



European Monitoring Centre
for Drugs and Drug Addiction



National Monitoring
Centre for Drugs

**2014 NATIONAL REPORT (2013 data)
TO THE EMCDDA
by the Reitox National Focal Point**

**SLOVAK REPUBLIC
New Development, Trends**

REITOX

NATIONAL REPORT

Bratislava
2014

2014 NATIONAL REPORT (2013 data)

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SLOVAKIA

New Development and Trends

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 2014 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.

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SUMMARY

NATIONAL DRUG POLICY

Since the drug policy of the Slovak Republic has been formulated, it is based on the UN international treaties concerning the drugs, the Political Declaration on the Guiding Principles of Drug Demand Reduction of the Special Session of the UN General Assembly to Political Declaration and Action Plan on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem (UN Commission on Narcotic Drugs, March 2009), and to World Health Organization's policy Health for all in the 21st century.

The basic programme documents for national drug policy are national strategies and related action plan/plans of the concerned ministries.

Over the last 18 years, since the first national strategic document in this field was adopted, the Slovak Republic became a member of international and European community that actively seeks solution to a complex of issues related to drug abuse and is open for any international activities that direct towards effective solution.

NATIONAL DRUG STRATEGY

In 2013 adopted¹ National Drug Strategy of the Slovak Republic for the years 2013-2020 (hereinafter the "NDS") is the fifth consecutive document of the Government of the Slovak Republic laying down the foundation for national drug policy being further developed and updated. The overall aim of the Antidrug Strategy is to contribute to drug demand reduction and drug supply reduction, as well as the reduction of health and social risks and harms caused by drugs.

The strategy has been built on an awareness of current drug problems, including poly-substance use, stimulant (including methamphetamine) use, the need to control medications containing psychoactive or drug precursor ingredients, the challenges posed by blood-borne viruses (HIV, HCV), the need for improved treatment service coverage and the changing dynamics of the drug markets.

The dominant characteristic of the NDS in both main fields (reduction of drug demand and reduction of supply) is an integrated and balanced European approach.

There are also other national programs covering the psychoactive substances and health consequences of their use/misuse: alcohol policy, tobacco policy and program for health promotion where psychoactive substances represent risky factor/determinant for health of individuals and his/her well-being, as well as consequences for public health.

COORDINATION MECHANISM IN THE FIELD OF DRUGS

The Government Council for Drug Policy is responsible for inter-ministerial coordination in the Slovak Republic. The Council has a wide brief addressing a range of issues, functioning as an advisory body for the government, and is tasked with submitting the national drugs strategy to the government, implementing and coordinating the

¹ resolution No. 380 of 10 July 2013 by the Slovak Government

strategy, proposing financial arrangements for drug policy issues, and suggesting responses to serious drug problems. The Council is also involved in the drafting of drug-related legislation, coordinating the Slovak Republic's obligations under the international drug control treaties, and liaising with international organizations.

Since 2013 the Council is chaired by the Minister for Health.

At the regional and local levels in the Slovak Republic in late 2007, following the decommissioning of the Regional Offices (Ministry of Interior) both the local/regional level coordinators and regional committees for the prevention of drug addiction ceased operations. In three years the regional coordinators for the prevention of criminality have been appointed, following the passing of the 2008 Act on the Prevention of Criminality and other Anti-Social Activity.

The **Department of Drug Strategy Coordination and Drug Monitoring** (hereafter DSCDM) is now based within the Ministry of Health. It functions as the Council's secretariat and oversees the coordination and implementation of the national drugs strategy. The Department is the responsibility of the Director General of the Health Section at the Ministry of Health.

The Department's Director also functions as the Secretary of the Council.

The DSCMD Department consists of two sub-sections. The National Drugs Strategy Section is tasked with national coordination and implementation of the National Anti-Drugs Strategy. It also contains a section dealing with institutional and international relations and information transfers related to drug issues. The National Monitoring Centre for Drugs Section functions as the Slovak Republic EMCDDA/Reitox National Focal Point. It is responsible for monitoring the drug situation and managing national drug information systems.

LEGISLATIVE FRAMEWORK

The legal framework covering the area of drug demand and drug supply has not changed in terms of a number of legislative tools and is composed by 21 acts².

The basic control rule is **Act No. 139/1998 Coll. of Laws on Narcotics and Psychotropic Substances and Preparations as amended**. There were several amendments in 2013 to control new psychoactive substances³ – provision which allows the control of these substances by their inclusion into the list of potentially hazardous substances and subsequent restriction of their distribution and sale. The Ministry of Health of SK is to issue the generally binding legal regulation setting the list of hazardous substances – first regulation covering 11 substances was effective since October 1, 2013

Since 2006 affected **Penal Code (Act No.300/2005 Coll. of Laws as amended** covers drug offences in several provisions:

The paragraph 171 of the Penal Code changed the offence of unauthorized possession (of drug – according above mentioned Act No.139/1998) for personal use, according to

² http://www.infodrogy.sk/ActiveWeb/d/aktualizacia_drogove/sk/drogova_legislativa.html

³ Effective from 1 April 2013.

the amount of drug possessed: up to three years' imprisonment may be imposed for personal possession of an amount corresponding to a maximum of three times the usual single dose for personal use; and up to five years may be imposed for personal possession of an amount corresponding to a maximum of 10 times the usual single dose for personal use. New penalties such as home imprisonment and community service may apply, though sentences of immediate imprisonment remain available as the 'ultimum remedium'.

Possession of any amount above 10 doses must be charged under Section 172.

Section 172 of the Penal Code lays down a penalty of 3–10 years' imprisonment for drug trafficking, supply or production. The minimum was reduced from four to three years in 2013 to enable alternatives to prison to be given. The penalty increases to a range of 10–15 years or 15–20 years, depending on the value involved and aggravating circumstances (repeated offence, involvement of minors) and up to 25 years if the crime was committed in the context of an organized group. Three convictions for certain serious offences may result in automatic imprisonment of 25 years or even life.

The lower age limit of criminal liability is now set at 14.

In 2010–11 the Penal Code was amended to include the compulsory forfeiture of property for drug-related criminal offences. Special provisions are specified under Section 61 of the Code for drug-related traffic offences, and under Section 289 for the performance of employment or activity that could endanger the life or health of others, while under the influence of addictive substances.

Last amendment of Penal Code (Act No.1/2014) in force since February 1, 2014 covers the issue of spectators 'violence on the sport stadium, the use of alcohol and drugs is forbidden.

DRUG SITUATION

USE IN GENERAL POPULATION

Cannabis remained the most prevalent illicit substance used in the general population. Seven general population surveys in Slovakia - since 1996 - have been conducted in Slovakia so far. The last general population survey, among a sample of 4 055 respondents aged 15–64, was carried out by the National Monitoring Centre for Drugs (NMCD) in 2010. Cannabis remained the most prevalent illicit substance used, however the prevalence of cannabis use has almost halved in 2010, compared to the rates reported from a similar study in 2006.

European School Survey Project on Alcohol and Other Drugs (ESPAD) studies conducted since 1995 showed an increase in illicit drug consumption among secondary school students aged 15–16. Although lifetime prevalence rates for cannabis more than tripled from 9 % in 1995 to 32 % in 2007. The results of the latest survey (2011) showed a decline to 27 %. Next year there will be the sixth wave of ESPAD (2015) which as usually covers over 10.000 students aged 15-19 years in national context. Then the appropriate sample of 15-16 years students/participants of the (pen and pencil) survey is extracted for international comparison.

ESPAD survey is preceded in one year with national school survey on tobacco, alcohol and drugs – TAD - among 10-19 year-old pupils/students has been carried out in Slovakia every four years since 1994, with the most recent in 2011.

Slovakia also participates in the Health Behavior in School-aged Children (HBSC) project, which covers 11-, 13- and 15-year-olds, for which the latest data collection was performed in 2013.

The cooperation with Statistical Office of Slovak Republic is considered in future regarding in the international survey EHIS (European Health Interview Survey) which was carried out in 2014.

In 2013 a pilot study of Slovak Technical University experts was carried out on the prevalence of illicit drug use based on testing of wastewaters in SK capital - Bratislava. Such studies either complement probabilistic estimation of drug consumption in general population or detect the drug market size. The study proved the primacy of cannabis use, which was followed by amphetamines (methamphetamine - pervitin). Supported by EMCDDA grant for Reitox Focal point at the Ministry of Health in second half of 2013 year the analyses were expanded on 9 cities/municipalities.

TREATMENT DEMAND

Treatment demand data are collected by the National Health Information Centre from outpatient and inpatient centres, and treatment centers in prison settings. Additional data on treated clients are collected by the national focal point directly from the therapeutic communities.

In 2013 treatment demand data were about 2 484 clients (45, 9/100 000 pop) (2 193 clients in 2012) who entered treatment, almost half of them were treated for the first time (1 238).

40 % (45% in 2012) of all clients were treated for dependence on stimulants (methamphetamine (pervitin) was the primary illicit drug in 98%). The treatment demand data indicate that amphetamines have replaced opioids in the last decade; nevertheless, opioids remain the most frequently injected substance, although the number of such patients was is.

Opiates as primary drug was registered in 22 % clients (26% in 2012) and the same share of 22% clients (21% in 2012) resulted from their cannabis use (97 % of them used marijuana).

The most frequented way of use was smoking (33%), injection use in 707 clients (29 %) and sniffing (22 %).

Treated clients are mostly men – 2013 ratio was 5:1 (2 077 males, 407 females).

Almost 1/3 (770 clients) were treated in Ministry of Justice facilities (special health care facility for prisoners as well as in healthcare department of prisons).

Majority of clients regarding age are young people aged up to 29 years (app. 65% of all treated clients in period 2010-2013) – see Fig.2.

Majority of treated clients were from Bratislava region (568) and Trnava region (391) where the highest growth in 59% – comparing 2012 year – was reported. Presov region was the last one among eight regions of Slovakia with 111 treated patients...

TREATMENT RESPONSES

Implementation of drug treatment is the responsibility of the Ministry of Health, while the Ministry of Justice plays a role in the provision of treatment in prisons.

Within the health sector, treatment is delivered through five public specialized Centres for the Treatment of Drug Dependencies (CPLDZ), mental outpatient clinics, psychiatric hospitals, and psychiatric wards at university hospitals and general hospitals. Private providers also deliver drug treatment. The distinctive features of the Slovak drug treatment services are close links to mental health services and integration with treatment services for alcohol addiction, which allows mental health issues among drug users and consequences related to polydrug use to be addressed. Drug treatment is funded by public health insurance, while long time residential care is funded through local or regional budgets, with variable degree of clients' co-financing.

Centres for the Treatment of Drug Dependencies are the main providers of all types of specialized drug treatment, while mental outpatient clinics, available nationwide, offer outpatient diagnostic services, detoxification and long-term opioid substitution treatment (OST). Drug-free treatment can be divided into two stages: detoxification and relapse prevention. Physicians and psychologists, nurses and psychotherapists provide outpatient treatment as a systematic therapeutic service. Detoxification treatment is available in outpatient and inpatient treatment centres.

Residential drug treatment is delivered in inpatient departments, at specialized dependency treatment departments of psychiatric hospitals, and in Centres for the Treatment of Drug Dependencies, which are specialized psychiatric institutes.

Specialized drug addiction treatment offices provide OST. Methadone maintenance treatment (MMT) has been available since 1997 and buprenorphine since 1999. In 2008 the buprenorphine/naloxone combination was introduced; it can be prescribed by psychiatrists who hold an additional license to treat drug dependencies or by psychiatrists working at Centres for the Treatment of Drug Dependencies.

Last available data (2012) showed a total of 465 clients were in OST, 98 % of whom received methadone.

A legal provision exists in Slovakia to order compulsory drug treatment in a prison environment, and in public healthcare facilities after a sentence is completed; however, the rationale for this and the effectiveness of the measure are currently being widely debated among professionals.

Opioid substitution treatment is not available in prisons.

AFTERCARE AND SOCIAL REINTEGRATION SERVICES

Aftercare and social reintegration services for people who are drug-dependent are provided by NGOs outside the healthcare sector, in residential facilities or through self-help groups.

The seventh wave of NMCD survey 2013⁴ found out that there was a growth in numbers of clients, incl. young clients. Problems with methamphetamine hold there the primacy among illicit drugs, followed by poly-consumption of psychoactive substances.

However the highest share of clients in 20 resocialisation centres has had problems with alcohol (40% of 5037 clients in period of 2007-2013).

In 2013 there were 893 clients, 60% of them were males. The order of primary drug which was the reason of clients to contact resocialisation centers was the same as in Fig.3 – in 2013 it means alcohol 34,8%, methamphetamine 29,1% poly consumption 20,6%, heroin 6 %. There were also 46 clients (5, 1%) with problems related to marijuana.

DRUG-RELATED INFECTIOUS DISEASES

HIV / AIDS

The National Reference Centre for HIV/AIDS collects human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) notifications nationwide (since 1995).

Long-term data indicate that HIV/AIDS infection among injection drug users (IDUs) in Slovakia is one of the lowest in the world. In 2012 one HIV positive case among was reported, in 2013 no one.

In total number of HIV persons in period 1995-2013 (639) there were 12 persons only (4 females and 8 males) where the way of virus' transmission was injecting drugs. Majority of HIV infection was transmitted by sexual intercourse (men with men in 334 cases, heterosexual – 122).

In addition, a specific sentinel monitoring study at the Centre for Treatment and Drug Dependencies in Bratislava is being carried out; targeting people who inject drugs (PWID) and who are in treatment. Voluntary HIV testing is offered to everyone entering healthcare settings.

HCV

The percentage of cases reporting with antibodies to the hepatitis C virus (HCV) among new treatment clients at the Centre for the Treatment of Drug Dependency in Bratislava remained fairly stable at 40.3 % in 2010–11, while in 2012 some 37.8 % of clients were HCV positive. About 28.1 % of the same group tested positive for hepatitis B virus (HBV – anti-HBc) in 2012. HCV is more common among opioid injectors than among those who inject other substances (mainly pervitin), while HBV indicates an opposite trend – it is less common among opioid injectors than among other subgroups of PWID.

⁴ <http://www.infodrogy.sk/index.cfm?module=Library&page=Document&DocumentID=1114>

DRUG-INDUCED DEATHS AND MORTALITY AMONG DRUG USERS

Since 2009 data on drug-related death cases have been collected through a nationwide database of autopsy protocols, so-called 'e-autopsies', under the Healthcare Supervision Authority. Data extraction and reporting is in line with the EMCDDA definitions and recommendations for Selection D. According the most recent data (2012) the drug-induced mortality rate among adults (aged 15–64) was 6.2 deaths per million, lower than the European average of 17.1 deaths per million.

In 2013 there were 27 drug-related deaths, in one case more than in 2012.

HARM REDUCTION RESPONSES

Low-threshold services and outreach harm reduction programs in Slovakia provide access to clean needles and syringes (mainly through exchange) and information on safer drug use, although coverage is limited – an estimated 21 % of problem drug users could be reached by existing low-threshold services. Because of this, public pharmacies remain the main source of clean needles and syringes in Slovakia.

Five organizations ran outreach needle, and needle and syringe, exchange programs (NSPs), in six towns. Three towns – Bratislava, Banská Bystrica and Košice – had both mobile/outreach and stationary syringe exchange programs. According to data from independent exchange programs provided by field services and treatment institutions, a total of 321,339 syringes were provided in 2013. The majority of harm reduction programme clients were methamphetamine (pervitin) users, while the proportion of those who inject heroin was declining.

Testing for infectious diseases among drug users who are not in contact with healthcare units (in treatment) is not regularly available, and most harm reduction organizations provide testing only occasionally.

DRUG MARKETS AND DRUG-LAW OFFENCES

This type of data are collecting in "law enforcement" agencies (Police, customs, Ministry of justice and prison facilities)

Drug market

After 1989 Slovakia gradually became a transit point on the routes through which several drugs are illegally transported.

Heroin is primarily imported from Afghanistan by Albanian criminal groups. In 2010–11 there were indications that fentanyl replaced heroin in the market; however, after a clandestine fentanyl laboratory was dismantled in August 2011 the trend did not continue. Distribution of heroin to users is obviously provided by Roma families organized according similar strong patterns as Albanians.

Herbal cannabis is increasingly supplied by domestic growers of Vietnamese ethnic origin, and the most recent trend indicates that it is intended for distribution not only in Slovakia but also in neighboring countries such as Hungary. An increase in smuggling herbal cannabis from the Czech Republic was also noted.

Methamphetamine (pervitin) has been increasingly available in the Slovak drug market since 2006, originating from domestic production. It is produced primarily in small 'kitchen laboratories' from ephedrine or from over-the-counter medications containing pseudoephedrine. In 2013 there were some indications regarding import of ephedrine from Asia, namely China. However, mobile laboratories and laboratories with a high production capacity, producing high-quality pervitin, have also been registered. Commonly available pervitin produced in these laboratories reaches an active substance concentration of over 65 %. Some cases of pervitin smuggling from the Czech Republic have been registered. The purity of seized pervitin originating from the Czech Republic may in some cases be above 70 %.

Cocaine is increasingly smuggled into Slovakia via land transport through the Schengen area by Albanian criminal groups. Ecstasy is mainly imported from the Czech Republic, Hungary, Poland, Austria or the Netherlands; however, tablets containing MDMA have almost completely disappeared from the drug scene, and have been substituted by tablets containing mCPP.

Seizures of drugs

In 2013 the total number of drug seizures slightly rose up to 2237 cases when compared to 2012 (2194 seizures) with the overwhelming majority of seizures involving cannabis (61%) and methamphetamine (28%). The seizures of new psychoactive substances (and other drugs not mentioned above) represented 6%. Antidrug agency of Police Corp registered the cases of opioid based medicines trafficking (methadone, subutex and subuxon) e, as well as misuse of medicines with tramadol substance.

Street price of drug are more or less stable, only street price of heroin has raised up to 25-100 €/g (25-80 €/g in 2012) Fig.5

Institute of Forensics Sciences of Police Corps has carried out 2636 analyses in 2013 – in 2, 9 % more than in 2012. While the concentration of effective substance in heroin seizures fall down, concentration of effective substance in cocaine has risen rapidly.

DRUG CRIME

In 2013 the number of convicted persons for drug related offences slightly dropped in 13 persons on 1 191. (In 2012 a total of 1 214 offenders were convicted according to the Penal Code). Majority of them were sentenced conditionally, and almost one half of all drug related sentence was put on marijuana offence, followed by methamphetamine.

DRUGS IN PRISON

By the time being prison facilities reported the highest share of drug users among prison inmates. Totally 9723 inmates were in prisons in 2013 and 2 446 persons were registered as drug users and/or having problems with drugs. The share of such persons in prisons is almost doubled from 11% in 2008 up to 21% in period of five years.

PART A: NEW DEVELOPMENTS AND TRENDS

1. NATIONAL POLICY – LEGAL FRAMEWORK, STRATEGIES AND CONTEXT

1.1. Introduction

Since the drug policy of the Slovak Republic has been formulated, it is based on the UN international treaties concerning the drugs, the Political Declaration on the Guiding Principles of Drug Demand Reduction of the Special Session of the UN General Assembly to Political Declaration and Action Plan on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem (UN Commission on Narcotic Drugs, March 2009), and to World Health Organisation's policy Health for all in the 21st century. The particular source of inspiration represent the EU drug strategies and action plans – the current EU Drug Strategy for the period 2013-2020 and the EU Drug Action Plan for two periods until 2017 and 2020.

The basic programme documents for national drug policy are national strategies and related action plan/plans of the concerned ministries.

Over the last 15 years, since the first national strategic document in this field was adopted, the Slovak Republic became a member of international and European community that actively seeks solution to a complex of issues related to drug abuse and is open for any international activities that direct towards effective solution.

1.1.1 National drug strategy 2013-2020

The currently adopted⁵ National Drug Strategy of the Slovak Republic for the years 2013-2020 (hereinafter the "NDS") is the fifth consecutive document of the Government of the Slovak Republic laying down the foundation for national drug policy being further developed and updated. The general aim of the new NDS is to continue to contribute in drug demand reduction and drug supply reduction, as well as in reduction of health and social risks and harms caused by drugs. The dominant characteristic of the NDS in both main fields is an integrated and balanced European approach.

The Strategy provides a common and evidence-based framework for addressing drug issues in the Slovak Republic and beyond its territory, and a framework for joint and complementary actions, ensuring both effective and efficient use of resources invested in this field, while taking into account institutional and financial restrictions and capacity of the Slovak Republic.

1.1.2 Drug policy coordination, development and current political, institutional and organisational arrangements

In the years 2011- 2013, some significant changes occurred in development of drug policy coordination (Report 2013).

In October 2012, the Government adopted a decision by the governmental regulation⁶ approving the transfer of competencies in the field of drug policy and monitoring of drug

⁵ Resolution No. 380 of 10 July 2013.

⁶ Resolution No. 610/2012 of 31 October 2012

situation in Slovakia. Since 1 January 2013 the Ministry of Health has become a new umbrella institution and bearer of objectives of drug policy in Slovakia. The Minister of the Ministry of Health has become a new political representative responsible for field of drug policy and a chairperson of a newly established advisory body of the Government of the Slovak Republic - Council of the SR Government for drug policy (hereinafter the "Government Council").

1.1.2.1. Current political and institutional framework for drug policy

The Government of the Slovak Republic adopted by Resolution No. 610 of 31 October 2012 transfer of competencies in the field of drug policy and monitoring of drug situation in Slovakia.

In the view of the fact that since 1 January 2013 drug policy has not been covered by the Government Office, under the responsibility of the Deputy Prime Minister, the transfer of competences in the field of drug policy and monitoring of drug situation in Slovakia, including staffing, material and technical equipment, contractual agenda and financial provision, from the Government Office to the Ministry of Health of the Slovak Republic, which cooperates with the central state administration authorities and institutions in the field of drug-related issues at international level, was proposed.

This procedure should ensure continuity of tasks fulfilment and coordination resulting from the relevant decrees of the Government of the Slovak Republic, in particular formulation, monitoring and evaluation of the NDS and monitoring of situation in the field of psychoactive substances in Slovakia, as well as actions of a coordinator of national drug information system through the National Monitoring Centre for Drugs (hereinafter the "NMCD") which is a representative of the decentralized European agency – European Monitoring centre for Drug and drug Addiction, with a seat in Lisbon.

1.2. Legal framework

The essential legal framework covering the area of drug demand and drug supply has not changed in terms of a number of legislative tools and is composed by 21 acts⁷. However, the following amendments were adopted in 2013.

1.2.1 Legislative changes related to new synthetic drugs

1.2.1.1. Amendment to Act No. 139/1998 Coll. on Narcotics and Psychotropic Substances and Preparations

To ensure more flexible response to development of new synthetic substances which have been and are available via internet (and in the chain of the so-called "Crazy shops" and Euphoria until August 2012) the Government of the Slovak Republic approved a decision allowing the control of these substances by their inclusion into the list of potentially hazardous substances and subsequent restriction of their distribution and sale. The amendment to the Act (Act No. 40/2013 Coll. of Laws) No. 139/1998 Coll. of Laws on Narcotics and Psychotropic Substances and Preparations introduced new provision effective from 1 April 2013.

⁷ http://www.infodrogy.sk/ActiveWeb/d/aktualizacia_drogove/sk/drogova_legislativa.html

Pursuant to Section 16a – List of hazardous substances

(1) Hazardous substance shall be included into the list of hazardous substances, if there are reasonable grounds for suspecting that it is abused for persistent or sporadic intentional and excessive use that is accompanied by harmful physical or psychological reactions.

(2) If it is proved within the period of three years following its inclusion in the list of hazardous substances that the hazardous substance has properties of narcotic or psychotropic substance, it shall be immediately included in the list of narcotic and psychotropic substances listed in Annex No.1 and at the same time it shall be excluded from the list of hazardous substances.

(3) A hazardous substance shall be, without undue delay, excluded from the list of hazardous substances, if it is proved within the period of three years following its inclusion in the list of hazardous substances that the hazardous substance has no properties of a narcotic or psychotropic substance. The hazardous substance shall be immediately excluded from the list of hazardous substances even if it is not proved within the period stated in the first sentence that the hazardous substance has properties of narcotic or psychotropic substance.

(4) The Ministry shall issue the generally binding legal regulation setting the list of hazardous substances.

1.2.1.2. Reduction of a term of imprisonment from four to three years – amendment to the Criminal Code

Since 1 August 2013 has entered into force the amendment to Criminal Code (Act No.300/2005 Coll. of Laws) in the meaning of which a term of imprisonment was reduced from four to three years by the Section 172. Defendant who a) manufactures b) exports, imports, transports or will transport, c) purchases, sells, exchanges, procures, or d) possesses for any period of time, any narcotic substance, psychotropic substance, poison or precursor, or who mediates such activity, shall be liable to a term of imprisonment of three to ten years.

1.2.2 Other legislative changes

Reporting within on patients treated at treatment centres, as performed by the National Centre of Health Information, is regulated by a new law since May 2013. The Act on the National Health Information System and amendments now gives more competencies to the NCHI regarding health statistics and surveillance as well as more responsibilities in data protection.

1.3. National drug strategy, evaluation and coordination

1.3.1.1. National Drug Strategy of the Slovak Republic for the period 2013 – 2020

The new National Drug Strategy of the Slovak Republic for the period 2013-2020⁸, is defined as the fundamental strategic document of the Slovak Republic in the field of drug policy, based on the Drug Strategy of the European Union for the period 2013-2020, was approved by the Government of the Slovak Republic by the resolution No. 380 of 10 July 2013.

