenced the prevalence of drug use and, consequently, the high drug-related mortality.

The number of hospitalisations due to illicit drugs changed significantly between 2004 and 2008; it increased from 45 to 75 in one year. It started decreasing in 2009, which applies to unplanned emergency admissions, overdoses as well as multi-drug poisonings; however, the last has decreased less significantly than the first two.

An overview of hospital statistics for the 2004–2012 period with regard to main poisoning diagnoses from T400 (opium) to T409 (other and unspecified psychodysleptics) shows that the number of heroin-related hospitalizations is decreasing. In addition, the number of hospitalizations due to other opioids decreased in 2011 compared to 2010, but increased again in 2012. The number of hospitalizations due to the use of cannabis, methadone and



other drugs increased from 2010 to 2012. Other synthetic narcotics hospitalizations decreased in the same period, while cocaine hospitalizations remained on the same level (Figure 6.6).



Source: Medical Report on the Deceased Person – NIPH 46

Figure 6.6: Trends in hospitalizations due to drug poisoning by type of drug, 2004–2012

The decrease in the mortality of drug users might have also been influenced by a lower availability of certain illicit drugs in 2011 compared to 2010 (heroin, cocaine, ecstasy), which is supported by the fact that the number of seizures by the police also decreased. The only exception is amphetamine tablets, seizures of which have been increasing. Police also detected an increase in both seizures and production of cannabis (Drev et al. 2012).

Data on drug users who entered treatment for the first time indicate decreasing number of first admissions. The difference between the median age at admission into treatment and that of the first use of the primary or any other drug is increasing and the continuation of this trend in the future could lead to an increase in the number of deaths, since the period when an individual is not receiving treatment but is using drugs is becoming longer.

Since 2008 we have been observing decreasing use of heroin as the primary or secondary drug among treated drug users. However, the use of cocaine, cannabis, benzodiazepines and methadone has remained unchanged in the past few years and accounts for more than half of all treatment needs (Drev et al. 2012:93). There has been an increase in unemployment among individuals who have entered a treatment programme.

Among users of low-threshold programmes the use of all drugs except heroin (lower quality and availability) increased in 2011. Thus, the number of heroin-related deaths did not increase in 2012, but the number of deaths due to methadone did. An increase in the number of hepatitis B and C infections has been recorded among anonymously tested injecting drug users.

ESPAD survey results indicate that the prevalence of illicit drug use among 15- and 16-year-olds has stabilized after 2007, which could have a long-term effect on the decrease in mortality. However, the use of inhalants and cannabis among high school students in Slovenia is higher compared to the average of the other countries participating in the ESPAD survey (Hibell et al. 2012).

## Conclusion

The results presented in the report indicate that the number of direct drug-related deaths in Slovenia was significantly lower in 2012 compared to the average of the past seven years. The number of drug overdoses – intentional, accidental or with undetermined intent – has been decreasing since 2007; however, it increased among men in 2012. In the period 2004–2012 an average number of drug-related deaths among men was six times higher than among women.

The highest number of deaths is moving towards older age groups, which, together with the decrease in YPLL and the increase in median age at death, indicates that the age at death of drug users is increasing. Mortality due to direct drug poisoning differs across Slovenian statistical regions. Two regions stand out: in one of them, the high number of deaths could be due to certain socio-economic factors, while in the other region significant influence is probably exerted by the presence of the largest Slovenian harbour and the proximity of the Italian border.

The increase in the number of deaths in 2012 might have been influenced by the trend in treatment of drug users, which shows that the number of first-time treatments is decreasing while the difference between the age at entry into out of hospital treatment and the age of first use of any drug or primary drug is increasing. The fact that the use of cocaine, benzodiazepines and cannabis as the primary or secondary drug at the time of entry into treatment accounts for more than half of all treatment needs indicates that, in addition to the existing programme for opioid addicts, other kinds of programmes should also be established.

The number of hospitalizations due to illicit drugs, including unplanned emergency admissions, overdoses and multi-drug poisonings, decreased between 2009 and 2011, which is consistent with the decrease in mortality. The stabilization of drug use among 15- and 16-year-olds since 2007 (ESPAD survey data) indicates that drug-related mortality is likely to further decrease. However, the relatively high prevalence of inhalant use among adolescents, the increase of the number of deaths due to methadone, high unemployment and the increase in the number of hepatitis B and C infections among anonymously tested injecting drug users are a cause for concern (Drev et al. 2012).

## Analysis of Nine-Year Follow-up Cohort Data on Treated Drug Users

Jožica Šelb Šemerl, PhD, Chief Physician

### Introduction and Methodology

In the previous two national reports, we presented in more detail the methodology of entering treated drug users into a cohort, the calculation methods used, and the differences in demographic, social and other factors recorded in drug users' treatment records. Thus, in this paper, we focus our reporting on mortality trends among all cohort members and on their causes of death in the period from 2004 to 2012. 2012 data on deceased treated drug users were added to the 2004–2006 cohort data, which had been followed-up on until 2011. The methods used to calculate age-standardized mortality rate and mortality ratio for all persons in the cohort and for those who entered treatment due to opioid use were used also to calculate both parameters for groups of deceased cohort members whose causes of death were diseases, accidental poisoning or suicide. We did not calculate the parameters for the

group of acute drug poisoning of undetermined intent, because this entity could not be used for preventive purposes, however if properly coded, it would only increase the number of accidental and intentional poisoning cases. Mortality rates in the cohort were calculated for persons aged 15 to 59 years of age, and compared with mortality rates for men and women of the same age in Slovenia in 2008, which is the middle year of the cohort follow-up period. Age-standardized mortality rates (using the old European standard population and mortality in Slovenia in 2007) per 1,000 were calculated using person-years (PY) as the denominator. Cumulative annual mortality was calculated based on the number of deaths in previous years up to the specified year per 1,000 person-years of follow-up.

## Results

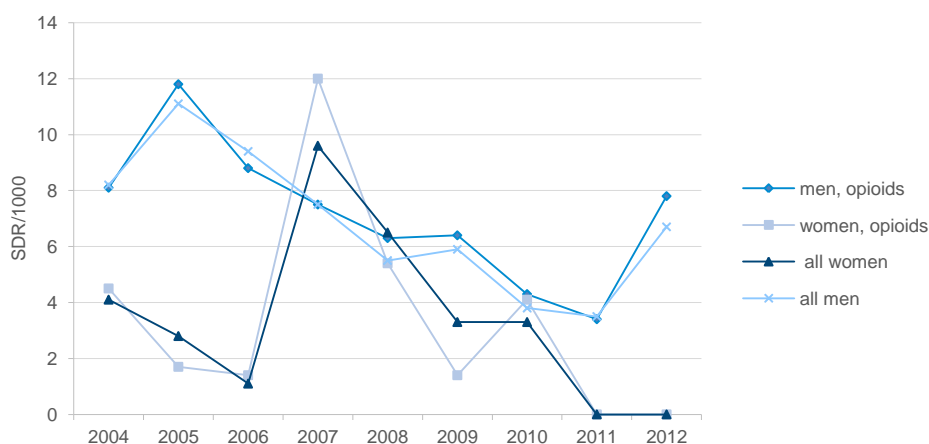
In the 2004–2012 period, there were 185 deaths in the group of 3,949 treated drug users included in the study between 2004 and 2006, which means that 4.7% of all included persons died in the mentioned period. More specifically, 5.3% of men and 2.7% of women included in the study died between 2004 and 2012. All persons were followed-up for 31,357.8 person-years, and the deceased users account for 5.9 deaths per 1,000 treated drug users aged 15 to 59 years of age. Compared with the mortality of inhabitants of Slovenia in the same age group (2.1/1,000 deaths), the mortality rate of treated drug users is almost twice as high, and their age-standardized mortality rate is little over twice as high (ST 18). The difference between deceased female drug users and female inhabitants of Slovenia of the same age is smaller (2.23 deaths per 1,000 women) than in men (3.8 deaths per 1,000 men), which means that the difference in mortality of treated male drug users to other deceased male inhabitants of Slovenia of the same age is less favourable than the same parameter of treated female drug users in relation to other deceased female inhabitants of Slovenia of the same age.

Age-standardized annual mortality rates (ASMR) were higher among men than among women. Between 2005 and 2011, mortality rates among men decreased significantly ( $R^2 = 0.5759$ ) by about one death per 2,000 drug users per subsequent calendar year, but increased again in 2012. Mortality rates among women have been decreasing since 2007; although this decrease is not significant, it shows that the health status of surviving female drug users has improved in recent years (ST18).

On the basis of cumulative mortality in the cohort, we estimate that, after the initial increase of mortality, the risk of death decreased with increasing duration of follow-up. Cumulative mortality started decreasing in 2005 for men and in 2008 for women. Since mortality rates of cohort members decrease with increased duration of follow-up both in men and women, but dropped after the initial increase thus representing the trend in mortality rate among treated drug users in a certain period of time after their entry into treatment. This trend could be calculated more precisely if we analysed drug users who entered treatment for the first time only and divided the cohort into smaller birth cohorts.

### **Age-standardized Mortality Rates** (ASMR) (SDR Standardized (direct) death rate)

In most years, the mortality rate among people who used opioids at the time of entry into treatment was higher than the mortality rate in the entire treated population, owing to the short duration of follow-up period of opioid users. Most deceased drug users in both groups were addicted to opioids (Figure 6.7) (ST18).



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

**Figure 6.7:** Changes in age-standardized mortality rates among treated drug users and opioid users by sex, 2004–2012

For men, mortality rates were the highest in older clients (7.84 deaths per 1,000 PY). New clients and clients in long-term treatment had the same mortality rate (4.67 deaths per 1,000 PY). For women, mortality rates were the highest in women in long-term treatment (5.54 deaths per 1,000 PY) and old clients (4.56 deaths per 1,000 PY).

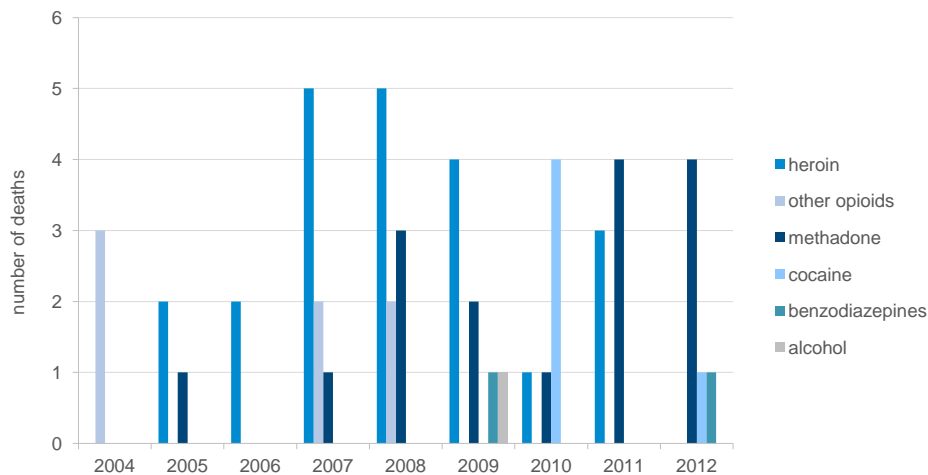
Of all people who died during the observed period, 29.2% died due to accidental poisoning, 17.8% died by suicide, 18.4% died due to poisoning of undetermined intent, 6.5% died in traffic accidents, 5.9% in other accidents, and 22.2% due to diseases. The leading cause of death among men was accidental poisoning (27.7%), followed by natural causes of death (21.4%). Poisoning of undetermined intent and suicide came in at third and fourth place. Of 26 women who died between 2004 and 2012, 9 died in 2007. In the remaining years, 7 women died of overdose, and the other deaths were due to different types of violent deaths and deaths due to disease.

### Acute Poisoning

In the nine-year follow-up period, of all 3,949 cohort members, 53 persons, i.e. 28.6%, died due to accidental poisoning. 43 accidental poisonings in men represent a third of all violent deaths among male drug users, and 10 accidental poisonings in women account for a little more than a half of all violent deaths among female users. The nine-year overdose rate was 1.81/1,000 PY for men and 1.31/1,000 PY for women.

Mortality due to accidental poisoning among treated users in the cohort changed from year to year. ASMR for women remained unchanged between 2004 and 2012, while ASMR for men increased, although not significantly ( $R^2 = 0.2457$ ).

As regards male cohort members, age-standardized annual cumulative mortality rate decreased in the early follow-up period, but has been increasing steadily since 2007, when it reached its lowest level. Among women, it increased between 2004 and 2010, and decreased in the last two years.



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

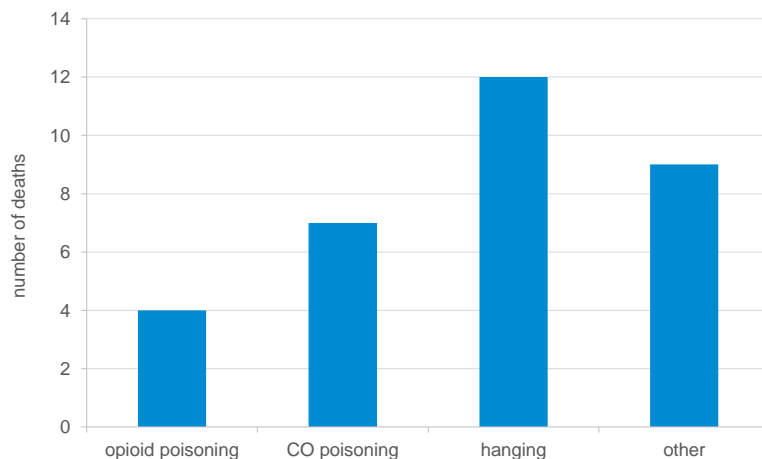
**Figure 6.8:** The number of accidental poisonings among treated drug users by type of drug, 2004–2012

The total number of accidental drug poisonings was the highest in 2007, 2008, 2009 and 2010, after which it decreased in 2011 and increased again in 2012. Most poisonings were due to heroin (22 out of 53) and methadone (16 out of 53). There have been some fatal cocaine overdose cases in recent years, while no poisonings by other opioids have been recorded since 2008 (Figure 6.8). Most fatal accidental poisonings occurred among people who had entered treatment, dropped out and then re-entered: 32 out of 44 men and 8 out of 10 women. The average age at death was 38.1 years for men and 34.2 years for women. The youngest victims of accidental poisoning were a 20.9 year-old man and an 18 year-old woman. Accidental heroin poisonings prevailed in the first years after the beginning of the study, while methadone and cocaine poisonings prevailed in the last years.

### Suicide

29 men and 4 women in the cohort died by suicide in the nine-year follow-up period, which means that there were 1.05 suicides per 1,000 years of follow-up or 1.22/1,000 for men and 0.53/1,000 for women. In 2008, the suicide rate among male cohort members was 3.9-times higher than among their male peers in Slovenia, and the suicide rate among treated female drug users in the cohort was 7.8 times higher than among their female peers in Slovenia. The suicide rate among treated drug users, both male and female, is lower than the rate of fatal drug poisoning.

The annual suicide-related mortality rate among treated male drug users decreased slightly in the first three years, and decreased at a faster rate after 2006. However, in 2011 and 2012, it increased and reached the 2008 levels again. As for treated female drug users, one or two deaths by suicide were recorded every few years. Cumulative mortality has decreased in both genders and is not yet stabilized.



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

**Figure 6.9:** The number of suicides among treated drug users by type of suicide, 2004–2012

Just over a third of all suicide deaths were by hanging, one fifth was by carbon monoxide poisoning, one tenth by heroin, other opioids or methadone, and one tenth by jumping from a high place; other types of suicide accounted for smaller proportions (Figure 6.9). The average age of men when committed suicide was 32.8 years, and the youngest was 23.8 years old. The average age of women when committed suicide was five years lower compared to men, and the youngest woman was 22.1 years old. All deceased women and 24 out of 29 men were previously treated for drug addiction or were in long-term treatment. The remaining deceased drug users were new clients, clients who were treated for the first time and previously treated clients.

