2012 NATIONAL REPORT (2011 data)
TO THE EMCDDA
by the Reitox National Focal Point

SLOVAKIA
New Development, Trends
and In-depth Information on Selected Issues

REITOX
Acknowledgement

National report for EMCDDA and its REITOX network was based on information and statistic sources from several institutions and from experts acting in the area of public health, educational system, social work, law enforcement authorities, and other areas. Information, as it has been up to now, shall become a part of Annual report 2013 of the EU specialized agency – European monitoring centre for drugs and drug addiction (EMCDDA). For this reason and for mutual comparability of the data from 27 EU member states, Norway and candidate countries, all reports of national monitoring centres must have the same structure. EMCDDA annually evaluates information quality and quantity implemented in specified structure.

Acknowledgement belongs to the experts and members of work groups for respective key and main indicators, who particularly participated at respective chapters, standard tables and structured questionnaires or their parts. Their names and organizations as well as information sources may be found in bibliographic references.

The main authors or compilers/designers of the chapters are listed also with respective chapters:

Chapter 1  Imrich Šteliar
Eleonora Kastelová
Miroslav Jablonický
Chapter 2  Eleonora Kastelová
Ján Luha
Chapter 3  Ivana Bučková
Eva Czuczorová
Eleonora Kastelová
Mária Slovíková
Chapter 4  Imrich Šteliar
Chapter 5  Ľubomír Okruhlica
Chapter 6  Ľubomír Okruhlica
Jozef Šidlo
Chapter 7  Ľubomír Okruhlica
Chapter 8  Eva Czuczorová
Eleonora Kastelová
Chapter 9  Ladislav Bodor
Alžbeta Bačíková
Eleonóra Kara
Ľudmila Vráblová
Chapter 10  Andrej Bolf
Ivana Bučková
Eleonóra Kara
Chapter 11  Mária Martinove jr.
Ľubomír Okruhlica
Chapter 12  Eleonora Kastelová
Kamil Bartoň


## Table of Content

<table>
<thead>
<tr>
<th>Section</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary</td>
<td>3</td>
</tr>
<tr>
<td>PART A: Development and new trends</td>
<td>5</td>
</tr>
<tr>
<td>1 National Policy and its Context</td>
<td>11</td>
</tr>
<tr>
<td>1.1 Legal Framework</td>
<td>14</td>
</tr>
<tr>
<td>1.2 Other drug policy developments</td>
<td>15</td>
</tr>
<tr>
<td>1.3 Political and Institutional Frame of Anti-Drug Policy</td>
<td>17</td>
</tr>
<tr>
<td>1.4 Coordination</td>
<td>18</td>
</tr>
<tr>
<td>1.5 Financing</td>
<td>20</td>
</tr>
<tr>
<td>2 Drug Use in Population</td>
<td>22</td>
</tr>
<tr>
<td>2.1 Drug Use in General Population</td>
<td>25</td>
</tr>
<tr>
<td>2.2 Drug use in schools</td>
<td>26</td>
</tr>
<tr>
<td>2.3 Drug Use among Certain Specific Groups or Environments on National and Local Level</td>
<td>30</td>
</tr>
<tr>
<td>3 Prevention</td>
<td>35</td>
</tr>
<tr>
<td>3.1 Introduction, Definitions, Data Collection Tools and Background Information</td>
<td>42</td>
</tr>
<tr>
<td>3.2 Environmental Prevention</td>
<td>46</td>
</tr>
<tr>
<td>3.3 Universal Prevention</td>
<td>52</td>
</tr>
<tr>
<td>3.4 Selective Prevention</td>
<td>61</td>
</tr>
<tr>
<td>3.5 Indicated Prevention</td>
<td>65</td>
</tr>
<tr>
<td>3.6 National and Local Media Campaigns</td>
<td>66</td>
</tr>
<tr>
<td>4 Problem drug use</td>
<td>72</td>
</tr>
<tr>
<td>4.1 Overview</td>
<td>72</td>
</tr>
<tr>
<td>4.2 Estimates of the prevalence and incidence of Problem Drug Use</td>
<td>77</td>
</tr>
<tr>
<td>4.3 Data on PDU from non-treatment sources</td>
<td>84</td>
</tr>
<tr>
<td>4.4 Related data and indicators</td>
<td>85</td>
</tr>
<tr>
<td>5 Drug-related treatment</td>
<td>89</td>
</tr>
<tr>
<td>5.1 Introduction</td>
<td>89</td>
</tr>
<tr>
<td>5.2 General description, availability and quality assurance</td>
<td>92</td>
</tr>
<tr>
<td>5.3 Access to treatment</td>
<td>92</td>
</tr>
<tr>
<td>6 Health Correlations and Consequences of Psychoactive Substance Use</td>
<td>92</td>
</tr>
<tr>
<td>6.1 Introduction</td>
<td>92</td>
</tr>
<tr>
<td>6.2 Drug-related infectious diseases</td>
<td>92</td>
</tr>
<tr>
<td>6.3 Other drug-related health correlates and consequences</td>
<td>92</td>
</tr>
<tr>
<td>6.4 Drug-related deaths and mortality of drug users</td>
<td>92</td>
</tr>
<tr>
<td>7 Responses to health correlates and consequences</td>
<td>92</td>
</tr>
<tr>
<td>7.1 Introduction</td>
<td>92</td>
</tr>
<tr>
<td>7.2 Prevention of drug-related emergencies and reduction of drug-related deaths</td>
<td>92</td>
</tr>
<tr>
<td>7.3 Prevention and treatment of drug-related infectious diseases</td>
<td>92</td>
</tr>
</tbody>
</table>
7.4 Responses to other health correlates among drug users .................................................. 94
8 Social correlates and social reintegration ....................................................................... 96
  8.1 Social Exclusion of Drug Users ..................................................................................... 96
  8.2 Social Characteristics of Drug Users Receiving Treatment ........................................ 97
  8.3 NMCD Surveys on Client Structure and Services of Re-socialization Centres .......... 101
  8.4 Social Integration of Problem Drug Users ............................................................... 108
9 Drug-related crime, prevention of drug related crime and prison ..................................... 109
  9.1 Drug-Related Crime ....................................................................................................... 110
  9.2 Prevention of Drug-Related Crime ............................................................................... 117
  9.3 Interventions in the criminal justice system ............................................................... 119
  9.4 Drugs in prison ............................................................................................................. 122
  9.5 Social reintegration of drug users after their release from prison ................................. 126
10 Drug market .................................................................................................................... 128
  10.1 Availability and Supply .............................................................................................. 128
  10.2 Seizures of Drugs and Precursors .............................................................................. 133
  10.3 Drug Price and Purity ............................................................................................... 136
  ........................................................................................................................................... 140
Part B: Selected Issues ........................................................................................................ 140
11 Residential (institutional) treatment of drug users in Slovakia (data 2011) ............... 141
  11.1 Historical and political framework ............................................................................. 141
  11.2 Availability and characteristic of residential treatment ............................................ 143
  11.3 Management of residential treatment from qualitative aspect ............................... 150
  11.4 Discussion and conclusion ....................................................................................... 152
12 Drug Policies of large European cities - Bratislava capital of Slovakia ..................... 155
  12.1 Overview ..................................................................................................................... 155
  12.2 Bratislava – capital of Slovakia ................................................................................ 155
  12.3 Current issues ............................................................................................................ 161
Part C Annexes: .................................................................................................................. 163
13 Bibliography .................................................................................................................. 165
  13.1 Alphabetic list of all bibliographic references used ................................................... 165
  13.2 Alphabetic list of relevant databases available on internet ..................................... 172
  13.3 Alphabetic list of relevant Internet addresses .......................................................... 173
  13.4 List of abbreviations: ............................................................................................... 173
14 Legislative framework .................................................................................................. 177
15 List of tables and figures ................................................................................................ 179
  15.1 List of tables ............................................................................................................... 179
  15.2 List of Figures ............................................................................................................ 180
16 List of 2012 standard tables provided ........................................................................... 182
SUMMARY

2011 was a year of tasks realisation of the fourth consecutive antidrug strategy and the action plan, scheduled for 2009 – 2012. In the beginning of 2011, the interim report was submitted to the Slovak government and to the National Council (parliament) to take cognisance of it. And, in 2012, preparation of the final evaluation of the national action plan has started to be submitted to the government session by the end of March 2012.

Although drug policy is not a priority for the new government that arose from elections in March 2012, there are some references to drugs in the Manifesto of the Government of the Slovak Republic¹, focused on a) international cooperation within UN antidrug policy programmes², and b) measures against tobacco, alcohol and drugs in the frame of health protection and health lifestyle promotion³.

In the second part of 2010, the Act № 575/2001 on the Government activities organisation and on organisation of the central state authority was amended and drug issue dropped out from the competency of Deputy Prime Minister for human rights and minorities. By the government resolution № 135/2011, Board of Ministers for Drug Addictions and Drug Control, specialised advisory body to the Government in the drug field, has been cancelled and replaced with the universal Ministerial Council that lost connections to the expert background, supporting activities and functions of the Board of Ministers. A new government created in 2012 did not restore the role and competence of the Deputy Prime Minister, such position has not been established within the new government.

By the government resolution № 1/2011, cancellation of the Antidrug Fund was decided, ending series of attempts to transform the Fund and make it more effective in money rising. This process has not been finished as yet and Fund issue has been remained deadlocked and unsolved.

In the course of 2010, some steps were undertaken, aimed to reduce “legal highs” distribution via network of internet as well as of regular shops (Crazy Shops), and, at the same time, legislative activity was initiated by the drug coordinating bodies, based on NMCD’s expert information. Drug control was extended, and preparatory works in 2010 led to the Act № 43/2011 Coll. approval at the National Council in the beginning of 2011 that renewed Act № 139/2008 Coll., and added 43 new substances on the list of controlled narcotic and psychotropic substances.

Government Council for the Crime Prevention, advisory body acting within the ministry of internal affairs, prepared Concept of Crime Prevention Strategy for 2011 to 2014 that involved, to some extent, also drug problem.

As in many other central and eastern European countries, the ESPAD national school surveys conducted repeated since 1995, showed an increase in illegal drug consumption among secondary school students aged 15–16. Although lifetime

---

² Manifesto of the Government of the Slovak Republic, May 2012, part Strengthening the position of the Slovak Republic in the European Union and the world
³ Manifesto of the Government of the Slovak Republic, May 2012, part Quality of life as the outcome of a cohesive society
prevalence rates for cannabis more than tripled from 9 % in 1995 to 32 % in 2007, the results of the last survey show decline to 27%. In 2011, this prevalence was reported by 31 % of males and 23 % of females. In 2011, last year prevalence of cannabis was reported by 19 % of the sample and 9 % reported a last-month prevalence. The proportion of those who reported having used ecstasy at least once in their lives was 0 % in 1995, raised to 6 % by 2007 and declined to 4 % in 2011. Lifetime prevalence rates for amphetamines and LSD remain unchanged from 2007 and 2011 at 2 % and 4 % respectively, while lifetime prevalence of inhalants dropped from 13 % in 2007 to 10 % in 2011.

In 2011 no new estimate of problem drug use in Slovakia was carried out. However, in 2012, like in 2011, study was carried out to know numbers of clients of low threshold harm reduction agencies that come to programmes of these agencies (especially to needles/syringes exchange/distribution programme) and the proportion of their clients that go to the treatment at the health care facilities. This was the first preparatory works for prevalence estimation, based on combined data from low threshold agencies and health care treatment centres. In 2011, the number of agencies' clients remained relatively stable, compared to 2010. The number, as well as a proportion of heroin users increased slightly in 2011, on the other hand, the number of buprenorphine using clients has stopped to increase. Also, the proportion of pervitin users declined in harm reduction services in 2011, but the proportion of polydrug users increased markedly.

2313 patients treated due to drug-related problems were reported in 2011. This means slight increase (as high as about 2%) in comparison with 2010, that concerns treatment facilities in prisons, as well as those of health care sector. In terms of the representation of the primary drug as the cause for treatment, no essential changes occurred in the order of the most frequent problems. More than one third of the patients were in treatment due to problems with stimulants (about 35%). Number of opioids users declined among FTD as well as among all treated. The proportion of cannabis users remained practically unchanged. The proportion of injecting drug users among the treated drug users in healthcare facilities decrease slightly in 2011 again.

In 2011, 20 deaths caused by the direct effects of psychoactive substances were reported. The important proportion, more than a half, of these were caused by opioids. The monitoring of deaths related to psychoactive substance intoxication was, as usual, impeded by limited sources and the complexity of toxicological expertises.

The share of individuals infected by the HIV virus remained low and non-epidemic. This is also true for the high risk population of injecting drug users. No new case was reported as HIV positive from among injecting users in Slovakia 2011.

The sub-population of injecting drug users traditionally includes high numbers of the prevalence of type C hepatitis antibodies, especially among the injecting users of opiates. According to the sentinel study at the CTDD Bratislava, the proportion of serum-positive VHC cases in patients remained 40% in 2011, which means stable trend. According to this study, the percentage of patients with prevalence of antibodies of type B hepatitis decreased to 22%.

There was an increase in toxic psychoses of schizophrenic nature, especially in connection with use of methamphetamine.

This applies in particular to the determination of a direct cause of death by a specific substance in case of the escalating poly-use amongst users, in which case use of different illegal psychoactive substances is often combined with alcohol and
psychotropic medicine. The emergence of new synthetic substances on the drug scene makes analyses even more difficult.

The sterile needle and syringe replacement/distribution programmes constitute a significant part of the activities of low threshold organizations in the field of harm-reduction. In 2011, a total of 281,416 syringes/needles were provided to the clients of these facilities, which is about 12% less than the year before. Further 15064 syringes were delivered within stationary programme of the Centre for Treatment of Drug Dependencies in Bratislava.

Drug addicts and individuals with other dependences are not explicitly mentioned in relevant measures to prevent social exclusion and to assure integration into society. However, they are not excluded from benefits what these measures provide.

The distinctive facilities only for people with problem of dependence were established to provide different social services serving to backward return of clients to society. There are at least 19 such facilities – resocialisation centres (RCs) which are certified by Ministry of Labour, Social Affairs and Family for their activities. According NMCD surveys in 2007-2011 the number of clients in these resocialisation centres is increasing (842 in 2011). Prevailing psychoactive substance that had led to the problem was alcohol, followed by illegal methamphetamine – pervitin and poly-drug abuse.

Some other data overview from demand reduction and supply reduction areas are in the table below ("Fact Sheet"): 

---

---

---
<table>
<thead>
<tr>
<th>Indicator / entry</th>
<th>2010 figures</th>
<th>Trend 2009-2010</th>
<th>2011 figures</th>
<th>Trend 2010-2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of treated due to drug use¹</td>
<td>1505</td>
<td>►◄</td>
<td>1609</td>
<td>▲</td>
</tr>
<tr>
<td>Number of treated for the first time ever</td>
<td>686</td>
<td>◄</td>
<td>732</td>
<td>◄</td>
</tr>
<tr>
<td>Share of injecting drug users in treatment</td>
<td>39,2%</td>
<td>◄</td>
<td>36.5%</td>
<td>◄</td>
</tr>
<tr>
<td>Share of treated for the first time ever</td>
<td>45.6%</td>
<td>◄</td>
<td>45.5%</td>
<td>►◄</td>
</tr>
<tr>
<td>No. of first treated ever – opioids</td>
<td>168</td>
<td>◄</td>
<td>162</td>
<td>◄</td>
</tr>
<tr>
<td>No. of first treated ever - stimulants (pervitin)</td>
<td>232</td>
<td>◄</td>
<td>283</td>
<td>▲</td>
</tr>
<tr>
<td>No. of first treated ever - cannabis</td>
<td>168</td>
<td>◄</td>
<td>174</td>
<td>▲</td>
</tr>
<tr>
<td>First treated ever – share of age under 20</td>
<td>27,6%</td>
<td>◄</td>
<td>73%</td>
<td>▲</td>
</tr>
<tr>
<td>No. of low threshold agencies/programmes</td>
<td>5 /</td>
<td>►kie</td>
<td>5 / 9</td>
<td>◄◄ / ▲</td>
</tr>
<tr>
<td>No. of clients in low threshold programmes</td>
<td>3588</td>
<td>◄</td>
<td>2267</td>
<td>◄</td>
</tr>
<tr>
<td>No. of accredited re-socialisation centres</td>
<td>19</td>
<td>►◄</td>
<td>19</td>
<td>►◄</td>
</tr>
<tr>
<td>No. of clients in ARCs²</td>
<td>802</td>
<td>◄</td>
<td>842</td>
<td>◄</td>
</tr>
<tr>
<td>Share of clients in ARCs - younger than 18</td>
<td>12,1%</td>
<td>◄</td>
<td>11,3%</td>
<td>▼</td>
</tr>
<tr>
<td>Share of clients in ARCs – primary drug: alcohol</td>
<td>37,8%</td>
<td>▲</td>
<td>42%</td>
<td>▲</td>
</tr>
<tr>
<td>Share of clients in ARCs – primary drug: pervitin</td>
<td>28,9%</td>
<td>◄</td>
<td>28,5%</td>
<td>▲</td>
</tr>
<tr>
<td>Share of HIV positive among drug users</td>
<td>&lt;1%</td>
<td>►kie</td>
<td>&lt;1%</td>
<td>▲</td>
</tr>
<tr>
<td>Share of hepatitis C positive among drug users (data from Bratislava only)</td>
<td>50%</td>
<td>►◄</td>
<td>40%</td>
<td>◄</td>
</tr>
<tr>
<td>No. of drug related deaths³</td>
<td>22</td>
<td>◄</td>
<td>20</td>
<td>◄</td>
</tr>
<tr>
<td>No. of drug related deaths due to opioid use</td>
<td>12</td>
<td>▼</td>
<td>12</td>
<td>◄</td>
</tr>
<tr>
<td>No. of persons prosecuted due to drug offences</td>
<td>1891</td>
<td>◄</td>
<td>2012</td>
<td>▲</td>
</tr>
<tr>
<td>No. of persons sentenced for drug offences / of which youthful offenders</td>
<td>1135 / 50</td>
<td>▲ /▲</td>
<td>1204 / 52</td>
<td>▲ / ▲</td>
</tr>
<tr>
<td>No. of persons sentenced due to drugs possession</td>
<td>629</td>
<td>▲</td>
<td>626</td>
<td>▲</td>
</tr>
<tr>
<td>No. of persons sentenced due to illegal production, trafficking, dealing</td>
<td>490</td>
<td>▲</td>
<td>551</td>
<td>▲</td>
</tr>
<tr>
<td>No. of persons sentenced due to other supply related offences</td>
<td>16</td>
<td>▼</td>
<td>27</td>
<td>▲</td>
</tr>
<tr>
<td>No. of persons sentenced due to offences related to cannabis</td>
<td>689 (62,6%)</td>
<td>▲</td>
<td>624</td>
<td>▼</td>
</tr>
<tr>
<td>No. of persons sentenced due to offences related to heroin</td>
<td>95 (8,6%)</td>
<td>▼</td>
<td>111</td>
<td>▲</td>
</tr>
<tr>
<td>No. of persons sentenced due to offences related to pervitin</td>
<td>190 (17,3%)</td>
<td>▲</td>
<td>237</td>
<td>▲</td>
</tr>
<tr>
<td>No. of persons sentenced due to offences related to other amphetamines/ecstasy</td>
<td>99 (9%)</td>
<td>▼</td>
<td>105</td>
<td>▲</td>
</tr>
</tbody>
</table>

Continuation on the next page
Continuation from the previous page

<table>
<thead>
<tr>
<th>Indicator / entry</th>
<th>2010 figures</th>
<th>Trend 2009-2010</th>
<th>2011 figures</th>
<th>Trend 2010-2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of persons sentenced due to offences related to other drugs</td>
<td>21 (0,9%)</td>
<td>▼</td>
<td>21</td>
<td>▲</td>
</tr>
<tr>
<td>No. of persons sentenced due to offences related to cocaine</td>
<td>7 (0,6%)</td>
<td>▼</td>
<td>12</td>
<td>▲</td>
</tr>
<tr>
<td>Number and share of drug addicted in prisons</td>
<td>1370 / 13,8%</td>
<td>▼</td>
<td>1863 / 18%</td>
<td>▲</td>
</tr>
<tr>
<td>Number of drug seizures</td>
<td>2042</td>
<td>▼</td>
<td>2528</td>
<td>▲</td>
</tr>
<tr>
<td>Seizures share - cannabis</td>
<td>59%</td>
<td>▼</td>
<td>65%</td>
<td>▲</td>
</tr>
<tr>
<td>Seizures share – pervitin</td>
<td>27%</td>
<td>▼</td>
<td>28%</td>
<td>▲</td>
</tr>
<tr>
<td>Seizures share – heroin</td>
<td>7%</td>
<td>▼</td>
<td>1%**</td>
<td>▼</td>
</tr>
<tr>
<td>Seizures share – cocaine</td>
<td>1%</td>
<td>▼</td>
<td>1%</td>
<td>▲</td>
</tr>
<tr>
<td>Concentration of marijuana – median</td>
<td>11,2</td>
<td>▼</td>
<td>11,3</td>
<td>▼</td>
</tr>
<tr>
<td>Concentration of hashish – median</td>
<td>10,2</td>
<td>▼</td>
<td>7,5</td>
<td>▼</td>
</tr>
<tr>
<td>Concentration of heroin – median</td>
<td>14</td>
<td>▼</td>
<td>14,6</td>
<td>▼</td>
</tr>
<tr>
<td>Concentration of cocaine – median</td>
<td>34,6</td>
<td>▼</td>
<td>29,1</td>
<td>▼</td>
</tr>
<tr>
<td>Concentration of methamphetamine – median</td>
<td>71,9</td>
<td>▼</td>
<td>71,8</td>
<td>▼</td>
</tr>
<tr>
<td>Average concentration of marijuana</td>
<td>12,4</td>
<td>▼</td>
<td>7,7</td>
<td>▼</td>
</tr>
<tr>
<td>Average concentration of hashish</td>
<td>8,2</td>
<td>▼</td>
<td>9,7</td>
<td>▼</td>
</tr>
<tr>
<td>Average concentration of heroin</td>
<td>14,3</td>
<td>▼</td>
<td>16,2</td>
<td>▼</td>
</tr>
<tr>
<td>Average concentration of cocaine</td>
<td>30,1</td>
<td>▼</td>
<td>48,3</td>
<td>▼</td>
</tr>
<tr>
<td>Average concentration of methamphetamine</td>
<td>67,1</td>
<td>▼</td>
<td>65,7</td>
<td>▼</td>
</tr>
<tr>
<td>Suspension of sentences</td>
<td>64,9%</td>
<td>▼</td>
<td>59,5%</td>
<td>▼</td>
</tr>
<tr>
<td>Unconditionally sentenced</td>
<td>26,3%</td>
<td>▼</td>
<td>30,6%</td>
<td>▼</td>
</tr>
<tr>
<td>Fine sentences</td>
<td>6,3%</td>
<td>▼</td>
<td>6,2%</td>
<td>▼</td>
</tr>
<tr>
<td>Alternative sentences4</td>
<td>1,6%</td>
<td>▼</td>
<td>3%</td>
<td>▼</td>
</tr>
<tr>
<td>Other sentences &amp; dropping the sentences</td>
<td>0,9%</td>
<td>▼</td>
<td>0,7%</td>
<td>▼</td>
</tr>
</tbody>
</table>

▲/▼ Steep increase/decrease  ▼/▼ Slight increase/decrease  ▼ Stable trend  - not available / not observed

1 Data on treatment cover treatment centres only within the health department (i.e. without those ones in prisons)
2 ARC – Accredited re-socialisation centre
3 Only toxicologically confirmed direct deaths from the forensic registry
4 Consisted of a sentence of convict labour in 2011
PART A: Development and New Trends

In this part, the National Report gives an overview of the situation in 2011 based on individual key indicators, and current development and trend in 2012, especially in Chapter 1.
1 NATIONAL POLICY AND ITS CONTEXT

In 2011, tasks were fulfilled stated by the fourth programme document of the Slovak Government – National Drug Strategy for the period 2009 – 2012. During 15 year period since the first strategic document in this field was adopted, Slovak Republic became a member of international community joined in combating drug danger and is open for any international activities that direct towards effective solution of drug problem.

Integrated and balanced European approach is the dominant characteristic of the national strategy of drug demand reduction and drug supply reduction.

In the beginning of 2011, the Anti-drug Strategy Coordination Department4 processed the Report on Mid-term Evaluation of the Drug Strategy for 2009-2010. This report then was submitted to the Government of the Slovak Republic and to National Council of the Slovak Republic.

Final evaluation of the National Drug Strategy 2009 – 2012 is scheduled to the beginning of 2013, to be talked over at the governmental session by the end of March 2013 and at the parliamentary session by the end of April 2013.

During 2011 and in the first half of 2012, some major changes occurred in the type, range and scope of drug policy coordination, after having been executed for 15 years. Competencies of the special political structure – Board of Ministers for Drug Addictions and Drug Control – that previously arched over the drug problem comprehensively – lapsed onto newly established Ministerial Council, a body to address universally various issues, across the whole range of political and social life. Previous executive body of the Board of Ministers – General Secretariat – moved from the Deputy Prime Minister’s section to the section of the Head of the Government Office, where it was incorporated into the Section of Foreign Cooperation and renamed to the Anti-drug Strategy Coordination Department. This arrangement created de facto two parallel structures, with different competencies and without internal links and mechanisms defined – at least preliminary. The new government, appointed after the parliamentary elections in March 2012, has kept the Ministerial Council in existence but has not used its functions. The government has also adopted a decision by the governmental regulation № 610/2012 of 31 October 2012, that Ministry of Health of the Slovak Republic becomes a new umbrella institution of the drug policy in Slovakia, instead of the Government Office, starting from the January 2013. There are expectation that the Minister of Health Care Department becomes a new political representative responsible for drug policy area.

The anti-drug policy of the Government of the Slovak Republic is based on international treaties of UNO with regard to drugs, Political Declaration on Guiding Principles of Drug Demand Reduction, Special session of the UNO General Assembly and other EU strategy and current Action Plan of EU Anti-Drug Strategy for the period 2009-2012.

The Government of the Slovak Republic is responsible for fulfilment of objectives of the anti-drug policy, which in cooperation with the National Council of the Slovak Republic influences forming of the respective legislative environment for the support

4 Former General Secretariat of the Board of Ministers for Drug Addictions and Drug Control
of main pillars of the strategy, namely reduction of drug demand (prevention, treatment, resocialization, reduction of harmful effects of drug usage) and application of law for the offer reduction.

1.1 Legal Framework

1.1.1 Legislative Changes Related to New Synthetic Drugs

Within legislative framework, by 15 June 2012 just some minor updates of drug related legislation have been made. The one worthy of note was an Act № 362/2011 Coll. on pharmaceuticals, health care material and on change and amendment of some acts where focus was on safety in introducing new pharmaceuticals and in dealing with them, bringing into effect EU legislation.

1.1.2 Legislation on precursors

In relation to the membership of the Slovak Republic in the EU, it has been continued to proceed with the fight against trading in narcotic and psychotropic substances and precursors pursuant to the Regulation (EC) № 273/2004 of the European Parliament and of the Council on drug precursors and Council Regulation (EC) № 111/2005, laying down rules for the monitoring of trade between Community and third countries in drug precursors. The national legislation implemented these regulations into the Act № 331/2005 Coll. on State Administration Authorities in the Matters of Drugs Precursors and on the amendment and supplement of certain laws. The Ministry of Economy of the Slovak Republic granted in compliance with the legislation (EU, SR) permits for export and import of chemical substances, which can be abused for illegal production of narcotic and psychotropic substances (precursors) and executed control and monitoring of reports from exporters and importers, who have statutory reporting obligation. Measures for prevention of abusing over-the-counter medicines containing pseudoephedrine were taken. Wholesale medicine distributors were asked within these measures to regularly submit monthly data about supplies of all medicines containing pseudoephedrine to individual customers (public pharmacies, hospital pharmacies and other holders of licences for wholesale distribution of medicines). Inspections in pharmacies with excessive sale of over-the-counter medicines containing pseudoephedrine were made on the grounds of assessment of such data. Another measure concerned the adopting of amendment entitling the pharmacist to refuse the sale of such medicines in amount larger than for one treatment cycle (amendment to the Act № 140/1998 Coll.). The amendment of the Act № 331/2005 Coll. on State Administration Authorities in the Matters of Drugs Precursors (as the Act № 425/2010 Coll.) came into effect on 1 December 2010, preventing the abuse of specified substances contained in over-the-counter medicines. The amendment amends the obligation of the pharmacist to give such medicines for only one treatment cycle and it was elaborated in cooperation with the Police Corps Presidium (hereinafter referred to only as the “PCP”), State Institute for Drug Control (SIDC) and Customs Administration of the Slovak Republic (CA SR) by

---

5 Inter-ministerial work group has been established composed of representatives of the Police Corps of the Ministry of Interior of the SR, Ministry of Health of the SR, Ministry of Economy of the SR, Customs Criminal Office, State Institute for Drug Control, Slovak Chamber of Pharmacists and centres for treatment of drug dependencies.

6 Ministry of Interior of the Slovak Republic 2011
the Ministry of Economy of the Slovak Republic. In relation to the said amendment of the act, also the Decree of the Ministry of Economy of the Slovak Republic № 380/2005 Coll. has been amended by the Decree of the Ministry of Economy of the Slovak Republic № 12/2011 Coll., which specified in more detail obligations to submit annual reports for operators marketing over-the-counter medicines containing specified substances in volumes higher than is necessary for one treatment cycle\(^7\). That has solved weak points in the area of registration of operators using specified substances of category 2 for legal purposes under rigorous application of provisions of respective EC regulations, the area of sanction imposition for administrative offences has been extended and possibilities to obtain data about specified substances necessary for the prevention of their illegal usage\(^8\) were made more precise.

Another measure adopted was a change incorporated to the law that authorises a pharmacist to refuse sales of suspect pharmaceuticals in amount bigger than for one treatment cycle (amendment of the Act № 140/1998 Coll.)

### 1.1.3 Changes in the Criminal Code

Only a few smaller adjustments were made in the Act № 300/2005 Coll. (Criminal Code) in 2010 and at the beginning of 2011. The Act № 224/2010 Coll.9 in effect from 1 September 2010 completes the imposition of protective measures with categories “confiscation of money” and “confiscation of property” (Section 33). The act further specified more exactly and in more detail drug-related criminal offences, for which it is possible to impose the sentence of property forfeiture\(^10\). Similarly, the Act № 262/2011 Coll.\(^11\), in effect from 1 September 2011, which primarily amends the Act № 301/2005 (Criminal Code), specified in the new wording the possibility of property forfeiture with regard to drug-related criminal offences (and some other) in the same way as with regard to especially serious property criminal offences, whereas the conviction of the offender for the life custodial sentence in not a condition (Section 58). The new wording says that court “impose” the sentence of property forfeiture, instead of “can impose” that, which means compulsory spirit of the sanction.

The Act № 313/2011 Coll., in effect from 1 November 2011\(^12\), specifies stricter sentences for offences committed by offenders in traffic under the influence of addictive substances. This concerns the criminal offence of endangering under the influence of addictive substance and criminal offence of causing death under the influence of addictive substance as driver of traffic vehicle. One of sentences for such criminal offences is the ban to perform activity. The new provision (Section 61) states

---

\(^7\) Ministry of Economy of the Slovak Republic 2011;  
\(^8\) Ministry of Economy of the Slovak Republic 2011;  
\(^9\) Act No. 224/2010 Coll., which changes and amends the Act No. 300/2005 Coll. as amended and on change and supplement of certain laws  
\(^10\) “... The court shall impose the sentence of forfeiture of property (...) if the offender is convicted for committing criminal offence of unpermitted production of narcotic and psychotropic substances, poisons or precursors, their keeping of trading with them pursuant to the Section 172 (2, 3, or 4) or Section 173,...”  
\(^11\) Act No. 262/2011 Coll., which changes and amends the Act No. 301/2005 Coll. Code of Criminal Procedure as amended, and which changes and supplements certain laws  
\(^12\) Act No. 313/2011 Coll., which changes and amends the Act No. 8/2009 Coll. on Road Traffic and on change and supplement of certain laws as amended and which changes and supplements certain laws
that in case of repeated committing of some of the said criminal offences (i.e. if the person was convicted for such criminal offence before), the sentence of ban of activity in the upper half of sentence rate should be imposed, which is for these criminal offences 1 – 10 years; the sentence from the upper half of the sentence rate is imposed also in case of juveniles, where the upper limit is 5 years. In case of yet another conviction, the life sentence of ban of activity shall be imposed, for juveniles for 7 to 15 years. The expungement of record does not have any impact on the imposition of these sentences. Also in case of these criminal offences, if it concerns the ban of driving any motor vehicle and if the offender has already been convicted for the same criminal offences during the last 10 years, and conditional discharge of the remaining sentence of ban of activity is not possible.

Sentences for performance of employment or other activity in condition excluding qualification, which could endanger life or health of people or cause significant damage on property were also made stricter – the offender can be sentenced to custody for as long as one year\(^\text{13}\). The same sentence can be imposed on the offender if s/he refuses to undergo examination for determination of addictive substance by breath test or orientation testing instrument, or medical examination by blood sampling and examination or examination of other biological material for presence of an addictive substance.

### 1.1.4 Other Legislative Changes

The Government of the Slovak Republic passed on 12 January 2011 by the resolution № 1 the draft of bill on the cancellation of the Anti-Drug Fund, which has been applied by the Act № 121/2011 Coll., subsequently after negotiation in the National Council of the Slovak Republic, with effect from 1 May 2011. The Act stipulated in addition to the cancellation of the fund also the position of fund adjuster (liquidator) and the time procedure of the liquidation.

Based on the amendment of the Act № 575/2001 Coll. On the government activity organisation and on organisation of the central state administration, competencies of the Deputy Prime Minister were strengthened in the field of human rights, rights of ethnic minorities, equal treatment and gender equality; drug policy was exempted from his powers.

### 1.2 Other drug policy developments

As a measure towards more flexible reaction to development of new synthetic substances, especially in relation to products available free-for-all via Internet or in regular Crazy shops, Slovak Government has approved the proposal that allows narcotic and psychotropic substances to be scheduled for the list of controlled substances in a form of a direction of the Government (and not through an amendment of the act). This would make the process faster and easier. Ministry of Health takeovers control over this proceeding\(^\text{14}\). Amendment of the act on narcotic and psychotropic substances has not been submitted until the middle of 2012.

\(^{13}\) Section 289 – endangering under the influence of an addictive substance

\(^{14}\) Inter-departmental working group has been created, composed of representatives of the Police Corps, ministry of health, ministry of economy, Custom Crime Office, State Institute for Pharmaceuticals Control, Chamber of Pharmacists and Centre for Treatment of Drug Dependencies Bratislava.
Health Care Committee of the National Council of the Slovak Republic discussed information concerning protection from intrusion of unregistered narcotic and psychotropic substances to Slovakia in May 2011, and bound, by its resolution № 55/2011, the Minister of Health to submit, in cooperation with ministry of economy, ministry of interior and ministry of justice, a proposal of system measure by 31 September 2011.

1.3 Political and Institutional Frame of Anti-Drug Policy

National Anti-Drug Strategy for years 2009 - 2012


The NADS as the basic tool for solving drug-related problems represents a set of measures taken at international, national and regional level. According to the report, the NADS can be in comparison with EU member states included among standard programmes within EU member states.

1.3.1 Interim Assessment of the Application of Strategy and Framework Action Plan for Years 2009-2010

Interim assessment of the National Antidrug Strategy implementation has been based on reports by respective departments – members of the Board of Ministers (until it was cancelled). These reports are descriptive, and summarize fulfilment of tasks in scope of central bodies of the state authority. Another important source for evaluation report were data of the National Monitoring Centre for Drugs and its annual report on the state of drug problem in Slovakia. Compilation of the report is a duty for Antidrug Strategy Coordination Department.

International conventions and principles of international cooperation and coordination in the area of control of illegal drug and their precursors production, restricting the illegal production and trading in drugs, were respected. The attention was focused on programmes for reduction of demand and offer of drugs, programmes of healthcare for addicted individuals, risk groups. The Slovak Republic supported by achieved results of implemented anti-drug policy in relation to adopted conclusions and documents of UNO and EU the significance of international coordination of anti-drug strategy.

According to the assessment report of NADS, the priority for the coming period remains to focus attention at the area of demand reduction. Problems related to the economic crisis cause difficulties and the sense of uncertainty among the weakest groups of population and often lead to risk behaviour, increase of drug consumption, or growth of drug-related criminal activities. Expenses for services and measures for the prevention of drug abuse are being decreased by means of various budget restrictions and they can thus negatively impact also the risk to the public health, social policy, enforcement of law and overall safety of the society. Part of ministries continues to have reserves in creation, implementation and evaluation of ministerial and regional strategies and policies and achieved results. The requirement for the

15 NADS 2009 – 2012
support of approach based on expanding knowledge and information about the drug phenomena, understanding risks, consequences and needs related to their use for the public health and health of the individual and the process of assessment of adopted objectives and aims of the anti-drug strategy has therefore prominence.

### 1.3.2 Crime prevention

Conceptual framework of crime prevention for period 2011 to 2014\(^\text{16}\) implies finalization of system and content of crime prevention at national, regional and local levels. Basically, each of following crime prevention priorities, which are starting point for creation of strategies of central bodies of state administration and for regional programs, relates to drug problem:

1. reduction of crime rate and crime severity as well as of other antisocial activities (especially major and organised criminal activity; drug trafficking; computer crime, human trafficking; sexual abuse of children and child’s pornography; economic crime and criminal activity related to property; arms trafficking; over-the-border crime; violence against women);

2. improvement of safety within cities and towns (inclusion of crime prevention ideas into the development concepts; improvement of quality of social relationships; increase security of residents and visitors);

3. elimination of socio-pathological phenomena in risk groups (children and youth endangered by the crime and socio-pathological phenomena; family; seniors; socially excluded communities, i.e. unemployed, homeless, disabled, released from prisons, first-time-offenders; recidivists).

### 1.3.3 Other programmes and strategies

A new act was adopted by the National Council of SR in September 2011 on tobacco products that was focused on production of tobacco products, their location on the market and labelling, as well as more precise specification of organisation, operation and competencies of tobacco regulation authorities.

In November 2011, government adopted, by its resolution № 763/2011 a new National Tobacco Control Action Plan for period 2012-2014. It is aimed to improve condition towards:

- Prevention of smoking in schools (including universities), in health care facilities and in facilities of social services;
- Control of smoking in public places;
- Control of content and composition of tobacco products;
- Consultant services network for weaning away smoking;
- Education in schools through edition of methodological guidelines for educationists, parents and children;
- Research on prevention measures effectiveness, especially evaluation of legislation adopted through public opinion surveys.

Document contains tasks for particular state departments.

In December 2011, government adopted, by its resolution № 797/2011, Update of the National Programme of Health Promotion. As the main objective, long-term health

\(^{16}\) Report on crime prevention strategy implementation
promotion of population is stated in the Slovak Republic, by elimination of health disorders that reduce the quality of life and attempt early the human life. Within the first area, Preventive Measures Oriented to Chronical Uninfecitious Diseases Reduction, part C of the document, named “Tobacco, Alcohol, and Drugs” addresses harmful and excessive use of mainly tobacco and alcohol. Main objectives of this part are:

- To improve effectiveness of preventive measures against consumption of alcohol, tobacco and drugs in youth;
- To reduce harms from smoking, excessive alcohol drinking and drug use;
- To improve availability of information about extent of harms due to smoking, excessive alcohol consumption and drug use and on effective interventions to reduce such harms;
- To pay attention to selected groups of population in risk (children, adolescents, women of fertile age, pregnant and nursing, as well as groups of populations living in areas of concentrated poverty and social exclusion)
- To increase common awareness on scope and nature of health related, social and economic problems caused by harmful alcohol and tobacco use and drug use, and to take relevant measures to address these issues.

1.4 Coordinatio

1.4.1 Coordination at the National Level

One of preconditions for the fulfilment of NADS objectives is the improvement of activity of decisive tools for its execution. Executive coordination bodies of the anti-drug policy underwent a significant change in years 2010-2012.

Until the parliamentary elections in June 2010 and follow-up change of competencies of central state administration bodies, the Deputy Prime Minister for epistemic society, European affairs human rights and minorities, was responsible for creation and implementation of Slovak Government drug policy. He also led specialised counselling body – the Board of the Ministers for Drug Addictions and Drug Control

Executive unit for the Board routine operation was the General Secretariat of the Board of Ministers for Drug Addictions and Drug Control, incorporated into the organisational structure of the Government Office. Establishing of the specialised governmental board, Slovakia ranked among those member states of the European Union, where drug policy was coordinated at the political level.

In the second half of 2010, coordination arrangement changed, based on amendment of the Act No 575/2001 on organization of activities of the Government and bodies of central state authority. This was followed by lowering of the number of counseling entities for the Government in order to make their activities and outcomes more effective.

The drug issue has dropped out of the agenda of the Slovak Republic Government vice-chairman for human rights and minorities; part of competences, especially management of transformed structures, passed to the scope of competence of the

---

17 Such model of coordination has been entrenched in 1995. The Board was coordination, initiative, consultation and control instrument of the Government of the Slovak Republic, in the scope of power of the deputy prime minister. The board consisted of 12 ministers of the Slovak Government and a representative of General Attorney of the Slovak Republic.
Head of the Government Office of the Slovak Republic. The resolution of the Slovak Republic Government № 135 of 2 March 2011 about the proposal of statute of the ministerial board and proposal for cancellation of certain advisory bodies of the Slovak Republic Government cancelled the advisory body of the Slovak Republic Government for drug issues – the Committee of Ministers for Drug Addiction and Drug Control established by the Slovak Republic Government in 1995. The new body – Ministerial Council\(^\text{18}\) was meant to take over its competences on the grounds of the same resolution. This advisory, consultation, initiative body of the Slovak Republic Government should coordinate the fulfilment of tasks at the national level in matters of drug issues arising from international treaties, which bound the Slovak Republic on the grounds of its membership in the European Union and in international organizations in compliance with the anti-drug policy and strategy of the European Union. The head of the Ministerial Council is the Prime Minister and the Council replicates by composition the Government of the Slovak Republic\(^\text{19}\).

After the governmental crisis in autumn 2011, a new government has arose from parliamentary elections in March 2012. Neither the co-ordination role of the Deputy Prime Minister responsible for drug policy has not been re-established, however, nor specialised inter-ministerial advisory body for drugs affairs.

### 1.4.1.1 Antidrug Strategy Coordination Department

Also, General Secretariat of the Board of Ministers overpassed changes, within reorganisation of the Government Office. Formerly incorporated as an autonomous department within the Government Office, belonging by the content to the sector of Deputy Prime Minister – though in operative matters governed by the Head of the Government Office – General Secretariat, with its whole agenda fell later into the direct management power of the Head of the Government Office as the Antidrug Strategy Coordination Department (ASCD). Since 1 July 2011 it has been incorporated into the Section of the Foreign Cooperation. In addition to drug field, the section within its other departments coordinates and carries out programming, implementation, monitoring and evaluation of the foreign (Norwegian, Swiss) financial mechanisms.

ASCD was responsible for realisation of drug policy of the government. The head of the department was a director who was by his/her function also the national drug coordinator.

ASCD consisted of following divisions:

1. Division of national antidrug strategy – at the national level ensured coordination of the national antidrug strategy realisation. It participated on development of coordination of and cooperation with regional self-administration authorities and with local state authorities. This activity was, however, limited by the absence of partnership structures at regional level – drug prevention coordinators\(^\text{20}\) that became extinct in 2007.


\(^{19}\) Position, composition, key tasks and proceedings of the Ministerial Council are regulated by the Statute of the Ministerial Council, adopted by the resolution of the Slovak Government No. 135 of 2 March 2011

\(^{20}\) At each regional office, a drug prevention coordinator had acted – 8 coordinators in total. They were coordinating activities of different subjects in the field of drug prevention, drug treatment, resocialization and law enforcement in their regions.
2. Division for foreign relations – fulfilled tasks of antidrug policy of the Slovak Republic Government towards international bodies, organisations and institutions relevant to drug problem and drug control. It ensured international communication, initiated and facilitated information transfer among governmental sectors and corresponding international bodies.

3. Division National Monitoring Centre for Drugs - still operates as the national focal point of the international drug network REITOX, carrying on by the EMCDDA. Key tasks of NMCD are to monitor situation concerning controlled psychoactive substances in Slovakia, and coordination role within national drug information system.

With the change of the government, also Headquarters of the Government Office of the Slovak Republic has changed and introduced a new policy toward the organisational structure of the Office. According to this new approach, all activities that are not directly connected with services for the government, should be avoided. Organisational entities that are carriers of these activities are being transferred to other ministries and institutions.

At the end of April, ASCD has been transformed to a new department, called National Monitoring Centre for Drugs Department, with an idea behind to transfer “political” divisions to the Ministry of Health and to leave division NMCD in its original position and function at the Office structure. As a consequence, the staff of ASCD has been reduced by four persons, including the director. The head of NMCD has been appointed as a provisional director of the new body. Later on, during the year, the original idea has changed and NMCD has been decided to be transferred to the Ministry of Health too. Within the transfer negotiations, the staff has been reduced by the Government Office again, by two persons. These events have damaged seriously ability of the NMCD-department to fulfil its coordination function, especially in relation to the foreign drug policy issues. 31 October 2012, the government adopted the resolution № 610/2012 towards a proposal on transmission of competences in the area of drug policy and of drug situation monitoring in Slovakia that bring into effect the decision on NMCD-department transfer to the Ministry of Health, from the 1 January 2013.

1.5 Financing

One of preconditions for the fulfilment of NADS objectives is the provision of corresponding financial resources and creation of funding tools. Solution of the funding system is one of the most complicated tasks within EU and individual member states.

Neither NMCD nor ASCD have capacities to figure out societal costs, direct or indirect, related to drug use, according to definitions of EMCDDA.

Public expenditures represent only one part of societal costs, namely those in form of direct costs. These costs can be explicitly labelled as “drug related” and can be summarised from the final financial reports. Complications come when expenditures are not labelled as such but are incorporated into the financing of broader fields.

1.5.1 Inter-sectorial program of financing “Drug Policy”

The efforts of the General Secretariat of the Committee of Ministers for Drug Addiction and Drug Control (currently the Department of Coordination of the Anti-Drug Strategy of the Government Office of the Slovak Republic) has been focused
since 2007 on the creation of optimal funding tool in compliance with NADS for the period 2009 – 2010. An inter-ministerial programme “Anti-Drug Policy” has been created within the state budget by the resolution of the Slovak Republic Government № 308 of 29 April 2009. Pursuant to this resolution, the administrator of the inter-ministerial programme (the Government Office of the Slovak Republic) received the task to elaborate the preliminary draft for the creation of inter-ministerial programme together with its participants, members of the Committee of Ministers for Drug Addiction and Drug Control. The elaboration of the inter-ministerial programme proceeded in compliance with the methodical instruction of the Ministry of Finance of the Slovak Republic for the guidance of programme budgeting № 5238/2004-42 as amended by the Amendments № 1 and № 2. The result of activities of the work group is the draft of the inter-ministerial programme, in which 13 administrators of budget chapters had to participate (Government Office of the Slovak Republic, 11 ministries and General Prosecution of the Slovak Republic). Its inclusion into the state budget has been planned for 2011. Aims and activities described in individual sub-programmes of the inter-ministerial programme follow the current NADS. The inter-ministerial programme has been inserted in May 2010 into the database of the Budget Information System of the state budget. Due to changes in the government after parliamentary elections in June 2010 and subsequent reorganization of the Department for Coordination of the Anti-Drug Strategy and transformation of the Committee of Ministers for Drug Addiction and Drug Control, the inter-ministerial programme was not established in 2011. The precondition for the execution of the draft of the inter-ministerial programme is the performance of an analysis of expenses of central bodies of state administration directed to anti-drug policy and analysis of programme budgeting within consultations with individual ministries.

After the change of Government in June 2010 and subsequent conceptual, structural and organisational changes in 2011, inter-sectorial program “Drug Policy” did not come into practice. A structure of 13 keepers of budget headers remained preserved however in the database of Budgetary Information System of the State Budget also in 2001, when a new proposal was prepared with the start expected in 2012 and planned also for following years 2013-2014.