The NDS document is the manifestation of political will of the Slovak Republic to address problems related to drugs, and it represents the essential document based on the former drug strategies in line with the level of current knowledge of drug phenomenon. It includes a balanced and integrated approach to one of substantial social problems, while respecting global and European values and standards focusing on respect for human rights, human dignity and protection of individual. The NDS defines direction of addressing the drug-related problems and basic framework for creation and implementation of drug strategies at the level of ministries, regions and municipalities. Its primary aim is to address problems in the area of drug supply reduction, drug demand reduction and harm reduction resulting from their use. It emphasizes the importance of reliable and comparable information, need for knowledge about development of drug scene in the context of European knowledge as a basis for making informed decisions. It is characterized by an effort to balance its individual areas and openness. It focuses on public health protection with an emphasis on ensuring the population protection against risk of drug addiction and drug abuse as well as issues related to social exclusion and social integration of excluded groups. The NDP is structured around two drug policy areas: 1) drug demand reduction and 2) drug supply reduction, and three cross-cutting themes: 1) coordination, 2) international cooperation, 3) research, information, monitoring and evaluation

The NDS takes into account new approaches and addresses new challenges and needs that have been identified over the recent years in the Slovak Republic, in particular:

- the increasing trend towards poly-substance use, including the combination of licit and illicit substances, such as alcohol and prescribed controlled medicines,
- the trend towards increase of stimulant use, mainly pervitin, other synthetic drugs of amphetamine type, as well as experimenting with new psychoactive substances (derivatives of synthetic cannabinoids and catinones),
- the need to ensure specific, effective control of prescribed controlled medicines, containing psychoactive substances and drug precursors,
- despite the decrease of injecting drug use, there is the continued high incidence of blood-borne diseases, mainly hepatitis C virus, among intravenous drug users,
- the continued potential risks of new outbreak of HIV infections and other infectious diseases as a result of risky behaviour of drug users,

⁸ The National Drug Strategy is available on <http://www.infodrogy.sk/indexAction.cfm?module=Library&action=GetFile&DocumentID=1043>

- the need to improve quality, coverage, and diversification of services for drug demand reduction (prevention, treatment, social reintegration and harm reduction) on platform of separate standards of provided services,
- the need to address drug use through an integrated health care approach focusing – inter alia – on co-morbidity,
- the growing dynamics of the market with illicit drugs and new psychoactive substances, mainly in the field of their manufacture, smuggling, distribution and trafficking,
- globalisation of illegal market with drugs and precursors accelerated by use of communication and information technologies,
- novelisation of legislation aimed to effectively use criminal sanctions for the less-serious drug offences, especially by increased application of alternative sentences,
- appropriate integration of measures and services in prison in order to reduce the risks related to drug use,
- the need to prevent diversion of precursors, pre-precursors and other essential chemical substances used in the illicit manufacture of drugs from legal trade to illicit market and the need to prevent diversion of chemical substances used as cutting agents,
- addressing insufficient legislative and institutional coverage of promotion, implementation and coordination of drug policy and multidisciplinary approach to drug issues at national level in relation to the requirements of the EU legislation,
- the need to use new methods of obtaining information on drug issues.

The objectives of NDS are:

- to contribute to a measurable reduction of drug demand, drug dependence and drug-related health and social risks and harms,
- to contribute to combat drug-related crimes and illicit market with drugs and precursors and to reduce availability of illicit drugs and new psychoactive substances,
- to encourage multilevel coordination through active discussion and analysis of developments and challenges in the field of drugs at national and regional level,
- to contribute to a better dissemination of monitoring, research and evaluation results and a better understanding of all aspects of drug phenomenon, as well as the impact of interventions in order to provide comprehensive evidence-base for policies and actions,
- to further strengthen dialogue and cooperation between the EU and third countries and international organisations in the field of drug demand and supply reduction.

Priorities and actions shall ensure a high level of human health protection, social stability and security, namely through a coherent, effective and efficient implementation of measures, interventions and approaches to drug demand and drug supply reduction at national, EU and international level.

Implementation of the objectives given in the document will be funded by the state budget within the approved limits and by the financial resources of the European Union and co-financing.

1.3.2 Other programmes and strategies

1.3.2.1. Crime Prevention Strategy 2012-2015⁹

The crime prevention objectives emerging from the prevention strategy were differentiated in the three-level system. At national level, the objectives mainly of conceptual legislative coordination, economic, advisory, information, initiating and executive nature were provided. At other two levels (regional and local) were performed the objectives resulting from real situation, conditions, structure and dynamics of crimes in the given area.

Each of the following priorities of crime prevention represents the base for creating a strategy of central state administration authorities and for regional programmes and it relates to drug issues in both main fields – drug demand and drug supply, namely:

reduction of crime rate and crime severity as well as other antisocial activities (in particular: major and organised criminal activity; drug trafficking; computer crimes; human trafficking; sexual abuse of children and child's pornography; economic and property-related crimes; corruption; arms trafficking and over-the-border crime; violence against women);

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

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

elimination of promotion of crime and other antisocial activities through all types of media (film, television, radio, internet, printed media).

1.3.2.2. National Action Plan for Alcohol Problems for the years 2013 – 2020¹⁰ (hereinafter the "NAPAP")

It was approved by the Government of the Slovak Republic by the resolution No.341/2013 of 3 July 2013. The main intention of the National Action Plan is primarily

⁹ Evaluation report on fulfilment of objectives in the field of crime prevention emerging from the Crime Prevention Strategy and Other Antisocial Activity in the Slovak Republic for the period 2012 – 2015 for 2012.

¹⁰ it was adopted by the governmental resolution No. 341/2013 dated 3 July 2013

to raise awareness about health in relation to promotion of responsible, cultural and controlled use of alcohol.

The important area is prevention related to raising awareness and knowledge on adverse health and social impact, control of alcohol sale, control of purchaser's age, control of alcohol consumption at workplace and in transport.

The objectives and tasks are transmitted to individual state administration authorities. The Report on preliminary progress of Action plan for the years 2013-2020 will be elaborated in the first half of 2017, the NAPAP will be updated during 2017, together with formulation of new objectives to be fulfilled by 2020.

The programme is sponsored by the Public Health Authority of the Slovak Republic. It overlaps with the NDS mainly in the field of demand reduction – prevention focusing on target group of children and youth and treatment – combined use of alcohol plus illicit drugs.

1.3.2.3. National Action Plan for Tobacco Control for the years 2012-2014¹¹.

The objectives of the Action plan are to improve conditions in the field of prevention of smoking at schools (including universities), in healthcare facilities and social services facilities;

- controls of smoking at public places;
- controls of content and composition of tobacco products,
- network of counselling services for weaning from smoking;
- education in schools by issuing methodological guides for teachers, parents and children;
- evaluation of effectiveness of preventive measures and adopted legislation by surveys on public opinion.

1.3.2.4. National Health Promotion Programme¹².

Main objective of the programme is a long-term improvement of health status of Slovak population by eliminating incidence of health disorders lowering the quality of life and threatening man by an early death. The latest update of the programme overlaps with the NDS objectives at least in two objectives

1) reduction of harms caused by alcohol, drugs and tobacco products and 2) reduction of a number of infectious diseases.

1.3.3 Coordination

1.3.3.1. Coordination of drug policy at national level

At present, the highest coordination body is the Council for drug policy of Government of the Slovak Republic (hereinafter the "Government Council") established on 30 April 2013. At the same time, it is an advisory and expert body of the Government of the

¹¹ Resolution No. 763/2011

Slovak Republic for drug policy and an issue of licit and illicit drugs. It discusses and submits to the Government

- a. National Drug Strategy as its fundamental document of implementation of state drug policy
- b. proposal for financial coverage of state drug policy,
- c. proposals addressing very serious problems in drug area in the Slovak Republic.

The Government Council also discusses

- d. the most important drug departmental programmes implementing main objectives of the National Drug Strategy,
- e. drafts of laws, legislative changes and changes related to implementation of the EU standards in the field of drug demand reduction and drug supply reduction,
- f. materials to be discussed by the Government, if their contents relate to the Government Council's scope of activity
- g. drafts for implementation of drug information system, creation of data flows and databank of information, analyses, scientific evidence and current information, foresight on character and scope of drug phenomenon,
- h. measures to implement and promote monitoring of situation in the area of drug issues under the international and national requirements, regular evaluation of monitoring,
- i. coordination and promotion of research in the field of drugs and drug addictions.

Composition of the Government Council

1. Chairman of the Government Council - minister of Health of the SR
2. Secretary of the Government Council – director of the Department¹³,
3. Permanent members of the Government Council,
4. Depute Prime Minister of the Government and Minister of Interior,
5. Depute Prime Minister of the Government and Minister of Finance,
6. Depute Prime Minister of the Government and Minister of Foreign and European Affairs of the SR,
7. Minister of Education, Science, Research, and Sport of the SR,
8. Minister of Labour, Social Affairs and Family of the SR,
9. Minister of Justice of the Slovak Republic,
10. Minister of Economy of the Slovak Republic,
11. General Prosecutor of the Slovak Republic,
12. Governmental Representative of the Slovak Republic for Development of Civil Society.

Members of the Government Council are appointed and recalled by the Government based on the proposal of the Minister of Health.

The Governmental Representative of the Slovak Republic for Development of Civil Society invites the selected delegate of non-governmental organisations (as a non-member of the

¹² Resolution No. 797/2011

¹³ Department of Drug Strategy and Monitoring of Drugs

Government Council), operating in the area of drug issues, to participate in governmental council session.

The Government Council ensures implementation of priorities and objectives of individual areas of the National Drug Strategy and coordinates activities of all concerned ministries, other central state administration authorities and other central bodies, organizations and institutions involved in its implementation. It ensures continuity of taken actions and activities in terms of material, temporal, spatial progress as well as in terms of ways of their implementation and fulfilment¹⁴. The Government Council also coordinates the fulfilment of tasks arising from the international treaties by which the Slovak Republic is bound based on its membership in the European Union and international organisations. It elaborates aims and objectives of the EU Drug Strategy and European Action Plan to Combat Drugs, provides their implementation at national level. Within the multidisciplinary cooperation, it mediates transfer of information from abroad, mainly from the European Union, United Nations, Council of Europe, World Health Organisation and other international bodies, organisations and institutions, involved in drug demand reduction and drug supply reduction and other addictive substances.

1.3.3.2. Department of Coordination of Drug Strategy and Monitoring of Drugs

The executive body of the Government Council is the Department of Coordination of Drug Strategy and Monitoring of Drugs (hereinafter the "Department") established within the organisational structure of the Ministry of Health of the SR. The Department executes the tasks related to organisational, administrative and technical provision of activity of the Government Council, is responsible for fulfilment of adopted resolution of the Government of the SR and Government Council, for coordination and implementation of the NDS.

It represents the SR in international bodies, organisations and institutions operating in the given area (mainly in the European Union, United Nations and Council of Europe), proposes the Slovak representatives and experts of these bodies, organisations and institutions.

It submits information on identification and competencies of bodies responsible for implementation of provisions of international conventions and their amendments to the Secretary General of the United Nations.

In the organisational structure of the Ministry of Health of the SR, the Department falls under the direct competency of the General Director of the Section of Health of the Ministry of Health of the SR. By transfer from the Government Office of the SR to the Ministry of Health of the SR, the number of employees was reduced, while making efforts to meet all activities of the Department (in 2010 there were 15 departmental employees, since 1 January 2013 there are only 7 employees). The last change concerned the

¹⁴ Evaluation of fulfilment of tasks arising from strategy and action plans is performed in two phases - interim or mid-term evaluation which is carried out when half of the given period is over.

Final evaluation of the NPS 2009-2012 will be officially submitted to the Government to be discussed at the end of 2013, instead of original deadline of 31 March 2013, due to organisational and technical reasons. The reason for a change of deadline was transfer of the Department of Coordination of Drug Strategy and Monitoring of Drugs from the Government Office of the SR to the Ministry of Health of the SR.

internal structure of the Department, namely from three to two sections: Section of Coordination of Drug Strategy and Section of Monitoring of Drugs - National Monitoring centre for drugs.

1. Section of National Drug Strategy – at national level provides coordination of implementation of national drug strategy. In this department, there is also a section with agenda of foreign relations ensuring international communication and transfer of information among the governmental departments and corresponding international authorities.
2. Section of National Monitoring Centre for Drugs – still works as a national focal point of international information network on drugs REITOX that is operated by EMCDDA. Key objective of the NMCD is to monitor the situation related to controlled psychoactive substances in Slovakia, and to coordinate national drug information system.

Activity of the Department is organized and managed by the Director who is also the Secretary of the Government Council. In relation to abroad, the Director is a national drug coordinator and represents the Slovak Republic in the managing board of the EMCDDA based on the mandate given by the Chairman of the Government Council.

The effort of the Department as a whole is to achieve, in future, re-transmission of coordination mechanisms and cooperation to lower levels, with regional authorities and local self-government authorities. This trend was stooped by eliminating the partnership structures at regional level – the coordinators of drug prevention¹⁵, whose positions were terminated in process of cancellation of the Regional authorities of state administration in 2007, and although being re-institutionalizing in law on crime prevention, they have not been established yet.

As concerns the Section of National Monitoring Centre for Drugs, its position within the political structure, is not the optimal solution, as the agenda and objectives which the NMCD has to fulfil primarily as a focal point of the European Monitoring Centre for Drugs and Drug Addiction is very different in terms of their nature and they require a certain degree of autonomy.

1.4. Economic analysis

One of the preconditions for fulfilment of the NDS objectives is to provide corresponding financial resources and to create financing tools.

1.4.1 Budget – interdepartmental programme of funding „Drug policy“

In 2012, the Slovak Republic created¹⁶ within the State Budget (hereinafter the “SB”) an interdepartmental programme “Drug Policy”. The programme was sponsored by the Government Office of the Slovak Republic, and in addition to the Government Office, up to 11 ministries participated in the programme – implementing the NDA and the General Prosecutor’s office). The interdepartmental programme was inserted into the database of

¹⁵ At each Regional authority, there was a coordinator of drug prevention – a total of 8 coordinators who coordinated activities of various subject in the are of drug prevention, drug addiction treatment, re-socialization and enforcement of law in their regions.

the Budget Information System of the SR in May 2010, and implementation of the programme in the SR was planned for 2011.

Despite the efforts of the Department, the departmental programme "Drug Policy" has not come into practice yet, and it is not possible to monitor and summarize state expenditures incurred in connection with the drug-related activities. Moreover, the public expenditures represent only the one part of social costs, mainly those in a form of direct costs. These costs may be expressly labelled as "drug-related", and it is possible to include them to final financial reports.

During budget planning for following years, the programme has been cancelled by the Government Office.

1.4.1.1. Public expenditures – sub-programme 01 Drug Policy - the Government Office of the Slovak Republic in the years 2009-2012

In the years 2009-2012, the programme Drug policy was sponsored by the Government Office of the Slovak Republic. At the same time, the Government Office was one of 13 programme participants with own sub-programme, named as the sub-programme 01. This sub-programme consisted of two autonomous parts, namely:

1. Amount of financial resources allocated to promotion of programmes, initiatives, and activities of the National Drug Strategy through state subsidies from the State budget.
2. Financial resources from the State Budget for financing of special activities of the National Monitoring Centre for Drugs, together with the grant resources of the EMCDDA.

1.4.1.2. State subsidies for promotion of anti-drug activities

The financial subsidies from resources of the State Budget were reallocated in the years 1997- 2008 by the non-profit Anti-Drug fund, cancelled by the Act No. 121/2011 Coll. of Laws on the Cancellation of the Drug fund. Since 2009, the competences of the Anti-Drug fund have passed on the Government Office of the Slovak Republic. In the years 2009-2012, it provided financial means through a subsidy programme from the State Budget to promote the programmes, initiatives and activities in the field of the national drug strategy. These financial subsidies were designed primarily for non-governmental, non- profit organisations.

The Department of Coordination of Drug Policy and Monitoring of Drugs - currently at the Ministry of Health of the SR- sponsored the provision of subsidies for anti-drug activity promotion at the Government Office of the SR from 2009 to 2012 and at the Ministry of Health of the SR since 2013. Table 1.4. xxx shows retrospectively the data on financial means allocated for promoting activities and programmes of the last- fourth National Drug Strategy for the years 2009-2012. Based on the data, the gradual reduction of financial means is apparent, projected also into drawing and number of supported projects.

¹⁶ Governmental resolution No.308 of 29 April 2009.

Table 1.1 Overview of subsidies provided for anti-drug activity promotion under the sponsorship of the Department (until 31 December 2012 at the Government Office of the SR)

Year/ Volume of allocated financial means	Subsidies for anti-drug activities in the years 2009-2012		
	required	drawn	Number of supported applications
2009 – 1 500 000 €	3 662 857.03 €	1 461 176.00 €	73
2010 – 980 000 €	2 133 666.69 €	639 203.00 €	47
2011 – 515 000 €	1 215 425.05 €	500 000.00 €	50
2012 – 515 000 €	2 485 318.06 €	484 025.00 €	38
Total	9 497 266.83 €	3 084 404.00 €	208

In 2013, there were used and allocated the financial means in a total amount of EUR 515 thousand for promoting anti-drug activities in line with the drug policy of the SR. By cancellation of the Department, the financial means used and allocated for these specific subsidies were transferred to the Ministry of Health of the SR since 1 January 2013. Mechanism of subsidies provision by the MoH of the SR is regulated by a separate law, and it differs from the procedures applied until 2012. Based on the fulfilment of the Call's conditions which have been already published, the financial means will be reallocated among successful applicants, under the applicable legislation of the Ministry of Health of the SR, in a kind of „provisional arrangement“¹⁷, with maximum effort to maintain the continuity of implemented activities and initiatives related to drug issues, which should cover prevention of drug addictions, drug addiction treatment, social integration of drug addicted persons and reduction of harmful impact of drug use.

¹⁷ The proposed solution is an amendment to Act No. 525/2010 Coll. of Laws on Provision of Grants in the Competence of the Ministry of Health of the Slovak Republic in order to reflect specific grant area.

2. DRUG USE IN THE POPULATION

2.1. Introduction

Drug use in the general population (General Population Survey - GPS) is one of the key¹⁸ EMCDDA indicators that are applied to describe the situation in the use of licit and illicit substances. The scope and use of various drugs in the general population (typically focusing on people aged 15-64, or specific age groups and/or cohorts), as well as the views and attitudes regarding the use of drugs within various population groups, are collected by means of surveys that are applying standard sociologic and psychological methods (a standardised questionnaire, face-to-face interviews, telephone interviews and the Internet). In order to ensure comparability of data within Europe and globally, the European Monitoring Centre for Drugs and Drugs Addiction (EMCDDA) recommends that the data formulated in the so-called European Model Questionnaire (2002) be also contained in the GPS indicator.

For every psychoactive substance (including tobacco and alcohol), the EMQ is identifying the following core variables: prevalence, age at first use of drug, frequency of use (or the amount of drug taken). The EMQ is open to changes and supplements¹⁹ prepared by the EMCDDA in cooperation with a narrower group of experts.

In the Slovak Republic, these criteria correspond, to a great extent, with the population surveys on drug use carried out by the Public Opinion Research Institute at the Statistical Office of the Slovak Republic (hereinafter referred to as the ÚVVM) in two-year intervals since 1994 or 1996. After the ÚVVM has been wound up, population surveys fell within the ambit of the National Monitoring Centre for Drugs (NMCD) which organised a pilot survey in the Bratislava region in 2009 using a modified questionnaire that was identical with the EMQ in the relevant variables and, one year later, in 2010, the first national survey was carried out. The second wave of this nationwide survey has not been carried out yet.

In both representative school surveys, i.e., Tobacco, Alcohol and Drugs (TAD) and the European School Survey Project on Alcohol and Other Drugs (ESPAD), the NMCD participated both financially and with its personnel – the head of the survey team. These surveys are compatible with the EQM in certain variables. TAD was organised in Slovakia for the fifth time in 2010 and, as usual, preceded the fifth ESPAD wave in 2011. At present, the sixth cycle of the national school survey Tobacco, Alcohol and Drugs among children and adolescents aged 10-19 is being organised with a financial backing from an EMCDDA grant.

An international project HBSC (Health Behaviour in School Aged Children) represents the third representative school survey not falling under the authority of the NMCD. HBSC maps the behaviour of schoolchildren in terms of their health, and covers tobacco, alcohol

¹⁸ In 2013, the five indicators were supplemented with the sixth indicator for the reduction of supply

¹⁹ For instance, the EMQ module – recommended in 2013 – for surveying the use of new psychoactive substances

and cannabis use as other forms with possible health implications. The data for HBSC 2014 was collected between May and June and the final national database has been sent to the HBSC headquarters in Norway. In addition to questions related to experience with the use of alcohol, tobacco and cannabis, the questionnaire also contained questions related to rules in terms of alcohol, tobacco and cannabis use. Based on a preliminary agreement with the organisers of this survey in Slovakia, it will be possible to provide, in 2015, the national HBSC 2014 data.

There has been long string of surveys on the use of psychoactive substances in the general population segment (aged 15-26) and the school-age population segment, or of surveys concerning the use of psychoactive substances in specific settings where particular propensity to such substances is presumed (children's homes, re-education centres). Until 2012, these surveys were continuously conducted by the Institute of Information and Prognoses in Education.²⁰ Even though the method and variables used in these surveys are essentially different from EMQ, the long-term use of a practically identical questionnaire and the processing of outputs made it possible to keep track of the prevalence of use of psychoactive substances in the target groups addressed by the surveys since 1995.

The individual sections of this chapter describe the findings of the available surveys carried out in 2013 or 2014, which are as follows:

1. a survey on health awareness and behaviour in the Slovak population in sub-chapter 2.2.1.
2. analyses of psychoactive compounds in wastewater in Slovakia, especially in wastewater of the Slovak capital Bratislava (sub-chapter 2.2.2)
3. data from the survey Eurobarometer Flash 401 (Slovak respondents aged 15-24) and comparison with the EU average with a focus on the use of new psychoactive substances in sub-chapter 2.3
4. in sub-chapter 2.4 programmed for the data on the use of psychoactive substances in specific settings or groups, the key element is the third cycle of the survey on drug use among university students - 2.4.1 (Nociar A.,2014); and
5. an online survey (NMCD 2014c) focusing on the use of new psychoactive substances, the motives for using such substances and the adverse medical signs associated with their use.

2.2. Use of psychoactive substances in the general population

The term "psychoactive substances", which covers, inter alia, tobacco and alcohol, reflects the current institutional position of the National Monitoring Centre for Drugs that falls under the Anti-drug Policy Coordination Department within the Health Ministry's structure under the Health Section. Through the prism of the Ministry of Health, all psychoactive substances – regardless of their legal status, as well as their immoderate consumption and abuse – are considered determinants of the health condition of

²⁰ The Institute of Information and Prognoses in Education has been part of the Slovak Centre of Scientific and Technical Information at the Ministry of Education since 2014

individuals (in terms of risk factors) and a matter of public health. As revealed by a survey entitled "Health and Health care"²¹, more than a quarter of adult population (60 %) are aware that there is a direct correlation between good or bad lifestyle of an individual and his/her health condition (the 2013 Report, chapter 2). Also, in the survey described in sub-chapter 2.1.1, as many as 92.6 % of respondents said their life expectancy was affected by their lifestyle and the way they take care of their health.

2.2.1 Report on health awareness and behaviour of the Slovak population in 2013

The aim of the survey carried out by the Public Health Authority of the Slovak Republic (ÚVZ SR) was to identify important attributes of health awareness and behaviour of the population based on the fulfilment of the National Health Promotion Programme.

The questionnaire survey was conducted in the course of 2013 (with fieldwork carried out in May and June) on a sample of respondents from the entire territory of the Slovak Republic by employees of health promotion departments at 35 regional offices of the Public Health Authority. The questionnaires were filled out by the respondents without any assistance.

Of the total of 93 questions, 12 dealt with smoking and the use of alcohol and illicit drugs.

The survey sample consisted of 3,679 respondents (1,840 men and 1,839 women) aged 15-95. The population is not explicitly specified in the report. The average age of men and women was 44.77 and, respectively, 45.40 years. The population was broken down into three age groups.

Table 2.1: Age structure of respondents in the Public Health Authority's survey, Source: ÚVZ SR, 2014 – Health awareness and behaviour of the Slovak population in 2013

Age	Males		Females		Total	
	Number	%	Number	%	Number	%
below 25	574	31.2	563	30.6	1,137	30.9
25 – 64	704	38.3	709	38.6	1,413	38.4
65 and more	562	30.5	567	30.8	1,129	30.7
Total	1,840	100.0	1,839	100.0	3,679	100.0

2.2.1.1. Data related to the use of licit and illicit drugs

2.2.1.2. Use of tobacco products

The majority of respondents (30.8%) who reported smoking were in the youngest age group below 25 years. A total of 26% of men reported smoking and, for women, this percentage was 17.4%, showing a statistically significant difference. 15.9% of men quit smoking, which was twice the amount seen among women (8.0%). The number of those

²¹ Džambazovič, R. - Gerbery, D. - Sopóci, J (2013): ISSP Slovensko 2012 - Zdravie a zdravotná starostlivosť. pramenná publikácia (*Health and Health Care*). (Stimul, Bratislava, 2013)

who quit smoking is increasing with age. Most of the respondents (66.3%) said they did not smoke, with the proportion of women (74.6%) being higher than that of men (58.1%) by a statistically significant margin. As regard the number of cigarettes smoked a day, majority (63.3%) said they were smoking less than 10 cigarettes a day.

2.2.1.3. Alcohol

7.4% of respondents are drinking beer every day/every other day and 23.5% of respondents drink beer one or two times a week. 25.9% of respondents drink beer once or twice a month. As regards those who reported excessive drinking, men have a statistically significant lead over women. Regular drinking of beer has been confirmed primarily with men; some 15% of men aged 35 – 65 and more are drinking beer every day or every other day. The proportion of those who drink beer regularly increases with age.

2.5 % of the respondents drink wine every day or every other day and 14.4% of respondents drink wine once or twice a week. 36.3% of respondents drink wine once or twice a month. As regards those who reported excessive drinking of wine, men have a statistically significant lead over women in all of the above categories.

Approximately 2% of respondents say they drink spirits every day or every other day. 9.4% of respondents drink spirits once or twice a week. 28.1% of respondents drink spirits once or twice a month. Even in the case of spirits, men have a statistically significant lead over women.

2.2.1.4. Drugs

The majority of respondents (95.8 %) say they have not used drugs in the past 12 months²² and 4.2 % of them say they have used some drug, with the proportion of men being higher than that of women (men=5.4 %, women=3.0 %).