The proportion of previously treated clients and clients in long-term treatment was larger among drug users who committed suicide than among victims of accidental poisoning. Furthermore, the proportion of persons living with their parents, persons who had never injected drugs and unemployed persons or occasional workers was also higher among drug users who committed suicide than among overdose victims.

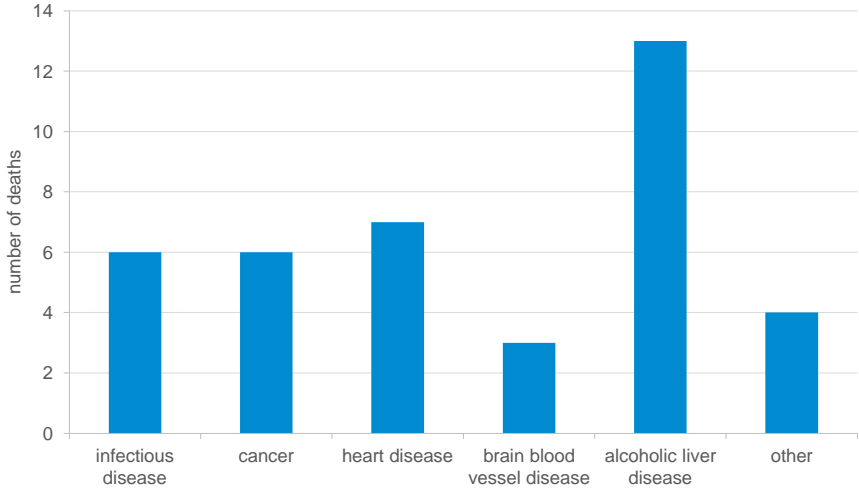
### Other Violent Deaths

Out of 144 violent deaths, 12 were due to transport accidents, and the victims were mostly drivers and passengers in cars, followed by motorcyclists or motorcycle passengers and pedestrians. Four persons died due to violent attacks and seven violent deaths were due to a fall, drowning or other accidents.

### Natural Causes of Death

In the nine-year follow-up period, 32 men and 7 women died due to diseases or natural causes. Out of 3,949 treated drug users, corresponding mortality rates due to diseases were 1.35 deaths per 1,000 PY for men and 0.92 deaths per 1,000 PY for women. The average age at death of men was 42.6 years and of women was 45.3 years. Most deceased persons had entered treatment several times or were in long-term treatment; only four out of thirty-nine were treated for the first time. Due to the low number of deaths per year, the difference between the effects of first-time treatment and long-term treatment could not be determined. Most men died in 2005, 2006 and 2007, and most female deaths occurred in 2007, 2008 and 2009; the number of male deaths increased in 2012 compared to 2011. There were no

deaths due to natural causes among the treated female drug users in 2012 and 2011. Cumulative mortality among men in the cohort was the highest in 2005, and for women it reached its peak in 2007. Risk of death among the remaining male cohort members decreased by 1/1,000 PY in 2008, after which it remained almost unchanged, while it decreased slowly among the remaining female cohort members.



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

Figure 6.10: Number of diseases as causes of death among treated drug users by type of disease, 2004–2012

Most deaths due to disease among treated drug users were due to alcoholic liver cirrhosis (Figure 6.10). Of thirteen persons who died from alcoholic liver cirrhosis, only two persons were treated for addiction for the first time, and the rest had entered treatment more than once or were in long-term treatment. The average age at death was 47.9 years; the youngest one who died from alcoholic liver cirrhosis was 31.5, and the oldest was 59 years old. Eleven deceased persons used opioids before entering treatment, almost all used heroin, and for two deceased, there were no data available on the primary drug before entry into treatment. Six deceased persons also used alcohol.

Deaths due to alcoholic liver cirrhosis were followed by deaths due to cardiovascular diseases. Drug users who died from cardiovascular diseases were between 23.7 and 56 years old, and they had all entered treatment due to heroin use. Half of them used cocaine or MDMA as secondary drug at the time of entry into treatment.

The third most frequent diseases were chronic hepatitis C and HIV, which caused deaths of six people aged between 28.9 and 44.2 years. All of them used heroin at the time of entry into treatment, and two also used cocaine. None of them were treated for the first time. All six injected drugs and most of them did not have a permanent partner at the time of entry. In addition to hepatitis C, two deceased drug users also tested positive for hepatitis B.

**Conclusion**

The mortality rate of treated drug users is a little less than twice as high as the mortality rate of their Slovenian peers. The mortality ratio is lower in men than in women, which, considering the low mortality rates among women, shows that the health of female drug

users is worse than of male drug users when compared to the male and female populations in Slovenia.

The risk of death in treated drug users decreased and is still decreasing for women after nine years of follow-up, while for men it stopped decreasing last year due to the increase in accidental poisonings involving methadone and cocaine.

Suicide rates among treated drug users are lower than accidental poisoning rates, and are gradually decreasing. Drug users entering treatment for the first time have the highest proportion of accidental poisonings, while those in long-term treatment have a higher proportion of suicides.

Nearly one-fifth of causes of death with undetermined intent of poisoning have reduced the mortality rates for both accidental poisonings and suicides; however, the fact that the number of poisonings of undetermined intent is decreasing is encouraging.

In addition to drug poisonings and suicides, deaths among drug users were caused by traffic accidents, violent attacks and other accidents.

The most frequent diseases that caused death among treated drug users were alcoholic liver disease and cardiovascular diseases. Half of the people who died from cardiovascular diseases used cocaine or MDMA at the time of entry into treatment.



## 7. RESPONSES TO HEALTH CORRELATES AND CONSEQUENCES

Prevention of drug-related emergencies and deaths as well as prevention of infectious diseases are performed in the public health network – in centres for the prevention and treatment of drug addiction – and by nongovernmental organisations, primarily through low-threshold harm-reduction programmes. Furthermore, the Ministry of Health RS has founded interministerial working group for Early-Warning System on new Psychoactive Substances which informs expert public as well as drug users of the emergence of dangerous or new psychoactive substances. The Poison Control Centre of the University Medical Centre Ljubljana also includes a 24-hour toxicological information-consultation service providing support to all Slovenian doctors treating patients poisoned with illicit drugs. The nongovernmental organisation DrogArt Association enables users of psychoactive substances to have new psychoactive substances tested if they suspect that they contain unusual substances or have effects different than expected. (Detailed descriptions are available in the 2011 and 2012 National Report on the Drug Situation in Slovenia)

This report presents in detail harm reduction programmes and their mobile units working in the field of illicit drugs. Their activities include distribution of free sterile materials among injecting drug users as well as counselling. Needle exchange programmes are carried out in day centres or in the form of fieldwork conducted by NGO workers at locations frequented by drug users. In addition to exchanging needles and distributing other injection materials (alcohol wipes, ascorbic acid), mobile staff and daily centre staff also distribute informative materials on infectious diseases and low-risk injection drug use. In 2012, 553,426 needles and syringes were distributed among harm reduction programmes, which recorded 11,639 contacts with injecting drug users. Six non-governmental organizations carrying out fieldwork via mobile units travelled 148,797 kilometres in total and provided assistance to 1,025 illicit drug users in 2012.

The Day Centre for abstinent with dual diagnosis is a high-threshold programme which has been operating since 2005 and is aimed at persons who have mental health problems in addition to drug addiction problems. So far, 40 persons have been admitted to the programme, and most of them suffered from depression or psychosis. Just over one-third of patients have completed the programme successfully, while almost two-thirds dropped out, mostly due to a lack of motivation.

## 7.1 Prevention of Drug-Related Emergencies and Reduction of Drug-Related Deaths and Prevention of Drug-Related Infectious Diseases

### Drug-Related Harm Reduction Programmes in Slovenia

Ines Kvaternik, PhD

The main objectives of drug-related harm reduction programmes in Slovenia are to promote social inclusion of illicit drug users, reduce adverse health and social effects directly or indirectly related to drug use, provide support and assistance to users who wish to abstain from drug use in their environment or enter a drug treatment programme (communes, therapeutic communities, detoxification); to encourage users of harm reduction services to be more active in terms of self-help, self-organization, expressing one's views and needs, and networking; and to inform lay and professional public and raise their awareness of the trends in the field of illicit drug use.

The first attempt to systematically introduce drug-related harm reduction programmes in Slovenia dates back to the early 1990s. The first needle exchange programme was established in 1992, i.e. ten years after such programmes first appeared around the world. It was the first of its kind established in countries in transition. The 1995 inter-ministerial meeting at Otočec reached a consensus on the importance of harm reduction programmes. Furthermore, these programmes are explicitly mentioned in drug legislation adopted in 1999. Article 13 of the Act Regulating the Prevention of the Use of Illicit Drugs and the Treatment of Drug Users mentions needle exchange programmes, fieldwork among drug users and other harm reduction programmes. The Resolution on the 2004-2009 National Programme on Drugs Control also places considerable importance on such programmes.

The following section focuses on the objectives relating to the prevention and reduction of health effects directly or indirectly related to illicit drug use. These objectives include: prevention of blood-borne viral infections (HIV, hepatitis) and other bacterial infections; prevention and effective treatment of drug overdose, reduction of drug use in public and in public places; ensuring contact with those difficult to reach.

The programme for sterile injecting equipment exchange is the basic starting point for all other harm-reduction approaches, since easy access to sterile equipment is important both for the purposes of prevention of infectious diseases and for ensuring easier access to the hidden population of drug users. Harm reduction programmes provide injecting drug users with free sterile materials and counselling. Needle exchange programme activities are carried out in day centres or in the form of fieldwork conducted at locations frequented by drug users. In addition to exchanging needles and distributing other injection materials (alcohol wipes, ascorbic acid), mobile staff and day centre staff also distribute informative materials on infectious diseases and low-risk injection drug use.

10 harm reduction programmes<sup>10</sup> carried out exchanges of sterile injecting equipment in Slovenia in 2012.

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<sup>10</sup> However, there are 11 programmes operating in the network of harm reduction programmes. One of them, namely the DrogArt Association, is aimed only at users of synthetic drugs, cocaine and alcohol, thus it does not carry out a sterile equipment exchange programme.



Source: RIPH Koper, 2012

Figure 7.1: Coverage of harm reduction programmes in Slovenia

Figure 7.1 shows that the coverage of drug-related harm reduction programmes in the form of day centres or mobile units is relatively good in Slovenia. Mobile exchange of sterile injecting equipment, ordinary fieldwork with primary or secondary exchanges of materials or fieldwork in mobile units is carried out in regions where there are no day centres (the Goriška region, a part of the Central Slovenia region and a part of the Southeast Slovenia region, a part of Koroška and the Pomurska region). Some parts of Southeast Slovenia and a part of Koroška are still not covered by such programmes.

The purchase and distribution of sterile materials for safe injection of drugs are organized by the Regional Institute of Public Health Koper (hereinafter: RIPH Koper), which provided regular supply to ten harm reduction programmes and four mobile units that carry out exchange of sterile equipment at specific locations in 2012. Materials and work carried out within the programme are funded by the Health Insurance Institute of Slovenia. 2,118 injecting drug users were admitted to these programmes in 2012, 279 of them for the first time. Harm reduction programmes recorded 11,639 contacts with injecting drug users.

In 2011, RIPH Koper distributed 553,426 needles and syringes among low-threshold programmes. 193,699 or 35% of all distributed needles and syringes were returned. Compared to 2011, the number of distributed needles and syringes decreased by 79,063 in 2012.

Injecting drug users can also buy syringes in pharmacies, which sold 121,846 syringes with an integrated needle in 2012. Most were sold in the Central Slovenia, Podravska and Gorenjska regions.

Collection of infected materials was organised in seven programmes and four vans (mobile units). Used materials are collected at locations where programmes are implemented and in mobile vans, and stored in safe packaging protecting the staff from getting injured with used needles or other equipment. Materials are disposed of by a competent company, which also

effectively destroys them. Expert used needle disposal services were provided to all harm reduction programmes.

In recent years, the need for systematic examination of locations where infectious materials are often found has increased in the Central Slovenia region, especially in Ljubljana and Kranj, mostly due to the increase in the number of homeless injecting drug users and the “open drug scene” phenomenon in city centres. Therefore, the Stigma Association for Harm Reduction started systematically examining such locations in 2011. Stigma also involves drug users in these activities. Stigma found a total of 19,000 needles in 2012, of which 7,000 were found in Kranj (the Gorenjska region).

In 2011, RIPH Koper prepared, in cooperation with harm reduction programmes, a 65-hour training course entitled Professional Work in the Field of Drugs, which was accredited with 4 credit points by the Social Chamber of Slovenia. In 2011 and 2012, 42 prison employees and other persons working in the field of harm reduction, social rehabilitation and treatment attended the training course.

In 2013, the RIPH Koper, in cooperation with the Institute of Public Health of the Republic of Slovenia and drug-related harm reduction programmes, prepared comprehensive documentation for the establishment of the Safe Room programme for injecting drug users, which includes an assessment of costs and impacts and could contribute to the reduction of infectious diseases and consequences of drug injection in public places.

### **Drug Demand Reduction Mobile Units**

Tamara Rakovec, Lidija Kristančič, Jože Hren, PhD

In 2006, the Ministry of Health (hereinafter: the Ministry) received EUR 276,960.00 from the European Commission (following a call for tender) for the implementation of a drug demand reduction programme in Slovenia. In the call for tender procedure, the subject of which was the provision of vehicles adapted for field work in the field of drug demand reduction, the Ministry chose six organizations (the Zdrava Pot association in Maribor, SOCIO public institution in Celje, Svit association in Koper, Pelikan/Karitas institute – operates throughout Slovenia, Stigma association in Ljubljana, Projekt Človek association – operates throughout Slovenia) and provided each of them with one vehicle, which they started using in June 2007 for the purposes of programme implementation. In the context of mobile unit programme, the Ministry of Health cooperates with the Ministry of Labour, Family, Social Affairs and Equal Opportunities. The latter provides financial resources for professional workers who carry out activities in mobile units.

The purpose of the mobile unit programme is to increase accessibility of drug demand reduction programmes, reduce regional disparities and gender differences, and work with marginalized groups. The main objective of the programme is to reduce harm (especially health and social consequences) in persons using illicit drugs. The programme also enables workers to establish contact with a large number of illicit drug users, especially those who are not in any kind of treatment or who do not have appropriate assistance (the hidden population of drug users). There is an office and convenient outpatient treatment space in each van used for field work. Activities carried out in mobile units include consultations, provision of information, group and individual work with drug users, home visits, clean-up

activities, provision of sanitary materials, needle exchange and provision of sterile instruments, unlinked testing, phone calls, etc. Activities are carried out in environments where users live. The programme is anonymous, and the workers keep record of illicit drug users for statistical purposes only.

Implementation of the programme by the aforementioned organizations covers the entire territory of Slovenia (Table 7.1). In 2012, mobile units travelled 148,797 kilometres in total. Stigma and Zdrava Pot mobile units travel the longest distances (36,682 km and 30,000 km, respectively), as they cover larger areas than other organizations. In the five and a half years of programme implementation, mobile units of the organizations in question travelled approximately 886,000 kilometres in total.

**Table 7.1:** Areas covered by mobile units

Organization	Area covered
Zdrava pot (Maribor)	Radlje ob Dravi, Dravograd, Ravne na Koroškem, Maribor, Ptuj, Murska Sobota, Lendava.  <b>Small towns by prior arrangement:</b> Ormož, Ljutomer, Gornja Radgona, Lenart, Moškanjci, Slovenska Bistrica, Makole, Kidričevo, Hajdina, Brezno.
Socio (Celje)	Celje, Žalec, Velenje, Vojnik, Dobrna, Zreče, Slovenske Konjice, Štore, Šentjur, Šmarje, Podčetrtek, Rogatec, Rogaška Slatina, Polzela, Prebold, Braslovče, Laško, Sevnica, Šempeter, Liboje.
Svit (Koper)	Izola, Piran, Koper.
Karitas/Pelikan (Ljubljana)	Nova Gorica, Divača, Tolmin, Sevnica, Posavje, Prekmurje.
Stigma (Ljubljana)	Kočevje, Novo Mesto, Kranj, Ljubljana, Jesenice, Trbovlje, Kamnik, Pivka, Postojna.
Projekt Človek (Ljubljana)	Sopotnica, Kočevje, Novo Mesto, Ruše, Piran, Ravne na Koroškem.