Expenditures for activities planned in subprograms are not a global representation of the extent of measures and tasks that are dealt by organisations of the central state administration as a part of drug strategy, because salaries are not included that are related to activities. Salaries are budgeted separately within State Budget. Another factor is current financial crisis and saving in departments; departments of health, culture, defence and foreign affairs did not allocate any amount for drug strategy realisation. Final overall amount allocated to inter-sectorial program Drug Policy will be known only after the 2012 State Budget approval.

1.5.2 Public expenditures “Drug Policy” at the Government Office of the Slovak Republic – subprogram 01

Subprogram 01 consists of two autonomous parts, namely:

1. Amount of financial resources allocated to maintenance of programmes, initiatives and activities of National Drug Strategy through state subsidies from the State Budget, and

2. Financial resources from the State Budget for financing of special activities of the National Monitoring Centre for Drugs, together with EMCDDA’s grant resources.
Total amount in subprogram 01 is represented by the sum of 949,029 EUR in 2010.

1.5.2.1 State subsidies schedule

The Government Office of the Slovak Republic provided in years 2009 and 2010 for the support of programmes, initiatives and activities in the area of the National Anti-Drug Strategy financial means by means of grant programme from the state budget\textsuperscript{21}. An amount of 1.5 million EUR was reserved in 2009, 980 thousand in 2010 and 515 thousand EUR in 2011.

1.5.2.2 NMCD activities

The second part of subprogram 01 represented costs for specific activities of the National Monitoring Centre for Drugs.

The activity in the area of monitoring was, also in 2011, performed from EU grant and state budget means, for the said year in total amount of 366,879 EUR from which the contribution of the state budget represented – according to the grant agreement with the EMCDDA – an amount of € 120,357 and valorised contribution from EMCDDA (2 %) an amount of € 103,173. The rest of financing comes from previous years.

According to the audited final financial report of January 2011, eligible costs in 2010 were 309,826 EUR in total.

\textsuperscript{21} An amount of € 1.5 million was reserved in 2009; 980 thousand in 2010; 500 thousand for 2011
2 DRUG USE IN POPULATION

Drug use in general population (General Population Survey - GPS) is one of five EMCDDA’s key indicators that is used to describe the state in the use of legal and illicit substances. The scope and method of the use of different drugs in general population (usually at the age of 15-64 or in specific age groups and/or cohorts), the opinions and attitudes to drug use within different population groups are investigated through surveys applying standard sociologic and psychological methods (standardized questionnaires, face-to-face interviews, telephone interviews and via the Internet – on-line) . For data comparison both within Europe and globally, the European Monitoring Centre for Drugs and Drug Addiction recommends that the GPS indicator contains data formulated in the so-called European Model Questionnaire (2002). For each psycho-active substance (including tobacco and alcohol) EMQ detects the basic variables: Prevalence, the age of first contact with drug, frequency of use (or the quantity of consumed drug).

In the Slovak Republic, these criteria were met to a great extent by population surveys for drug use conducted by the Institute for Public Opinion Research at the Statistical Office of the SR (hereinafter referred to as the PORI at the SO). After the cancellation of the PORI, population surveys passed under the sponsorship of NMCD, which in 2009 ensured a pilot survey in the Bratislava Region, applying a modified questionnaire identical with EMQ in relevant variables. At the end of 2010, the first national survey was carried out.

Other representative - both schools – surveys Tobacco-Alcohol-Drugs (TAD) and the European School Survey Project on Alcohol and Other Drugs (ESPAD) in certain variables are compatible with EMQ in terms of the content. In Slovakia, TAD was organized for the fifth time in 2010, and as usual preceded the fifth ESPAD cycle. The NMCD participated in both surveys financially in the long term and with professional capacities through the main researcher - the principal investigator.

The third representative school survey which was organized for the second time in Slovakia is an international project HBSC (Health Behaviour in School Aged Children. It maps the behaviour of school-aged children related to health and among others, forms that may affect health is smoking, alcohol and marijuana consumption. The research is beyond the sphere of authority of NMCD.

Other surveys being carried out in Slovakia differ in investigation methods and target groups. Their aim is to map the situation and estimate the use of psycho-active substances in certain age segments of population, also with respect to different possible co-acting factors and declare recommendations for specific preventive measures.

In this chapter we briefly summarize certain data from surveys which were carried out in order to estimate the use of psycho-active substances in general population (NMCD 2010), population of pupils and students (TAD 2010, HBSC 2010 and ESPAD 2011). All of the surveys stated herein signal stabilization in Slovakia in

---

22 In 2011, a Slovak version of the Annual Report on the state of drug problem in Slovakia was not published. The key information except data from the ESPAD 2011 have already been published in the English version of the 2011 Report
the period of 2009-2011 regarding the use of the most common illicit drug – marijuana in different age groups and some other drugs as well.

2.1 Drug Use in General Population

2.1.1 Prevalence of Drugs, Alcohol and Smoking – NMCD 2010 Survey

After cancellation of the PORI at the SO SR (2009), which conducted population surveys in two years intervals from 1994, the NMCD undertook to follow up the surveys. After a pilot survey in the Bratislava region in 2009 (A 2010 Report, Chap.2.1) applying a modified23 questionnaire, at the end of 2010, they succeeded to renew the national scope of population survey (A 2011 Report, Chap.2.1). A public opinion survey and survey for the use of psycho-active substances in general population entitled “Prevalence of Drugs, Alcohol and Smoking” was conducted for the client the National Monitoring Centre for Drugs, by TNS SK, s.r.o24. The sample included 4055 respondents who represented the basic sample of Slovak population aged 15 – 64 years regarding quotas.

Information on the use of psychoactive substances in different age groups in 2010 were given in a standard table ST 01.

---

23 NMCD modified the questionnaire on the basis of the original questionnaire of the IPOS at the SO SR, in particular in the module “Illicit drugs” harmonized with the European model questionnaire

24 A TNS Report, 2010
According to this survey, in 2010, the most frequently consumed psychoactive substances were: 1. alcohol, 2. tobacco 3. marijuana. The fourth place belongs to medicaments – sedatives and tranquillizers without prescription (Šteliar et al.2012), followed by ecstasy.

For the comparison of trends in the development we state that the identical order of psychoactive substances was reported in the survey of the IPOS at the SO in 2006. In certain cases there was a slight drop – e.g., LTP of marijuana by almost 6%, however, at least according to the comparison of data in 2006 and 2010 we can speak about stabilization in the consumption of psychoactive substances on the level of lifetime prevalence – used sometimes in life - in the whole sample of 15-64 (Table 2.1.2), and also in the subgroup of 15-34 years old young adults (Table 2.1.3).

Over the course of four years (2006 - 2010), a change occurred in the prevalence of cannabis consumption, in the entire sample of 15-64 years aged (Figure 2.1.1) and also in the group of young adults aged 15-34 years (Figure 2.1.2).

In the group of the youngest respondents aged 15-24 years, the difference in cannabis consumption figures for 2010 in comparison with 2006 was almost 10% in LTP, in LYP 9% and 2% in LMP (ST 01 2006 and ST 01 2010).
Table 2.1.2: Prevalence LTP in 2010 and 2006 in the sample of 15-64 aged. Source of data ST 01 2010, ST 01 2006, NMCD 2010

<table>
<thead>
<tr>
<th>LTP lifetime prevalence %</th>
<th>15-64</th>
<th>2006</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Any illicit drug including marijuana</td>
<td>26</td>
<td>20.09</td>
<td></td>
</tr>
<tr>
<td>2. Cannabis (EMQ)</td>
<td>16.1</td>
<td>10.49</td>
<td></td>
</tr>
<tr>
<td>3. Opioids (total)</td>
<td>na</td>
<td>0.96</td>
<td></td>
</tr>
<tr>
<td>4. Heroin (EMQ)</td>
<td>0.9</td>
<td>0.27</td>
<td></td>
</tr>
<tr>
<td>5. Other opioids</td>
<td>na</td>
<td>0.74</td>
<td></td>
</tr>
<tr>
<td>6. Cocaine (total, including crack (EMQ)</td>
<td>1.2</td>
<td>0.61</td>
<td></td>
</tr>
<tr>
<td>7. Amphetamines (EMQ)</td>
<td>1.2</td>
<td>0.53</td>
<td></td>
</tr>
<tr>
<td>8. Ecstasy (EMQ)</td>
<td>4.3</td>
<td>1.86</td>
<td></td>
</tr>
<tr>
<td>9. Hallucinogens (total)</td>
<td>1.2</td>
<td>1.26</td>
<td></td>
</tr>
<tr>
<td>10. LSD (EMQ)</td>
<td>na</td>
<td>0.43</td>
<td></td>
</tr>
<tr>
<td>11. Other hallucinogens</td>
<td>na</td>
<td>0.96</td>
<td></td>
</tr>
<tr>
<td>12. Sedatives and/or tranquillizers (EMQ)</td>
<td>9.5</td>
<td>9.84</td>
<td></td>
</tr>
<tr>
<td>12. Solvents or inhalants</td>
<td>1.7</td>
<td>1.37</td>
<td></td>
</tr>
<tr>
<td>13. Anabolic steroids</td>
<td>na</td>
<td>1.5</td>
<td></td>
</tr>
<tr>
<td>14. Alcohol (EMQ)</td>
<td>90.08</td>
<td>91.01</td>
<td></td>
</tr>
<tr>
<td>15. Tobacco (EMQ)</td>
<td>59.8</td>
<td>60.47</td>
<td></td>
</tr>
<tr>
<td>16. Pervitin</td>
<td>na</td>
<td>1.36</td>
<td></td>
</tr>
<tr>
<td>17. Products from smart shops and crazy shops</td>
<td>na</td>
<td>1.22</td>
<td></td>
</tr>
</tbody>
</table>

Table 2.1.3: Prevalence LTP in 2010 and 2006 in the sample of 15-34 aged. Source of data ST 01 2010, ST 01 2006, NMCD 2010

<table>
<thead>
<tr>
<th>LTP lifetime prevalence %</th>
<th>15-34</th>
<th>2006</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Any illicit drug including marijuana</td>
<td>36.9</td>
<td>25.7</td>
<td>6</td>
</tr>
<tr>
<td>2. Cannabis (EMQ)</td>
<td>28.6</td>
<td>18.7</td>
<td>9</td>
</tr>
<tr>
<td>3. Opioids (total)</td>
<td>na</td>
<td>1.35</td>
<td></td>
</tr>
<tr>
<td>4. Heroin (EMQ)</td>
<td>1.8</td>
<td>0.61</td>
<td></td>
</tr>
<tr>
<td>5. Other opioids</td>
<td>na</td>
<td>0.86</td>
<td></td>
</tr>
<tr>
<td>6. Cocaine (total, including crack (EMQ)</td>
<td>2</td>
<td>1.14</td>
<td></td>
</tr>
<tr>
<td>7. Amphetamines (EMQ)</td>
<td>2.4</td>
<td>1.16</td>
<td></td>
</tr>
<tr>
<td>8. Ecstasy (EMQ)</td>
<td>8.4</td>
<td>3.51</td>
<td></td>
</tr>
<tr>
<td>9. Hallucinogens (total)</td>
<td>2.7</td>
<td>2.32</td>
<td></td>
</tr>
<tr>
<td>10. LSD (EMQ)</td>
<td>na</td>
<td>0.80</td>
<td></td>
</tr>
<tr>
<td>11. Other hallucinogens</td>
<td>na</td>
<td>1.81</td>
<td></td>
</tr>
<tr>
<td>12. Sedatives and/or tranquillizers (EMQ)</td>
<td>8</td>
<td>7.52</td>
<td></td>
</tr>
<tr>
<td>12. Solvents or inhalants</td>
<td>na</td>
<td>2.20</td>
<td></td>
</tr>
<tr>
<td>13. Anabolic steroids</td>
<td>2.4</td>
<td>2.33</td>
<td></td>
</tr>
<tr>
<td>14. Alcohol (EMQ)</td>
<td>89.7</td>
<td>87.3</td>
<td>6</td>
</tr>
<tr>
<td>15. Tobacco (EMQ)</td>
<td>58.8</td>
<td>58.5</td>
<td>5</td>
</tr>
<tr>
<td>16. Pervitin</td>
<td>na</td>
<td>2.79</td>
<td></td>
</tr>
<tr>
<td>17. Products from smart shops and crazy shops</td>
<td>na</td>
<td>2.09</td>
<td></td>
</tr>
</tbody>
</table>

Note: na – non available, in 2006 they were not monitored
2.1.2 Flash Eurobarometer 330 - 2011

A stabilization trend in cannabis consumption in the identical 15-24 age group in Slovakia signalled also data from a Flash Eurobarometer 330 survey (June 2011). Despite the stabilization the current figures for LTP and LYP of cannabis were higher than the EU average; LTP SK 16.1% > EU 12.2% and LYP SK 10.3% > EU 7.6%. An exception was a higher figure of the variable LMP - current consumption - in the last month/30 days in the group of 15-24 year-old Europeans 6.2% > 4.3% in comparison with Slovak respondents of identical age. This prevalence LMP corresponds to the value discovered in the survey of NMCD GPS 2010; LMP cannabis in the group of 15-24 year-olds = 4.3%.
2.1.3 Tobacco-Alcohol-Drugs TAD 2010

Similar stabilization trend in the use of illicit drugs and smoking was claimed also by Nociar (2010) according to data on TAD 2010 school survey in comparison with the results of TAD 2006 in the group of 11-19 year-old school children (e.g., in case of marijuana, there is a drop of 3 percentage points).

2.2 Drug use in schools

2.2.1 European School Survey Project on Alcohol and Other Drugs ESPAD 2011

The aim of the European School Survey Project on Alcohol and Other Drugs (ESPAD) is to collect comparable data on psychoactive drug use among 15-16 year-old students in Europe. Surveys allow the monitoring of trends both within particular countries and comparing particular countries. Up till now five ESPAD survey cycles have been carried out; the first study in 1995 in 26 countries, the last one - fifth – cycle of surveys in 2011 even in 36 countries or regions, the Slovak Republic participated in all ESPAD survey cycles.

2.2.1.1 The fifth cycle of the international school survey project ESPAD in Slovakia

was conducted in April 2011 (a field stage). The ESPAD’s questionnaire was applied here – just like in the previous cycles - for the research of a wider age group than the age cohort of 16 year old students whose data are passed to an international comparison. In Slovakia, 11,270 school children and students aged 15-20 from among 110 randomly selected elementary schools (9th Year/grade) and secondary schools (1st - 4th Year/grade) participated in the ESPAD 2011 survey. 11,136 anonymous questionnaires got into the final processing.

Figure 2.2.1 shows the order of psychoactive substances, which was most frequent among the respondents of this age group as a whole (LTP). The dominance of marijuana is evident - 40.4% (in 2007 = 44.2%).
Parallel use of certain substances was investigated as well – i.e. whether respondents used a psychoactive substance in the last year/12 months (LYP) and in the last month /30 days (LMP). All prevalence data for such drugs are shown on Figure 2.2.2

Figure 2.2.2: Prevalence of cannabis, volatile substances and ecstasy in the 15-20 years aged sample – Nociar, 2011
When comparing the figures from ESPAD 2007 and ESPAD 2011 among 16 year-old Slovak students, a stabilization in the use of marijuana was confirmed also by an international comparison among 16 year-old students (the size of Slovak sample N=2009). A comprehensive ESPAD 2011 report claimed in a representative sample frame of 16 year-old Slovak students higher levels of variables than the ESPAD 2011 average. Thus it seems that the combination of the three - smoking, drinking of alcohol and experience with marijuana in this 16 year-old cohort is considerably extensive (ESPAD 2011, p.118). Heavy episodic drinking during the past 30 days (50% vs. 38% ESPAD average) is also above the ESPAD average (Figure 2.2.3). On the other hand, when comparing development trends represented by data from the previous cycles of surveys (in particular, ESPAD 2007 and ESPAD 2011, there was a stabilization in the consumption of marijuana (Figure 2.2.4).

Figure 2.2.3: Comparison of data for 16 year-old Slovak students with average data for ESPAD 2011 in main variables. (Source: Summary of key data ESPAD 2011, 31 May 2012).

---


---
Figure 2.2.4: Developments in the prevalence of parallel use in particular cycles of ESPAD surveys among the age 16 group in “Used in last 360 days“ (LMP) use of alcohol, cigarettes, marijuana (source: The 2011 ESPAD Report, The 2007 ESPAD Report)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>LMP alcohol</td>
<td>53</td>
<td>60</td>
<td>63</td>
<td>63</td>
<td>60</td>
</tr>
<tr>
<td>LMP cigarettes</td>
<td>27</td>
<td>37</td>
<td>37</td>
<td>37</td>
<td>39</td>
</tr>
<tr>
<td>LMP marihuana</td>
<td>3</td>
<td>6</td>
<td>10</td>
<td>11</td>
<td>9</td>
</tr>
</tbody>
</table>

2.2.2 Health Behaviour of School Children

In an HBSC 2009/2010 survey\textsuperscript{26}, (N=1568) at an average age of 15.46 years, 21% of boys and 12% of girls have some experience (LTP) with marijuana. Use in the past month was declared by 9% boys and 3% girls. In comparison\textsuperscript{27} with data from the previous cycle of HBSC 2005/2006 survey, there is a slight drop or stabilization in experimenting with marijuana. HBSC results were consistent with the results of ESPAD.

\textsuperscript{27} A 2009 Report
Table 2.2.1 Lifetime use of cannabis in the ESPAD (2011) and HBSC (2009/10) surveys. LTP among boys and girls a), \( r_{xy} \) and Spearman’s rank correlation coefficient (\( r_{rank} \)). Source: ESPAD 2011 Report p.59

<table>
<thead>
<tr>
<th>Country</th>
<th>ESPAD</th>
<th>HBSC</th>
<th>ESPAD</th>
<th>HBSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>France</td>
<td>39</td>
<td>30</td>
<td>39</td>
<td>24</td>
</tr>
<tr>
<td>Slovak Republic</td>
<td>31</td>
<td>21</td>
<td>23</td>
<td>13</td>
</tr>
<tr>
<td>Belgium (Flanders)</td>
<td>28</td>
<td>23</td>
<td>21</td>
<td>17</td>
</tr>
<tr>
<td>Estonia</td>
<td>29</td>
<td>27</td>
<td>19</td>
<td>18</td>
</tr>
<tr>
<td>Latvia</td>
<td>29</td>
<td>30</td>
<td>19</td>
<td>21</td>
</tr>
<tr>
<td>Poland</td>
<td>28</td>
<td>24</td>
<td>18</td>
<td>14</td>
</tr>
<tr>
<td>Lithuania</td>
<td>25</td>
<td>29</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>Italy</td>
<td>24</td>
<td>23</td>
<td>18</td>
<td>16</td>
</tr>
<tr>
<td>Hungary</td>
<td>21</td>
<td>19</td>
<td>18</td>
<td>12</td>
</tr>
<tr>
<td>Croatia</td>
<td>21</td>
<td>16</td>
<td>14</td>
<td>11</td>
</tr>
<tr>
<td>Ireland</td>
<td>22</td>
<td>18</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td>Denmark</td>
<td>22</td>
<td>16</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>Ukraine</td>
<td>15</td>
<td>18</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Finland</td>
<td>12</td>
<td>11</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Iceland</td>
<td>13</td>
<td>12</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Greece</td>
<td>12</td>
<td>11</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Norway</td>
<td>6</td>
<td>7</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

\( r_{xy} = 0.89 \) \( r_{xy} = 0.89 \) \( r_{rank} = 0.90 \) \( r_{rank} = 0.88 \)

A similar correlation was found out also for LMP (ESPAD 2011 Report, p. 59)

2.2.3 Surveys of the Institute of Information and Prognoses of Education consumption of legal and illicit drugs between 1995 and 2009

Annual surveys of the Institute of Information and Prognoses of Education between 1995 and 2009 reported a trend of permanent growing experience with illicit drugs among respondents aged 15-26. In 1995, 18% respondents admitted their experience with an illicit psychoactive drug, whereas in 2009 - which is the last year of survey yet - it was almost one third, 30.1%. For the whole 15 year-long period

\[28\] Repeated surveys of the Institute of Information and Prognoses of Education (hereinafter: the IIPE) in 2010, the Institute analysed in detail data obtained on a yearly basis over the course of 15 years.\[28\] A representative sample consisted of roughly 900 respondents aged 15-26 years and the basic research method was a questionnaire compiled in 1995, which was modified on a yearly basis and extended by issues allowing continuous monitoring of significant parts; the questionnaire was administered to respondents individually by interviewers from a professional agency.
under review, the most frequent illicit drug was marijuana, but here was a change as well, when since 2000 there has been a drop of respondents who used marijuana as the first illicit drug and since 2002 also a decrease in LTP of marijuana as the most frequent drug. (A 2011 Report, p.43)

2.3 Drug Use among Certain Specific Groups or Environments on National and Local Level

2.3.1 Consumption of Legal and Illicit Drugs among Young People Living in Diagnostic and Re-education Centres

An IIPE’s survey was conducted in June 2011 as recurrent. In the preceding surveys (1998 and 2005) focused on the use of legal and illicit drugs among the clients of Diagnostic and Re-education Centres, which present special educational facilities in the school department. The target group of the survey is the endangered group - the reason for the placement into such re-education facilities are in most cases conduct disorders including experience with the use or abuse of psychoactive substances. As regards the interpretation of obtained data, similarly to surveys in the 15-26 year-old population, a group of respondents who do not have experience with drugs is compared with a group experimenting with drugs.

In 2011, in a survey Opinions and Attitudes of Young People Living in Diagnostic and Re-education Centres to Drug Consumption participated 292 respondents from eight re-education centres and three diagnostic centres in Slovakia, at the age of 15 - 19 years, among whom no mental handicap was diagnosed. 83.9% of respondents (245 persons) declared an experience with illicit drugs; 233 smoke daily and 125 declared that they are getting drunk regularly (Figure 2.3.1 Profile of RC residents/clients). In comparison with data from the previous surveys, in 1998 and 2005 there was a shift in the age limit of the clients of such re-education facilities, and today in dealing with educational problems younger clients need help - the shift is roughly 1 year, from 17 years to 16 years.

---

29 Pětiová, M. a kol. Názory a postoje mladých ludí žijúcich v diagnostických a reedukacných centrách ku konzumácii drog. UIPŠ, Bratislava 2011
The consumption of spirits is growing, 1998 21.3%, 2005 38% and 43.4% in 2011, and still there is a high share of daily cigarette smokers. The most frequent age at which the clients of diagnostic and re-education centres started to experiment with drugs was 13 and 14 years, and they were predominantly “younger” boys.

Experience with at least with one type of illicit drugs was declared by 244 respondents; 44.7% of respondents took four and more types of drugs. Smoking prevails – as much as 82.3% of respondents declared their experience with smoking of drugs; 16% had experience with intravenous application. In the range of tested drugs since 1998 there have been changes in the shares of most frequent drugs; marijuana remained the most frequently tried drug, in 2011 it’s followed by pervitin and relatively stable volatile substances.
Table 2.3.1: Overview of result from IIPE surveys among school pupils on drugs use prevalence.

<table>
<thead>
<tr>
<th></th>
<th>1998 Share %</th>
<th>2005 Share %</th>
<th>2011 Share %</th>
</tr>
</thead>
<tbody>
<tr>
<td>volatile substances</td>
<td>175</td>
<td>56.6</td>
<td>85</td>
</tr>
<tr>
<td>marijuana</td>
<td>279</td>
<td>90.3</td>
<td>208</td>
</tr>
<tr>
<td>pervitin</td>
<td>42</td>
<td>13.6</td>
<td>77</td>
</tr>
<tr>
<td>ecstasy</td>
<td>11</td>
<td>3.6</td>
<td>57</td>
</tr>
<tr>
<td>heroin</td>
<td>81</td>
<td>26.2</td>
<td>23</td>
</tr>
<tr>
<td>LSD</td>
<td>49</td>
<td>15.9</td>
<td>34</td>
</tr>
<tr>
<td>cocaine</td>
<td>37</td>
<td>12.0</td>
<td>22</td>
</tr>
<tr>
<td>pills</td>
<td>118</td>
<td>38.2</td>
<td>71</td>
</tr>
<tr>
<td>medicaments and alcohol</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>hashish</td>
<td>19</td>
<td>6.1</td>
<td>89</td>
</tr>
<tr>
<td>crack</td>
<td>2</td>
<td>0.6</td>
<td>21</td>
</tr>
<tr>
<td>mushrooms</td>
<td>N</td>
<td>N</td>
<td>50</td>
</tr>
<tr>
<td>other drug</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>not able to specify the substance</td>
<td>1</td>
<td>0.3</td>
<td>8</td>
</tr>
</tbody>
</table>

Note: Percentage figures are calculated from the total amount of answers given by respondents. N- Not identified

The clients of re-education centres experimenting with drugs earlier believed that they do not see much sense in life, so they live as they can. 50% are not happy with their stay in the facility and had experience with playing on slot machines, motivated to win money. Almost two thirds (59% out of 245) have declared frequent truancy. The reason was no interest in the lessons. A higher share was aware of the phenomenon of bullying, not only in the position of witnesses.

Respondents who tried the effects of drugs often did not have sufficient information on drugs or considered themselves informed and showed more interest in this issue than respondents with no experience with drugs, obtained information from friends and on the basis of own experience. A half (50.4%) would agree with the legalization of drugs in Slovakia. As much as 52.4% claimed to know a peer using drugs; from the school and family environment it was almost 10%. They had more contacts with addicts and as much as 91% had friends who had experience with the consumption of illicit drugs.

Pétiová (2011) highlights the importance of prevention in diagnostic and re-education centres. The staff of such types of re-education facilities often comes into
contact with young people who tried several types of drugs and can be drug addicts, and therefore it is important that teaching staff is prepared for such situations and able to help such persons not only in the physical but mainly in the mental aspect. In addition, it is necessary to create good free time (leisure) conditions for young people in RC and DC to satisfy the interests and needs of clients, which, on the other hand, could be reflected on their mental resistance and physical health and help them in integration into society without significant problems.

2.3.2 Investigation of the Use of New Psychoactive Substances

The situation related to the legal sale of unregistered psychoactive substances in the network of the so-called “Crazy shops” in Slovakia, and on the Internet at the end of 2010 caused many reactions in public and in the media (A 2011 Report). In 2011, the efforts to deal with the situation - prohibit trading in substances initiated an amendment of Act of the National Council of the SR №139/1998 Coll. on Narcotic Drugs and Psychotropic Substances and Preparations, as amended. It lists controlled substances in the appended schedules (in particular, Schedule 1) of Act on 38 psychoactive drugs including Mephedrone and synthetic cannabinoids with effect from 1 March 2011.

2.3.2.1 Before adopting the amendment – initiated to a great extent by the EWS reference point in NMCD - NMCD included in its questionnaire GPS 2010 in a set of psychoactive substances such substances as Spice, Mephedrone and products obtained in the Crazy shops at that time, which expanded into Slovakia from Poland. Respondents answered two questions, whether they know someone who uses Mephedrone, Spice and legal highs and whether they personally have ever tried these substances (Table 2.3.2 a Table 2.3.3).

---

30 A new psychoactive substance, a new narcotic or psychotropic drug in pure form or in a preparation, which is not controlled according to the 1961 United Nations Single Convention on Narcotic Drugs or to the 1971 United Nations Convention on Psychotropic Substances, however, may pose a comparable threat to public health as the substances listed in these Conventions (the Council Decision 2005/387/SVV).
Table 2.3.2: He/she knows a person who uses “legal highs”. Source of data: NMCD 2010, Marchevský P. 2011

<table>
<thead>
<tr>
<th></th>
<th>Sample 15-64</th>
<th>Sample 15-34</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Spice” Products</td>
<td>1.50%</td>
<td>2.50%</td>
</tr>
<tr>
<td>Mephedrone</td>
<td>0.80%</td>
<td>1.20%</td>
</tr>
<tr>
<td>Other legally purchased psychoactive substances (products from “smart shops, “legal highs”, “smart drugs”, Tvrdý Miša, Rýchly Lopéz…)</td>
<td>3.00%</td>
<td>4.60%</td>
</tr>
</tbody>
</table>

Table 2.3.3: Personal experience (LTP). Source of data NMCD 2010, Marchevský P. 2011

<table>
<thead>
<tr>
<th></th>
<th>15-64</th>
<th>15-34</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Spice” Products</td>
<td>0.3%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Mephedrone</td>
<td>0.00%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Other legally purchased psychoactive substances (products from “smart shops, “legal highs”, “smart drugs”, Tvrdý Miša, Rýchly Lopéz…)</td>
<td>0.7%</td>
<td>1.2%</td>
</tr>
</tbody>
</table>

In case of summation all three types of substances the LTP variable for “legal highs” in the group of 15-24 year-old respondents reached 2.75%.

2.3.2.2 In the Eurobarometer 2011\textsuperscript{31} survey 3.1% Slovak respondents aged 15-24 years declared, in May 2011, experience with this type of products (the EU 27 average was 4.8%). Almost one third of young Slovaks obtained the substance in specialized shops and another one third was offered it on a party or in a club, one third was offered it by friends.

2.3.2.3 The use of synthetic cannabinoids and Mephedrone was investigated also in the fifth cycle of school survey project ESPAD 2011 in Slovakia (Nociar, A.2011). In April 2011,\textsuperscript{32} 15 - 20 year-old respondents (N= 11 136) were interviewed about their experience with the products of Crazy shops containing synthetic cannabinoids and Mephedrone. The questionnaire contained also the business names of products such as Spice gold, Spice silver, Rýchly Lopéz, Tvrdý Miša, etc. LTP prevalence (lifetime prevalence) was discovered for synthetic cannabinoids 4.1% and Mephedrone 1.7%, which are figures for the whole sample. 3 out of 8 Slovak regions exceeded this nationwide average according to the data, in particular for synthetic cannabinoids: the Bratislava Region 7.9%/ or 1.8%, the Trnava Region 5.8%/ 3.9% and the Žilina Region 4.6%/ or 2% for Mephedrone. Two out of three regions – the Bratislava and the Trnava Regions appear to be problematic in the long-term context whether regarding the demand for drug or regarding the offer and observance of the law.

2.3.2.4 According to the results of face-to-face survey among a sample of visitors in the largest open air Bažant Pohoda festival,\textsuperscript{33} Tejová (2011) found out that in 2011, 75% of respondents (N=100) were aware of such products, and 18.7% of them

\textsuperscript{31} Flash Eurobarometer 330, June 2011
\textsuperscript{32} Effective amendment of Act of the National Council of the SR No.139/1998 Coll. on Narcotic Drugs and Psychotropic Substances and preparations, as amended
\textsuperscript{33} Pohoda festival started in 1997 and has gradually grown into one of the most visited multicultural open-air events in Slovakia, which is held at the beginning of summer holidays – in the first half of July.
had tried such products, and 17.3% had a positive attitude to such products. In July 2012, this benchmark survey was repeated in the Pohoda festival. Moreover, an identical questionnaire was, at the initiative of NMCD, placed on the website www.rastamama.sk.

The results of all three benchmark surveys on “new drugs“ were already presented at the 10th Slovak and 52nd Czecho slovak AT conference 34 in September 2012 and were impressed for professional audience.

Table 2.3.4: Data obtained on the awareness and experience with products from Crazy and Euphoria shops

<table>
<thead>
<tr>
<th></th>
<th>Pohoda 2011</th>
<th>Pohoda 2012</th>
<th><a href="http://www.rastamama.sk">www.rastamama.sk</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Investigation method</td>
<td>F2F questionnaire</td>
<td>F2F questionnaire</td>
<td>on-line questionnaire</td>
</tr>
<tr>
<td>N</td>
<td>100</td>
<td>121</td>
<td>109</td>
</tr>
<tr>
<td>Age range</td>
<td>18-40</td>
<td>16-40</td>
<td>14-50</td>
</tr>
<tr>
<td>Standard Deviation (SD)</td>
<td>SD±4.35</td>
<td>SD± 4.61</td>
<td>SD± 7.81</td>
</tr>
<tr>
<td>Has heard of shops</td>
<td>75%</td>
<td>74.40%</td>
<td>79.80%</td>
</tr>
<tr>
<td>N*</td>
<td>75</td>
<td>90</td>
<td>87</td>
</tr>
<tr>
<td>Has met with product</td>
<td>49.30%</td>
<td>38.90%</td>
<td>51.70%</td>
</tr>
<tr>
<td>Out of which - those who have seen</td>
<td>48%</td>
<td>38.90%</td>
<td>56.30%</td>
</tr>
<tr>
<td>- were offered it</td>
<td>12%</td>
<td>11.10%</td>
<td>16.10%</td>
</tr>
<tr>
<td>- have bought</td>
<td>12%</td>
<td>4.40%</td>
<td>28.70%</td>
</tr>
<tr>
<td>- have tried</td>
<td>18.70%</td>
<td>8.90%</td>
<td>42.40%</td>
</tr>
</tbody>
</table>

Note: N* represents the number of respondents who are aware of products from such shops.

As concerns respondents interviewed during both years of Pohoda festival, it was assumed that among the participants is an increased concentration of young people who are open to new experience (novelty seeking) on which the dealers of the given products focus. Tejová (2012) claims, however, that in comparison with the previous year there was a certain shift in respondents thinking (Figure 2.3.2) and it appears that experimenting with NPS on the basis of these data and in this segment of population drops (from 18.7% to 8.9%). The share of negative opinions has increased and the share of positive attitude towards new drugs has decreased.

---

34 Tejová M., Kara E. 2012 Nové psychoaktívne látky v rekreačnom a virtuálnom prostredí
Other data were obtained in an on-line survey when an identical questionnaire was published approximately for 8 weeks on the website www.rastamama.sk. The motive of the functioning of this website is more or less harm reduction - thus here a higher number of young people is expected who already have certain experience with drugs and could also have problems with their use, which finally to a certain extent confirmed an on-line survey CAST, in which roughly 80% of respondents (N=65) consuming marijuana admitted problems with memory and almost 70 % the family and the neighbourhood recommend to stop or at least reduce marijuana smoking (A 2011 Report).

Almost one fifth of these respondents had a positive opinion on products (Figure 2.3.2); more than one fourth has bought them and two fifths have used them (Table 2.3.4), which distinguishes this group as a whole from the respondents in Pohoda 2011 and Pohoda 2012 – recreational environment.
3 PREVENTION

3.1 Introduction, Definitions, Data Collection Tools and Background Information

From the early establishment of national drug strategies in Slovakia, prevention, with special emphasis on children and youth, was one of its essential pillars with a core responsibility of the Ministry of Education in collaboration with the Ministry of Health, Ministry of Labour, Social Affairs and Family, and the Ministry of Interior.

At different levels, it is of the nature of measures or interventions aimed at different target groups, starting from the general population (universal prevention) through vulnerable and endangered groups (selective prevention) to the more predisposed individuals requiring forms of indicated prevention in the environment of a school, community and family in order to prevent and avoid future problems.

However, the evaluation of the preventive interventions and programmes effectiveness, i.e. what and if it works at all, which should be an integral part and sine qua non, is rare. As in many other countries, this is particularly true at the level of universal prevention. This may be a result of various sectoral priorities, as well as the continued absence of prevention standards and a single framework. Lack of mutual awareness of subjects participating in prevention (including and especially civil society) and different interpretation of terminology concepts are other causes affecting the quality of prevention moving it to isolated activities.

Data and information in this chapter is updated for 2011, particularly with regard to the quantitative data from the sources of the Ministry of Education (Institute of Information and Prognosis of Education, Research Institute for Child Psychology and Pathopsychology), Ministry of Health (Public Health Authority), Ministry of Labour, Social Affairs and Family in terms of measures of social and legal protection of children and social guardianship and psychological services in this sector, and partially from the Ministry of Interior. They are supplemented by certain data from the subsidy schemes of the Government Office for the support of anti-drug activities and of the Crime Prevention Council of the Government.

The chapter is structured according to the scheme prescribed by EMCDDA. A limiting factor in the quality of information as well as their completeness is the fact that the documents supplied by cooperating institutions were, with few exceptions, compiled as descriptive reports on the activities of those institutions. The second reason is the lack of comprehensive information on this type of activities undertaken by non-governmental entities.

3.2 Environmental Prevention

Previous reports submitted by the National Monitoring Centre for Drugs (NMCD) have already contained (Chapter 1 or Chapter 3) existing legislative and other measures that are currently summarised under the category of environmental prevention strategies, i.e. (anti) alcohol and (anti) tobacco policies and other social and normative measures, especially in recreational environments and communities.
According to EMCDDA (Annual Report on the State of the Drugs Problem in 2012) and others\(^{35}\), the environmental prevention strategy is focused on the immediate change of a cultural, social, physical and economic environment, in which the individual can opt to use or not to use psychoactive substances.

The applicable legal framework in the Slovak Republic ensures regulating the availability of alcohol and tobacco in a public commercial network for minors – less than 18 years of age, being the age limit corresponding to reaching the legal capacity – a lawful age.

Control of the prohibition on the sale of tobacco, cigarettes and alcohol (and serving alcohol) to minor is performed mainly by the Slovak Trade Inspection, and in the event of violation of the prohibition, financial sanctions are imposed on retailers. General binding regulations issued by municipalities may adjust particularly the closing time of restaurants to local conditions and limit points of sale and so on, although such legal measures must be formulated in accordance with higher legislative standards. The latest measure of this kind is a generally binding regulation of the capital city of the Slovak Republic – Bratislava\(^{36}\) – limiting, from 1 November 2012, the sale of alcoholic beverages, particularly in terms of space and time.

Advertising of both substances in general and particularly with respect to minors (under 18) has been regulated since 1996. A special law regulates advertising on television and radio (a complete ban on advertising and sponsorship of tobacco products and cigarettes and a ban based also on a brand – advertising on alcohol except beer may be broadcast after 10 p.m.\). Regulation of advertising is supplemented by the advertising industry’s self-regulatory body – the Slovak Advertising Standards Council that, in its advertising code, has defined special requirements of advertising in relation to minors and of alcohol advertising.

Regarding other environmental measures in the Slovak Republic, they were and are, with respect to alcohol and tobacco, formulated explicitly in the two following strategic documents:

1) **The National Action Plan on Tobacco Control (under the jurisdiction of the Ministry of Health)** is based on the theme of the National Tobacco Control Programme (2007) and the National Action Plan on Tobacco Control for 2009-2010 (2008). It should improve (already existing) conditions in smoking prevention at all levels of schools, in hospitals and social service facilities, increase the control of smoking\(^{37}\) in public places and control of the contents of tobacco products, expand a network of advisory centres for stopping smoking in regional public health authorities and universities (including equipment for measurement of carbon monoxide, blood pressure, blood sugar, vital capacity, and other material and technical equipment). Just like up to the present, activities in relation to the World No Tobacco Day (31 May) will be implemented, for example carbon monoxide measurement outside busy shopping centres, popular exchanges of cigarettes for fruit, and the organisation of the Quit and Win competition.


\(^{36}\) Generally Binding Regulation No. 9/2012

\(^{37}\) In accordance with Act No. 377/2004 Coll. on the Protection of Non-smokers and on amendments and supplements to certain acts, as amended.
Considerable progress in the evaluation of prevention can be deemed a programmed survey\(^ {38} \) on the effectiveness of preventive measures in order to evaluate the effectiveness of approaches used and funds spent. The survey should cover in particular legislative measures to protect non-smokers, which were adopted in the past and whose effect can be assessed by public opinion polls.

In 2011, the draft amendment\(^ {39} \) to Act No 377/2004 Coll. on the Protection of Non-smokers and on amendments and supplements to certain acts, as amended, was presented to the Government. The amendment introduced a new definition of a shopping centre for legislation regulating smoking in the shopping centres (the individual operations in shopping centres – the so-called shopping malls, where smoking is allowed, are not structurally separated) as well as the extension of the smoking ban to the premises of primary and secondary schools, school facilities, preschools and playgrounds. Today, the relevant legislation applies only to the premises of primary schools, secondary schools, school facilities and pre-schools. The modification of the prohibition of tobacco products sale should apply to grocery stores, except for those that have earmarked maximum one point of sale or stand for selling tobacco products. At such point, even other products may be sold. Also the modification of sanctions was proposed – the increase of the minimum (EUR 3,319 instead of EUR 331) and the maximum (EUR 15,000 instead of EUR 3,319) amount of fines.

The Ministry of Education (after the methodology and educational materials on the problems of alcohol abuse) prepares the issue of an educational material – *methodology of tobacco smoking prevention*. It is a transfer of the international project called *Everyone Does That* together with the additional text entitled *Prevention in Schools*. As part of the development project Health in Schools\(^ {40} \), specific projects aimed at preventing smoking will be supported. The Ministry of Education, Science, Research and Sport will issue, through Pedagogical and Organisational Instructions, recommendations for the area of smoking prevention for each school year.

The Ministry of Economy of the Slovak Republic\(^ {41} \) (MoE SR) through its control body – the Slovak Trade Inspection – will continue to check as follows:

- Placing warning labels on consumer packaging of tobacco products leading to compliance with the ban on misleading advertising;
- Compliance with the ban on selling products imitating tobacco products by their shape and appearance or the ban on selling tobacco needs in the form of food products;
- Compliance with the ban on the sale of tobacco products and products intended to be smoked and containing no tobacco in places where the sale of such products is prohibited;

---

\(^ {38} \) Implementation of a two-year survey (2012-2014) on assessment of measures for protection of non-smokers and compliance with Act No. 377/2004 Coll. on the Protection of Non-smokers and on amendments and supplements to certain acts, as amended.

\(^ {39} \) In 2011 the draft amendment was not included in the programme of the meetings of the Government of the Slovak Republic.

\(^ {40} \) The Ministry of Education, Science, Research and Sport of the Slovak Republic.

\(^ {41} \) The Ministry of Economy of the Slovak Republic – the Slovak Trade Inspection – supervision of compliance with the relevant provisions of Act No. 377/2004 Coll. on the Protection of Non-smokers and on amendments and supplements to certain acts, as amended.
• The sale of tobacco products in grocery stores;
• Prohibition of the sale of tobacco products in a doorstep and distance selling;
• The ban on the sale of tobacco products in the form of piece sale;
• The ban on the sale of tobacco products through vending machines;
• Placing safety and health signs of smoking bans and information where and which supervisory authorities a notice of violation of the smoking ban may be filed with;
• Checks of information in stores about prohibiting the sale of tobacco products to persons less than 18 years of age.

Economic measures – Since October 2012, prices of tobacco and cigarettes have increased, representing a growth by about EUR 0.10 per pack of cigarettes. The minimum tax rate on cigarettes has risen to EUR 91 per thousand pieces. The increase was justified by the need to consolidate public finances and is enshrined in the amendment to the Act on the Excise Duty on Tobacco Products.

2) The National Action Plan for Alcohol Problems (in the jurisdiction of the Ministry of Health of the Slovak Republic) emphasises, among other things, the importance of the measures having an impact on the social accessibility of alcohol and the change of social stereotypes and attitudes towards experimentation and excessive and harmful drinking in order to change social attitudes towards drinking of individuals, towards abstinence and towards the respect for the rights of the individual not to drink, the importance to improve the image of a non-drinking individual as a positive example of behaviour and health, the importance to emphasise the responsibility of individuals for their drinking and to change the manners of drinking alcohol towards less harmful and less dangerous.

As Ochaba stated, for the public health system solving the alcohol problem constitutes challenges, which, besides enhancing the consulting activity in the prevention of drug addiction in the health protection and promotion consulting centres in public health authorities, may be implemented only in cooperation with other ministries and in cooperation with municipalities and NGOs, as they mean restriction of the number of alcoholic beverages sales points, limitation of the sale time and a ban on alcohol advertising.

Economic measures – The uniform Act on the Excise Duty on Alcohol and Alcoholic Beverages has taken effect in January 2012 and regulates the taxation of alcoholic beverages, which include “spirits, wine, intermediate product and beer”, by imposing the excise duty in the territory of the Slovak Republic. The basic tax rate on alcoholic beverage was established by the Ministry of Finance of the Slovak Republic in the amount of EUR 1,080 and tax rates for different types of alcoholic drinks are determined with using a percentage – according to the actual alcohol content.

The Slovak Republic applies zero tolerance for blood alcohol levels of drivers (Blood Alcohol Concentration – BAC). Refusal of a control is sanctioned. Since 2011, driving intoxicated has been considered a criminal offence (see the Report for 2011 – section 1.1.3).

42 http://www.cpldz.sk/storage/data/nappa.pdf
43 http://www.cpldz.sk/storage/data/nappa.pdf
44 Source: http://spravy.pravda.sk/zdanovanie-alkoholu-sa-bude-riadit-jednym-novym-zakonom-p2y-sk_ekonomika.asp?c=A111130_180509_sk_ekonomika_p01#ixzz2BYG1k23A
Environmental measures for the prevention of alcohol and tobacco as risk factors include also other strategic documents, such as the Programme on Health Promotion, where the last update was approved by the Slovak Government in December 2011. Furthermore, it is the Youth Action Plan for the years 2010-2011, resulting from the Key Areas and Action Plans of the State Policy towards Children and Youth in the Slovak Republic for the years 2008-2013. Both documents emphasise the control of the application of legal regulations for the prevention of alcohol abuse (the ban on sale and restriction of the possibilities for consumption of alcoholic beverages by minors and adolescents).

The representation of one spectrum of public opinion in this area is also the article published on the website www.infodrogy.sk stating that the strategies reflected in practice should be implemented through the following specific activities:

- Legislative restrictions on advertising of alcoholic beverages, which is implemented through sponsorship of leisure-time activities of children and youth and sponsorship of professional sporting events by alcohol industry;
- More repressive punishment of offences and crimes committed under the influence of alcohol;
- Increasing the price of alcohol;
- Creation and support of prevention programmes focused on reducing risk drinking;
- Increasing the age limit for buying and drinking alcohol to 21 years.

3.3 Universal Prevention

3.3.1 Schools – Interventions for Pupils and Students

Objectives: Prevention of the development of drug dependence or increasing the age of first contact with drugs through health education, health support and protection (alcohol, tobacco, illegal drugs, sexual health), and reduction of socio-pathological phenomena.

Primary prevention involves creating optimal conditions for the physical, mental and social development of children and youth, and, in particular, it means the integration of prevention of using psychoactive substances and the development of drug addiction in the educational process and the establishment of drug prevention coordinators and socio-pathological phenomena in schools (Reports for 2008 to 2011).

In the education sector, the schools themselves are the institutions active in the area of prevention of various aspects (the Report for 2011 – section 3.1.1.1), Educational and Psychological Counselling and Prevention Centres (EPCPC), Methodological and Educational Centres, the National Institute for Education, the Institute of Information and Prognoses of Education (IIPE), and the Research Institute for Child Psychology and Pathopsychology (hereinafter referred to as the “RICPaP”).

Key special facilities that are set up in almost each of the 79 districts of Slovakia and operate on each of the levels of prevention – universal, selective and indicated – are EPCPCs.

---

47 E:\KAP 1\Informacia_o_plneni_uloh_AP_2010-2011__(3)\rtf_rtf.mht
48 http://www.infodrogy.sk/ActiveWeb/d/alkohol_1/sk/legalne_drogy.html
3.3.1.1 Certain Programmes, Projects and Activities in 2011

In the school year 2010/2011, EPCPCs implemented a total of 894 prevention programmes at the level of universal prevention. Compared to the school year 2009/2010, there was the increase by more than a quarter (28%, i.e. 252 programmes) and compared to the school year 2008/2009 by 338 prevention programmes (Slovíková, 2012).

Target groups of the prevention programmes implemented in the school year 2010/2011 are shown in Figure 3.3.1 below.

Figure 3.3.1: Structure of target groups related to prevention programmes implemented in school year 2010/2011. Source: Slovíková, 2012

The highest number of programmes was directed to the target group of “elementary school pupils” – 540 programmes (60.40%), peer programmes accounted for almost 8%, and 7% of prevention programmes were designed for endangered groups. Of the total number of programmes, most were short-term; long-term programmes accounted only for 16%.

In the school year 2010/2011, 49 programmes were evaluated, representing 5.48%.

3.3.1.2 The Prevention Programme WAY to Emotional Maturity (the programme of the MUSTAP type)

It is one of the nation-wide prevention programmes, which has been implemented since the beginning of the school year 1999/2000, and in the school year 2010/2011, the twelfth year of its implementation was recorded. Within the framework of 10 content topics, designed to contribute, by exercises and model situations, to gradual awareness of the one’s own self, self-reflection and, in relation

---

49 Slovíková, 2012

50 Taking into account the experimental verification carried out in the school year 1998/1999, it has already been the 13th year.