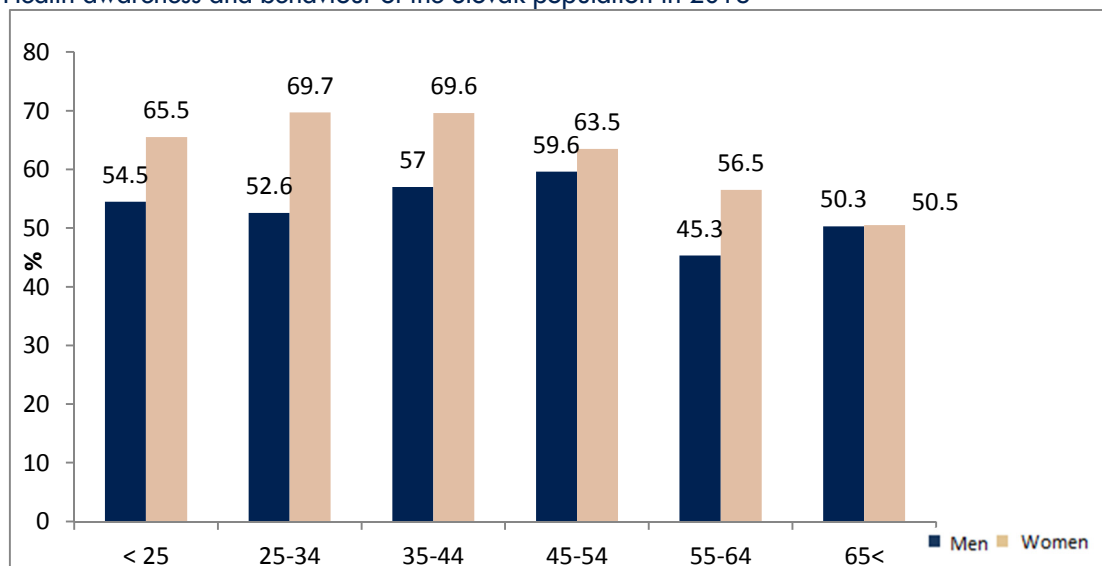
2.2.1.5. Use of medicinal products in the past 12 months

The use of medicinal products prescribed by a physician was reported by 80.5% of women and 71.2% of men, with a significant difference in the favour of women.

In terms of the use of over-the-counter medicinal products, there is a similar inter-gender difference as was the case with medicinal products prescribed by a physician. Women have a statistically significant lead over men in such use of medicinal products (63.5% against 53%) and the inter-gender difference remains constant across all age groups. Irrespective of the specific figures revealed by the survey, this confirms a trend that over-the-counter medicinal products are used, and sometimes misused, without advice of a physician and, as regards the difference between men and women, this behaviour tends to be more common among women.

²² Question No. 57 is formulated in a way that applies to drugs in general, Question No. 58 – “What drug have you used?” is not evaluated in the available report.

Figure 2.1: The proportion of respondents who said they have used, over the past 12 months, medicinal products without prescription by a physician, broken down by gender and age. Source: ÚVZ SR , 2014 - Health awareness and behaviour of the Slovak population in 2013



When comparing the data from this survey and the data from specific surveys²³ on the use of drugs, it is necessary to emphasise that, in accordance with the conclusions emanating from an EMCDDA comparative study, the estimates of the prevalence of use of psychoactive substances are significantly lower in health surveys than in specific surveys. The differences are likely to be explained by methodologically different procedures – method of data collection, age groups – even in this case, the age group was broader than groups commonly used in the case of population surveys (15-64), which may cause the flattening of overall data, but also the context of the entire survey (for instance, social desirability of answers, cultural context, as well as the legal status of illicit drugs).

2.2.2 Occurrence of psychoactive substances in wastewater in Slovakia²⁴

Based on an international study²⁵, the first pilot project for the monitoring of drugs in wastewater was carried out in Bratislava, the capital city of the Slovak Republic (the 2013 Report, chapter 2.1) in February 2013 and, later on, as part of the VEGA grant and the NMCD subsidy – wastewater was analysed in nine Slovak cities (twelve sewage treatment

²³ Data supplied to the REITOX network

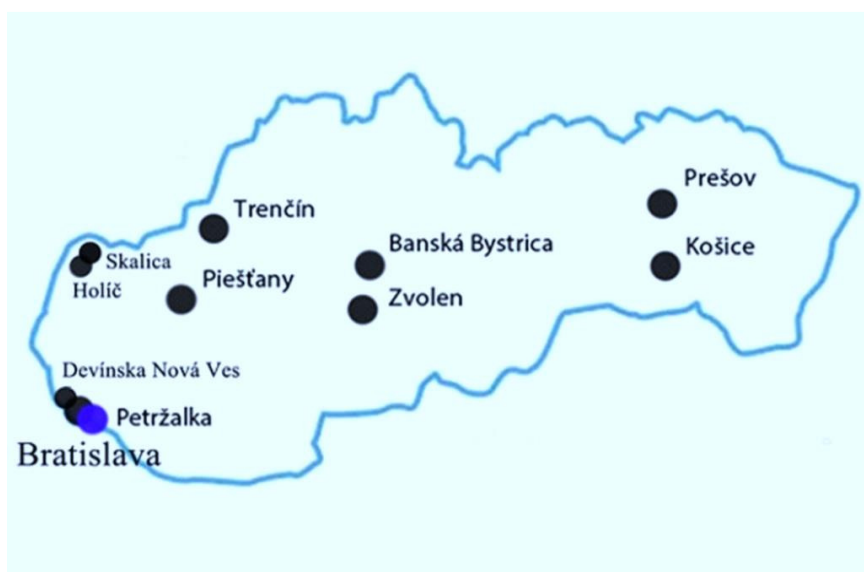
²⁴ Final report (prepared on the basis of Contract No. 225/2013 on the provision of research services in the area of drug monitoring in wastewater for the purposes of monitoring drug situation in the Slovak Republic in line with the requirements of the European Union) Authors: Ing. Tomáš Mackuľák, PhD., Ing. Dr. tech. Jaroslav Škubák, PhD., doc. Ing. Igor Bodík, PhD. 31.1.2014 (*hereinafter only referred to as Mackuľák T. et al. 2014*)

²⁵ Thomas K. et al. (2012): Comparing illicit drug use in 19 European cities through sewage analysis. *Science of the Total Environment* 432, 432 – 439 (2012).

plants) for the presence of 26²⁶ drugs, psychoactive substances and metabolites. Between July and November 2013, point analyses were performed at selected sewage treatment plants, as well as 24-hour analyses at the outlet of selected treatment plants. Three out of twelve sewage treatment plants are located in the capital city: the central sewage treatment plant in Bratislava which collects wastewater from greater centre of the Bratislava city, the sewage treatment plant in Petržalka which collects wastewater from Slovakia's largest housing estate on the left bank of the Danube River in Bratislava and the sewage treatment plant in Devínska Nová Ves which collects water from the city districts Devínska Nová ves, and partially from Dúbravka, Lamač and Devín. The remaining sewage treatment plants in Košice, Banská Bystrica, Zvolen²⁷, Prešov, Skalica, Holíč, Trenčín²⁸ and Piešťany²⁹ were selected to allow better comparison of the drug situation outside the capital city.

The total population in the above cities was some 1.1 million (approximately 20% of Slovakia's population which represented 5,415,949 as at 31 December 2013 – Source: Statistical Office of the Slovak Republic)

Figure 2.2: A map of Slovak cities analysed for the presence of drugs and psychoactive substances (Mackulák T. et al, 2014)



²⁶ **systemic name** benzoylethanamine, oxycodone, methamphetamine, ketamine, 2-oxy-3-hydroxy-LSD, LSD (lysergic acid diethylamide), amphetamine, cocaine, benzoylecgonine, THC – tetrahydrocannabinol (monitored compound THC-COOH (11–nor–9–karboxy–delta9–tetrahydrocannabinol), buprenorphine, tramadol, oxazepan, codeine, mephedrone, MDMA - 3,4-methylen-dioxy-N-metyl-amphetamine (ecstasy) MDA (3,4-methylenedioxyamphetamine) MDEA (3,4-methylebedioxy-N-etthylamphetamine) MBDB (N-methyl-1-(1,3-benzodioxol-5-yl)-2-butamine), methylphenidate (MPH), risperidone, midazolam (INN), methadone (synthetic opioid) heroin (diacetylmorphine).

²⁷ Sewage treatment plant in Zvolen is also collecting wastewater from the nearby spa resort Kováčová, the location of the National Rehabilitation Centre.

²⁸ In Trenčín, music festival “Pohoda” is organised every year

²⁹ Piešťany is the place of Slovakia’s largest spa resort for the treatment of locomotive system diseases, with a high number of foreign clients as well as tourists. It is also the venue of the “Lodenica” music festival which is held every year.

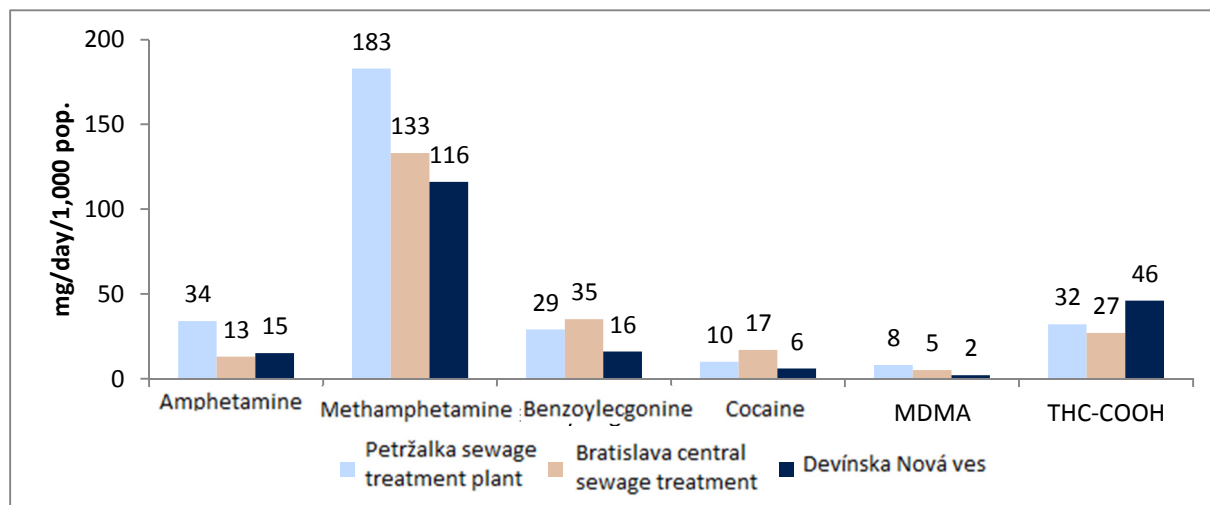
The report, including tables and charts, is published in the final report available on the information web portal www.infodrogy.sk; the study was also published in a specialised periodical "Science of the Total Environment" under the title 'National study of illicit drug use in Slovakia based on wastewater analysis'³⁰.

For this part of the chapter, the following key data are provided for Bratislava – the capital city of Slovakia, where the pilot survey was carried out already in February 2013 (Chapter 2 – Report 2013).

Based on the collected data and comparison with data from other locations, the highest occurrence in wastewater of Bratislava was measured in the case of methamphetamine metabolites (Figure 2.3), followed by THC-COOH, amphetamines and cocaine. The quantity of drugs in Bratislava and Petržalka significantly differs from other Slovak cities. The highest use of cocaine per 1000 population was measured in Bratislava (95 mg/1000 pop/day) and Petržalka (78 mg/1000 pop/day).

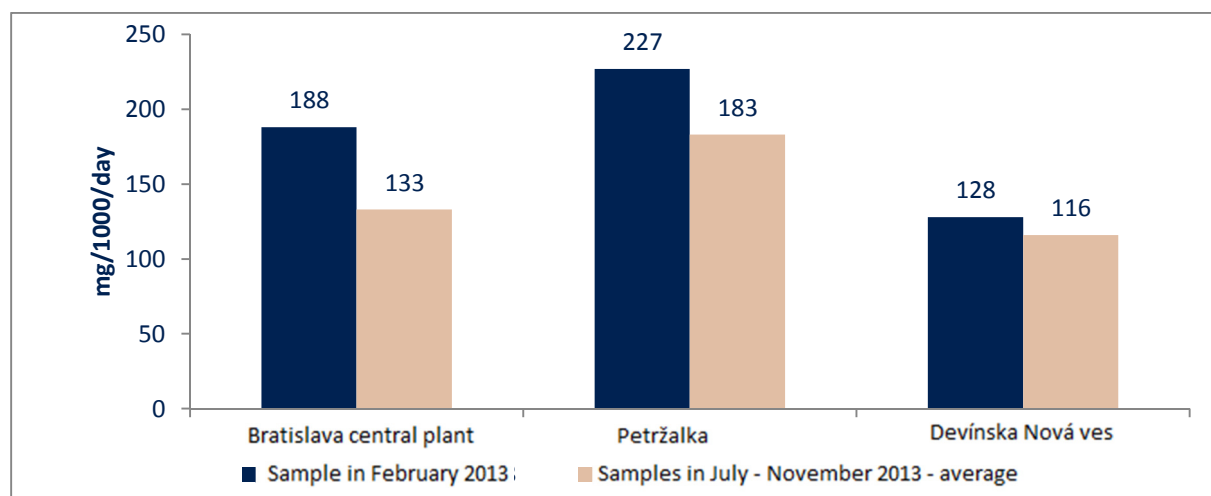
The highest quantities of methadone were measured in Bratislava, Petržalka and Devínska Nová Ves. This may be attributed to the number of addicted people in treatment (majority of them are undergoing treatment in the Bratislava region – in 2013, there were 92.3 patients per 100,000 population).

Figure 2.3: Measured data, converted to mg/day/1000 pop. (Source of data :Mackuľák T. et al.,2014)



³⁰ Mackuľák T., Škubák J., Grabic R., Ryba J., Birošová L., Fedorova G., Špalková V., Bodík I.: *National study of illicit drug use in Slovakia based on wastewater analysis* a Science of the Total Environment 494–495 (2014) 158–165, www.elsevier.com/locate/scitotenv

Figure 2.4: Comparison of average values from individual sewage treatment plants in Bratislava (June – November 2013) with a single sample taken as part of the pilot project in February 2013. Concentrations of the metabolites of methamphetamine (Source of data: the 2013 Report and Mackulák T. et al., 2014)



According to this study, the highest concentration identified (of the 26 analysed substances) in wastewater in locations subject to analysis was that of tramadol in the range between 225 and 1560 ng/l. (Other data taken over from the study are provided in Chapter 10 Drug market).

2.3. Drug use at schools and among adolescents

2.3.1 The 5th Flash Eurobarometer 401

“Young people and drugs” was carried at the request of the European Commission, Directorate General for Justice, and was coordinated by Directorate General for Communication. The survey was carried out on a sample of 13,128 respondents aged 15–24 in all 28 Member States of the EU in the course of June 2014 and served as a representative sample for the ‘young Europeans’ group.

Slovak respondents (N=500) participated in this European survey for the third time³¹. Data was collected by calling the respondents both on fixed lines and mobile phones.

The following information was processed³² with an emphasis on comparing the data of Slovak respondents with the EU average, in particular as regards new psychoactive substances, the perceived ease of access to drugs, experimentation with NPS, health risks, level of regulation (bans) and measures to be taken in tackling the problems with drugs.

³¹Young people and drugs 2008, <http://www.infodrogy.sk/index.cfm?module=Library&page=Document&DocumentID=642>; Youth attitudes on drugs 2011, http://www.infodrogy.sk/index.cfm?module=activeweb&page=WebPage&s=flash_eurobarometer

³² Kastelová E. Young people and drugs, <http://www.infodrogy.sk/index.cfm?module=Library&page=Document&DocumentID=1112>, 28.8.2014

2.3.1.1. Access to and use of illicit drugs and substances that imitate the effects of illicit drugs

A significant majority of Slovak respondents (90%, as compared to 92% in the EU) have never used any new psychoactive substance (NPS) imitating the effects of an illicit drug. 6% of Slovak respondents have tried NPS, 3% (same for both the European and Slovak respondents) have used them within the past 12 months, and 1% tried them in the last 30 days.

Of the total number of 30 Slovak respondents who have tried the NPS, 22 obtained/bought them from a friend, 20 have used NPS with friends and 36% (11) said they were offered these substances during a party. Only 3% (but none of the young Slovak interviewees) have bought the substances on the Internet.

Almost ¼ (23%) of respondents in Slovakia find it easy to obtain NPS within 24 hours. To allow comparison, this figure is only 11% in the Czech Republic, but as many as 37% in the United Kingdom.

Cannabis use - 14% of EU respondents aged 15-24 have used cannabis (life time prevalence/LTP), 17% of respondents in Slovakia admitted to have used it. Table 2.2 shows the data on the prevalence of cannabis use.

Table 2.2: Cannabis use in the EU, Slovakia and several Member States (Source: Eurobarometer Flash 401 – data, 2014)

%	EU	SK	Czech Republic	Slovenia	Ireland
LTP (life time prevalence)	14	17	25	15	14
LYP (last year prevalence)	10	11	15	12	12
LMP (last month prevalence)	7	4	5	13	16

2.3.1.2. Banning or regulating the illicit drugs and NPS imitating the effects of illicit drugs

Almost all respondents said that heroin, cocaine and ecstasy should be banned (or continue to be banned); however, just over half say the same about cannabis.

Slovak respondents are on par with the EU average (35%) as regards banning NPS under any circumstances and almost a half of respondents in Slovakia (49%, as compared to 47% in the EU) think they should only be banned if they pose a health risk. To allow comparison, 63% of young respondents in Lithuania agree with the view that they should be banned under any circumstances.

2.3.1.3. Becoming better informed about illicit drugs and adverse consequences

According to 59% of respondents in EU and 75% of respondents in Slovakia, the Internet is the most widely used source of information about illicit drugs. Friends were mentioned

as the source of information by 36% of respondents in the EU and 35% of respondents in Slovakia. Telephone helpline is the least used source of information (EU: 4%, SK: 3%).

The Internet is also the most-mentioned source of information about the effects and risks of drugs (EU: 37%, SK: 45%). School prevention programmes follow with 32% (EU: 32%), media campaigns 30% (EU: 33%) and friends 20% (EU: 21%). Even in this case, telephone helpline was the least used source of information. In general, however, the position of media campaigns and school prevention programmes has worsened since 2011 (by 12 or, respectively, 9 percentage points).

2.3.1.4. Perceived health risks of using drugs

In this survey, the respondents answered a set of questions as to how much of a health risk would be associated with a given frequency of use, while estimating the health risk levels on a scale from “no risk” to “high risk”. The risks of using drugs once or twice, or the risks of their regular use, have been estimated with respect to cannabis, ecstasy, alcohol, cocaine and new psychoactive substances. Respondents in Slovakia consider that, as regards regular use, there may be the highest risk in using cocaine (94%), ecstasy (90%) and new psychoactive substances (84%) (Table 2.3). On the other hand, “the least risky” of the above list of substances when used regularly is cannabis (55%) and alcohol (66%).

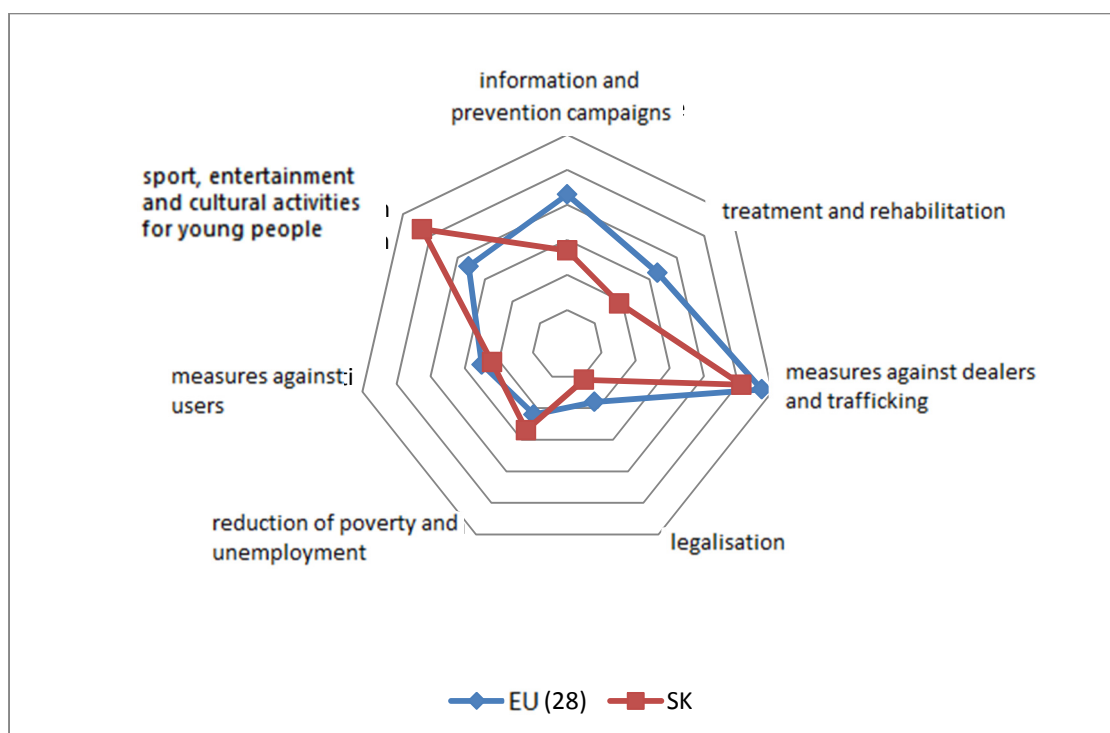
Table 2.3 To what extent do you think the regular use of new psychoactive substances may pose a risk to a person's health? Comparison between EU data (average), Slovakia and several other Member States

%	EU	SK	Portugal	Malta	Netherlands	Czech Republic	United Kingdom
high risk	87	84	92	81	88	84	80
low risk	1	1	1	4	4	2	2
no risk	0	1	0	0	0	0	0

2.3.1.5. How should society’s drug problems be tackled?

53% of young respondents in Slovakia think that more sport, entertainment and cultural activities should be offered, whereas 51% said there should be tough measures against drug dealers. The same proportion of respondents would prefer information and prevention campaigns and 27% think that poverty and unemployment should be reduced (27%). As regards measures against drug dealers and traffickers, the proportion of respondents in Slovakia was the same as the EU average.

Figure 2.5: What do you think would be the three most effective ways for public authorities to reduce drugs problems?" – a comparison between Slovak respondents and the EU average



2.4. Use of psychoactive substances in specific group/settings

2.4.1 Survey on drug use among university students in Slovakia³³

Institution responsible for survey coordination: Vysoká škola zdravotníctva a sociálnej práce sv. Alžbety (St. Elizabeth University of Health and Social Sciences), Department of Psychology

Cooperating institutions: Public Health Authority of the Slovak Republic, Institute of Information and Prognoses in Education, National Monitoring Centre for Drugs at the Ministry of Health.

There were three representative surveys carried out in 1999³⁴, 2008³⁵ and 2013³⁶ on the use of licit and illicit drugs among university students in Slovakia as a follow up to

³³ Nociar, A.(2014): Survey on drugs among university students in Slovakia. Final report. Bratislava, St. Elizabeth University of Health and Social Sciences 2014.

³⁴ The survey based on the ESPAD method was conducted in December 1999 with the participation of 1,602 university students (men: 44.3%, women: 55.7%) from 17 faculties.

³⁵ The survey based on the ESPAD method was conducted in December 2008 with the participation of 1,874 university students (men: 39.4%, women: 60.6%)

³⁶ The survey based on the ESPAD method was conducted in November and December 2013 with the participation of 1,065 university students (men: 34.5%, women: 65.5%) from 30 faculties. The lower number reflected the tendency of respondents and institutions to reject participation in drug surveys, as well as any surveys in general.

previous surveys carried out at elementary and secondary schools³⁷. They were aimed at mapping the use of alcohol, tobacco and illicit drugs among students of all types of universities in the entire territory of the Slovak Republic. In addition, questionnaires also contained questions focusing on retrospective self-estimate (students were asked to estimate their use of licit and illicit drugs four years ago). In order to supplement the core questions, all versions of the questionnaires used in ESPAD 1999, 2008 and 2013 also contained questions for surveying (estimating) the level of tolerance towards alcohol and nicotine dependence; the 2008 and 2013 versions included the Alcohol Dependence Scale (ADS) and CAGE³⁸ screening. The Cannabis Abuse Screening Test (CAST) represented another scale for estimating problem use of cannabis (Results in Table 2.4).

Table 2.4: Results of the study in university student - life time prevalence (%) for primary substances – experience of drug use, tried once or twice in life (Source of data: Nociar, A., 2014, ST 30)

	Men %	Women %	Total %	Order
Any illicit drug (including cannabis)	62.2	45.7	51.5	
- (excluding cannabis)	15.2	9.2	11.3	
Cannabis (total)	62.2	44.6	50.8	1
Opioids (total)	1.1	0.4	0.7	12
Cocaine (total, including crack)	3.0	2.6	2.8	9
Amphetamines (total)	8.6	5.7	6.7	3
Ecstasy (total)	11.2	5.8	7.7	2
Hallucinogens (total)	9.3	3.2	5.3	6
Sedatives or tranquilizers (total)	2.5	7.4	5.7	5
Inhalants / volatile substances (total)	9.0	4.9	6.4	4
Methamphetamine	5.9	3.2	4.1	7
Hallucinogenic mushrooms	9.0	4.5	5.3	6
Synthetic cathinones (mephedrone/ MDPV/ other)	0.8	0.3	0.5	13
Synthetic cannabinoids (Spice / other)	6.1	1.1	2.9	8
GHB / GBL / 1,4-BD	0.5	0.9	0.8	11
Anabolic steroids	4.4	0.3	1.8	10
Sample size	370	695	1065	

³⁷ TAD surveys since 1994 and ESPAD since 1995 – National Health Promotion Centre in cooperation with the Institute of Health Education and the network of State Health Institutes. The coordinator of all waves of surveys –TAD (six cycles), ESPAD (five cycles) and university students (three cycles) – is doc. PhDr.Alojz Nociar, CSC-

³⁸ An internationally proven method for the screening of alcohol problems [CAGE](#) is an acronym of four keywords in four questions: Cut down; Annoyed; Guilty; Eye opener.

The third report on drug use among university students is based on a survey with fieldwork carried out between November and December 2013. A total of 1,800 questionnaires have been distributed - of which 1,065 questionnaires (men: 370, or 34.5 %, women: 65.5%) from 30 faculties were processed in the end. The average age of university students was 21.6 years (respondents aged 19-25). The population consisted of 135,736 students of Slovak universities in 2013 (men: 57,966, women: 77,770).