Source: Ministry of Health

In 2012, mobile units provided assistance to 1,025 drug users, of which 247 were female and 778 were male. Stigma (305 users in 2012) and Zdrava Pot (303 users in 2012) deal with the highest number of people annually. Other organizations deal with an average of about 100 users a year. The Zdrava Pot association dealt with the largest proportion of female drug users in 2012 (36.6%), while the average proportion of female drug users who sought assistance in other organizations' mobile units was 20%. In 2012, the average age of drug users was 33 for males and 32 for females. The youngest male drug user was 15, and the oldest 65 years old; the youngest female drug user was 17, and the oldest 55 years old.

During the five and a half years of its implementation, the mobile unit programme has complemented other assistance programmes for drug users in Slovenia. Outreach to the most vulnerable groups of users has increased significantly thanks to the programme. There have been some technical issues due to the wear-and-tear of vans, and there is a growing need for new vehicles. Local communities and illicit drug users believe that mobile units should stay active in their area. Especially the municipalities that, due to relatively low numbers of drug users and high costs of stationary forms of assistance for drug users, cannot expect to be able to establish such forms of assistance in the near future have expressed the desire to have mobile units present in their area.

## 7.2 Responses to other Health Correlates among Drug Users

### Social Rehabilitation of Drug Addicts with Comorbid Mental Disorders

Polona Kersnik

In recent years, there has been an increase in the number of addicts with dual diagnoses entering drug rehabilitation with the Projekt Človek Association. This is why the Association has developed an individualised high-threshold programme Day Centre for Dual Diagnosis Abstainers (DC-DID), which has been in operation since 2005. The programme is intended for those who, apart from addiction problems, also have mental health issues. Its purpose is to help users acquire basic life skills and habits, while also providing various opportunities to develop their inner potentials. The programme is intended for addicts with comorbid mental disorders from across Slovenia.

#### Programme Description

The condition to enter the programme is to abstain from all psychoactive substances, including alcohol and benzodiazepines. During the programme, the participant can only receive the pharmacological therapy prescribed by a psychiatrist (and for which the participant submits written proof) and includes no benzodiazepines, opiates, opiate analgesics or opiate substitution therapy. Upon entering the programme, the individual is also expected to have valid personal documents and health insurance. Since participation in the programme is subject to a fee, it is important for the individual to have at his/her disposal minimal financial resources equal to the sum of social assistance; however, the latter can also be arranged after entering the programme.

Lasting up to three years, the programme is executed in three phases, in which the users follow the objectives of their individual treatment plans. The programme (in its first two phases) is held at the Ljubljana Day Centre each working day from 7 am to 5 pm observing a permanent schedule, which helps the participants learn how to structure and plan their time. The schedule comprises activities that enable participants in the programme to gain new experience in a life of abstinence. It is composed of everyday working activities, with participants divided into three teams. Mentored by an employee, members of the Kitchen team prepare breakfast, lunch and snacks for the entire group (approximately 12 people) by themselves. They learn how to prepare meals and manage their tasks. The person responsible for the kitchen also takes care of the weekly food purchases. Members of the Hygiene team clean the centre premises, thus learning how to maintain the premises in which they reside clean and tidy. The person responsible for the hygiene also takes care of the supply of cleaning agents, toilet paper, paper towels and other supplies. Members of the Maintenance team learn about basic repair work and how to take care of a house and its surroundings (garden and backyard).

In the teams, participants learn about daily routines and assuming responsibility in their lives, thus getting ready for living independently, which is the final goal of the entire programme. The programme includes a number of internal rules and limitations, the purpose of which is to teach the participants about accepting rules and limitations, while also learning that actions always have consequences. When an individual breaks the rules or fails to fulfil his/her assignments, there will be measures: warnings, temporary cancellation of privileges (coffee, treats), additional work assignments. In case of repeated breaches, the measures

intensify: the first step is intensive personal work related to a certain topic, this is followed by the reflection measure, which means the user returns to his home environment to think whether they want to change anything about themselves and make more effort in the programme; the final measure is the termination of participation if the user keeps breaking the ground rules (abstinence from psychoactive substances, nonviolence towards fellow people) or when they fail to make an effort with regard to their topics and objectives defined in their individual treatment plan.

In the narrow sense of the word, therapy activities are organised twice a week within therapy groups and once a week or when necessary as individual sessions. There is also a weekly seminar (education group) on a certain topic: prevention and relapse, direct communication, addiction dynamics, etc. For the duration of the programme, an expert or therapist works with the participants and monitors their rehabilitation process on an individual basis, thus helping them form their individual goals in certain areas of life, directing them in group activities and providing them with guidelines for therapy activities. Alongside two therapists, the centre also employs two nonprofessional workers who are in charge of organising and running the agenda, of individual teams and social, creative and recreational activities.

In phase one of the programme, the treatment objectives are maintaining abstinence, preventing relapse, training in orderliness and punctuality, learning to perform basic house chores and building good work habits, discovering risk and protective factors for developing addiction as well as comorbid mental disorders, motivation for further treatment, resolving emotional distress, acquiring social skills and learning to accept mental disorders (through seminars and therapy groups). The criteria allowing a move to the next phase are a positive reaction by the group and the therapist, but based on group reaction, the participants have to evaluate their own progress or work so far according to certain personal goals.

In phase two of the programme, the objectives are: intensive work on relations with one's parents (seeking the origin of familiar reactions in interpersonal relations – uncovering their origins based on the past); conduct constituting fault (potential court proceedings); self-acceptance; feelings of guilt and resentment from the past (reconciliation plan); identity; sensing and expressing emotions and needs; preventing relapse; attitude towards alcohol (reading a book on alcohol consumption, linking it to personal experience and making a decision in relation to it).

In the final phase of the programme, users are assisted with re-integration into society. We offer them assistance with managing their everyday life, be it continuing their education, finding employment, with resolving housing problems, encouraging them to find a hobby outside the programme... In the re-integration phase, the activities that are structured “from the outside” (as part of the programme) are gradually reduced as the participants are supposed to internalise structure and begin managing their own time by themselves. The programme is therefore less and less intensive. At first, activities are held three times a week, and eventually the user only attends support sessions and group therapy sessions. The aim is for the individual to actively transfer the acquired knowledge as well as reinforced habits, diligence and skills into everyday real-life situations in this transitional phase.

The programme is tailored according to the individual's specific needs originating in the comorbid mental health disorder. The main features of individualisation relate to an

individualised therapy plan (objectives of rehabilitation), with particular emphasis on educating the individual about the comorbid mental disorder and its connection to using psychoactive drugs. There is little to no immediate confrontation of the users or social pressure; however, there is emphasis on education and intensive work with close relatives. The structure of the day (schedule, rules, responsibilities) and work activities (the ratio between rest and optional activities) are also adapted to the individual's ability. The therapy groups have fewer members, the sessions are shorter; there is more individual monitoring and assistance with tasks. The emphasis is on the empathic approach to the users and seeking positive resources.

The programme can be carried out in outpatient, day care or resident form. If at their place of residence a safe environment with regard to psychoactive substances and alcohol can be provided to the individual (24-hour monitoring by key persons close to the participant) and if their residence is not too far from Ljubljana (i.e. transportation is possible), they can enter the day centre form of the programme. If at home the individual does not have a safe environment or if their residence is too far away, they can enter the resident form of the programme. This means an integrated community of users without comorbid disorders. They reside in the community in Sopotnica near Škofja Loka, from where they are transferred to Ljubljana each working day. The outpatient form of the programme is particularly suited for the re-integration phase when an individual is leaving the safe environment, and in cases when the individual has integrated socially, yet requires expert monitoring or treatment to maintain abstinence.

The programme comprises parallel diagnostics and psychiatric treatment of comorbid disorders, which is organised in cooperation with external health institutes as the association employs no doctors or psychiatrists. When treating addicts with dual diagnoses, various problems can be encountered, particularly the “revolving door” phenomenon, referring to the individual's multiple entries to and exits from various types treatment in various institutions. Other problems include irregular taking or self-willed cancellation of pharmacological therapy, insufficient support of family members, the issue of long-term substitution therapy with the aim of stabilising the individual, and insufficient sleeping capacity which prevents for the entire programme to be held separately from other treatment programmes, which partly reduces the possibilities of adapting the programme to a specific population.

Between 2005 and 2013, 40 people participated in the programme, 30% of which had been diagnosed with depressive disorder, 30% with psychotic disorder, 10% with bipolar disorder, 10% with borderline personality disorder, 10% exhibiting symptoms of post-traumatic stress disorder, 5% with panic disorder and obsessive-compulsive disorder, 5% with psychoorganic syndrome, 5% with symptoms of narcissist personality disorder. These people can also have several comorbid mental disorders at a time (multimorbidity).

### **Programme Efficiency**

Most commonly measured after completion, the programme efficiency relates to the individual's success in maintaining abstinence and in integrating into society (inclusion in education and/or employment, establishing a healthy social network, quality spare time activities, etc.). So far, 35% of the 40 participants have completed the programme successfully, 62.5% fell out (in great part due to a lack of motivation), and 2.5% continue to



participate in the programme. Of those who have completed the programme successfully, 78.6% have been abstaining and have managed to re-integrate. The success of participants is measured once a year with the by means of individual interviews and/or surveys, and the users evaluate their efforts on a regular basis.

### **Conclusion**

In Slovenia, we are faced with a deficient scope of psychosocial rehabilitation programmes for addicts with comorbid mental disorders, both as regards social and protective as well as health services. At the same time, a rising trend for such population has been detected. The programme of the Projekt Človek Association has filled a gap in this area by providing the population segment facing such problems with long-term monitoring and distress resolution in a safe environment as well as in-depth treatment with a relatively high effectiveness of the programme upon completion.

## 8. SOCIAL CORRELATES AND SOCIAL REINTEGRATION

Social problems related to illicit drug use fall under the jurisdiction of the Ministry of Labour, Family, Social Affairs and Equal Opportunities. Professional activities aimed at solving these social problems are carried out in the framework of public service (62 Centres for Social Work) and in private and non-governmental organizations which implement complementary social care programmes. Centres for social work recorded 220 cases of treatment related to drug problems in 2012. In the same year, about 4,500 users participated in social care programmes in the field of drug abuse prevention co-funded by the Ministry of Labour, Family, Social Affairs and Equal Opportunities. Data on social care programmes is collected at the national level by the Social Protection Institute of the Republic of Slovenia, and data on activities carried out by centres for social work are recorded in the social database. The Social Protection Institute collects and compiles these data for the purposes of preparing national reports.

A survey on the needs of illicit drug users who offer sexual services showed that most of them become involved in such activities due to drug use. There are more women (89%) than men (10%) among drug users who offer sexual services. Most of them became involved in this activity at a very young age, mostly before 20 years of age. Most of them work independently; they have up to three sexual contacts a day and earn up to EUR 100 a day or more. As regards drug use among such users, most use cocaine, followed by pills and heroin. More than half of them inject drugs. Two thirds of respondents stated they had health problems, and more than half stated that they had already been sentenced to jail time or probation.

A social entrepreneurship project was launched in 2012, which provides training in the field of design, programming and web application design to young people who have experienced drug use, and offers them employment opportunities.

### 8.1 Social Exclusion and Drug Use

#### **Study: Identifying Needs of Drug Users Providing Sexual Services**

Ines Kvaternik, PhD

In 2012, the Regional Institute of Public Health Koper (RIPH Koper), in collaboration with nongovernmental organisations<sup>11</sup>, carried out research on the needs of drug users providing sexual services. The target population of the study were drug users who are in contact with the above-mentioned programmes and who provide sexual services. The main goal of the

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<sup>11</sup> Participants in the research process: Stigma Association for Reduction of Drug-Related Harm, SVIT Koper Association for Assisting Addicts and Their Families, Socio Public Institute, ŠENT – Slovenian Society for Mental Health, Nova Gorica Unit, Pot Association Ilirska Bistrica, DrogArt Association, Kralji Ulice Society for Help and Self-Help of Homeless People.

research was to document the needs of the aforementioned target group, for which it was presumed they exceeded the basic needs of being informed about safe sex and sexually transmitted diseases. We wanted to establish what risk situations the members of the target group were facing and how they solve them, to what extent they are informed of health risks related to providing sexual services, how they care for their own health, in what social and economic conditions they live, to what extent they take into account the information on preventing contractions of sexually transmitted diseases in specific situations and what harm reduction services they require.

### **Methodology and Sample**

The study was carried out in two phases. In phase one, users of illicit drugs who provide sexual services were interviewed. 30 users who provide or have previously provided sexual services responded to the questionnaire. We contacted them through fieldworkers, experts in harm reduction who reached out to the respondents by applying snowball sampling into networking. Interviews were carried out between June and September of 2012 in Ljubljana, Koper, Celje, Ilirska Bistrica and Nova Gorica. When reaching out to the respondents, the fieldworkers encountered a series of problems. The greatest challenge was to motivate drug users to participate in the study. During interviews, they realised that the phenomenon is actually much more common than the users dare disclose.

The questionnaire is composed of closed and open-ended questions. Answers to closed-ended questions were processed with the SPSS data processing software. Answers to open-ended questions were coded and analysed.

In phase two, we organised a focus group with six experts employed in drug-related harm reduction programmes who participated in the interview process. A reminder was created to serve the focus group, based on which we acquired demographic data on drug users providing sexual services and defined risk situations encountered by drug users when providing such services. We also assessed their medical condition, needs and the like. The data acquired was coded and analysed.

## **Results**

### **Demographical Data**

There is much incidental prostitution among drug users. In the Littoral and central Slovenian regions, around 80% of drug users are presumed to be providing sexual services occasionally, and 90% in the northern Primorska region. The percentage is somewhat lower in the Celje region, i.e. around 30%.

Analyses of the questionnaires and the focus group show that more female (89.7%) than male (10.3%) drug users provide sexual services, the majority of them having primary or secondary education. The average age of respondents was 34 (the youngest being 23 years old, and the oldest 59).

Most of the respondents began working in the trade at a very young age. More than half began younger than 20, and 31% of respondents began providing such services as minors.

More than half of the respondents were introduced into the trade through friends or acquaintances, pimps or other prostitutes. Most of the respondents are in a stable relationship (55%), with 58% of the partners knowing about their partners providing sexual services to other people. A third of the respondents have children.

### **Providing Sexual Services**

The two analyses show that the majority of respondents establish contact with clients using a mobile phone, through acquaintances, classifieds, the Internet, pimps, in the street or in person. Some of them establish contact by chance (*“you meet a person, exchange a few words and you know what's up in a second”*), through another client or prostitute. Only one respondent claims to only have one client. Most commonly, they work in the car, in their own flat, in the client's home and in the street. Some of them also provide sexual services online, in massage parlours, bars, pimps' flats, outdoors and at their friends' places. Users providing sexual services also establish contact with clients through web portals. A presentation on a portal like this can contain a significant amount of very personal data (i.e. whether a person uses drugs or is infected with a virus). Visitors to such a web portal can also rank the users.

Respondents mostly work independently (80%) and have quite diverse daily numbers of contacts with clients. They mostly have up to 3 contacts per day, whereas 10% of respondents and even up to 10. 82% of respondents have regular clients and only 18% state that their clients are not regulars.

Slightly over a half of the respondents went into prostitution to make a living (the reasons stated include money, finances, source of income, lack of money, making a living). Respondents have very diverse earnings. Most of them stated to be earning up to EUR 100 daily, followed by those earning up to EUR 200 daily, and some earn up to EUR 300. There are also people who earn up to EUR 1000 per day.

### **Assessment of Health**

71% of respondents are covered by basic and supplemental health insurance. Most of them see the doctor when necessary, less than a half (48%) see their gynaecologist regularly. More than two thirds of respondents report having medical problems, most commonly as consequences of drug abuse (27%). 10% of respondents report having viral infections. Other medical problems are mental health problems, headaches, low weight, rheumatism, cardiovascular problems and injuries.