51 During the twelve-year period of the implementation of the prevention programme Way to the Emotional Maturity in schools, it was realised in 24,959 classes and attended by 385,888 pupils (or 389,612 pupils).
to it, to group experience of signs of emotional maturity, occurs positive strengthening of the emotional component of personality of children aged 12 to 15 years. In the school year 2010/2011, the programme Way to Emotional Maturity included a total of 259 schools and 1,055 classes in the Slovak regions, it was attended by 14,178 (14,096 in 2009/2010) pupils and implemented by 486 teachers (Slovíková, 2012).

The decline in the number of participating schools (less by 19) and the decrease in the number of classes (less by 93) continued. On the other hand, a slight increase in the number of pupils taking part in the programme and the number of trained teachers occurred. It has been carried out during lessons on ethics (35%) and at other lessons during school teaching (about 26%). Compared to the previous school year, more lessons organised by class masters (29% versus 22% in 2010) as well as discussions were used. The programme is regularly assessed, both by teachers and pupils.

Evaluation of the Programme WAY by Pupils (Slovíková, 2012)

40.0% of pupils that took part in the programme consider the programme WAY to be interesting and 26.62% find interesting only certain parts of the programme. The prevention programme brought something new and was enriching for a third of respondents (4.12% of pupils reported negative views). Cooperation and communication was the most frequently reported reason for popularity of the programme, as well as activities used within the programme. Solving tasks and relationships as well as interesting topics were highly appreciated by respondents. Thus, in the opinion of addressed pupils, the programme, helps in self-knowledge, the knowledge of classmates and communication with them, reinforces their own point of view and helps them to solve problems. These positive results also arise out of open answers that pupils could state, for example: perceiving friends and their problems; expressing my own opinion; I got to know my classmates better; it’s easier for me to understand why someone behaves the way he does; I take more notice of the others; I am not afraid to speak; I have improved my communication skills; I gained the courage to speak my mind; this programme is great.

As much as 95% of the pupils highly appreciated the teacher implementing the programme – he is communicative, popular, ready to help and advice and the pupils can confide in him.

Implementation of the programme and methodological guidance is ensured by the EPCPC staff, and the programme implementers in schools are teachers in elementary schools, 8-year grammar schools or secondary schools.

Also other school programmes have been implemented (e.g. Before It Is Too Late; We Know That...; Independence Is Trendy; Take a Ball, Not Drugs; Your Right Choice; Do Not Destroy Your Wise Body).

In the school year 2010/2011, EPCPCs carried out also 9,348 preventive activities, of which group activities accounted for the highest proportion, i.e. 77% of the total. Most were lectures and discussions (57%); training groups accounted for 43%. Compared to the school year 2009/2010, the number of activities in the area of social pathology has increased (by 1,390 activities – a growth by almost 15%). For other activities, see Table 3.3.1 below.

52 Another assessed project was the pilot project of the rope training® within the internationally coordinated programme TAKE CARE (for more information, see section 3.2 Selective Prevention).

53 Qualified for the programme in further education (professional career).
Table 3.3.1: The number of activities and participants in drug prevention activities in terms of EPCPCs in the school year 2010/2011

Source: The Institute of Information and Prognoses of Education – Slovíková, 2012

<table>
<thead>
<tr>
<th>Activities</th>
<th>Activities</th>
<th>%</th>
<th>Participants</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td></td>
<td>Number</td>
<td></td>
</tr>
<tr>
<td>Group activities with clients</td>
<td>7,202</td>
<td>77.04</td>
<td>132,461</td>
<td>84.97</td>
</tr>
<tr>
<td>within that training group</td>
<td>3,099</td>
<td>43.03</td>
<td>44,563</td>
<td>33.64</td>
</tr>
<tr>
<td>lectures, discussions</td>
<td>4,103</td>
<td>56.97</td>
<td>87,898</td>
<td>66.36</td>
</tr>
<tr>
<td>Services for teachers</td>
<td>1,527</td>
<td>16.34</td>
<td>5,013</td>
<td>3.22</td>
</tr>
<tr>
<td>within that methodological consultation</td>
<td>1,395</td>
<td>91.36</td>
<td>2,121</td>
<td>42.31</td>
</tr>
<tr>
<td>courses, seminars, lectures</td>
<td>132</td>
<td>8.64</td>
<td>2,892</td>
<td>57.69</td>
</tr>
<tr>
<td>Education of preventists</td>
<td>31</td>
<td>0.33</td>
<td>296</td>
<td>0.19</td>
</tr>
<tr>
<td>Other professional activities</td>
<td>588</td>
<td>6.29</td>
<td>18,118</td>
<td>11.62</td>
</tr>
<tr>
<td>within that publications and public education</td>
<td>312</td>
<td>53.06</td>
<td>9,760</td>
<td>53.87</td>
</tr>
<tr>
<td>promotion and information events</td>
<td>235</td>
<td>39.97</td>
<td>7,788</td>
<td>42.98</td>
</tr>
<tr>
<td>events with stays</td>
<td>41</td>
<td>6.97</td>
<td>570</td>
<td>3.15</td>
</tr>
<tr>
<td>TOTAL</td>
<td>9,348</td>
<td>100.00</td>
<td>155,888</td>
<td>100.00</td>
</tr>
</tbody>
</table>

The highest number of training groups was in the Bratislava Region (750).

In 2011, as part of the development project Health in Schools, the Ministry of Education provided funding\(^{54}\) in the amount of EUR 61,957 for 30 school projects, mainly aimed at the training of teaching staff\(^{55}\).

### 3.3.1.3 The Project Your Right Choice

The Report for 2011 included the project of the Presidium of the Police Force – Your Right Choice. The project designed for 9 to 10 year-olds informed adequately about the harmful effects of using psychoactive substances (tobacco, alcohol and marijuana), and in the case of marijuana also about legal and criminal aspects of its use. The 45-minute activity was carried out in an interactive workshop environment. The implementation phase of the project lasted 21 months and in Slovakia it was completed in June 2011 and in the Czech Republic in September 2011. Overall, 27,478 students from 1,393 classes and 617 schools in the two republics took part in the project. Interactive workshops were installed in 55 towns and lectures were ensured by 217 animators from among Police Force officers, employees of regional public health authorities and municipal police, social workers and the like. In the Slovak Republic\(^{56}\), 19,762 pupils from 1,033 classes and 419 elementary schools participated in the project implemented by a total of 171 animators (e.g. the staff of

\(^{54}\) No funds were provided in 2010.

\(^{55}\) Letter from the Ministry of Education of the Slovak Republic, Department of Regional Education, 2012-14465/44305-6-915 of 5 October 2012.

\(^{56}\) In the Czech Republic, 7,716 pupils from 360 classes and 198 schools were involved in the project. The project was implemented by 46 animators in 18 towns of the Olomouc and Moravian-Silesian Regions.
12 regional public health authorities\textsuperscript{57}). Media coverage of the project was carried out at the national level and during the implementation at the regional and local level. Coordination of the project at the level of regional directorates of Police Force (hereinafter referred to as “PF”) was ensured by Police Force officers – specialists in communication and prevention departments of the PF regional directorates. As stated in the report on the evaluation of the project\textsuperscript{58}, based on the feedback of direct participants, animators and cooperating entities, the project got a very positive response.

During 2011, regional public health authorities conducted 1,169 health and educational activities with the theme of prevention of drug addiction, where the target group of children and youth represented the majority, i.e. 79\% of the activities. Support for non-smoking and abstinence for that target group was represented by 1,520 activities, i.e. 64\%, and the education for partnership, parenthood, marriage and prevention of the transmission of sexually transmitted diseases, HIV, and AIDS accounted even for 88\%. The last category includes the fifth year of a continuing education campaign Red Ribbons\textsuperscript{59} as well as the ongoing project Game against AIDS (14 regional public health authorities participated in it), which gives young people the basic information about transmission and prevention of HIV / AIDS and the possibilities for responsible behaviour in situations of risk.

3.3.2 Interventions Aimed at Young People in Alternative Leisure Facilities and Programmes for Young People outside Schools and in Sports Clubs

At the end of November 2011, the staff of the ward Bratislava – Rača implemented the project Prevention of Drug Addiction and Effective Leisure Time Activities. The project supported by NMCD set several goals – to inform, in a half-day workshop, and in an interactive form, on addictive substance abuse and possibilities for leisure time activities. Concerning later to support motivation to organise leisure time activities and to choose suitable activities, as well as the way how teens themselves can create their leisure time activities was the goal. The project included a survey – a questionnaire addressed to pupils of the 8\textsuperscript{th} grade of elementary schools – a total of 36 young respondents (20 respondents aged 13 years and 16 respondents aged 14 years, 24 girls and 12 boys). The data obtained from that target group represented the basis for the “tailor-made” workshop. The experts who participated in the project and, in particular, in the workshop provided the feedback appreciating the connection of both topics as well as participants skills concerning their creating leisure time activities, and they would recommend to use such form of prevention systematically for a longer time and as part of peer programmes (Ferenčík M., 2012)\textsuperscript{60}.

In 2011, the Government Office of the Slovak Republic provided support for the anti-drug activities in the total amount of EUR 500,000. The largest share, 58\% of the funds, went to the projects categorised as prevention projects, which, in addition to universal forms of prevention in schools and communities (municipalities – 17

\textsuperscript{57} Hamade, Janechová: Report to NMCD, 2012
\textsuperscript{58} http://www.minv.sk/?Vyhodnotenie, downloaded on 20 July 2012
\textsuperscript{59} http://www.cervenestuzky.sk/aktivity.php
\textsuperscript{60} Ferenčík, M. (2012): Processing of the Results of the Pilot Survey on the Review and Possible Drug Use and the Potential Effect of Leisure Activities on Such Use, Final Report to NMCD, January 2012, unpublished
projects), supported also selective prevention, research activities, further education of professionals in that field and several media projects or projects using information technology. (Source of the data: The list of approved projects to support anti-drug activities in 201161)

Figure 3.3.2: Structure of demand reduction projects supported from budget grants provided within the grant scheme of the Government Office in 2011. Source: NMCD.

<table>
<thead>
<tr>
<th>Prevention</th>
<th>Harm reduction</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>58%</td>
<td>8%</td>
<td>4%</td>
</tr>
<tr>
<td>Resocialisation</td>
<td>30%</td>
<td></td>
</tr>
</tbody>
</table>

From among the universal prevention projects, the continuation of a peer programme of the civic association FILIA in Košice can be mentioned as well as peer programmes at the Centre for the Prevention of Youth in Čadca, the Drug Abuse and AIDS Prevention Programme for university students of the Pavol Jozef Šafárik University in Košice with a focus on the creation and implementation of the alcohol policy (Campus Alcohol Policy), the 17th year of the national62 thematic art competition Why Am I Glad to Be in the World, etc.

In 2011, the Crime Prevention Council of the Government63 approved a total of 164 projects64. They were projects of social65, victim and situational prevention. The largest proportion of funds was provided to municipalities and NGOs for the situation prevention – mostly for construction and operation of CCTV systems. The social prevention projects (aimed at the perpetrators and potential perpetrators and being the closest to the universal and selective prevention of socio-pathological phenomena, the category of which includes alcohol consumption, smoking and use of illicit psychoactive substances) accounted for 38%. The projects represented activities such as local or regional sport events and competitions (Come on the

---


62 With international participation.


64 Source: www.rokovania.sk/File.../Mater-Dokum-143760, downloaded on 19 April 2012

65 Social prevention of crime means action on the perpetrators or potential perpetrators. It is general prevention of all socio-pathological phenomena.

Source: Bubeliny, 2001
Playground, Forget the Slippery Slope; Take a Ball, Not Drugs; Five Pillars of School Prevention; Stop Using Alcohol and Drugs – You Have a Choice. In the field of social prevention, also projects of religious institutions are important, particularly the project entitled We Create a Community of People Sharing Responsibility for Their Own Future prepared by the Salesians of Don Bosco and the project implemented by the Association of Salesian Youth in Košice named A Step to the Prevention of the Evangelical Diakonia of the Evangelical Church of the Augsburg Confession. In 2011, most supported projects in the category of social prevention (a total of 62 projects) were in the Košice Region (14), followed by the Bratislava Region (10), the Trnava Region and the Žilina Region (9 projects).

3.4 Selective Prevention

3.4.1 Risk Groups – Interventions for Pupils / Students with Learning Difficulties, Social Problems and Truancy

3.4.1.1 Reasons of Clients for Coming to EPCPCs in the School Year 2010/2011 (Sloviková, 2012).

As the primary reason, professional orientation dominated, and further reasons included learning problems, school maturity, personality and psychological problems as well as behavioural problems of clients. Compared to the previous school year, in case of all the reasons a slight increase was recorded. In the overall structure, explicit categories of socio-pathological phenomena and dissociative activity (Table 3.4.1) are represented to a lesser extent (1.22% or 0.37%), but compared to the previous school year, in the school year 2010/2011, their number in the group of socio-pathological phenomena increased by almost 50% (a growth by 410 clients). Other reasons such as personality and psychological problems, behavioural problems, family and other problems, and finally learning problems are represented to a higher extent, and they indicate a fairly significant proportion of more vulnerable and higher-risk school population as well as the number of individuals who might choose using psychoactive substances as a way of solving their problems.

---

66 The latest project Take a Ball, Not Drugs (the 2010 Report) has been sponsored in 2011 and 2012 by a number of private companies and intensively promoted in public service radio.
Table 3.4.1: Reasons and initiators leading clients to come to EPCPCs in the school year 2010/2011
(The Institute of Information and Prognoses of Education – Slovíková, 2012)

<table>
<thead>
<tr>
<th>Clients Total</th>
<th>%</th>
<th>Screening</th>
<th>Client himself</th>
<th>Parent</th>
<th>School</th>
<th>Education facility</th>
<th>Health care facility</th>
<th>Curator Police Force</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>School maturity</td>
<td>21,983</td>
<td>21.48</td>
<td>4,236</td>
<td>29</td>
<td>10,206</td>
<td>7,337</td>
<td>59</td>
<td>85</td>
<td>6</td>
</tr>
<tr>
<td>Learning problems</td>
<td>23,642</td>
<td>23.11</td>
<td>1,444</td>
<td>309</td>
<td>8,342</td>
<td>13,206</td>
<td>105</td>
<td>145</td>
<td>13</td>
</tr>
<tr>
<td>Behavioural problems</td>
<td>6,858</td>
<td>6.7</td>
<td>42</td>
<td>51</td>
<td>3,153</td>
<td>3,450</td>
<td>35</td>
<td>89</td>
<td>17</td>
</tr>
<tr>
<td>Dissocial activity</td>
<td>585</td>
<td>0.57</td>
<td>1</td>
<td>9</td>
<td>182</td>
<td>379</td>
<td>0</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Personality and psychological problems</td>
<td>9,162</td>
<td>8.95</td>
<td>331</td>
<td>626</td>
<td>2,661</td>
<td>5,325</td>
<td>34</td>
<td>136</td>
<td>10</td>
</tr>
<tr>
<td>Professional orientation</td>
<td>32,665</td>
<td>31.92</td>
<td>239</td>
<td>5,941</td>
<td>7,764</td>
<td>18,652</td>
<td>16</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Socio-pathological phenomena</td>
<td>1,245</td>
<td>1.22</td>
<td>8</td>
<td>35</td>
<td>148</td>
<td>935</td>
<td>13</td>
<td>3</td>
<td>97</td>
</tr>
<tr>
<td>Speech development disorders</td>
<td>2,685</td>
<td>2.62</td>
<td>1,040</td>
<td>32</td>
<td>1,237</td>
<td>310</td>
<td>2</td>
<td>60</td>
<td>2</td>
</tr>
<tr>
<td>Family and other problems</td>
<td>2,852</td>
<td>2.79</td>
<td>784</td>
<td>174</td>
<td>796</td>
<td>1,011</td>
<td>15</td>
<td>27</td>
<td>13</td>
</tr>
<tr>
<td>Peer activist</td>
<td>643</td>
<td>0.63</td>
<td>0</td>
<td>100</td>
<td>30</td>
<td>468</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>102,320</td>
<td>100.00</td>
<td>8,125</td>
<td>7,306</td>
<td>34,519</td>
<td>51,073</td>
<td>280</td>
<td>558</td>
<td>167</td>
</tr>
<tr>
<td>%</td>
<td>100.00</td>
<td>7.94</td>
<td>7.14</td>
<td>33.74</td>
<td>49.91</td>
<td>0.27</td>
<td>0.55</td>
<td>0.16</td>
<td>0.29</td>
</tr>
</tbody>
</table>

In the school year 2010/2011, the visits of clients in EPCPCs were most often initiated by schools, representing almost 50%. Parents or legal guardians of children were the second most frequent initiator, representing more than one third. A higher proportion in the initiation of clients to come to the facilities was screening, representing almost 8% (see the section Selective Community Prevention).

IIPE monitors, on a long-term basis, the state and development of truancy as a phenomenon of social pathology according to data about missed and unexcused lessons. Pursuant to the last monitoring (Slovíková, 2012), a slight growth was recorded (by 0.16 hour) to 0.89 hours in case of grammar schools students, however, in case of students of another selection type of a secondary school – conservatory – it even declined. In general, however, truancy as the phenomenon has increased, and it is apparent when monitoring this phenomenon at vocational schools. In that type of schools, the number of lost lessons per pupil increased from 7.17 in 2009 to 8.21 in 2011, i.e. a growth even by one lesson in two years. Compared to the average of the Slovak Republic, the worst situation is in the Banská Bystrica Region (10.9 hours), the Košice Region (10.5) and the Bratislava Region (9.2). Bradová
(2011) came also to similar conclusions to the detriment of secondary vocational schools. In addition to quantitative indicators, in her survey and subsequent study, she monitored also the reasons for truancy and raised a number of recommendations for practice (ibid p. 116-119). In addition to more general recommendations regarding improvement of the level of collaboration of schools with professionals and providing space for prevention programmes, improving cooperation between schools and families, creating conditions for regular (and attractive) hobbies, Bradová also highlights the need to retreat from the repressive attitude (see the Analysis of Screening within USI) towards helping and supportive environment so that a student is not afraid of returning to school, is not stressed by educational demands, tests and exams, and so that he does not choose the path of escape. An equally important element of the solution of truancy is considered more intensive support for professional orientation of pupils at the level of a secondary school choice.

3.4.1.2 Model of the Universal-Selective-Indicated Prevention (USI)

Some information on a modular integrated system of prevention of socio-pathological phenomena in children and adolescents in the city district of Bratislava – Ružinov (2010-2013) had already been provided in the 2011 Report. The aim of the project is to create conditions for effective cross-sectoral participation and cooperation of components involved in the implementation of preventive activities in Ružinov ward. During the first phase of USI, at the level of community a network of partners / components being involved in the implementation of prevention of socio-pathological phenomena in the ward of Ružinov was created (counselling psychological services, parish, municipal police, Police Force, and others).

As a second step, screening of problematic pupils was carried out. All elementary schools in the wards of Ružinov, Vrakuňa and Podunajské Biskupice were involved in the project, where the screening of “problem behaviour” of children and young people took place. Most of a total of 14 schools in the respective territory were involved in the project, and teachers monitored problem behaviours of pupils. In the opinion of class masters, 227 pupils had the problematic behaviour, which could not be controlled by educational tools in schools. According to teachers, most problematic behaviour includes negativism, impulsive behaviour and dissocial behaviour occurring in almost 80% of cases. The highest accumulation of troubled pupils was in the 8th grade (14-15 year-old pupils), followed by the 7th grade; a milestone was also the 5th grade, which accounted for almost 12%, and the 4th grade accounted for 11%.

Of 227 pupils with behavioural disorders, 137 (60.35%) children had already been provided professional care especially by psychologists; psychiatric care had been provided to 13%, and the care provided by a social curator/probation officer to nearly 12%. Conclusions from the analysis of the screening results were directed both


68 By its area (39.6 km2) and population (71,284), it is the largest of the 17 wards of Bratislava. http://www.ruzinov.sk

69 There were a total of 4,486 pupils in those schools. 1,360 pupils (28.7%) did not participate in the screening.

against the school management, which showed the need for changes in favour of helping approach over the repressive one and pointed to the need to improve coordination of activities – an educational counsellor – a psychologist – a special educator. It also showed the need to improve cooperation of schools with parents of pupils attending the second degree of elementary schools. Secondly, the screening analysis indicated also the need for training of coping with manifestation of negativism, impulsive behaviours and asocial and antisocial behaviours of pupils, and for practicing communication methods based on motivational interviewing and non-directive approach in case for teachers and school professionals.

The diagnostic part of the project was aimed at detecting of causal reasons of problem behaviour of pupils in schools. Request for consent to examination was personally served to parents of 227 pupils identified as having problem behaviour. The consent of their parents to psychological examination was obtained in 42 cases.

The next phase in the USI community project included direct counselling or preventive activities with pupils. The Research Institute for Child Psychology and Pathopsychology, in collaboration with the civic association “V&P Prevencia”, offered pupils the opportunity to participate in another project entitled Take Care focused on the issues of hazardous drinking and compliance with the legislative framework in the field of alcohol drinking. The project Take Care was launched in March 2010, and is programmed to December 2012. It is funded by the Executive Agency for Health and Consumers. The project coordinator is the German organisation LWL Münster, and the Slovak partner in the project is the civic association “V&P Prevencia”. The characteristic of the project is a multi-level intervention towards four target groups: adolescents / young people, parents, the so-called key persons, and alcohol retailers in the respective locality. The aim is to strengthen the skills of young people through the rope training© in order to manage risk situations by experiential learning methods along with peer learning and psycho-education. The rope training© should reduce alcohol consumption and related risks in adolescents and young people, promote compliance with national laws relating to alcohol consumption, and enhance a responsible approach to alcohol among young people over 18 years. In 2011, pilot mentoring for the rope training© project took place in Bolzano, Italy, and it was attended by two psychologists from the RICPaP. In June 2011, the first pilot project was implemented, for which, based on data from the screening, educational consultants selected 10 pupils aged 13 to 15 years (the 7th and 8th grade, 8 boys and two girls) who had experience with alcohol. The programme combined structurally the activities from the draft training manual and the techniques of socio-psychological approach, with emphasis on group dynamics and current topics of the group members. The training consists of (a) experiential learning

Methodological material, Research Institute for Child Psychology and Pathopsychology, 2011

72 Information about the implementation and offering for realisation of the rope training© programme were sent to the schools, which carried out screening and teachers reported the increased occurrence of alcohol problems.
73 https://www.lwl.org/LWL/Jugend/lwl_ks/Praxis-Projekte/Take_Care_Start/newsletter?lang=en
75 The first four-day training was held in Modra-Harmónia in June 2011.
methods – passing climbing course, when young people have the opportunity to experience risk taking and then reflect on the situation and transfer it to other risk situations such as consumption of addictive substances (alcohol), and (b) interactive exercises focusing on perception and creativity – adolescents themselves take pictures or shoot videos on the topic “Things in my neighbourhood that have anything to do with alcohol”, which they present each other. Both methods are designed to optimise the perceived risk (risk optimisation). The second part is the psycho-education – providing information on the effects of alcohol, on legal regulations, on how to create dependency, how to deal with friends who have a problem with alcohol or drugs, how to perceive reasons for drinking, options to say NO, and how to find alternatives to consumption of addictive substances. Finally, the third part is the peer education – in addition to training graduates, also other peers can benefit from the knowledge and changed attitudes and behaviour in their peer group (learning by example).

Based on the objectives of the project, a research pilot sample (N=10, mean age 14.5 years) monitored the following hypotheses: 1/ After completing the rope training©, adolescents will have more information on the risks of alcohol effects; 2/ After completing the rope training©, a change in their own assessment of the risk perception will occur. Assessment questionnaires detected their own experience with alcohol and perception of risk situations in the last three months. Adolescents filled out the questionnaire before the rope training© and immediately after it; another measurement was carried out three months after completing the training.

The results of the pilot project evaluation

1. The awareness of adolescents of alcohol has increased (statistically significantly more answers about the risks of alcohol were correct, compared to the beginning of the training).

2. Attitudinal shifts in self-assessment of own competences, for example, very strong agreement with the statement – When I'm in trouble, I usually figure out how to get out of it at the beginning of the training shifted to the consent at the end of the training, and concerning the item I tend to feel quite like a man who failed shifted, with a statistically significant difference, from strong disagreement to disagreement.

3. Attitudinal shifts in the perception of risk situations occurred. In the item I was able to handle risky situations statistically significant shift in the confirmation of the veracity of the statement was found.

According Kopányová (2012) the content and structure of the programme is suitable for the selective prevention in adolescents. Its effectiveness is increased by the fact that the project TAKE CARE includes a multilevel approach of prevention. The level of awareness of the risks of alcohol effects has increased in the examined group of participants in the rope training© programme. Changes – as measured by a scale of self-efficacy76 – occurred also in the inner experience of participants. Self-confidence of adolescents concerning the fact that they are able to cope with problem situations fell slightly, which may be due making their actual possibilities real, as during the training each of the participants experienced a situation when they were getting closer or exceeded their normal limits. On the other hand, there was a

76 (Rosenberg in Košč et al., 1993)
positive shift of experiencing themselves as successful men (I coped with it – I feel good about myself).

In October 2011, the next rope training was realised for 19 elementary school pupils. Moreover the adaptation of evaluation questionnaires for each target group and basic training manuals for key persons and sellers of alcohol were prepared. In 2012, the project continues by further rope training and interventions for the other target groups (parents, key persons and sellers of alcohol). The current year of the project Ružinov implementation means focusing on working with parents, training of specialised staff for educational counselling and prevention through education, motivational interviewing and non-directive approach in working with troubled children. Another source of potential participants for the rope training programme would be using another partner of the Ružinov project – municipal police, in cooperation with the Social Department of the Municipal Office Ružinov.

For the present, the best cooperation was with educational counsellors in elementary schools. The course of the screening, diagnostic and intervention phase of the project pointed to the possibilities, where the implementation of the secondary prevention in the respective community ran conceptually and systematically. Also possible barriers and obstacles to its implementation were found.

### 3.4.2 Other Risk Groups in the Community

**Prevention of HIV / AIDS in risk groups**

In addition to the SUNFLOWER project aimed at young people representing a significant proportion of newly diagnosed cases of HIV infection, regional public health authorities (hereinafter RPHA) participated in health education of men having sex with men (including providing information about the EMIS project – the European Internet research), continued in the EUROSUPPORT VI project, which is used for mapping and subsequent reductions in risk behaviour among people with HIV from a group of men having sex with men in the Slovak Republic in the EU countries, and participated in the SIALON II project aiming to map the prevalence of HIV infection and other sexually transmitted infections in a group of men having intercourse with men in terms of their risk behaviour.

Health education focused on the social and health prevention of sexually transmitted infections and HIV / AIDS among persons providing paid sexual services and injecting drug users is also reflected in the programme Protect Yourself and the SEX / DRUGS programme – the programme of the field social work of the civic association Odysseus realised in summer festivals, concerts and nightclubs, is primarily devoted to two topics – safer sex and safer drug use.

In 2011, the initiative was established and represented by the website www.drogy.org designed for people using heroin and methamphetamine (pervitin),

---

77 For example, the offer for the rope training was sent even to the OLSAF employees cooperating with parents despite the fact that the programme is not the programme accredited for the social sector, the Director of OLSAF provided space to its experimental use. Parents were sent an offer for their child to participate in the rope training, however, none of the addressed parents used the offer. The cause could be the fact that the parents – in their own opinion – perceive the work of social workers more as the work of a formal, authoritative body with more or less punitive approach.

78 www.ozodyseus.org Nowadays, the civic association Odysseus manages the following programmes: Protect Yourself, Intoxi Magazine, Social Assistance, SEX / DRUGS, Red Umbrella, and HIV / AIDS. In the past, they were also the projects Pikadu, Subway Club or the Community Centre in Kopčany.
containing also information on the prevention of HIV transmission through injecting drug use.

Health education including the HIV / AIDS prevention agenda was also carried out in specific groups – members of the Armed Forces of the Slovak Republic and the Prison Service establishments.

At the level of selective prevention, two projects / community programmes continue. The first is the Health Promotion Programme for Disadvantaged Communities in Slovakia for the years 2007-2015 of the Ministry of Health and the other one is the Community Social Work Programme (Ministry of Labour, Social Affairs and Family). Both are implemented in marginalised, mostly Roma communities. The year 2011 was specific by focusing the community social work programme also on the group on abstainers (Czuczorová, 2012).

In 2011, the Health Promotion Programme for Disadvantaged Communities in Slovakia for the years 2007-2015 was implemented by 12 RPHAs located in Košice, Bardejov, Rimavská Sobota, Rožňava, Spišská Nová Ves, Michalovce, Stará Ľubovňa, Poprad, Prešov, Banská Bystrica, Humenné, and Vranov nad Topľou. There were 30 community health education workers in the field (10 coordinators, 20 assistant coordinators). Their work was focused on working with families directly in the settlements, as well as specific activities with specific target groups, children and youth, and young adult women. Health education takes place in schools or community centres and is focused on taking care of the children’s own health, in which information is presented about the harmful effects of tobacco, alcohol, drugs. In 2011, in such way 34,898 people were educated living in segregated and isolated Roma settlements and sites. In the context of drug prevention, activities were conducted for children and youth on the following topics: drug prevention, drugs and the immune system, wellbeing, drugs – myths and facts, training on group pressure, and smoking kills. Educational material was distributed – leaflets Why and How to Quit Smoking. One day a week community workers organised sport afternoons, while part of the games was also talking to the young on the following topics: alcohol, smoking, drugs, gambling (Hamade, Janechová, 2012).

3.4.3 Help and Support for Families having a Risk Child or Dependent Member

3.4.3.1 Counselling and psychological services

(hereinafter referred to as “CPS”), located at the Offices of Labour, Social Affairs and Family (hereinafter referred to as “OLSAF”) are provided in cooperation with the departments of social and legal protection of children and social guardianship (hereinafter referred to as the “SLPCaSG”) and are aimed to provide counselling and psychological support and care for the family. In the field of prevention of drug and other addictions, it was the preparation and implementation of prevention programmes for the target group of children placed in the SLPCaSG institutions, assessment of individuals, families, and groups at risk of drug and other addictions, or the so-called co-dependents, as well as the cooperation in the implementation of the programmes. In 2011, CPS were provided as part of collaboration with children’s homes (prevention of drug addiction in children with ordered inpatient care in a
children’s home\textsuperscript{79} and to the target group of clients experimenting with drugs or risk groups in terms of addiction. Psychological counselling was also provided to families, whose member is drug addict or there is a risk of occurrence or deepening of his addiction. And finally it was provided in cooperation with other stakeholders (i.e. networking of services), as well as in the education through the programme Say It Directly (supervising part and group dynamics). The issue of drug addiction was resolved in 210 cases in 2011, representing 2.4\% share\textsuperscript{80} in the activities of the offices providing CPS, which is a stabilised state.

Czuczorová (2012) states that preventive drug interventions of all the offices providing CPS can also be considered participation in 360 preventive and educational events for 7,231 participants (most of them children – 5,282 and 1,954 adults); 666 cases of detection of causes of negative effects on children and providing information on the child’s mental development for the purposes of implementation of measures of social and legal protection of children and social guardianship that, was implemented for a total of 1,398 clients in 2011; 2,076 cases of counselling and psychological assistance to clients – children or children’s parents or other persons in dealing with family and educational issues and problems in interpersonal relationships, which was provided to 3,508 clients.

In terms of prevention through CPS, the activity of 7 regional professional advisers specialised for drug prevention is important (OLSAF in Trnava cancelled the position of such prevention counsellor). The number of cases in which specialised counselling was provided totalled 399 (a decrease\textsuperscript{81} by 147 cases compared to 2010) in 2011. Just as in 2010, also in 2011 the highest number of experimenting clients continued, i.e. 245 (61\%).

Table 3.4.2: Interventions of regional professional advisers specialised for drug prevention in 2011 and 2010 (Czuczorová, 2012)

<table>
<thead>
<tr>
<th>Interventions of regional professional advisers specialised for drug prevention</th>
<th>2011 (7 regions)</th>
<th>2010 (8 regions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>245</td>
<td>321</td>
</tr>
<tr>
<td>From that: experimenting or threatened by</td>
<td></td>
<td></td>
</tr>
<tr>
<td>alcohol</td>
<td>115</td>
<td>135</td>
</tr>
<tr>
<td>drugs</td>
<td>60</td>
<td>79</td>
</tr>
<tr>
<td>Pathological gamblers</td>
<td>30</td>
<td>31</td>
</tr>
<tr>
<td>Any other type of dependency</td>
<td>10</td>
<td>42</td>
</tr>
<tr>
<td>After treatment / abstaining</td>
<td>18</td>
<td>45</td>
</tr>
<tr>
<td>Persons who committed crimes associated with addiction (suspension of sentences)</td>
<td>12</td>
<td>28</td>
</tr>
</tbody>
</table>

\textsuperscript{79} Part of the preventive agenda in children’s homes is taken by the psychologists in the children’s homes, and counsellors cooperate with them in creating and implementing prevention programmes and activities for this target group of children.

\textsuperscript{80} Mainly due to the cancellation of the position of a specialised regional professional adviser in Trnava.
3.4.3.2 Social Guardianship

Help and support for drug or otherwise dependent clients (or clients belonging to a group at risk of developing or deepening drug addiction) and for their families was provided within the implementation of SLPCaSG measures through OLSAF (especially SLPCaSG departments, non-governmental organisations with the accreditation for implementation of the respective measures granted by MLSAF SR, municipalities and higher territorial units).

OLSAF provided group programmes and supported the involvement of parents or close relatives of children in the implementation of those programmes. In 2011, a total of 1,274 children and 805 parents or persons who personally took care of children were involved in the group programmes (an increase by 83.4%). Such joint participation of children and parents in the implementation of programmes proved extremely effective, because it supported the implementation of positive changes in the behaviour and established relationships of families. Another positive was that part of the respective programmes could also be activities focused on the prevention of first use of drugs or the combined use of legal and illegal drugs. The programmes were mostly implemented for children with behavioural disorders and problem behaviour.

Measures of social guardianship for children were implemented for a total of 26,186 children (an increase by 1,000 children) in 2011. The majority of children (64%) were aged 15 to 18 years. Due to experimentation and drug addiction and other addictions, the measures were implemented for a total of 779 children (an increase by 60 compared to 2010), of that 108 were children under the age of 14 years and 671 aged 15 to 18 years. In both age groups boys dominated (girls accounted for 30%). The most experimented psychoactive substances were tobacco, alcohol and marijuana, in other cases the drug addiction to methamphetamine, alcohol, and marijuana and to toluene in the eastern part of Slovakia (the Košice Region especially – marginalised communities) were diagnosed (by medical professionals). Dependence on heroin, cocaine and datura was observed to a lesser extent. Reasons for experimentation and subsequent drug addiction were the impact of a pathological group of friends / a peer group in which the child wanted to engage as well as his curiosity to try something new and forbidden. The second most common cause was a leak from a dysfunctional family environment (parents’ lack of interest in the child, disrupted marriage of the child’s parents, alcoholism in one or both parents of the child, failure to fulfil parental rights and obligations, a disturbed relationship between parents and children, families with lower social status, etc.

Other measures of social guardianship directed to minors due to neglect school attendance (7,986 cases out of 11,912) and to 14% of children with behavioural disorders.

The educational measure – the obligation to take part in educational or social programme – was implemented for a total of 100 children in 2011, which has already represented the level of indicated prevention, alike the other type of the educational measure – stays in re-socialisation centres (hereinafter referred to as “RC”) for drug addicts which were ordered by courts to 41 children. Overall, in 2011, based on court decisions and due to drug addiction of parents 1.9% of children were placed in the facilities as judgement execution (children’s homes, re-education centres, crisis

---

82 Overall, the SLPCaSG activities were provided for a total of 121,553 cases and 184,079 children in 2011.
centres\textsuperscript{83}, homes of social services and re-socialisation centres), and 0.9% of children were placed there due to their own problems of such type (see also section 3.5 Indicated Prevention).

3.5 Indicated Prevention

3.5.1 Interventions focused on Children with ADHD Syndrome and Behaviour Disorders

In the jurisdiction of the Ministry of Education, there are three types of special educational facilities of residential type, where stays and a relevant educational process represent the level of indicated drug prevention in the event that the outpatient form (see the section Selective Prevention – Reasons and Initiators for Clients Coming to EPCPCs and CPS ) is not sufficiently effective.

In 2011, 1,199 children were placed in all the three types of the facilities. Representation of girls decreases slightly (e.g. in 2002 they accounted for 34.0\%, nowadays it is 29.4\%).

Children are placed in special educational facilities upon court orders or at the request of legal guardians. Proportions of those two ways have changed significantly during the period under consideration (Slovíková, 2012). Judicial resolutions of institutional care ( incl.interim measures) have declined since 2002 from 68\% to 45\%, while cases where children were placed to the facilities at the request of their legal guardians have increased. In 2001, it was 14\%, nowadays the proportion is more than double, i.e. 37\%.

\textsuperscript{83} 141 children were placed to Crisis Centres because of their own drug problems and more than 80 children due to the problems of their parents with drugs (a rapid growth by 25 children) Totally 3,450 children in 2011 – a significant increase by 1,344 children were treated in Crisis centres
Table 3.5.1: Development of indicators for all types of special educational facilities in the years 2001 to 2011 (Source: The Institute of Information and Prognoses of Education – Slovíková, 2012)

<table>
<thead>
<tr>
<th>Number/Year</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of facilities</td>
<td>29</td>
<td>28</td>
<td>29</td>
<td>28</td>
<td>30</td>
<td>31</td>
<td>32</td>
<td>31</td>
<td>27</td>
<td>26</td>
<td>27</td>
</tr>
<tr>
<td>Number of children in facilities</td>
<td>1,153</td>
<td>1,098</td>
<td>1,123</td>
<td>1,248</td>
<td>1,322</td>
<td>1,335</td>
<td>1,333</td>
<td>1,267</td>
<td>1,245</td>
<td>1,176</td>
<td>1,199</td>
</tr>
<tr>
<td>from that: girls</td>
<td>382</td>
<td>373</td>
<td>366</td>
<td>402</td>
<td>406</td>
<td>411</td>
<td>411</td>
<td>372</td>
<td>375</td>
<td>340</td>
<td>353</td>
</tr>
<tr>
<td>Number of educational groups</td>
<td>84</td>
<td>119</td>
<td>129</td>
<td>129</td>
<td>126</td>
<td>131</td>
<td>135</td>
<td>128</td>
<td>133</td>
<td>140</td>
<td>131</td>
</tr>
</tbody>
</table>

1) Educational sanatoria (hereinafter referred to as “ES”) provide professional assistance to clients with behavioural disorders, ADD, ADHD syndrome, learning disabilities, and disorders of emotional and social development. They play the role in protecting clients against socio-pathological phenomena in the prevention of problematic and delinquent development. The preventive action is also aimed at protecting children from the risk of drug addiction. They cooperate actively with a family to improve and maintain its functionality.

The number of ESs grew gradually – nowadays there are 8 and their occupancy has increased, e.g. in 2001 one facility had 29.3 wards on average, and ten years later it was 41.4. The number of educational groups has increased from 23 (in 2002) to the current 36, with an average of 8.3 children.

Table 3.5.2: Development of indicators in ESs in the years 2001 to 2011 (Source: The Institute of Information and Prognoses of Education – Slovíková, 2012)

<table>
<thead>
<tr>
<th>Number/Year</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of facilities</td>
<td>6</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>7</td>
<td>8</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Number of children in facilities</td>
<td>176</td>
<td>169</td>
<td>175</td>
<td>208</td>
<td>259</td>
<td>326</td>
<td>321</td>
<td>310</td>
<td>310</td>
<td>290</td>
<td>299</td>
</tr>
<tr>
<td>from that: girls</td>
<td>31</td>
<td>23</td>
<td>29</td>
<td>29</td>
<td>27</td>
<td>40</td>
<td>53</td>
<td>32</td>
<td>44</td>
<td>37</td>
<td>33</td>
</tr>
<tr>
<td>Number of educational groups</td>
<td>24</td>
<td>23</td>
<td>23</td>
<td>28</td>
<td>33</td>
<td>34</td>
<td>34</td>
<td>36</td>
<td>34</td>
<td>36</td>
<td>36</td>
</tr>
</tbody>
</table>

84 A basic organisational unit for work with children is an educational group, in which children are placed with respect to their educational and health needs.
In 2011, 299 children were placed in ESs, including 33 girls. The highest number of children was placed in the facilities at the request of their parents or persons taking care of the children (266, i.e. 89%)

2) Diagnostic Centres (hereinafter referred to as “DC") – Under Act № 245/2008 Coll. and Decree № 323/2008 on special educational facilities, these special education coeducational facilities are designed for children aged 3 to 15 years. DCs provide diagnostics and consulting services to children with an endangered or impaired psycho-social development in order to determine the next appropriate educational, re-socialisation or re-educational care, develop diagnostic reports of children, and prepare a recommendation on the placement of children after their stay. A child’s stay in the diagnostic centre takes the necessary time to determine the diagnosis, usually twelve weeks.

Since 2001, the number of DCs has not changed; in the SR there are five of such facilities. Since 2001, children were placed in DCs mostly upon judicial resolutions of institutional care and the interim measures, but in recent years the prevalence of reason for placement of children at the request of parents or other legal guardians occurred, as illustrated by the situation in 2011, when of 205 children placed in DCs, 127 children (62%) were placed there for that reason.

Table 3.5.3: Development of indicators for DCs ( incl. DCD, DCM and since 2009 as DC) in the years 2001 to 2011 Slovíková, 2012

<table>
<thead>
<tr>
<th>Number/Year</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of facilities</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Number of children in facilities</td>
<td>222</td>
<td>223</td>
<td>221</td>
<td>225</td>
<td>229</td>
<td>214</td>
<td>199</td>
<td>192</td>
<td>191</td>
<td>189</td>
<td>205</td>
</tr>
<tr>
<td>from that: girls</td>
<td>92</td>
<td>93</td>
<td>80</td>
<td>78</td>
<td>85</td>
<td>76</td>
<td>62</td>
<td>62</td>
<td>65</td>
<td>55</td>
<td>76</td>
</tr>
<tr>
<td>from the number of children</td>
<td>judicial resolution</td>
<td>93</td>
<td>131</td>
<td>118</td>
<td>114</td>
<td>114</td>
<td>81</td>
<td>26</td>
<td>3</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>institution al care</td>
<td>8</td>
<td>10</td>
<td>2</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>protective care</td>
<td>109</td>
<td>60</td>
<td>81</td>
<td>81</td>
<td>80</td>
<td>52</td>
<td>49</td>
<td>58</td>
<td>25</td>
<td>30</td>
<td>42</td>
</tr>
<tr>
<td>interim measure</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>educational measure</td>
<td>12</td>
<td>22</td>
<td>20</td>
<td>25</td>
<td>33</td>
<td>79</td>
<td>124</td>
<td>131</td>
<td>139</td>
<td>146</td>
<td>127</td>
</tr>
<tr>
<td>request of legal guardians</td>
<td>16</td>
<td>26</td>
<td>26</td>
<td>25</td>
<td>23</td>
<td>22</td>
<td>20</td>
<td>21</td>
<td>21</td>
<td>21</td>
<td>22</td>
</tr>
<tr>
<td>Number of educational groups</td>
<td>63</td>
<td>63</td>
<td>63</td>
<td>63</td>
<td>63</td>
<td>63</td>
<td>63</td>
<td>63</td>
<td>63</td>
<td>63</td>
<td>63</td>
</tr>
</tbody>
</table>

3) Re-education Centres (hereinafter referred to as “RC") provide children under the age of 18 years (extendable by one year) training and education based on the educational programme and individual re-education programme, including vocational training with a view to their reintegration into the original social environment at the request of a child.

To 2008, the number of RCs kept at a stable level of 19 facilities. It fell to 14 in the following year, which represents the current situation. The number of children in RCs

---

culminated in 2005 (834 wards), then it decreased, and currently it is 695 children in RCs. The proportion of girls was relatively stable, fluctuating at around one-third. Children are admitted to the RCs at the request of a legal guardian or by agreement with the facility, which executes a court decision, upon a court interim measure under special regulations, court decision imposing protective care, court decision imposing an educational measure, and a court decision ordering inpatient care. In each reporting period, most children were placed into RCs upon a court order. In 2011, of 695 children, 80%, i.e. 562 children were placed in RCs upon a court decision on institutional or protective care.

Table 3.5.4: Development of indicators for RCs in the years 2001 to 2011 (Slovíková, 2012)

<table>
<thead>
<tr>
<th>Number/Year</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of facilities</td>
<td>18</td>
<td>18</td>
<td>19</td>
<td>18</td>
<td>19</td>
<td>19</td>
<td>19</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>Number of children in facilities</td>
<td>755</td>
<td>706</td>
<td>727</td>
<td>815</td>
<td>834</td>
<td>795</td>
<td>813</td>
<td>765</td>
<td>744</td>
<td>697</td>
<td>695</td>
</tr>
<tr>
<td>from that: girls</td>
<td>259</td>
<td>257</td>
<td>257</td>
<td>295</td>
<td>294</td>
<td>278</td>
<td>286</td>
<td>278</td>
<td>266</td>
<td>248</td>
<td>244</td>
</tr>
<tr>
<td>from the number of children</td>
<td>618</td>
<td>591</td>
<td>603</td>
<td>632</td>
<td>652</td>
<td>636</td>
<td>637</td>
<td>593</td>
<td>564</td>
<td>529</td>
<td>511</td>
</tr>
<tr>
<td>judicial resolution on institutional care</td>
<td>35</td>
<td>53</td>
<td>62</td>
<td>65</td>
<td>71</td>
<td>55</td>
<td>40</td>
<td>37</td>
<td>49</td>
<td>46</td>
<td>51</td>
</tr>
<tr>
<td>protective care</td>
<td>102</td>
<td>62</td>
<td>62</td>
<td>102</td>
<td>109</td>
<td>97</td>
<td>112</td>
<td>105</td>
<td>65</td>
<td>71</td>
<td>68</td>
</tr>
<tr>
<td>interim measure</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>19</td>
<td>11</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>educational measure</td>
<td>0</td>
<td>0</td>
<td>16</td>
<td>2</td>
<td>7</td>
<td>24</td>
<td>30</td>
<td>47</td>
<td>51</td>
<td></td>
<td></td>
</tr>
<tr>
<td>request of legal guardians</td>
<td>79</td>
<td>80</td>
<td>80</td>
<td>80</td>
<td>74</td>
<td>78</td>
<td>83</td>
<td>76</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

According to a survey carried out by NMCD (see Chapter 8), in 2011, 95 clients under 18 years who had problems with psychoactive substances were in the accredited re-socialisation centres and most, 37 children in the specialised department of the re-socialisation centre “Čistý deň” – the Children’s Therapeutic Institute. 28 clients under 18 years were in the oldest specialised facility for juveniles in the “Komunita Ľudovítov”, non-for-profit organisation.

86 http://www.cistyden.sk/http404.html
87 http://komunita.sk/
Figure 3.5.1: Proportion of juvenile clients compared to the total number of all clients in re-socialisation centres in Slovakia, 2011. Source: NMCD

<table>
<thead>
<tr>
<th>Year</th>
<th>All clients</th>
<th>minor clients under 18</th>
<th>clients under 16 (included)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>614</td>
<td>50</td>
<td>5</td>
</tr>
<tr>
<td>2008</td>
<td>741</td>
<td>80</td>
<td>5</td>
</tr>
<tr>
<td>2009</td>
<td>857</td>
<td>106</td>
<td>14</td>
</tr>
<tr>
<td>2010</td>
<td>802</td>
<td>97</td>
<td>18</td>
</tr>
<tr>
<td>2011</td>
<td>842</td>
<td>95</td>
<td>9</td>
</tr>
</tbody>
</table>

3.6 National and Local Media Campaigns
NMCD has no information available or did not register any national media campaign in 2011 in the form of an identification campaign (identification with positive forms of behaviour – without the use of psychoactive substances) or spreading information.
4 PROBLEM DRUG USE

4.1 Overview

The definition of problem drug use that is used to estimate the prevalence and incidence of drugs in the Slovak Republic and for the collection and analysis of data for this report is based on the definition corresponding to the EMCDDA's operational/pragmatic definition for the indicator Problem Drug Use: Injecting drug use or long term/regular use of opioids, cocaine and/or amphetamines in the 15–64 age group in the given year.\(^88\)

Cocaine users have been included into comparisons too, though they create just a small proportion in Slovakia. There are some signs, also from other indicators, that their number could become increasing, though still in small relative numbers as well as in absolute ones. No increase in the number of cocaine users was recorded by low threshold agencies in 2011. Cocaine as the primary drug was reported in one case by low-threshold agencies in 2011. 17 persons came to treatment due to their primary problems with cocaine, of which 12 to civil health care facilities (not in prisons). This represented some slight increase, comparing with 2010. In addition, most of those patients were newly treated in their lives. These data could indicate cocaine slowly becomes a more problematic drug. Cocaine appeared as a secondary drug among population in treatment, and usually (in 41.2%) was connected with use of amphetamine-type stimulants as the primary drug.