Table 2.5: Co-consumption of certain psychoactive substances over the last 12 months (last year prevalence /LYP) and in the last 30 days (last month prevalence/LMP) (Source of data: Nociar,A.,2014,ST 30)

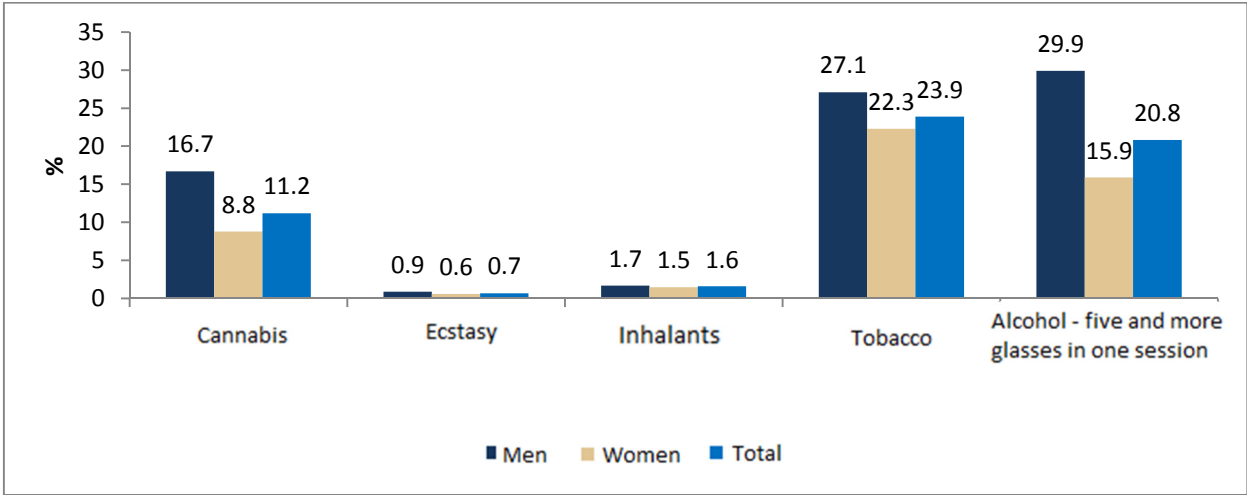
LYP (used in the last year/12 months) %	M	F	Total	LMP (used in the last month/30 days)	M	F	Total
Cannabis (total)	37.7	21.1	27.1	Cannabis (total)	16.7	8.2	11.2
Ecstasy (total)	6.4	1.5	3.2	Ecstasy (total)	0.9	0.6	0.7
Inhalants / volatile substances (total)	2.2	1.8	2	Inhalants / volatile substances (total)	1.7	1.5	1.6
				Tobacco	27.1	22.3	23.9

As a part of surveying the prevalence of the use of psychoactive substances as shown in tables 5 and 6, cannabis is by far the most common substance in the entire set (LTP 50.8, LYP 27.1 and LMP 11.2), with men prevailing.

However, based on this survey among university students, the highest values in terms of co-consumption were seen in the case of licit psychoactive substances, i.e., tobacco use and binge drinking (Figure 2.6).

In the population of university students in 2014, the collected data suggest life time prevalence in the drinking of alcohol at 99.2% for men and 97.9% for women. The decisive portion of the sample – 85.0% of young men and 82.9% of young women – used alcohol in the last month (LMP), and most of this number did so in the last 7 days (both 57.7%), part of them reported drinking alcohol last year (9.7%) and a very negligible number of respondents (2.2%) said the last time they drank alcohol was more than one year ago. Based on data collected using the ADS scale, the highest increase in 2013 in the item “signs of severe dependence” was reported in the case of 2.8% of male students – which is seven times higher than in 2008.

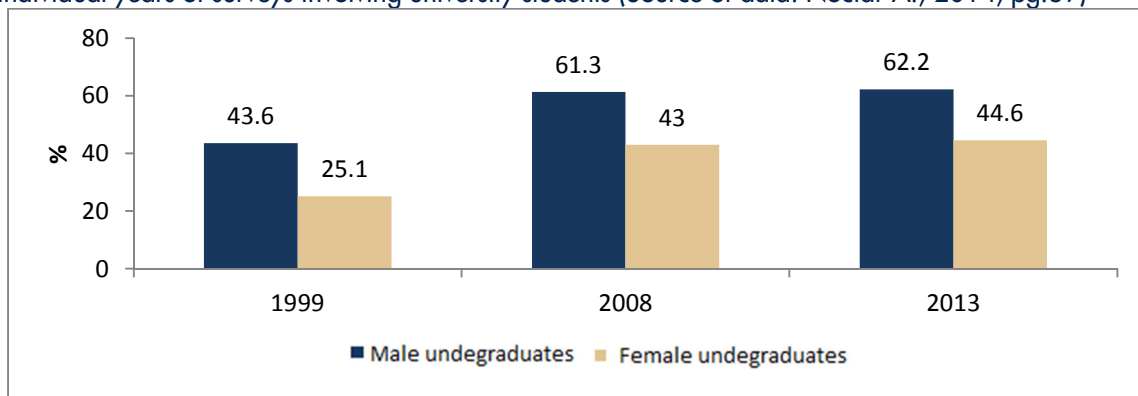
Figure 2.6: Co-consumption “triple combination” – cannabis, tobacco and binge drinking (Source of data: Nociar,A.,2014,ST 30)



In addition to the frequency of drinking and the so-called binge drinking, the risk of drinking and possible adverse consequences can be indicated by the absolute alcohol volume (beer, wine, spirits) converted to grams. The ESPAD questionnaire allows for such estimate based on the above types of alcohol also in their combination, or by gender. In 2013, in the case of male undergraduates, this accounted for 95.8 grams, which means an equivalent of six beers, more than one litre of wine or 3 dl of spirits; for female undergraduates, the average value was 68.6 grams which means an equivalent of 4.3 beers, more than 7 dl of wine or some 2.1 dl of spirits consumed alongside other beverages. According to WHO, the risky drinking threshold for women and men is at 20 and, respectively, 40 grams of alcohol per day, whereas harmful drinking threshold is at 40 grams (women) and 60 grams (men).

Following an analysis of all waves of surveys carried out at secondary schools and universities, Nociar noted that the data sorted by age indicate an increase in the consumption of all types of drugs in the age category of 15 to 19 years, with the highest increase reported in cannabis (surveys TAD 2, ESPAD). With increasing age, life time prevalence of cannabis use for age group of 20 years and more has stabilised at some 33% (survey involving university students in 1999), or at some 50% (surveys involving university students in the years 2008 and 2013). Every other university student has tried cannabis once in his/her life, one quarter of university students have used it in the last 12 months and every tenth student used it in the last 30 days. However, consumption increasing with age is not characteristic of the population of university students, as is typical of secondary school students.

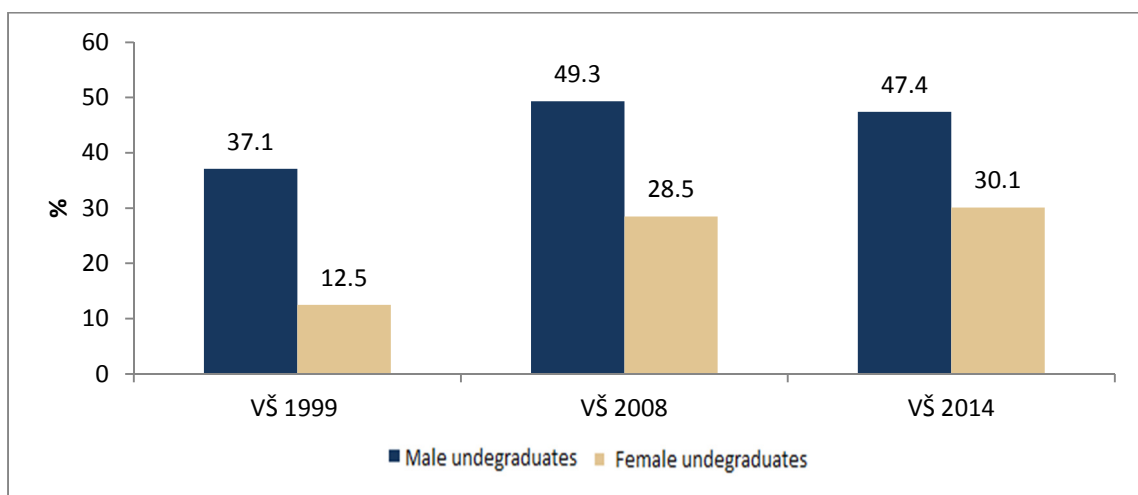
Figure 2.7: Life time prevalence of the use of cannabis among male and female undergraduates in the individual years of surveys involving university students (Source of data: Nociar A., 2014, pg.39)



The risk levels in the use of cannabis over the last 12 months in the CAST screening – high risk based on the CAST scale dropped from 13.9% in 2013 to 3% and medium risk to 11.3% (from 13.5%).

The increase in the use of licit and illicit drugs was steady, albeit not too steep. Alcohol and tobacco use is on the rise, as confirmed by school surveys particularly in the case of young girls aged 14 – 15 to 18 – 19 and, partially, female undergraduates. The trends seen among undergraduates until 2008 were as follows – prevalence of regular smoking was either stagnating or declining with increasing age and the prevalence of excessive drinking was not higher than that seen among secondary school students. An increase in drug use continued to be noticeable, even though this was rather the case with life time prevalence (has experimented with or has tried it once or twice in life).

Figure 2.8: Comparison by gender: five and more doses of alcohol in a row and on 3-5 and more occasions in the last 30 days (Source of data Nociar, 2014 pg.35)



The 2013 survey among university students revealed a similar effect of certain “saturation” with drugs among the population and the experimentation with drugs has slowed down or stopped, or was on a slight decline. As far as licit drugs are concerned

(tobacco and alcohol), the slight decline has continued after 2008, in particular in the case of young women.

The use of both licit and illicit drugs among secondary school students and undergraduates has reached an unacceptably high level around which it will most likely be hovering in the future. (Nociar 2014, pg.50)

2.4.2 Use of new psychoactive substances in specific groups

This is the fourth time that the NMCD has used the Internet website www.rastamama.sk for online surveys; and the current one was the third survey on the use of new psychoactive substances. This internet website is more or less “drug friendly” and is visited, inter alia, also by drug users.

The questionnaire contained nine questions and basic information consisting of gender, age category and the district of residence. It was published on the website for approximately eight weeks between August and September 2014. There were 258 visitors participating the questionnaire – and four incorrect answers were disregarded after a preliminary check. The number of participants in the survey was, therefore, N=254, of which 209 were men and 45 women.

Most respondents (109) stated their age was between 19 and 24 years; after adding 17 respondents aged 15-18, there were 49.6% of respondents aged 15-24. (in 2013, the proportion of this age group was 51.30%.)

90% of respondents (N=254) gave a positive answer to the first question as to whether they had heard about products which have similar effects as illicit drugs (82.20% of respondents in the NMCD 2013 survey).

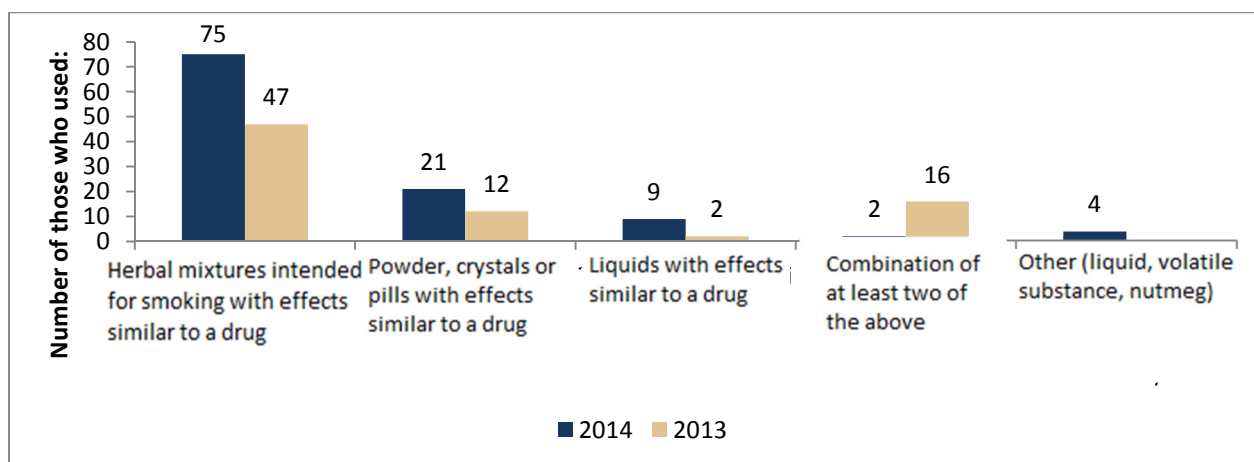
145 of respondents said they had tried such drug, or that they were not sure whether such drug was a new psychoactive substance (in 19 cases). Of this number, 67 reported having used NPS during the last 12 months – seven of them were not sure whether it was a new psychoactive substance.

Table 2.6: Use of a new psychoactive substance once or twice in life and over the last 12 months (NMCD 2014c)

	LTP (once or twice)	LYP (last 12 months)
Has used a new psychoactive substance	126	60
Not sure whether it was a new psychoactive substance	19	7
Total	145	67
% z N = 254	57.08. or 49.60	26.37 / 23.62
% z N = 191 (2013)	50.26	20.94%

111 respondents specified the form of NPS which they had tried. Even in 2014, the number of respondents (75) consuming herbal mixtures with effects similar to those of drugs prevailed significantly and, in comparison with 2013, there was a slight increase in the share of this type of NPS (from 61% to 67%) – Table 2.6, Figure 2.9.

Figure 2.9: The prevalence of herbal mixtures intended for smoking with effects similar to a drug – comparison of the forms of NPS in 2013 and 2014 / numbers of respondents specifying the individual forms of NPS (N=111) (NMCD 2014c)



2.4.2.1. Source of new psychoactive substances

According to the 2013 survey, respondents obtained these substances either in specialised shops³⁹ (N=83, 32.53%), or they obtained/bought the new psychoactive substance from a friend. (26=31%).

In 2014, according to the data collected in the survey (N=96 respondents), the difference between these two sources of NPS shifted towards “obtained/bought from a friend” and the proportion of “offered/sold by friend” represents two fifths. Almost 17% represent a combination of three or four sources referred to above. (Table 2.7)

Table 2.7: Stated sources of NPS in the NMCD survey in 2013 and in 2014

Respondents	2013		2014		Trend
	N=83		N=96		
NPS sources	Number of respondents	%	Number of respondents	%	
Obtained/bought NPS from a friend	26	31.33	38	39.58	rising
On the Internet	12	14.45	8	8.33	↓
In a specialised shop	27	32.53	22	22.9	↓
From a dealer	5	6.00	7	7.29	rising↑
A combination of 3-4 sources above	n.a.	-	16	16.66	
From other sources (including cultivation)	7	8.43	5	5.20	↓
Source unspecified	6	7.22	-	-	-

³⁹ The options concerning the source of NPS were defined as part of fixed question of the new EMQ module.

2.4.2.2. Reasons for using NPS

The survey contained a new question about the motives behind using new psychoactive substance. The question was inspired by a new online survey⁴⁰ carried out by the Centre for Drug Research in Frankfurt am Main that was presented in June 2014 at a meeting of EWS coordinators in Lisbon. The original options as possible answers to questions (motives) were supplemented, in the online survey conducted by the NMCD, with the motive "recreational use" formulated as "Parties and opportunity (holiday and weekend parties, summer music festivals)". The question was answered by 129 respondents in the survey.

Of all motives offered, the following answers prevailed:

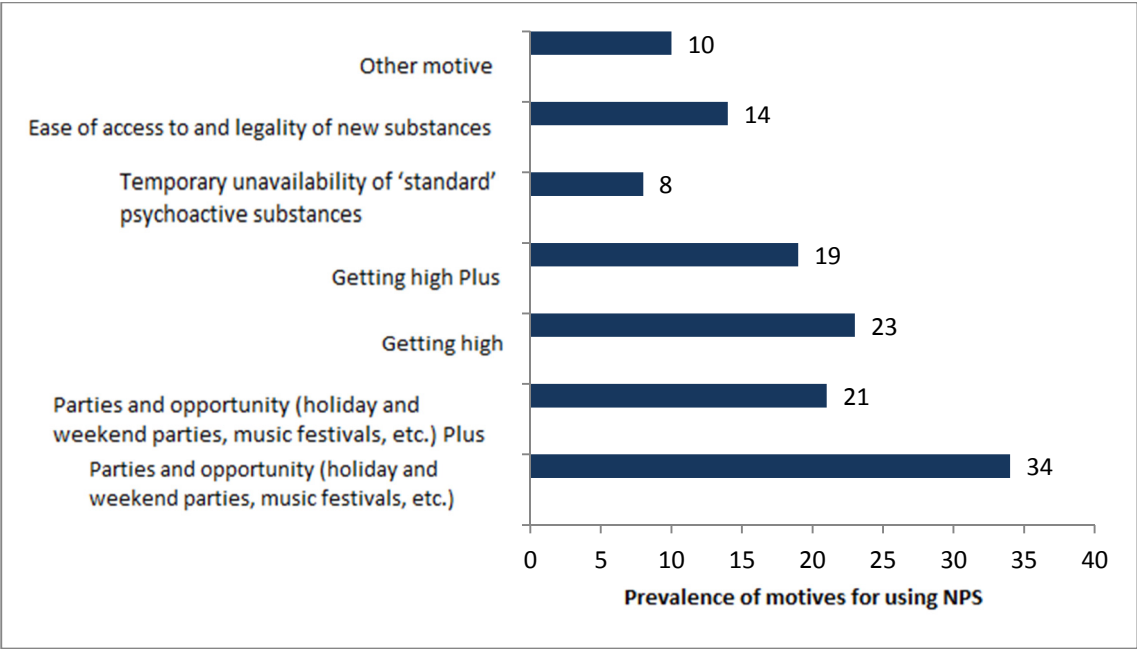
Parties and opportunity (holiday and weekend parties, music festivals) were stated as the only motive by 34 respondents, and an additional 21 respondents specified this motive as the first motive in combination with one or more motives from the given options. In total, this motive was indicated by 55 respondents (37.9% out of N=145/respondents who have used NPS).

"Getting high" – This was presented as the only motive by 23 respondents, and an additional 19 respondents specified this motive as the first motive in combination with other motives. In total, this motive was stated by 42 respondents (28.9% out of N=145/respondents who have used NPS).

The motives encompassing 'ease of access to and legality of new drugs' (14) and temporary unavailability of 'standard' (illicit) psychoactive substances (8) as the key and (the only) motive for experimentation with new psychoactive substances are less decisive. Both motives are occurring in combination with the 'parties and opportunity' and 'getting high' motives which are marked with "Plus" (Figure 2.10)

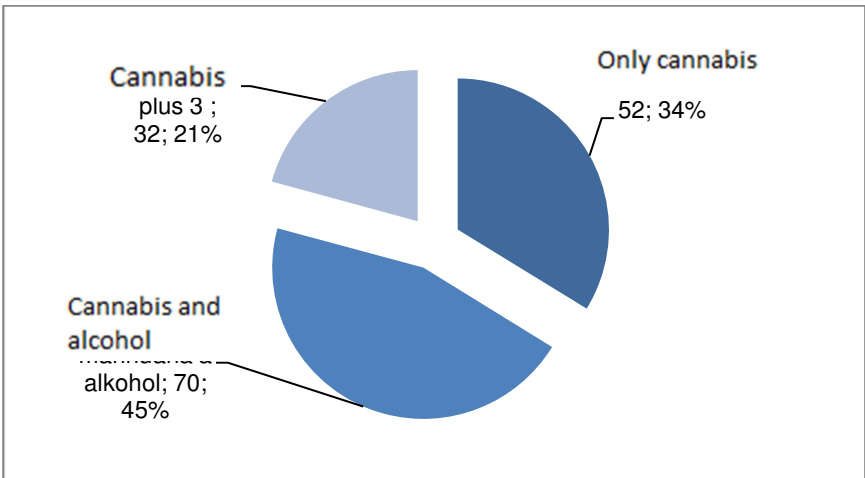
⁴⁰ Dr. Bernd Wersé & Dr. Cornelia Morgenstern: Risk behaviour, changes in patterns of NPS use and consumers' motivation in Germany, Centre for Drug Research Report – June 2014: -Goethe University Frankfurt, Germany within the project - SPICE II Plus, as part of the call "Drug prevention and information" – researchers from Germany, Switzerland, Austria and Finland.

Figure 2.10: Motives for the use of new psychoactive substances as stated by respondents participating in the NMCD 2014c online survey



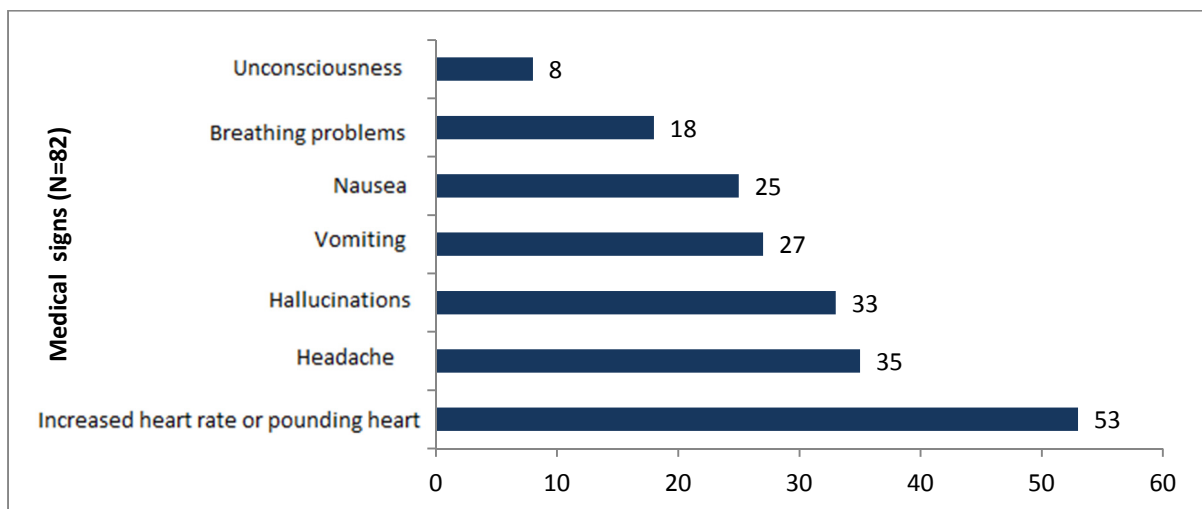
In the online survey, question No. 6 in the wording “Are you taking/consuming any of these standard substances more or less regularly?” (with the following available options: alcohol, cannabis, ecstasy, pervitin, sleeping pills/tranquilizers, other substances) was answered by 162 respondents – 63.77% of the total population (N=254). Cannabis was indicated by 154 respondents (60.6%), either as the only psychoactive substance – 52 respondents (33.7%), or in combination with alcohol – 70 respondents (45%), or with other substances (ecstasy – 15x, tranquilizers/sleeping pills 11x, pervitin 7x, mushrooms/magic mushrooms 3x, cocaine 3x, LSD 1x).

Figure 2.11: The leading position of cannabis as primary drug used more or less regularly by the respondents participating in the online survey N=154 NMCD 2014c



The online survey by NMCD 2014 also contained a new question aimed at surveying "adverse medical signs/symptoms" experienced by respondents after taking NPS, and an additional question about seeking medical assistance, either by the respondents themselves or by any of their friends. The question was answered by 94 respondents, 82 of whom indicated at least one or more of such adverse medical signs, with increased heart rate or pounding heart reported as the most frequent problems. Twelve respondents did not report any problems.

Figure 2.12: Prevalence of medical signs after taking NPS (N=94), 84 respondents reported at least one of the indicated symptoms (NMCD 2014c)



In addition to these symptoms, the respondents also reported to have experienced kidney pain, paralysis, psychotic episode and short-term (10-minute long) loss of hearing in single cases. Of 82 respondents, seven said they had to seek medical assistance. The symptoms reported by respondents were as follows: nausea (1x), vomiting (3x), increased heart rate and pounding heart (6 cases), headache (5 cases), unconsciousness (2 cases). In all cases (7), the respondents were men, four of whom were aged 19-24, three were aged 25-34. All of them have taken NPS – in five cases, the respondents used herbal mixtures (Puff, Diablo, Spice, Diviner’s Sage, ‘some seed’), and, in two cases, substances in liquid form and powder/pills (speedball). Six of them use cannabis, alcohol and tranquilizers more or less regularly, one respondent did not report primary drugs. In four cases, the use of NPS was motivated by temporary unavailability of standard drugs.

16 respondents said that medical assistance was called to help one of their friends (who used NPS).

2.4.2.3. Views on NPS

During assessment, answers to the question "What do you think about these products" were broken down between positive/accepting views and negative/rejecting views which, however, were associated with the rejecting stance towards synthetic NPS. This broad question was answered by 151 respondents, and 147 views were included in the final assessment.

Of this number (N=147), 111 (75.51%) respondents have in principle rejected new psychoactive substances – more specifically, new synthetic psychoactive substances – including medicinal products, and rather supported natural products, decriminalisation and legalisation of "soft" drugs, in particular those of natural origin, and pointed to hazards associated with the use of synthetic substances, the composition and effects of which have not yet been thoroughly explored. Majority of views of this type were presented in a sophisticated and qualified manner.

On the other hand, the opinions of respondents accepting NPS (29 – 19.72%) were brief and emotionally coloured (it's great, no sweat ..., allowing to relax and escape from this system, there is not enough of them, great stuff, not bad, should be used with caution, better than alcohol- original statements).

The proportion was similar to that seen in the last year's survey when only one fifth (20.5%) out of NLTP =83 were satisfied with such substances and, on the other hand, 52 respondents (63%) did not see anything special about them and rejected "chemicalisation", while preferring natural origin and legalisation/decriminalisation of naturally occurring substances with psychoactive effects.

2.4.3 Prevalence of selected psychoactive medicines in wastewater during two selected music festivals (recreational settings)

To supplement information and data on drug use in specific groups/settings, this section contains data from a study containing wastewater analysis (chapter 2.2.2) during two major music festivals in Slovakia.

Pohoda is a multi-cultural music festival held in the vicinity of the Trenín city with an estimated number of visitors reaching 30,000, thus making it the biggest music festival in Slovakia. During the festival, wastewater is collected in the sewage treatment plant in Trenín (left bank of the Váh River), or in special reservoirs. It is presumed that, within 24 hours, approximately one half of wastewater produced reaches the sewage treatment plant in Trenín (right bank of the Váh River). There was an increase in the consumption of cocaine during the Pohoda festival – with measured values reaching 5-28 mg/1000 pop/day); in addition, there was an increase in the amount of the MDMA drug (5-28 mg/1000 pop/day).