The two analyses show that drug users providing sexual services have extensive knowledge on how contagious diseases can be transmitted (90% of respondents are acquainted with the information of transmitting sexual diseases), but they do not utilise this information in their everyday lives: their behaviour is very risky and they mostly don't use condoms when having sex. More than half of the respondents never use a condom with their partner. People providing sexual services would be expected to take better care of their health. They should be aware that sexual and other risk behaviours can have long-term negative consequences on their lives (injuries, infections, illness, behavioural patterns, self-image...). Especially because of the risk related to infections with sexually transmitted diseases, they would be expected to see their gynaecologist more often and to use condoms more often when having intercourse with clients and particularly with their partners.

The two analyses show that the problems of drug users providing sexual services are not considerably different from the problems of those not providing such services. *“Most of the problems originate in drug abuse rather than sexual activity.”* Speaking of their medical problems, respondents also mentioned consequences of violence, pill (ab)use, and unwanted pregnancy. They stressed specifically that upon introducing abstinence, medical problems begin to show with problematic drug users. *“Yes, abstinence is also a problem; they begin abstaining and then the disease begins to develop.”*

Findings from the focus group analysis show that there is a difference in the attitude towards personal health among drug users who only provide sexual services occasionally and those who provide them regularly. *“Those doing it occasionally take very good care of their health.”* Respondents have noticed that drug users providing sexual services only see the doctor when their medical condition gets considerably worse: *“.../ When things are bad enough, when they no longer have anything to lose, when it is clear, it is obvious, and then, if anything can be saved, fine, and if not, you're screwed...”*

## Drugs

In most cases, providing sexual services is a consequence of using drugs. *“Prostitution is only a means of getting money, which is then used to buy drugs.”* 79% of respondents use drugs, 80% of which began using drugs before providing sexual services, and 20% began to use drugs because of providing the services. The two analyses show that using cocaine stand out particularly among respondents, followed by pills, heroin, THC, methadone, stimulants and alcohol. More than half of the respondents inject drugs, followed by sniffing, smoking and oral use. A half of them use drugs regularly. 82% of respondents have been participating in substitution therapy.

The drug users, who have been providing sexual services regularly and for a longer period, often use drugs to survive. Most of the respondents have never offered drugs to their clients, it is clients, however, who often offer drugs as 82% of respondents answered the question of whether they had ever been offered drugs by a client. In the cases when clients offer drugs, these are intended either as payment or as a means to enhance sexual pleasure in case of shared use.

## Violence

Most of the respondents (63%) report no violence in providing sexual services. However, 37% of respondents claim to be experiencing violence in this activity, mostly several types of violence at once, from physical (23%), mental (33%), economic (30%) to sexual (17%) and verbal violence (17%). Violence towards respondents is mostly exercised by clients (17%), followed by pimps and romantic partners.

Findings from the focus group analysis show that drug users providing sexual services often live with their pimp or with him or another older man, which puts them in a subordinate position. *“It often happens that the 'client' refuses to use protection, which is also violence in a way.”* Marked as particularly risky were situations related to pimps (shutting in, incidences of gang rapes, etc.).

## **Breach of law**

Most of the respondents have already been involved in criminal proceedings. However, they were connected to other criminal and minor offences related to the purchase of illicit drugs rather than prostitution.

More than half (53%) of the respondents have already been sentenced to imprisonment or conditional sentence, which does not mean, however, that they have served the sentence. They were mostly imprisoned for illicit drug possession or reselling, minor or major thefts, violence and human trafficking.

34% of respondents have already served a prison sentence, 7% have been detained, 20% have served a sentence of under a year and a half, almost 7% have served a longer sentence, and 66% of respondents have never served a sentence.

## **Conclusion**

Since the majority population considers the provision of sexual services a behaviour much less acceptable than drug use, the target group in question is stigmatised doubly, which often leads to their needs being overlooked. Drug users providing sexual services are mostly stigmatised in their environment, which is not due to either drug use or provision of sexual services exclusively. Rather, it is due to the combination of what they do: drug use, criminal record, prostitution, conspicuous behaviour, violence.

Most of the respondents (64%) wish to quit this activity. This, however, would require additional assistance in arranging their lodging, employment and in solving other problems that originate in the stigma related to drug use and provision of sexual services. What this target group needs is better-targeted prevention both in preventing infections with contagious diseases as well as harm reduction (better-targeted information). Phone counselling should be set up and premises not connected to associations providing assistance to drug users should be made available. Such people require conversation, the feeling of safety, advice, special medical treatment and inclusion in special support and counselling programmes where participants could also be provided with psychotherapist treatment.

## **8.2 Social Correlates and Social Reintegration**

Simona Smolej, M.Sc., Marjeta Ferlan Istinič

The legal framework governing the operation of the social care system is set out in the Social Security Act (Official Gazette RS, No. 3/2007 et seq.), and the field of financial social assistance is governed by the Financial Social Assistance Act (Official Gazette RS, No. 61/2010 et seq.), Exercise of Rights to Public Funds Act (Official Gazette RS, No. 62/2010 et seq.) and the Fiscal Balance Act (Official Gazette RS, No. 40/2012). The last three acts came into effect in 2012 and introduced severe cuts to the social assistance system. Some of the solutions brought about by the new social legislation turned out to be ineffective. Therefore, as regards major deficiencies and identified problems which proved to be most urgent after the date of application of the said legislation, i.e. after 1 January 2012, the Ministry of Labour, Family, Social Affairs and Equal Opportunities (MLFSAEO) wishes to remedy and solve them as soon as this year.

The basic substantive and normative starting points for dealing with individuals in social distress are specified in the National Social Assistance Programme, which is adopted by the state for a period of several years. In April 2013, the National Assembly adopted the Resolution on the National Social Assistance Programme 2013–2020 (hereinafter: the Resolution or ReNPSV) (Official Gazette RS, No. 39/2013), which constitutes the fundamental programming document in the field of social care in Slovenia for the period up to 2020. The Resolution defines the basic starting points for the development of the system, specifies the objectives and strategies for social care development, establishes the public services network of social care services and programmes, and defines the method of their implementation and monitoring as well as the responsibilities of different stakeholders at different levels. In recent years, social problems in Slovenia have been becoming more severe, mainly due to the economic crisis lasting several years, high unemployment and a lack of job opportunities as well as lower incomes in general. These circumstances are reflected in the growing poverty rates and increasing social distress and problems faced by individuals and families. The key objectives pursued by the Resolution are as follows:

- to reduce the risk of poverty and increase social inclusion of socially disadvantaged and vulnerable populations;
- to improve the availability and diversity of services and programmes, and ensure their accessibility;
- to improve the quality of services, programmes and other forms of assistance by increasing the efficiency of management and guidance of implementing organizations, increasing their autonomy and managing quality as well as by increasing the influence of users and their representatives in the process of planning and implementation of services (ReNPSV13–20, Official Gazette RS, No. 39/2013).

In the context of the network of public services in the field of social care programmes, the Resolution also sets out a framework for developing a network of programmes in the field of addiction, intended for illicit drug users and persons who are in social distress due to alcoholism or other forms of addiction (eating disorders, gambling etc.). Regarding this field, the Resolution provides for the development of prevention, information and advisory programmes, telephone counselling programmes, coordination and support programmes, assistance and self-help programmes, harm reduction programmes, day centres performing fieldwork, housing and therapy programmes, reintegration and activation programmes (ReNPSV13–20, Official Gazette RS, No. 39/2013).

### **Social Care Programmes**

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

In centres for social work, most drug-related problems, more specifically more than half of all drug-related cases, are dealt with in the framework of social first aid. It may be noted that centres for social work do not often deal with drug-related problems. Between 2009 and 2012 there were between 220 and 365 such cases dealt with every year. The number of cases was the lowest in 2012, when it decreased to 220 (Table 8.1).

Table 8.1: Number of drug-related treatment cases in centres for social work, 2009–2012

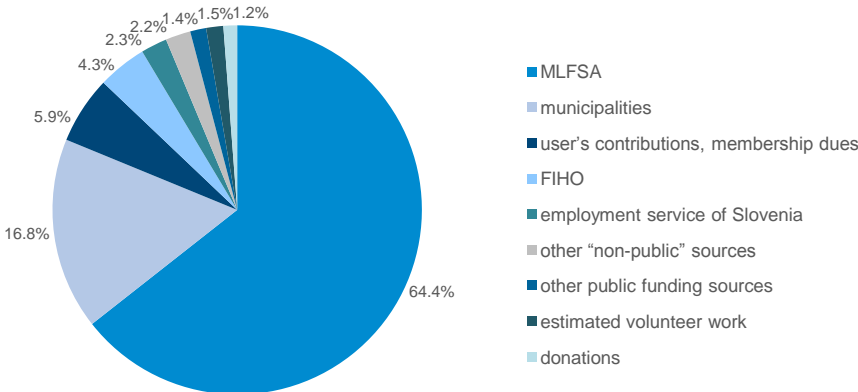
Problem	2009	2010	2011	2012
Illicit drugs	275	365	298	220

Source: MLFSAEO, Social database extract

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

In 2012, the MLFSAEO co-funded 29 social care programmes in the field of illicit drug addiction prevention. Of these 29 programmes, 15 were high-threshold programmes and programmes that offered a wide range of services and activities for users at different stages of illicit drug use, and 11 were low-threshold programmes; the remaining programmes include two shelters for illicit drug users and one reintegration programme (reintegration is also implemented in two of the programmes that offer a wide range of services and activities for users in different stages of illicit drug use) (Smolej et al. 2013).

Programmes received financial resources totalling EUR 4,410,213.10. A large proportion of the resources, more precisely nearly two thirds, was provided by the MLFSAEO. Major fund providers included municipalities (16.8% of resources) and programme users, who provided 5.9% of resources (Figure 8.1) (Smolej et al. 2013).



Source: SPIRS, own calculations

Figure 8.1: Sources of funding for drug-related social care programmes, 2012



According to SPIRS data, about 4,500 users were admitted to drug-related social care programmes co-funded by MLFSAEO in 2012, excluding users of various Internet forums, telephone and Internet-based counselling and wider preventive actions (e.g. of the DrogArt Association, which accepted more than 2,000 users). There were 181 beds available for the housing of users in social care programmes in 2012. Most beds were available in high-threshold programmes (Smolej et al. 2013).

Among drug addiction-related social care programmes co-funded by the MLFSAEO in 2012, there was only one programme dedicated exclusively to reintegration, i.e. the Reintegration Centre, which is operated by the Centre for Social Work in Kranj. There were 16 users housed in the Reintegration Centre, and another 57 users participating in sub-programmes (out-patient treatment, reintegration group, medical first aid users, introductory interviews – information required for admission). Reintegration was also carried out as part of a programme implemented by the “UP” Association for addicts and their families, which had 47 users (18 were accommodated by the Association, and 29 stayed elsewhere<sup>12</sup>), and a programme implemented by the Projekt Človek Association, which had 55 people undergoing reintegration (27 were accommodated and 28 stayed elsewhere<sup>13</sup>) (Smolej et al. 2013).

All existing programmes in the field of social rehabilitation allow for participation of users' relatives (parents and other important close persons), who contribute significantly to their social treatment. In 2012, hundreds of relatives or close persons participated in social rehabilitation programmes co-funded by the MLFSAEO, 464 in the Projekt Človek alone. All programmes offer, among other activities, self-help group activities for parents and important close persons, and some of the programmes also include schools for parents, therapy groups, individual counselling and partner therapy.

Considering the growing number of addicted adolescents under 18 years of age, some programmes have developed specialized sub-programmes aimed at young adolescents. In particular, we should point out the Programme for Children and Adolescents (POM, see Chapter 3) and the reception centre for children and adolescents, both operating under the auspices of the Projekt Človek Association. The Programme for Children and Adolescents is aimed primarily at young adolescents who merely experiment or already have problems with illicit drugs (or other forms of addiction) and, consequently, have difficulties with integrating into the educational process. By entering the programme, these users enter an intensive and continuous process which includes, among other things, the provision of learning support. The primary purpose of this programme is to prevent addiction from developing and to enable adolescents to stay involved in the regular school system. 148 adolescents and 164 parents or close persons participated in the programme in 2012. Sub-programmes for young adolescents are implemented by the POM project and several other programmes across Slovenia.

The number of drug users with children is also increasing; to address this issue, the Therapeutic Community for addicted parents with small children carries out activities in the field of social rehabilitation and can admit both parents and their children. In addition to

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<sup>12</sup> Includes former drug users and their families.

<sup>13</sup> Includes former drug users and their families.

addiction treatment, the programme also aims to provide intensive parenting support and ensure the best possible conditions for the healthy development of children.

### **Social Entrepreneurship – the “Iz Principa” Project**

Matej Sande, PhD

At the end of 2012, the DrogArt Association launched a social entrepreneurship programme “Iz Principa” (“On Principle”), under which it provides services in the field of design and social marketing to non-profit organizations and other clients. Persons involved in conducting the project include young persons and adolescents who have experienced drug use or addiction, and young people aged up to 25 who are unemployed or have only attained a low level of education.

Under the project, 7 persons who have experienced drug addiction underwent 100 hours of training in graphic design in one year, and the Association employed four of them. The project currently employs three people from vulnerable target groups who provide clients with different services, such as design, visual identity design, web design and the development of web and mobile applications. In cooperation with a coordinator and mentors, they plan individual activities, from preparing designs to printing, and cooperate in the preparation of visual identities of projects and non-governmental organizations.

Through the project, we seek to train young people from vulnerable target groups with fewer opportunities, thus enabling them to work independently in design, programming and web application design, as well as employ them, thus creating new creative industry jobs.

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

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

The Ministry of the Interior has been collecting data on criminality with the help of the central computer, into which the data from the national, regional and local police levels are entered. In 2012, the police recorded 1,969 criminal offences (according to the Criminal Code) and 3,423 offences (as defined in the Production of and Trade in Illicit Drugs Act) involving illicit drugs, and investigated 2,235 people on suspicion of criminal offence involving illicit drugs. In 2012, cannabis remains the illicit drug that accounts for the largest proportion of criminal and minor offences.

In 2012, the police treated 69 suspects who upon committing a criminal offence were under the influence of illicit drugs, as well as 123 criminal offences committed with the intention of acquiring money to purchase illicit drugs. Compared to 2011, the proportion of criminal offences committed with the intention of acquiring money to purchase illicit drugs investigated by the police decreased by 41% in 2012. The police also ordered 780 expert examinations to establish the presence of illicit drugs and other psychoactive substances in drivers, 280 of which tested positive for drugs. Most drivers were driving under the influence of methadone, followed by cannabinoids and cocaine.

The Prison Administration of the Republic of Slovenia is a body of the Ministry of Justice and Public Administration that provides for prison administration and organises and manages prisons and the juvenile correctional facility. In Slovenia, there are six prisons and one juvenile correctional facility. On a specific day, every three months, The Prison Administration of the Republic of Slovenia determines the number of imprisoned persons having problems with illicit drugs as well as the number of those infected with HIV, hepatitis or tuberculosis. Data on the prison system and persons imprisoned is published in annual reports. According to latest report, more than a fifth of all prisoners had problems with illicit drugs, of which 60% were in substitution therapy in 2012. Judicial police officers found illicit drugs in prisons in 116 cases, cannabis accounting for the majority of finds and the largest share of total amount.

In 2012, no specific surveys on drug use and problem drug use in prison were made. The Survey on risky behaviour data were presented in 2010 National Report on Drug Situation.

## 9.1 Drug-related Crime

Staša Šavelj

### Crimes and Minor Offences

In 2012, the Slovenian police recorded 91,430 criminal offences, which is almost 3% more than in 2011 (88,722). Of all criminal offences recorded in 2012, 1,969 were drug-related (Table 9.1). The number of recorded criminal offences involving illicit drugs in 2012 is about the same as it was in 2011 and 2010, which means that the situation in this field has not deteriorated in Slovenia. Also, the number of people suspected of committing drug-related criminal offences did not change significantly compared to 2011. However, the number of drug-related minor offences as well as the number of drug offenders decreased slightly in 2012.