Last available, general population survey of 2010 (representative, N=4055) reported life-time prevalence for cocaine use at level 1.8% in young males (15-34) and 1.4% in total in the same age group.

Opioids use among users of low-threshold agencies is represented mostly by use of heroin (93.1% of opioid users), and within the amphetamine-type stimulants group, pervitin is the only reported primary drug. Number of polydrug users increased by more than 100% in 2011, in comparison with 2010 (from 315 up to 645), bridging the last year fall in trends. And, this pattern of drugs use created much higher proportion within all drug using clients of low-threshold agencies in 2011, as much as 29% (see Figure 4.1.1) compared to 14.8% in 2010.

Data on problem drug use in treatment are based on the Protocol on Treatment Demand Indicator. Collecting data on problem drug use, diagnostic categories by ICD-10, recorded at four-figure level, are available, as well as the information on injection of the primary drug and other secondary drugs, on lifetime injecting behaviour, and on duration and frequency of the primary drug use.

Analysing data from low threshold agencies that are the most important source of information on the indicator, slight increase has been observed in the number of clients in 2011. This has occurred on the account of increase in groups of opioids users and polydrug users. Especially the latter one has increased rather significantly, by almost 90 clients (16%) comparing to 2010, up to 645 (see Table 4.3.1).

\(^{88}\) EMCDDA: Key epidemiological indicator: Prevalence of problem drug use. EMCDDA recommended draft technical tools and guidelines. Lisbon, EMCDDA, 2004

\(^{89}\) National Centre of Health Information: 2011 Data on TDI, 2012.
In a broader context of lowered heroin availability, the increase of the clients using heroin as their primary drug in low-threshold services seems surprising. Renewal of some programs provided by low-threshold harm reduction agencies could be a reason. Enhancement of health and social problems in a group of chronic opioid users could also give a possible explanation for that fact.

Some fluctuation in proportions could be caused by the fact that there is no common understanding of polydrug use criteria and coding, contrary to the medical diagnostics.

Figure 4.1.1: Composition of clients of low threshold harm reduction NGOs in Slovakia 2011, by the type of primary drug used. Source: NMCD survey among harm reduction agencies, 2011.

4.2 Estimates of the prevalence and incidence of Problem Drug Use

No new estimation on prevalence or incidence was made in 2011. The multiplier method, used in previous years for a series of prevalence estimation over the data from low threshold agencies\(^90\), brought irregular results on 2008, as a consequence of considerable changes in the number and distribution of those agencies\(^91\). The multiplier method, using data from harm reduction NGOs, remains still a valid method for prevalence estimation on problem drug use; however it appears to be suitable for local prevalence estimation, especially in the Bratislava Region.

\(^{90}\) Published in Slovak national reports 2006-2009
For national prevalence estimate, a study is being prepared using treatment data or combined sources. For this purpose, a repeated survey was conducted in 2011 and 2012 to estimate the in-treatment rate among drug users.

Within these surveys that have been carried out in cooperation with low-threshold agencies among their clients, using nomination technique to reach as many clients as possible, samples of 253 and 310 respondents respectively were interviewed and thus data on 1123 and 1238 clients have been collected.

As far as the first sight to data allows, it could be estimated that a relatively stable proportion of clients, around 20% (20.9% in 2011, 21.3% in 2012), was in treatment at health care facilities within the previous year. As regards current/last month presence of clients in treatment, response was positive in 10.2% the first year and in 8% the second year of survey.

4.3 Data on PDU from non-treatment sources

In 2011, data on 9 programmes from five non-governmental harm reduction agencies acting in 6 Slovak cities has been collected. The number of agencies and programmes stayed the same as in 2010 but number of programmes provided by the NGO Storm increased.

The information has been obtained the same way as for several years before, via paper form/questionnaire\(^\text{92}\).

Taking into account data from other indicators, and data from NGOs – especially number of drug users among clients, their composition regarding primary drug used, injecting, number of contacts and other factors – more or less steady trend continued in problem drug use. Some changes were observed that could be just a fluctuation but can also adumbrate some more persisting trend. A proportion of injecting users increased; it was 99.6% in 2011 (comparing with 97.2% in 2010). This is, however, relative figure that speaks more about clients’ structure than on real trends, but the absolute number of injector increased too, from 2075 to 2213 in 2011, as the absolute number decreased reasonably (from 3489 to 2075, i.e. by 40%), as well as the total number of clients (see above, section 4.1).

The ratio of males to females has fallen from 1.55 : 1 in 2010 to 1.19 : 1 in 2011, and 14.7% of clients were of age less than 18, which is much less steep increase comparing with the one between 2009 and 2010. This value increased also in absolute numbers (from 300 up to 338), and there were no clients reported in 2011 younger than 15 from NGOs.

Programmes for the exchange/distribution of sterile needles and syringes constituted a significant part of the activities of low threshold organizations in the field of harm-reduction. In 2011, a total of 281,418 syringes/needles were provided to the clients of these facilities, which is by 12% less than the year before, and, with number of patients increased, this means also decrease in the number of syringes/needles per a client.

Structure of clients of low threshold programmes is described in Table 4.3.1 and plotted in Figure 4.3.1.

---

\(^{92}\) See in: NMCD: Slovakia. New development, trends and in-depth information on Selected Issues, the national report to Reitox, Bratislava, 2010, p. 72
Table 4.3.1: Structure of clients in harm reduction low threshold programmes
Source: Report of low threshold programmes for 2011

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>% of clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients</td>
<td>3,979</td>
<td>3,957</td>
<td>4,023</td>
<td>3,542</td>
<td>3,769</td>
<td>2,267</td>
<td>2306</td>
<td></td>
</tr>
<tr>
<td>of whom, users</td>
<td>3,773</td>
<td>3,722</td>
<td>3,812</td>
<td>3,310</td>
<td>3,588</td>
<td>2,134</td>
<td>2221</td>
<td>100</td>
</tr>
<tr>
<td>of whom, injecting</td>
<td>3,576</td>
<td>3,560</td>
<td>3,658</td>
<td>3,184</td>
<td>3,489</td>
<td>2,075</td>
<td>2,213</td>
<td>99.6</td>
</tr>
<tr>
<td>Heroin</td>
<td>1,430</td>
<td>1,452</td>
<td>1,341</td>
<td>1,489</td>
<td>1,225</td>
<td>656</td>
<td>705</td>
<td>31.7</td>
</tr>
<tr>
<td>Cocaine</td>
<td>0</td>
<td>7</td>
<td>6</td>
<td>0</td>
<td>44</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Pentazocine (Fortral)</td>
<td>247</td>
<td>162</td>
<td>107</td>
<td>7</td>
<td>n.a.</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Pervitin</td>
<td>1,418</td>
<td>1,403</td>
<td>1,314</td>
<td>1,146</td>
<td>1,510</td>
<td>852</td>
<td>810</td>
<td>36.5</td>
</tr>
<tr>
<td>Polydrug use</td>
<td>436*</td>
<td>437*</td>
<td>722</td>
<td>474</td>
<td>652*</td>
<td>556</td>
<td>645*</td>
<td>29</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>109</td>
<td>109</td>
<td>102</td>
<td>50</td>
<td>75</td>
<td>60</td>
<td>52</td>
<td>2.3</td>
</tr>
<tr>
<td>Volatile substances /solvents</td>
<td>5</td>
<td>5</td>
<td>22</td>
<td>0</td>
<td>42</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>10</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cannabinoids</td>
<td>6</td>
<td>6</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>0.1</td>
</tr>
<tr>
<td>Others (e.g. alcohol etc.)</td>
<td>112</td>
<td>131</td>
<td>198</td>
<td>2</td>
<td>31</td>
<td>1</td>
<td>5</td>
<td>0.2</td>
</tr>
</tbody>
</table>

* Estimation

Buprenorphine users create still relatively considerable proportion of harm reduction agencies’ clients (about 7.5%) although their number is lower and their occurrence is less prevalent (in terms of geographical spread) than it was in 2010.

According reports collected in 2011, decreasing trend in the number of clients of harm-reduction agencies stopped for that year. It seems difficult to understand relations between numbers of client in low threshold harm reduction agencies and number of patients coming to treatment, as they show incomparable development. From epidemiological point of view, this – at least – could support the idea about their relative mutual independency. Thoroughful analysis is to be done to confirm or refute this assumption.
4.4 Related data and indicators

Though health damage is one of major complications related to problem drug use, not all problem drug users seek treatment. Preliminary result of the study on in-treatment rate coefficient (noted also in section 4.2) showed in two consecutive years that some one fifth of clients of harm-reduction agencies were in treatment in 2010 and 2011.

Preliminary checking of data coming from the pilot drug testing survey, carried out in one prison unit at the second half of 2012, suggested that real drug use in prison is probably not as high as it had been expected after the analysis of anamnestic data and data on testing results collected before. Several rare cases of suspect cocaine use revealed by testing were proven as false positive ones later on, in follow up specific blood tests.

A major part of problem drug users enter some treatment programme at certain moment of their drug career. Patients who meet current EMCDDA operational definition of problem drug use create a huge proportion among treated patients. Selecting a subgroups of patients according the definition, we can estimate that more than two thirds of all treated are problem drug users; this proportion differs significantly comparing those who are treated first time in their lives with those treated repeatedly – while in former group a proportion was nearly 70% in 2011, in the latter one it reaches more than 80%. This applies to treatment in whatever treatment centres, i.e. including prisons’ ones. However, patients treated in prisons’ treatment centres/units appeared as a much more risky group in 2011: e.g. among subgroup of repeatedly treated patients in prisons as much as 93.6% were treated due to use of opioids, stimulants or polydrug use (compared to 78.6% in non-prison
treatment centres). Also patients reported injecting any drug within last 30 days created 71.7% in prisons treatment units while in non-prison treatment centres they created 30.4%.

In accordance with other finding and indices, there are no sharp qualitative or quantitative changes in problem drug users that entered treatment in 2011. As mentioned in Chapter 5.3.1, some increase was recorded in a group of patients treated due to their problem with amphetamine-type stimulants (i.e. especially pervitin in Slovakia), which increased further in all treated in prisons and remained stable in non-prisons centres, while in those treated for the first time ever the increase stopped in 2011, no matter whether prisons treatment centres are included or not.

An overall proportion of repeatedly treated, which is a group with higher risk of problem use, remain stable for several years as regards treatment centres in the health care department, thought figured out in absolute numbers it has been increasing steadily for several last years (since 2008). With decrease of the number of patients treated for the first time in 2011, this proportion exceeded 60%.

Figure 4.4.1 Trend in repeated treatments demands (RTD) and first treatment demands (FTD). Source: NCHI.
5 DRUG-RELATED TREATMENT

5.1 Introduction

Treatment, according to the EMCDDA definition, encompasses medical as well as non-medical approaches. It includes any focused intervention provided to a drug user with a structured goal-oriented plan. This could be residential or can take place in the community. Such interventions include: detoxification, mid- or long-term residential or out-patient abstinence-oriented treatment, substitution treatment, treatment in therapeutic communities and half-way houses and brief interventions or coerced treatment in prison. The treatment of overdoses in emergency units, needle and syringe exchange on the street and the treatment of other health problems associated with drug use, such as treatment for hepatitis C provided to an injecting drug user, are excluded. An anonymous or non-anonymous request for information about treatment options by phone, email or in person is here not considered as treatment. The treatment of co-dependency of relatives and significant others without the presence of the drug user is also not included.

Despite this broader definition, the majority of treatment interventions for drug users are medical in Slovakia. Historically, treatments are realised in medical settings. Non-medical treatment plays only a complementary role.

An important distinction is between voluntary treatment and involuntary treatment coerced by a court order. Voluntary treatment admission is the main part of treatment entry; however, there are a significant number of involuntary treatments.

Three data sources of treatment demand are used for monitoring in Slovakia. They correspond with three different systems of treatment according to the treatment environment and are organised by three different ministries: the Ministry of Health, the Ministry of Social Welfare and Family and the Ministry of Justice. Methodological guidance is elaborated by the Ministry of Health, but it has limited implementation in the prison system and only a marginal role in therapeutic communities.

Treatment-demand data collection has full coverage on the national level in Slovakia. A harmonised reporting form based on the TDI protocol is used to collect individual information from users who have requested treatment. Data collection is realised separately in medical facilities, prisons and therapeutic communities. The first two participate in data collection through unified reporting systems managed by the National Centre of Health Informatics (Národné centrum zdravotníckych informácií – NCZI), and this organisation forwards the aggregated information to the National focal point (NFP). NCZI collects individual data with unique identifiers from treatment providers. It processes them to get aggregated information and publishes an annual statistical bulletin: ‘Drug Addiction – Drug user treatment in the Slovak Republic’ (NCZI, 2012). The publication is a descriptive overview and a presentation of the tables derived from the dataset, which is split according to different variables and their combinations, such as: sex, age, type of primary or secondary drug, education, employment, geography, etc. In addition, the NFP also collects data on treatment demand from the therapeutic communities.

We face three important tasks in the processing of data collection, their quality improvement and assurance: the diagnostic consistency of drug-related problems among different treatment providers, the response rate, and double counting. Systematic attention is paid to these issues.
In the year 2011 a specific survey was conducted among the patients of three specialised Centres for Treatment of Drug Dependencies (CTDD) on the use of fentanyl in cooperation with Early Warning System (EWS) of the Slovak NFP. There were no serious problems with fentanyl abuse reported in the past decade, but recent police seizures, patients’ reports of fentanyl appearing on the market and the risk of fatal overdoses triggered this special survey. Patients diagnosed with a dependence on opioids were screened for fentanyl use. Several hundred out-patients in drug-free treatment and substitution treatment were screened by urinalyses for the presence of fentanyl. Only a couple of samples were positive, all of them from the Bratislava treatment facility in the western part of the country. The CTDD located in Banská Bystrica, in Central Slovakia, and the centre located in Košice, in Eastern Slovakia, did not report any positive samples. However, there were a few self-reports from patients in Banská Bystrica indicating that they had occasionally taken fentanyl, but this was without laboratory confirmation. The occurrence of fentanyl use by some of the opiate users in Bratislava was in the middle of the year 2011, with its peak in the summer months of August and September. There were no patients positive for fentanyl use from November 2011 till the early months of 2012, when the surveillance for fentanyl abuse among treated users of opioids was stopped.

5.2 General description, availability and quality assurance

5.2.1 Strategy/policy

The ‘National anti-drug strategy for the period 2009-2012’ is the main political document for coordinating a drug strategy and activities in the field of reduction of the drug supply and drug demand in Slovakia. In its inter-sectorial approach, the health sector takes on the main role and responsibility in the fulfilment of treatment-demand goals. This is in close coordination with the social and welfare, interior and judiciary sectors. The largest portion of programmes is realised in health programmes and supplemented by social-reintegration programmes, which are mostly run by NGOs and operate within the social and welfare sector and are registered with the Ministry of Interior. A smaller proportion of treatment is involuntary, coerced by court orders in prisons. This is the responsibility of the Ministry of Justice. All of the sectors and their institutions make a concentrated effort to realise the common aims of the ‘National anti-drug strategy for the period 2009-2012’, in its part related to treatment. The treatment of drug users, together with prevention, is considered as the most important part and is an instrument of the national policy. The Ministry of Health is responsible for the organisation, availability, good access and quality of treatment for drug users.

Drug-related problems, especially harmful use and dependence, are considered to be brain diseases. Treatment is organised according to Act № 576/2004 on Health Care and Act № 581/2004 on Health Insurance. Treatment is based on the WHO ICD-10 classification, which is an addendum to the Health Care Act. Medical approaches are prevailing. A smaller proportion of treatment, which fulfils EMCDDA criteria, is also conducted in therapeutic communities outside of the health sector. These are non-medical facilities. The primary task of the therapeutic communities is to facilitate social reintegration of already-abstaining former drug users. Programmes for social reintegration (TCs) of former drug users operate according to Act № 305/2005 on Social-Legal Protection of Children and of Social Guardianship. The Slovak Penal Code (Collective authors, 2011) and Penal Order (Collective authors, 2011) establish the legal framework for procedures of involuntary treatment ordered
by courts. Despite the political changes in the government after the general elections, there was no principal change in the 'National anti-drug strategy for the period 2009-2012' in Slovakia (www.infodrogy.sk).

5.2.2 Treatment systems

5.2.2.1 Organisation and quality assurance

A treatment system is organised in such a way that its continuation and flexibility to changing conditions can be achieved. A high degree of treatment availability and accessibility are the other system requirements. The standards of treatment quality in the health sector are regulated by the Ministry of Health and health insurance companies. The quality of the health care is also under the auspices of the independent Office for Control of Health Care ('Úrad pre dohľad nad zdravotnou starostlivosťou'). Certification of programmes for social reintegration and tying them to grant provision is one of the ways of ensuring quality assurance in non-governmental institutions which are the providers of the non-medical treatment outside of the health sector.

The mental health system provided in community or in residential institutions is the core for the treatment of people with drug-related problems in the country. It is interconnected with the work of general practitioners, with the outreach work mostly done by the social workers in NGOs, and also with the after-care realised in programmes for social-reintegration based on the system of therapeutic communities. These are the different ways by which users get into treatment. Referrals can be made through general practitioners or from street-workers, but self-referrals are the most common. People can just walk-in.

Primary health care specialists and other specialists refer patients to mental health clinics. These are: out-patient and in-patient; general psychiatric or those specialised in addictions; public and private; not for profit and for profit. According to the level of specialisation, three levels of the health care providers exist: primary health care, secondary health care (general psychiatrists) and tertiary (psychiatrists specialised in the addictions). The highest level of specialised care is provided in Centres for treatment of drug dependencies. People can approach any level of the health system, even without a referral. No sharp division exists in the Slovak treatment system between treatment of alcohol-related problems and treatment of problems with controlled psychoactive substances. They are treated in the same programmes, with slightly different protocols. Problems with alcohol, tobacco and all illicit drugs are considered as having a common biological aetiology caused by the influence of psychoactive substances on the brain. It is also difficult to categorise and separate programmes and institutions as out-patient or in-patient. Most of them are a mixture of both approaches.

The development of drug-related problems in Slovakia in the last two decades has confirmed two existing trends: (a) the number of substance users with a double diagnosis of psychosis, affective disorders and other psychiatric conditions in whom addiction-oriented treatment only would not be effective is continuously growing; and (b) the increase of heavy poly-drug use, in which alcohol is involved as a primary or secondary drug. Therefore, it would not be practical to separate in treatment patients with alcohol and other drug-related problems.

Referrals to programmes for social reintegration are made by, or with the approval of, a specialist psychiatrist. The importance of this procedure is higher due
to the increase in patients with a double diagnosis, but also because short periods of
detoxification in medical facilities are not enough to deal with the treatment of all the
other psychiatric or physical signs of withdrawal that frequently occur in these
patients. This trend goes hand-in-hand with the increase in the use of
methamphetamines, cannabis and non-prescribed medicines. Sudden affective
swings, neurological seizure conditions or hidden psychotic cognitive and perception
symptoms develop during the first months of abstinence. Drug-free, non-medical
therapeutic communities are not able to cope with such conditions.

Quality assurance of treatment is based on health legislation and the requirements
of treatment contractors – the health insurance companies. The Office for Control of
Health Care is authorised to supervise the implementation of good medical practices
and to sanction treatment providers in the case of irregularities. The health insurance
companies use contracts and prices as instruments for maintaining the high quality of
the services provided by the treatment providers they have contracted.

Instructions on minimum standards for personnel and material requirements
have been issued by the Ministry of Health for addiction out- and in-patient clinics.
Non-compliance with the given standards may end up in the closure of the facility.
The main difficulty is aging and a reduction of qualified personnel, especially medical
doctors, but also nurses in the health sector in general and also in the field of
addiction treatment. Young health professionals are choosing other specialisations or
are simply moving westward. For this reason three out of eight specialised addiction
CTDD clinics were shut down one after another. This happened in Humenné, Nitra
and Nové Zámky during the last decade. Fortunately, this was when the peak of the
heroin epidemic was already over. The majority of their patients and functions were
moved to and covered by the remaining specialised services. The quality of health
education on the undergraduate and post-graduate levels has been at a good
standard in Slovak medical schools. Curricula contain classes on addictions. Also,
training for specialisation in psychiatry devotes a sufficient amount of time to
diagnostic processes and treatment methods for patients with drug-related disorders.
Modern Slovak textbooks have been published by university teachers. Unfortunately,
due to a lack of interest in obtaining specialisation and working in the field of
addictions in Slovakia, the result was the closure a few years ago of the educational-
training programme for drug counsellors organised by the Institute for Drug
Dependencies in Bratislava. In addition, there are no experts among psychiatrists
willing to obtain another specialisation in the field of addictions. Doctors, nurses and
psychotherapists are obliged to update their professional knowledge and to
participate in continuous lifelong education. The obligation is written into the law.
Professional chambers are responsible for the system and its organisation. Besides
the legal requirements for treatment standards, the Ministry of Health and its expert in
the medicine of drug dependencies are editing the methodological guidelines.

Aside from the legal regulation of treatment quality, the health market is also
an important stimulus. High quality standards of treatment are also requirements of
the health insurance companies. They have set up criteria of quality for treatment
providers, and they contract and price the services accordingly. Among their criteria
is, for example, the requirement to obtain a certificate of the international system of
quality – ISO 9001:2000. An external audit is periodically carried on all diagnostic
and treatment processes in order to retain the certification. All principal addiction
facilities have obtained it. Treatment evaluation and patients’ satisfaction are the
other components which are monitored by the health providers and required by the
insurers. Private health insurance companies are trying to construct a list of health
care providers according to the quality of service. Because these health insurance companies are for-profit, there is a strong economic incentive as well. Therefore, this type of the quality surveillance should be performed by an independent organisation in the future. Despite some shortcomings, in general this effort has a positive impact on the quality of treatment.

Partial indicators of treatment effectiveness are monitored in different programmes, but the most important for evaluation are outcomes in the reduction of drug-related harm, such as low mortality rates among drug users or low non-epidemic incidence and prevalence of HIV infection among drug injectors in international comparisons.

### 5.2.2.2 Availability and diversification of treatment

The provision of sufficient financing is a precondition for the good functioning and good quality of a treatment system. The funding of health care for drug users comes predominantly from health insurance. Every Slovak citizen is insured by law. Instalments are paid to health insurers on a monthly basis. This is obligatory for employed people. The state covers health insurance for those who cannot work: children, retired people, those on long-term sick leave and adults who are registered as unemployed at the labour office. Three health insurance companies were operating on the Slovak health insurance market in the year 2012. Two of them were private and one in the ownership of the state. Health insurance companies contract health care providers, usually renewing or extending their contracts on a yearly basis. Given their restricted resources, how much they are able to contract for a given time-period thus becomes critical for treatment providers. The amount should cover the expected treatment demands from patients. This differs according to the insurance company. The Ministry of Health regulates the prices that can be charged to health companies for diagnostic processes and treatment. It issues a price-list catalogue for all health care activities. The Ministry indicates the minimum prices according to the type of care provided in out-patient clinics and per day for in-patient treatment. The prices are also negotiated between health insurers and health care providers. If an institution’s treatment capacity is full, another facility is recommended to patients, or they are put on the waiting list. Treatment is provided for people who are not insured only in the case of a health emergency. The costs in such instances are paid by the state from a special budget. However, people can pay for treatment themselves directly. This occurs mostly in cases involving foreigners.

Involuntary treatment in prisons is covered by health insurance on the same principles as for health care in the civic community outside the prison system. Two studies have dealt with the system problems of treatment ordered by courts. A retrospective study from the biggest specialised health institution, the Centre for Treatment of Drug Dependencies in Bratislava, analysed the records of 1,484 patients who were sentenced to treatment outside of prison in this health institution during a 12-year period (from 1998 to 2009) (Okruhlica, Ľ., Alexanderčíková, Ž., Olejárová, V., 2011). The majority were sentenced to out-patient treatment; 893 were discharged from treatment, the majority still under the court order, but many of them not attending the treatment. A more detailed analysis was done on a small sample of 58 offenders sentenced to treatment, 69% to out-patient treatment, all of them for alcohol or drug treatment. 56% of them reported for the treatment on time, while 37% did not turn-up for the treatment at all; the rest came late. The most frequent were specific drug-related criminal offences, such as possession, production or distribution of drugs. Such offences were present in the histories of 69% of the persons
sentenced to drug treatment. This was in contrast to the prevailing violent criminal offences in 65% of those with court orders to alcohol treatment. The authors concluded that the existing system is not very efficient and suggested replacing it with coerced treatment as an alternative to punishment. The second study was theoretical (Kolesár, J., Martinove, M., 2011). The authors also came up with a suggestion for amending the Penal Code. They proposed making it possible to use therapeutic communities in programmes for social-reintegration as an effective option for alternative punishment of drug users. Despite the fact that both studies were different in many aspects, they both provide evidence of the intensive professional discussion in this field and the necessity to make changes to it. The topic of involuntary treatment of patients with alcohol and drug dependence was identified as one of the three main problems to be opened for discussion by top forensic experts working in the field of psychiatry (Lexman, J., Droba, S., Kostár, A., 2011). This theoretical paper, supplemented with brief case study, was presented for discussion at the ´7. Bojnické AT dni´ (7th Bojnice AT days), which was the annual meeting of the Section of Drug Dependencies of the Slovak Psychiatric Association in Bojnice.

Therapeutic communities and all programmes for social reintegration receive funds from various resources: grants from the local and regional authorities, grants from the Ministry of Welfare and Family and also funding through a special grant scheme from the Office of the Government. All of them also requested a financial contribution from clients, the amount of which differed from one institution to another.

Some patients with low socioeconomic status, but also some providers, can face problems with the purchase of costly medicines. Naltrexone-assisted treatment in particular did not, in fact, exist in practice, because the costly medication was not covered by health insurance and patients could not afford it. But in general, treatment availability for people with drug-related problems was good. Even homeless people could easily get treatment.

5.3 Access to treatment

Diagnostic and treatment programmes were concentrated in the mental health services. The whole country is covered by a network of mental out-patient psychiatric clinics. More than 90% of them are private. All of them are authorised for out-patient treatment of people with drug-related problems, either through detoxification accompanied by a psychotherapeutic approach, or by long-term substitution treatment in the case of dependence on opioids. The only limitation might be the full treatment capacity in some clinics. However, the density of out-patient mental services was such that it was not a problem to find available treatment slots somewhere in a radius of 30 kilometres from the patient’s residence, and because treatment is fully covered by health insurance, there was no financial barrier to get into such treatment. A small financial contribution was necessary from patients to buy certain medications. If there was such a treatment need, patients from the out-patient clinics were referred for in-patient treatment either to the psychiatric department of a general hospital in the case of serious physical co-morbidity, or to a psychiatric hospital with specialised unit for the addictions. Again, inpatient care was also fully covered by health insurance. The medications provided in wards were free of charge without a patient’s co-financing. The highest degree of specialised treatment for drug-related problems was provided in the Centres for treatment of drug dependencies. Three of them are complex health institutions with in- and out-patient treatment programmes and substitution therapy, and they are connected to street workers on
one side of the treatment spectrum and with after-care in therapeutic communities on the other side. The centres for treatment of drug dependencies and hospitals are mostly in public ownership. General practitioners are not authorised to treat patients with drug-related problems, but must refer them to the mental health services. There is access to addiction-treatment programmes in prisons, with the exception of substitution. Prisons provide voluntary in- and out-patient treatment programmes, as well as coerced treatment upon a court order. This is free of charge for the prisoners. None or only short waiting lists existed for drug treatment, especially in the case of residential treatment, which is a sign of good treatment access. Still, there are a few barriers, and some improvements are possible.

Only one specialised unit for the treatment of children with drug-related problems exists in Slovakia, and sometimes this is not enough. Also, single mothers with small children cannot enter residential treatment, because they are not allowed to take the children with them and have nobody to look after them during their stay in the hospital. They face the same problems in residential therapeutic communities.

Due to the strict drug-free policy, people on substitution were not allowed to continue with this treatment in therapeutic communities. Thus, it was not possible for them to get into a programme for social reintegration.

Access to treatment might be sometimes more difficult due to problems with transport. Not everybody could get into methadone substitution treatment, because there were only two programmes in the whole country and it was not technically feasible to cover several hundred kilometres to get to one.

Another serious problem is the discontinuation and non-provision of substitution treatment in prisons, even for a short term of imprisonment. Restrictions have been introduced by the prison system.

Specialised out-patient addiction clinics and centres for treatment of drug dependencies are low-threshold. They do not require referrals; the patients can just walk-in. No waiting lists exist for out-patient centres. Neither money nor abstinence is required at admission. Urinalysis is a rule, but not for all the patients, and its refusal was not a reason for discharging patients from the programme.

Methadone maintenance and the use of buprenorphine-naloxone were the two main options for patients who were on opiates and asked for this type of treatment. Methadone maintenance is provided in Bratislava and Banská Bystrica, and buprenorphine-naloxone can be prescribed by any psychiatrist in an out-patient clinic. The WHO guidelines for medically assisted treatment are the main methodological guidance for practitioners, and specific national methadone guidelines which are also applicable to buprenorphine-naloxone substitution were designed in line with them. There were no waiting lists for substitution treatment, and the overall treatment coverage, together with drug-free therapy, should be somewhere between 70-80% of all people with heroin dependence in Slovakia.

5.3.1 Characteristics of treated clients (TDI data included)

The situation on drug-treatment demand did not undergo any remarkable changes in the year 2011. The population of drug users is slowly, but gradually ageing; poly-substance use is on a slow, but steady increase, and the same trend is observed in the demand for treatment due to methamphetamine-related problems, while the situation and trend with regard to treatment demand due to opioid dependence is the opposite. Injecting drug use is at a relatively low level mainly due to the decreased numbers of opiate users in the country. The total number of users
asking for treatment due to drug-related problems was on about the same level as it was in the year 2010 and during the whole previous decade.

5.3.1.1 Sex distribution

Male patients predominated over female patients at a rate of more than 4 to 1. There was a slight increase in the number of treated males and a decrease in the number of females, which resulted in a proportional change from 26% female patients in 2010 to 18% in the year 2011. The highest representation of females (48%) was in a poorly represented group (4%) of patients with a dependence on sedatives and hypnotics, and the lowest (8%) was among patients who requested treatment for problems related to the use of cannabinoids. Male patients exceeded the number of treated females in all other drug categories by three to four times.

5.3.1.2 Age of treated population

People entering treatment were still young, with a mean age of 24 years, despite the slight shift to the older age categories. Cannabis users were the youngest group, with a mean age of 23 years (Figure 5.3.1), followed by the users of inhalants – 24 years, stimulants – methamphetamines – 26 years, cocaine – 29 years, opiates – heroin – 31 years, and the oldest age group was made up of patients on sedatives and hypnotics – 43 years.

The median age of drug users demanding treatment shifted from the 20-24 years age group to the 25-29 years age group for the first time. This aging of treated drug users was observed in all age groups. What is important is that there was not only an increase in the number of patients in the older age groups, but at the same time a decrease in the younger age group from 15-19 year-old patients: from 106/100,000 in 2001 to 89/100,000 in the year 2011. It might be interesting to find out how much this might have been influenced by a cohort effect.

5.3.1.3 Education status and employment

Patients with a lower education status, mostly with only an elementary or secondary level of education, were overrepresented in comparison with the situation in the general population. This could be partially attributed to demographics – the young age of the users. More than half of the patients (57%) were unemployed at the time of their admission to treatment.

5.3.1.4 Treatment demand according to primary drug

The amphetamine type of stimulants (mostly methamphetamine - pervitin) was the most frequently used primary drug (34%). This is what drove the demand for treatment in the year 2011. It was followed by opioid (mostly heroin) users (30%), cannabis (mostly marijuana) users (17%) and by demand for treatment due to polysubstance use (11%) (See Figure 5.3.2). Interestingly, treatment demand due to cocaine-related problems remained very low (below 1%) in Slovakia in the year 2011.

An interesting phenomenon on the Slovak drug scene was the small pockets of drug users using buprenorphine in the Nitra region and pentazocin in Kosice. The substances have a tradition lasting several years in these places. The accessibility of drugs in communities plays an important role. The low accessibility of heroin and transitory easy access to fentanyl was an important factor in the small epidemic of fentanyl use among opiate users in the Bratislava region in 2011. Fentanyl overdoses
were also a signal for the police, and this drug was whipped off of the illicit market relatively fast.

5.3.1.5 Methods of drug use

Thirty-five percent of patients who asked for the treatment in 2011 injected their primary drug, with 23% injecting opioids, mostly heroin, and 10% stimulants, mostly pervitin. The majority of opioid users (74%) – had a history of injection drug use. In the case of pervitin, the injectors were in a minority at 31%. Sniffing was the prevailing method of methamphetamines (pervitin) use (by 47% of patients) among those entering the treatment in the year 2011. Among those who used cannabis as their primary drug, smoking was the method of use in 92% of them. Looking at the way in which drug users take drugs, changes on the Slovak drug scene in the last couple of years were in favour of a reduction in harmful activities. The reduction in injecting is reducing the risk of transmission of blood-borne infectious diseases and fatal drug overdoses.

5.3.1.6 Secondary drugs in treatment

The use of a secondary drug(s) was recorded in 46% of patients (in 1,188 out of 2,559). The most frequent were marijuana and pervitin, both of which were reported by 14% of patients, followed by alcohol (5%) and heroin (2%). Many other psychoactive substances, but in small numbers below 1%, were recorded as secondary drugs: petidin, dolsin, buprenorfin, pentazocin, cocaine, MDMA, benzodiazepines, inhalants and LSD. Many patients reported the use of more than one secondary drug. Two methodological problems regarding the TDI indicator are persistent: inconsistency between the way alcohol use is recorded versus other secondary drugs, and tobacco not being included among secondary substances. The number of alcohol users in the coding of secondary drugs is underestimated. The reason might be the positive cultural bias towards alcohol consumption as a part of socially acceptable behaviour. The use of benzodiazepines as secondary drugs also seems to be underestimated. Data are collected from self-reports, but the results of urinalysis did not always match such reports.

5.3.2 Trends in the treated population and treatment provision

5.3.2.1 Trends

Structural changes and trends according to the type of drugs used are of interest. The rate of heroin users dropped from 34.6/100,000 inhabitants in 2001 to 9.9/100,000 in 2011; the use of stimulants (predominantly methamphetamines) increased from 2.7/100,000 in 2001 to 14.6 in 2011, and cannabis from 3.4/100,000 to 7.3/100,000 in the same time period. The changes were consistent in both sexes, but driven mostly by use among males, who are significantly more prevalent in overall treatment demand. The only exception was that there was no change in the rate of female cannabis users. Their treatment demand did not change in the eleven years from 2001 to 2011, remaining at very low levels: 1.2 and 1.1/100,000, respectively. But demand by male cannabis users asking for treatment increased from 5.8/100,000 in 2001 to 13.8/100,000 in 2011. A continuous decrease is observed in the demand for treatment because of the problems associated with the use of inhalants. This phenomenon, which was common more than two decades ago, was represented by only a small, marginal number of patients in 2011.
The heroin drought in parts of Europe, Slovakia included, was probably behind several important changes in drug-treatment demand. It was associated with a decline in heroin use. There were not very successful attempts to replace heroin with other opioids such as fentanyl, but many former regular heroin users switched to a stimulant instead - pervitin. Treatment for opioid dependence and its maintenance were no longer at the centre of drug treatment efforts. The main illicit drug was pervitin, and the popularity of alcohol consumption has been on the increase among young people in Slovakia in the last decade. A shrinking number of the patients in substitution was one of the consequences. There were about 500 such patients at the end of 2011. There was low demand for this type of treatment in the year 2011 in comparison with the 1990s. Estimates of the numbers of problem opiate users in Slovakia were either a reflection of the situation about fifteen years ago during the peak of heroin epidemics, or were biased by some methodological factor, because the numbers in the perspective of treatment demand seems to be grossly overestimated. Methamphetamine dependence and poly-substance use, often combined with alcohol, were the main issues which pushed aside opioid-related drug problems in the year 2011. These were the main topics at the ‘7th Bojnické dni’, the Annual Meeting of the Section for Drug Dependencies of the Slovak Psychiatric Association (Alkoholizmus a drogové závislostí, 2011). Trokanová (Trokanová, Z., 2011) discussed the not so frequently presented problem of co-dependence on sedatives and hypnotics with alcohol among women. Supported by case studies, she identified the over-prescription of medicines by general practitioners and some specialists and the low level of social nuisance as the factors supporting this poly-substance use with dependence. Problem-focused analysis was provided by I. Šteliar from the Slovak NFP (Šteliar, I., 2011). In his retrospective epidemiological statistical analysis, he combined data reported by health facilities with data from low-threshold NEPs and data from the questionnaires used in population surveys. This revealed a stable situation, even a decrease in the use of illicit psychoactive substances mixed together with alcohol during the same occasion by drug users. Because of the signs of more intensive marketing of the new synthetic, so-called designer drugs in the Central Europe, a limited but interesting survey was conducted on a selected sample of 100 young participants at the ‘Pohoda´ open-air music festival (Tejová, M., 2011). There was a higher proportion of males (65%) in the study. The average age was 24 (SD±4) years. A total of 75% of the respondents had knowledge about the existence of synthetic drugs, while 19% had personal experience with their use and 17% had a positive attitude toward them. These products were available in “Crazy shops”, later called “Euphoria shops”, and via the Internet. However, no treatment demand due to dependence on these substances was recorded in Slovakia in 2011. Reports and case studies from the clinical health setting brought evidence of the use of other psychoactive substances such as mefedron (4-methylmethkathinon) (Korcsog, P., Strečka, P., 2011), even if they were still ‘under the detection threshold’ of TDI in Slovakia. Their use was not extensive, but it was associated with dependence.

5.3.2.2 Geography - distribution

Geography, it seems, was still playing an important role in the field of drug use in Slovakia in the year 2011. The majority of treated drug users had permanent residence in the Western parts of the country, and the highest number was in the Bratislava region (the capital); only a few were from the Eastern region of Prešov. But the distribution of patients according to their place of residence is more even than it was in the year 2000, when over 50% of patients were from the Bratislava region,
while this figure was only 30% in 2011. The total number of the patients asking for treatment in Bratislava did not change in the previous five years, but there was an increase in some regions of the rest of the country: in the Trnava, Nitra, Žilina and Košice regions. Statistical analysis show that even if there are a reduced number of treated heroin users, it is still the primary drug in Bratislava, but demand for treatment by methamphetamine users is closing in. In the regions outside of the capital it is methamphetamine which is the number one drug responsible for the increase in drug-treatment demand. The only exception was the Prešov region, which had the lowest overall treatment demand incidence and prevalence of drug users. There the most frequently demanded treatment was by people with problems related to cannabis use (2.6/100,000), followed by methamphetamine users (2.2/100,000) and heroin users (only 0.4/100,000). This was in sharp contrast with the 47/100,000 opioid patients in Bratislava in 2011. One of the plausible explanations is the existence of huge difference in the economic conditions, personal income and rate of unemployment between these two regions. While Bratislava is the richest part of the country, the Prešov region is the poorest, with the lowest per capita income and the highest rate of the unemployment. This might explain why the overall prevalence of drug use is lowest there, and why consumption of the relatively cheap cannabis prevails in the Prešov region.

Figure 5.3.1: Treated patients according to their age group and type of primary drug. Source: NHIC
Figure 5.3.2: Share of treated drug addiction patients according to the main groups of drugs. Source: NHIC
6 HEALTH CORRELATIONS AND CONSEQUENCES OF PSYCHOACTIVE SUBSTANCE USE

6.1 Introduction

The prevention and reduction of health-related harm associated with drug dependence was the subject of a Council Recommendation in 2003 (2003/488/EC) and is addressed in the current EU Drug Strategy in its Action Plan and also in the Slovak ‘National anti-drug strategy for the period 2009-2012’. The specific, concrete tasks were targeted efforts to develop a range of specific services and programmes which are aimed at risk reduction. Among them are measures to reduce the incidence of infectious diseases, fatal overdoses and morbidity among drug users. The National Focal Point at the Slovak National Monitoring Centre for Drugs organises data collection. It selects the organisations to perform the tasks. In addition, the methodology of the relevant data collection is, to the extent possible, harmonised with EMCDDA standards.

Monitoring the prevalence of blood-borne infections among drug users is among the health correlates with high priority. HIV incidence and prevalence data are gathered from the health sector, from the database at the National Centre for Reference on HIV/AIDS. The centre uses European methodology of data collection, in which the method of transmission is also a variable, and via injecting drugs is among the several response options. There has been a national register of all HIV-positive cases tested by the Slovak health services in the country since 1982. The register is exhaustive, but only findings from people who were tested in Slovakia and were known to the Slovak health system are recorded.

The Centre for Treatment of Drug Dependencies (CTDD) in Bratislava was selected as the main source of pilot data on the incidence and prevalence of hepatitis C, HIV, syphilis and other infections transmitted by the use of shared injection paraphernalia, or which are frequently associated with drug-using behaviour, such as other STDs, tuberculosis and other infections, if there are any signs of their possible occurrence. The CTDD was selected because it is located in the centre of the capital city, where the occurrence of drug use is the highest and has the longest history. The centre has the largest clientele and longest history of collected data, which goes back to the mid-1990s.

The Office of Public Health collects notifications about new infections on the national level. It is limited by the oscillating degree of reporting and cooperation of doctors. The main method is the testing of biological samples and the collection of behavioural data by self-reporting questionnaires. The use of qualitative information is sporadic.

Additional sources provide the data which are not collected regularly but which come from ‘ad hoc’ surveys and studies, predominantly from the population treated in health institutions. This approach was used to obtain information on the occurrence of psychiatric and somatic co-morbidities. The studies focused on emerging health problems in clinical practice which were frequently associated with drug use. Most of them were quantitative, clinical and retrospective with simple statistical analysis.

Fatal overdoses are reported with yearly periodicity from departments of forensic medicine. All the sections of all deaths caused by suspected intoxication should be done there. The other type of study started only last year. Its aim is to detect the
mortality of former patients treated for drug related problems in the CTDD via a national register of people with Slovak health insurance.

### 6.2 Drug-related infectious diseases

Testing for HIV and hepatitis C infections has been prioritised among drug users. The reason is that regular drug users, especially those who are injecting drugs, are at high risk of contracting these infections and their treatment is both difficult and expensive. Less emphasis has been placed on screening by testing for other infections among drug users, such as hepatitis B, STDs and tuberculosis, because they are less prevalent and/or not transmitted directly by the methods of drug use. The number of infected problem drug users with the hepatitis B virus has been low for several years due to continuous vaccination of all newborns.

#### 6.2.1 HIV

**Methods:** Testing is voluntary with signed informed consent. It takes place in a doctor’s office during the admission procedure. A patient can refuse testing without any sanctions. Pre-test and post-test counselling are parts of the process. HIV testing is done from the blood of patients who have asked for treatment in an addiction facility selected for sentinel monitoring of the incidence and prevalence of blood-borne infectious diseases. Firstly, the front line immunoassay testing is conducted in the laboratory and then, if the sample is reactive, confirmatory testing with ELISA and Western Blot follows. Because of different causes of cross-reactivity of immunoassay, only approximately 1 in 10 reactive samples were confirmed as positive for HIV infection in the Slovak National Reference Laboratory for HIV/AIDS.

HIV testing is routinely offered to people attending health care facilities in Slovakia as patients. Especially high coverage has been achieved among pregnant women and also a high response rate occurred in testing which is done prior to surgeries. No significant change was registered in the incidence and prevalence of HIV infection in the general population or among problem drug users in Slovakia in the year 2011. It did not achieve the level of an epidemic. However, the prevalence in the general population is on a slow, but continuous increase, because of the effective medical treatment of those who are already infected. Even in these small numbers, it is apparent that drug injecting as a probable method of transmission is far behind heterosexual and man-with-man sex as modes of transmission in the country. There were no cases of new HIV infection identified in the sentinel monitoring during the year 2011. The majority of the reported cases of HIV from the general population were from the Western regions, mostly from Bratislava, and the lowest prevalence was in the Eastern parts of Slovakia.

The results of a large sero-prevalence study of 846 injecting drug users from the years 2004 – 2008 was recently published (Gazdíková et al., 2012). Nobody tested positive for HIV antibodies in this sample. According to statistics from the National Reference Centre for HIV/AIDS, only two males were confirmed as positive for the HIV antigen out of 548 tested drug users. The prevalence rate in the subpopulation of drug users was less than 1% (0.4%) and remained on the same level as the findings from the previous five years. However, the number of persons tested was the largest in the year 2011.

A project of HIV and HCV testing has been designed by the NGO Odyseus, which is working in the streets with the injecting drug users. The results are not yet available.
6.2.2 Hepatitis C (HCV)

The most probable and high-risk mode of hepatitis C virus transmission is through the sharing of used injecting paraphernalia among drug users. There is an epidemic of hepatitis C (HCV) infection among problem drug users in Slovakia which has lasted for more than 10 years. This is in contrast with the spread of HIV infection in the country. The findings do not support the hypothesis of their co-occurrence. Consequently, it probably indicates the different effectiveness of selective harm-reduction measures, such as NEPs, with regard to HIV and HCV infections.

The CTDD implemented the same clinical protocol for the testing of HCV antibodies as was used in the case of HIV. The testing of HCV antibodies in the serum from venous blood was conducted in a medical laboratory upon request of the clinical addiction centre, with confirmatory testing in the case when positive HCV antibodies were detected. For logistical reasons and cost-effectiveness, RNA testing and genotyping was not done. Patients who tested positive for antibodies were advised during the post-test counselling to visit specialist in hepatology or in infectious diseases for further diagnostic specification and treatment. More detailed virology testing was also performed. All of the procedures were done with informed consent and thus on a voluntary basis.

Overall HCV prevalence in our sentinel sample remained at 40% in 2011, thus at a level identical with the 2010 findings (Graph 1-6). As was expected, the rates of patients with HCV positive test results correlated with the age of injecting drug users, and the rates showed an increase: 30% in the age group below 25 years of age, 32% in the age group from 25 to 34 years and 80% in the age group of the patients older than 34 years. However, the validity of these findings is not very strong because of the small sample size, because the difference between 30% and 32% is not significant, and because there were only five injecting users above the age of 34 years. There was no increase in the rates of HCV positive patients who asked for treatment in comparison with the year 2010. A little more convincing is the evidence of higher rates of HCV infection, which are growing over time from first injection in these data. While HCV positive results were 26% and 17% among injectors who injected drugs for the first time in their life less than 2 years ago and from 2 to 5 years ago, respectively, this figure was already 50% and 71% positive for HCV in the group with a history of the first injecting from 5 to 10 years ago and more than 10 years, respectively. No change was observed in comparison with the previous year. Still, the highest rate of HCV infections (68%) was found among injecting drug users who were dependent on opioids, while only 28% were found among those whose primary drug was another substance, mostly methamphetamines – pervitin. A decrease in HCV infections was observed among IDUs in the first treatment demand, from 52% in 2010 to 32% in 2011 (Figure 6.4.1), which should not be overestimated because of the small samples: 33 and 32 patients. What is important, on the other hand, are the small samples of injecting drug users in the last two years out of total treatment demand, which did not change. Three years ago the number was nearly double – 59 injectors.

A more detailed serological prevalence study of 846 injecting drug users tested in the period of time from the year 2004 to the year 2008 was recently published (Gazdíková et al., 2012). The prevalence of HCV antibodies in this sample increased from 34% in 2004 to 78% in 2008, and HCV RNA assessed by PCR rose from 17% to 71%. Genotype distribution was in favour of genotype 3.
6.2.3 Hepatitis B (HBV)

A similar protocol concerning medical office procedure was used with HBV as was used in the case of testing for HIV and HCV infections. The core antigen was requested as a marker of hepatitis B virus, as it is indicative of past HBV infection.

The overall prevalence remained on the stable low level of 22% in the year 2011. This might be even lower if there was not a high rate of 57% HBC positivity in the group with the longest history of injecting; that is of 10 or more years. In groups with shorter periods of injecting, this varied between 9% and 14%. The cohort effect could be responsible. Again, as in the case of HCV infection, the prevalence of 32% was higher among IDUs with opioids as their primary drug than it was among users with another primary drug, mostly methamphetamines - 16%. A slight decrease to 14% of HBV was observed among IDUs in the first demand for treatment. This small prevalence rate is associated with, and might be explained by, the extensive vaccination against HBV in the population.