Lodenica⁴¹ is the largest Slovak festival of folk and country music which is held at the end of the summer near Piešťany. In 2013, the attendance was estimated at approximately 10,000 visitors. During the festival, sewage produced by some 50% of participants is drained off to the sewerage system of the sewage treatment plant in Piešťany. In comparison with regular (monitored) days, there was a slight increase in cocaine (5 - 32 mg/1000 pop/day), amphetamines (17-22 mg/1000 pop/day) and methamphetamine, as well as codeine.

⁴¹ <http://www.lodenica.sk>

No increase in the amount of THC-COOH metabolite in wastewater during both festivals (Lodenica THC-COOH 19 - 23 mg/1000 pop/day and Pohoda - 13 mg/1000 pop/day) has been identified.

Table 2.8: Metabolites of several psychoactive substances in wastewater during two recreational events. Source of data: Mackulák et al.2014

Mg/day/1000 pop	Amphet-amine	Meth-amphet-amine	Benzoyl-ecgonine	Cocaine	MDMA	THC-COOH
Trenčín (left river bank) regular day	7	54	1	1	2	21
Average – including the festival	6	48	3	2	7	14
POHODA	5	38	4	3	5	13
POHODA	6	51	10	5	28	13
Piešťany – regular day	16	126	3	3	4	32
Average – including the festival	18	152	6	3	4	25
LODENICA	17	152	2	3	4	19
LODENICA	22	179	12	3	3	23

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 co-operation 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.

Data and information in this chapter is updated for 2013, particularly with regard to the quantitative data from the sources of the Ministry of Education (former Institute of Information and Prognosis of Education⁴², 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.

Quite limiting factor is the lack of comprehensive information on prevention activities/programmes undertaken by non-governmental entities, which are not obliged to provide information to NFP. When found (on web and/or in media outputs) due the rules of donors the information priority is put more on their promotion and/or finances. Detailed content, goals of programs, their evaluation and efficiency are missing.

The evaluation of the preventive interventions and efficiency of programmes, i.e. what and if it works at all, which should be an integral part and sine qua non, is rare in public grant systems too. As in many other countries, this is particularly true at the level of universal prevention. This may be a result of various sectorial priorities, as well as the continued absence of prevention standards and a single framework.

Lack of mutual awareness of subjects participating in prevention, different interpretation of concepts and terminology are other causes affecting the quality of prevention moving it to isolated activities.

3.2. Environmental Prevention

Previous reports submitted by the National Monitoring Centre for Drugs (NMCD) have already contained (Chapter 1 or Chapter 3, respectively) 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. In accordance with EMCDDA definition of the term “environmental prevention” this type of prevention is to

⁴² Since January 1 st , 2013 is IIPE a part of Scientific and Technical Information Centre

cover 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.

Existing and/or considered environmental measures in the Slovak Republic with respect to alcohol drinking and smoking are formulated in the – at least - two governmental documents:

3.2.1 The National Action Plan on Tobacco Control (under the jurisdiction of the Ministry of Health)

Legislative background: The Act No 377/2004 of Coll. on the non-smokers protection as amended. Last year novel (Act 142/2013 of Coll.) reduced the smokers 'places again by the ban of smoking in open bars/café in shopping malls.

The Ministry of Education 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 Schools⁴³, specific projects aimed at preventing smoking will be supported. Through Pedagogical and Organisational Instructions, recommendations for the area of smoking prevention for each school year are issued.

For adults „anti –tobacco“ activities are provided by Regional offices of Public Health – as well as counselling in special advisory services - related to the World "No Tobacco Day - 31 May; popular exchanges of cigarettes for fruit, and the organisation of the Quit and Win competition. The European campaign "Ex-smokers are unstoppable" and its promotion in Slovakia started already in 2011. The most active NGO "Stop fajčenie" (Stop smoking) has publicised contact on "i-couch"⁴⁴.

The ban of tobacco sale for minors is inspected regularly by Slovak Trade Inspection. Since 2008 the number/share of banned sale of tobacco products to children dropped from 64% to 42% in 2013 (SK Ministry of Economy, 2014)

3.2.2 The National Action Plan on the problems with alcohol use for 2013-2020

Legislative background: The Act No 219/1996 as amended on Alcohol Misuse Protection and on Sobriety Facilities as amended. In 2013 the novel – Act No.88/2013 – empowered municipalities to ban consumption and sale of alcohol in some public places.

The program is in the jurisdiction of the Ministry of Health of the Slovak Republic and its latest version⁴⁵ emphasises, among other things, the importance of the measures regulating the products themselves, regulating of their sale and distribution (incl. ads and sponsorship of attractive events). Latest discussion of Working Group for NAPPA were concentrated on alcohol warning labels at the bottles and regulated localisation of

⁴³ The Ministry of Education, Science, Research and Sport of the Slovak Republic.

⁴⁴ <http://www.exsmokers.eu/dayoftheexsmokers>

⁴⁵ National Action Plan on the problems with alcohol use for 2013-2020, MH SR and WHO Country Office in the Slovak republic, Bratislava 2013

outdoor advertisements (city lights, big boards) promoting alcohol and easy accessible and visible for children and youths.

Environmental measures for the prevention of alcohol and tobacco as risk factors raised from other strategic documents also, such as the National Health Promotion Program, the Youth Action Plan, resulting from the Action Plans of the State Policy towards Children and Youth in the Slovak Republic for the years 2008-2013. 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).

Finally the important environmental measure regarding new psychoactive substances has to be mentioned – through the novel of the Act No 139/1998 of Coll. on narcotic substances, psychoactive substances and preparations (in force since April 1, 2013) the intersection of listed⁴⁶ hazardous NPS on the market was eliminated.

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” (definition of universal prevention in Reports 2008 - 2011).

In the education sector, the schools themselves⁴⁷ are the institutions active in the area of prevention supported by 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”). To support pedagogues in implementing and drafting of right prevention programs and/or best practices for whole scale of social pathology and risk behaviour signs there is a special interactive web portal www.bezpre.sk. The European Standards of Quality Drug Prevention and PERK reference book (translated into Slovak language) were publicised there also.

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 Educational and Psychological Counselling and Prevention Centres. (71 state EPCPCs and 12 off-shores and 12 private centres with 415 psychologists, 251 special pedagogues and other professionals).

⁴⁶ First list of 11 hazardous NPS was released by MH SR in October 2013

⁴⁷ Through Prevention coordinators set in each school

3.3.2 Selected Programmes, Projects and Activities in 2013

In the school year 2012/2013, EPCPCs implemented a total of 1,240 (1108 in 2012 and 894 in 2011) prevention programmes. Compared to previous years there is a constant increase in numbers of programmes. The highest number of programmes was aimed – as usually - to the group of “elementary school pupils” – 789 programs/63, 63% (595 /61% in previous year), pupils of high schools were addressed by app. one fifth of programs. In the school year 2012/2013, EPCPCs carried out also preventive activities, of which group activities accounted for the highest proportion. Most were lectures and discussions.

Table 3.1: Schools Preventive Programs in 2012/2013 (Slovíková, 2014)

Numbers of programs		Total	Prevention program aimed on					Share of programmes according coverage, target groups and duration	
			Pre-school children	Pupils in elementary schools	Peers	Risk groups	Pupils in high schools		Lectures, discussions
%		100	12,26	53,31	3,47	8,06	19,03	3,87	
Total		1 240	152	661	43	100	236	48	1 240
Coverage	Local (schools)	678	91	347	20	27	174	19	54,68
	Regional / multiregional	540	54	306	21	69	61	29	43,55
	National	18	7	7	2	1	1	0	1,45
	Cross borders / international	4	0	1	0	3	0	0	0,32
Target groups/level	Pre-school children	152	152	0	0	0	0	0	12,26
	Pupils in elementary schools	789	0	645	29	80	0	35	63,63
	Pupils in high schools of different type	271	0	0	14	20	236	1	21,85
	Health – damaged / handicapped pupils	11	0	5	0	0	0	6	0,89
	Parents	1	0	1	0	0	0	0	0,08
	Teachers, coordinators of prevention	16	0	10	0	0	0	6	1,29
Duration	Short-term	774	106	420	9	45	167	27	62,42
	Midterm	212	24	110	7	23	45	3	17,10
	Long-term (6-12 months)	254	22	131	27	32	24	18	20,48

Small share of programmes was aimed on risks groups (8, 06%) and peer-groups (3, 47%). 3 fifths of programmes were of short duration and only one fifth programmes were long-term. The data on programs evaluation is not available.

3.3.2.1. 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 1999/2000⁴⁸, and in the school year 2012/2013, the 14th year of its implementation was recorded. It is aimed on pupils 12-15 years old. According its author – psychologist Štefan Matula – the emotional maturity is the seventh key competence.

In the school year 2012/2013 the programme Way was realised in 189 schools - 12,4% of all schools and it was attended by 9,919 pupils (4,38% of all pupils) and implemented by 353 trained teachers 399 (Slovíková, 2014). The decline of coverage (numbers of participants/schools) was visible since 2009 and continued⁴⁹ mainly due demographical development in school population of that age.

Except the program „Way“ some other MUSTAP type programs have been implemented in schools (e.g. Before It Is Too Late; We Know that...); Everybody Does That, Alcohol - My Hidden Enemy, sports competition **“Take a Ball, Not Drugs”**. (Slovíková, 2014). Participation of 26 Regional Public Health Authorities⁵⁰ (hereinafter RPHA) in project **“Game against AIDS”** regarding 2013 have to be mentioned, as well as continuing of seventh cycle of school project **“Red Ribbons”** (Hamade, Janechová 2014).

3.3.2.2. “Unplugged” program

With the support of the Slovak Research and Development Agency⁵¹ and in cooperation with Czech experts from the Clinic of Addictology of the 1st Faculty of Medicine at the Charles University in Prague and the General University Hospital in Prague, research works (starting in 2012 – Report 2013) are aimed to verify influence of the “Unplugged” program on prevalence of drug use among adolescents in Slovakia (smoking of tobacco cigarettes, alcohol consumption, marijuana use). The EU-DAP Unplugged programme of universal prevention of drug use is designed for pupils aged 12 to 14 years. It is based on the strategy of social influence in drug use prevention, and implements the components of life capabilities to a cognitive model of social influence, special attention is paid to correction of normative beliefs relating to drug and drug use. In accordance with theoretical and methodological base of the programme, the research includes methodologies allowing implementation of mediation analyses aimed to answer a question concerning not only whether the unplugged programme has an influence on risky behaviour of adolescents but also how it operates.⁵² In 2013 preparation/ training of teachers was provided, realisation of the program itself as well as first two stages of data collection (before and after completion of the program in elementary schools).

69 schools were participated and provided two groups; experimental and control group of pupils in 6th grades (app. 12-13 years old) of elementary schools

⁴⁸ Taking into account the experimental verification carried out in the school year 1998/1999, it has already been the 15th year.

⁴⁹ 11, 875 pupils in 2012, 14,178 pupils in 2011, 14,096 in 2010

⁵⁰ Mostly in the East of Slovakia

⁵¹ Under the contract No. APW-0253-11

⁵² <http://www.infodrogy.sk/indexAction.cfm?module=Library&action=GetFile&DocumentID=1062>

Unplugged program was realised in experimental group within 12 weeks (from September 16, until December 6, 2013).

Table 3.2: SK Unplugged - Research sample, number of participants and data collection (Orosová, 2014)

	Experimental group	Control group	Total research sample
Data collection (T1) September 2, to September 13, 2013			
Numbers of participants	708	721	1429
Numbers of questionnaires obtained	622 (87, 85%)	661 (92%)	1283
Data collection (T2) December 9, to December 20, 2013 , immediately after Unplugged program			
Numbers of participants	708	977	1685
Numbers of questionnaires obtained	594 (84%)	940 (96%)	1534

In first half of 2014 the database of both phases of data collection was established and primary outputs/results were released; e.g. confirmation of relations between „novelty seeking“ and lower level of emotional regulation, self-regulation, parental control and alcohol consumption (Janovska, Orosová, Berinšterova, Gajdošova, 2014); boys are significantly more experienced in alcohol consumption than girls as well as pupils who are influenced by number of peers consuming alcohol, with lower level of positive life orientation, those who have experience with smoking and with lower parental control (Orosová,Gajdošová, Janovská, Berinšterová, Gabrhelik, 2014); boys reported higher experience with smoking than girls – the difference was significant, pupils with higher normative beliefs and lower level of parental control (Berinšterová, Orosová, Miovský, 2014) etc.⁵³.

Effect of Unplugged program was found in girls regarding smoking in last 30 days – LMP in T2 data was smaller. Perception of risks related to smoking tobacco, marijuana and alcohol consumption was influenced by participating in „Unplugged “program (Berinšterova, Orosová, Gabrhelik, 2014). The increase of awareness regarding negative consequences of alcohol drinking was observed (Orosova, Berinšterova, Benka, Gabrhelik, 2014). Finally participation in preventive program has increased the self-liking in boys and self-competence in girls (Berinšterova, Orosová, 2014).

3.3.2.3. Programmes for Young People outside Schools and in Sports Clubs

250 School centres for hobbies were transformed into form of “Playtime/leisure centres” (from January 1st 2013) and some important amendments in financing such facilities were enacted. Such changes influenced mostly the number of professional employees (in two fifths) and numbers of children in reduced number of hobby groups - mostly in sports activities.

In 2013 there were totally 495 Leisure centres in Slovakia, most of them in Prešov region 136, fewest in Bratislava region (18). Almost two fifths of hobby groups (from total

⁵³ Detailed outputs of research were publicised on <http://www.infodrogy.sk/index.cfm?module=Library&page=Document&DocumentID=1119>

number of 12 717 hobby groups) were aimed on different sports. Children with parents can spend leisure time together in 155 groups – 1, 22%. Majority of participants were boys (52%) and 81% (from total number 210 494 children) were children under 15 years. (Slovíková 2014)

Already 19th thematic art competition **Why Am I Glad to be in the World**⁵⁴ – it is the key antidrug project of Ministry of Culture - aimed on school children was carried out in 2013. National competition initiated by Public Health Authority „**The best antidrug wall-poster**“ provided the opportunity to participating classes (350 classes of seventh grade – pupils in age 13-14 years) to prepare in teamwork the concept and realisation of their wall-posters/newspapers. The three top ranking wall-posters were: „Don´t step across the hedge“, „Give the helping hand “and „Make the choice of sunshine side of life“

Don´t be Drug Vassal – project of State News Agency⁵⁵ – 643 participants mostly from elementary schools presented at the special section⁵⁶ of Official web portal of TASR their shorts stories and drawings concerned on the topic.

Alcohol misuse prevention activity aimed also on information regarding negative consequences of harmful drinking has been organised in 36 localities by regional/local public health authorities as the Day of Responsibility⁵⁷.

3.4. Selective Prevention

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

Detailed definition of prevention of risk behaviour was found on the website of National Educational Institute⁵⁸. The term risk behaviour of pupils covers whole whack of unacceptable features of pupils behaviour in school environment, e.g. smoking, alcohol consumption and other addictive substances, bullying, aggressiveness, and intolerance of diversity due to race or health. For pupils manifesting such behaviour the „*Intentional, comprehensive, co-ordinated and coherent assertion of psychological, psychotherapeutically, formative methods and methods of social reintegration*“ are assigned.

These interventions are provided and /or /supervised mainly by EPCPCs, however reasons of clients for coming to EPCPCs in the school year 2012/2013 were not changed and behavioural disorders and so called social pathology behaviour forms relatively smaller part of EPCPCs agenda, comparing the issues of professional orientation, learning difficulties, and school maturity issues.

⁵⁴ <http://www.infodrogy.sk/index.cfm?module=Library&page=Document&DocumentID=1018>

⁵⁵ http://www.infodrogy.sk/ActiveWeb/c/6478/nebud_otrok_drog.html

⁵⁶ <http://skolskyservis.teraz.sk>

⁵⁷ aimed on whole population, but for youngs there were some more attractive events

⁵⁸ (www.spu.sk) <http://www.statpedu.sk/sk/Vyhľadavanie.alej?s=prevencia>

3.4.2 Complex system of counselling and influencing of social pathology appearance

3.4.2.1. Project by RICPP

Is the title of project financed by ESF and managed by Research Institute for Child Psychology and Psychopathology. The aim of project was to depict pupils with problems such as behavioural disorders, learning difficulties and speech difficulties, social exclusion, truancy and experimenting with psychoactive substances, which must be dealt by professionals. Recognition of problems in pupils was carried out by school-teachers/class masters using the special questionnaire. Questionnaires were distributed in 2023 schools in seven Slovak regions (except Bratislava) and processed were questionnaires from 1,509 schools (74, 59%) with 326 809 pupils.

Pedagogues have indicated 59 155 pupils (18%) as children who are in need of psychological counselling and interventions.

Table 3.3: Key findings presented on the press conference and publicised in media (June 2014 - SITA, 2014)

1) The share of problem pupils raised in elementary school in grades 1-5
2) The share of girls with problems rose
3) the most frequented disturbance is learning difficulties – 62, 2%
4) Behavioural /conduct disorders – 56% (at least one symptom: impulse behaviour, negativism, affinity to the problem groups, antisocial behaviour, experimenting with drugs, truancy...) each tenth pupil has experimented with smoking, each twentieth with alcohol. 4, 1% of pupils with problems came into contact with police and 621 pupils (1% from 59 155 pupils with problems) have ascertained criminal offences.
5) Social disadvantage 47, 5% (social exclusion of the family, unemployed or not employed-able parents, low level of parent's education) mostly in Košice, Prešov and Banska Bystrica regions.

3.4.2.2. Early school leavers

Another group of potential interventions recipients consists of children – early school leavers. Such cases are especially serious for future of these children and their perspectives in job market. Petiová (2013) carried out the survey⁵⁹ aimed on school masters and their perception of this situation. The survey (620⁶⁰ questionnaires were processed) showed that early school leavers came from socially and economically marginalised communities, from Roma settlements, from immigrant's groups and often the school leavers are children healthy handicapped or children in institutional care). To eliminate early school leave school masters proposed better co-operation/communication with parents, better motivation of such pupils who are threatened by early school leave (poorly rated achievements, truancy, etc.), and individual care of school counsellor and/or school preventive services. Regarding the total number of early school leavers it was not available in the report; however the important – although not unknown -

⁵⁹ Petiová (2013) Predčasné ukončenie povinnej školskej dochádzky z pohľadov riaditeľov základných a stredných škôl v SR – UIPŠ (Early school leavers from school masters' point of view).

⁶⁰ The survey was not representative

difference among type of elementary and high schools was confirmed. The fewest number 1-3 early school leavers were registered in gymnasiums (grammar schools). On the opposite the number of early school leavers up to 21 pupils yearly was reported from school masters of apprentice's/continuation schools.

3.4.2.3. Training in short intervention method in drug addiction

Next phase of training in short intervention method⁶¹ in drug addiction was organized⁶² in the third quarter of 2013. It was supervisory–counselling workshop-like meeting of participants and the realization team members, which address exchange of experiences in the so-called good practice when implementing drug prevention in schools and school counselling facilities. (Participants were employees of the educational counselling institutions and of special educational facilities - psychologists, special pedagogues and special employees). Two reference books⁶³ on practical implementation of short intervention were issued, aimed firstly on trainees of these workshops and other experts in future. (Kopányová, 2014)

3.4.3 Other Risk Groups in the Community / Communities

Prevention of HIV / AIDS (Hamada, Janechová, 2014)

RPHAs participated in health education of men having sex with men as well as in the SIALON II project aiming to map the prevalence of HIV infection and other sexually transmitted infections. 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 Odysseus⁶⁴ realised in summer festivals, concerts and nightclubs, is primarily devoted to two topics – safer sex and safer drug use. The initiative www.drogy.org designed for people using heroin and methamphetamine continues.

At the level of selective prevention, there were two projects / community programs for marginalised and socially excluded persons. The first one was the Health Promotion Programme for Disadvantaged Communities in Slovakia for the years 2007-2015 of the Ministry of Health – project was interrupted in 2012 due lack of finances.

Project was more or less transformed into „Healthy Communities „project (under the Ministry of Interior) considered being more effective when higher number of Health Promotion Assistants was involved into activities in Roma settlements⁶⁵. Currently 144 such

⁶¹ international prevention project „Fred Goes Net“

⁶² Supported by the Ministry of Health by its grant programe 2013 to support National Antidrug Strategy

⁶³ 1) Kopányiová, A., Vojtová, Z. (ed): FRED GOES NET - VČASNÁ INTERVENCIA PRE MLADÝCH UŽÍVATEĽOV DROG. (Early intervention for young drug users) OZ Prevencia V&P, MZ SR, VÚDPAP Bratislava, March 2014; 2) Kopányiová, A.: Metodická príručka programu FreD (Reference book of FreD program) OZ Prevencia V&P, MZ SR, VÚDPAP Bratislava, March, 2014.

⁶⁴ www.odysseus.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 (locality in Bratislava where socially marginalised inhabitants are concentrated).

⁶⁵ app.600 Roma settlements

assistants (from Roma people) and 16 coordinators were trained who are militating in 108 communities/settlements. Since October 1, 2014 the program is back under the SK Ministry of Health jurisdiction (The Office of the Governmental Representative for Roma communities, 2014). Details can be found on <http://www.ppzss.sk/>.

The second one was the Community Social Work Programme (Ministry of Labour, Social Affairs and Family), implemented in marginalised, mostly Roma communities. Regarding activities in 2013 no new information is available from MLSFAF.

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

3.4.4.1. 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. 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. In previous reports the activities of 7 regional professional advisers specialised for drug prevention were mentioned. Since 2010 the number of specialised "drug" cases was winding down rapidly and according the information from CPS (Czuczorová 2014) specialised advisers/obviously psychologists were charged by other pivotal tasks of CPS departments in 2013.

3.4.4.2. Social Guardianship measures as selective prevention tool

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. From total number of 22 967 children who were addressed these measures, the share 1, 66% (382 children) was managed either due their own drug problems or their parents. Latter situation was the reason for 53 children who were set up in foster homes or in crisis centres. 70 youths in age 16-8 who have problems with drugs were admitted to resocialisation centres.

OLSAF provided group programs (educative and social) and supported the involvement of parents or close relatives of children in the implementation of programmes for children with behavioural disorders and problem behaviour, incl. problem with drugs 1057 children and 723 adults (parents) in 2013 (In 2012 - 1151 children and 598 adults participated in educative and social programs).

3.5. Indicated Prevention

3.5.1 Interventions focused on Children with ADHD Syndrome and Behaviour Disorders

3.5.1.1. Situation

According to information from the only one specialised Children Psychiatry Clinic⁶⁶ in Bratislava there was app. 30% of all patients (up to 18 years) with ADHD diagnosis in last three years. The relations between ADHD and higher predisposition to psychoactive substances addiction are well-known⁶⁷ ADHD and male gender predicted higher rates and an earlier onset of psychoactive substances use disorders.

Table 3.4: Numbers of patients treated at Child Psychiatry Clinic for ADHD, drugs and alcohol (Škodáček, 2014)

Year	2011 N=556		2012 N=577		2013 N=603	
	N	%	N	%	N	%
Diagnosis						
ADHD ± 30%	149	26.8	198	34.3	183	30.3
Problems with drugs ± 11%	65	11.7	77	13.3	62	10.3
Problems with alcohol ± 9%	41	7.4	60	10.4	58	9.6

3.5.1.2. Special school facilities

Three types of special educational facilities⁶⁸ of residential type are to provide indicated (incl. drug) prevention in case that the outpatient forms⁶⁹ is not sufficiently effective. In 2013, 1,195 children were placed in all the three types of the facilities (Slovíková, 2014).

3.5.1.3. Educational sanatoria (hereinafter referred to as "ES")

Nowadays 7 facilities 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.

In 2013, 277 (288 in 2012) children were placed in ESs, in 89 % of cases the parents and/or people who take care of children decided to solve the situation in this way.

⁶⁶ Škodáček, 2014

⁶⁷ e.g. Milberger S¹, Biederman J, Faraone SV, Wilens T, Chu MP.: Associations between ADHD and psychoactive substance use disorders. Findings from a longitudinal study of high-risk siblings of ADHD children.

⁶⁸ Jurisdiction of Ministry of Education

⁶⁹ Provided by EPCPCs

3.5.1.4. Diagnostic Centres (hereinafter referred to as "DC")

There are five of such facilities. Under Act No. 245/2008 Coll. and Decree No. 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.

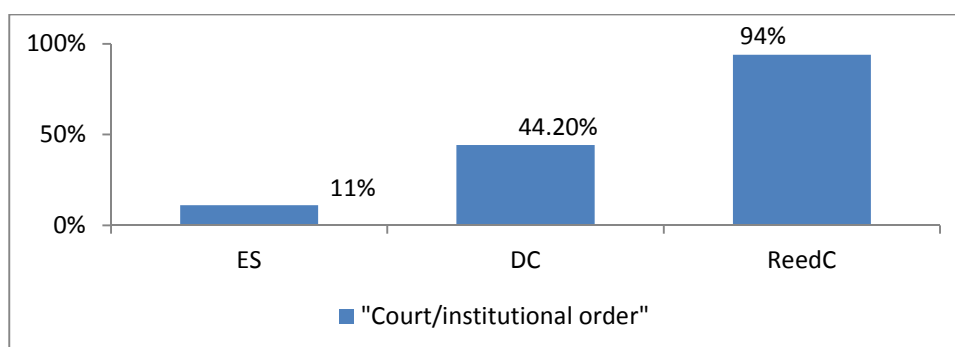
In 2013 269 (204 children in 2012) children were in Diagnostic Centres, the intent of parents or legal guardians has represented the share of 55, 8% (65% in 2012).

3.5.1.5. Re-education Centres (hereinafter referred to as "Reed")⁷⁰

14 facilities of this type of special education facility 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.

Children are admitted to the Reed at the request of parents/ legal guardians or by the court decision (on institutional or protective care). In 2013 majority of children were placed into re-education centres upon a court order, 94%/649 - (comparing 80% in 2012).

Figure 3.1: The share of enacted education (by court or social services of OLSAF – social and legal measures) in three types of special school facilities in 2013 (Source of data –Slovíková, 2014)



3.5.2 Accredited resocialisation centres (RCs)

are other institutions where measures of social and legal protection of children are implemented. Statistical data from MLSAF presented number of 70 youths (16-18 years old) set in resocialisation centres. According to a survey carried out by NMCD (see

⁷⁰ <http://portal.gov.sk/Portal/sk/Default.aspx?CatID=39&etype=1&aid=1878&Template=Print>

Chapter 8), in 2014, there were 145⁷¹ clients (app.16% from total number of clients) in age 16-18 years (106 in 2012 - 95 clients in 2011) in the accredited re-socialisation centres. Most of them were in the specialised department of the re-socialisation centre "Čistý deň"⁷² – the Children's Therapeutic Institute and in the oldest specialised facility for juveniles in the RC "Komunita Ľudovítov"⁷³.