The data shown in Table 9.1 relate to criminal offences as defined in Articles 186 and 187 of the Penal Code of the Republic of Slovenia<sup>14</sup>, and do not include the so-called secondary crimes (other criminal offences committed to acquire money to purchase illicit drugs). As much as two thirds of all recorded criminal offences involve unlawful manufacture and trade of illicit drugs (Article 186), and most common drug-related offences include the purchase or production of illicit drugs, and offering for sale or selling of illicit drugs.

**Table 9.1:** Total number of recorded criminal offences, the number of drug-related criminal offences, the number of people suspected of committing criminal offences, the number of minor offences involving illicit drugs and the number of offenders who violated the Production of and Trade in Illicit Drugs Act, 2009–2012

	2009	2010	2011	2012
Total number of criminal offences	87,463	89,489	88,722	91,430
No. of drug-related criminal offences	2,231	1,969	1,925	1,969
No. of persons suspected of committing drug-related criminal offences	2,570	2,240	2,229	2,235
No. of minor offences under the Production of and Trade in Illicit Drugs Act	3,338	3,328	3,691	3,423
No. of offenders who violated the Production of and Trade in Illicit Drugs Act	3,336	3,327	3,690	3,421

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

In addition to criminal offences, the police also recorded 3,423 drug-related minor offences in 2012, as defined in the Production of and Trade in Illicit Drugs Act. Cannabis still accounts for the largest proportion of drug-related criminal and minor offences, followed by heroin, amphetamines and cocaine.

### Criminal Offences Committed Under the Influence of Alcohol or Illicit Drugs

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

<sup>14</sup>Article 186 of the Penal Code of the Republic of Slovenia – “Unlawful Manufacture and Trade of Narcotic Drugs, Illicit Substances in Sport and Precursors to Manufacture Narcotic Drugs” and Article 187 of the Penal Code of the Republic of Slovenia – “Rendering Opportunity for Consumption of Narcotic Drugs or Illicit Substances in Sport”

In 2012, the police investigated 386 suspects who were under the influence of alcohol at the time of committing a criminal offence, and 69 suspects who were under the influence of illicit drugs (Table 9.2). This means that the number of suspects who were under the influence of alcohol and/or illicit drugs at the time of committing a crime decreased in 2012 compared to 2011.

**Table 9.2:** Number of suspects who committed a criminal offence under the influence of alcohol or illicit drugs, 2009–2012

	2009	2010	2011	2012
No. of suspects who committed an offence under the influence of alcohol	625	535	463	386
No. of suspects who committed an offence under the influence of illicit drugs	137	94	128	69
<b>Total No. of suspects under the influence of alcohol or illicit drugs</b>	<b>762</b>	<b>629</b>	<b>537</b>	<b>437</b>

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

The majority of criminal offences (as defined in the Penal Code) committed under the influence of illicit drugs are no longer classified as crimes against property, but as unlawful manufacture of and trade in illicit drugs, rendering opportunity for consumption of illicit drugs, domestic violence offences, violent conduct and grand larceny (Table 9.3).

**Table 9.3:** Number of suspects who committed a criminal offence under the influence of illicit drugs, by types of criminal offences under the Penal Code, 2009–2012

Criminal offence as defined in PC	2009	2010	2011	2012
Larceny, Art 204 PC	7	18	19	1
Grand Larceny, Art 205 PC	11	10	21	4
Unlawful Manufacture and Trade of Narcotic Drugs, Illicit Substances in Sport and Precursors to Manufacture Narcotic Drugs, Art 186 PC	36	11	11	14
Rendering Opportunity for Consumption of Narcotic Drugs or Illicit Substances in Sport, Art 187 PC	5		7	5
Violent Conduct, Art 296 PC	3	10	8	4
Robbery, Art 206	1	2	2	1
Obstructing the Performance of Official Acts or Revenge upon an Official, Art 299	7	2	4	4
Actual Bodily Harm, Art 122	6	3	11	1
Manslaughter, Art 115	2	3	2	3
Damaging Another's Object, Art 220 PC	1	5	4	1
Family Violence, Art 191			9	6

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

## Secondary Crime

The number of criminal offences committed in order to acquire money to purchase illicit drugs continued to decrease in 2012. The police investigated 123 of such criminal offences in 2012, which indicates a decrease of 41.4% compared to 2011 (when 210 such offences were investigated). Most of these offences were crimes against property (larceny, grand larceny, and robbery), infliction of grievous bodily harm, blackmail and violent conduct.

## Driving Under the Influence of Illicit Drugs, Psychoactive Medications or Other Psychoactive Substances

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

Compared to 2011 (1,162 examinations), the police ordered a substantially lower number of medical examinations in 2012 (only 780) to establish the presence of illicit drugs, psychoactive medicinal products or other psychoactive substances in drivers. Thus, the proportion of such examinations decreased by 33% in comparison with 2011, and the proportion of drivers who tested positive for the mentioned substances decreased by 56.8%. Of all medical examinations ordered, 280 revealed the presence of illicit substances in blood/saliva or urine samples (Table 9.4). Since 2010, the Slovenian police have recorded a decrease in the number of road users testing positive for the presence of psychoactive substances. Due to a higher standard of proof and the requirement to prove beyond any doubt diminished driving capacity, the number of medical examinations ordered has also decreased. Illicit substances usually remain in urine longer than in blood. Therefore, the process of proving the presence of illegal substances, psychoactive medications or other psychoactive substances in a person's body has become much more complex and expensive.

**Table 9.4:** Number of examinations ordered to determine the presence of illicit drugs and other psychoactive substances, and the number of positive blood/saliva or urine test results, 2010–2012

	2010	2011	2012
Ordered examinations	1.501	1.162	780
Positive tests	870	648	280

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

**Table 9.5:** Illicit drugs, psychoactive medications or other psychoactive substances found in samples with positive analysis results, 2010–2012

	2010	2011	2012
Amphetamines	48	50	16
Benzodiazepines	173	103	37
Cannabinoids	115	72	58
Cocaine	210	88	43
Methadone	239	142	68
Opiates	309	134	47

Table 9.5 continues ...

	2010	2011	2012
Antidepressants	2	0	4
Antipsychotics	1	0	1
Hypnotics/sedatives	1	3	1
Opioids	18	10	7
Other	614	409	204

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

Positive blood and urine tests carried out during medical examinations ordered in 2012 showed that most drivers were under the influence of methadone, followed by cannabinoids, opiates and cocaine (Table 9.5).

## 9.2 Prevention of Drug-Related Crime

Staša Šavelj

Preventive action by the police against crimes involving illicit drugs mostly entails raising awareness among target groups of the adverse effects of illicit drug use and providing information on self-protection. To this end, the police cooperate with non-governmental organizations, municipal panels, educational institutions and all other players working towards reducing drug-related problems at the national, regional and local level. Preventive work includes giving targeted lectures, providing advice to public authorities, presenting police activities at various events and preparing various preventive materials, such as brochures.

### Drugs and prison

Eva Salecl Božič

The Prison Administration of the Republic of Slovenia is a body within the Ministry of Justice of the Republic of Slovenia responsible for the enforcement of criminal sanctions as well as organising and managing prisons and a juvenile correctional facility. Slovenia has six prison facilities at thirteen locations, and one correctional facility, which are as follows:

- Dob Prison, which houses male convicts; the Dob Institution also comprises the Slovenska vas semi-open unit and the Puščava open unit;
- Ig Women's Prison: female convicts, remand prisoners, women in compliance detention as well as minors convicted to juvenile detention;
- Celje Prison and Juvenile Prison for convicts, male and female remand prisoners, persons in compliance detention as well as minors convicted to juvenile detention;
- Koper Prison for convicts and remand prisoners; the Koper institution also comprises the Nova Gorica Unit for convicts, remand prisoners and persons in compliance detention;
- Ljubljana Prison and the Novo Mesto Unit for convicts, remand prisoners and persons in compliance detention; the Ig open unit for convicts operating as part of Ljubljana Prison;

- Maribor Prison and the Murska Sobota Unit for convicts, remand prisoners and persons in compliance detention; the Rogoza open unit for convicts operating as part of Maribor Prison;
- Radeče Correctional Facility for juveniles sentenced to the correctional measure of placement in a correctional facility.

In prisons, there are three regimes or sections for serving sentences, i.e. open, semi-open and closed, which differ mainly in the degree of restriction of movement.

Imprisoned persons are categorised as follows (hereinafter: all imprisoned persons):

- Convict: a person found criminally liable by a final (*res judicata*) judgment.
- Remand Prisoner: a person temporarily deprived of liberty due to criminal proceedings.
- Person in compliance detention: a person who has failed in part or in whole to pay a fine within the specified period and is forced to settle the payment by being placed in compliance detention. Such detention is imposed by the court.
- Juvenile convict: a person under 18 who has been found criminally liable by a final (*res judicata*) judgment;
- Young persons in a correctional facility: young adolescents (aged 14 to 21) who have been sentenced to the correctional measure of placement in a correctional facility where they can be held up to the age of 23.

Basic legislation regulating the operation of prisons:

- The Criminal Code (Official Gazette of the Republic of Slovenia, No. 50/12 – official consolidated text)
- Enforcement of Criminal Sanctions Act (Official Gazette of the Republic of Slovenia, No. 110/06 – official consolidated text, 76/08, 40/09, 9/11-ZP-1G, 96/12-ZPIZ-2 and 109/12)
- Rules on the Implementation of Prison Sentences (Official Gazette of the Republic of Slovenia, No. 102/2000)

Key sources:

- Data on the prison system and persons imprisoned is collected and processed by the Prison Administration of the Republic of Slovenia, and published in annual reports, which are available online (in Slovenian):  
[http://www.mp.gov.si/si/o\\_ministrstvu/ursiks\\_organ\\_v\\_sestavu/dokumenti/letna\\_porocila](http://www.mp.gov.si/si/o_ministrstvu/ursiks_organ_v_sestavu/dokumenti/letna_porocila).
- The 2012 Annual Report is available at the following link:  
[http://www.mp.gov.si/fileadmin/mp.gov.si/pageuploads/UIKS/Letna\\_porocila/LP\\_2012.pdf](http://www.mp.gov.si/fileadmin/mp.gov.si/pageuploads/UIKS/Letna_porocila/LP_2012.pdf).

### **9.3 Alternative Methods of enforcing Criminal Sanctions**

Eva Salecl Božič

The criminal code (Official Gazette of the Republic of Slovenia, No. 50/12 – official consolidated text) in conjunction with Article 12 of the Enforcement of Criminal Sanctions Act (Official Gazette of the Republic of Slovenia, No. 110/06 – official consolidated text, 76/08, 40/09, 9/11-ZP-1G, 96/12-ZPIZ-2 and 109/12) offers a number of more lenient forms of



-serving a sentence, i.e. serving a sentence by weekend imprisonment, home detention and the alternative sentence of performing community service.

- Weekend imprisonment: 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 proposal lodged by a convict already serving a sentence of imprisonment 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: With a judgment or special decision, the court may allow enforcement of imprisonment in the form of home detention 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 imprisonment institution to which the convict would otherwise be referred, and the police station competent in 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: Community service, with which the court replaces a prison sentence of up to two years, is arranged, run and overseen by a Social Work Centre. The agreement on the beginning of community service adopted by 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 data provided relates to all convicts in 2012, not only those with a drug problem.)

Weekend imprisonment is imposed by a court order based on a proposal lodged after the judgment has become final. Weekend imprisonment can also be authorised based on a proposal lodged by a convict already serving a sentence of imprisonment 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.

Such service is allowable if the convict has suitable personal qualities as to be trusted not to abuse this type of sentencing. In such cases, the convicts can continue their employment or education while residing at home, except for rest days, which are generally weekends, which they have to spend in prison. Weekend imprisonment was being served by 86 convicts in compliance with Article 12 of the Enforcement of Criminal Sanctions Act (Table 9.6). They all had permanent employment and did not terminate their employment relationships, and two of the convicts continued their education.

With a judgment or special decision, the court may allow enforcement of imprisonment in the form of home detention and order or change its enforcement method. The enforcement of home detention is overseen by the court or enforced by the police. In 2012, eight convicts were granted this type of sentencing in compliance with Article 12a of the Enforcement of Criminal Sanctions Act – Home Detention (Table 9.6). The data on the sentence served is not recorded.

According to the available Prison Administration data, eleven convicts were referred to the alternative sentence of community service in compliance with Article 13 of the Enforcement of Criminal Sanction Act (Table 9.6). Community service, with which the court replaces a prison sentence of up to two years, is arranged, run and overseen by a Social Work Centre.

**Table 9.6:** Number of convicts serving an alternative sentence in the past three years  
(The data relates to all convicts, including those with no drug problem.)

	Year	2010	2011	2012
Article 12 of the Enforcement of Criminal Sanctions Act (ZIKS-1)		63	60	86
Article 12a of ZIKS-1		2	2	8
Article 13 of ZIKS-1		12	9	11

Source: Prison Administration of the Republic of Slovenia, 2012 Annual Report

**Persons in Compliance Detention**

In 2012, there were 1,665 persons in compliance detention in Slovenian prisons. (The data encompasses all persons in compliance detention – those with a drug problem as well as without.) In comparison to the preceding year, the number of persons in compliance detention decreased by 151 or 9%.

21.5%, or 7.1% more than in 2011, of those in compliance detention served the entire duration of the sentence (one month). Due to a change to the Minor Offences Act, which entered into force on 14 March 2011, stipulating that an individual may only propose to the court to substitute the payment of fine with performing a specific service for the public good or to the benefit of a locally governed community before the commencement of compliance detention, a 11.2 per cent drop was recorded for 2012 in the number of persons to whom the relevant 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 compliance detention not being enforced shall be issued within 24 hours of receiving the proposal. Proposals are mostly related to poor health and poor social conditions of the person brought in to serve compliance detention. In 2012, 19.1% of persons in compliance detention were discharged based on the director's proposal.

When people in compliance detention have a substance abuse problem, the following practice has been established: if the prison establishes that the person 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. In the procedure, the person is examined in the prison surgery by a doctor from the competent health centre who assesses whether there are valid health concerns for the prison to propose to the court not to enforce the imprisonment.

Among those in compliance detention in 2012, 112 were discovered to be having alcohol addiction-related problems, which is 6.7% of all such detainees, and 158 with drug addiction-related problems, which is 9.5% 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 situation in prisons in relation to drugs by collecting data for the annual report. On a certain date every three months, it checks the number of persons imprisoned with an addiction to psychoactive substances (drugs, alcohol) and the number of people infected with HIV, various types of hepatitis or tuberculosis. The Administration also monitors all incidents related to the issue by daily contact with the penal institutions.

The persons imprisoned with problems related to using illicit drugs are treated in compliance with an elaborate strategy of treating drug addiction comprising medical attendance, an educational programme and a process of motivation, the aim of which is for the imprisoned person to start 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, and the Instructions on Collecting Urine Samples and Performing Control Tests (both documents were prepared in 2010 by the Prison Administration of the Republic of Slovenia).

When making an assessment on the problems connected to using psychoactive substances, the medical diagnosis is considered as well as the data derived from the judgment (criminal offence committed under the influence of psychoactive drugs), expert opinion, report of the Social Work Centre, findings of the professional conducting interviews, statements of the imprisoned person, commencement of the sentence under the influence of alcohol, and the discovery of the use of psychoactive substances that are not part of the medical therapy.

In 2012, 1,076 of 5,040 imprisoned persons were identified as having problems due drug use (Table 9.7. A statistically smaller drop was identified than the year before as their numbers decreased by 0.3%. The group included eight people who were subjected to the measure of compulsory drug addiction treatment.

**Table 9.7:** The number of people with drug use-related problems in comparison to the total number of all prisoners, 2004–2012

Year	2004	2005	2006	2007	2008	2009	2010	2011	2012
No. of all prisoners	4,344	3,097	3,572	4,311	4,383	4,730	4,592	4,975	5,040
People with drug-related problems	944	868	948	1,090	1,210	1,209	1,215	1,073	1,076
Share in %	21.7	28.0	26.5	25.3	27.6	25.6	26.5	21.6	21.3

Source: Prison Administration of the Republic of Slovenia, 2012 Annual Report

### Prison Drug Trafficking

Persons imprisoned introduce drugs into prisons in various ways, always seeking new concealment methods. The common techniques remain hiding them on the body (glued) or in

clothing (sewn into hems, etc.), throwing them over the fence and entry with parcels, particularly with food in original packaging. It is thought that persons imprisoned most often hide drugs in their bodies, which causes additional problems in detection as any invasive exams of the human body are forbidden. However, in all the cases that were discovered, only small amounts of drugs were brought into prisons.