Hepatitis B as a recent infection, as disease, was present in only 0.4% - 3 cases in the above mentioned large sample (n = 846) of tested injecting drug users. Each HBsAg that was found positive was confirmed by HBV DNA (Gazdíková et al., 2012).

6.2.4 Other viral hepatitis

Testing for hepatitis A, D and others is not included in the list of routine tests of blood for viral infections for epidemiological purposes. Their occurrences are very small in association with drug use in Slovakia at present.

6.2.5 Syphilis

The prevalence of syphilis among the first admissions of injecting drug users was 1.5% in the Centre for Treatment of Drug Dependencies in Bratislava in the year 2011, which was the lowest rate in the last three years. Only one of 67 patients was positive for BWR.

6.2.6 Other STDs

The impression based on clinical practice shows that other sexually transmitted diseases (STDs) also frequently occur among drug users. Gonorrhoea and trichomoniasis are found especially among those who earn money in the sex business. We do not have any quantitative data, because the screening of these STDs was not conducted.

6.2.7 Tuberculosis

Tuberculosis also belongs among diseases which occur among drug users. TB was last screened for in the CTDD at the end of the 1990s. The testing was stopped because there were no positive results for TB among the tested patients, and it has not been renewed since that time. There has been a continuous decrease in the number of the patients diagnosed with TB in the general population in Slovakia. The rate has dropped below 10/100,000, which indicates, according to WHO standards, the possibility to stop vaccination in the population. The majority of the reported cases of TB in the general population were from the Eastern regions, and the lowest prevalence was in the Western part of Slovakia. This is just the opposite of what was recorded for HIV. The findings support the hypothesis that there are two different sources of these two infections, and thus far they are not associated together in
Slovakia. Their transmission by drug injecting does not seem to be their common denominator.

### 6.2.8 Other infections

There was no monitoring of any other infections among drug users in Slovakia. In part, this could be because there was not sufficient clinical evidence for the need to do so. This might be the case for abscesses, which are very rare due to changes on the Slovak drug scene at present. But it is also partially due to the unrecognised non-specific symptomatology covered by the use of drugs, which might be the case of endocarditis. There was anecdotal clinical evidence of cases of injecting drug users diagnosed with endocarditis, but extensive screening was not available. No cases of tetanus, botulism or any other rare infections associated with injecting drug use were reported.

### 6.3 Other drug-related health correlates and consequences

Several studies focused on selected psychiatric comorbidity and a few dealt with the co-occurrence of somatic disorders other than infections.

The majority of the studies on psychiatric co-morbidity dealt with the co-occurrence of psychotic disorders mainly among patients with dependence on methamphetamines – pervitin. This was demonstrated by quantitative research and also described in case studies. Palkovič et al. (2011) in their retrospective clinical study used the case register of patients from the Centre for Treatment of Drug Dependencies in Bratislava. They searched for the presence of psychotic symptomatology in the records of all the patients treated for dependence on methamphetamines during the time period from the year 2004 to 2008. A sample of 318 patients with an average age of 23 years was made up of 68% males and 32% females. Psychotic disorders were detected in the histories of 29% of the whole sample. Psychotic symptoms were more frequently found (in 35%) in the subgroup of patients who injected pervitin. Researchers from the Department of Psychiatry School of Medicine at Comenius University in Bratislava studied the prevalence and psychopathology of toxic psychosis (André et al., 2011). Their study was a descriptive, retrospective clinical study of in-patients. A study sample with ICD-10 diagnosis of non-alcohol toxic psychosis was formed from 93 patients with an average age of 29 years; 86% were males and 14% females. The most frequent cause of the psychotic condition was poly-substance use (F19.5) in 45%, followed by amphetamine and methamphetamine use (F15.5) in 32% and by cannabinoid use (F12.5) in 9% of the patients. Both of the above-mentioned studies also noted the importance of distinguishing between toxic psychosis and schizophrenic psychotic disorder associated with psychoactive substance use or dependence. An extended demonstration of different psychiatric co-morbidities with dependence was presented in case reports from clinical practice by Bohonová (2011). She noted that personality disorders, affective, anxiety and acute transitory psychotic disorders were the most frequent co-morbid psychiatric disorders among patients with dependencies in her outpatient clinic.

Scientific, evidence-based data on other co-morbidities are rare. One prospective, comparative clinical study on sexual disorders among patients entering addiction treatment is in print (Alexanderčíková et al., in print). Another long-term, prospective study followed the changes in Body Mass Index (BMI) of 42 patients in methadone substitution treatment (Slezáková, S., Okruhlica, L., 2012). No correlation was found
between the daily dose of methadone and BMI. The authors came to the conclusion that weight gain cannot be considered as a pharmacological side effect of medication with methadone, but it is more probably attributable to changes in the patients’ lifestyle and as their convergence with nutritional population habits.

Emergency departments treat the majority of drug overdoses, but sometimes patients with drug intoxication are taken directly to a psychiatric department or psychiatric hospital. No systematic data collection or register of non-fatal drug intoxications exists. This does not mean that overdoses do not exist or that they are rare. Treatment of drug overdoses is part of the routine work in the health emergencies. Only sporadic reports on non-fatal overdoses appear in Slovak professional journals. This, for example, was the case report on acute cocaine intoxication (Višňovský, E., 2011).

6.4 Drug-related deaths and mortality of drug users

According to official statistics, 51,903 people died in Slovakia in the year 2011. Medical autopsies were performed in 7,370 cases, which was 14% of all recorded deaths.

6.4.1 Drug-induced deaths (overdoses/poisonings)

The departments of forensic medicine reported 42 cases of direct fatal drug-induced poisoning. Medicines were the cause in 62% (26 cases) of cases, and overdoses by illicit psychoactive substances and inhalants were the cause in 38% (16 cases). Opioids were the main cause of 12 and benzodiazepines of 9 deaths (DRD statistical data). Males dominated with 69%. Most of the deaths occurred in the age range from 30 to 54 years, with the peak in the age group from 30 to 34 years.

6.4.2 Mortality and causes of death among drug users (mortality cohort studies)

A retrospective cohort study on mortality among patients treated at the Centre for the Treatment of Drug Dependencies in Bratislava was completed in 2012 (Slezáková, S., Okruhlič, L., in print). The highest mortality rate was among patients with a dependence on sedatives (25.0 deaths per 1,000 persons-year) and on inhalants (21.3 deaths per 1,000 persons-years, but this was only a small group), which was followed by patients with dependence on opioids (7.3 deaths per 1,000 persons-years). The overall mortality rate was 6.1 deaths per 1,000 patients in a year.

Despite the fact that drug-related deaths and mortality of drug users seems to be clearly below the European average in Slovakia (Figure 6.4.2), they are still well above the average for mortality in the corresponding age group of the general population. Therefore, more efforts should be made to improve data collection with regard to drug-related deaths, but also non-fatal drug overdoses. More information would serve in the process of developing new interventions and responses in the future.

6.4.3 Specific causes of mortality indirectly related to drug use

Departments of forensic medicine reported 67 deaths indirectly related to drug use in the year 2011 in Slovakia. Males in the range from 20 to 39 years of age were predominant among them (79%). The peak was observed in the age group between
20 and 24 years. Suicides represented 43% of the causes of deaths, followed by accidents (40%) and by drug-related diseases in 9% of the cases. Benzodiazepines were the most frequently found substance, occurring in 34% of cases, followed by amphetamines and methamphetamines in 27% and by opioids and cannabinoids, each found in 10% of deaths. Interpretation of the statistics is limited by the small number of post-mortem toxicologies which were conducted in the whole country.

There are several reasons for the low death rates in Slovakia in comparison with Europe: the young population of current and former drug users, especially those who inject drugs; the decrease in opioid use and decrease in drug injecting in general; as well as the good availability of health services. An increase in the numbers of premature deaths associated with hepatitis C infection contracted by injecting drug use is a threat in the future. This is increasing with the aging population of people who injected drugs in the past and have been positive for the hepatitis C virus for several years. The remedy should be appropriate responses from the existing health care system in the country. The main task seems to be an effort to increase the motivation of these people to enter treatment for HCV infection and to comply with it, despite the fact that they are not suffering from any signs of the illness at present.

Figure 6.4.1: Trend of the occurrence of HCV among first admissions to the CTDD Bratislava. Source: CTDD
Figure 6.4.2: Comparison of mortality among the cohorts of patients treated for opioid addiction in Slovakia with programmes in selected EU countries (selected EMCDD data on mortality was used, EMCDDA, 2011). Source Slovakia: CTDD
7 RESPONSES TO HEALTH CORRELATES AND CONSEQUENCES

7.1 Introduction

Needle and syringe programmes (NSP), (programy výmeny/poskytovania sterilných ihiel a striekačiek) provide sterile needles and syringes and other equipment to drug users to prevent health-related harm.

The provision of sterile needles and syringes covers exchange, sale and free distribution.

Low-threshold programmes, programmes to assist drug users without high demands, which are entered without high requirements imposed on clients as a condition for their admission, such as free-of-charge NSPs, outreach street work and low threshold substitution treatment for people with dependence on opioids.

Blood-borne infections, typical representatives are viral hepatitis C and B and HIV, which can be transmitted from person to person by blood, either by sharing non-sterile needles, syringes, or other injecting paraphernalia, or by blood transfusion or tattooing.

Co-morbidity, the co-occurrence of psychiatric or somatic disorders together with drug dependence.

7.2 Prevention of drug-related emergencies and reduction of drug-related deaths

The Early Warning System (EWS) functions in both directions, up and down, from the drug scene, through services, to the National Focal Point and vice versa. The important role of EWS in the prevention of fatal and non-fatal overdoses has been proven by the prevalence of fentanyl and other synthetic drugs in so-called Crazy and Euphoria shops in Slovakia. Health officials and other authorities adopted preventive and repressive measures, and police acted swiftly. The reaction was the closure of the shops and an illicit fentanyl laboratory and reduced availability of the new synthetic drugs, which resulted in a decrease in temporarily increased drug overdoses.

Prevention is based on health education and prevention in young people who are at risk of drug use and prevention among drug users. The aims are different. In the case of primary prevention, the goal is to avoid drug use, while in the case of drug users it is an effort to change their behaviour, to enter drug treatment programmes, or at least to not combine drugs at the same time and to move from injecting drug use to safer ways of drug-taking behaviour.

7.3 Prevention and treatment of drug-related infectious diseases

Prevention and education of drug users, specific selective prevention targeting injecting drug users: NSP, which are ‘needle and syringe exchange programmes’ to prevent the spread of infectious diseases; targeting chronic opiate users with dependence: OST, opioid substitution treatment with methadone and buprenorphine-naloxone; availability and access to specialised addiction treatment and to treatment in general. The demand for substitution treatment has been continuously decreasing in Slovakia for the last decade. Not only is there a lower incidence of new opioid...
users demanding treatment in the country (see TDI), but the prevalence of those in OST, for example at the CTDD in Bratislava, is also gradually decreasing. Therefore, the recent challenging task is to find effective responses to prevent the spread of infections among methamphetamine users who are injecting pervitin.

7.3.1 NSP

An NSP is organised in different ways: the exchange of used needles and syringes by street workers, the provision and exchange of used syringes for free through specialised addiction treatment facilities and the provision of inexpensive sterile needles and syringes in pharmacies. Public pharmacies are the main source of sterile injecting equipment. They cover the whole country.

7.3.2 HCV and HIV testing

The motivation for and the provision of testing for HCV and HIV, especially for injecting drug users, is the first step for detection of those already infected and is followed by the motivation to enter specific antiviral treatment. Testing alone even increases responsibility and changes the behaviour of drug users. Those who are negative are more cautious not to inject anymore, or to not share injecting behaviour in the future, and those who are infected, except for the possibility of entering treatment, are more careful not to infect others. One important element is a standard process consisting of pre-test and post-test counselling.

7.3.3 HCV and HIV treatment

HCV and HIV treatment is free of charge. The combination of pegylated interferon with ribavirin is a standard treatment for hepatitis C infection. The latest approach, specifically for non-responders infected with genotype 1 HCV, was the introduction of new direct-acting antiviral medications from the protease inhibitor group – telaprevir and boceprevir – into practice (Kristian P. et al., 2011). The treatment period is for 6 or for 12 months, if necessary, based on the presence of the virus. Also, patients on substitution treatment have access to treatment of HCV infection without payment. This was a positive change, because in the past health insurance companies did not cover the treatment of HCV for patients on substitution treatment. Treatment is not reimbursed only for those who are active problem drug users. Such a barrier does not exist in prison, and so it is available free of charge for all those who are in need of it.

HIV treatment is also free of charge for all drug users. It is fully paid by the health insurance companies. The anti-retroviral treatment with a combination of medicines starts according to the detected viral load.

Treatment of blood-borne infectious diseases in drug users is voluntary. But sometimes the problem is the intention to start treatment and compliance with it.

As has been shown by a survey conducted among infected drug users with HCV, their motivation to enter anti-retroviral treatment was low, even among those who were already abstaining from drugs (Slezáková & Okruhlica, 2011). Out of 290 HCV infected non-treated patients 45% did not comply with conditions set by the health insurance company, 22% were not interested in HCV treatment, 6% were afraid of its side-effects and 27% mentioned other reasons, such as, for example, pregnancy (Figure 7.4.1).
7.4 Responses to other health correlates among drug users

7.4.1 Toxicology/Urinalysis

The appearance of new synthetic drugs especially put extra demand on the thorough evaluation of mental status, namely in psychiatric emergencies. The toxicology of biological material plays an important role. So the toxicological screening of all psychiatric emergencies for the presence of psychoactive substances should become part of the standard psychiatric examination. The aim is to improve the diagnostic process, to make it faster and to avoid misdiagnosis. A pilot study of 22 patients sent for further treatment of dependence to the CTDD in Bratislava after previous treatment of acute psychotic episode revealed that only 6 (27%) had undergone a toxicological urinalysis (Palkovič, P. et al., 2011). Korcsog demonstrated in his case study (2011) an example of the difficulties of proper diagnostic assessment of the psychotic condition associated with chronic methamphetamine use without early toxicology.

7.4.2 Surveys on availability and access to treatment

Two surveys which could be relevant to the year 2011 were conducted with respect to the availability and access to treatment for drug users (Cole. authors, 2009; Plán B, 2011). The first, an international IATPAD study, had a broader concept and goals dealing with people having problems with the whole spectrum of psychoactive substances, while the second focused on access to substitution treatment for people with a dependence on opiates. Despite the different methodological approaches, the emphasis on qualitative information (Plan B) and more balanced qualitative and quantitative methods (IATPAD), the studies came to identical conclusions based on their findings: that in some places access to treatment, especially for injecting drug users, is difficult because of the prejudices on the side of the health care personnel and also because of the shortage of specialised care providers in the field of addiction.

7.4.3 Education and training

Great attention is paid to education: the education of medical nurses and pharmacy students, as well as the on-going education of health professionals about new drugs, trends and treatment opportunities. Teaching papers were published for a wide spectrum of health professionals in the professional, specialised Slovak journal ˝Alkoholizmus a drogové závislostí˝ (Novotný & Kolibaš, 2011; Kolibáš & Novotný, 2011; Krajčovičová & Hanzelová, 2011).

All health personnel should undergo lifelong education to update their knowledge of the latest news in the field. This is also in accordance with the Act № 366/2005 Coll. (MZ SR, 2005) and on the basis of agreement between The Slovak Accreditation Council for Continuing Medical Education and The European Accreditation Council for Continuing Medical Education. Except for self-education, several other structured forms of learning are required: regular attendance at teaching seminars, professional and scientific seminars and conferences, the presenting and writing of professional papers and research. This applies to every individual health worker registered with the Slovak Medical Chamber, the Slovak Chamber of Nurses, the Slovak Psychological Chamber and so on. In the year 2011 the most important scientific event with learning components was the conference on ˝Alcoholism and Toxicomanies˝ - ˝Bojnické dni AT˝ of The Slovak Psychiatric
Association in Bojnice. Specialised addiction clinics hold regular training open-seminars during the academic year which are registered with the Slovak Medical Chamber.

### 7.4.4 Quality Assurance

The quality of the services is under the control of the Ministry of Health, the Health Departments of the Offices of the Regional Governments and the Office for the Control of Health Care, which is a body independent from the state. These authorities are responsible for the control of health care providers, determining if in their clinical practice they comply with the health laws, methodological recommendation guidelines on diagnostic and treatment processes, the requirements of quality, the types and numbers of personnel, as well as diagnostic and treatment equipment. Similarly, quality requirements demanded of health care providers by health insurers are even more demanding. To be able to cope with them, specialised addiction centres and mental hospitals have entered the process of continuous certification of quality – ISO 9001:2000. The facilities also have internal systems of quality control of their diagnostic and treatment processes. Feedback from patients/clients is an important part of it. The CTDD in Bratislava, for example, periodically administers the CSQ-8 (Client satisfaction Scale) to its patients. For treatment outcome evaluation studies, monitoring is conducted by larger addiction service providers (OLÚP Predná Hora, CTDD Bratislava). No results from the year 2011 were available.

Figure 7.4.1: HCV positive drug users, reasons for not taking anti-retroviral therapy (from Slezáková, Okruhlica, 2011)
8 SOCIAL CORRELATES AND SOCIAL REINTEGRATION

The use of drugs and mainly addiction to psychoactive substances can be understood as a cause of social exclusion in consequence of reduced income or job loss and deterioration of the housing condition leading to homelessness. On the other hand, social exclusion resulting from other reasons can be the cause for which individuals exposed to such risk begin to consume psychoactive substances.

Social reintegration is considered an inevitable component of complex anti-drug strategies and can take place at any stage of drug use and in a variety of environments. It comprises the building of capacities, improvement of social skills, measures to facilitate and support employment, and acquisition or improvement of dwelling.

The primacy among the consequences of drug use is ascribed by the population addressed within recent surveys (NMCD 2009, NMCD 2010) to social factors – unemployment, destruction of the family, social exclusion (47.5% and 49.3%, respectively). More than one fourth of respondents in both surveys (29.3% and 29.8%, respectively) associate a growth of the crime rate with the use of drugs. Impacts on health of the users are claimed by 38.4% and 40% of the respondents aged 15 to 64, and 19.8% and 27.3% of respondents are scared of the impacts on public health represented by the spread of HIV/AIDS and other blood-borne diseases (Klobucký, 2011 in the 2011 Report, Tab. 1.6.4).

In previous reports, a reference was made to the National Plan of Social Inclusion (2008-2010) where main groups of population exposed to the risk of poverty and social exclusion were explicitly defined. They include unemployed persons, specific long-term job seekers, marginalized communities (mainly the Roma) affected by multiple exclusion, homeless persons, disabled individuals, migrants, and multi-child or incomplete families. Other vulnerable groups include but are not limited to individuals with the problem of alcohol and drug dependence, pathological players, abused children, victims of domestic violence, released persons, and young people who, after reaching the age of majority, leave institutions of institutional care (Czuczorová 2010). However the individuals addicted to drugs or former addicts were not explicitly categorized.

On the other hand the National Anti-Drug Strategy for 2009-2012 emphasized the importance of continued development of rehabilitation, re-socialization and social reintegration services and programs aimed at the achievement of measureable progress.

8.1 Social Exclusion of Drug Users

No new studies or surveys, except for data from annual statistical surveys of the National Health Information Centre (hereinafter referred to as the “NHIC”) concerning the drug users who receive treatment and partial data of 262 clients of re-socialization centres in 2010 from Tománek survey (2011), are available to the NMCD.

93 The concept of vulnerable groups according to the EMCDDA
8.2 Social Characteristics of Drug Users Receiving Treatment

Some social characteristics of the clients - patients receiving in-patient and out-patient treatment are monitored within the health statistics (namely economic activity/inactivity, education received, living conditions, living with a child). The NHIC provides the NMCD with data for standard statistical tables - TDI (Treatment Demand Indicator) in a detailed structure which partly differs from publicly available statistical yearbooks. The required breakdown of patients receiving treatment is limited here to patients within the responsibility of the Ministry of Health (a total of 1,639 patients in 2011) and to patients (674 persons) within the responsibility of the Ministry of Justice. The majority of patients receive a court-ordered treatment (in-patient or out-patient) that is not always voluntary and does not always correspond to the characteristic of the TDI – treatment demand. For the purposes of this chapter, the number of all patients is listed, i.e. 2,313 in 2011. It is to be noted, however, that the share of stable long-term unemployment is significantly reflective of a 29% share of patients within the responsibility of the Ministry of Justice covering all facilities for service of custody of the accused and convicted, including a special healthcare facility in Trenčín.

Findings:

Compared with the last year, the share of patients with elementary education slightly decreased from 41% to 37.8% (from 2,313). The most common level of educational attainment is secondary school (with or without a secondary school-leaving examination), namely a 51.7% share which has been stable for a long time (51.6% and 50% in 2010 and in 2009, respectively).

The second predominant and stable characteristic of the treated patients in the long-term overview is the majority of the unemployed persons. In 2011, a significant share in the category of the unemployed (1,300 people) was represented by patients treated for heroin dependence (223 men and 68 women – a 22.4% share in total) and for pervitin dependence (360 men and 56 women – a 32% share in total).

Development in some social characteristics of the patients receiving treatment since 2003 is shown in Table 2.1.1

---

Table 8.2.1: Overview – Share of patients receiving treatment in selected social characteristics since 2003. A total of 2,313 patients were treated in healthguardianship facilities in 2011, of which 6 people were not permanent residents of Slovakia. Source: NHIC, ZŠ-44/2012

<table>
<thead>
<tr>
<th>Social characteristics</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unstable housing</td>
<td>6.6</td>
<td>7.6</td>
<td>8.9</td>
<td>8.6</td>
<td>9.6</td>
<td>7</td>
<td>10.6</td>
<td>11.9</td>
<td>11.2</td>
</tr>
<tr>
<td>Share of patients within the responsibility of the Slovak Ministry Justice/prison</td>
<td>1.9</td>
<td>1.6</td>
<td>1.6</td>
<td>1.0</td>
<td>0.8</td>
<td>1.4</td>
<td>0.6</td>
<td>0.8</td>
<td>8.3</td>
</tr>
<tr>
<td>Unemployed persons</td>
<td>55.2</td>
<td>54.2</td>
<td>54</td>
<td>55.2</td>
<td>56.5</td>
<td>53</td>
<td>63.2</td>
<td>59.7</td>
<td>56.3</td>
</tr>
<tr>
<td>Highest education received - elementary</td>
<td>40.3</td>
<td>43</td>
<td>39.1</td>
<td>38.5</td>
<td>40.3</td>
<td>39.5</td>
<td>39</td>
<td>41</td>
<td>37.8</td>
</tr>
<tr>
<td>No education or incomplete compulsory education</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>2.5</td>
<td>2.6</td>
<td>1.3</td>
</tr>
</tbody>
</table>

Some social characteristics (data obtained in 2010) were identified by Tománek (2011) in the entire sample of respondents - clients of 17 RC (N=262) and in the final95 sample (N=221). Some of them are shown below in the Table 8.2.2 for the purpose of comparison with Table 8.2.1:

Table 8.2.2: Social characteristics of clients at re-socialisation centres. Source: Tománek (2011)

<table>
<thead>
<tr>
<th></th>
<th>N=262</th>
<th></th>
<th>N=221</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployed persons</td>
<td>77</td>
<td>29.4%</td>
<td>66</td>
<td>29.9%</td>
</tr>
<tr>
<td>Persons in material need</td>
<td>110</td>
<td>42%</td>
<td>91</td>
<td>41.2%</td>
</tr>
<tr>
<td>Evaluation of one’s own financial situation as significantly or slightly substandard</td>
<td>138</td>
<td>52.7%</td>
<td>124</td>
<td>56.1%</td>
</tr>
<tr>
<td>Highest education received - elementary</td>
<td>60</td>
<td>22.9%</td>
<td>50</td>
<td>22.6%</td>
</tr>
<tr>
<td>Incomplete elementary education</td>
<td>5</td>
<td>1.9%</td>
<td>4</td>
<td>1.8%</td>
</tr>
</tbody>
</table>

8.2.1 Legal and Institutional Framework of Reintegration/Re-socialization Measures

General measures aimed at addressing the needs of socially excluded groups and supporting inclusion are set forth in the political document/s, e.g. National Program of Social Inclusion, Strategy for Employability – Operational Program Employment and Social Inclusion, and established by laws (Act № 5/2004 Coll. on employment services, as amended, Act № 305/2005 Coll. on social and legal protection of children and on social guardianship, as amended, and lastly, Act № 448/2008 Coll. on social services, as amended). Even though no explicit reference to drug addicts or to persons who had a problem with dependence is made in any of the abovementioned laws, they are not excluded from the options available under such acts to other vulnerable and excluded groups. Such options include, for example, accommodation (housing as a social service) provided individually by regional self-governments, municipalities and cities (public providers) and non-public providers – non-profit organizations, unincorporated associations, religious associations, etc.

95 Without incorrect replies
Accommodation is provided in low-threshold facilities (dormitories), and in crisis centres and Half way Houses.

Other types of long-term housing – supported or social housing in flats are addressed by the Act № 443/2010 on subsidies for housing development and on social housing. Subject to this act, social housing procured with the use of public funds is designed for reasonable and humanly dignified housing of individuals who cannot procure housing through their own initiative and meet the conditions laid down in the act. Eligible persons include: a person living in a household with the household’s monthly income not exceeding three times the subsistence level; a person living in a household with the household’s monthly income not exceeding four times the subsistence level, if members of such a household include a severely disabled person, it is a household of a single parent with a dependent child, or when at least one of the household members provides for health care, education, culture or protection for inhabitants of the municipality; a person whose institutional care, substitute personal care, foster care or special guardian as defined in a separate regulation was terminated, if such a person is not more than 30 years old; and a person living in a household who is given substitute housing for an apartment surrendered under a separate regulation. The lease term agreed in the lease agreement cannot exceed three years, except for cases defined in the act.

8.2.1.1 Measures of social guardianship for adults (social guardianship) in 2011

They follow from the Act № 305/2005 Coll. on social and legal protection of children and on social guardianship, as amended.

In 2011, social measures for adults addressed a total of 9,299 persons. The situation is stable compared with 2009, but reasons for implementation of the measures in the area of drug-related problems of the clients had a growing trend – e.g. there was a significant increase from 8 cases in 2010 to 70 clients in 2011 who had problems with drugs. Up to 47 clients put under guardianship were released from a drug addiction treatment facility and 31 clients were released from the RC (Czuczorová 2012). Out of the total number of 9,229 cases, the highest share (51%) was represented by people released from prison; 6% were released from custody. The measures of social guardianship are implemented by the Offices of Labour, Social Affairs and Family (OLSAF) in the place of such clients’ usual residence (for more details, see Chapter 9 – post-penitentiary care).

Assistance in searching for housing was provided to 838 persons. In 2011, a total of 28 people (of which 3 women) were placed in the existing types of accommodation facilities. As regards the accommodation of the RC clients, in 2011 there were 104 clients who returned to their natural family environment after successful completion of the re-socialization process, and 23 major persons who became independent after successful completion of the re-socialization programme and did not return to their original family.

The system of assistance to drug-addicted clients also covers education and employment. Given the fact that such clients are not primarily included in the group of disadvantaged job seekers as defined in the Employment Services Act, no requalification courses or education projects are developed specifically for their target group, but if they meet general conditions for admission to work of a registered unemployed job seeker, they can participate in the given education activities. (Czuczorová, 2012)
8.2.2 Social Re-integration of Drug-Addicted Persons

The term social reintegration, social rehabilitation and re-socialization are used simultaneously – however, re-socialization is the most frequently used term in Slovakia and it is directly related to the function of the re-socialization centres as defined by law. “Activation of internal abilities of children and adults with the aim of overcoming psychological, physical and social consequences of drug or other dependence and integrating oneself into life in natural environment”.

### 8.2.2.1 Re-socialization Centres

The main institutional element in the process of social re-integration is the residential re-socialization centres (hereinafter referred to as the “RC”) for drug addicts.

Establishment of the re-socialization centres is the responsibility of higher territorial units – eight regional self-governments as well as cities. They are operated by non-governmental organizations (non-profit organizations and unincorporated associations) which must be accredited by the Ministry of Labour, Social Affairs and Family (MLSAF) on terms laid down by law to provide social and legal protection of children and social guardianship. A certain uniform level in the quality of provided services has been ensured since 2008 by the adopted standards which are still acceptable based on the MLSAF survey (Czuczorová 2011).

The activity of the RCs is financed by more sources – a part of funds is provided by the founder and a part of them comes from the OLSAF resources designed for financing of the implementation of measures related to social and legal protection of children. In 2011, the activity of the RCs was supported by subsidies from grant schemes of the Government Office, MLSAF SR as well as from the grant scheme of the Government Council for Crime Prevention.

Based on the statistical survey of the MLSAF (Czuczorová 2012), in 2011 the total number of clients in the accredited RCs was 632\(^{96}\) (of which 108 children\(^{97}\)) (in 2010 - 787 clients, of which 114 minor under 18 years of age). There were 68 women (87 in 2010 and 96 women in 2009, respectively).

There were 369 new clients (454 in 2010).

The average duration of the client’s stay in the RC slightly increased from 9.98 months in 2010 to 10.39 months, and it is 11.59 months in case of children. The protection allowance was paid to 302 clients in total (decrease by 51 clients). The majority of the RC clients had problems with alcohol in the past.

Efficiency of the re-socialization program is monitored on the basis of successful completion of the entire program which is planned individually according to the needs and motivation of the client. See Table 8.2.3.

\(^{96}\) A decrease by 155 clients

\(^{97}\) A total of 21 children (a decrease by 8 children) out of 108 children were admitted to the RC based on agreement with a parent or a person taking take of the child; 2 children came from children’s home. Other children were admitted to the RC based on the enforcement of corrective court ruling or preliminary ruling.
Table 8.2.3: Termination of re-socialization program in 2010. Source: Czuczorová, 2011 and 2012

<table>
<thead>
<tr>
<th>Termination Type</th>
<th>Number of clients in 2010</th>
<th>Number of clients in 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Successful termination of the entire program (minimum of 12 months)</td>
<td>153 (incl. 19 children)</td>
<td>156 (26 children)</td>
</tr>
<tr>
<td>Early termination by the client</td>
<td>216 (18 children)</td>
<td>193 (17 children)</td>
</tr>
<tr>
<td>Early termination by the RC (violation of community rules, etc.)</td>
<td>66 (1 child)</td>
<td>64 (1 child)</td>
</tr>
<tr>
<td>Other reasons</td>
<td>32 (10 children)</td>
<td>24 (4 children)</td>
</tr>
</tbody>
</table>

The predominating activities in the RC included social team work with the client, work therapy in the facility, individual social work with the client, and advisory and first contact services, monitoring of the efficiency of re-socialization upon its completion together with intermediation of the post re-socialization activity.

8.3 NMCD Surveys on Client Structure and Services of Re-socialization Centres

In 2012, the fifth questionnaire-based survey of this type was conducted in 19 RCs. Data are usually completed by the appointed employee of the facility and the RC is financially rewarded for the provision of data.

As already stated in the previous reports, there existed and still exist two reasons for such surveys – the first one was the need to identify the structure of clients in terms of the type of the abused psychoactive substance or of other non-substance dependence. Even though the majority of the clients (if coming from healthcare facilities) has already been recorded in the system of medical statistics (47% share and 45% share in 2010 and in 2011, respectively), a rather significant part of the clients and particularly young people enter the RC upon a recommendation of psychiatrist or addictologist but without any specialized treatment in healthcare facilities.

The second reason was the effort to monitor efficiency of the services provided in the re-socialization centres which should lead to social re-integration – i.e. the return of the client to his/her natural environment. In addition, the survey monitored the number of clients who abstained after one year.

8.3.1 Basic Data of 2012 NMCD RC Survey (2011 Data)

The total capacity of 425 places in 19 RCs was used in 2011 by 842 clients, the majority of which are men - 53%. In 2011, 452 new clients were admitted by the RCs. Up to 95 clients were 16 to 18 years old, including 9 at age of 16 years old persons (Tab. 8.3.1.1)

Up to 998 clients used the RC services as a form of post penitentiary care – i.e. they entered the RC after being released from custody. The 2012 survey included a question about the clients’ past in terms of criminal law – i.e. if they were in prison or

---

98 (17 clients came to the RC due to post penitentiary care in 2010, 12 in 2009).
on parole for drug-related offenses, or they were in contact with police. The RCs reported a total of 121 (14.4%) clients with such experience.

The dominance of alcohol abuse (Table 8.3.1 and Figure 8.3.1 and Figure 8.3.2), is followed by the illicit drug methamphetamine (pervitin) and the use of more drugs. Contrary to alcohol where the share of clients grows, the shares in case of pervitin and poly-use are more or less stable and the share of clients with injecting drug use in past is on the decline.
Table 8.3.1: Overview of basic data about the RC client structure in 2007-2011 (Source: NMCD surveys on RC’s clients and services)

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>%</th>
<th>2008</th>
<th>%</th>
<th>2009</th>
<th>%</th>
<th>2010</th>
<th>%</th>
<th>2011</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of clients</td>
<td>614</td>
<td>100%</td>
<td>741</td>
<td>100%</td>
<td>857</td>
<td>100%</td>
<td>802</td>
<td>100%</td>
<td>842</td>
<td>100%</td>
</tr>
<tr>
<td>New clients</td>
<td>382</td>
<td>62.2</td>
<td>470</td>
<td>63.4</td>
<td>521</td>
<td>60.7</td>
<td>448</td>
<td>55.9</td>
<td>452</td>
<td>53.68</td>
</tr>
<tr>
<td>Men</td>
<td>420</td>
<td>68.4</td>
<td>487</td>
<td>65.7</td>
<td>531</td>
<td>62</td>
<td>426</td>
<td>53.1</td>
<td>445</td>
<td>52.85</td>
</tr>
<tr>
<td>Minor clients under 18 years of age</td>
<td>50</td>
<td>8</td>
<td>80</td>
<td>10.7</td>
<td>106</td>
<td>12.3</td>
<td>97</td>
<td>12.1</td>
<td>95</td>
<td>11.3</td>
</tr>
<tr>
<td>Thereof client at 16 years of age</td>
<td>5</td>
<td>0.8</td>
<td>5</td>
<td>0.6</td>
<td>14</td>
<td>1.6</td>
<td>18</td>
<td>2.2</td>
<td>9</td>
<td>1.1</td>
</tr>
<tr>
<td>Clients with injecting drug use history</td>
<td>168</td>
<td>27.3</td>
<td>150</td>
<td>20.2</td>
<td>184</td>
<td>21.5</td>
<td>113</td>
<td>14.1</td>
<td>140</td>
<td>16.6</td>
</tr>
<tr>
<td>Primary drug heroin</td>
<td>74</td>
<td>12</td>
<td>60*</td>
<td>8.5</td>
<td>77</td>
<td>9</td>
<td>70</td>
<td>8.7</td>
<td>66</td>
<td>7.8</td>
</tr>
<tr>
<td>Methamphetamine (Pervitin)</td>
<td>159</td>
<td>25.8</td>
<td>229*</td>
<td>32.4</td>
<td>270</td>
<td>31.5</td>
<td>232</td>
<td>28.9</td>
<td>240</td>
<td>28.5</td>
</tr>
<tr>
<td>Cocaine</td>
<td>2</td>
<td>0.3</td>
<td>4*</td>
<td>0.5</td>
<td>7</td>
<td>0.8</td>
<td>3</td>
<td>0.3</td>
<td>3</td>
<td>0.3</td>
</tr>
<tr>
<td>Poly-use</td>
<td>101</td>
<td>16.4</td>
<td>117*</td>
<td>16.6</td>
<td>139</td>
<td>16.2</td>
<td>127</td>
<td>15.8</td>
<td>117</td>
<td>13.9</td>
</tr>
<tr>
<td>Cannabis (THC)</td>
<td>27</td>
<td>4.4</td>
<td>15*</td>
<td>2.1</td>
<td>36</td>
<td>4.2</td>
<td>38</td>
<td>4.7</td>
<td>46</td>
<td>5.5</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>0</td>
<td>-</td>
<td>2</td>
<td>0.2</td>
<td>0</td>
<td>-</td>
<td>1</td>
<td>0.1</td>
<td>1</td>
<td>0.1</td>
</tr>
<tr>
<td>Volatile substances</td>
<td>5</td>
<td>0.2</td>
<td>6</td>
<td>0.8</td>
<td>13</td>
<td>1.5</td>
<td>9</td>
<td>1.1</td>
<td>11</td>
<td>1.3</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>6</td>
<td>0.9</td>
<td>4</td>
<td>0.6</td>
<td>4</td>
<td>0.4</td>
<td>4</td>
<td>0.4</td>
<td>3</td>
<td>0.3</td>
</tr>
<tr>
<td>Methadone</td>
<td>0</td>
<td>-</td>
<td>1</td>
<td>0.1</td>
<td>1</td>
<td>-</td>
<td>2</td>
<td>0.3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Alcohol</td>
<td>211</td>
<td>34.4</td>
<td>259</td>
<td>36.6</td>
<td>293</td>
<td>34.2</td>
<td>303</td>
<td>37.8</td>
<td>353</td>
<td>41.98</td>
</tr>
<tr>
<td>Non-substance dependences (F 63, PC, gambling, bulimia)</td>
<td>29</td>
<td>5</td>
<td>9</td>
<td>1</td>
<td>17</td>
<td>1.7</td>
<td>13</td>
<td>1.6</td>
<td>11</td>
<td>1.3</td>
</tr>
</tbody>
</table>
Figure 8.3.1: Development of the share of RC clients with a problem in key psychoactive substances in 2007-2011

Figure 8.3.2: Shares of clients with a problem of the most frequently abused psychoactive substance in five cycles of NMCD surveys: Source of data: Surveys of the client structure and re-socializations services in 2007 to 2011
8.3.2 Efficiency of Re-Socialization Program and Provided Services

Up to 12 RCs answered the question about whether they monitor their former clients after one year (decrease by 2 compared with 2010) – they reported a total of 119 traced clients.

Verity of the abstinence from the primary drug by objective test was checked in not more than 3 RCs; the remaining RCs use telephone contact and personal visit to obtain additional information from family, school or place of residence. Another source of information about the situation of the former clients is post re-socialization activities – weekend communities, field family therapies and AA clubs.

Up to 153 clients (more than in 2010 - 132 clients, 113 clients in 2009) completed the entire program. Up to 290 clients terminated the program early (it is less than in 2010 - 309 clients) – it was 169 clients in the first adaptation phase and 121 clients in the later stabilization phase). The ratio of the clients who successfully completed the entire program to the clients who did not complete it is in favour of the latter, which is also explicit from the statistical data of the MLSAF.

8.3.3 Reintegration Criteria

Up to 12 RCs reported a total of 42 clients who educated themselves in the given forms (44 clients were reported by 14 RCs in 2011). The majority of such clients came from the RC Komunita Ľudovítov – 10.

<table>
<thead>
<tr>
<th>Table 8.3.2: Education of clients of re-socialisation centres (data 2011)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of clients – education</td>
</tr>
<tr>
<td>Continued or successfully completed their study</td>
</tr>
<tr>
<td>Started a new level of education</td>
</tr>
<tr>
<td>New short-term course, training</td>
</tr>
</tbody>
</table>

Up to 85 former clients from 12 RCs were economically active, of which 66 (78.5%) reported regular employment, which is a significantly higher share compared with 2010 (66%) and a higher share than in 2009 (41%).

<table>
<thead>
<tr>
<th>Table 8.3.3: Employment status of clients of re-socialisation centres (data 2011)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of clients - economic activity/inactivity</td>
</tr>
<tr>
<td>Unemployment</td>
</tr>
<tr>
<td>Occasional job</td>
</tr>
<tr>
<td>Regular employment</td>
</tr>
<tr>
<td>Self-employment</td>
</tr>
<tr>
<td>Beneficiary of pension/social security benefits</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 8.3.4: Housing status of clients of re-socialisation centres (data 2011)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of clients - accommodation</td>
</tr>
<tr>
<td>Sheltered housing facility, Halfway houses</td>
</tr>
<tr>
<td>Dormitory, lodging house</td>
</tr>
<tr>
<td>With parents, family</td>
</tr>
<tr>
<td>Independent accommodation in their own apartment, house</td>
</tr>
</tbody>
</table>
8.3.4 Quality of Provided Services

Let alone any differences in the data surveyed within the statistical data of the MLSAF and the NMCD surveys which should be identical (given the set standards in keeping documentation and recording clients), the trends in the structure of primary problems of the clients are almost the same – alcohol predominates and it is followed by illicit drugs. The number of new clients grows and, based on both sources of information, the number of those who did not complete the entire re-socialization program is significantly higher than the number of those who completed it.

As mentioned elsewhere\(^99\), there are still differences among the RCs, which we believe arise mainly from the client structure (the RCs with younger clients have a higher capacity of reintegration possibilities and services, which has an impact on the selection of the facility (mainly by the parents), and the RCs with older clients who had problems with alcohol focus on the work therapy and basic social services – meal and accommodation).

Such a differentiation or specialization of RC is not a primary problem, but it seems that it can affect the evaluation of the re-socialization centres and services as a whole.

The RCs that have direct links to the healthcare facilities or were established with a direct or significant participation of medical experts can be considered a part of comprehensive care provided to the drug-addicted persons. The recent NMCD RC survey (2012) also addressed the share of medical professions in the RCs and the share of other professions – (relevant shares are shown in Figure 8.3.3 and in overview in Table 8.3.5).

Up to 8 out of 19 RCs made no mention of any contact with a psychiatric expert. On the other hand, 2 RCs stated up to two experts - psychiatrists.

Table 8.3.5: Structure of re-socialisation centres staff in 2011

<table>
<thead>
<tr>
<th>Professional Role</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrist</td>
<td>12</td>
</tr>
<tr>
<td>Psychologist</td>
<td>27</td>
</tr>
<tr>
<td>Other medical staff</td>
<td>17</td>
</tr>
<tr>
<td>Social worker</td>
<td>58</td>
</tr>
<tr>
<td>Pedagogue</td>
<td>19</td>
</tr>
</tbody>
</table>

\(^{99}\) Prieskumy NMCD vo vzťahu k štruktúre klientov a služieb resocializácie - sociálnej reintegrácie v akreditovaných RS na Slovensku za obdobie 2007-2009
In 2012 (2011 data), the NMCD questionnaire was completed with a question about whether the re-socialization centre makes use of the principles of therapeutic community in terms of both the methods and the organization of environment. The question about what predominates in the RC when it comes to therapeutic community in terms of the organization of environment or the method of therapy, 7 facilities out of 19 RCs answered that they applied both; the method of therapeutic community is predominant in 8 RCs and the organization of environment predominates in the remaining four facilities.

Tománek (2011) conducted a survey of subjective perception of quality of life by the clients in 17 RCs (N of the final sample = 221) through the SQALA questionnaire. One of hypotheses was that perception of quality of life in the Slovak RCs would not differ substantially from perception of quality of life by the clients of the therapeutic communities in the Czech Republic as presented by a Czech study. He observed (ibid, p. 56) that the overall index of perception of quality of life by the clients of the Slovak RCs was not in conflict with data obtained in the Czech therapeutic communities, with which we can agree. Based on the survey findings, he also assumed that the quality of services provided in the RC was reasonable, because the customer model is one of the models for measuring the quality of social services (ibid, p. 56). Such an assumption – if it is to refer to the system of re-socialization services – should be further verified because it is impossible, based on our findings, to be applied to all RCs. Not all RCs are focused on “customer satisfaction” and require a feedback. Up to 15 out of 19 RCs inquire about satisfaction of their clients with the provided services, mainly in the form of an anonymous questionnaire, in post re-socialization weekend meetings or other meetings.

---

100 Identical to the NMCD survey, except for two RCs which did not respond to the survey offer.
101 In 2010, 802 clients were in 19 RCs according to the NMCD 2011 survey.
Cooperation with other entities (within the system of helping services) is informal, based on long-time founders personal contacts, which can facilitate the achievement of the quality of services, but need not guarantee its maintenance for a long time (a formal contract is made in not more than five cases).

Up to 15 RCs declared full and almost full satisfaction with their position within the helping services; two RCs declared dissatisfaction justified by “failed collaboration of the self-government, competent bodies, no interest in resolving the given issue, no one being interested in what is going on, and how the non-profit organizations which provide help and steal nothing manage to survive and exist; they do not consider us partners in therapeutic terms... (NMCD, 2012).

8.4 Social Integration of Problem Drug Users

If such problem drug users are in the healthcare or in re-socialization facilities, the support of social integration is ensured by qualified social workers in such facilities. The current problem drug users who use the services of low-threshold “harm reduction” agencies can rely on a kind of social assistance with official issues or in healthcare facility, if they decide to undergo treatment (documents, health insurance, social security benefits, information about accommodation options, daily facilities for homeless persons, etc.).

For more information about social reintegration, see chapter 5.

---

103 See chap. 4
9 DRUG-RELATED CRIME, PREVENTION OF DRUG RELATED CRIME AND PRISON

The chapter describes in more detail the key social aspects of a drug phenomenon in the Slovak Republic, primarily relying on standardly obtained statistical data of criminal authorities: Ministry of the Interior, Prosecutor’s Offices, and the Ministry of Justice dealing also with prisons statistics.

In the Slovak Republic, the term “drug-related crimes” includes the offences and offenders arrested, prosecuted and convicted of the following crimes: possession of a drug\textsuperscript{104} for personal use (Section 171 of the NCC\textsuperscript{105}/Section 186 of the OCC\textsuperscript{106}); manufacturing, trafficking or possession of a drug in a quantity exceeding 10 standard doses (hereinafter referred to as the “dealing”) (Section 172 of the NCC/187 of the OCC); manufacturing or procurement of an object\textsuperscript{107} to be used for manufacturing of a drug (Section 173 of the NCC/Section 188 of the OCC), and promotion of drug addiction (Section 174 of the NCC/Section 188a of the OCC). As the cases of the offenders prosecuted within the meaning of the OCC were recorded in 2011, it is necessary to count the relevant sections within the meaning of the OCC in the overall picture of the drug-related crimes. In addition to the abovementioned drug-related crimes, the chapter describes in detail the area of prevention of drug-related crimes, interventions within the system of criminal law, the issue of use and consequences of drug use in prison, as well as social reintegration of the accused and convicted persons after their release from prison.

In 2011, the share of the offenders prosecuted by the police and the share of drug-related crimes was higher by 6.4% and by 38%, respectively, compared with the previous year. There was no change in the structure of the prosecuted offenders. Again, more than one half of the offenders were prosecuted by the police for crime related to marijuana (62%), and more than two thirds of them were prosecuted for its possession for personal use. The second major group after the marijuana offenders comprised the persons prosecuted for crime related to methamphetamine also called such as “Pervitin” (27%) who were followed by offenders prosecuted for drug-related crimes associated with heroin (6%) and cocaine (1.8%).

The highest share in drug-related crimes nationwide was in 2011 in the Bratislava Region which was followed by Nitra and Trnava Regions.

In 2011, the number of the accused persons convicted by courts for drug-related crimes was higher by 6% compared with 2010. The number of persons convicted of drug possession for personal use stabilized. On the contrary, there was an increase in the number of people convicted of offenses related to drug supply – mainly for production and trafficking. The majority of persons were convicted for crimes related to: marijuana (56%), pervitin (21%) and heroin (10%).

\textsuperscript{104} The term “drug” within the meaning of the Criminal Code (No. 300/2005 Coll.) includes any intoxicant, psychotropic substance, poison or precursor.

\textsuperscript{105} An abbreviation for the New Criminal Code effective from 1 January 2006 (No. 300/2005 Coll.)

\textsuperscript{106} An abbreviation for the Old Criminal Code effective until 31 December 2005 (No. 140/1961 Coll.)

\textsuperscript{107} It refers to an object which is usually an essential component in the manufacturing of an intoxicant, psychotropic substance, poison or precursor, and it usually refers to devices, other equipment as well as raw materials fit and designed for such manufacturing (Čentéš, J. 2007, p.116)
In 2011, the courts imposed one of the following alternative sentences to imprisonment on more than two thirds of the offenders: suspended sentence (60%), fine (6%) and community service (3%). There was an increase in the number of convicted persons who were imposed an alternative sentence of community work for possession of a drug for personal use, and no offender was condemned to home curfew in 2011.

In case of the convicted juveniles (N=52), the suspended sentence was imposed most frequently in 2011 (90%). Two juveniles were condemned to imprisonment – one for drug dealing and the second one for drug trafficking.