3.6. National and Local Media Campaigns

No information available on national/local media campaign (as such) in 2013 and in first half of 2014. Some TV media broadcasted spots regarding National Drug Strategy 2013-2020 promotion, and series of short movies under the title "Drug pitfall" . Several new drug information webpages were set on attractive social networks e.g. „Save yourself and you'll save others". Above mentioned projects⁷⁴ were financed by Ministry of Health from special grant scheme for NDS 2013-2020 support.

⁷¹ The difference in numbers is caused by „private“ clients of RCs. Resocialisation program initiated as the measure of social and legal protection is financed by OLSAF.

⁷² <http://www.cistyden.sk/http404.html>

⁷³ <http://komunita.sk/>

⁷⁴ http://www.infodrogy.sk/ActiveWeb/c/6481/podporene_projekty_sa_zviditelnuju.html

4. HIGH RISK DRUG USE

4.1. Introduction

There were no new studies carried out in 2013 so there were no practical requests to change EMCDDA operational definition of “high risk drug use” and it could be fully used for description of high risk drug use in Slovakia:

‘High-risk drug use is measured as the use of psychoactive substances (excluding alcohol, tobacco and caffeine) by high-risk pattern (e.g. intensively) and/or by high-risk routes of administration in the last 12 months.’⁷⁵

Data sources for assessment of the situation in Slovakia are various, and, accordingly, tools for data collection differ. Rich source of information on people using drugs high risky way are specific reporting forms for low threshold harm-reduction agencies/programmes that had been constructed by NMCD⁷⁶ for this purpose. The scope of the questionnaire is, of course, broader, and comprises also some administrative entries on services provided. In addition, standards for personal data protection within these agencies/programmes are rigorous commonly, so some details requested are not available from all responding units (e.g. age classification or records on risk behaviour related to drugs (groups)).

Another data source is treatment services where, however, high-risk drug users should be selected from the whole group of patients as not all of them respond to the definition. There is specific reporting system on drug treatment used for TDI. As additional sources another specific data collection systems within health care department could be used, especially data on hospital discharges and data on psychiatric care, both selected by ICD-10 diagnoses (F.11x – F.19x). Since they contain low degree of details on drug specific items, including behavioural, they are used more for data cross-checking or for extrapolations of more general data, like number of patients in treatment in given year etc.

Some parts of data collected within GPS can be analysed too. In GPS questionnaire, as well as in questionnaires for national school surveys (ESPAD, TAD⁷⁷), CAST⁷⁸ scale is built-in by default.

High-risk drug use picture is completed by law-enforcement data, especially seizures that speak about extent to what given drugs are spread and also drug-related offences that describe some aspects of social harm and social impact.

⁷⁵ Thanki, D. et al. (2014): High risk drug use prevalence estimation by indirect methods: guidelines, Volume I. Introduction, definitions, study planning, interpretation and reporting of results. EMCDDA, Lisbon.

⁷⁶ National Monitoring Centre for Drugs, Slovak Reitox Focal Point

⁷⁷ Tobacco, Alcohol, Drugs – Slovak national survey in high schools in Slovakia, based on ESPAD methodology, see Chapter 2

⁷⁸ Cannabis Abuse Screening Test

There are some signs, especially from the wastewater monitoring, about consumption of cocaine in population. But it is probably either at low level in terms of individual use and thus causing not so much harms to persons that use it or it is not widely available and thus causing harms only to lower number of persons. According to preliminary results of the supplementary study on drug consumption in population using analysis of banknotes⁷⁹, it seems that mostly rich people use the drug on regular basis/more frequently; for others it is drug used mostly occasionally while methamphetamine (pervitín) is used as a main stimulant drug in them. Pervitin as a regionally specific drug is, along with cannabis, the most widely used illegal drug in Slovakia as could be drawn from treatment data, data on seizures as well as from data on drug offences (See Chapters 5, 9 and 10 for reference).

Data from treatment should be, however, used carefully as they are composed of data from both, civil treatment centres as well as prison ones. While formers provides data in line of common understanding of treatment demand, latter are not so rigorous in terms of TDI protocol – records on drug use reported from prisons are sometimes based only on self-reference / anamnestic data on a history of a given person coming to a prison,. And the proportion of such records – and thus extent of bias – is not known. In addition, numbers of persons reported from prisons are increasing year by year and their total number among all treated was about one third (31%) in 2013 in all treated, with higher occurrence among first time ever treated (almost 36%) and less frequent among repeatedly treated (27%). That is the reason why we voted to exclude the population of treated in prisons from our thoughts about high-risk drug use and to include only records that come from regular treatment centres outside prisons.

4.2. Prevalence of and trends in HRDU

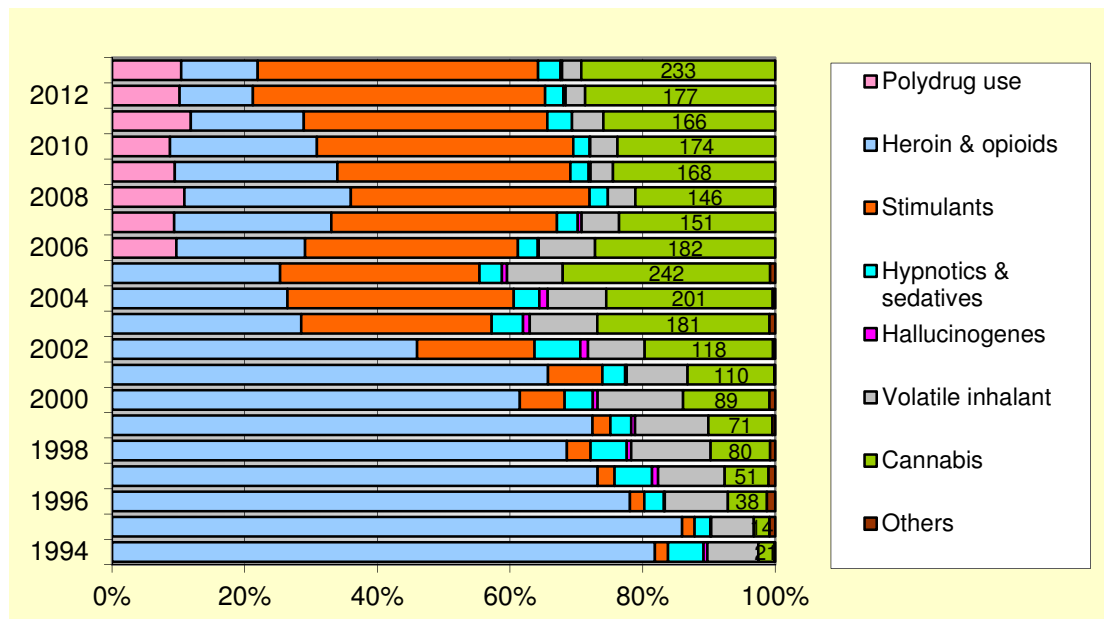
4.2.1 Cannabis use

High risk drug use in Slovakia is concentrated mainly to the use of methamphetamine (pervitin) and opioids.

As regards to high risk drug use cannabis, it is associated with the frequent use the drug and/or use of concentrated products. The average concentration of THC in herbal cannabis drug remains, however, stable with minor fluctuation around 10-11% (see respective reference in Chapter 10, part 10.4.2 Purity and composition of illicit drugs). Some small of THC concentration in hashish is visible; on the other hand hashish does not belong to popular drugs in Slovakia as could be assumed from amount of seizures as well as from quantity of seized drug, which is measured in several grams per year. Still, treatment data indicate increasing problems with use of cannabis. Since 2007-2008 we witness permanent increase of the number of persons entering treatment due to their problems with cannabis use, which was even more evident in 2013. It concerns all treated patients as well as first treatments; patients of civil treatment centres as well as those in prison; relative numbers as well as absolute ones (Figure 4.1, Figure 4.2 and Chapter 5).

⁷⁹ A pilot study carried out by the Slovak Technical University during the summer music festival

Figure 4.1: Composition of patients treated due to their drug use in the Slovak Republic. Percentage by the primary drug - first treatments ever

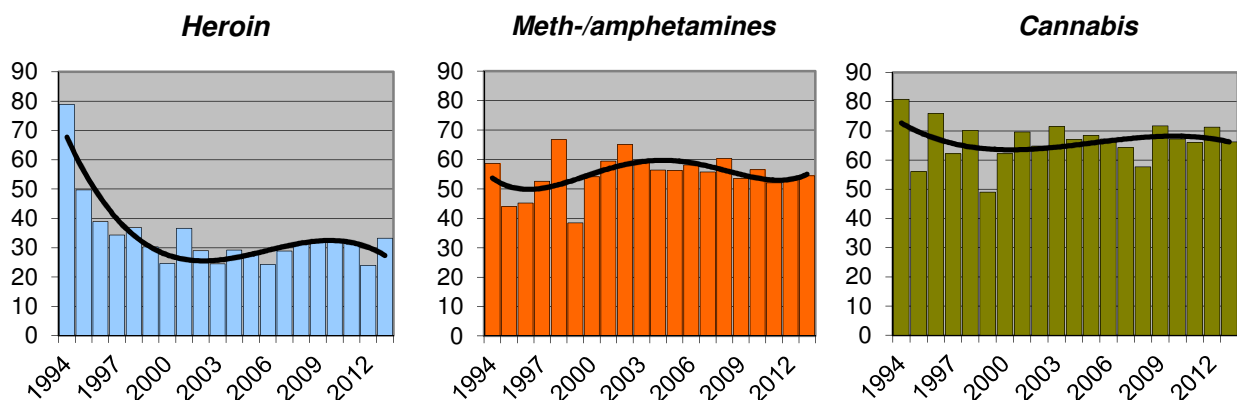


We assume that this phenomenon could be probably explained better by spread of marijuana use in population in combination with its illegal status than by risky ways of use or increased harm to users' health. To support such assumption we could point to two points from treatment data: 1. symptoms of epidemiological dynamics of cannabis use, as expressed in Chapter 5, and 2. unchanged patterns of cannabis use in terms of frequency.

4.2.1.1. Dynamics of cannabis use

There is highest proportion of first treated among patients entering treatment due to cannabis use: while in opioids, where population gets older, it is at the level of around 30%, in amphetamine-type stimulants the proportion of first treated oscillates around 50%, in cannabis using patients it is between 65% to 70% in the last five years (see Figure).

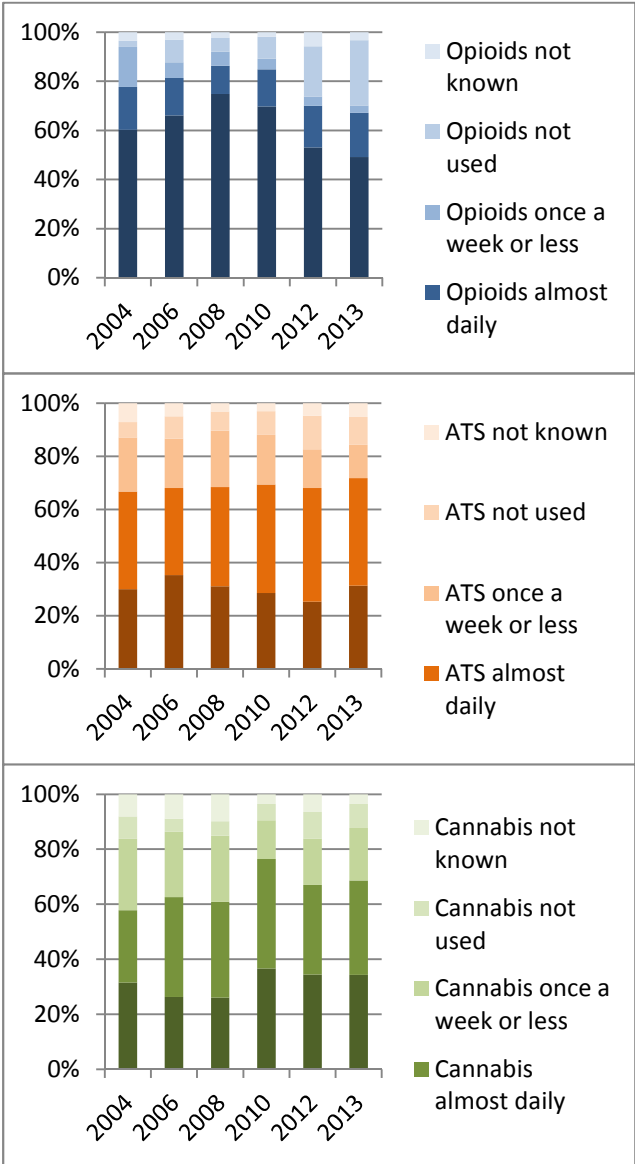
Figure 4.2: Proportion of first-time treated in various drug types



Also ratio of first treated to repeatedly treated (FTD/RTD) is in cannabis users considerably higher in comparison with other drug users, having values between 1.5 – 2 in the last five years while e.g. in opioid users it makes less than 0.5 and in amphetamine-type stimulants approximately 1.

4.2.1.2. Frequency of cannabis use

Figure 4.3: Frequency of use of selected types of drugs in drug treatment. Source: NCHI



In 2013, there were more frequent cannabis users in treatment (135 using daily and 135 almost daily) than it was ten years ago (101 and 84 respectively). This responds to increase of the number of patients entering treatment due to cannabis use in period referred. On the other hand, the proportion of daily users did not change so much, and it is of 30% more or less all that time (see Figure 4.3) and the group of frequent users (i.e. using cannabis daily or almost daily) in all cannabis using patients have increased only slightly (by 11% in 10 years). This correspond to spread of marijuana use in young people when many of them give up their cannabis use or shift to (also) other drug(s) and only part of them continue using it so intensively that they need medical help later on.

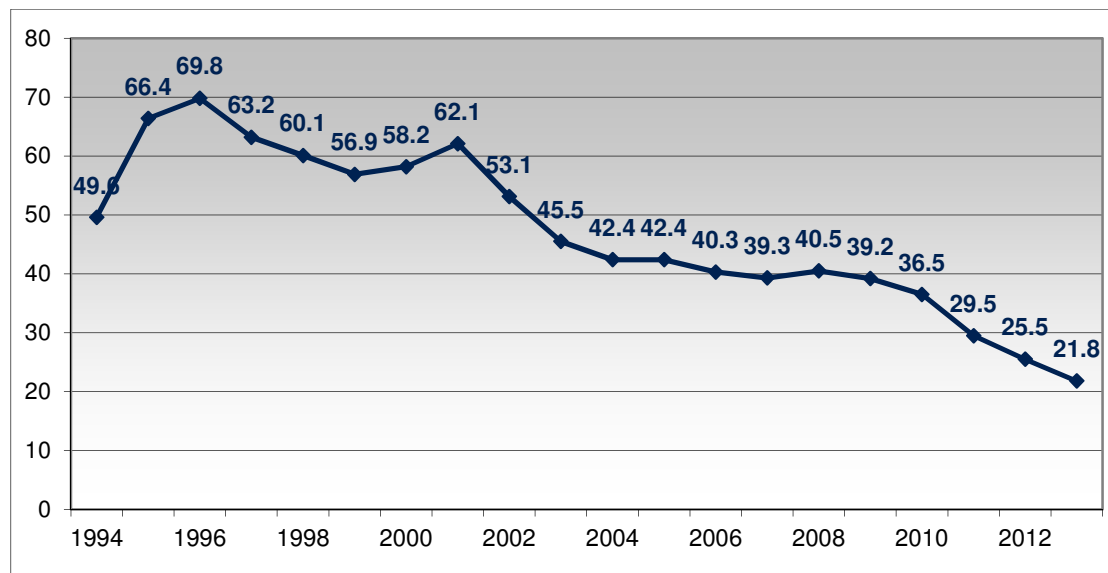
Operational definition does not give answer to question which part of treated population of cannabis users could be considered as “high risk” users. Their entering to treatment could give certain signal that there are some kinds of problems that are related to

drug use. On the other hand, users that use only cannabis, with frequency of once a week or less could be hardly considered as high risk cannabis users, even if they seek for medical help/treatment. Among those treated in civil treatment centres (i.e. excluding prisons), two thirds (262) have the diagnosis of dependence (F12.2). Frequent use corresponds closely to that proportion (270 using daily or almost daily), and thus could be indication of high risk use, especially if associated with use of cannabis products with high concentration of THC.

4.2.2 Injecting

Traditionally, injecting is perceived as one of the most risky way of drug use. In treated population, injection use of the primary drug is permanently decreasing and in 2013 it reached lowest values in history, regarding relative numbers (21.8%, see Figure 4.4) as well as absolute ones (374).

Figure 4.4: Percentage of patients injecting the primary drug



Decrease in use of heroin is supposed to be behind this trend, which goes hand in hand with declining in frequent users, as shown also on Figure 4.3. In 2010 there were 70% of daily opioids users and 85% of those using opioids daily or almost daily. In 2013 daily users made only one half of opioid users and daily or almost daily use was reported in ca two thirds of opioids users in treatment (67.1%), that all in context of fall in treated opioid users by 40% (from 552 in 2010 to 343 in 2013). Also police records on drug seizures and reports from prisons inform us that heroin is more and more substituted by other opioids, which are either substances used in substitution therapy (buprenorphine, methadone) or medicaments with content of opioids.

There is clear evidence that less and less opioid users in treatment administer their drug by injecting. It is shown on Figure 4.5 that such development – decrease of proportion of injecting – concerns not only opioid users but also users of other drug groups in treatment.

Within the overall trend in injecting of two main injectable drugs – opioids and amphetamine-type stimulants – it is interesting to compare those who enter treatment for the first time with those who are in drug treatment repeatedly. Looking at the Figure we can notice several points.

Figure 4.5: Trends in injection by drug groups among patients, Slovakia 2010. Source: NCHI

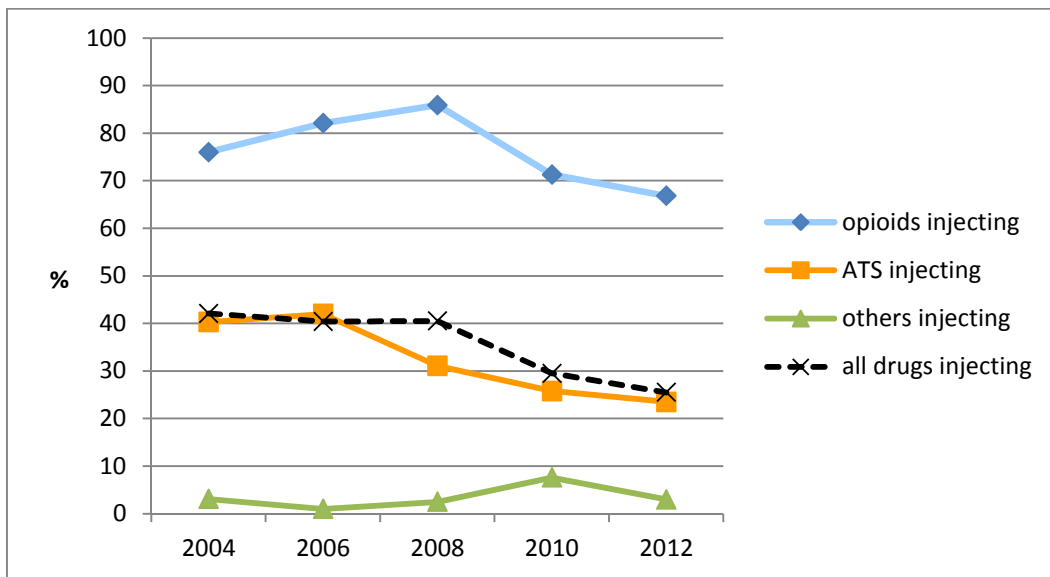
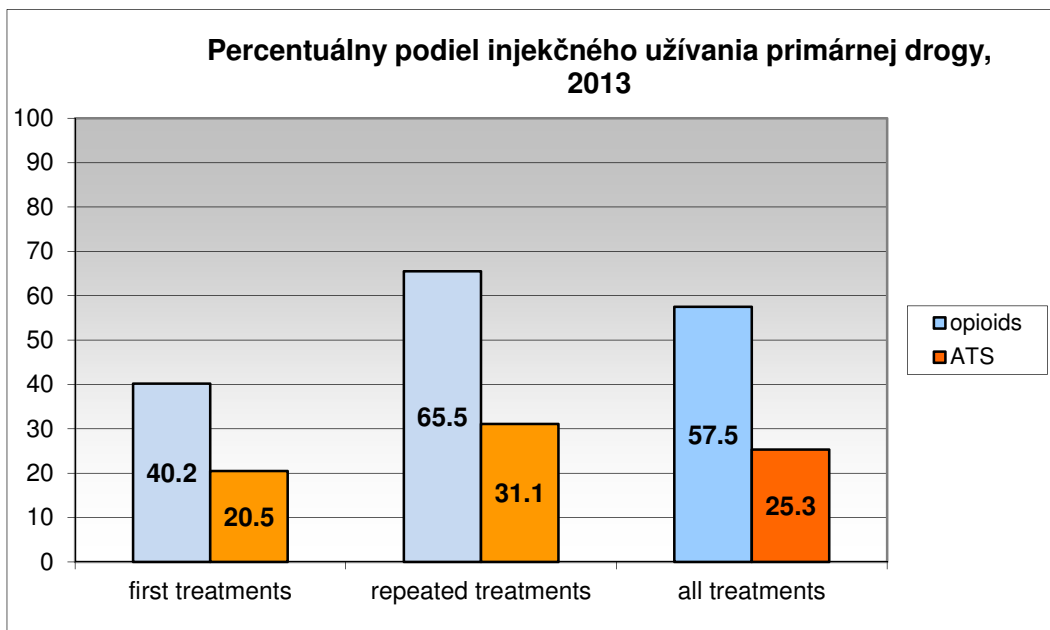


Figure 4.6: Percentage of injection use of the primary drug: opioids vs. stimulants. Source: NCHI

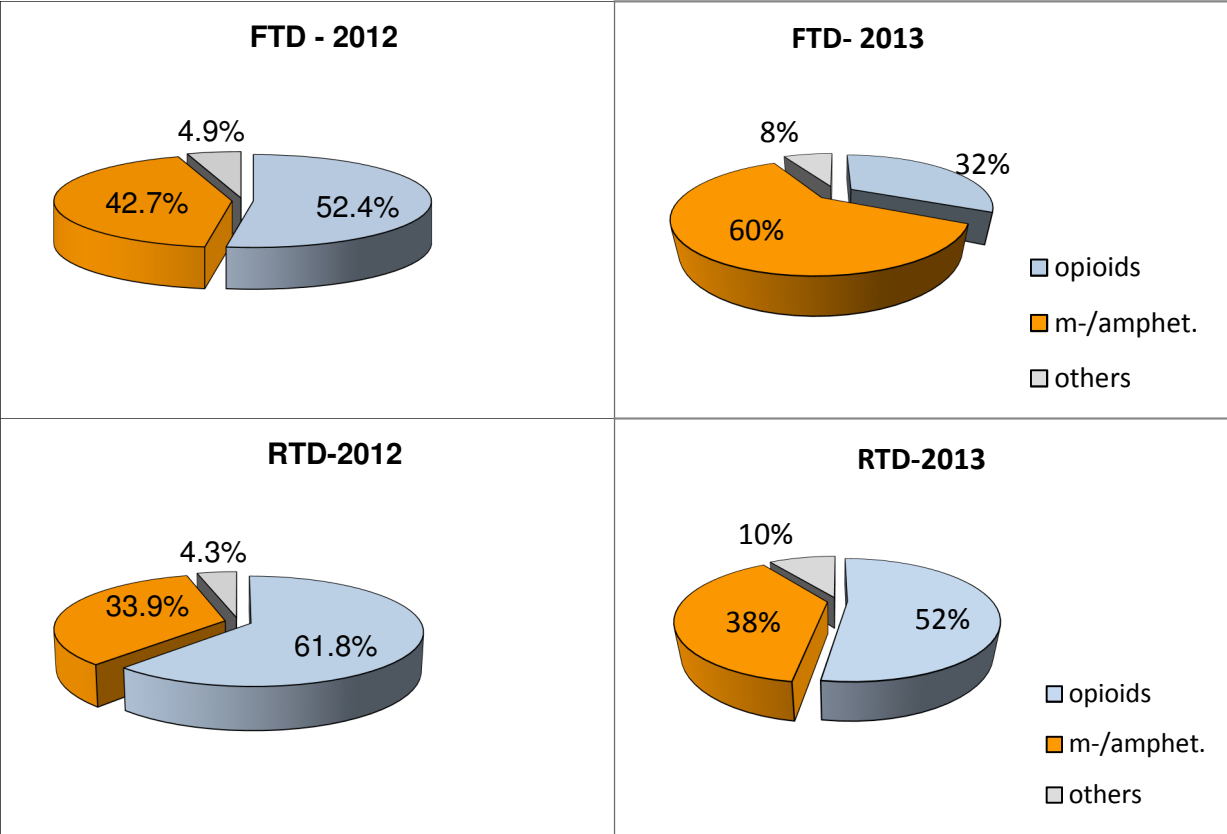


First, injecting of opioids in treated patients is more than twice higher than injecting of amphetamine-type stimulants (ATS). Second, there are evident distinction between first treated (first treatment demands, FTD) and repeatedly treated (repeated treatment demands, RTD). While in FTD a proportion of injecting users of ATS is one fifth of all users of ATS, in RTD the proportion rises up to almost one third. The same picture is visible in opioids users: RTD patients inject by more than one half more, compared to FTD.

Thus, all injecting patients could be divided according to the drug they inject: opioid injectors, ATS injectors and "other drugs" injectors (see Figure 4.7). In 2013 32% of injectors were injecting opioid drugs, 60% were injecting ATS and 8% were injecting

other drugs (see figure). Looking back, at year-over-year comparison of those treated for the first time in their lives (FTD), a proportion of opioid users among drug injecting patients dropped down from 52% in 2012 to less than one third (32%) in 2013. Contrary to that, a proportion of ATS users among injectors increased from 43% in 2012 up to 60%. A proportion of users of other drugs grew from 4.9% to 8%. The same shift is visible in proportions of RTD.

Figure 4.7: Comparison of injecting use of primary drug in treated patients – first treated vs. repeatedly treated, by type of injecting drugs.