More thorough control upon entering the prison, regular inspections of the facility and the people, cooperation with the police in gathering information and discovering drugs with trained dogs – all of this forces the people imprisoned to be more inventive in seeking new ways of bringing drugs into prison; that is why we also remain alert to any efforts by the people imprisoned to take advantage of the staff. If there is a suspicion in relation to this, we cooperate with the police in investigating such events.

**Table 9.8:** Number of finds of illicit drugs and psychoactive substances by type

No. of Finds Prison	Heroin	Cannabis	Cocaine	Hashish	Alcohol	Methadone	Pills	Para-phernalia	All finds	All drugs
Dob	2	10	0	0	4	5	29	1	52	12
Slov. vas	0	0	0	0	0	0	0	0	0	0
Puščava	0	0	0	0	0	0	0	0	0	0
Ig	0	0	0	0	0	0	7	1	9	0
Celje	0	6	1	0	0	0	9	1	18	7
Koper	6	11	1	1	2	0	22	1	45	19
N. Gorica	1	1	1	0	0	0	2	0	5	3
Ljubljana	0	40	1	3	6	0	13	3	69	44
N. mesto	0	0	0	0	1	1	10	1	14	0
OO Ig	0	0	0	0	0	0	0	0	0	0
Maribor	5	18	2	4	0	0	37	3	76	29
M. Sobota	0	1	0	0	0	0	0	3	4	1
Rogoza	0	1	0	0	0	0	0	0	1	1
Radeče	0	4	0	0	1	0	0	0	8	4
<b>Total</b>	<b>14</b>	<b>92</b>	<b>6</b>	<b>8</b>	<b>14</b>	<b>6</b>	<b>129</b>	<b>14</b>	<b>301</b>	<b>116</b>

Note: The total number of finds (events) was 268, but in many cases, judicial police officers discovered several types of drugs at once.

Source: Prison Administration of the Republic of Slovenia, 2012 Annual Report

**Table 9.9:** The quantity of discovered illicit drugs and psychoactive substances by type

Total quantity Prison	Heroin	Cannabis	Cocaine	Hashish	Alcohol (l)	Methadone (ml)	Pills (items)
Dob	12.54	43.42	0	0	2.62	355	1723.25
Slov. vas	0	0	0	0	0	0	0
Puščava	0	0	0	0	0	0	0
Ig	0	0	0	0	0	0	25.5
Celje	0	7	0.9	0.5	0	0	172
Koper	15.7	57.3	0.4	0	3.45	0	232.25
N. Gorica	3	19	1	0	0	0	76
Ljubljana	0	402.3	0.7	21.2	4.15	0	313
N. mesto	0	0	0	0	3	10	67
OO Ig	0	0	0	0	0	0	0

Table 9.9 continues ...

Total quantity Prison	Heroin	Cannabis	Cocaine	Hashish	Alcohol (l)	Methadone (ml)	Pills (items)
Maribor	9	100.7	6.9	15	0	0	227
M. Sobota	0	1	0	0	0	0	0
Rogoza	0	10	0	0	0	0	0
Radeče	0	135.5	0	0	1	0	0
<b>Total</b>	<b>40.24</b>	<b>776.22</b>	<b>9.9</b>	<b>36.7</b>	<b>14.22</b>	<b>365</b>	<b>2836</b>

Note: Discovered drugs are weighed in gross quantities (g), i.e. together with the wrapping, and are handed over to police as a whole.

Source: Prison Administration of the Republic of Slovenia, 2012 Annual Report

In 2012, drugs were discovered in 116 instances, with the total number of finds/occurrences reaching 268 (Table 9.8). Considering the total quantity of drugs discovered in 2012, the drug discovered by the judicial police officers in the largest amount was cannabis with 776.22 g, followed by heroin (40.24 g), hashish (36.7 g) and cocaine (9.9 g) (Table 9.9). Judicial police officers also discovered 365 ml of methadone, 14.22 l of alcohol and 2,836 pills.

## 9.5 Responses to Drug-Related Health Issues in Prison

Eva Salecl Božič

Health care services in prisons are provided by regional health centres, meaning that prison doctor's surgeries are part of the public health care network. The imprisoned persons addicted to drugs therefore have to be provided with the same access and quality of health services as outside of prison. Upon being admitted into prison, each imprisoned person is examined in the prison surgery. If they have addiction problems, the doctor makes an assessment about whether medical treatment is required to ease the effects of drug withdrawal or prescribes a substitution therapy to the prisoner. The Instructions on the Treatment of Imprisoned Drug Users have been developed in cooperation with the coordination of drug addiction treatment centres, comprising a unified doctrine of substitution therapy in prisons.

### Substitution Therapy

The patient consumes the substitution drug under supervision. In the case of methadone, the substance is distributed as a solution mixed with fruit juice. Among 1,076 persons imprisoned with problems due to drug use, 645 were receiving substitution therapy, which is 59.9% of the total number of prisoners with problems due to drug use, of which 190 were remand prisoners, 366 convicts (Table 9.10) and 89 people in compliance detention.

**Table 9.10:** The number of people imprisoned receiving substitution therapy by category in years 2006–2012

Year Category	2006	2007	2008	2009	2010	2011	2012
Remand Prisoners	242	234	196	219	219	182	190
Convicts	290	352	346	328	319	378	366
<b>Total</b>	<b>532</b>	<b>586</b>	<b>542</b>	<b>547</b>	<b>538</b>	<b>560</b>	<b>556</b>

Source: Prison Administration of the Republic of Slovenia, 2012 Annual Report

## Drug Tests

(The data relates to all imprisoned persons, including those without a drug problem.)

Considering the available data on test results obtained in surgeries organised within relevant regional health centres, 222 imprisoned persons opted to be tested for HIV and hepatitis in 2012. Among the persons tested, one was infected with HIV, one was confirmed to have hepatitis A, five were diagnosed with hepatitis B and twenty with hepatitis C. Nobody was infected with tuberculosis. Testing is anonymous and voluntary. Patients also sought help and counselling in AIDS surgeries.

Table 9.11: Results of voluntary and confidential tests for hepatitis and HIV, 2004–2012

Year	2004	2005	2006	2007	2008	2009	2010	2011	2012
Persons tested for HIV and hepatitis	448	608	564	675	561	473	481	326	222
HIV	0	0	2	1	1	2	1	0	1
Hepatitis A	3	2	1	2	0	0	0	0	1
Hepatitis B	10	7	12	15	7	13	11	15	5
Hepatitis C	90	85	87	97	75	47	60	55	20
Total	103	94	102	115	83	62	72	70	27

Source: Prison Administration of the Republic of Slovenia, 2012 Annual Report

The medical staff has been implementing the recommendations of medical professionals regarding the timely discovery of patients as well as treatment and care as instructed by specialist doctors. All the imprisoned persons are to be provided advice and education on the dangers of infections with HIV and hepatitis, and be encouraged to get tested, to receive hepatitis B vaccination and to be treated. The imprisoned persons are ensured the supply of disinfectants, cleaning agents, latex gloves and condoms.

Imprisoned drug users are to be warned before release about their significantly decreased tolerance for drugs, which could result in relatively low amounts of drugs or combinations of drugs, alcohol and medicines being fatal. In compliance with the Instructions for Treatment of Imprisoned Drug Users, the centre or another institution where the released person shall continue their treatment is to be informed a week before release (if possible) what drug treatment they receive, at what times and how much supply they received last, and also, whether they were given a sufficient prescription for medicinal products.

## 9.6 Treatment Programmes and Reintegration

Eva Salecl Božič

Work with imprisoned persons in Slovenian prisons has been organised in such a way as to prevent recidivism and facilitate reintegration of the imprisoned persons back into society. Upon commencement of imprisonment, prison professionals devise a plan for each imprisoned person, stating the needs and goals of serving a sentence. Each imprisoned person is 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 in accordance with the convict's service.

While serving the sentence, persons with problems due to drug use may join low-threshold, higher-threshold and high-threshold drug addiction treatment programmes.

**Table 9.12:** The number of persons imprisoned with drug-related problems involved in treatment programmes, 2012

Low-Threshold Programmes	Higher-Threshold Programmes	High-Threshold Programmes
500	230	123

Source: Prison Administration of the Republic of Slovenia, 2012 Annual Report

In comparison with 2011, a higher number of imprisoned persons involved in treatment programmes was recorded last year (Table 9.12). To ensure a higher number of people in low-threshold and high-threshold programmes, it is of key importance to provide a team-based interdisciplinary approach that involves both, prison professionals (educators, social workers, psychologists) as well as prison medical staff and other external experts from the governmental and non-governmental sectors. Persons participating in various treatment programmes while serving a sentence are also provided access to individual and group treatment within the prison. Also available to them is treatment in medical institutions outside the prison and in programmes of non-governmental organisations (psychiatric hospitals, centres for the prevention and treatment of drug addiction, Up Association, Srečanje Community, Karitas – Pelikan Institute, Vir Institute, Projekt Človek Association, Stigma Association, Križišče Association, etc.). In 2012, 96 imprisoned persons opted for this type. Upon completion of service, 58 of the persons imprisoned continued the treatment in institutions outside the prison.

Integration of imprisoned persons with problems due to drug use with governmental and non-governmental organisations and individual experts can be run in various ways, either within the prison exclusively, or on the outside as well. This depends on the effectiveness of treatment during service, on the regime of the prison in which they reside (closed, semi-open, open) and on formal reasons (open criminal procedure, pending sentence, etc.). External organisations run their programmes adapted to imprisoned persons. Their basic methods are providing advice and information, mostly concerning addiction-related issues: assistance in uncovering the phenomenon, identification of the complexity of the problem with regard to pharmacology, age, gender, social status or role, personal traits and family circumstances. Such organisations provide assistance with interpreting and assessing the problem as well as solution planning and implementation. The information required most often comprises addresses of counselling services and conditions of entering the programme, information on the dangers of drug use and other related facts, on harm reduction and preventive measures. Alongside informing and counselling, programmes also include practical assistance (writing applications, submissions and complaints, support and advocacy with various services and institutions, gathering specific information required to solve problems, establishing the first contacts and making arrangements...). An important part of the programme enables escorting convicts on their special day leaves, which enables them to manage their lives, settle current issues and prepare the foundations for successful reintegration after the completion of service.

While serving a sentence, each person imprisoned (either having drug problems or not) is enabled integration in various activities. Diverse experts (educators, social workers, psychologists...) encourage imprisoned persons to establish their daily routine featuring work, education and active leisure, and help them reconnect with close family members. Changes on the personal level are attempted to be reached through individual and group sessions that involve a change in the way of thinking and overcoming difficulties, the attitude to self and others, resolving conflict situations, encouraging self-respect, managing impulsive behaviour as well as setting and reaching life goals during and after the service.

The realisation of personal plans and the return of individuals into society could not be possible, were it not for integration of prison professional services with external institutions. Before release, the entire treatment focuses on actual preparation for release: employment, accommodation, solving material circumstances and preparation of the close family environment for the return of the convict. Cooperation with social work centres is both the most defined and the most frequent, followed by educational and humanitarian organisations in the number of contacts established. In prisons, preparations for release are implemented within individual and group treatment; also, post-penal coordination is carried out with the relevant social work centres, employment services, housing funds, etc.



## 10. DRUG MARKETS

According to Slovenian legislation, the police have the sole authority to confiscate or seize items that may be used as evidence of the offence charged. In cases when Customs Administration of the Republic of Slovenia discovers illicit drugs, it informs the police accordingly, who then start the seizure or confiscation procedure. The Slovenian police systematically collect and process data on seized illicit drugs as well as data on prices of individual illicit drugs. Based on such data, an estimate of availability of individual drugs in the Slovenian market can be made. Data on the quality or purity of drugs are only available for some common types of seized drugs. The National Forensic Laboratory, which has been carrying out regular annual monitoring since 2006, carried out the sampling, analysis and processing of results also in 2012.

In 2012, there was a significant increase in the seized quantities of most illicit drugs in Slovenia compared to 2011, with the exception of methamphetamines and hashish. However, the total number of seizures of illicit drugs remains almost unchanged compared to previous years, while seizure quantities have increased for most illicit drugs. The traditional Balkan Route is still used for smuggling illicit drugs in both directions, and it is estimated that illicit drug smuggling has increased. Heroin and cannabis are usually transported to countries in the European Union, while synthetic drugs and mostly cocaine are transported in the opposite direction. Not a single laboratory for producing synthetic drugs, cocaine or heroin has been found in Slovenia. The only exception is the production of cannabis, which has increased in recent years. Thus, the Slovenian police discovered and destroyed 52 enclosed spaces adapted for cultivating cannabis under artificially created conditions in 2011, while there were 75 such rooms discovered in 2012.

The prices for 1 gram of heroin, cocaine, amphetamine, cannabis and hashish have dropped compared to 2011. The most significant drop has been observed in amphetamine prices, since the supply of amphetamines has increased significantly on the Slovenian market.

479 samples of heroin mixtures, 426 samples of cocaine mixtures, 495 samples of cannabis, 9 samples of hashish, 108 amphetamine samples and 5 methamphetamine samples were analysed in 2012. Almost all heroin samples contained heroin in base form, and its concentration was comparable to concentrations from previous years. All cocaine samples contained cocaine in a hydrochloride form, and the average cocaine content was 43.1%, which is higher compared to previous years. The average concentration of THC in cannabis plant were similar to those from previous years, while the average concentration of THC in hashish (2.4%) was significantly lower compared to previous years. The average concentration of amphetamine was 6.6%. 15 new psychoactive substances appeared in Slovenia in 2012, including mainly cathinones and synthetic cannabinoids.

## 10.1 Availability and Seizures of Illicit Drugs

Staša Šavelj

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

In 2012, we recorded a significant increase in the seized quantities of most illicit drugs in Slovenia compared to 2011. In 2012, the exceptions were methamphetamines and hashish. Of the total quantity of cannabis seized (706.06 kg), 117.06 kg was seized in especially adopted enclosed spaces. Smugglers use busses and trucks or goods vehicles to transport large quantities of cannabis across the Slovenian-Croatian border. To smuggle small quantities of illicit drugs, they use personal luggage transported with busses or passenger cars, or hide drugs by taping them to their body (e.g. abdomen or legs).

**Table 10.1:** Total quantity of seized illicit drugs by type of drug, 2009-2012

Type of illicit drug	Unit	2009	2010	2011	2012
Heroin	Kg	41.787	36.203	4.394	20.34
Cocaine	Kg	2.867	2.012	1.697	26.82
Ecstasy	Tabs	16,872	399	33.5	960
	Kg	0.0361	0.003	0.007	0
Amphetamine	Tabs	778	7,524	150	80
	Kg	3.214	2.831	0.724	9.28
Cannabis plant	Pcs	9,373	9,278	12,836	11,166
Cannabis marijuana	Kg	242.025	188.760	613.045	706.06
Cannabis resin-hashish	Kg	0.689	0.224	4.240	2.56
Benzodiazepines	Tabs	5,116	1,927	5,012	3,251
Methadone	ml	5,111.4	3,654.1	926.92	2,670
Methamphetamine	kg	0.003	0	0.124	0.05
	Tabs	0	0	61	43

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

The estimate of illicit drug availability is influenced also by data on illicit drugs seized from Slovenian citizens abroad. Similar to 2011, amphetamines and cannabis remain the drugs most commonly seized in large quantities in EU Member States, such as Sweden and Germany, and in Western Balkan countries – Montenegro, Serbia, and Croatia. Based on this data, we can conclude that, in addition to the classical Balkan Route, there is a smuggling path for these illicit drugs leading from the above mentioned countries to Slovenia.