In 2011, the number of registered drug users in prison increased by more than one third, and their share in the total number of the accused and convicted reached the highest recorded level (18%). Qualitative screening of the use of drugs among the prison population continued in 2011, when a total of 2,304 screenings were made for the presence of drugs in biological samples. Positivity was confirmed in more than 10% of the tested samples, and the following substances were most often confirmed in the prisoners' urine and saliva: benzodiazepines (N=93), marijuana (N=70) and amphetamines\(^\text{108}\) (N=46).

In 2011, a total of 5,719 prisoners were subject to screening examination for the presence of selected infectious diseases, and almost 7% of the tested prisoners were positive. The majority of people were seropositive for HCV (20%) and syphilis (5.6%).

In 2011, more than 70% of the total social care services were provided to persons released from prison.

### 9.1 Drug-Related Crime

This chapter mainly relies on the statistical data of the Ministry of the Interior\(^\text{109}\) (hereinafter referred to as the “MI”), the General Prosecutor’s Office, and the Ministry of Justice (hereinafter referred to as the “MJ”). As the statistical systems of the abovementioned criminal institutions are not interconnected, it is impossible to compare them.

To provide for easier comparability of criminal data of the Slovak Republic with equivalent data from other EU countries, and to provide for compatibility of data stated in the ST11, we report adjusted categories of offenses in the Report (according to EMCDDA directives). Therefore, the drug-related crimes are classified in the following three categories:

1. the offense of possession of a drug for personal use (Section 171 of the NCC and 186 of the OCC)
2. the offense of manufacturing, trafficking or dealing of drugs (Section 172 of the NCC and Section 187 of the OCC)
3. other drug supply offences (Sections 173 and 174 of the NCC and Sections 188 and 188a of the OCC)

---

\(^{108}\) In particular methamphetamine

\(^{109}\) Including statistical data obtained from the police and other specialized police offices (Organized Crime Bureau)
9.1.1 Persons Prosecuted for Drug-related crimes

The MI keeps in its statistical system a register of offenses and offenders against whom criminal prosecution was commenced.

In 2011, the police prosecuted a total of 2,012 offenders for drug-related crimes (an increase by 121 and by 1 compared with 2010 and 2009, respectively) and recorded 2,422 drug-related crimes (an increase by 668 compared with 2010 and a decrease by 17 compared with 2009). The long-time growing trend in the field of drug-related crimes in Slovakia was not influenced by the single decrease in the number of prosecuted offenders and offenses recorded in 2010 either (see Figure 9.1.1).

Figure 9.1.1: Number of arrested persons and drug law offenses in Slovakia (2001-2011).
Source: MI, 2012

* includes all drug related offenses: possession for personal use; trafficking/production/dealing and other drug supply offenses.

In terms of regions, the highest share in drug-related crimes nationwide has been held for a long time by the Region of Bratislava, even though in the most recent year its share was reduced from 47.6% (2010) to 36.6% (2011). The second region with the highest rate of drug-related crimes in 2011 was Nitra with a 14% share of the prosecuted offenders which outstripped the Region of Trnava for the first time (10.5%).

Out of the total number of 2,012 prosecuted offenders, the type of drug was recorded in 2011 in 76.7% cases (N=1,543). Compared with the previous year, there was no significant difference in the structure and order of drugs in whose connection the persons were prosecuted most often. Almost two thirds of the offenders were prosecuted by the police in connection with marijuana (N=959/62.1%). They were

---

110 The rate of drug-related crime in the individual regions of Slovakia was assessed in terms of the number of offenders prosecuted for drug-related offenses who are registered in the individual regions.
followed by persons prosecuted in connection with Pervitin (N=420/27.2%), heroin (N=93/6%), cocaine (N=28/1.8%), other substances\textsuperscript{111} (N=22/1.5%), amphetamines/ecstasy (N=14/0.9%) and LSD (N=7/0.5%). Even though the number of people prosecuted in connection with marijuana (+410 persons), Pervitin (+210 persons) and heroin (+30 persons) increased in the last year, their share in the total number of the prosecuted people by the type of drugs\textsuperscript{112} remained unchanged compared with the previous year.

More than two thirds of the offenders prosecuted in 2011 in connection with marijuana possessed the drug for personal use. Not more than one third of the offenders were prosecuted for manufacturing, trafficking or dealing of the drug.

In case of Pervitin, the situation was balanced in terms of the structure of drug-related crimes – one half of the offenders was prosecuted by the police for the possession of the drug for personal use, and the second half of them was prosecuted for its manufacturing, trafficking and dealing.

\textbf{9.1.2 Convicted Persons and Juveniles Convicted of Drug-related crimes}

In 2011, the MJ recorded a total of 1,204 persons who were adjudged guilty by a court of the commission of the following offenses: possession of a drug for personal use; manufacturing, trafficking and dealing of drugs, or other offense related to the supply of drugs. Compared with the previous year, the share of the persons convicted in connection with drug-related crimes increased by 6.1%. Even though the New Criminal Code № 300/2005 Coll. (hereinafter referred to as the “NCC”) took effect as early as in January 2006, there were cases in 2011 of the offenders convicted under the Old Criminal Code № 140/1961 Coll. (hereinafter referred to as the “OCC”) which was effective until the end of 2005 (N=20).

\textbf{9.1.2.1 Structure of convicted persons in terms of individual drug-related crimes}

In 2011, the courts convicted 626 persons (52%) for the possession of a drug for personal use, 551 persons (45.7%) for illicit manufacturing, trafficking or dealing, and 27 persons (2.3%) for other offenses related to the supply of drugs\textsuperscript{113} – for development since 2002 see Tab. 9.3.

Almost three fourths of the persons convicted of the possession of a drug for personal use (N626) possessed the drug in a quantity not exceeding 3 doses (457). The offenders convicted of illicit manufacturing, trafficking and dealing (N=551) were most often persecuted in 2011 for dealing (200 persons/36.3%) – even though their number was reduced by 16 persons compared with the last year. On the contrary, the number of the convicted persons who manufactured (+9), smuggled (+10) and trafficked (+26) the drugs increased. The number of people who were repeatedly convicted of an offense related to the supply of drugs increased as well (+6).

\textsuperscript{111} Methadone, morphine, psilocin, ephedrine/pseudoephedrine and hashish

\textsuperscript{112} Including the total number of people prosecuted for drug-related offences with whom the specific type of drug was recorded by the police in 2011 (N=1,543).

\textsuperscript{113} Representing the total number of persons convicted of the offense of manufacturing or possession of an object to be used for manufacturing of a drug, and the number of persons convicted of the offence of promotion of drug addiction.
In the most recent three years, we can observe stabilization of the number of persons convicted of the possession of a drug for personal use. On the contrary, there is an increase in the number of persons convicted of the offenses related to the supply of drugs (an increase by 12.4% and by 27.3% compared with 2010 and 2009, respectively).

Shown in Table 9.1.1 is the structure of the convicted offenders by the individual paragraphs of the Criminal Code sections. The finding is that even though in the most recent three years the number of those adjudged guilty by a court of the illicit manufacturing of drugs increased almost twofold (from 29 convicted in 2009 to 56 convicted in 2011), and the number of those convicted of trafficking in drugs increased almost fourfold (from 46 convicted in 2009 to 175 convicted in 2011), the number of persons convicted of drug dealing dropped by almost one fourth (from 261 convicted persons in 2009 to 200 convicted persons in 2011).

The decrease in the number of people convicted of dealing could be affected by an amendment of the drug legislation\textsuperscript{114} which increased the limit of tolerable quantity of drug, classified as possession for personal use (from usually a single dose of the drug to ten times the given quantity). Based on this, a part of the dealers distributing drugs in smaller quantities (up to 10 doses) could declare during their arrest that they possessed the drug for personal use, thus hoping for mild (alternative) punishment (see chap. 9.4). The possibility of latency of the dealers among those convicted of the possession of a drug for personal use is also suggested by the seizure statistics according to which the number of seizures of the selected types of drugs (in particular Pervitin) increased significantly after 2006, with the seized quantity being unchanged or slightly lower (for more details, see Chapter 10.2).

<table>
<thead>
<tr>
<th>Type of Offense</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>possession for personal use (max. 3 doses)</td>
<td>437</td>
<td>433</td>
<td>457</td>
</tr>
<tr>
<td>production</td>
<td>29</td>
<td>47</td>
<td>56</td>
</tr>
<tr>
<td>smuggling</td>
<td>0</td>
<td>9</td>
<td>19</td>
</tr>
<tr>
<td>trafficking</td>
<td>46</td>
<td>149</td>
<td>175</td>
</tr>
<tr>
<td>dealing</td>
<td>261</td>
<td>216</td>
<td>200</td>
</tr>
<tr>
<td>recommittal</td>
<td>14</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>other serious drug-related crime</td>
<td>45</td>
<td>30</td>
<td>58</td>
</tr>
<tr>
<td>gravest drug-related crimes</td>
<td>8</td>
<td>2</td>
<td>11</td>
</tr>
</tbody>
</table>

Source: MJ, 2011

9.1.2.2 Convicted persons by the type of drug

The MJ records in its statistical system the type of drug with four drug-related sections: Sections 171, 172, 173 and 174 of the NCC effective from 1 January 2006.

The type of drug is not recorded in case of equivalent drug-related sections: Sections 186, 187, 188 and 188a of the OCC effective until 31 December 2005. Therefore, the total number of persons convicted of drug-related crimes, broken down by the type of drug, is not identical with the total number of persons convicted of drug-related crimes.\textsuperscript{115}

More than one half of the offenders were convicted in 2011 for a marijuana-related offense (624 persons/56.2%). They were followed by the persons convicted in connection with Pervitin (237 persons/21.3%), heroin\textsuperscript{116} (111 persons/10%), other amphetamines and ecstasy (105 persons/9.5%), other (unspecified) drugs (21 persons/1.9%), cocaine (12 persons/1.1%) and LSD (1 person/0.1%).

Almost two thirds of the offenders convicted in connection with marijuana were adjudged guilty by a court of its possession for personal use. Pervitin was possessed by less than one fifth of the convicted persons. In case of the offense of illicit manufacturing, trafficking and dealing, there was no change in the order of the most abused drugs – more than one half of the offenders were convicted in connection with marijuana and one fourth of them were convicted in connection with Pervitin.

Table 9.1.2: Number and share of persons convicted of drug-related crimes by the type of drug (2011). Source: Standard Table 11 / 2012

<table>
<thead>
<tr>
<th></th>
<th>Possession for personal use</th>
<th>Dealing/trafficking/production</th>
<th>Other drug supply offenses*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Cannabis</td>
<td>372</td>
<td>62</td>
<td>244</td>
</tr>
<tr>
<td>Heroin</td>
<td>56</td>
<td>9</td>
<td>55</td>
</tr>
<tr>
<td>Cocaine</td>
<td>4</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>106</td>
<td>18</td>
<td>126</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>56</td>
<td>9</td>
<td>36</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>LSD</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Other drugs**</td>
<td>6</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>600</td>
<td>100</td>
<td>482</td>
</tr>
</tbody>
</table>

* illicit production/possession of items intended for drug production and promoting of drug addiction.
** includes other unspecified kind of drugs and prescription drugs

Table 9.1.3: Number of offenders/juveniles convicted of drug possession, trafficking, and for other drug supply offences in Slovakia (2002-2011). Source: MJ SR 2011

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Possession for personal use</td>
<td>166</td>
<td>192</td>
<td>185</td>
<td>205</td>
<td>406</td>
<td>454</td>
<td>620</td>
<td>629</td>
<td>626</td>
</tr>
<tr>
<td>Dealing/trafficking/production</td>
<td>297</td>
<td>413</td>
<td>435</td>
<td>375</td>
<td>300</td>
<td>319</td>
<td>433</td>
<td>490</td>
<td>551</td>
</tr>
<tr>
<td>Other drug supply offenses</td>
<td>5</td>
<td>6</td>
<td>15</td>
<td>10</td>
<td>15</td>
<td>13</td>
<td>26</td>
<td>16</td>
<td>27</td>
</tr>
<tr>
<td>Total</td>
<td>468</td>
<td>611</td>
<td>635</td>
<td>590</td>
<td>721</td>
<td>786</td>
<td>1,079</td>
<td>1,135</td>
<td>1,204</td>
</tr>
</tbody>
</table>

\textsuperscript{115} Including the total of the persons convicted of drug-related offenses under the NCC and the OCC.

\textsuperscript{116} The share of the persons convicted of heroin-related offenses increased in 2011 and reached the 2009 level (9.9%).
### 9.1.2.3 Convicted juveniles

In 2011, the courts in Slovakia condemned 52 juveniles for a drug-related offense (in 2010, N=50). More than one half of the convicted juveniles possessed drugs for personal use (N=27). More than one third of the juvenile delinquents were convicted of drug manufacturing and trafficking (N=21). Three juveniles were adjudged guilty by a court of other drug supply-related offenses (specifically, of promotion of drug addiction).

The majority of the juveniles were convicted of the possession of a smaller quantity of drugs - not exceeding 3 doses (N=18). Eight juveniles were adjudged guilty by courts of the possession of 3 to 10 doses of drugs. Up to 9 offenders aged 14 to 18 years were convicted of dealing and possession of a quantity exceeding 10 doses of a drug.

### 9.1.3 Other Drug-related crimes

This chapter relies on data obtained from the following criminal institutions: MI SR (PP), General Prosecutor’s Office of the SR, and MJ SR.

#### 9.1.3.1 Criminal activity committed for the purpose of procuring funds for drugs

The criminal activity and abuse of psychoactive substances are closely related to each other (Nešpor, K., 2009). The given aspect is statistically monitored in its system by the MJ through the statistical sheet T\(^{117}\) (column 30, line 11, in which drug addiction is listed as a specific reason for committing an offense).

Based on the statistical data of the MJ, drug addiction was specified by the convicted persons (2011) as a reason for committing the following offenses: theft (10), serious threats (9), robbery (3), obstructing the execution of an official decision (2), extortion (2), battering a close person and a person entrusted to one’s care (2), menace due to intoxication (2), forcible entry into dwelling (2), unlawful interference with a title to a house, dwelling or non-residential premises (2), prohibited acquisition and possession of firearms and trafficking in them (1), illicit manufacturing and use of money (1), assaulting a public authority (1), corrupting morals of youth (1) and intoxication (1). (Source: MJ, 2012)

---

\(^{117}\) It refers to a standard record sheet which is completed for each convicted offender in the Slovak Republic and which provides complex information about the offender (what offense he/she was convicted of, what punishment was imposed on him/her, or what type of protective measure was implemented, and the reason for committing the offense).
9.1.3.2 Offenses committed under the influence of drugs

Both the Prosecutor’s Office and the Ministry of Justice make special monitoring in their statistical system of the offenses committed under the influence of alcohol or other illegal drug. The Prosecutor’s Office records cases of the persons whose criminal prosecution was terminated: by conditional discontinuance of criminal prosecution, by approval of settlement and subsequent discontinuance of criminal prosecution, by agreement on guilt and punishment, or by indictment. The Ministry of Justice records the cases of persons who were condemned, upon a final and conclusive decision, to unconditional sentence, conditional sentence, and conditional sentence with probation supervision, house arrest, community service works, pecuniary punishment or prohibition to undertake certain activities.

Based on the statistical data of the General Prosecutor’s Office, in 2011 there was a decrease in the number of prosecuted persons who committed an offense under the influence of a psychoactive substance other than alcohol - from 548 (2010) to 532 prosecuted persons (2011). The number of those who committed an offense while intoxicated has been in the decline since 2007. Over the most recent five years, their number decreased from 5,362 (2007) to 3,673 prosecuted persons (2011), which means that their share is lower by almost one third compared with 2007 (31.5%). In 2011, 203 people (a decrease by 56 compared with 2010) and 2,306 people (a decrease by 364 compared with 2010) were accused of committing an offense under the influence of other psychoactive substances and under the influence of alcohol, respectively.

In 2011, the Prosecutor’s Officer recorded 61 juveniles who were prosecuted for committing an offense under a psychoactive substance other than alcohol. They represent a 1.5% share in the total number of prosecuted juveniles in 2011 (N=3,934). Up to 23 persons (1.2%) out of 1,990 accused juveniles committed an offense under the influence of drug in 2011. (Source: Statistical yearbook of the GP’s Office 2011, 2010)

In the most recent year, the number of the convicted persons in Slovakia decreased (from 31,179 in 2010 to 30,110 in 2011), and so did the number of persons committing an offense under the influence of an illegal drug (from 269 in 2010 to 257 in 2011). In 2011, the share of the convicted persons who committed an offense under the influence of an illegal drug or under the influence of alcohol amounted to 0.85% and to 7.9%, respectively. The highest share of the convicted persons who committed an offense under the influence of an illegal psychoactive substance was reported by the Regions of Košice (1.46%) and Trnava (1.22%). (Statistical yearbook of the MJ SR, 2011)

9.1.3.3 Drugs and driving

No new information about the launch of testing of the illegal drugs with motor car drivers through saliva testers is available.

In 2011, the police commenced a criminal prosecution for menace due to intoxication (Section 289 of the Criminal Code) against 1,369 persons. (Source: MI SR, 2012)

Up to 1,146 persons (of which 57 women and 8 juveniles) were prosecuted for the same offense by the Prosecutor’s Office. Out of the given number of the prosecuted persons (N=1,146), 649 offenders were intoxicated and 4 offenders were under the influence of drugs. It mainly referred to traffic accidents in which drivers were under the influence of psychoactive substances. The presence of drugs was determined in
this case by a blood sample of the motor car driver. (Statistical yearbook of the GP’s Office 2012)

9.2 Prevention of Drug-Related Crime

9.2.1 Police Priorities and Projects Focused on Prevention of Drug-Related Crime

Preventive projects implemented by the police are primarily focused on causes and conditions of delinquency. The projects are aimed at preventing and reducing any negative social behavior and supporting the creation of optimum social conditions without delinquency. The number of children and juveniles participating in the abovementioned anti-drug projects has grown every year. In 2011, the police in cooperation with the MLSAF implemented 27 anti-drug projects in which 50,321 pupils of elementary and secondary schools were involved (an increase by 2,921 children compared with 2010).

In 2011, the following successful projects popular among the pupils continued to be implemented:

The “Behave normally” project which is designed for 5th graders of the elementary schools. The project is aimed at building a bridge of confidence among the police, school, child and family. The project gives specific advice to children on how not to become victims of an offense, advice on how to deal with burdensome situations, and provides information on where to seek help in case of need. In 2011, 14,536 children aged 10 to 11 years participated in the project.

The “I am young and nothing can happen to me” project, aimed at familiarizing the pupils of the elementary and secondary schools through lectures focused on criminal liability of the offender with legal consequences of the commission of drug-related crimes, thefts and robberies. Up to 180 students of six education facilities participated in the project.

The aim of the “I protect myself” project is to give lectures to students with behavior disorders attending special 118 elementary and secondary schools on consequences of the commission of acts of violence, thefts and drug-related crimes. Up to 30 students of special elementary schools and 180 students of the elementary schools participated in the project.

The aim of the “The good police officer gives advice to Ivo” project was to inform preschoolers and 1st graders of the elementary schools of traps they can encounter when being alone on streets, at home, and of socio-pathological phenomena and dependences. A total of 200 children from 9 kindergartens in the Region of Bratislava participated in the project.

The “Drug dog” project was implemented in 2011 by the police in Nitra Region. The project was aimed at reducing the occurrence and use of narcotic and psychotropic substances with the pupils and students. A total of 150 pupils of the elementary and secondary schools participated in the project.

The “Juveniles without drugs” project was focused on strengthening the individual’s responsibility to his/her health and it was also intended to warn of the risks associated with the use of drugs as well as with consequences under criminal

118 Special elementary schools are designed for children with behavior disorders and other mental handicap.
The target group were the students of the elementary and secondary schools (N=1,575).

The project entitled “Did you know it?” was implemented in Trenčín Region in 2011 with the aim of: increasing legal consciousness of the students and providing information about consequences of the commission of offenses together with activities focused on prevention of the commission of the acts of violence and property offenses. The so-called drug glasses which allow the participants to see the world through the “eyes” of a man under the influence of drugs were used as part of this project. The target group were the 8th and 9th graders of the elementary and secondary schools (N=1,908).

“Why I am happy in this world”, the national project with international participation points out the priority importance of primary prevention and, using competitions and exhibitions, develops an active anti-drug attitude in the participants. Up to 459 students of the elementary and secondary schools participated in the project in 2011.

In the Region of Žilina, the police held (2011) a series of lectures, discussions and video projections on the topic of “liability under criminal law” which were focused on the area of property offenses, acts of violence, drug-related and economic offenses. A total of 1,254 students of the elementary and secondary schools participated in the project.

“I have both feet firmly on the ground”, the project of selective prevention focused on all types of crimes was designed for delinquent students of secondary schools from the district of Dolný Kubín (N=26). The project was aimed at familiarizing the target group through compact education/training activities and experience learning with consequences of antisocial behavior under criminal law, at increasing legal consciousness, providing positive and active forms of self-realization within the meaning of healthy lifestyle, and helping develop positive value orientation.

In Banská Bystrica Region, the police continued implementing the following popular projects in 2011:

- “Police officer, my friend” - in which 1,905 of 3rd, 4th, 6th and 7th graders participated.

- “I am big, but not yet adult” - in which 2,212 secondary students participated.

The following projects were implemented in 2011 for the first time:

“Don’t be afraid of prevention” – aimed at developing activities in the area of primary prevention of drug addictions, acceptance, empathy and assertiveness in communication 3/2 – prevention in school and within leisure time activities. Up to 8 pupils of the elementary school were actively involved in the project and participated in the implementation of preventive projects and activities (discussions, competitions, etc.).

“Police, known-unknown” – it is the project aimed at developing negative attitude in children to criminal activities, bullying, violence and use of narcotic and psychotropic substances. The target group included children from kindergartens and pupils of the elementary and special elementary schools (N=200).

The “No to drugs” project was implemented in 2011 in the Region of Prešov. It was aimed at combatting drug addiction by spending leisure time on artistic and sport activities. The actual project consisted of three parts – artistic, literary and entertaining. A total of 398 students of the elementary and secondary schools participated in the project.
The project entitled “Delinquency of juveniles and impact of drug addiction on the commission of crime” was implemented by the police in Košice Region. The project was aimed at pointing out the harmful effect of drugs on organism, criminal liability for the commission of offenses related to the possession, use and distribution of psychoactive substances. The target group included the 1st and 2nd graders of grammar schools, secondary schools and secondary vocational schools (N=102). (Bučková, I., 2012)

9.2.2 Prevention measures related to Drug Use in Prison

In 2011, up to 210 lectures on the issue of drug addictions and 130 discussions focused on the prevention of drug addictions attended by 7,062 and 4,209 convicted persons, respectively, were held in the facilities for service of a term of imprisonment. Up to 197 lectures and discussions on the prevention of drug addictions and on the prevention of drug-related crimes, attended by a total of 4,475 juveniles, were organized for the convicted juveniles by psychologists and medical staff of the prison in Sučany. The given preventive activities were focused on strengthening the ability to refuse a drug, on training of resistance to the pressure of peers, and on prevention of return to abuse of psychoactive substances after the termination of the term of imprisonment.

A total of 364 different educational activities were held in 2011 in the facilities for service of custody into which a total of 2,051 convicted persons participated (of which 234 juveniles).

Major room for performance of anti-drug activities is created in the facilities for service of a term of imprisonment where persons, who have already been proved guilty and have been imposed a sentence, are kept in prison. The main content of the activities carried out by the facilities for service of custody consists in the reduction of the availability and supply of drugs and in the control of the presence of drugs with the accused persons, with zero tolerance being declared.

As regards the reduction of the availability and supply of drugs, the corps implemented effective measures in 2011 to prevent the penetration and uncontrolled distribution of synthetic drugs and suspicious products in the facilities.

Members of the corps (performing service activities in the following areas: preventive and security activities, safeguarding the facility entrances, admission of the accused and the convicted into custody and in prison, respectively, delivery of correspondence and packages for prisoners, inspections in the prison premises) were informed about new synthetic drugs. In 2011, up to 29,903 packages, 385,786 pieces of correspondence, 1,533 means of conveyance, 9,664 cells, rooms and other selected premises and areas, and 56,148 pieces of baggage and garments of the accused and convicted were inspected and checked.

9.3 Interventions in the criminal justice system

The current system of penalties in Slovakia does not allow the convicted drug addicts to choose voluntarily between prison and therapy. The Criminal Code and the Criminal Procedure Rules regulate only the possibility of imposing the so-called protective therapy, either independently or in addition to a penalty or in case of remission. A judge can order such a therapy to the offender who committed an offense under the influence of a drug (alcohol or illegal drug) or in consequence of drug addiction (e.g. theft for the purpose of purchasing drugs, or any of drug-related offences).
9.3.1 Sentences Statistics – Alternatives to Imprisonment

The GP’s Office keeps a record of prosecuted drug offenders whose criminal prosecution was discontinued. The MJ keeps statistical records of sentences imposed by a judge on the persons convicted of drug-related crimes.

In 2011, the prosecutor discontinued the criminal prosecution of 2,311 persons prosecuted for drug-related crimes. The criminal prosecution was discontinued most often by indictment (N=995, 43%) which was followed by: agreement on guilt and punishment (N=660, 28.5%), conditional discontinuance of criminal prosecution (N=428, 18.5%), and the remaining 10% of cases were closed by the prosecutor by imposing other\textsuperscript{119} penalties which are not monitored statistically. Up to 1,146 persons were prosecuted by the Prosecutor’s Office for the offense of menace due to intoxication (Section 289 of the NCC), out of which 839 persons were accused (73.2%); an agreement on guilt and punishment was made with 267 persons, criminal prosecution against 22 persons was conditionally discontinued, and in one case a decision was made on approval of settlement and discontinuance of criminal prosecution. (Statistical yearbook of the GP’s Office 2012, p. 99 and 106).

In 2011, up to 368 offenders/30.5% (an increase by 69 compared with 2010) were condemned to immediate custody. Alternative to imprisonment was imposed by a judge on more than two thirds of the convicted persons. The majority of the offenders were condemned to suspended sentence (N=716; 59.5%) which was followed by fine (N=75; 6.2%), community services (N=36; 3%) and other penalties not specified in detail (N=9; 0.7%). No offender was condemned in Slovakia in 2011 to home curfew. One of the reasons for which the abovementioned alternative punishment is not used in practice is the insufficient technical equipment for monitoring the movement of prisoners.

More than one half of the offenders prosecuted for the possession of a drug for personal use was condemned in 2011 to suspended sentence and to suspended sentence with probation supervision (64.4%). Compared with the previous year, there was an increase in the number of the convicted persons who were imposed the community services by a court for the possession of a drug for personal use (from 2.9% in 2010 to 5.4% in 2011).

The majority of the offenders involved in dealing, trafficking or illicit manufacturing of drugs were condemned to suspended sentence and suspended sentence with probation (53.7%). The share of those sentenced by a court to imprisonment for drug trafficking was slightly increased compared with the last year - from 40.8% in 2010 to 46.3% in 2011.

Almost two thirds of the offenders adjudged guilty by a court for other offences related to the supply of drugs\textsuperscript{120} were sentenced to suspended sentence (63%).

\textsuperscript{119} Closing, transfer of the file, discontinuance or suspension of criminal prosecution; more information about the given forms of discontinuance of criminal prosecution is available in the 2008 Annual Report, chap. 11. Criminal Law Statistics

\textsuperscript{120} Including the offense of manufacturing or possession of an object to be used for manufacturing of drugs, and the offence of promotion of drug addiction

<table>
<thead>
<tr>
<th>Imposed punishment</th>
<th>Possession for personal use</th>
<th>Dealing/trafficking/production</th>
<th>Other drug supply offenses</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Immediate custody</td>
<td>105</td>
<td>16.8</td>
<td>255</td>
<td>46.3</td>
</tr>
<tr>
<td>Alternative to imprisonment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suspended sentence</td>
<td>403</td>
<td>64.4</td>
<td>296</td>
<td>53.7</td>
</tr>
<tr>
<td>Fine</td>
<td>75</td>
<td>12</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Home curfew</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Community services</td>
<td>34</td>
<td>5.4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other*</td>
<td>9</td>
<td>1.4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>626</td>
<td>100</td>
<td>551</td>
<td>100</td>
</tr>
</tbody>
</table>

* including other types of punishments which are not specified and monitored in detail (e.g. confiscation of a thing, confiscation of property).

9.3.1.1 Sentences imposed on juveniles convicted of drug-related crimes

The structure and order of sentences imposed on juveniles convicted of drug-related crimes remained comparable with 2010. More than four fifths of the total number of the convicted juveniles (N=52) were punished in 2011 by suspended sentence and by suspended sentence with probation. Two juveniles were sentenced to immediate custody; one for dealing and trafficking of drugs, and the second one for promotion of drug addiction. The remaining four juveniles were imposed pecuniary and other not specified punishment by a court. (Source: MJ, 2011)

9.3.2 Probation in Cases of Drug-related crimes

No data about the cases (prosecuted offenders) forwarded to probation and mediation, including the cases associated with drug-related crimes, was available in 2011. For the last statistical data about the forwarded cases related to drugs, see the 2010 Report, chap. 9.4.

9.3.3 Other interventions in the criminal justice system

No progress towards its implementation was recorded in 2011 with the proposed project of the Ministry of Justice and the Ministry of Education entitled “The Concept of Early Preventive Intervention in Case of First-Time Drug Users” (hereinafter referred to as the “FreD Project”). The first expert meeting of the representatives of the Ministry of Justice, the Ministry of the Interior, the Ministry of Education, the Ministry of Health, the Ministry of Labor, Social Affairs and Family, the NMCD as well as of the experts in medicine, drug addictions and psychology was held in May 2012. It was agreed by the representatives at the opening meeting that the FreD project will be sponsored by the Ministry of Justice that will be responsible for availability of trained probation/mediation officers. The majority of the participants recommended designing the FreD project exclusively for the juvenile delinquents who come into conflict with the law for the first time for drug offenses related to marijuana.
9.4 Drugs in prison

9.4.1 Drug use and problem drug use in prisons

In 2011, the service of custody (hereinafter referred to as the “SoC”) and the service of a term of imprisonment (hereinafter referred to as the “SoTI”) was performed in 18 facilities of the Corps of Prison and Court Guards (the “CPCG”) that report to the MJ.

In the conditions of the CPCG, the term “recorded drug addict” includes the following cases: anamnestic survey of the use of drugs before the admission to prison (within the initial medical examination of the accused/convicted), random drug screening with positive result, and seizure of a drug with the accused/convicted.

In late 2011, a total of 10,360 accused and convicted persons were placed in the CPCG facilities, out of which 1,863 persons were recorded as drug addicts (i.e. 18%). Compared with the previous years, it is the highest share of the recorded drug users in prisons of all time. Out of eighteen operated CPCG facilities, the prisons in Bratislava (18.5%) and Leopoldov (18.9%) approximated most the average share.

Figure 9.4.1: Number of drug users in prison and their share in total prison population (2005-2011). Source: CPCG, 2012

The highest share of the drug addicts was recorded in 2011 by the facility for service of a term of imprisonment in Hrnčiarovce nad Parnou (44.2%). On the contrary, the lowest share was reported similarly to the previous year by the facility for service of custody and the facility for service of a term of imprisonment in Prešov (1.2%).

9.4.1.1 Spectrum of drugs seized in prison

In 2011, the use of Pervitin in civil life was reported in the initial anamnestic questionnaire by the majority of the accused and convicted (36.6%). The second most used drug before the admission to prison was heroin (34.7%) followed by
marijuana (14.9%). In terms of the method of drug use, intravenous application (47.8%) and smoking (26.6%) continue to predominate among the prisoners.

9.4.1.2 Drug screening in prison

In 2011, screening testing of the accused and convicted persons for the presence of drugs in urine and, for the first time, in saliva samples continued to be carried out as part of the preventive activities of the CPCG focused on the use of drugs. Screening was carried out at random, or it was indicated for prisoners in case of a reasonable suspicion of the use of drug. The results of the abovementioned testing were listed for the first time in 2012 in a standard table – use of drugs in prison (ST-12). Positive cases were specified as a special form of drug use in prison which can be perceived as the prevalence of current use.

In 2011, a total of 2,304 screening tests for the presence of drugs in biological samples (urine and saliva) were carried out in the Slovak prisons. Compared with the previous year, the number of screenings was reduced – by 573 cases. Out of the abovementioned 2,304 screening tests for the presence of drug, up to 238 samples were positive (10.3%). The presence of the following substances was confirmed in the prisoners’ urine and saliva samples: benzodiazepines (N=93, i.e. 4%), marijuana (N=70, i.e. 3%), amphetamine (N=46, i.e. 2%), morphine/opiates (N=16, i.e. 0.7%), barbiturates (N=7, i.e. 0.3%), and other substances not specified in more detail (N=6, i.e. 0.3%).

The majority of positive samples were confirmed by the facility for SoC in Banská Bystrica (N=76) which was followed by the prisons in Žilina (N=62) and Bratislava (N=36).

Intensity of the screening tests is primarily dependent on financial condition of the CPCG and the available quantity of multi-detection test boxes. In 2011, the economic situation of the individual facilities was less favorable, which was also reflected in a decreased number of performed screening tests. In 2012, up to € 13,000 were allocated to the purchase of test boxes and, therefore, the number of screenings is expected to be higher compared with 2011.

9.4.2 Responses to drug-related health issues in Prison

9.4.2.1 Treatment in prison facilities

The quality of the provided drug treatment in prisons is determined by general standards prepared by the Ministry of Health of the Slovak Republic and by a national expert of the Slovak Republic in the field of psychiatry. The court ordered treatment in the conditions of the corps is regulated by Sections 80 through 88 of the Regulation № 368/2008 Coll. of the Ministry of Justice of the Slovak Republic issuing the Imprisonment Rules.

With regard to the fact that the environment for service of custody and for service of a term of imprisonment creates protective environment where absolute abstinence can be reached, the application of substitution therapy is not used in medical procedures (Bačíková A., 2012).

A total of 352 convicted persons (a decrease by 19.6% compared with 2010) were treated in healthcare units of four facilities in 2011 within the court-ordered protective therapy. Up to 34 convicted juveniles (a decrease by 18 persons compared with the previous year) underwent voluntary alcohol and drug addiction treatment.

---

121 Custodial Sentence Institution (CSI) Hrnčiarovce nad Parnou, CSI Košice, CSI Leopoldov, CSI, and hospital for the accused and convicted in Trenčín
Court ordered treatment was provided in designated facilities in the form of out-patient and in-patient treatment, either in the healthcare unit of the relevant facility or in psychiatric ward of a hospital for the accused and convicted persons. During the protective therapy, the convicted person can be employed (with consent of the facility director). If possible, court ordered treatment begins to be provided as soon as after the admission of the convicted in prison, if less than five months are left until the end of the term of imprisonment.

Based on the TDI data (2012), a total of 20 healthcare facilities of the Crops of Prison and Court Guards (CPCG) presented reports and information about in-patient treatment in 2011. A total of 674 accused and convicted persons underwent anti-addiction therapy in the facilities, and more than one half of them underwent such a therapy for the first time in their life (59%). Less than 40% of people were treated repeatedly and the remaining percentage of the treated persons did not specify the given parameter. More than 43% of the total number of persons treated in the CPCG facilities underwent treatment upon request of a court or criminal law enforcement authorities. Shown in Figure 9.4.2 is the total number of treatments broken down by primary drug in prison (2010-2011).

Figure 9.4.2: Number of treatments\textsuperscript{122} by primary drug in healthcare units of CPCG (2010-2011) Source: TDI data, 2011, 2012

Similarly to the previous year, in-patient treatment was most often provided in 2011 to patients dependent on opiates (41.5%), Pervitin/other amphetamines (38%) and marijuana (17%).

\textsuperscript{122} Including first treatment and previous treatment
### 9.4.2.2 Measures to prevent spreading of infectious diseases in the conditions of the CPCG

Activities focused on early detection and prevention from spreading of infectious diseases associated with the injecting drug use are carried out in the CPCG facilities as part of the prevention from spreading of such diseases. It mainly refers to the blood-borne infectious diseases.

Screening examinations for the presence of selected infectious diseases, in particular hepatitis B and C, HIV/AIDS, syphilis and other diseases, are carried out as part of preventive examinations of the prisoners on the basis of anamnesis' data. In 2011, a total of 5,719 screenings were carried out, with positive test results being identified in almost 7% of cases (N=400). The majority of screening tests were focused on the incidence of HCV and HBV with which a higher positivity among the prison population was assumed. The assumption was partly confirmed by the results of screening, as seropositivity was proved in more than 20% of cases (N=236) within the examination for the presence of HCV. The presence of HCV was confirmed within the confirmation analysis (PCR) in 10.1% of cases (N=49). The second most frequent infectious disease among the persons serving a term of imprisonment (2011) was syphilis which was positive in 5.6% of cases (N=63).

<table>
<thead>
<tr>
<th>Examination</th>
<th>Number of examinations</th>
<th>Negative result</th>
<th>Positive result</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>1,039</td>
<td>1,037</td>
<td>2</td>
</tr>
<tr>
<td>HCV</td>
<td>1,154</td>
<td>918</td>
<td>236</td>
</tr>
<tr>
<td>PCR HCV</td>
<td>482</td>
<td>433</td>
<td>49</td>
</tr>
<tr>
<td>HBsAg</td>
<td>1,284</td>
<td>1,245</td>
<td>39</td>
</tr>
<tr>
<td>HAV</td>
<td>652</td>
<td>641</td>
<td>11</td>
</tr>
<tr>
<td>BWR</td>
<td>1,108</td>
<td>1,045</td>
<td>63</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5,719</td>
<td>5,319</td>
<td>400</td>
</tr>
</tbody>
</table>

In 2011, a total of 10,000 copies of informative leaflets concerning the prevention of infectious diseases related to drugs and designed for the accused and convicted persons were distributed in the corps.

In 2011, a single screening focused on detection of the presence of HIV was carried out in CSI in Hrnčiarovce nad Parnou. No AIDS positive case was confirmed by screening in the facility.

### 9.4.2.3 Measures to prevent and eliminate the risk of overdosing in prison

The CPCG have no special standards to eliminate the risk of overdosing. They primarily pay attention to measures aimed at eliminating the penetration of drugs in prisons.

In 2011, up to 70 new places were created in six CPCG facilities in which the so-called “drug-free zones” are operated. Their capacity was thus increased to 332 places comparing the last year – see Table 9.4.2
Table 9.4.2: Drug-free zones in facilities for SoTI and open units (2010-2011). Source: L’ Vrábolová, CPCG, 2012

<table>
<thead>
<tr>
<th>Drug-free zone</th>
<th>Number of places (2010)</th>
<th>Number of places (2011)</th>
<th>Difference +/-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility for CSI in Košice - Šaca</td>
<td>29</td>
<td>20</td>
<td>-9</td>
</tr>
<tr>
<td>Facility for CSI for juveniles in Sučany</td>
<td>25</td>
<td>18</td>
<td>-7</td>
</tr>
<tr>
<td>Facility for CSI in Nitra – Chrenová (women)</td>
<td>10</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>CSI Open unit in Opatovce</td>
<td>43</td>
<td>53</td>
<td>+ 10</td>
</tr>
<tr>
<td>CSI Open unit in Prešov</td>
<td>100</td>
<td>164</td>
<td>+ 64</td>
</tr>
<tr>
<td>Facility for CSI in Želiezovce</td>
<td>55</td>
<td>59</td>
<td>+ 4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>262</strong></td>
<td><strong>332</strong></td>
<td><strong>+ 70</strong></td>
</tr>
</tbody>
</table>

A decision on the creation and dissolution of the drug-free zone is taken by the general director of the corps. Upon his/her admission to prison, every convicted person is informed about the possibilities of and conditions for being placed in a drug-free zone, about its rules and principles. Persons placed in the facility’s drug-free zone can include the convicted person who did not traffic any drug, who did not use any drugs, who used a drug but is currently motivated to abstain and is willing to subordinate himself/herself to the rules of the drug-free zone, and the convicted person who successfully completed voluntary drug-addiction therapy and anti-alcohol therapy or protective therapy ordered by a court. A decision on the convicted person’s application for placement in the facility’s drug-free zone is taken by the facility director upon discussion within the placement committee. The convicted person’s application for placement in the drug-free zone is presented to the placement committee by the appointed pedagogue in cooperation with psychologist who shall attach their expert opinion to the application. Before being placed in the drug-free zone, the convicted person shall sign a declaration in which he/she agrees to respect the rules and principles of the drug-free zone.

No event in connection with a threat to life or death of the accused/convicted person due to overdosing was recorded in 2011 during the service of custody or a term of imprisonment.

9.4.2.4 Measures to eliminate the penetration of drugs in prison

One of the significant measures to eliminate the penetration of drugs in the prison environment is systematic controls and inspections of things, cells, rooms, selected areas and means of conveyance in the premises of the corps. In 2011, up to 29,903 packages, 385,786 pieces of correspondence, 1,533 means of conveyance, 9,664 cells, rooms and other selected premises and areas, and 56,148 pieces of baggage and garments of the accused and convicted were inspected and checked.

9.5 Social reintegration of drug users after their release from prison

9.5.1 Cooperation with social services in the area of post penitentiary care:

Assistance provided to the convicted persons during and after their release from a CSI (prison) also includes guardianship measures which are implemented by the offices of labour, social affairs and family in the place of such persons’ usual residence. The implementation of the given measures for the target group of drug...
addicts and clients suffering from other additions after their release from the facilities for CSI is not monitored by any special statistic. Shown in the Table 9.5.1 are the social guardianship measures implemented in 2011 for the adults for the reason of their release from the facilities for CSI.

Table 9.5.1: Reasons for social guardianship services for individuals in 2010-2011. Source: Statistical reports of the MLSAF SR, 2011

<table>
<thead>
<tr>
<th>Reason for implementation of guardianship measures</th>
<th>Number of persons</th>
<th>Difference +/-</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2011</td>
<td>2010</td>
</tr>
<tr>
<td>Total cases of persons</td>
<td>9,229</td>
<td>8,935</td>
</tr>
<tr>
<td>Released from custodial sentence</td>
<td>4,705</td>
<td>4,239</td>
</tr>
<tr>
<td>Released from detention</td>
<td>546</td>
<td>504</td>
</tr>
<tr>
<td>Suspended release from custody</td>
<td>1,156</td>
<td>1,197</td>
</tr>
<tr>
<td>Suspended release from detention</td>
<td>99</td>
<td>84</td>
</tr>
<tr>
<td>Suspended imprisonment</td>
<td>182</td>
<td>283</td>
</tr>
<tr>
<td>Released from institutional care / re-educational centres after full-age of 18 years</td>
<td>125</td>
<td>110</td>
</tr>
<tr>
<td>Participant in probation/mediation</td>
<td>211</td>
<td>195</td>
</tr>
</tbody>
</table>

In 2011, more than two thirds (70.5%) of the total social guardianship services (N=9229) were provided to persons released from prison/custody. The guardianship services were subsequently provided in cases of conditional sentence of the offenders (2%), release from an institutional care / re-educational centres after reaching the full-age of 18 years (1.4%), as well as in the cases of probation/mediation (2.3%).

According NMCD survey on clients and services of (drug) resocialisation centres (NMCD 2012) there were 9 clients in facilities, who in 2011 began resocialisation programme as the part of post penitentiary care after release from prison.

A re-socialization allowance\textsuperscript{123} totalling EUR 154,162 was paid in 2011 by the OLSAF to the accused and convicted after their release from prison (N=3044). The maximum amount of the re-socialization allowance was EUR 75.93. Compared with the last year, the share of persons to whom the re-socialization allowance was allocated after their release from prison/custody was increased by 7.6%. In addition to the increase in the number of allocated allowances, a growth was also recorded in the total amount of payments (by EUR 14,771).

\textsuperscript{123} The maximum amount of the re-socialization allowance is determined as 40% of the subsistence. From 1 July 2011 to 1 July 2012, the subsistence amount was EUR 189.83.
10  **DRUG MARKET**

The position of the most accessible and the most frequently used drug in Slovakia was strengthened also in 2011 by marijuana which was mainly grown indoors by members of the Vietnamese ethnic group. The majority of marijuana grown in this way was designed for the local market and a smaller part of it was exported abroad (Hungary). Similarly to marijuana, the position on the black market was also strengthened by Methamphetamine which was accessible in all Slovak regions and was mainly produced from medications containing pseudoephedrine. In addition to locally produced Methamphetamine, Methamphetamine imported from the Czech Republic (with concentration exceeding 80%) appeared on the drug scene as well.

In 2011, the number of drug seizures increased by almost one fourth compared with the previous year. Nearly two thirds of the total number of seizures (N=2528) were represented by seizures of cannabis products (65%) and more than one fourth of the cases were the seizures of Methamphetamine (27%).

Compared with the previous year (2011), there was an increase in the seizures of: marijuana (+356), Methamphetamine (+147), hashish (+10), cocaine (+9) and cannabis plants (+2).

Even though the number of Methamphetamine seizures increased, the seized quantity dropped below 2 kg (to 1.64 kg), i.e. the police seized 2.37 g per seizure on average (about 3 to 5 doses of Methamphetamine).

The declining trend of heroin on the market and its replacement by fentanyl, observed as early as in 2010, fully manifested itself in the next year. In the first half of 2011, heroin was almost entirely squeezed out of the market by fentanyl (particularly in Bratislava and its surroundings). Reduced presence of heroin on the market was confirmed not only by a decreased number of its seizures (a decrease by 77.4% vis-à-vis 2010) but also by a significant decline in its concentration (from 14.6% in 2010 to 4.1% in 2011).

The most abused precursors in Slovakia (2011) include ephedrine and pseudoephedrine, even though their total seizures reached the lowest level for the most recent six years (N=11). Seizures of Acetic Anhydride declined as well – in 2011 this precursor was seized in Slovakia only marginally (upon destruction of a fentanyl laboratory) in the volume of 1 l.

In terms of the development of drug prices, the year 2011 was characterized by a growing price of methamphetamine (EUR 20-100/g) and cocaine (EUR 50-100/g) and a decreasing price of heroin (EUR 20-55/g). The price of marijuana stabilized at a level comparable with 2009 (EUR 6-22).

10.1  **Availability and Supply**

The situation concerning the supply of drugs is monitored in Slovakia by specialized police offices: the National Drug Service of Bureau Fight against Organized Crime of the Police Force (NDS BFOC PF); the Customs Criminal Office (CCO) operating in the area of supply reduction and the Institute of the Forensic Science of Police Force (IFS PF) conducting a qualitative analysis of the seized drugs.
10.1.1 Availability of Drugs Perceived in Public

In 2011, the “European School Survey Project on Alcohol and Other Drugs (ESPAD)” inquired about perception of the availability of illicit drugs among the school population aged 15 to 20 years. In the above survey, a total of 11,136 respondents of elementary and secondary schools answered the question: “How difficult would it be for you to procure any of the following types of drugs 124, if you wished to?” More than one half of the respondents (52.1%) stated in the questionnaire that it would be “quite easy” to “very easy” for them to procure marijuana or hashish. One fifth of pupils and students (21.2%) said that it would be “quite easy” to “very easy” for them to procure ecstasy. Procurement of amphetamines is perceived as “very easy” to “quite easy” by 12.1% of respondents aged 15 to 20 years. (A.Nociar, 2011) Compared with the previous cycle of the ESPAD survey (2007), there was a decline in the perception of accessibility with all monitored types of drugs. The most significant decrease in the perceived accessibility was recorded in case of ecstasy and marijuana. See Table 10.1.1.

Table 10.1.1: Availability of drugs in Slovakia perceived by population aged 15 to 20 years. Source: ESPAD (Nociar, 2011)

<table>
<thead>
<tr>
<th>Type of drug</th>
<th>Years</th>
<th>1995</th>
<th>1999</th>
<th>2003</th>
<th>2007</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana/hashish</td>
<td>1995</td>
<td>29.5</td>
<td>45.6</td>
<td>56</td>
<td>61.8</td>
<td>52.1</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>1999</td>
<td>8</td>
<td>14.1</td>
<td>15.6</td>
<td>15</td>
<td>12.1</td>
</tr>
<tr>
<td>Tranquilizers/Sedatives</td>
<td>2003</td>
<td>12.3</td>
<td>19.5</td>
<td>20.3</td>
<td>21.8</td>
<td>16.9</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>2007</td>
<td>4.7</td>
<td>17.6</td>
<td>26.2</td>
<td>34.8</td>
<td>21.2</td>
</tr>
<tr>
<td>Inhalants</td>
<td>2011</td>
<td>32.3</td>
<td>39.5</td>
<td>42.5</td>
<td>41.6</td>
<td>-</td>
</tr>
</tbody>
</table>

In addition to the abovementioned school survey, accessibility of the selected types of drugs was surveyed in the population aged 15 to 24 years also by the Eurobarometer Flash survey (2011) – for more details see the 2011 Report, chap. 10.1.