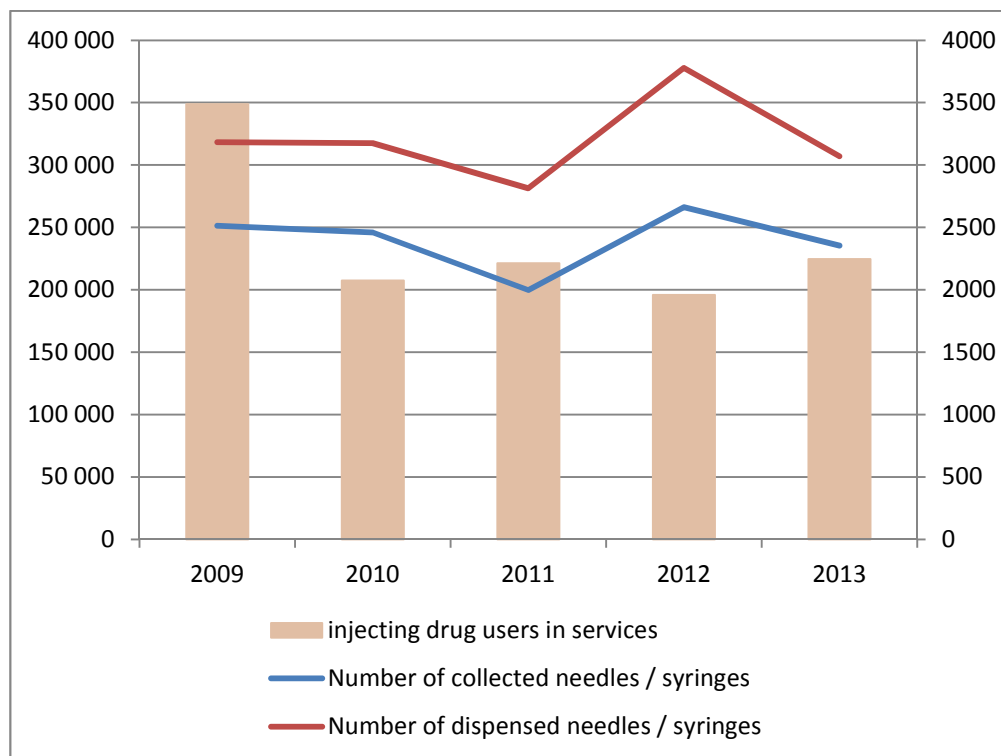


Despite of evident decrease of drug injecting, trends in injecting material (syringes, needles) distribution by field social programmes (NSP) remain relatively stable and it even did not reflect reasonable decrease of programmes and of the number of their clients in 2009-2010 and in 2013 the level of syringes/needles provided was practically at the same level as it was before that steep fall (Figure 4.8). There are several possible explanations of this relatively stable rate in syringes / needles delivery that can act separately or in concerted effect:

- Rising awareness on injecting-related risks and on availability of such helping services;
- Demand was so high in past that it was not possible to meet it all and even now, with decrease of injection drug use, it is not fully saturated;
- Reduction of the network of services did not influence syringes / needles demand that remained at the stable level and pickers come to services to supply wider community;

- Other reasons, connected e.g. to users' behaviour / lifestyle, that are beyond our knowledge.

Figure 4.8: Trends in development of the number of injecting drug users in programmes of harm reduction agencies (bars, right axis) and of needles / syringes disposal (lines, left axis). Source: NMCD



4.2.3 Polydrug use patterns

Secondary drug use, as recorded in reports from treatment centres can provide a (limited) sight on polydrug use in patients who are at health risk due to their drug use. Therefore we analysed the picture (Figure 4.9) although – as mentioned in Chapter 5 – there are some unclarity in secondary drugs data recording that must be kept in mind.

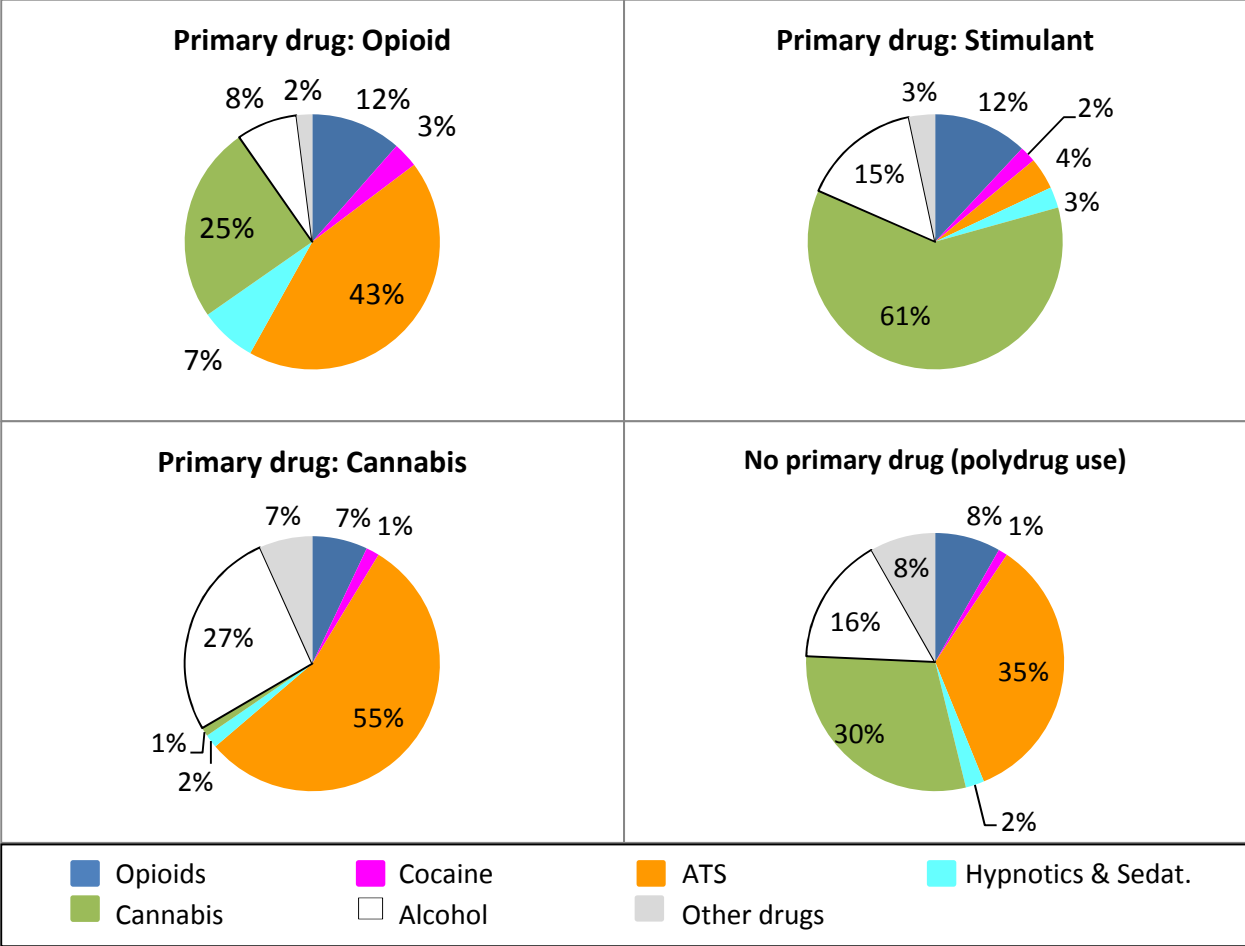
Secondary drugs in patients treated due to opioid use

Relatively high use of amphetamine-type stimulants as a secondary drug in this group (43% of secondary drugs were ATS), is a little bit surprising because of different effect of these two types of drug. In addition, also secondary cannabis use is relatively high (25% proportion of secondary drugs). Within this group, the highest proportion of all compared groups was in secondary hypnotics and sedative use, where proportion of all secondary drugs was 7%. The explanation of this diversiform picture could be that most of the users started with other drug(s), coming to opioids use later (i.e. in fact, in these users opioid was first a secondary drug) or they could be polyusers, but due to high dependency potential of opioids and development of harms they are coming to treatment centres declaring opioid as the primary drug.

Another notable fact is that in this group a secondary opioid is used as a secondary drug (a proportion of 12%). This supports the idea that users try more opioid drugs, perhaps

according availability or due to the lack of heroin (and even of the poor quality) in the market.

Figure 4.9: Distribution of secondary drugs used in patients treated in health care centres of the Health Department in Slovakia, 2013, by primary drug type. Source: National Centre of Health information



Secondary drugs in patients treated due to use of (amphetamine-type) stimulants

In this group, most of secondary drugs were cannabis drugs (61%). This association (i.e. use of stimulants and cannabis at the same time) is confirmed also vice-versa, in the group of patients using cannabis as the primary drug. It is possible, that users in this group overcome the same development like opioid users – using more types of drugs or replacing cannabis with stimulants they encounter more (health or social) harms connected with stimulants use so they then seek for medical help as a stimulant users, while keeping cannabis use as well. In this group, there is no extensive use of secondary stimulant visible.

Secondary drugs in patients treated due to cannabis use

More than one half (55%) of secondary drug in primarily cannabis users were stimulants. Circumstances of this phenomenon should be analysed in specialised study. One idea could be again polydrug use – beginning phase of taking stimulants on board or their so called “recreational” or occasional use. Remarkable is high proportion of alcohol as the

secondary drug in this group. Many studies report simultaneous use of these drugs and this mixing – as a high risk way of cannabis use – is a challenge for prevention measures.

4.3. Characteristics of high risk drug users

One of the most important sources of information on high-risk drug use is harm reduction services. In Slovakia, they consist of 8 programmes distributed in 5 cities across Slovakia, mostly in the western part of the country. All these programmes are based at low threshold non-governmental agencies. In 2013, all existing agencies continued their activities, despite the fact that still no systemic way has been created for financing of their work, and the network remains fairly reduced.

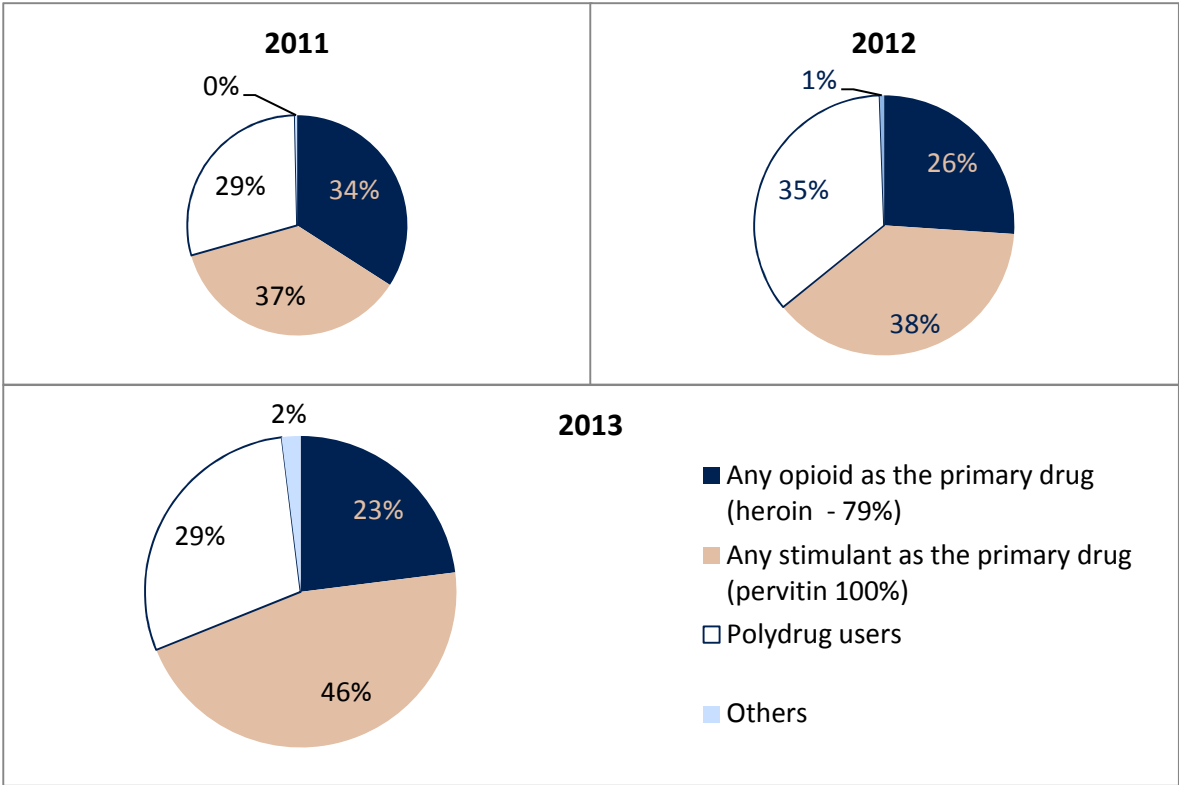
Table 4.1: Development of numbers and composition of clients in low-threshold harm reduction organisations in Slovak Republic. Source: NMCD

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2013 % of clients
Reported clients	3,979	3,957	4,023	3,542	3,769	2,267	2,306	2,030	2,313	-
reported drugs users	3,773	3,722	3,812	3,310	3,588	2,134	2,221	1,960	2,252	100.0
injecting users	3,576	3,560	3,658	3,184	3,489	2,075	2,213	1,958	2,247	99.8
Primary drug used										
Heroin	1,430	1,452	1,341	1,489	1,225	656	705	443	409	18.2
Cocaine	0	7	6	0	44	0	1	0	6	0.3
Pervitin	1,418	1,403	1,314	1,146	1,510	852	810	747	1,028	45.6
Polydrug use	436	437	722	474	652	556	645	691	656	29.1
Methadone	n.a.	n.a.	n.a.	1	32	0	0	0	39	1.7
Buprenorphine	109	109	102	50	75	60	52	57	64	2.8
Other opioids	0	0	0	0	0	0	0	8	6	0.3
Volatile substances/solvents	5	5	22	0	42	0	1	2	4	0.2
Ecstasy	10	10	0	0	0	0	0	0	0	0.0
Cannabinoids	6	6	0	2	2	2	2	2	0	0.0
New psychoactive substances	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	15	0.7
Others (e.g. alcohol etc.) & not known	112	131	198	148	6	8	5	10	25	1.1

In total, 2 313 clients were reported from the agencies in 2013, of which 2 252 use their programmes for drug users. Practically all of them was created by injecting drug users (2 247 or 99.8%), most of them were males (61%) with the average age of 33.85; the average age in females was 29.95. A small proportion, about 1.6%, were juvenile clients (aged 15-18 – this information is not available from all agencies). After the last drop in 2010, number of clients stayed rather stabilised at the level about 2000 people more or less (Table 4.1). The proportion of clients using opioids continued to decrease, and, on the contrary, number of clients using stimulants was rising in the last four years.

As about composition of clients according to the primary drug used, in 2013 most of clients coming to low threshold services, almost one half, were users of stimulants (46%, see Figure 4.10), polydrug users created the second largest part of harm reduction services clients (29%) and the third last group consisted of opioids users (23%).

Figure 4.10: Composition of users in services of harm reduction agencies by the primary drug used. Source NMCD



Stimulants have been predominant primary drug among clients of harm reduction services for at least three years, but its' proportion increased from 37% in 2011 up to 46% in 2013. During the same time, a proportion of opioid users among clients decreased from 34% to 23%. The polydrug use proportion increased in 2012 to 35% but one year later it decreased back to the level of 29%. Some fluctuation in proportions could be caused by the fact that there is weak common understanding of polydrug use criteria and of coding it in low threshold organisations, contrary to the medical diagnostics in health care centres.

As it seems, a proportion is increasing of the category "other drugs". That responds to the picture of diversification of drugs that are used and widening their range, along with decrease of the proportion of heroin users among opioid users and increase of users of "other opioids" – while in 2011 heroin users created 93% of opioid users, one later it was 87% and came to 79% in 2013. New psychoactive substances use was reported from low threshold programmes as well, for the first time in 2013.

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

5.1. Introduction

Treatment of drug-related problems in Slovakia aims to be participatory, professional, complex and continuous. It is based on the provision of appropriate health and social services with the main goals to increase the health condition and quality of life of its patients and clients.

Treatment, as it is defined according to EMCDDA, encompasses medical, as well as non-medical approaches. It means any focused intervention provided to drug user with structured goal-oriented plan. This could be residential, or can take place in the community. The interventions, which are considered as treatments are: detoxification, mid- or long-term residential or out-patient abstinence-oriented treatment, opiate substitution treatment, treatment care in therapeutic communities, half-way houses, counselling and brief interventions, mandatory treatment in the prisons ordered by courts.

Which is not included in this 'core' definition of treatment of drug-related problems is the treatment of overdoses in the emergency units, needle and syringe exchange in the streets, treatment of other related health problems associated with drug use, such as treatment of hepatitis C provided to injecting drug users. Anonymous or non-anonymous request on information about treatment options by phone, email, or in person, here is not considered as treatment, too. Not included is treatment of co-dependency of the relatives and the significant others in the absence of drug user. But all these services are also available.

Despite of the extensive definition, which includes a wide spectrum of not always medical treatment interventions for drug users, the prevailing treatment programs, are organized and managed by the health authorities in Slovakia. Social care and other forms of treatment outside of the health sector are playing an important, but complementary role.

Distinction between voluntary and involuntary or mandatory treatment, which is ordered by courts, has its implications also on data collection for the monitoring of treatment demand indicator. The voluntary treatment entries are forming the main part of all the admissions, but also a significant number of involuntary treatments do exist.

Main sources of data collection for treatment demand indicator are the health care providers, who are operating within the health sector and those who are providing the health services in the judiciary in the prisons. People, who are in the aftercare programs provided by the sector of The Ministry of Social Welfare and Family are in the same time in the out-patient care of the health specialist – addictologist. Therefore, the TDI data are channelled this way. Methodological guidance, common protocol and sheets for data collection are organized by The Ministry of Health.

Treatment demand data collection system is covering on national level the whole Slovakia. Harmonised reporting form based on TDI protocol is used to collect the individual information about users, who asked for the treatment. Data collection is realised separately from the medical facilities and separately from the prisons. The whole reporting system is managed by the National Centre of Health Informatics (Národné centrum zdravotníckych

informácií – NCZI) and this is forwarding aggregated information to the National Focal Point (NFP) at The Ministry of Health. NCZI is collecting individual data with unique identifiers from treatment providers. The individual data are protected by the law, which is strictly observed. Only the health care providers have the access to personal data and NCZI to the individual, but already anonymous data. It is processing them to get aggregated information on national level. Annual statistical bulletin is published by NCZI: 'Drug Addiction – drug user treatment in Slovak Republic 2013' (NCZI, 2014). The publication is descriptive overview, presentation of the tables derived from the datasets, which are spilt according to different variables and their combinations such as: sex, age, type of primary, secondary drug, education, employment, geography etc. Data presented here are without further interpretations or comments.

5.2. General description, availability & quality assurance

5.2.1 Strategy/policy

The objectives of the National antidrug strategy 20013 – 2020 in its part of drug demand reduction were serving as the main political guidelines, which were followed accordingly also in the year 2013. Prevention of negative health consequences and correlates of drug use together with reduction of drug supply are the main pillars. This priority has been also expressed by the fact, that The Ministry of Health was designated to coordinate the intersectional National antidrug strategy. The drug demand policy was consistent and with continual implementation of the effective approaches from the previous years. Not only in public, but also on the expert level has started discussion on decriminalisation of drug users caught by the police with the possession of the small amount of drugs for their personal use. The discussion is going on. However, there was not significant change, or corrections in the Slovak antidrug policy in the year 2013.

5.2.1.1. Financing

Drug treatment was paid by the health insurance in the health sector and also in the prisons. It was fully covered by mandatory health insurance for every Slovak citizen with permanent residency in the country. It is based on the principle of solidarity, in which employed people with resources are contributing with payments to the health insurance companies and state is paying on behalf of those who cannot afford it, for children and pensioners. Only small amount should be paid by patient for some medications in an addition to the price covered by health insurance, in the case of the out-patient treatment. All the costs of residential, in-patient treatment of patients with drug use related problems are covered by health insurance in the health facilities, including the whole costs for all medications.

Residential stay in the therapeutic communities for social reintegration is covered by grants from local or regional authorities with variable degree of co-financing by the clients. Grants for the specific projects and donations were also the main source of the income for low-threshold programs, which are realized by non-governmental organizations. Limited amount of the money for the projects fulfilling important tasks of

the National antidrug strategy was distributed also by The Ministry of Health of the Slovak republic.

5.2.2 Treatment systems

5.2.2.1. Organization

Treatment programs and the institutions are public or private, not for profit, or for profit. Treatment, which is available in prisons, is provided only by the state owned health providers.

The health services are based on medical model of addiction, most of the people in treatment are with diagnosis of drug dependence and not so prevalent is treatment demand due to harmful drug use according to ICD-10 / WHO diagnostic criteria.

Treatment in the prisons is organized by prison health service, which is methodologically under the guidance of The Ministry of Health, but The Ministry of Justice is responsible for its day to day operational functioning.

The Ministry of Social Welfare and Family according to the law is responsible for social reintegration of children, adolescents and young adults with drug-related problems. This usually is an after care measure, which follows after the medical treatment for the condition of drug dependence in the health program. However, some admissions into the residential programs for social re-integration of adolescents were ordered by the courts and youngsters were transferred directly from their families into the therapeutic communities. These were mostly the young people with drug-taking behaviour without dependence but with social problems. Behavioural, educational approaches, therapeutic communities and socio-therapy are the main elements of these programs.

The health and social sectors are separate, and are under the two different ministries – The Ministry of Health and The Ministry of Social Welfare and Family.

Mutual cooperation, complex structure and clear defined responsibilities do exist among the different sectors which are providing treatment services for people with drug-related problems. Still, the main entry into the drug treatment is after being examined by the specialists-psychiatrists via health care providers, through the out-patient mental health clinics and through the in-patient residential treatment in the addiction clinics. The vast majority of these admissions are voluntary. The limited number of the patients was referred to treatment by courts. Different situation was in the prisons, where the majority of the patients, which was entering treatment was referred to it by courts, so it was involuntary. The option of voluntary treatment admission for the inmates also does exist in the prison system in Slovakia.

5.2.2.2. Availability

Availability and affordability of treatment services was and is in general good in Slovakia. The problems might occur from time to time, if the capacity of the program was fully occupied. Because of that, the short temporary waiting lists for treatment admission emerged in some of the facilities, episodically. However, the patients had always the option to be treated in the other programs with free slots - vacancies. There is free choice of care providers in Slovakia. The majority of the out-patient clinics are run by the private specialists – psychiatrists in the health care system and vice versa most of the in-patient

facilities are public, not for profit, in the state ownership, or were established by the local communities.

5.2.2.3. Accessibility

Accessibility of the services was and is regulated by treatment demand and depends on the contracts between the health insurance companies and health care providers. The network of the out-patient mental health clinics is covering the whole country. Specialised addiction Centres for Treatment of Drug Dependencies are in larger towns and cities, where is higher concentration of drug users.

5.2.2.4. Quality assurance

The international system of quality assurance ISO 9000 is a standard in all specialized Centres for Treatment of Drug Dependencies and in the psychiatric units and hospitals, where treatment for drug-related problems is offered. Organization of specialized services is regulated by the documents from The Ministry of Health, or in the case of residential facilities for social re-integration by The Ministry of Social Welfare and Family. The guidelines for methadone substitution treatment has been used in clinical practice and wider updated guidelines for OST, which will include also treatment with buprenorphine-naloxone were worked on by the group of the experts in the year 2013.

The professionals, medical doctors, specialists in psychiatry are required to be in charge of all treatment programs. The other staff members are qualified nurses, clinical psychologists with training in the psychotherapy, educational therapists and the social workers. There are three health insurance companies, which as the main contractor and source of the income for treatment providers are checking the quality of care using different quality indicators. One of the most important is the clients' satisfaction. The efforts were made by some institutions to make a ranking list of all residential health treatment providers according to the quality of their care provision. This pilot project should be further developed and serve as an instrument for the enhancement of the quality also in the addiction treatment field in the future.

Some of the specialized addiction facilities are conducting also prospective long-term out-come studies with main indicator, which is the abstinence from the illicit drugs. It gives an important feedback to the staff, health insurance companies and the society as a whole.

5.2.2.5. Treatment entry

The entry into the addiction treatment was possible with or without any referrals from other medical specialists or general practitioners. The self-referrals were the most common way. Participatory, non-judgmental approaches with high degree of personal data protection are implemented to lower the barriers, to avoid the prejudices, which are persisting in some parts of the Slovak society. Support of close family members and the significant others is playing an important role. Motivational enhancement therapy is part of pre-treatment interventions in such low-threshold programs as are the needle-exchange programs for drug users in the streets.

Extensive effort was made to provide treatment entry without any delay for everybody who was it seeking for drug related problems. At least this was the case in the out-patient treatment provision in psychiatric clinics. Availability of residential in-patient treatment also did not pose any barrier for the treatment entry. Patients seeking treatment on voluntary basis could get it in a few days, or in one to two weeks, which depended on their condition. Treatment is generally free of charge for the patients, it is paid by health insurance, so this was not a barrier for those who were in need of it and wanted it. Legally twotypes of treatment entries exist in Slovakia: voluntary and involuntary, mandatory on the court orders. Signed inform consent is required form the adult treatment seekers, or from their guardians in the case of adolescents and children. It is precondition for the admission into voluntary treatment. The consent is not required from the patients who are entering treatment because of the court orders. In some cases longer waiting lists lasting for several weeks were for treatment admissions on mandatory treatment. Most of the facilities have limited capacity for non-motivated involuntary patients - drug users. But the majority of the patients treated for drug-related problems were seeking treatment and have been admitted on voluntary basis into Slovak treatment programs in the year 2013.

5.2.2.6. Treatment programs

Treatment is organized in out-patient or in the residential settings. There is continuity between these two forms of the treatment. All patients treated as the in-patients should continue as out-patients, the opposite is not always the case. There is significant number of people, which is successfully treated in the out-patient programs without any history of previous residential treatment.

Abstinence-oriented treatment modality has two stages: detoxification and relapse prevention phase. Opiates Substitution Treatment (OST) is considered as intermediate stage for those, who are in the need of it, before later detoxification, after achieving stabilization. The patients are not forced to detoxify from OST and many are staying in the OST program for the rest of their life. Duration of OST has no time limit..

The increase in treatment demand and so the importance of abstinence oriented, so called drug-free treatment approach has been observed especially in the last decade. The reason was the increase of drug demand treatment by non-opiod drug users, where substitution medication is non existing alternative.