**Table 10.2:** Number of seizures by individual illicit drugs, divided by minor offences or criminal offences, and as a total amount, 2009-2012

	2009			2010			2011			2012		
	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
Cocaine	158	113	271	145	133	278	167	105	272	142	109	251
Ecstasy	8	8	16	4	5	9	9	5	14	12	4	16
Amphetamine	111	46	157	135	62	197	166	38	204	146	44	190
Cannabis plant	219	83	302	85	93	178	87	91	178	80	94	174
Cannabis marijuana	2,285	460	2,745	2,600	490	3,090	2,790	516	3,306	2,697	653	3,350
Cannabis resin-hashish	74	9	83	48	9	57	67	22	89	51	15	66
Benzodiazepines	67	49	116	56	40	96	92	42	134	54	32	86
Methadone	62	23	85	50	14	64	29	11	40	38	9	47
Methamphetamine	1	1	2	0	0	0	8	10	18	5	8	13
<b>Total</b>			<b>4,549</b>			<b>4,689</b>			<b>4,758</b>			<b>4,632</b>

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

The total number of seizures of illicit drugs in criminal and minor offences remains almost unchanged compared to previous years. The number of seizures of individual illicit drugs has decreased, while seizure quantities have increased for most illicit drugs. The number of seizures of heroin has decreased significantly, despite the fact that the amount of heroin seized was much higher in 2012 than in 2011. This is partly due to three seizures at the Jože Pučnik Airport in Ljubljana, where a total of 10 kg of heroin was seized from three Tanzanian citizens. The seized heroin was not intended for the Slovenian market. The increase in the total seized quantity of cocaine is due to one seizure of 20 kg of cocaine from a Slovenian citizen who travelled by ship from South America to France, and from there to Slovenia. The slight upward trend in the number of cannabis seizures continues, which is partly due to the increased supply on the Slovenian market. The number of seizures of amphetamine, methamphetamine and benzodiazepines decreased in 2012 compared to 2011.

Based on available data, Slovenia is considered a country with a problem of illicit drug use, and a transit or intermediate country for smuggling of illicit drugs. Certain amounts of illicit drugs stay in Slovenia. The traditional Balkan Route is still used for smuggling illicit drugs in both directions, and it is estimated that illicit drug smuggling has increased. Heroin and cannabis are usually transported to countries in the European Union, while synthetic drugs and mostly cocaine are transported in the opposite direction. Heroin comes from Kosovo, northeast Albania and Macedonia, where it is cut with dilutents and prepared for further distribution and sale.

There are still organised criminal groups in Slovenia that mostly engage in the organisation, logistic support and execution of criminal operations related to supplying the European market with illicit drugs. Most of them are small in size, and their members are connected with criminal groups from other countries, both Western Balkan countries and EU Member States. It is increasingly evident that the abolition of border controls within the EU has contributed greatly to increased opportunities and almost limitless ideas for smuggling illicit

drugs. International criminal groups act in accordance with the trends in illicit drug demand and supply.

Not a single laboratory for producing synthetic drugs, cocaine or heroin has been found in Slovenia. However, there is still an upward trend in the activity of criminal groups engaged in the cultivation of cannabis in especially adopted enclosed spaces. The Slovenian police discovered and destroyed 42 such spaces in 2010, and 52 in 2011, while there were 75 enclosed spaces discovered in 2012. The upward trend in the number of especially adopted enclosed spaces for hydroponical cultivation of cannabis found continues in 2013, as there were 45 such rooms discovered and destroyed in the first six months. It seems that the reasons why there are so many enclosed spaces for cultivation of cannabis are mostly of a financial nature. As the necessary investments are quite small and legal, individual criminal groups or individuals can obtain disproportionate financial gains from such activities. Based on available data, it is estimated that cannabis cultivated in Slovenia is still sold exclusively in the Slovenian territory.

New psychoactive substances available on the Slovenian market are still increasingly discovered in Slovenia. It is often the case that a seized drug thought to be amphetamine actually turns out to be a new psychoactive substance. Such substances are most often first discovered by customs authorities, particularly during control of shipments. In August 2013, 49 new psychoactive substances were added to the list of illicit drugs in the Decree on the Scheduling of Illicit Drugs (Official Gazette of RS No. 62/2013).

## **10.2 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 decrees by competent public prosecutors and investigating judges.

Table 10.3 shows prices of illicit drugs most commonly sold on the Slovenian market, more specifically the lowest and the highest prices as well as the average price; the price usually depends on the purity of an illicit drug, its supply on the market and the area in which it is sold.

The most frequently occurring prices for 1 gram of heroin, cocaine, amphetamine, cannabis and hashish have dropped compared to 2011. The most significant drop has been observed in amphetamine prices, and it appears that the supply of amphetamines has increased significantly on the Slovenian market. This trend continues also in 2013. Furthermore, increased supply of other illicit drugs has resulted in a drop in prices. It appears that the drop in the cannabis plant price is mainly due to the growing supply of high-quality cannabis cultivated in especially adopted enclosed spaces.

Table 10.3: Prices of illicit drugs in EUR, 2012

Type of illicit drug		1 gram	1 kg	1 tab	1000 tabs
Heroin	Min.	20	10,000		
	Max.	60	25,000		
	Typical	40	17,500		
Cocaine	Min.	35	35,000		
	Max.	120	52,000		
	Typical	60	43,500		
Ecstasy	Min.			3	1,000
	Max.			10	5,000
	Typical			5	3,000
Amphetamine	Min.	10	1,800		
	Max.	40	3,000		
	Typical	10	2,650		
Cannabis marijuana	Min.	2	1,300		
	Max.	10	4,000		
	Typical	6	2,650		
Cannabis resin-hashish	Min.	5	2,350		
	Max.	15	6,000		
	Typical	10	4,100		

Source: Ministry of the Interior RS, General Police Directorate

### 10.3 Quality and Purity of Illicit Drugs

Sonja Klemenc, PhD, Mojca Janežič, Katja Benčina, PhD, Rajko Koren, Brigita Nemeč, Andreja Vidic

Data on the quality and purity of drugs are only available for some common types of seized drugs. The National Forensic Laboratory (NFL), which has been carrying out regular annual monitoring since 2006 (since 1995 for heroin mixtures), also carried out the sampling, analysis and processing of results in 2012.

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 for illicit drug production, new psychoactive substances (NPS) as well as samples brought to NGOs by drug users if they suspect that samples contain unusual substances and/or experience unexpected effects with drug use.

Quantitative analysis is carried out mainly for monitoring purposes, and less frequently at the request of clients (police, prosecution, courts). Samples are collected according to pre-set criteria as part of routine examinations of the material received. Quantitative analysis is only performed on samples the weight of which exceeds a certain lower limit (in 2012: more than 0.1 g of heroin, cocaine, amphetamine or other amphetamine-type compounds; and more

than 10 g of cannabis or hashish). The number of samples for analysis in a single case may be reduced, namely in cases where populations of many similar samples are seized. In such cases, the number of samples for analysis is determined on a statistical basis – 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 results of preliminary test and qualitative analysis.

Qualitative and quantitative chemical tests are performed using various analytical methods – mainly GC-MS and HPLC. Data on illegal substance concentrations in samples are always presented in terms of base forms. For cannabis, the purpose of tests is to determine the total concentration of THC (tetrahydrocannabinol), i.e. the summed concentrations of delta-9-THC and THCA. The proportion of total THC content is always determined in dried plant materials.

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

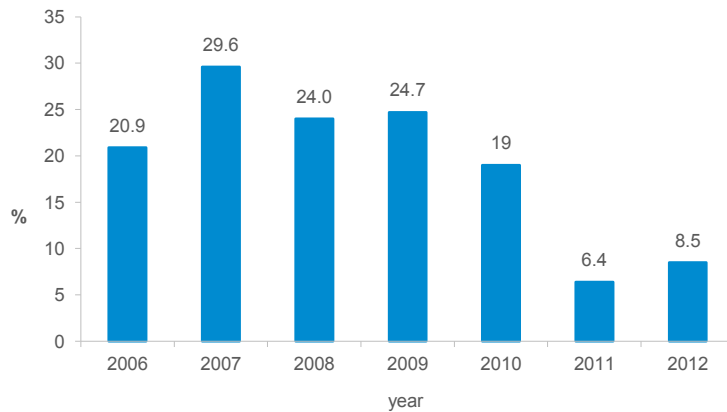
### **Heroin Mixtures**

479 seized samples (with a total weight of approximately 21 kg) from 193 cases were analysed in 2012.

With the exception of the three samples which were proven to contain heroin (diacetylmorphine) in a hydrochloride form, all other samples contained heroin in its base form, the usual accompanying compounds, which are basically derived from opium, as well as paracetamol and caffeine.

Because it is poorly soluble in water, heroin base is particularly suitable for smoking. It should be noted, however, that data on the form of heroin do not indicate the typical method of use (smoking, inhaling, injection), as heroin base is soluble in liquids with a low pH, and thus users who inject heroin intravenously often improve solubility by adding acid, such as citric acid. Based on the results of analyses where NFL measured the pH of aqueous solutions of the seized samples, it can be concluded that acid is added, if necessary, immediately before use.

The average concentration of heroin (calculated for a population of 479 samples) was 8.5%, which is comparable with the 2011 data (Figure 10.1). The highest measured concentration in 2012 was 50.9%, while the lowest was 0.3%. 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).

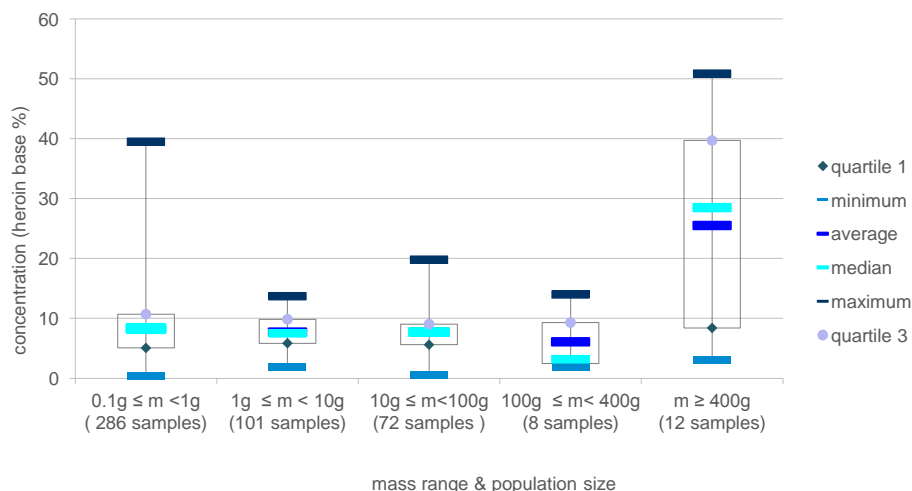


Source: NFL

Figure 10.1: Average concentration of heroin, 2006–2012

Figure 10.2 shows the relationship between the concentration of heroin and the net weight of seized samples in more detail. It is evident that the largest group of investigated samples are the so-called “street heroin samples” weighing up to 1 g (286 samples). In this group, about 50% of the population (population between quartiles 1 and 3) contain between approximately 5% and 10% of heroin. A similar finding concerning the typical range of heroin concentration applies to the remaining three groups of samples weighing up to 400 g (Figure 10.2).

The group of samples with the net weights exceeding 400 g (12 samples), which may be labelled “wholesale samples”, has a slightly different concentration profile (Figure 10.2). In this group 50% of samples contain between approximately 10% and 40% of heroin. The average content of heroin is about 25% and the median approximately 28%. Although the population of “wholesale samples” is small, the above data suggest that at the local distribution level heroin mixtures are further diluted with other substances (most commonly with additional quantities of paracetamol and caffeine). This is contrary to the findings of the NFL (Klemenc 2003, Klemenc and Kalinger 2010) which relate to the period 1995–2009, when the contents of heroin in “wholesale samples” and “street samples” were about the same.



Source: NFL

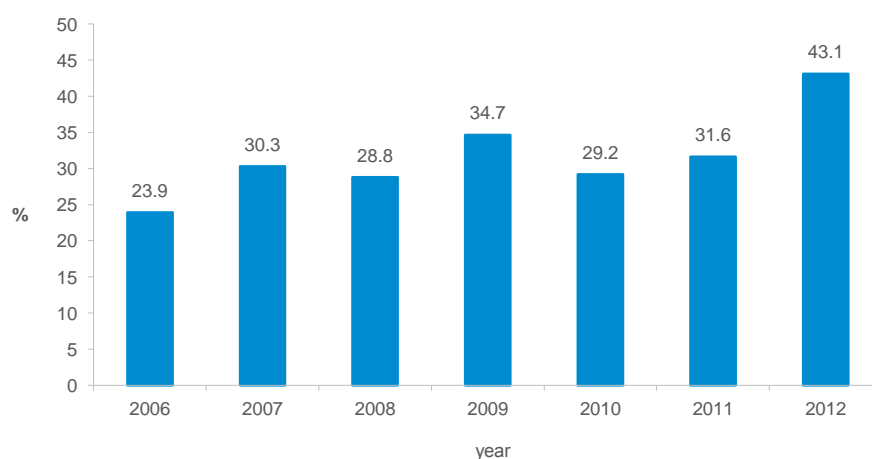
Figure 10.2: Heroin concentration in relation to the net sample weight

The hypothesis on further local dilution of heroin with a paracetamol/caffeine mixture is supported by the fact that the police have seized several samples that only contained paracetamol and caffeine. All seized paracetamol/caffeine mixtures were of a brown colour very similar to that of heroin mixtures. It is known (Ahrens 2013) that such mixtures of brown colour are used exclusively in the illegal market. Brown paracetamol/caffeine mixtures are prepared in illegal laboratories by the addition of synthetic food colorants.

In 2012, 200 heroin samples of illegal origin mixed with paracetamol and caffeine were tested by the NFL for the presence of food colouring. Test results (Verbič and Klemenc 2013) showed that a combination of three food colorants, i.e. E 102 (tartrazine), E 110 (sunset yellow) and E 151 (brilliant black), is most commonly used, which is comparable to German research findings (Ahrens 2013).

### Cocaine Mixtures

Analysis was carried out on 426 samples from 127 seizures. All samples contained cocaine in a hydrochloride form. In comparison to previous years, the established average cocaine content was slightly higher, amounting to 43.1% (Figure 10.3). The lowest cocaine content was 3.3%, while the highest was 90.8%<sup>15</sup>. In three cases in 2012, the police also seized 24 samples of “pure” cocaine in a hydrochloride form (with a total net weight of about 22 kg).



Source: NFL

Figure 10.3: Average concentration of cocaine, 2006–2012

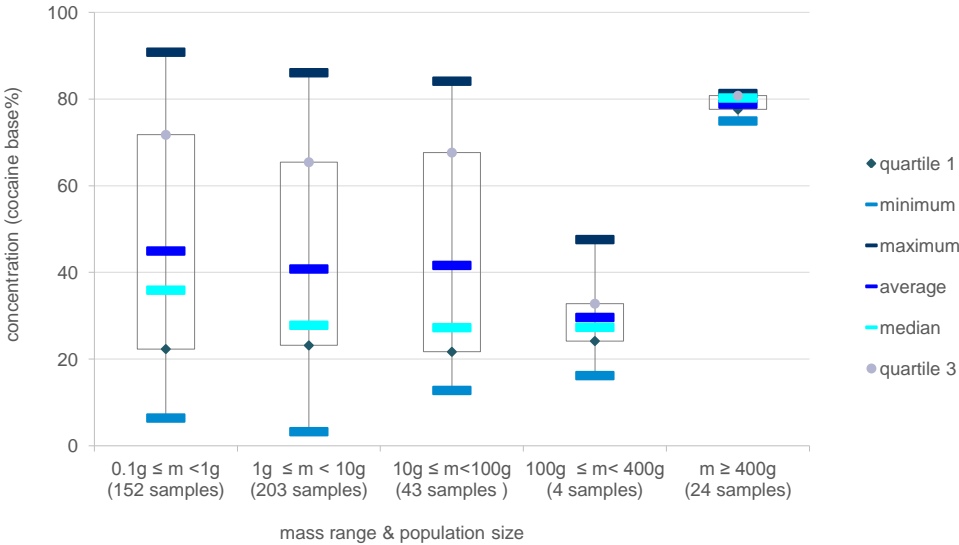
Most common cutting agents detected in cocaine are levamisole and lidocaine, which is similar to the data from previous years (Gostič 2006, Gostič et al. 2010).