10.1.2 Drug Supply – Production and Trafficking

The provided information is based on the report of the NDS BFOC PF which obtains the given pieces of information through its operative and investigative activity.

10.1.2.1 Marijuana

The trend of indoor growing of marijuana in large laboratories established and operated by the members of the Vietnamese ethnic group continued also in 2011. The large-capacity laboratories were established all around Slovakia, and the majority of produce was designed, after processing, for foreign drug markets (mainly in Hungary).

Smaller establishments located in family houses were controlled by groups of Slovak offenders focused on breeding of smaller quantities of marijuana for Slovak users. Seeds, fertilizers and equipment were procured via Internet from abroad or in

124 Marijuana/hashish, amphetamines, tranquilizers/sedatives and ecstasy

Information obtained through the operative and investigative activity of the NADS refers to the breeding of cannabis in abandoned premises in southern Slovakia, where large-scale vegetable growing in greenhouses was widespread in the past. New, cultivated species of marijuana are more resistant to external meteorological conditions and have a higher content of THC compared with the past. Information about the outdoor breeding of cannabis in the areas of southern Slovakia and around Piešťany was confirmed.

10.1.2.2 Methamphetamine (Pervitin)

In 2011, Methamphetamine appeared on the Slovak drug scene. It mainly came from domestic production, but information about the import of high-quality Methamphetamine (with a high concentration exceeding 70%) from the Czech Republic was confirmed as well. In 2011, a part of Methamphetamine made in Slovakia was exported abroad (to Austria).

Methamphetamine was manufactured in 2011 in Slovakia in three types of laboratories:
- *in small, the so-called kitchen laboratories* with simple equipment. Even though the produce of such a laboratory was rather small, the drug was manufactured more frequently.
- *in mobile laboratories* that were regularly relocated to other premises;
- *in special laboratories* with a high productivity and concentration of the active substance,

Methamphetamine was mainly produced from pure ephedrine.

Methamphetamine was most often sold in small re-closable bags or sealed syringes (in the form of doses). The drug was distributed by organized groups of the offenders through the so-called “dead boxes”, with the drug being buried or hidden in publicly accessible places (e.g. in parks). They communicated the place of drug hideout to each other by phone, using a variety of pre-agreed passwords. Dealers usually carried the minimum quantity of drug (less than 10 doses). The so-called transferors, who were usually taken by the dealers to the meeting point, were also used for delivery of the goods and collection of the money.

Members of the Albanian ethnic groups were involved in the manufacturing and distribution of larger quantities of high concentration Methamphetamine.

10.1.2.3 Heroin

In 2011, heroin of brown color coming from Afghanistan, smuggled along one of the Balkan Route branches, appeared on the drug market. Compared with the last year, its concentration was reduced even more to about 3-8%. In the first half of 2011, heroin was almost entirely squeezed out of the Slovak market by fentanyl (particularly in Bratislava and its surroundings).

During the “Medik” (*Medical Student*) operation of the Bratislava squad of the OCB, a network of the offenders involved in the manufacturing of fentanyl was destroyed in August 2011. The result of the operation was destruction of a fentanyl

---

125 The main producer with accomplice whom he “trained” in the preparation of fentanyl
laboratory, detention of the offenders, and seizure of 4.4 kg of fentanyl (from which 24,187 single doses of fentanyl could be made). During its operation, the police seized not only fentanyl but also 20 kg of pure caffeine and 3 kg of paracetamol designed for its dilution as well as 1l of acetane hydride.

As a result of detention of the main producer of fentanyl in Slovakia, the abovementioned substance has not been present in Slovakia since September 2011. Heroin appeared on the drug market again, but in a significantly lower concentration compared with the previous periods.

### 10.1.2.4 Cocaine

In 2011 there was a declining trend of cocaine smuggling in bodies of persons with Nigerian origin (recorded since 2009). In the monitored period, customs officers recorded only one case of cocaine smuggling in the body of a courier from Nigeria. It usually referred to persons with criminal experience who were not members of any organized group. They were individuals who decided to carry out such activities for the purpose of financial gain, despite the risks associated with smuggling of drugs in body cavities.

With regard to a high frequency of detention of couriers by the police units in the European countries as well as to stricter measures of the European airports, the smuggling routes were changed. Smuggling of cocaine by air traffic was replaced with other methods - cars, buses or trains running across the Schengen area.

Up to 37 bird sculptures filled with cocaine of the total weight of 32.6 kg were hidden in boxes containing stone products in the Bratislava airport. The consignment came from Brasilia and it was transported through three shipping companies and deposited in the Bratislava airport.

The center of cocaine trafficking was situated in Bratislava, Senec and Sered. Cocaine diluents included not only creatine and paracetamol but also melanin, phenacetin or other medications of veterinary and human medicine. In 2011, 30% cocaine was accessible on the Slovak drug scene.

### 10.1.2.5 Ecstasy

Considering the group of synthetic drugs of amphetamine type, ecstasy containing MDMA, MDEA or MDA was hardly present on the Slovak drug scene in 2011. Substances containing mCPP were sold to consumers under the name of ecstasy. The trend of replacing the active substance MDMA in ecstasy tabs with mCPP was confirmed as early as in 2010 also by other European countries. Tablets containing mCPP are sold under the name of ecstasy without the buyer knowing it. Operative information indicates that ecstasy was imported to the Slovak territory from Hungary, Poland, Austria or the Netherlands.

The highest quantity of amphetamine in our territory in 2011 was seized by the Anti-Drug Squad East of the OCB PP during the “Blcha” (Flea) operation. Amphetamine in the form of powder and pressed into shape of bars had a weight of 13.17 kg in dry condition, and its concentration ranged from 28.8% to 42%. Two persons of Turkish nationality attempted to smuggle amphetamine designed for distribution in Ukraine through our territory from the Netherlands.

---

126 A Nigerian citizen was hiding 403.9 g of 26.3% cocaine and 1,011.1 g of 64.5% cocaine in his body.
10.1.2.6 LSD

Situation in consumption of this drug has been stabilized in our territory for a longer time. It is confirmed by the minimum number of seizures of the drug in Slovakia – see chap. 10.2.

Hallucinogenic effects of LSD are often substituted by the use of other hallucinogens, such as mushrooms (Psilocybe mushroom), plants (nutmeg, thorn apple, calamus).

10.1.3 Precursor Supply – Production and Trafficking

As of 31 November 2011, the Act № 140/1998 Coll. on drugs and medical devices, which authorized a pharmacist to refuse to sell medicines containing a drug precursor in a quantity exceeding one treatment cycle, was repealed. On 1 December 2011, the Act № 362/2011 Coll. on drugs and medical devices and on amendments to certain laws, and the Regulation № OF/1111/2011 of the Ministry of Health of the Slovak Republic from 24 November 2011, regulating the number of medicine packages containing a drug precursor necessary for one treatment cycle, took effect.

10.1.3.1 Ephedrine /Pseudoephedrine

The trend of the previous years – abuse of medicines containing pseudoephedrine in small methamphetamine laboratories (of the so-called “kitchen type”) persisted all around Slovakia in 2011.

The main source of pseudoephedrine was over-the-counter medicines for flu and fever treatment (Modafen, Nurofen, Disoprophol, etc.).

Ephedrine designed for manufacturing of a more concentrated methamphetamine (in special laboratories with a higher produce) was smuggled into Slovakia in 2011 from Turkey, Hungary (in the form of tablets) or Poland (in the form of powder).

10.1.3.2 Acetic Anhydride

In 2011, the Slovak Republic was a transit country in the illicit trafficking of acetic anhydride. Slovakia was involved in the illicit trafficking of this precursor through a Slovak legal entity that acquired (procured) it legally for further diversification.

To avoid the abuse of precursors for drug manufacturing, the Slovak police and the customs administration collaborate with partner bodies in the Czech Republic, Hungary, Austria, Romania, Bulgaria and Poland. In 2011, closer cooperation was established also with partner bodies from Serbia.

As regards trafficking of acetic anhydride, Slovakia is a country in which the given substance is legally procured and subsequently sent to other countries where it is further processed and used for illicit manufacturing of heroin. In 2011, the police in Hungary succeeded in seizing 6.5 t of acetic anhydride on the basis of close cooperation with the Slovak police and customs authorities.
10.2 Seizures of Drugs and Precursors

10.2.1 Drug Seizures

This chapter is based on data of the IFS PF PP and the Customs Criminal Office (CCO) which are summarized in a standard table EMCDDA №13 dedicated to drug seizures.

In 2011, a total of 2,528 drugs were seized in the Slovak Republic, which is an increase by 23.8% vis-à-vis the previous year.

Compared with 2010, there was an increase in the seizures of all cannabis products. The seizures of marijuana grew by almost one third (+356) and reached again the 2009 level (see Tab. 10.2.). A rise was also recorded in the seizures of hashish (+10) and cannabis plants (+2). Besides the cannabis products, a higher number of seizures was also recorded with methamphetamine (+147) and cocaine (+9).

In 2011, the number of heroin seizures decreased significantly (a decrease by 113 seizures and by 192 seizures compared with 2010 and 2009, respectively). An extreme decline in heroin seizures in 2011 resulted from the presence of fentanyl which started to appear regularly on our market as early as in 2010. By August 2011, it almost entirely replaced heroin (for the first half of 2011, 113 fentanyl seizures were recorded). This synthetic opiate was diluted by caffeine and paracetamol and it was brown-colored, exactly the same as heroin, and it was sold as heroin. In case of fentanyl, it referred to a drug which was illegally synthetized in Slovakia. After the revelation of the laboratory for its manufacturing (in August 2011), fentanyl abandoned the market (A. Bolf, 2012).

As regards the quantity of drugs seized in 2011, a decrease was recorded with marijuana (from 170.9 kg in 2010 to 137.02 kg in 2011) and Methamphetamine (from 2.95 kg in 2010 to 1.64 kg in 2011), even though the number of such drugs’ seizures increased. A significant decline in the quantity of the seized cannabis plants (in kg) resulted from a change in the method of reporting such seizures – from 2011, the seizures are counted in pieces (until 2010, the seizures of cannabis plants were reported only in kg). In 2011, up to 18.34 kg and 10,045 pieces of cannabis plants were seized in total.

A decrease in the seized quantity of ecstasy in 2011 was substantially affected by the single seizure of 968 ecstasy tabs in 2010. Similarly to amphetamine, the cause of a decline in the seized quantity of the drug in 2011 was the single huge seizure of 13.17 kg of amphetamine in the previous year.

On the contrary, the huge seizure of cocaine in 2011 (32.6 kg) brought about a significant increase in the total quantity of the seized cocaine compared with 2010. Besides cocaine, coca leaves as well as tea mixtures prepared from such leaves were seized for the first time in 2011 (there were 3 seizures in total).
Table 10.2.1: Number of cases and quantity of drugs seized in Slovakia (2009 - 2011), ST 13
Source: IFS PF (A., Bolf 2012)

<table>
<thead>
<tr>
<th>Type of drug</th>
<th>Unit</th>
<th>2009</th>
<th>Seized quantity</th>
<th>2010</th>
<th>Seized quantity</th>
<th>2011</th>
<th>Seized quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Number of seizures</td>
<td></td>
<td>Number of seizures</td>
<td></td>
<td>Number of seizures</td>
<td></td>
</tr>
<tr>
<td>Hashish</td>
<td>kg</td>
<td>36</td>
<td>1.1</td>
<td>12</td>
<td>0.21</td>
<td>22</td>
<td>0.017</td>
</tr>
<tr>
<td>Marijuana</td>
<td>kg</td>
<td>1,527</td>
<td>68.6</td>
<td>1,156</td>
<td>170.9</td>
<td>1,512</td>
<td>137</td>
</tr>
<tr>
<td>Cannabis plants</td>
<td>kg</td>
<td>61</td>
<td>2,589.9</td>
<td>43</td>
<td>1,986.3</td>
<td>45</td>
<td>18.34</td>
</tr>
<tr>
<td>Heroin</td>
<td>kg</td>
<td>225</td>
<td>14.3</td>
<td>146</td>
<td>1.3</td>
<td>33</td>
<td>0.32</td>
</tr>
<tr>
<td>Cocaine</td>
<td>kg</td>
<td>26</td>
<td>7.42</td>
<td>21</td>
<td>0.39</td>
<td>30</td>
<td>35.26</td>
</tr>
<tr>
<td>Amphetamine</td>
<td>kg</td>
<td>7</td>
<td>0.56</td>
<td>12</td>
<td>0.03</td>
<td>10</td>
<td>13.2</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>kg</td>
<td>817</td>
<td>2.17</td>
<td>545</td>
<td>2.95</td>
<td>692</td>
<td>1.64</td>
</tr>
<tr>
<td>Ecstasy tabs</td>
<td>tablet</td>
<td>5</td>
<td>12</td>
<td>5</td>
<td>993</td>
<td>5</td>
<td>27</td>
</tr>
<tr>
<td>LSD</td>
<td>dose</td>
<td>4</td>
<td>37</td>
<td>3</td>
<td>135</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>89</td>
<td>99</td>
<td>177*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>2,797</td>
<td>2,042</td>
<td>2,528</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* It comprises the following substances: fentanyl (N=113), benzodiazepines (N=27), psilocin (N=12), Morin and opiates (N=9), buprenorphine (N=7), mephedrone (N=3), dried coca leaves (N=3), ketamine (N=2) and barbiturates (1).

Figure 10.2.1: Share of seizures of selected types of drugs in Slovakia in 2011. Source: ISF PF (A., Bolf), 2012

Note: Shown in the graph are only the seizures of drugs whose share is at least 1%. As the share of hashish, ecstasy and LSD seizures did not reach 1% in 2010, the drugs are not included in the graph.
10.2.2 Precursor Seizures

In legislative terms, the control and handling of drug precursors are regulated by the Act № 331/2005 Coll. on public administration bodies in the matters of drug precursors, which also delegates responsibilities in the matters of drug precursors to the public administration bodies. In practice, the movement of drug precursors is monitored by the joint police and customs office of the NDS BFOC PF. All seized precursors are analyzed in the Slovak Republic by the IFS PF.

Table 10.2.2: Number of seizures and quantities of precursors seized in Slovakia in 2011, broken down by the seized form Source: IFS, 2012 (A,Bolf)

<table>
<thead>
<tr>
<th>Type of precursor</th>
<th>Form</th>
<th>Number of seizures (N)</th>
<th>Seized quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ephedrine</td>
<td>Powder (g)</td>
<td>1</td>
<td>4.04</td>
</tr>
<tr>
<td>Pseudoephedrine</td>
<td>Powder (g)</td>
<td>6</td>
<td>159.15</td>
</tr>
<tr>
<td></td>
<td>Tablet</td>
<td>4</td>
<td>1,734</td>
</tr>
<tr>
<td>Acetic Anhydride</td>
<td>Solution (liter)</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

The most abused precursors in the Slovak Republic have included for a long time the substances used for illicit manufacturing of methamphetamine – ephedrine and pseudoephedrine. In 2011, the total number of their seizures was reduced and reached the lowest level for the most recent 6 years (N=11). Even though the total number of ephedrine/pseudoephedrine seizures has systematically declined since 2008 (see Figure 10.2.2), the pseudoephedrine\textsuperscript{127} seizures have recorded a growth in the most recent year not only in terms of the number of seizures (from 2 seizures in 2010 to 4 seizures in 2011) but also in terms of the seized quantity (from 432 tabs in 2010 to 1,734 tabs in 2011). The recorded trend points out an increased production and supply of Methamphetamine (with concentration exceeding 60%) which is most often made from pseudoephedrine obtained from over-the-counter medicines in the laboratories of the so-called “kitchen type”. It refers to small simple laboratories with smaller productivity but higher frequency of production.

\textsuperscript{127} Used for manufacturing of methamphetamine in small “kitchen” laboratories
In 2011, Acetic Anhydride (AA) was seized in Slovakia only marginally, upon destruction of the fentanyl laboratory. During the abovementioned operation, the police seized not only fentanyl and substances designed for its dilution (caffeine and paracetamol) but also 1 liter of Acetic Anhydride in liquid form. Compared with the previous years, there was a significant decrease in the seized quantity – in 2009 (860 kg AA), in 2010 (5 l AA), in 2011 (1 l AA).

10.2.3 Dismanteled Laboratories

Statistical data related to the number of dismantled laboratories intend for manufacturing of narcotic drugs, psychotropic substances and precursors are not standardly monitored by the police corps. The main reasons for which it is impossible to record the abovementioned data globally is the absence of a legal definition of the term “laboratory” (flask, filtration device, cooker, etc.). Therefore, no official data for 2011 concerning the number of destroyed laboratories in Slovakia were available.

10.3 Drug Price and Purity

10.3.1 Drug Prices

The NDS BFOC PF inquires about the prices of the individual types of drugs in the Slovak Republic on the basis of its operative and investigative activity and discloses them for the purposes of this report through a standard table - ST16. For a more detailed description of the method for determining the price of drugs in the Slovak Republic, see the 2011 Report – chap.10.3.1.

In terms of prices, the year 2011 was characterized, on the one hand, by the growing prices of methamphetamine and cocaine and, on the other hand, by a decline in the heroin price.
The price of marijuana remained stable in 2011 at the level of EUR 6-22/g, which is comparable with the 2009 price. Cannabis resin (hashish) was sold for EUR 8 to 20/g. After a sharp decline in 2010 (EUR 25-59/g), the price of methamphetamine grew to EUR 20-100/g in 2011. A big difference between the minimum and the maximum price of methamphetamine (2011) was significantly influenced by its quality – Methamphetamine with concentration exceeding 80% was sold for the max. price (EUR 100/g).

The price of heroin dropped from EUR 28-60/g (in 2010) to EUR 20-55/g (in 2011), thus reaching the level comparable with 2009. The decline in the heroin price in 2011 could result from a significant decrease of its concentration (see chap. 10.3.2) and its mixing with fentanyl\textsuperscript{128}.

In 2011, the highest price of cocaine increased and reached its long-time high of EUR 100/g. Such a change could result from an increase in cocaine concentration from 29.1% in 2010 to 36.5% in 2011.

Based on findings of the NADS, ecstasy tabs and LSD trips were sold in 2011 for EUR 2-16 and for EUR 10-20, respectively.

Figure 10.3.1: Minimum, maximum and average price of selected types of drugs in Slovakia in euro in 2011. Source: ST16 (NDS BFOC PF, 2012)

10.3.2 Drug Purity and Composition

Drugs seized in the Slovak territory are analyzed by the Institute of the Forensic Science of Police Force (IFS PF) by three departments: in Bratislava, Slovenská Ľupča and Košice. The central register is kept with the IFS PF in Bratislava.

In 2011, the IFS PF conducted 2,912 quantitative analyses of drugs, which is an increase by 31.7% compared with 2010 (N=2211). The growth vis-à-vis 2010 results from a higher number of drug seizures. No quantitative analyses were made in case

\textsuperscript{128} In the first half of 2011, heroin was almost entirely replaced on the market by fentanyl.
of the seizures of small quantities of marijuana (not more than 1,000 mg) and Methamphetamine (not more than 200 mg).

Concentration of the active substance in heroin in 2011 dropped significantly in both indicators to 4.1% for median and to 4.5% for weighted average. They are the lowest values since 2001, which resulted from replacement of heroin with fentanyl and subsequent reduced availability of heroin on the market.

The average concentration of THC in case of marijuana remained constant to 2010 (see Table 10.3.1). It is noted, however, that the number of quantitative analyses was significantly lower than in 2009 when considering the number of marijuana seizures (1,512 seizures and 1,499 quantitative analyses in 2011, and 1,527 seizures and 2,156 quantitative analyses in 2009).

In case of methamphetamine, there was a slight increase in concentration of the active substance compared with the recent years - median of 73.4% and weighted average of 69.2%, which is the highest value since 2001.

The cocaine concentration median grew to 36.5% and the weighted average slightly dropped to 46.7%. Such values were obtained from 55 samples, which is the highest number since 2001.

Table 10.3.1: Number of samples, weighted average and median of the content of active substance in selected types of drugs in Slovakia in 2008 – 2011, ST 14. Source: IFS PF, (A. Bolf), 2012

<table>
<thead>
<tr>
<th>YEAR</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Weighted average</td>
<td>Median</td>
<td>Number</td>
</tr>
<tr>
<td>Hashish (% THC)</td>
<td>30</td>
<td>13.4</td>
<td>10.1</td>
<td>64</td>
</tr>
<tr>
<td>Marijuana (% THC)</td>
<td>1,655</td>
<td>7.6</td>
<td>9.6</td>
<td>2,156</td>
</tr>
<tr>
<td>Heroin (%)</td>
<td>1,185</td>
<td>15.4</td>
<td>13</td>
<td>763</td>
</tr>
<tr>
<td>Cocaine (%)</td>
<td>46</td>
<td>36.8</td>
<td>29</td>
<td>25</td>
</tr>
<tr>
<td>Methamphetamine (%)</td>
<td>1,000</td>
<td>63.5</td>
<td>69.8</td>
<td>1,027</td>
</tr>
</tbody>
</table>
Figure 10.3.2: Development of concentration median in selected types of drugs in Slovakia (2003 - 2011), ST 14, IFS PF. Source: IFS PF (A. Bolf), 2012
NOTE

Chapter 11 – Selected issue *Residential (institutional) treatment of drug users* was elaborated by external experts - collaborators of the National Monitoring Centre for Drugs as an author craft. In order to avoid unprofessional interferences, the National Monitoring Centre for Drugs did not change the text, except of formal modifications and formatting.
11 RESIDENTIAL (INSTITUTIONAL) TREATMENT OF DRUG USERS IN SLOVAKIA (DATA 2011)

In Slovakia, residential health care for patients with drug addictions is provided in psychiatric hospitals and medical institutions, in clinics or departments for drug dependence treatment, but mainly in Specialized Centres for Treatment of Drug Dependencies (CTDD). Outside the health sector, accredited resocialization facilities operate in Slovakia, which fall under the Ministry of Labour, Social Affairs and Family (MLSAF), which provide a concentrated form of psychosocial care provided in the community within a long-term stay of clients pursuant to Article 63 of Act No 305/2005 Coll. on Social and Legal Protection of Children and on Social Legal Guardianship, as amended.

11.1 HISTORICAL AND POLITICAL FRAMEWORK

11.1.1 HISTORY OF INSTITUTIONAL TREATMENT

A significant personality in the history of Czechoslovak addictology was psychiatrist Jaroslav Skála, a promoter of psychotherapy and community therapy. In 1948, he founded the first residential (institutional) department for the treatment of alcoholism in Prague. Gradually specialized institutional and residential departments are established in several places in former Czechoslovakia, and thus also in Slovakia. In addition to the issue of dependence on alcohol, which markedly dominated at that time, to a reduced extent also patients with dependence on pills were treated institutionally – opioids (Alnagon, Dinyl) and medicaments with a stimulating effect and containing amphetamine substances (Fermetratin, Dexphenmetrazine) and adolescents with dependence on volatile substances (toluene, acetone).

40 years later, with the opening of the borders after 1989, addictology was increasingly dealing with psychoactive substances, in addition to alcohol, as a result of a marked growth of their use. In Slovakia, Centres for Treatment of Drug Dependencies (CTDD) were established as public allowance organizations established by the Ministry of Health of the SR. The first CTDD was established in Nové Zámky and in 1992 CTDD in Bratislava in the former Alcohol Advisory Centre. It is the largest central specialized health institution in Slovakia, whose main scope of business is prevention, diagnostics, treatment and subsequent after-treatment care for patients with health problems resulting from the use of psychoactive substances. CTDD’s structure is formed according to the state-of-the-art principles for health care provision according to the recommendations of the WHO, the European Commission DG SANCO and the National Institute on Drug Abuse in the USA. In 1995, the CTDD was founded in Banská Bystrica. In 2000, the CTDD was founded at the Specialized Psychiatric Clinic - Odborný liečebný ústav psychiatrický (OLÚP) n. o. in Predná Hora. In 2004, the CTDD was founded in Košice and in Žilina. One year later, the CTDD Rieka is founded in Šútov. In the same year, however, two CTDD cease to exist, in Nitra and Humenné. Shortly after, due to the lack of qualified staff - physicians-specialists, also the CTDD in Nové Zámky ceases to exist.

The first resocialization centre in Slovakia, Komunita Ludovítov n. o., up till now the largest of its type, was founded in 1995 at the initiative of the citizens’ association Život bez drog (Life without Drugs) and active support of the Ministry of Labour,
Social Affairs and Family. It followed the institutional care of CTDD in Nové Zámky. In 1992, other resocialization centres are gradually founded. Long-term care with a shift to social therapeutic rehabilitation is covered by Sanatórium AT MUDr. Ivana Novotného in Bratislava, which has been operating since 1996. Today the Ministry of Labour, Social Affairs and Family has a record of 19 accredited resocialization centres. At present these therapeutic communities focused on social reintegration of drug abstainers after previous withdrawal medical treatment are predominantly non-profit organizations based on non-governmental organizations, citizens' associations or religious organizations.

Institutional health care of drug users is a medical programme, which consists of medium-term residential treatment, which is carried out for 6 - 12 weeks.

The resocialization programme is conducted usually for at least eight months, in most facilities it is 12 - 24 months, according to client's individual needs.

The key forms of treatment are ambulatory treatment and institutional treatment in healthcare facilities. The institutional form is provided most commonly at initial stages, during and after a short interruption of drug use. However, in Slovakia still patients prevail who were treated only by ambulatory form according to their own decision.

11.1.2 Strategy and political framework of Residential (institutional) treatment

The Slovak Government, by Resolution № 259/2009 dated 1 April 2009 adopted, inter alia, the National Drug Strategy 2009-2012 (see NPDS 2009-2012). Several tasks result from it for the public health sector.

Priorities of the public health within the Action Plan for the National Programme for the Fight against Drugs include also the provision of quality and available health care for drug users.

Medical care related to the treatment of drug addictions in the public health sector is provided free of charge; its availability and accessibility depends on specific contracts of healthcare facilities with Health Insurance Companies (HIC), which publish the relevant facilities. The volumes and amounts of payments to healthcare facilities depend on the policy of particular Health Insurance Companies and vary (roughly €40 and more bed/day/patient paid by HIC). They vary on the basis of contracts on yearly basis and according to the financial status even more often. The users of psychoactive substances with chronic ailments do not belong to attractive insured persons from the point of view of Health Insurance Companies. Even despite that the availability of health care is ensured and an access to treatment for people from the whole socio-economic spectrum. Every citizen is covered by health insurance according to the law and is entitled to the provision of health care of this type. For the groups of the unemployed, children and pensioners, where we can classify a major part of drug users with dependence, the state pays fees to Health Insurance Companies. Other citizens pay insurance on a monthly basis on their own or it is paid by their employer. Beyond the scope of the volume of provided health care or at one’s own request a patient can get treatment for direct payment according to the respective pricelist in certain healthcare facilities.

If a patient with drug addiction is employed during residential treatment and has card issued proving the duration of temporary incapacity for work (TIW), they shall be entitled to the payment of income during TIW from their employer for the first 10
calendar days and to medical benefits from the Social Insurance Agency during the remaining period of TIW. If a patient is voluntarily unemployed, then he/she is not socially insured (has not pension insurance) and payments for him/her for social insurance are not paid by the state (it means that he/she is not entitled to medical benefits). If he/she is involuntarily unemployed, during the treatment he/she can get unemployment benefits (if the right to it was created), and if he/she is not entitled to unemployment benefits, he/she can apply for a social assistance benefit at the Office of Labour, Social Affairs and Family.

Resocialization facilities financially depend on finances from higher territorial units (HTU). A client entering the resocialization programme participates in the payment of stay himself/herself (in certain facilities even with an initial fee of approx €65), at regular monthly intervals (unemployment benefits, social assistance benefits, invalidity pension and others) by a monetary amount ranging approximately from €95 to €225. In some places an agreement is made with the client on the method of financial payment for resocialization stay, or relevant resocialization facility sets client’s co-payments according to the relevant provisions of Act No 305/2005 Coll. on Social and Legal Protection of Children and Social Legal Guardianship, i.e. the client pays €3.33/day for boarding (according to the number of meals taken) and €3.48/day for lodging (when social assistance benefits are drawn and a protected allowance, the fee for stay is €87.60 per month and €37.97 pocket money per month).

Each taxpayer in the SR (both physical and legal persons) can donate 2% of taxes to resocialization facilities, if their type is citizens' association or non-profit organization, including healthcare facilities. Various providers can also contribute financially to the development of such facilities (Drugs Fund, Office of Labour, Social Affairs and Family, HTU, entrepreneurs, individuals, etc.)

11.2 AVAILABILITY AND CHARACTERISTIC OF RESIDENTIAL TREATMENT

11.2.1 NATIONAL AVAILABILITY AND ACCESSIBILITY

The availability and access to treatment related to residential treatment capacity is fast and further remains on a good quantitative and qualitative level in the Slovak Republic.

Within the whole territory of the SR, in 2011, as much as in 38 healthcare facilities patients were admitted with the diagnosis F 19 (the so-called polyusers), which was followed by the users of psychostimulants (F 15), treated at 27 facilities. The diagnosis F 11 (opiates) was present in 24 facilities and F 12 (cannabinoids) in 20 facilities. At least, hallucinogen users (F 16) and also patients with diagnosis F 17 (tobacco) were admitted into one facility (See more in Chap. 5).

The reporting methodology on drug users treated from dependence focuses on the follow-up of the first demand for treatment in the relevant facility and in the respective year.

In clinical practice after a basic examination in psychiatrist's office the physician recommends the form of treatment. For a clear diagnosis of dependence in an active, clinically developed phase with symptoms the patient has an opportunity to choose either ambulatory or institutional form of treatment, but the physician in principle in such cases recommends starting the institutional form of treatment. The final decision is, however, up to the patient and if he/she refuses physician's proposal of
institutional treatment, the ambulatory form of treatment will be provided to him/her. During the treatment the patient has the right to re-assess his/her decision.

The availability of treatment which is fully covered for Slovak citizens from public health insurance is proved also by the fact that among treated patients including institutional treatment are regularly also the homeless.

Neither the access to treatment was and has been a problem for patients. The evidence of this is very short or absent waiting lists for the commencement of institutional treatment due to drug problems. If somewhere a waiting list is created for admission into institutional health care, if the patient wishes to get the treatment promptly, he/she can choose another facility where no waiting is needed as the Slovak healthcare system has a free selection of healthcare provider by patients. However, certain Health Insurance Companies sometimes impose as a precondition for the payment of treatment preliminary approval of the patient’s treatment stay by them. A special situation represents the access to institutional court-ordered drug addiction treatment ordered for performance in a civil healthcare facility. In certain institutional health care facilities, long waiting lists, even with several months waiting time, arise especially for this group of patients. Due to regime and capacity reasons, specialized addictological institutional facilities often admit only a limited and specific number of patients who were sentenced to the treatment by court. The reason is often a low motivation to treatment, frequently occurring personality disorders of antisocial type, which are factors that can disturb and usually disturb the drug regimen of other patients, if there are several such patients in the department. If such a patient gets into a long waiting list, unlike patient who is treated voluntarily, he/she cannot change the medical institution himself/herself, but it is possible only by decision of the court. He/she has no free choice of the provider. However, he/she can theoretically apply just like other patients for the performance of institutional treatment in another place, but if this is without the consent of the court which imposed the treatment on him/her, it is questionable, whether the court accepts a proposal for its completion from a centre other than specified by it. Thus, also in case of court-ordered institutional form of treatment the patient can freely choose an institutional facility for medical reasons.

Figure 11.2.1: Number of patients admitted in psychiatric healthcare facilities due to problems with drug use (F11 - F19) – comparison of hospitalization length (2011). Source: Reporting of patient’s institutional psychiatric care of HF (Ministry of Health of the SR) 1-12
Within a medical model of diagnosing drug addiction, patients who demand residential treatment are directed to healthcare facilities either without a recommendation, by a clinical psychologist or by a field worker, social worker, general practitioner for children, adolescents and adults, or by an ambulatory psychiatrist or another specialist. These healthcare facilities are subsequently enriched with the activities of organizations providing social assistance (resocialization facilities). Residential treatment can be voluntary according to patient’s demand who due to problems with drugs has called on himself/herself, or non-voluntary on the basis of court ruling after determining drug addiction by an authorized expert from the public health sector – psychiatrist, with respect to the criminal activity.

Conditions for admission to residential treatment include an age above 18 years (in some places they admit patients younger than 18, however, with the consent of their parents), a voluntary patient’s consent (not applicable to treatment ordered by the court), health insurance (or without health insurance according to a valid pricelist of the relevant facility). In some facilities the condition for treatment can be also direct relation to previous patient’s detoxification. The residential treatment can be repeated several times in the same year for a complicated, chronic, recurrent course of the illness according to the patient’s clinical condition (it also depends on approval by the relevant HIC). Patients can voluntarily leave residential treatment at any time at their own request and continue in the ambulatory programme. If they terminate themselves the protected institutional (residential) treatment ordered by the court, the attending physician will report the same to the competent court.

Conditions for the admission of clients to the resocialization programme are in most of such facilities identical. Before admission the client sends an application for admission to resocialization along with curriculum vitae drawn up by him/her. The admission of client usually follows after a previous treatment process (medium-term withdrawal institutional treatment) in a healthcare facility documented by a preliminary discharge report or a resocialization recommendation (note: certain facilities admit clients also without this condition, e.g. on the basis of an interview on the entry). The client’s personal decision and a personal motivational interview, a valid ID card and an insurance card are among the conditions of admission. Another condition is the payment of stay from client’s income (unemployment benefits, social assistance benefits, or another income). Client’s age limited to minimum 16 years (finished compulsory school attendance) or 18 years of age and more. Abstinence is a compulsory condition; the client is obliged to stop the resocialization programme in the event of its breach.

In 2011, 842 clients were in RS (of whom 95 younger than 18) in Slovakia; 153 clients completed the resocialization programme. With 425 beds, the average length of stay in RS was 12 months; the shortest was 4 months (Teen Challenge), and the longest was 28 months (Pahorok) (See more in Chap. 8).

11.2.2 TYPES AND CHARACTERISTICS OF INSTITUTIONAL TREATMENT FACILITIES

11.2.2.1 COMMON APPROACHES

Institutional residential patient care in the public health sector contains comprehensive medical, psychotherapeutic and nursing care comprising diagnostics and the treatment of dependence-related disorders. Medical care covers both the care of somatic and mental health. Patients are provided with medicine against drug
addictions through a team of physicians, specialists in the field of psychiatry, medicine for drug addictions. The psychotherapeutic care consists of psychotherapy and psychodiagnostics. (Please add other specialists – psychologists, special teachers…) The nursing care focuses on a holistic approach, while maintaining and promoting health, including in prevention. The philosophy of addiction treatment is a stay in a special organized healthcare department where active patient’s participation is required. The basis is a behavioural structured drug regimen applying the elements of the organizational structure of therapeutic community and the principles and techniques of cognitive-behavioural therapy. Stress is laid mainly on group psychotherapy. Medicamentous treatment applying the latest spectrum of pharmacotherapy is no less important part of treatment. The daily regime consists of compulsory and voluntary therapeutic activities. CV writing, rational therapy (didactic therapy), thematic groups (written preparation of assigned topics), individual psychotherapy, assertiveness training, stress handling training, social skills training, series of lectures on craving and recurrences, Programme 12 – steps (NA), anti-smoking, anti-depression and anti-anxiety groups, resocialization group, autogenous training (relaxation training), psychogymnastics, bibliotherapy (reading of specialized literature), ergotherapy, artetherapy, music therapy, field therapy, physiotherapy, abstainer N - club, social and legal advisory, passes belong among them. An important part of treatment is sport and movement activities (fitness centre, tourist trips in the vicinity). Part of the comprehensive treatment in some facilities is also possible use of an educational stay for patient’s family members entitled Family therapy.

The resocialization programme in terms of the organization and content is adapted to clients in the form of life in community, which allows their participation in managing and planning the community life. An overwhelming majority of resocialization programmes is based on the principles of classic therapeutic community for addicts. The community is the highest authority and decides on principal issues of its members, such as individual therapeutic procedures up to the highest stages, on rewards and sanctions for the breach of community rules up to exclusion from the therapeutic community. However, the level of community autonomy and self-management and the participation of therapists in the management as rational authorities are not unified in different programmes. A wider community mostly includes also the client’s family members as cooperation with the family and its willingness to participate actively in client’s therapy is the key priority in reaching long-term abstinence. On the one hand, resocialization facilities are located in lonely places where they have conditions for parallel therapeutic and resocialization programme with frequent therapy on a farm, but today they are located also in urban conglomerations (Bratislava, Košice), which facilities their readaptation in the shift into unprotected environment of society. Individual social work?, individual psychotherapy, community work, group psychotherapy, phase groups, sponsorship groups, thematic groups, self-management groups, NA meetings – a 12 Step Programme, bibliotherapy, music therapy, artetherapy, sport therapy, family therapy, group advisory, field family therapy, work therapy, with an exactly set day plan belong among the basic methods. They ensure also necessary health care for clients in collaboration with specialized healthcare centres. They have conditions for special interest, sport and cultural activity, zoo therapy (canistherapy? where, hippotherapy), gardening or fruit production. Clients are fully involved in self-service activities, they prepare meals themselves, clean the premises themselves, wash laundry, iron, etc. The structure of resocialization plan consists of an adaptation, therapeutic
and resocialization period. The clients go through several phases during their stay. The first phase is initial, motivational for newly admitted clients into the facility. It focuses on client’s entry into the community by explaining of its functioning, principles and usually lasts for 6 – 7 weeks. In the second, reference phase the client has a chance to understand himself/herself, understand the reasons for which they started to use addictive drugs. They can meet their close relatives in this phase. The third phase is curative and focuses on an enhancement of client’s self-regulation, on the redevelopment and strengthening of their socially accepted forms of behaviour, moral and ethical norms, performed for instance in the form of passes. The fourth, rehabilitation phase focuses on overall physical and mental renewal of an individual leading to the ability to become independent gradually, searching for a job or going on with the studies. It identifies problematic areas, which can endanger his/her life in abstinence after his/her departure from resocialization. In the last, reintegration phase the client spends more time outside the community, creates conditions for his/her professional fulfilment, housing, change of family relations; he/she searches for forms of meaningful spending of free time, fixes positive habits in a natural environment.

Clients who finish their stay in a resocialization facility can use also the services of protected housing, the so-called “Houses on the halfway,” which will provide them with year-long housing and supervision to give them assistance in passage of situations immediately after the departure from the resocialization facility.

11.2.2.2 TYPICAL MIX/INTEGRATION OF SERVICES

In the Slovak conditions, integration of several necessary services for people who have problems with drugs and require a treatment is in principle provided in two ways. Both of them include also institutional form of treatment. On the one hand, it is the integration of services within the network of different specialized independent programmes, providers, which have interlinked collaboration and, on the other hand, various levels of the integration of several services within the same facility up to complex Centres for Treatment of Drug Dependencies (CTDD). But CTDD also must ‘out-source’ certain services and depend on collaboration with other institutions.

The complexity and types of integrated services must be understood in different planes. For example, by division of integrated programmes into health care services, including mental and physical health, and social services, including for instance social reintegration (resocialization), but also social assistance, low-threshold programmes. Within institutional care in our facilities, which are included in psychiatry, comprehensive treatment of drug addictions is provided, including often attached other diagnoses and mental disorders, and diagnostics and treatment of concurrent physical diseases. The treatment of double diagnoses, for instance, the combination of affective disorder and addiction, or the treatment of both types of addictions, e.g. dependence on methamphetamines and pathological gambling. CTDD have standard institutional treatment of later occurring dependence on methamphetamines and continuous substitution treatment, which a patient received in the past due to dependence on opioids. A different view is the integration of subsequently provided different types of services: a low-threshold programme for the replacement of needles and syringes, ambulatory or residential detoxification with the shift to institutional treatment of addiction, which after three months again follows up the ambulatory treatment, but also resocialization in the form of stays in a therapeutic community of non-medical type. It is a recommended line of the curative process, which, however, may not be fully utilized depending on the situation of the user.
However, the organizational arrangement and direction of recommendations is important for the client/patient in the integrated care system. Centres for Treatment of Drug Dependencies located in towns provide in most cases the replacement of sterile needles and syringes, ambulatory treatment, substitution treatment, institutional detoxification and institutional addiction treatment, ambulatory after-treatment and resocialization in clubs for long-term abstainers, within one facility. Although AT sanatórium I. Novotného does not have low-threshold programmes, unlike the others it has also institutional form of resocialization in the form of a residential-type therapeutic community. Testing for infectious diseases: HIV, hepatitis, syphilis, etc. and, if necessary, cooperation in the treatment with the relevant physicians-specialists also belong to the range of integrated services. For services, which are not provided by the institutional facility, within the network of cooperating institutions it has agreements on cooperation with other specific facilities where the patient/client can be sent. In healthcare facilities intended for residential care of patients having problems with drugs, the integration of medicamentous treatment is typical, as well as of cognitive-behavioural individual and group psychotherapy, and social therapy.

Residential detoxification treatment belongs among programmes provided by facilities for the treatment of drug dependencies. It usually takes 1-2 weeks, or can be performed also in ambulatory form. This does not belong here!

A hepatitis B vaccination programme, a testing programme for blood-borne infectious diseases (HIV/AIDS, hepatitis B, C, syphilis), a programme for the provision of sterile needles and syringes, medical education among the users of psychoactive substances, toxicological examinations of the urine for all addictive drugs, the issue of curative tools, e.g. in the form of the journal “Nezávislosť” (“Independence”), or an Internet service for the public in the field of addictions belong among programmes, which are predominantly carried out by specialized Centres for Treatment of Drug Dependencies.

When performing the diagnostics and treatment of patients with mental disorders related to the use of psychoactive substances, the medical staff follows the latest criteria of the World Health Organization and consistently respect the International Classification of Diseases – its 10th revision (MKCH-10, Chapter V.), following the medical concept of the medicine of drug addictions of the MH SR.

Within a long-term after-treatment process, special healthcare facilities provide supporting and refresher stays lasting 1-2 weeks, with possible use ¼, 1/2 and ¾ per year depending on approval by the HIC for patients, who have already passed the basic institutional treatment and abstain. Their purpose is the prevention of the occurrence of possible recurrence through the strengthening of motivation to maintain abstinence, continuous solving of problems, which occur in the patient’s life.

Professionally patient’s overdosage falls within the competence of urgent medicine, for the purpose of the monitoring of vital functions and application of symptomatic treatment. In practice, however, it looks completely different and an overdosed drug user or his team does not seek for such assistance and tries do handle the overdosage without professional assistance. In Slovakia, for instance, also for this reason several Internet portals have been developed for drug users, dealing with “overdosage management”.

The Public Health Authority (PHA) of the SR participates in activities in the area of drug prevention. Primary prevention of the abuse of illegal addictive drugs is implemented within the National Health Support Programme and the National Programme for the Fight against Drugs, which are implemented by the Health
Support Departments and Health Consulting Centres at the regional PHA in the SR. Activities are focused mainly on children and young people and are performed in the form of advisory, lectures, meetings, film projections and peer activities.

According to a study of the International Organization for Migration, migrants who belong to the main population group vulnerable to social exclusion, asylum seekers in Slovakia in certain asylum centres have problems with the provision of specialized health care, mainly as regards the issue of drug abuse and mental disorders.

11.2.2.3  SUBSTITUTION TREATMENT OF OPIOID DRUG USERS IN THE CONDITIONS OF INSTITUTIONAL - RESIDENTIAL TREATMENT

In Slovakia, substitution treatment for patients with dependence on opioids is carried out either in the form of methadone substitution therapy or by administering buprenorphine with naloxone. Roughly 500 – 600 patients currently receive substitution treatment in Slovakia.

Since induction and the whole treatment in principle is performed in ambulatory conditions, stays for such patients in the environment of institutional treatment are not frequent. They are, however, more frequent in CTDD where substitution programmes and also residential departments exist. The indications of substituted patients for institutional form of treatment are several, for instance, it is the treatment of another dependence, which is not manageable in ambulatory form, first of all on methamphetamines, sometimes on alcohol, sedatives, etc., along with the substitution of opiates. Another reason is the need to treat the stabilization of toxic psychosis or affective disorder.

A gap is in the absence of possible provision of substitution treatment in resocialization facilities and in institutions for the service of a term of imprisonment (in prisons) where for organizational and technical reasons they do not accept substitution therapy during the stay for clients in any of such facilities. A methodological guideline of the MH SR, however, does not exclude its provision in prisons and in therapeutic communities.

11.2.2.4  TYPICAL LEVELS AND DEVELOPMENT OF COOPERATION in terms of the organizational standards for health care amend and highlight the basic cooperation axis of residential facilities with ambulatory services of a general psychiatrist or addictologist and with a general practitioner, before and after discharge from residential treatment.

(Level 1) The client receives information on voluntary institutional treatment of drug addictions usually in the psychiatrist’s office, which is the first contact place, or in the general practitioner’s office. He/she can become aware of the treatment also from family members, friends or relatives, independently from the Internet or leaflets or booklets with a detailed description of services provided, which are issued and distributed by the relevant specialized facilities. He/she can select a specific specialized facility on the national level, there are regional limits.

Over the course of institutional treatment the client becomes aware of possible after-treatment in a resocialization facility, and in case of interest through a psychologist who leads the resocialization group, he/she will select a specific facility within the whole territory of the SR, according to information provided.
(Level 2) Specialized facilities for treatment cooperate with all psychiatric subspecializations such as gerontopsychiatry, pedopsychiatry or sexuology. One of the basic and necessarily cooperating branches in diagnostics and treatment of drug addicts is clinical psychology and subsequent after-treatment (sociotherapeutic clubs, resocialization facilities). Meetings on the local, regional, national and international level are organized on a regular basis for the purpose of cooperation, exchange of experience or solving topical problems of clients in the form of case seminars and workshops. Cooperation with other medical branches such as internal medicine, pediatrics, urgent medicine, surgery, neurology, and also gynecology, dermatovenerology or infectology is necessary, as well as consulting cooperation with the departments of laboratories and clinical biochemistry, mainly in dealing with serious somatic damage and complications. It is also performed from the local up to the (inter)national level.

(Level 3-4) If it is necessary to deal with psychical or somatic complications, there is close cooperation among particular branches, including the provision of patient’s medical documentation.

A permanent task of the medicine of drug addictions in reducing the social consequences of drugs is the participation of experts from the branch (who work in specialized facilities) in the commissions of state administration for antidrug policy, specialized advisory activity for the bodies of executive powers, and participation in legislative boards and commissions of legislative power. Workers of the field in the interest of and in favour of patients collaborate actively with all paramedical organizations and institutions of the company, including mass media, for compliance with legislative norms related to civil laws and ethics in carrying out the profession.

11.3 MANAGEMENT OF RESIDENTIAL TREATMENT FROM QUALITATIVE ASPECT

11.3.1 AVAILABILITY OF GUIDELINES AND STANDARDS FOR RESIDENTIAL TREATMENT SERVICES

In Slovakia, residential treatment for people who have problems with drugs is governed by statutory rules, decrees regulating public bodies in this area, mainly of the Ministry of Health of the SR and the Ministry of Labour, Social Affairs and Family of the SR, as well as by methodological instructions, specialized directives issued by the WHO, for instance for medically assisted treatments, as well as by the Ministry of Health and the main specialist for drug addiction medicine at the Ministry of Health of the SR. An integral part of the management of residential treatment is also control mechanisms and drawing conclusions.

The quality control system of health care provided in the residential form of treatment is similar to other forms of curative care in the public health (see also Chap. 7). The supervision of correct medical procedures, performance of standards for staff and material provision falls within the competence of the Ministry of Health of the SR, and in some cases of higher territorial units, of the Healthcare Surveillance Authority. Inspection is conducted also by health insurance companies as the contractors of institutional facilities. Also for institutional facilities the quality guarantee is continuous performance of ISO 9001:2000 quality standards certification.

Diagnostic and therapeutic processes are managed according to basic healthcare laws, in particular by Act № 576/2004 Coll. on healthcare providers and by others. In Slovakia, the diagnostics of mental disorders resulting from the use of psychoactive substances is
performed according to Annex № 1, which is the 10th Revision of International Classification of Mental Disorders of the World Health Organization (MKCH-10/SZO).

The system of drug addiction treatments is based on science-based approaches. It is concentrated in the field drug addiction medicine, which is a superstructure field of psychiatry and methodologically is managed by the main specialist for drug addiction medicine at the Ministry of Health of the SR.

The Ministry of Health of the SR, pursuant to Article 74 par. 1 c) of Act of the National Council of the SR № 277/1994 Coll. on Healthcare, as amended, issued a Specialized Guideline regarding Standards for Diagnostics and Treatment in the field of drug addictions, with effect from 1 June 2003. The subject of the Specialized Guideline is a proposal of diagnostic standards, treatment and preventive activities for patients dependent on psychoactive substances from the aspect of organizational and competence procedures (See: Article IV - Treatment, Patient Resocialization).

Just like it has been stated above, quality is ensured by external audit for certification according to ISO 9001:2000. Moreover, healthcare facilities have an approved internal inspection system, which relates to inspection procedures for quality assurance, availability, specialized medical care, as well as the organization management. Here belong, for instance, the recording and method of handling complaints, cost efficiency, etc. The implementation of an internal inspection system is under the supervision of the promoter of organization; for most CTDD it is the Ministry of Health of the SR. Slovakia has set standards for minimum staffing in residential departments within healthcare facilities, reflecting the standard in the provision of institutional care in the medical sector. Specification of the structure and required number of jobs is left to the competences of the director of the relevant healthcare facility. The staffing of CTDD (set for 20 beds) is developed by the physician with specialization in psychiatry or by a physician with specialization in drug addiction medicine, quantity 1, a nurse or a nurse with specialization in nursing care in psychiatry or a nurse with a certificate for the care of drug addicts, quantity 2, other healthcare specialists with university education with specialization in clinical psychology, quantity 1, another healthcare specialist with university education in the field therapeutic teacher, quantity 1.

In the past, on the basis of results from an inspection of the MH SR, due to the non-performance of standards for minimum staffing of residential facilities, CTDD in Humenné and Nové Zámky were closed.

The professional provision of resocialization facilities must have ambulatory form of psychiatric care secured under contract. It should have psychologists - certified therapists, social workers, therapeutic teachers, nurses and labour therapists. In 2011, in accredited RS, 12 psychiatrists worked (8 RS does not have them), 27 psychologists in 18 RS, they had maximum social workers - 58, 19 teachers and 17 other medical staff.

The MH SR in collaboration with HIC, specialized companies and the Healthcare Surveillance Authority (HSA) prepares indicators for the assessment of health care availability, efficiency of the use of sources, efficiency and adequacy of health care and its results. All institutional facilities in the sphere of authority of the MH SR, where most of CTDD belong, are evaluated, for instance, also according to the bed capacity occupancy indicator. Also Health Insurance Companies attempt to evaluate them, and they apply several criteria such as patient satisfaction, length of admission, etc. Their evaluative criteria and also the results, however, are not single and are often inconsistent. Two out of three facilities operating in Slovakia are private joint-stock
companies doing business for profit, and they stress economic criteria in the evaluation, and for residential treatments they tend to shorten the stay.

An internal efficiency assessment of treatment is in place almost in every specialized facility, however, in particular in CTDD Bratislava along with IDZ and OLÚP n. o. Predná Hora, through repeated collection of data (e.g. after a year, two, three years, etc.). The assessment relates not only to the stay of patient in institutional care, but to the entire system of services provided, whereas abstinence is an important but not inevitable and the only indicator.

Thanks to balanced management, several CTDD did not need financial resources for payments to creditors from the public sector. According to a budgetary guideline of the Ministry of Finance of the SR, on the basis of application of the Government Office of the SR, CTDD in Bratislava had approved financial resources, which were designated for the implementation of research services in the field of drug addictions for the needs of the monitoring of drug situation in the Slovak Republic according to the requirements of the European Union.

The Ministry of Labour, Social Affairs and Family of the SR manages and controls non-medical institutional facilities for clients having problems with drugs, which in the Slovak conditions include resocialization facilities in the form of therapeutic communities. The basic specialized norms are contained for them in Act № 305/2004 on Social Care and Guardianship of Children.

11.4 DISCUSSION AND CONCLUSION

11.4.1 ATTITUDES, OPINIONS

The availability and access to institutional, medical and resocialization care is relatively good. Treatment in healthcare facilities is free, and except court-ordered institutional treatments also waiting lists are short and often do not exist. In most facilities, the institutional form of treatment during the patient’s stay provides several services within the organization, or ensures services externally by integration with other providers. Institutional treatment is not an alternative of ambulatory treatment, but usually forms its part. In most cases it is integrated in it, and the patient comes for institutional treatment from a doctor’s office and usually returns to ambulatory treatment. Despite physician’s – psychiatrist’s recommendation (“matching”), institutional treatment is an alternative on the part of patient who can refuse it and choose ambulatory form of treatment. It is true, for instance, for detoxification. In such a modern participative process of treatment, institutional treatment is not in opposition to ambulatory treatment. In our conditions, for instance, the option of institutional treatments in indicated cases is used along with substitution treatment, which is predominantly ambulatory for patients with opioid dependence. Another example of the integration of both forms of treatment for one patient is short-term institutional stays, the so-called refreshing stays of long abstainers in ambulatory treatment. Both forms supplement one another, and therefore have a synergic effect in the therapeutic process.

In social discussions we can sometimes find an opinion that the institutional treatment of addictions is expensive in comparison with ambulatory treatment, and therefore should be reduced to the minimum, or it should be paid by patients from their own resources. Our assessment studies of treatment efficiency indicate that institutional form of treatment has an unsubstitutable position in the therapeutic process for a major part of patients. Imposition of a fee on it or partial imposition of a
fee would generally make the availability of addiction treatment harder in the population. Attempts to reduce institutional treatment to one episode paid to the patient from solidary national health service contravene the findings of medicine based on evidence, which refer to that heavy addiction is a chronic recurrent ailment and repeated decompensation of the condition after a time limited stabilization period is just like for other chronic ailments a reason for intensive treatment, and not for its rejection. The medical model of addiction as a chronic ailment is often a strong professional counterargument.

Among old, authoritative approaches applied in psychiatric practice in the past, but also among social stereotypes in a part of medical staff, a moralistic, condemning attitude to patients dependent on drugs and alcohol appears even today. Typically the staff of specialized institutional addictological facilities least frequently stigmatizes its patients. A moral stigma is, however, for many people for social reasons an internal barrier for the start of residential treatment of drug addiction. This issue will need yet long systematic education focused mainly outwards to the general population, also in Slovakia.

The current economic and financial crisis is a threat for a relatively well set system of residential treatment of patients with addictions in Slovakia. In the past due to the lack of finances for qualified medical staff that migrated to other places, certain residential addictological centres stopped their activity. Also for this reason consistent evaluation of treatment is necessary, including the highlighting of not only its medical effects, but also its related economic benefits for society. Efficient treatment needs also good social marketing.
12 DRUG POLICIES OF LARGE EUROPEAN CITIES - BRATISLAVA CAPITAL OF SLOVAKIA

12.1 Overview

In Slovakia the drug policy was predominantly visible at the national level. For short time period within the framework of National Antidrug strategy 2004-2008 the posts of eight regional drug coordinators were established. In addition the principles of national strategy were projected into eight regional Action plans (2005).

The key responsibility of regional coordinators who were acting within the regional state administrative offices (controlled by Ministry of Interior of SR) was to coordinate regional drug policies mainly in prevention, treatment, resocialisation and reduction of drug demand. The urban areas (in Slovakia seven relatively small regional capitals – under 300,000 residents – and only one exception Bratislava city as the capital) were included into complex regional Actions plans. In 2007 this useful idea to shift drug policy from the central level to regional was limited, when the regional state administrative bodies were cancelled together with the functions of regional drug coordinators.

Partially the agenda of drugs was included into mission of eight crime prevention regional coordinators. They are localised at the State Administrative Offices in eight regional “capitals”. One of their key activities is to administrate the process of allocation of finances for the crime prevention projects in their respective regions.

12.2 Bratislava – capital of Slovakia

Bratislava, capital of Slovakia is not the exception within the large cities affected by both drug trafficking and drug use problems (see the summaries of National reports).

Due its geographical location in the extreme southwest of Slovakia, the edge of the city actually forms Slovakia’s borders with Hungary, to the south, and Austria, to the west, making it the only capital city to border two neighbouring countries. In addition, the Czech Republic is only 62 kilometres away. Moreover Bratislava lies on the banks of the Danube, the second longest river in Europe with frequented shipping.

Population of capital city Bratislava by December 2011 was 413,192 residents, with majority of women. According statistical data of Statistical office of Slovak republic age structure of Bratislava residents is as follows in Figure 12.2.1:

---

129 See Chapter 3 – Financing of social prevention projects
130 www.bratislava.sk
12.2.1 Functioning of capital Bratislava

Bratislava is governed by elected local self-government. The Mayor is the highest representative of the city executive; the city’s highest legislative authority is the 80-member City Council. The Mayor of Bratislava is directly elected by residents; the candidate receiving the most votes is elected to serve a four-year term. Like the Mayor, the City Council's 80 members are also elected by residents to serve four-year terms. The City Council usually convenes once a month. Its main duty is to prepare and approve municipal legislation, so-called generally binding regulations or ordinances. The City Council is also responsible for approving the city budget, the closing account of the city, and the land use plan, as well as for managing the city’s assets. This local government structure has been in place since 1990. Bratislava is divided into 17 boroughs/wards. The largest of them is Petržalka, which is home to almost 120,000 residents. The boroughs are independent legal entities that manage their own assets and budget. Each borough has its own mayor, local borough office, and local council. The number of councillors depends on the size of the borough and its population. The Mayor has City Hall/Mayor Office at his or her disposal to provide expert, administrative and service-related activities. The staff of City Hall consists of professionals with no political bias. City Hall is managed by a CEO.

Until now there is neither written drug strategy nor action plan. Some basic documents e.g. The Programme of Bratislava Social and Economy Development in 2010-2020 had mentioned drug problems within developments of the healthcare services and public safety.

---

133 See Chapter 3 – examples of specifical (antidrug) activities in Bratislava city wards Ružinov, Podunajské Biskupice, Vrakuna, and Rača selective prevention in community
134 http://www.bratislava.sk/vismo/zobraz_dok.asp?id_org=700000&id_ktg=11006261

Figure 12.2.1: Age structure of population of Bratislava, the capital. Source: Statistical Office of Slovak Republic, 2012
12.2.2 Case study of municipal resocialisation centre RETEST

A more in-depth investigation (Bartoň 2012) in this chapter is put on the existing resocialisation centre RETEST (post treatment care and social reintegration facility) established and functioning within the capital Bratislava.

The re-socialization centre RETEST (hereinafter referred to as the “RC RETEST”) was originally established in 1997 as a facility of the Bratislava borough Staré Mesto (Old town) providing social care and services to inhabitants dependent on psychoactive substances.

Its establishment was a response to the situation in the area of drug addictions in the capital in the nineties. Bratislava as the capital with an excellent geographical location and openness to a new social order after the Velvet Revolution in 1989 naturally had a high concentration of problem drug users. Moreover, there were an insufficient number of traditional healthcare facilities and treatment programs for the specific group of people dependent on illicit addictive substances. The date of establishment of the re-socialization facility RETEST makes it ranks among one of the first facilities of its kind. The re-socialization centre was not defined by law until the adoption of the Act № 195/1998 Coll. on social assistance.

In 2007, based on organizational changes, the facility was transformed into an organization fully funded by the Slovak capital Bratislava, and its activities include activation of internal abilities of major individuals to overcome psychical, physical and social consequences of drug addictions or other dependences and to integrate themselves in life in natural environment as defined in the Act № 305/2005 Coll. on social and legal protection and on social care and on amendments to certain laws.

Currently, there are 22 re-socialization facilities in Slovakia, and only two of them are established by the municipality and the higher territorial unit, respectively. From this point of view, RETEST is a sort of unique facility and represents professional care which is provided by the capital to the people dependent on psychoactive substances.

Despite the fact that the origination and development of therapeutic communities for drug addicts (in our context, the re-socialization centres) had many similar features with countries having long-time experience in taking care of the addicted persons, RETEST as an “urban community” represented at the time of its establishment a facility which, to a certain extent, challenged the traditional idea of the need to isolate completely the clients from their natural environment.

PhDr. Peter Šulák, director of the facility, developed the program on the basis of the fact that the facility was primarily designed for the clients from Bratislava and that the capital draws in many drug users from regions outside Bratislava who remain living in the capital for a variety of reasons also after the completion of the program. Therefore, the philosophy of the facility is mainly built on training of skills which both teach and allow the clients to adopt a non-drug-related lifestyle in direct confrontation with the environment in which drugs were actively used by them.

RETEST is a mixed community with the current capacity of 13 beds and one of the conditions for admission is the age of more than 18 years. The philosophy of the

---

135 Bartoň (2012): Inhabitants of Ladova Street (report for NMCD)
RETEST facility is represented by employment of the clients who, assisted by social workers, seek full-time employment after having spent three or four months in the facility and after having completed the first phase (the so-called “Quarantine”). Despite the ideas which are sometimes distorted, the clients list this opportunity as one of the important reasons for which they chose our facility. The client has a chance to get involved in the work process and be confronted with the “external world” with active support of the therapeutic community. One of the advantages consists in the fact that, upon leaving the facility, the client is relatively stabilized in terms of the job opportunities, and he/she can concentrate on other aspects of re-integration. Early combination of the re-socialization program and employment outside the facility can be one of the reasons for which RETEST is sometimes associated with the midway house (Okruhlica, 1998). Despite hard economic times and specific needs of the clients, they have succeeded so far in playing a full role in the labour market. This is also possible due to contacts and cooperation with employers who have a positive past experience with the clients of RETEST and are thus more approachable to their employment. The employers category also includes organization (in particular social service facilities) founded, similarly to RETEST, by the capital Bratislava. Mutual cooperation makes it possible to extend the job opportunities of our clients as well as to render mutual assistance, where appropriate. As part of cooperation with the employers, visits are made to them by a RETEST staffer with the aim of familiarizing the employers and giving them a better understanding of the clients’ needs at the time of re-socialization, and creating a network of workplaces at which such clients could find their position.

In the past, the re-socialization program in RETEST was organized in 24 months. In 2011, the program was modified in terms of its duration to 18 months. The stay thus limited is structured in six phases. At their admission, the clients are recommended to complete the entire stay, while the recommended minimum length of stay is one year.

One of the reasons for shortening the stay was the establishment of cooperation with the midway house which is operated by the unincorporated association “Brána do života” (Gate to Life). Previous informal cooperation was given an official form which gives our clients, if interested, the option of sheltered housing after the completion of the re-socialization program and it also defines in more detail the possibilities of further collaboration between the facilities. From the clients’ point view; we consider this opportunity to be very beneficial also with regard to the fact that these are the forms of subsequent, post re-socialization care which can increase significantly the efficiency of re-socialization care in terms of long-time abstinence.

There is also close cooperation with Centrum pre liečbu drogových závislostí (Centre for Treatment of Drug Dependencies) in Bratislava. As part of the program, the clients must undergo regular monitoring of urine and they also use certain out-patient forms of care offered by the centre which serves as a healthcare facility.

The alcohol dependent clients are recommended to join abstainers clubs, and they can start attending some of the activities as early as during the re-socialization process. In this context, we closely collaborate with Bratislava JAS-club.

Clients infected with hepatitis C are taken care of in cooperation with Národné referenčné centrum pre liečbu chronických hepatitíd (National Reference Center for Treatment of Chronic Hepatitis).

RETEST has also participated in practical training of university students in a variety of assistance professions (social work, therapeutic pedagogy, andragogy,
psychology), and it mainly concentrates on students of the Department of Social Work, Faculty of Education, Comenius University. The facility staff has also contributed to preventive and education programs in selected schools.

The RC RETEST provides for a broad range of leisure time activities in the urban environment which are offered to the clients as a wider part of healthy lifestyle. There is an opportunity to collaborate with the Capuchin community and to attend a great number of cultural or sport events designed for the general public. Organizations operated by the capital allow us to attend such events on favourable terms.

RETEST is a specific facility of its kind in terms of its founder and location. It is embedded in the environment where services designed for the target group of people dependent on addictive substances are widely used. Mutual cooperation of the providers of various types of services in the broader context of the urban environment thus extends the possibilities of assistance for clients in the process of re-socialization.

Mutual cooperation usually takes place at an informal level, or the possibilities are mutually “discovered” in the process of searching for help for RETEST clients. Mutual awareness and networking of services at the level of both the city and the wider region could help provide more efficient services to people dependent on addictive substances.

12.2.3 Four areas of drug policies

12.2.3.1 Community/Municipal Police

(hereinafter MP) is to provide public order and co-operates – with state police forces - in protection of residents and other persons as to avoid jeopardising of their lives or health, private or public property etc. MP is established and financed by municipalities and villages. MP in Bratislava has been established in 1991.

Among other activities MP performs some forms of prevention at schools (Report 2010, chapter 3 Prevention). Since 2010 MP have to carry out the special mission according the Act which banned the use alcoholic and other addictive substances by minors under the age of 15 and adolescents under the age of 18.

Bratislava municipality issued recently a generally binding regulation which limits, from 1 November 2012, the sale of alcoholic beverages, particularly in terms of space and time.

The renewing of the sobriety–up centre in Bratislava (the only one was demolished by “clients” in 2004) seems to be a long term problem issue for three possible stakeholders (municipality, police and health sector).

12.2.3.2 Interventions in recreational nightlife settings

No available information related to special interventions in Bratislava

136 http://mestskapolicia.bratislava.sk/index.asp
137 Act No. 219/1996 Coll. on Protection from the Abuse of Alcoholic Beverages and on the Establishment and Operation the Sobering-up Stations; it amend specification of alcohol beverages, examination and alcohol or other addictive substances detection as well as other conditions of operation of sobering-up stations.
138 Generally Binding Regulation No. 9/2012
Public order is provided by the Municipal Police Forces in cooperation with (State) Police Force. There are periodical control in the recreational facilities aimed on presence of children under 15 years, consuming of alcohol by minors under 18 years and detection of illicit drugs.

12.2.3.3 Low threshold services for problem drug users

1997 - Establishment of CA Odyseus (civic association) its history officially started to be written a day before the Christmas Eve in 1997. In the organization there worked 7 workers – mostly the university students. In 10 years later (2007), 40 workers work in the organization. The first project was Protect Yourself. (1998) aimed on IDUs. In 2007, CA Odyseus runs four independent programs: PROTECT YOURSELF, SEX/DRUGS, RED UMBRELLA, SOCIAL ASSISTANCE, harm reduction magazine INTO. Since 1998 CA Odyseus is the member of the Central and Eastern European and Central Asia Harm Reduction Network, since 2000 the member of AC Company, which in 2005 transformed into the Correlation Network – European Network for Inclusion and Health, since 2002 member of the TAMPEP - European Network for HIV/STI Prevention and Health Promotion among Migrant Sex Workers. Since 2006 we are a member of the SWAN network – SexWorkers’ Rights and Advocacy Network.

1999 - Establishment of CA PRIMA civic association has provided streetwork, NSP and other harm reduction activities, social assistance. Since 2005 CA PRIMA has managed the low threshold contact centre K

12.2.3.4 The response to the development of (head/smart) shops selling psychoactive substances and/or related paraphernalia

The most important legislative initiative started already in 2010 and completed within few months was the update of the Act № 139/1998. Coll. – completion of the list of regulated substances. This was a reaction to the occurrence of the so-called “Crazy shops” – originally internet shops offering new synthesized psychoactive analogues, later also brick-and-mortar (physical) shops, where these products were sold masked as “gift” or “commemorative” objects, “spa salts” and so on, with warning about the ban on their consumption. These shops appeared in several towns in the north of Slovakia (Dolný Kubín, Žilina, Martin) and their network gradually expanded to the south and east. (Report 2011, part 1.1.1).

There were at least two Crazy shops in capital Bratislava – one in the “vulnerable” city ward so far as drug scene and use of drugs is concerned and the second Crazy shop was established nearly university students residences. Both shops called out public nuisance, robustly supported by the media.

12.2.3.5 Some other important milestones of bottom-up set policies in Bratislava

1992 - Establishment of the Centre for Treatment of Drug Dependences (CTDD)

---

Nowadays the CTDD in Bratislava is the biggest multimodal treatment centre for dependencies. Since 1994 CTDD has provided the exchange of needles and syringes and till 2011 there were 3 178 registered patients (Annual report of CTDD for 2011).

It is worth to mention although there were thousands of IDUs in the last decade of 20 century this first NSP conducd markedly to the lowest occurrence of HIV/AIDS among IDUs - 0.1% what is the lowest prevalence in Europe and internationally. (Ibid p.3).

Since 1998 CTDD has started with substitution methadone treatment - in 2011 531 patients were registered.

1996 – Project Antidrug forum (Protidrogové fórum) project in form of public hearing initiated by citizens, who were interested in reduction of drug abuse. The aim of almost periodical meetings (once in a year) is to inform public on antidrug activities (treatment, prevention, resocialisation, harm reduction) and establish some form of relations among public, professionals, state, regional self government (Bratislava region) and non-governmental sectors.

The event realised in 2011 dealt with the topic Drugs and paragraphs, and the agenda of the Antidrug-forum last event in June 2012, was oriented on principles of works with vulnerable and excluded groups (HIV/AIDS patients in some African countries; slovak children in marginalised community of Petřžalka - Kopčany; activities of CA Ulita (the conch) covered the children and youths in this city ward).

12.3 Current issues

It is worth to mention that in the absence of regional and /or municipality coordination dozen of activities were and are carried in Bratislava. At nineties Bratislava was the city with high levels of problem drug use and populations of heroin injecting drug users what in fact led to the range of treatment options and harm reductions interventions, such as NSP and opioid substitution treatment (both in the CTDD in Bratislava in 1994 and 1998 respectively). Moreover the situation in the ground has led to establishment of the central coordination Governmental body – Board of Ministers in 1995, and the first National Antidrug Strategy in 1999.

At the beginning of 2012 National monitoring centre for drugs had an intent to bring these key activity to the surface of drug policy and to contribute to renewing the position of regional or even municipality Bratislava drug coordinator. The planned conference in June 2012 which topic was highly appreciated by the Mayor of Bratislava would have bring together different stakeholders - providers of helping services, medical professionals, psychological and counselling services, decision makers on municipality level and local politics. Because of internal structural changes in the Governmental Office (see Chapter 1) the conference was recalled. Very fresh draft of the document “Community Social Services Development” (November 2012) besides other issues is to bring detailed analysis of drug situation in the capital Bratislava, the survey of existing helping services (in the area of drug

141 In 2011 CTDD managed the exchange of 15 064 syringes
142 So called heroin epidemics since early nineties
143 http://www.kzp.sk/kzp-subory/105-projekt-protidrogove-forum
145 http://www.bratislava.sk/vismo/zobraz_dok.asp?id_org=700000&id_ktg=11004490&archiv=0&p1=11049947
demand reduction) and the needs and challenges for development of such services
in future. The draft would be the subject of approval of the City Council and the
relevant part - related to drugs could serve as the Bratislava drug strategy.

Figure 12.3.1: Graphical illustration of the biggest share of Bratislava region and its two
“key” districts (Bratislava II and Bratislava V.) in numbers of treated drug patients since 2000.
Source of data: NHIC, 2012 Drug users’ treatment in 2011

Note: Bratislava region\textsuperscript{146} is one of the administrative regions of Slovakia. Its capital is Bratislava. It is the
smallest of the eight regions of Slovakia.

\begin{table}
\centering
\begin{tabular}{|c|c|c|c|c|c|c|c|c|}
\hline
\hline
Bratislava region & 1355 & 825 & 797 & 685 & 688 & 594 & 683 & 684 \\
Bratislava II. & 365 & 200 & 204 & 165 & 213 & 192 & 171 & 175 \\
Bratislava V. & 525 & 277 & 234 & 215 & 189 & 159 & 171 & 190 \\
\hline
\end{tabular}
\end{table}

\textsuperscript{146} Area: 2 052,6 km\textsuperscript{2}
Total number of inhabitants - 31.12.2007 610 850
Number of municipalities: 73
Number of towns: 7
Urban population: 504 741
Urban level: cca 82,63%
Number of Districts: 8 (Bratislava I - Bratislava V, Malacky, Pezinok, Senec)
Metropolis: Bratislava - www.bratislava.sk
Malacky - www.malacky.sk
Pezinok - www.pezinok.sk
Senec - www.senec.sk

162
PART C ANNEXES:
13 BIBLIOGRAPHY

13.1 Alphabetic list of all bibliographic references used


15. Coll. Nº 581/2004 (§ 7) on Health Insurance Companies

16. Concept of the field “drug addictions” of the MH SR


30. EMCDDA, ST 34 TDI, 2012


41. Hamade, J., Janechová, H. Univerzálna a selektívna prevencia – opatrenia na podporu a ochranu zdravia – Úrad verejného zdravotníctva Slovenskej republiky
73. Ministry of Justice (2011): Convictions for drug-related offences by type of drug, Report for the NMCD by L. Bodor
82. National strategy against drugs for the years 2009-2012 www.infodrogy.sk
84. NHIC - Health Yearbook of the Slovak Republic 2010
86. NHIC - Report on drug users treated from dependence ZS (MH SR) 4-12
89. NHIC (2011): Data for ST34 (TDI), National Health Information Centre, unpublished
90. NMCD - Annual Report on the Condition of Drugs in Slovakia 2003-2010
91. NMCD - Drug Policy Implementation by Resorts
93. NMCD - National Programme for the Fight against Drugs 2004–2008
94. NMCD - Origination and History of NMCD
100. NMCD (2009) Pilot regional GPS survey “Prevalence of alcohol, tobacco and illicit drug consumption in Bratislava region, database of collected data and statistical processing done by research agency MVK Ltd.
107. NMCD (2011) GPS survey “Prevalence of alcohol, tobacco and illicit drug consumption in Slovakia in 2010” -


116. Okruhlica, L., Alexanderčíková, Z., Slezáková, S., Olejárová, V (2010): Preco je potrebné zmeniť zákon o súdom nariadených lieceniach (Why it is necessary to change the law on legally mandated treatment/ court-ordered treatment), Alcoholism and Drug Addictions 2011, 46(1) p. 35-40


139. Specialized guideline regarding standards for diagnostics and treatment in the field of drug addictions

140. Standards for minimum occupancy of residential departments of healthcare facilities with physicians (2002)


146. Šteiliar I. (2009b) ST 7 and ST 8 for REITOX


153. Tejová M., Kara E. 2012 Nové psychoaktívne látky v rekreacnom a virtuálnom prostredí


13.2 Alphabetic list of relevant databases available on internet

http://statistics.sk
http://vyskumymladeze.sk
13.3 Alphabetic list of relevant Internet addresses

- http://jaspi.justice.gov.sk
- http://www.cpldz.sk
- http://www.drogy.org
- http://www.drogyinak
- http://www.economy.gov.sk
- http://www.emcdda.europa.eu
- http://www.employment.gov.sk
- http://www.euphoria-shop.sk
- http://www.genpro.gov.sk
- http://www.health.gov.sk
- http://www.hiv-aids.tym.sk
- http://www.infodrogy.sk
- http://www.justice.gov.sk
- http://www.minedu.sk
- http://www.minv.gov.sk
- http://www.nczisk.sk
- http://www.nrsr.sk
- http://www.prima.sk
- http://www.rastamama.sk
- http://www.ruvzba.sk
- http://www.statistics.sk
- http://www.sukl.sk
- http://www.uips.sk
- http://www.upsvar.sk
- http://www.vlada.gov.sk
- http://www.vzbb.sk
- http://www.zvjs.sk
- http://www.cpldz.sk
- http://www.cpldz-bb.sk
- http://www.cpldz-kosice.sk
- http://www.cpldz-zilina.sk
- http://www.infodrogy.sk
- http://www.liecebnarieka.sk
- http://www.olup-prednahora.sk

13.4 List of abbreviations:

- 2-CB: 4-bromo-2,5-dimethoxyphenethylamine
- ADF: Anti-Drug Fund
- ADHD: Attention Deficiency Hyperactivity Disorder
- ADS: Alcohol Dependence Scale
- ASCD: Antidrug Strategy Coordination Department
- AIDS: Acquired Immune Deficiency Syndrome
- BM, BM DADC: Board of Ministers for Drug Addictions and Drug Control
- BZP: 1-benzylpiperazine
- CA: Civil associations
- CAGE: Cut-Annoyed-Guilty-Eye Opener, screening test on alcohol abuse
- CAST: Cannabis Abuse Screening Test
- CATI: Computer Assisted Telephone Interview (Standardised interview by telephone)
- CCO: Customs of Criminal Office
- CCP: Code of Criminal Procedure
- CCPS: Centres for Counseling and Psychological Services
- CEPP: Centre for Educational and Psychological Prevention
- CLT: Centre of Leisure Time (CVČ in Slovak)
- Coll.: The Collection of Laws
CPCG  Corps of Prison and Court Guards
CSI  Custodial sentence institutions
CSP  Community Social Programme
CTDD  Centre for the Treatment of Drug Dependencies
CWS  Community Social Work Programme
CZ  Czech Republic
DRID  Drug Related Infection Diseases
EC  The European Commission
EMCDDA  European Monitoring Centre for Drug and Drug Addictions
EMQ  European model questionnaire
EPIS  Epidemiological information system
EPPC  Educational and Psychological Prevention Centres
ESPAD  European School Survey Project on Alcohol and Other Drugs
Et seq.  Et sequent
EU  European Union
EUROPAD  European Opiate Addiction Treatment Association
FPP  Fluorophenylpiperazine
FreD  German model of timely intervention for first-time drug delinquent
GDP  Gross Domestic Product
GPO  General Prosecutor Office
GPS  General Population Survey
GS, GS  General Secretariat of the Board of Ministers for Drug Addiction and Drug Control
BMDADC
      HAV  hepatitis type A
      HBsAg  antigen hepatitis type B
      HBSC  Health Behaviour of School Aged Children
      HBV  hepatitis type B
      HCV  hepatitis type C
      HIV  Human Immunodeficiency Virus
HOLSAF  Head Office of Labour, Social Affairs and the Family
IDU  Injection drug user
IFS PF  Institute of the Forensic Science of Police Force
IIPE  Institute of Information and Prognoses of Education
IIPE  Institute of Information and Prognoses in Education
ITR  In-treatment rate
LMP  Last month prevalence
LSD  Lysergic acid diethylamide
LTP  Lifetime Prevalence
LYP  Last Year Prevalence
mCPP  1-(4-chlorophenyl)piperazine
MD  Ministry of Defence
MDMA  metylenedioxymetamphetamine
ME  Ministry of Education
MF  The Ministry of Finance
MH  Ministry of Health (MZ SR in slovak)
MI  Ministry of Interior (MV SR in slovak)
MJ  Ministry of Justice (MS SR in slovak)
MLSAF  Ministry of Labour, Social Affairs and Family (MPSVaR SR in slovak)
MO  Morphines
MT  Ministry of Transportation
MUSTAP  Multisession Standardised Printed Programme
NA  Not available
NAPPA  National Action Plan for Alcohol Problems (NAPAP)
NCC  New Criminal Code
NCMTCHB  National Centre for the Management and Treatment of Chronic Hepatitis
NCZI  National Health Information Centre (see NHIC)
NDS BFAOC  National Drug Service Bureau Of Fight Against Organised Crime; NPJ in Slovak
NGO  Non-Governmental Organization
NHIC  National Health Information Centre
NMCD  National Monitoring Centre for Drugs, Slovak Republic National Focal Point
NPFD  National Program for the Fight against Drugs
NPJ  National Drug Service Bureau Of Fight Against Organised Crime Of the Police Force Headquarters (NDS BFAOC PFH)
NPS  New psychoactive substance
NR SR  National Council of the Slovak Republic (Parliament)
NRC  National reference centre
OCC  Old Criminal Code
OLPL  narcotic substance, psychotropic substance
OP  Opioids
OSF  Open Society Foundation
PCP  Police Corps Presidium
PDU  Problem Drug Users
PORI  Public Opinion Research Institute (cancelled in 2009)
PPCC  Pedagogical and Psychological Counselling Centres (CPPPaP in Slovak)
PFP  Presidium of the Police Force
PSI  performance of the sentence of imprisonment
PSVaR Office  Local Office of Labour, Social Affairs and the Family
RC  Resocialisation centre (rehabilitation and social reintegration services in therapeutical community
REITOX  The European Information Network on Drugs and Drug Addiction
RNA  Ribonucleic acid
RPHA  Regional Public Health Authority
RR  Reasonable restrictions
SC  facility for serving of custody
SK  Slovak Republic, see SR too
SKK  Slovak koruna
SQ  Structured questionnaire
SR  The Slovak Republic, see SK too
ST  Standard table
SYPH  syphilis
TAD  Tobacco, Alcohol, Drugs – a school survey based on ESPAD methodology
TDI  Treatment demand indicator
THC  Tetrahydrocannabinol
ÚDZS  Health Care Surveillance Authority
UN  United Nations
UNODC  United Nations Office on Drugs and Crime
ÚVZ SR  Public Health Authority of the Slovak Republic (PHA SR)
VÚDPaP  Research Institute of Child Psychology and Pathopsychology (RICPaP)
ZŠ  Elementary School
ZVJS  Zbor väzenskej a justičnej stráže = Corps of Prison and Court Guard
LEGISLATIVE FRAMEWORK

1. Act № 372/1990 Coll. on Offences, which amends offences that are committed in relation to drugs.
2. Act № 219/1996 Coll. on Protection from the Abuse of Alcoholic Beverages and on the Establishment and Operation the Sobering-up Stations
3. Act № 121/2011 Coll. on the cancellation of the Anti-Drug Fund
   a. Government resolution № 1/2011 the draft of bill on the cancellation of the Anti-Drug Fund
4. Act № 139/1998 Coll. on Narcotics and Psychotropic Substances and Preparations determines conditions for growing, processing, production, control, distribution, issue, usage for scientific, development, educational and expertise activities, for import, export, transit and transport of narcotics, psychotropic substances and preparations and for handling wastes with content of narcotics and psychotropic substances.
5. Act № 575/2001 Coll. On the government activity organisation and on organisation of the central state administration
10. Act 377/2004 Coll. on the Protection of Non-Smokers and on changes and amendments to certain Acts as amended.
18. Act № 124/2006 Coll. on Safety and Health Protection at work.
20. Act № 245/2008 Coll. on Upbringing and Education (the School Act) and on changes and amendments to some Acts
24. Act № 313/2011 Coll., which changes and amends the Act № 8/2009 Coll. on Road Traffic and on change and supplement of certain laws as amended and which changes and supplements certain laws
27. Resolution № 534 of May 22, 2002 – approved proposal of institutional and financial requirements fulfilment of the SR participation in European monitoring centre for drugs and drug dependence, constituted National monitoring centre for drugs
28. Resolution № 339 of May 4, 2005 – on extension of Board of ministers mandate for drug dependences and drug control also for legal drugs – alcohol and tobacco
15 LIST OF TABLES AND FIGURES

15.1 List of tables

Table 2.1.1: LTP, LYP and LMP prevalence of particular psychoactive substances in the sample 15-64 years aged. Source: ST 01 2010 and NMCD 2010 population survey .................................................. 27
Table 2.1.2: Prevalence LTP in 2010 and 2006 in the sample of 15-64 aged. Source of data ST 01 2010, ST 01 2006, NMCD 2010 ................................................................. 28
Table 2.1.3: Prevalence LTP in 2010 and 2006 in the sample of 15-34 aged. Source of data ST 01 2010, ST 01 2006, NMCD 2010 ................................................................. 28
Table 2.2.1: Lifetime use of cannabis in the ESPAD (2011) and HBSC (2009/10) surveys. LTP among boys and girls \( r \), Spearman’s rank correlation coefficient (\( r_{\text{rank}} \)). Source: ESPAD 2011 Report p.59 ........................................................................................................... 34
Table 2.3.1: Overview result from IIPE surveys among school pupils on drugs use prevalence. 37
Table 2.3.2: He/she knows a person who uses “legal highs”. Source of data: NMCD 2010, Marchevský P. 2011 ............................................................................................................. 39
Table 2.3.3: Personal experience (LTP). Source of data NMCD 2010, Marchevský P. 2011 .... 39
Table 2.3.4: Data obtained on the awareness and experience with products from Crazy and Euphoria shops ............................................................................................................. 40
Table 3.3.1: The number of activities and participants in drug prevention activities in terms of EPCPCs in the school year 2010/2011 ........................................................................ 49
Table 3.4.1: Reasons and initiators leading clients to come to EPCPCs in the school year 2010/2011 .................................................................................................................. 53
Table 3.4.2: Interventions of regional professional advisers specialised for drug prevention in 2011 and 2010 (Czučorzová, 2012) ................................................................. 59
Table 3.5.1: Development of indicators for all types of special educational facilities in the years 2001 to 2011 (Source: The Institute of Information and Prognoses of Education – Slovíková, 2012) ...................................................................................................................................... 62
Table 3.5.2: Development of indicators in ESs in the years 2001 to 2011 .................................. 62
Table 3.5.3: Development of indicators for DCs (incl. DCD, DCM and since 2009 as DC) in the years 2001 to 2011 Slovíková, 2012 .......................................................... 63
Table 3.5.4: Development of indicators for RCs in the years 2001 to 2011 (Slovíková, 2012) .... 64
Table 4.3.1: Structure of clients in harm reduction low threshold programmes .......................... 69
Table 8.2.1: Overview – Share of patients receiving treatment in selected social characteristics since 2003. A total of 2,313 patients were treated in healthguardianship facilities in 2011, of which 6 people were not permanent residents of Slovakia. Source: NHIC, ZŠ-44/2012 ........ 98
Table 8.2.2: Social characteristics of clients at re-socialisation centres. Source: Tománek (2011)98
Table 8.2.3: Termination of re-socialization program in 2010. Source: Czučorzová, 2011 and 2012 .......................................................................................................................... 101
Table 8.3.1: Overview of basic data about the RC client structure in 2007-2011 (Source: NMCD surveys on RC’s clients and services) ...................................................... 103
Table 8.3.2: Education of clients of re-socialisation centres (data 2011) ................................. 105
Table 8.3.3: Employment status of clients of re-socialisation centres (data 2011) ..................... 105
Table 8.3.4: Housing status of clients of re-socialisation centres (data 2011) ............................ 105
Table 8.3.5: Structure of re-socialisation centres staff in 2011 .................................................. 106
Table 9.1.1: Structure of convicted offenders by offenses in the Slovak Republic (2009-2011) 113
Table 9.1.2: Number and share of persons convicted of drug-related crimes by the type of drug (2011). Source: Standard Table 11 / 2012........................................................................................................ 114
Table 9.1.3: Number of offenders/juveniles convicted of drug possession, trafficking, and for other drug supply offences in Slovakia (2002-2011). Source: MJ SR 2011 .......................................................... 114
Table 9.3.1: Number and percentage of offenders sentenced for possession, drug trafficking and other drug law offenses in Slovakia (2011). Source: MJ, 2011 ........................................................................... 121
Table 9.4.1: Number and result of screening examinations for the presence of selected infectious diseases among prison population in Slovakia in 2011 Source: CPCG, 2012 ................................................. 125
Table 9.4.2: Drug-free zones in facilities for SoTI and open units (2010-2011). Source: L. Vrábolová, CPCG, 2012 ................................................................................................................................. 126
Table 9.5.1: Reasons for social guardianship services for individuals in 2010-2011. Source: Statistical reports of the MLSAF SR, 2011 ........................................................................................................... 127
Table 10.1.1: Availability of drugs in Slovakia perceived by population aged 15 to 20 years. Source: ESPAD (Nociar, 2011) ......................................................................................................................... 129
Table 10.2.1: Number of cases and quantity of drugs seized in Slovakia (2009 - 2011), ST 13 Source: IFS PF (A., Bolf 2012) ......................................................................................................................... 134
Table 10.2.2: Number of seizures and quantities of precursors seized in Slovakia in 2011, broken down by the seized form Source: IFS, 2012 (A,Bolf) ...................................................................................... 135
Table 10.3.1: Number of samples, weighted average and median of the content of active substance in selected types of drugs in Slovakia in 2008 – 2011, ST 14. Source: IFS PF, (A. Bolf), 2012 ......................................................................................................................... 138

15.2 List of Figures

Figure 2.1.1: Cannabis - comparison of changes in the prevalence of cannabis consumption in the entire set of aged 15-64 years in 2006 and 2010 Source of data: ST 01 2006, ST 01 2010 ......................................................................................................................... 29
Figure 2.1.2: Cannabis - comparison of changes in the prevalence of cannabis consumption in the entire sample of aged 15-34 in 2006 and 2010 Source of data: ST 01 2006, ST 01 2010 29
Figure 2.2.1: Order of psychoactive substances, which was most frequent among respondents aged 15-20 years LTP in % - Source of data: ST 02 2011, Nociar 2011 ...................................................... 31
Figure 2.2.2: Prevalence of cannabis, volatile substances and ecstasy in the 15-20 years aged sample – Nociar, 2011 ......................................................................................................................... 31
Figure 2.2.3: Comparison of data for 16 year-old Slovak students with average data for ESPAD 2011 in main variables. (Source: Summary of key data ESPAD 2011, 31 May 2012). ....................... 32
Figure 2.2.4: Developments in the prevalence of parallel use in particular cycles of ESPAD surveys among the age 16 group in “Used in last 360 days” (LMP) use of alcohol, cigarettes, marijuana (source: The 2011 ESPAD Report, The 2007 ESPAD Report) ............................................. 33
Figure 2.3.1: “Profiles of the Groups of Clients in RC and DC in particular survey years........ 36
Figure 2.3.2: Opinions on products – new psychoactive substances (NPS) in different environments and groups (Tejová, Kara 2012) ........................................................................................................ 41
Figure 3.3.1: Structure of target groups related to prevention programmes implemented in school year 2010/2011. Source: Slovíková, 2012......................................................................................................................... 47
Figure 3.3.2: Structure of demand reduction projects supported from budget grants provided within the grant scheme of the Government Office in 2011. Source: NMCD......................... 51
Figure 3.5.1: Proportion of juvenile clients compared to the total number of all clients in re-socialisation centres in Slovakia, 2011. Source: NMCD ................................................................................. 65
Figure 4.1.1: Composition of clients of low threshold harm reduction NGOs in Slovakia 2011, by the type of primary drug used. Source: NMCD survey among harm reduction agencies, 2011.

Figure 4.3.1 Number and structure of clients classified as problem drug users pursuant to the reports of low threshold programmes in Slovakia, 2004 – 2011.

Figure 4.4.1 Trend in repeated treatments demands (RTD) and first treatment demands (FTD).

Source: NCHI.

Figure 5.3.1: Treated patients according to their age group and type of primary drug. Source: NHIC.

Figure 5.3.2: Share of treated drug addiction patients according to the main groups of drugs.

Source: NHIC.

Figure 6.4.1: Trend of the occurrence of HCV among first admissions to the CTDD Bratislava.

Source: CTDD.

Figure 6.4.2: Comparison of mortality among the cohorts of patients treated for opioid addiction in Slovakia with programmes in selected EU countries (selected EMCDD data on mortality was used, EMCDDA, 2011). Source Slovakia: CTDD.

Figure 7.4.1: HCV positive drug users, reasons for not taking anti-retroviral therapy (from Slezáková, Okruhlica, 2011).

Figure 8.3.1: Development of the share of RC clients with a problem in key psychoactive substances in 2007-2011.

Figure 8.3.2: Shares of clients with a problem of the most frequently abused psychoactive substance in five cycles of NMCD surveys: Source of data: Surveys of the client structure and re-socializations services in 2007 to 2011.

Figure 8.3.3: Structure of re-socialisation centres staff in 2011, visual presentation.

Figure 9.1.1: Number of arrested persons and drug law offenses in Slovakia (2001-2011).


Figure 9.4.1: Number of drug users in prison and their share in total prison population (2005-2011). Source: CPCG, 2012.

Figure 9.4.2: Number of treatments by primary drug in healthcare units of CPCG (2010-2011).


Figure 10.2.1: Share of seizures of selected types of drugs in Slovakia in 2011. Source: ISPF PF (A., Bolf), 2012.

Figure 10.2.2: Number (N) of ephedrine/pseudoephedrine seizures in Slovakia (2006-2011).


Figure 10.3.1: Minimum, maximum and average price of selected types of drugs in Slovakia in euro in 2011. Source: ST16 (NDS BFOC PF, 2012).

Figure 10.3.2: Development of concentration median in selected types of drugs in Slovakia (2003 - 2011), ST 14, IFS PF. Source: IFS PF (A. Bolf), 2012.

Figure 11.2.1: Number of patients admitted in psychiatric healthcare facilities due to problems with drug use (F11 - F19) – comparison of hospitalization length (2011). Source: Reporting of patient’s institutional psychiatric care of HF (Ministry of Health of the SR) 7-12.

Figure 12.2.1: Age structure of population of Bratislava, the capital. Source: Statistical Office of Slovak Republic, 2012.

Figure 12.3.1: Graphical illustration of the biggest share of Bratislava region and its two “key” districts (Bratislava II and Bratislava V.) in numbers of treated drug patients since 2000. Source of data: NHIC, 2012 Drug users’ treatment in 2011.
### List of 2012 Standard Tables Provided

<table>
<thead>
<tr>
<th>Standard Table</th>
<th>Title</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Table 01</td>
<td>Basic results and methodology of population surveys on drug use</td>
<td></td>
</tr>
<tr>
<td>Standard Table 02</td>
<td>Methodology and results of school surveys on drug use</td>
<td></td>
</tr>
<tr>
<td>Standard Table 05</td>
<td>Acute/direct related deaths</td>
<td>Also 2009 eked</td>
</tr>
<tr>
<td>Standard Table 06</td>
<td>Evolution of acute/direct related deaths</td>
<td>Also 2009 eked</td>
</tr>
<tr>
<td>Standard Table 07</td>
<td>National prevalence estimates on problem drug use</td>
<td>No new data</td>
</tr>
<tr>
<td>Standard Table 08</td>
<td>Local prevalence estimates on problem drug use</td>
<td>No new data</td>
</tr>
<tr>
<td>Standard Table 09-1</td>
<td>Prevalence of hepatitis B/C and HIV infection among injecting drug users: methods</td>
<td></td>
</tr>
<tr>
<td>Standard Table 09-2</td>
<td>Prevalence of hepatitis B/C and HIV infection among injecting drug users</td>
<td></td>
</tr>
<tr>
<td>Standard Table 09-3</td>
<td>Voluntary results for Behavioural Surveillance and Protective Factors</td>
<td>Voluntary</td>
</tr>
<tr>
<td>Standard Table 09-4</td>
<td>Notified cases of hepatitis C and B in injecting drug users</td>
<td></td>
</tr>
<tr>
<td>Standard Table 10</td>
<td>Syringe availability</td>
<td></td>
</tr>
<tr>
<td>Standard Table 11</td>
<td>Arrests/Reports for drug law offences</td>
<td></td>
</tr>
<tr>
<td>Standard Table 12</td>
<td>Drug use among prisoners</td>
<td></td>
</tr>
<tr>
<td>Standard Table 13</td>
<td>Number and quantity of seizures of illicit drugs</td>
<td></td>
</tr>
<tr>
<td>Standard Table 14</td>
<td>Purity at street level of illicit drugs</td>
<td></td>
</tr>
<tr>
<td>Standard Table 15</td>
<td>Composition of tablets sold as illicit drugs</td>
<td></td>
</tr>
<tr>
<td>Standard Table 16</td>
<td>Price in Euros at street level of illicit drugs</td>
<td></td>
</tr>
<tr>
<td>Standard Table 17</td>
<td>Leading edge indicators for new developments in drug consumption</td>
<td>Voluntary, not provided</td>
</tr>
<tr>
<td>Standard Table 18</td>
<td>Overall mortality and causes of deaths among drug users</td>
<td>n.a.</td>
</tr>
<tr>
<td>Structured Questionnaire 23</td>
<td>Harm reduction measures to prevent infectious diseases</td>
<td></td>
</tr>
<tr>
<td>Standard Table 24</td>
<td>Access to treatment</td>
<td></td>
</tr>
<tr>
<td>Standard Table 30</td>
<td>Methods and Results of youth surveys</td>
<td>Voluntary</td>
</tr>
<tr>
<td>Standard Table</td>
<td>Public expenditure</td>
<td>Voluntary, Not provided</td>
</tr>
</tbody>
</table>