The NFL detected an interesting cutting agent (admixture) in one of the samples. Based on the mass spectrum, the cutting agent was identified as octadecyl 3-(3,5-di-tert-butyl-4-hydroxyphenyl)propionate (CAS 2082-79-3). This compound is typically used as a stabilizer (antioxidant) in some plastics. The NFL was unable to explain the origin or the role of this compound in the sample.

<sup>15</sup> The concentration measured exceeded 89.3%, which represents the concentration of cocaine base in pure cocaine hydrochloride and is due to the measurement uncertainty of the method.



The graph below (Figure 10.4) presents the concentration of cocaine in relation to the net weight of a seized sample. It shows that the quality of samples on the illegal market varies significantly.



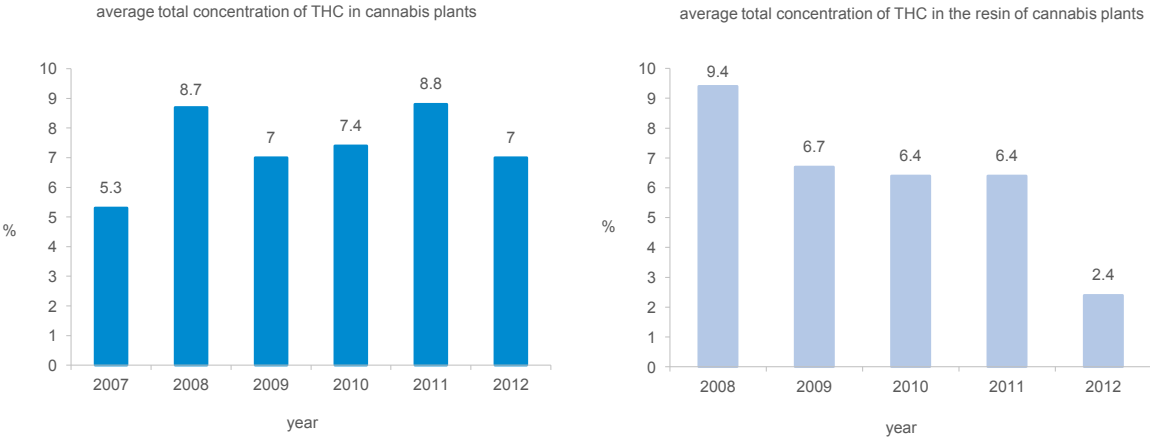
Source: NFL

Figure 10.4: Heroin concentration in relation to the net sample weight

**Cannabis and Cannabis Products**

Analysis was carried out on a population of 495 samples of cannabis from 343 cases, and 9 samples of hashish from 8 cases.

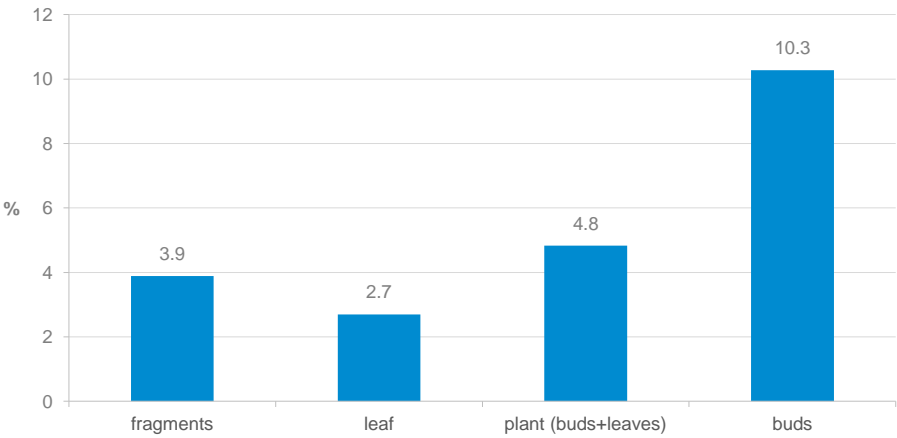
The average concentration (Figure 10.5) of total THC in plant material was similar to those from previous years (average 7.0%; minimum 0.1%; maximum 22.7%), while the average concentration of total THC in hashish samples was significantly lower compared to previous years (average 2.4%; minimum 0.1%; maximum 5.2%).



Source: NFL

Figure 10.5: Average concentrations of total THC in cannabis samples (marijuana and hashish), 2006–2012

Average total THC content in different types of materials (crushed plant fragments; cannabis leaf only; whole plants, where both leaves and buds were sampled for analysis; cannabis buds only) are shown on the graph below (Figure 10.6).



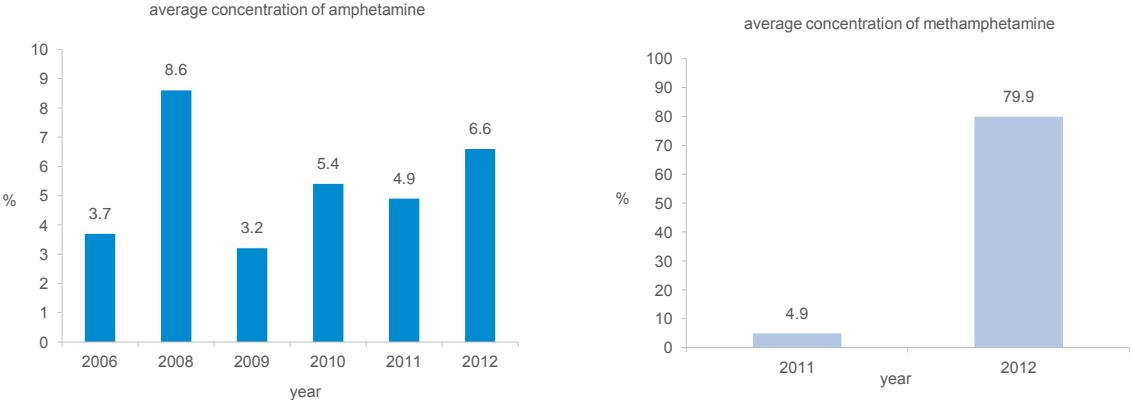
Source: NFL

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

**Amphetamine-Type Stimulants and New Psychoactive Substances**

Most of the samples seized in 2012 contained amphetamine. Methamphetamine seizures were rare.

The average concentration of amphetamine in a population of 108 samples from 42 cases was 6.6%, which is slightly higher than in 2011 (Figure 10.7). The lowest concentration was 1.1%, while the highest was 41.3%. 5 of the seized methamphetamine samples were found to contain a high concentration of this compound, namely around 80%, which corresponds to pure methamphetamine hydrochloride.

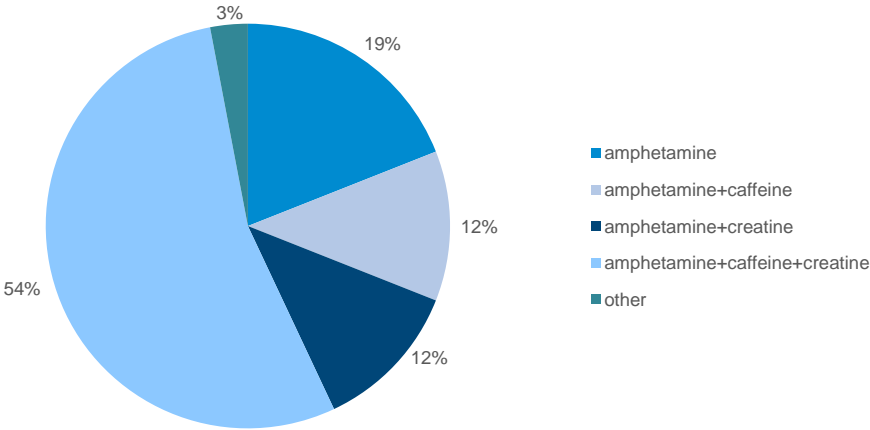


Source: NFL

Figure 10.7: Average concentrations of amphetamine (in 2006 and 2008 to 2012; no data are available for 2007) and methamphetamine (2011–2012)

The NFL also detected certain cutting agents in amphetamine samples (e.g. creatine, caffeine), but it did not test the samples for sugars.

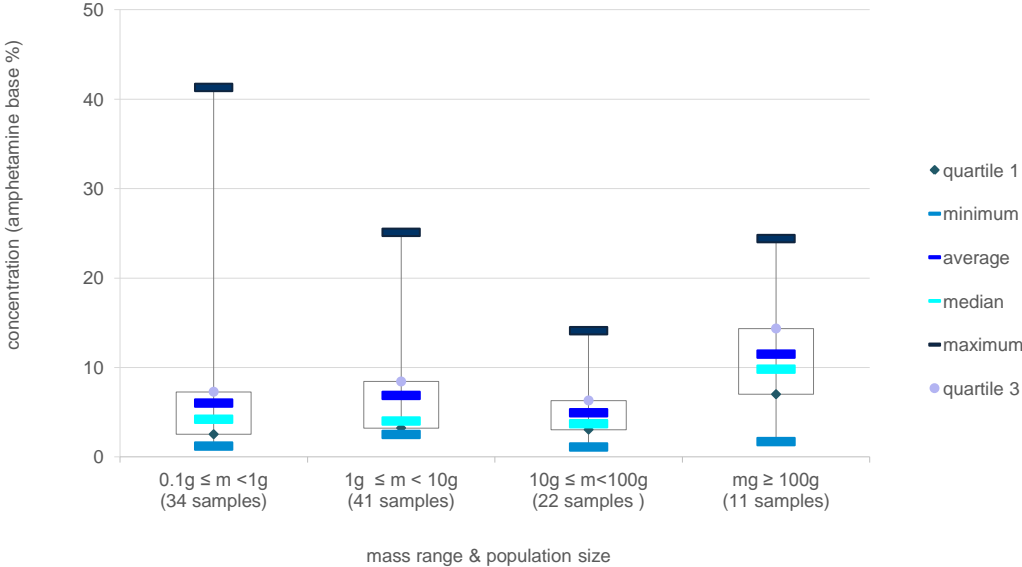
The composition of samples with respect to cutting agents is presented on the graph below (Figure 10.8). 54% of amphetamine samples were mixed with creatine and caffeine. Caffeine was the only cutting agent in 12% of the samples, and 12% of the samples were mixed with creatine only. 19% of the samples only contained amphetamine (no active additives). The remaining 3% of the samples contained different admixtures (e.g. methylamphetamine).



Source: NFL

Figure 10.8: Proportions of amphetamine samples by cutting agents or admixtures

On average, samples weighing more than 100 g contained twice as much amphetamine as samples weighing less than 100 g. Details are shown in the figure below (Figure 10.9).



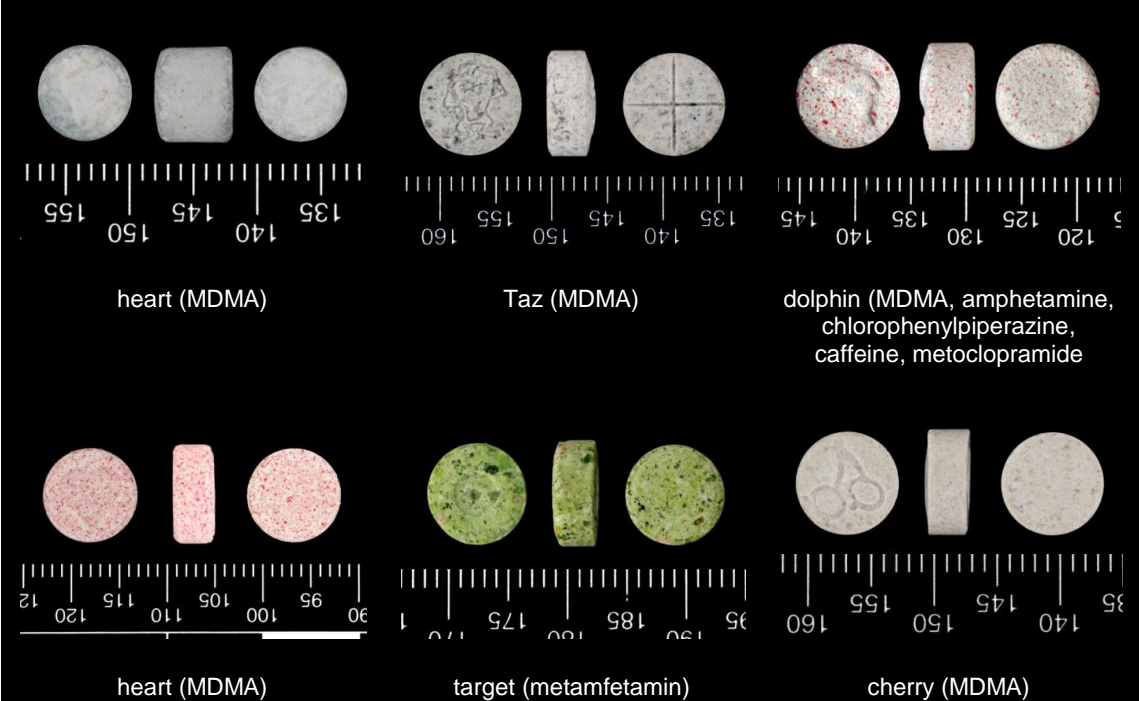
Source: NFL

Figure 10.9: Concentration of amphetamine in samples by weight

In 2012, the Slovenian police seized six new types of ecstasy pills and other synthetic drugs or new psychoactive substances. Three new types of pills only contained MDMA, and one type contained a combination of MDMA, amphetamine, chlorophenylpiperazine, caffeine and

metoclopramide (Photo 10.1). The estimated average amount of MDMA in the new types of pills (Photo 10.1) is approximately 80 mg per pill.

The NFL found methamphetamine in one type of pills, while another type contained 4APB and 6APB (see Table 10.4, Photo 10.2).



Source: NFL

Photo 10.1: Types of pills seized in Slovenia in 2012. For tablets containing 6APB and 4APB, see the Photo 10.2



Source: NFL

Photo 10.2: Pills (in the form of pellets) containing new psychoactive substances 6APB and 4APB, seized in 2012.

In addition, several other new psychoactive substances appeared in Slovenia in 2012, mainly cathinones and synthetic cannabinoids. Details are shown in the Table 10.4.

Table 10.4: New psychoactive substances seized in 2012

Substance	Form	No. of seizures	Total seized quantity
25I-NBOMe*	liquid	1	0.2 ml
MDPV	white powder	1	6.68 g
butylone	white powder	3	758.7 g
MDPV+4-MEC	white powder	1	1.1 g
4-fluoroamphetamine	white powder	1	1.3 g
4-MEC	white powder	2	26.9 g
2C-E	blotting paper	1	5 pieces
methoxetamine	white powder	2	45.71 g
$\alpha$ -methyltryptamine (AMT)	white powder	1	1.01 g
methiopropamine (MPA)	white powder	1	2.01 g
PVP	white powder	1	0.02 g
AM-2201	green pasty substance	3	4.40 g
JWH-122	green pasty substance	1	1.03 g
6APB+4APB*	pellets (see Photo 10.2)	1	17.02 g
methylamphetamine + amphetamine	white powder	2	107.17 g

\* Compound was confirmed by GC-MS on the basis of mass spectrum only – reference material was not available.  
Source: NFL

### Illicit Drug Precursors

In early 2012, Slovenian customs officers discovered 5 drums containing a suspicious liquid in the port of Koper. The total volume of the liquid was about 1000 l. The NFL analysed it and found that it contained about 85% of 3,4-MDP-2-nitropropane (an unregulated precursor). It is relatively easy to chemically convert 3,4-MDP-2-nitropropane into 3,4-MDP-2-propanone (PMK), which is a regulated precursor for the synthesis of MDMA. NFL estimates that, after chemical conversion into PMK, at least 4.5 million ecstasy pills could have been produced from the seized material. (Janežič et al. 2013).

## **PART B:**

### **BIBLIOGRAPHY, ANNEXES**

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