Majority of the treatment facilities are mixed and accept patients with drug related problems, users of the illicit substances, as well as people with alcohol related problems. The increase of patients with pathological gambling problems with or without associated drug use disorder was also observed in the last year. But special, tailored made treatment procedures and programs may be different for different patients within the same treatment facility. Transition to alcohol use disorder after on abstinence-oriented treatment for drug dependence has occurred in some cases despite of the fact that necessary preventive measures were taken.

Pharmacotherapy and psychosocial approaches are implemented in the treatment. Medications are part of the treatment, mostly as adjuvant symptomatic therapy in the phase of detoxification in abstinence-oriented therapy and obviously in the OST. Pharmacologically assisted detoxification is as a rule, when it is needed. But treatment is participatory and the choice of the form of treatment program by the patients is respected. Motivational enhancement therapy, cognitive behavioural therapy (CBT) and structured relapse prevention are the main elements of psychosocial interventions.

OST is provided as complex treatment program with pharmacological, psychological and psychosocial parts. The criteria for OST entry has extended to drug users with dependence on opiates and in the same time with co-dependence on other psychoactive substances, mostly on methamphetamines, cannabis and alcohol. Such patients, apart of the OST, are also frequently entering abstinence-oriented treatment programs with the purpose to stop taking other substances than opiates.

5.3. Access to treatment

5.3.1 Characteristics of treated clients (TDI data included)

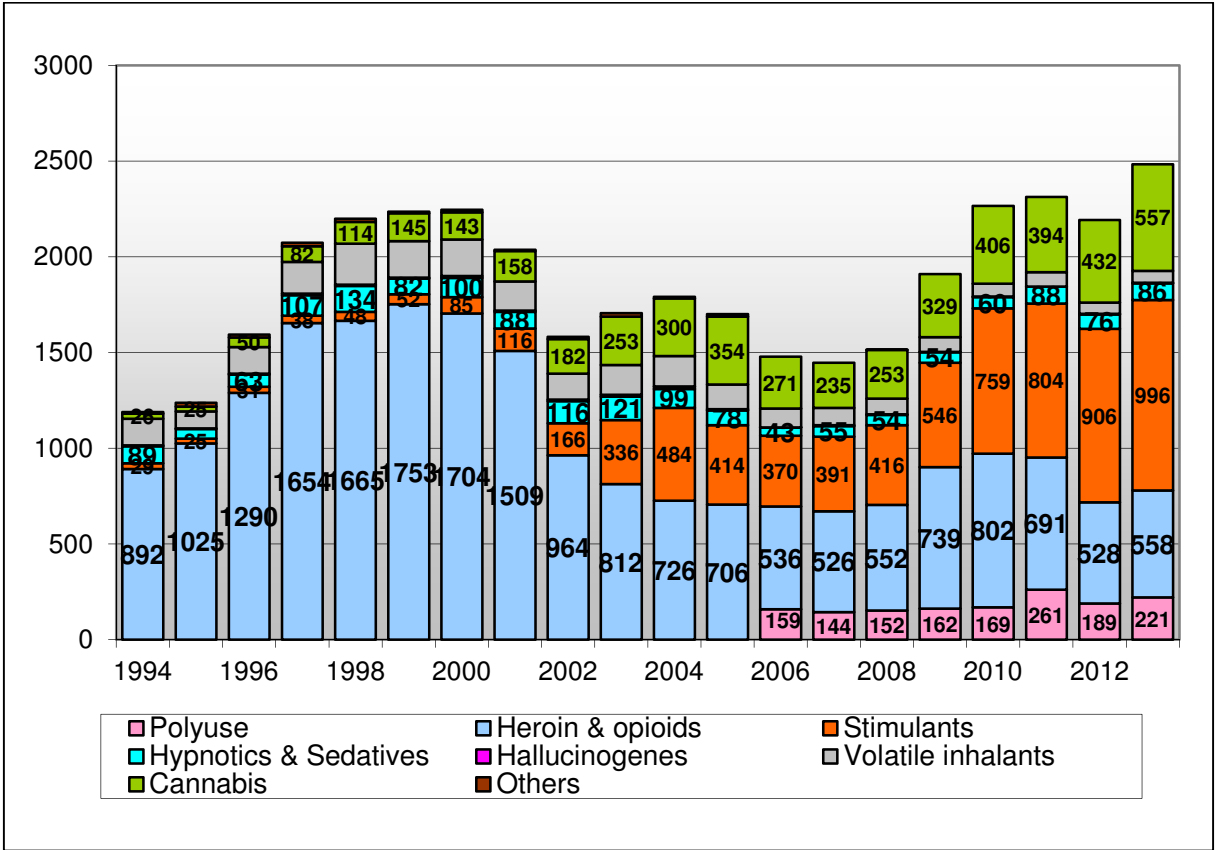
5.3.1.1. Type of drugs

Poly-substance use with dependence is emerging characteristic of the clients who are asking for treatment of drug-related problems in Slovakia, in the recent years. The on-going trend, the shift from mono- to poly-drug use was also visible in the year 2013. 62% of 2,484 patients treated for dependence on any illicit drug were also using other drugs with or without dependence. The most commonly mentioned secondary drug was cannabis by 24%, followed by methamphetamine type stimulants used as secondary drug by 20% of the patients, and alcohol on the third place by 8%. Many polysubstance users were using more than two different psychoactive substances. Reporting and recording of alcohol use as secondary drug is questionable and might be underestimated.

The total number 2,484 patients were recorded in the treatment due to drug related problems in Slovakia in the year 2013. It was 45.9 per 100,000 people of the general population, which was the highest annual rate in the last decade. There were 2,193 patients registered in treatment in 2012 with the increase of 13% in the year 2013. This high number that even exceeds the peak in 2000 can be charged to an account of permanent increase of numbers of patients in prisons in last years (it increased by 75% in the last five years, taking 2009 as a baseline). Numbers of treated within the Health Department increased reasonably in 2013 too, by 14%, equalling the value of 2004, but this number is still lower than highest historical values at the turn of the century.

What has been changing steadily during the last decade was diagnostic structure of the patients admitted to the treatment due to drug-related problems (Figure 5.1). The largest group according to their primary drug of use was formed by 996 patients who were in the treatment due to dependence on stimulants. The proportion was 40% of all patients in treatment, the same as it was a year ago. But in absolute figures was evident the increase in comparison with the previous year from 906 patients in 2012 to 996 in 2013 and also in the rates from 16.6 in 2012 to 18.2 per 100,000 persons in 2013. 98% of them were methamphetamine – “pervitin” users.

Figure 5.1: Development of treatment demand due to drug related problems in Slovakia Source: National Centre of Health Informations



The number of patients with heroin related problems has reduced from 936 to 414 during the period of the last ten years. This decline continued also in the last three years 2011, 2012 and 2013, from 536 to 424 and 414 patients, respectively. Decline was Recorded from 7.8 to 7.6 per 100,000 between 2012 and 2013. Treatment for dependence on heroin was 17% of all treatments for dependence in 2013. But there was slight increase in the treatment demand due to dependence on other opioids from 1.9 patients in 2012 to 2.7 per 100,000 people in the general population in 2013. All together patients treated for dependence on opioids constituted 22% of all treatments in the year 2013.

The same proportion 22% of all the patients in the treatment were treated also due to cannabis related use disorders. Same as it was with the opioids, but here significant increase was recorded from 432 patients in 2012 to 557 in the year 2013 and from 8.0 to 10.3 patients per 100,000 persons in general population. The numbers are growing. 97% of them has problem with marijuana.

9%, which were 221 of all the patients were treated due to polysubstance dependence, coded under the code F19.2 according to ICD-10/WHO diagnostic criteria. This was again below 5.0 patients per 100,000 persons, so as it was in the previous years. Methamphetamines, cannabis, opiates and alcohol were the most frequently present.

The data are indicating a long-lasting trend of decrease in the consumption of heroin in Slovakia. Still, the highest treatment demand is by the patients with stimulant related problems. Their rate has even increased from 7.0 to 18.2 per 100,000 thousand people of the general population from the year 2003 to 2013. In the addition, stimulant use, predominantly of the methamphetamines, is also wide spread as secondary drug among the patients who were registered in the treatment of addiction with dependence on other primary drugs and also among the patients treated due to polysubstance dependence, under the diagnostic coding F19.2.

The number of patients admitted to treatment for cannabis related problems was in the second consecutive year higher than number of the patients who were seeking treatment because of the heroin dependence, and was even for the first time equal to all treated for dependence on opioids, which means it was same as if people who were seeking treatment due to dependence on heroin and dependence on all other opioids are put together. Cannabis is also the most prevalent illicit drug used as secondary drug by the patients seeking treatment for drug dependence. It is consistent with the findings in population surveys. Other substances as primary drugs were very little represented among the patients in treatment in 2013: sedatives and hypnotics, volatile agents, cocaine – 1.6; 1.2 and 0.2 patients per 100,000 persons, respectively. Small proportion among users in treatment for primary drug represented patients with petidine 3% and dolsine 1%, related problems. Very rare were methadone, buprenorphine, pentasocine, codeine, MDMA and LSD. Use of hallucinogenic mushrooms as a secondary drug was also recorded. What is important to mention is the fact, that no patients with use problems of other types of drugs, especially so called new psychoactive substances, were recorded as treatment seekers in the year 2013.

Drug use disorder related treatment demanded for the first time in their life 50% of the patients treated in the year 2013. Previous treatment, before this one, had 66% of the patients with opioid dependence, 44% with methamphetamine dependence and 28% of patients with cannabis related disorders. The only change in comparison with the year 2012 was decline in the proportion of previous treated for opioid related problems from 73% in 2012 to 66% in 2013.

Distinct, frequently discovered associated problem of methamphetamine use, besides toxic psychosis, was loss of impulse control and pathological gambling. Pathological gambling as behavioural disorder is not recorded by treatment demand indicator.

5.3.1.2. Gender

A proportion of the males and females among the patients in drug treatment is showing constantly a higher representation of males: 77% in 2003, 83 % in 2012 and 85% in 2013. But in the years in between were recorded ups and downs. The highest proportion of males – 92 %, as always, was among the patients with cannabis problems in treatment and traditionally the lowest – 53 % among patients treated for dependence on sedatives and hypnotics. Gender characteristics of the patients in treatment are quite stable in the time perspective. No significant or major changes were observed in the year 2013.

5.3.1.3. Age and type of drugs

So as it was in the past, the highest proportion 70% in the population in treatment, were the young people in the age category from 20 to 34 years. Methamphetamine related problems, which were leading to seek treatment were prevailing by 56% among teenage girls, while among boys it was on the first place cannabis by 54% of all males in the age group from 15 to 19 years who were entering treatment in 2013. The majority, 59% of all the patients who were asking for treatment due to problems with methamphetamines, was from the age cohort between 20 and 29 years. In the diagnostic category indicating problems with opioids was the peak of treatment demand with 48% in the age group from 30 to 39 years. The males 40 years old and older were mostly asking for the treatment due to dependence on opioids, while female patients of the same age were treated primarily for dependence on sedatives and hypnotics.

Patients in the treatment for drug-related problems are slowly, but steadily getting older. The average age of heroin users in treatment were 33 years, of methamphetamines users it was 27 years, for cannabis users 24 years, but the oldest were patients dependent on sedatives and hypnotics – 45 years old on an average. There was in one year shift towards higher average age in the all above mentioned diagnostic categories of the patients with substance related problems, except of the last one, where was slight drop from 47 to 45 years.

5.3.1.4. Duration of primary drug use

More than one third – 36% (895) of the patients in the addiction treatment in the year 2013 started with use of their primary drug eleven or more years ago and only 3% (84) started with drug use less than one year prior to the treatment entry. There is gradual increase in the patients who entered the treatment after one, two, three, four up to five years from the beginning of drug use when was achieved the peak with 186 entries. This is followed by decrease in the numbers of entries by the patients who started with drug use six, seven, eight and nine years prior to this treatment, with oscillating frequency about 120 patients in each category.

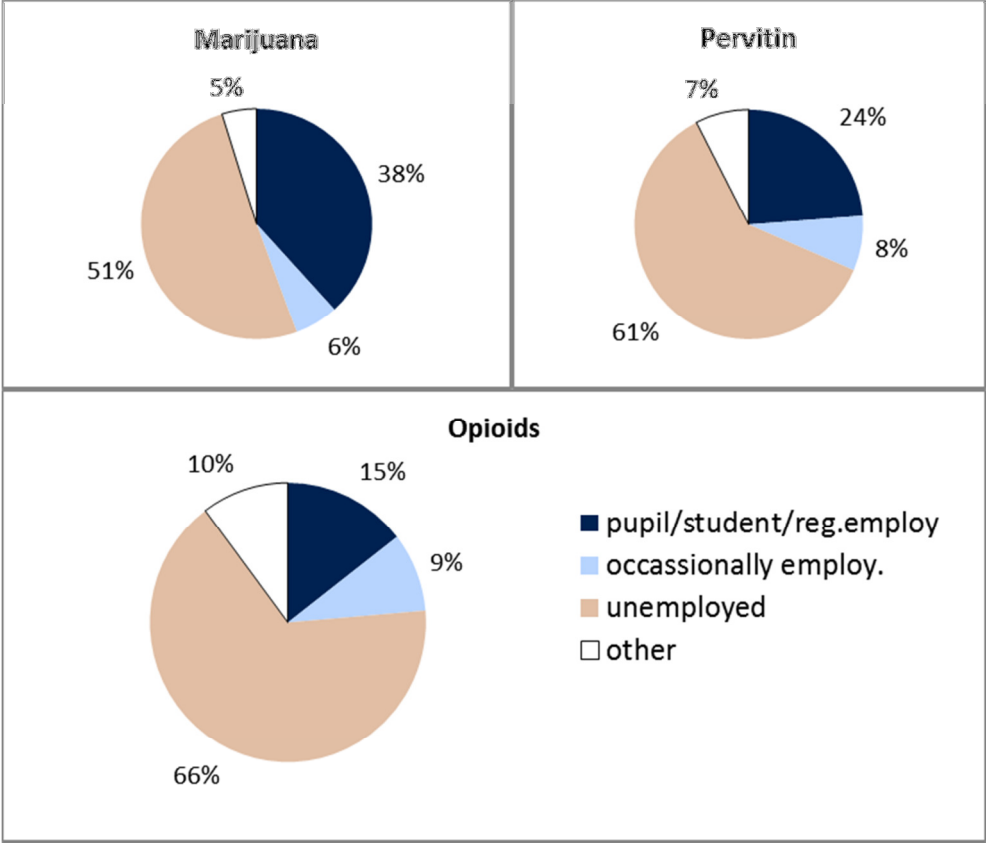
It is not the same for each type of primary drug. As it was expected the highest number of long time drugs using subjects was among heroin users, where 69% - 284 patients, started with it eleven or more years ago. The low popularity of this drug is signalling also the fact, that the numbers of treatment entries with shorter duration of opioid use before it were low, between 8 and 15 subjects. If we shift our focus on the treatment demand figures with shorter duration of primary drug use, the clear, even if not very prominent peak in the seeking the treatment was after the five years. Cannabis had not clear peak in the number of treatment entries frequencies, which might be correlated with the time after beginning of primary drug use. The same situation is with the other primary drugs use durations before the admissions of the patients into the treatment. The highest number of patients with the longest history of regular primary drug use, for ten years and more, who entered the treatment was from the birth cohort from 25 to 30 years old in 2013.

5.3.1.5. Routes of drug use

Small shift has been registered towards higher proportion of smoking and lessening of injecting drug use in the year 2013. There were 33% of drug users who were smoking

drug prior to the treatment entry in 2013 versus 30% in 2012; and 29% in 2013 versus 30% in 2012 who were injecting the drugs. 22% were sniffing drugs, the same as a year ago, and 8% were eating or drinking the drugs. 78% of heroin users injected the drug some times in the past, while only 31% of stimulant users did so. No other drugs were injected.

Figure 5.2: Structure of drug treated dependent persons – employment status Source: National Centre of Health Information



5.3.1.6. Education and employment

The majority – 35% of the patients in treatment with drug-related problems have completed elementary education, only. They were followed by 32% of those who attended, but did not finish the secondary school and the smallest group of 3% had some type of the university degree.

60% of them were unemployed in the time, when they entered treatment in the year 2013, 25% of them had regular job, or were with temporary employment, which was same as it was in the previous year 2012 and 8% were students (Figure 5.2). The most of the opiate and stimulant users in treatment were unemployed, slightly lower was the unemployment rate among cannabis users. It was about half of them.

5.3.1.7. Marital status and accommodation

84% out of the patients who were in the treatment were singles, 7% were divorced and also 7% were married (Figure 5.3). 60% were living with their parents, 12% alone, 10% with their partner, 8% with partner and child/ren, 6% with other persons (Figure 5.4). Stable accommodation had 84% and 14% had unstable accommodation. They were homeless (Figure 5.5).

Figure 5.3: Structure of drug treated dependent persons – marital status. Source: National Centre of Health Information

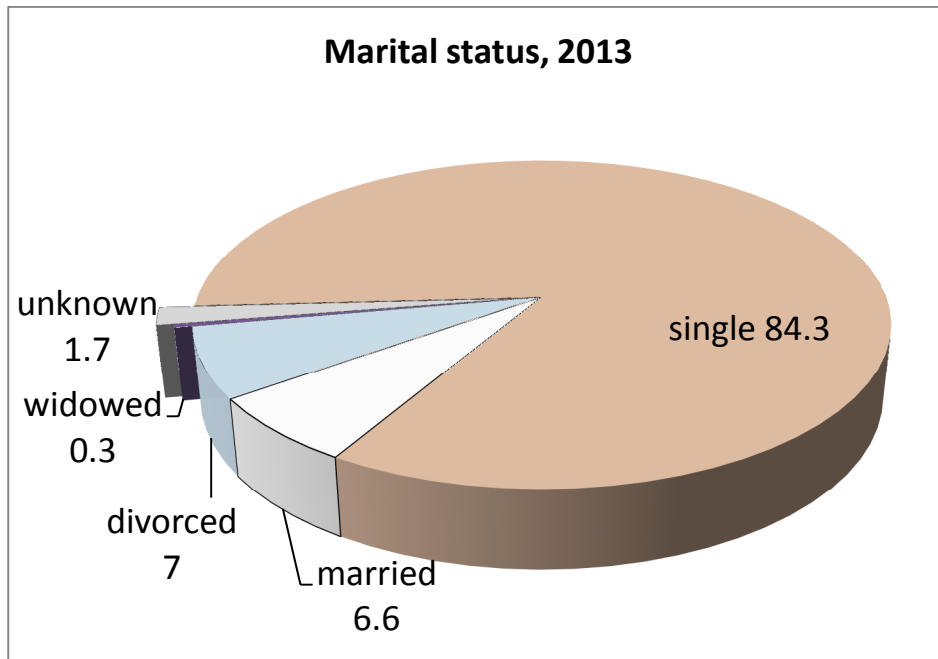


Figure 5.4: Structure of drug treated dependent persons – life with whom. Source: National Centre of Health Information

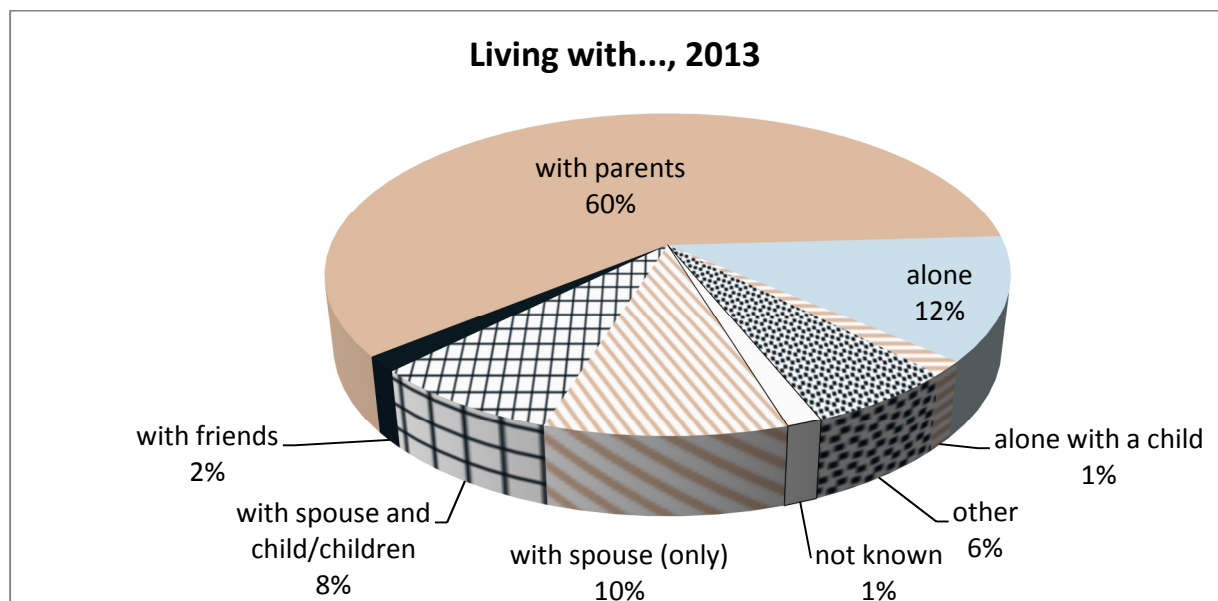
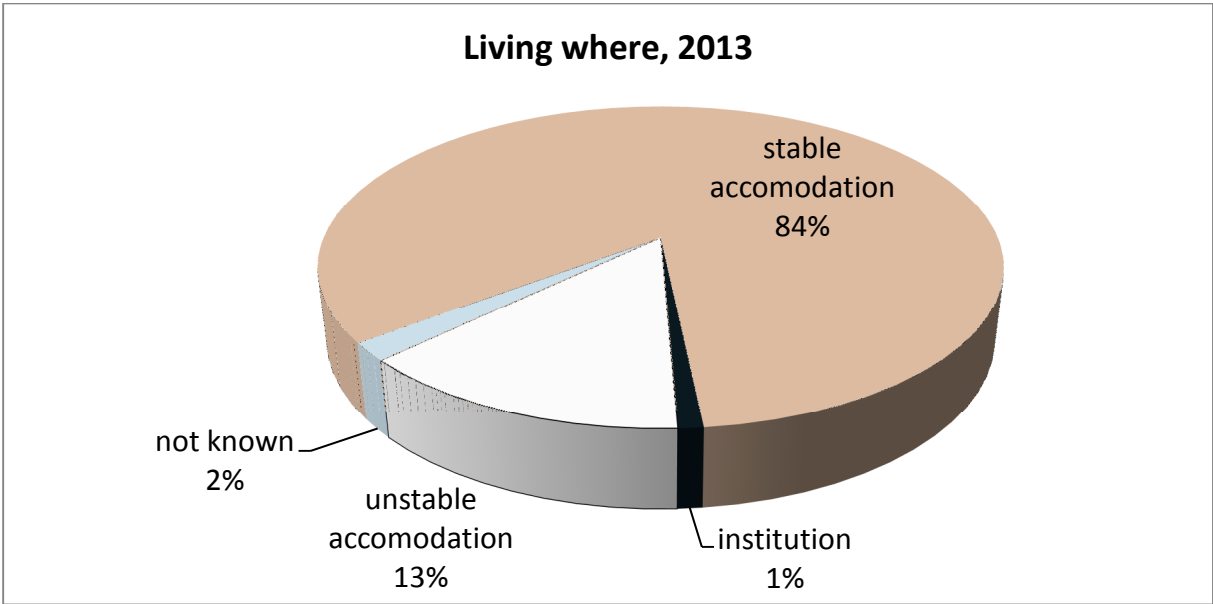


Figure 5.5: Structure of drug treated dependent persons – life where Source: National Centre of Health Information



The typical profile of drug user seeking admission to drug treatment in Slovakia in the year 2013 was as it follows. He was a male, 25 to 30 years old, who has started with regular methamphetamine sniffing about ten or more years ago. He completed elementary school, was unemployed, and was living in stable accommodation together with his parents.

5.3.2 Trends of treated population and treatment provision (incl. numbers)

5.3.2.1. Geographic distribution

There were no significant changes registered in the geographic distribution of the patients treated for drug related problems in comparison of the year 2013 with a previous one. The only remarkable exception was significant increase of the patients who had permanent residence in the Trnava region in the Western part of Slovakia. The total number of treated patients has increased here by 59% from 246 to 391. Because of that there was also the most significant increase in the proportion of treated patients among all Slovak regions. Trnava region went up from 11% to 16% and was closing on the second place to traditionally dominant Bratislava region which has shown a slight decrease from 26% of treated in 2012 to 23% in 2013. But total figures were stable in Bratislava region and also in other geographic parts of Slovakia, the situation did not change.

Geographic West to East equalizing of the density of patients in the treatment for drug related problems has continued in the year 2013. When 63% of all treatments were from Bratislava in the year 2000, last year it was only 23%. Still, the majority of the patients were from three rich South-Eastern regions: Bratislava, Trnava and Nitra, 52% all

together. On the other side continuous small increase was observed in the poorest North-Eastern Presov region from 3% ten years ago to 4% in 2012 and to 5% in 2013.

This geographic distribution of the patients seeking treatment and its changes are associated with such indicators as is the income of the households which is higher in the West, but is increasing also in direction to the East of the country, with population density, which is the highest in Bratislava where is capitol city and low in the rural Presov region and associated negatively with the opposite trend, which was observed with alcohol consumption. The Eastern part of Slovakia is traditionally known for the highest alcohol use related problems.

5.3.3 Treatment evaluation

Direct treatment evaluation, which is focused on abstinence from illicit drugs as the main indicator has not been finalized in the year 2013. But there is ongoing periodic, cohort, evaluation study in the Centre for Treatment of Drug Dependencies in Bratislava. The results from the last cohort which was evaluated in the year 2012 revealed that more than two thirds of the patients were abstaining from the illicit drugs after three years from their treatment entry.

Looking at treatment outcomes also in the context of the other findings it is possible to conclude, that treatment is working and is effective in achieving its goals. The numbers of opiate users entering treatment are at its lowest figures, proportion of drug injectors is on steady decline and incidence of main blood borne infections, which are spread among drug users is either very low, as is the case of HIV, or on decline in the case of hepatitis C incidence.

6. HEALTH CORRELATES AND CONSEQUENCES

6.1. Introduction

Epidemiological surveillance of the human immunodeficiency virus infection has continued to be the highest priority among drug users in the monitoring of drug related infectious diseases. This is followed by hepatitis C and B, which were also in the centre and in the focus of the systematic epidemiological surveillance of the health correlates and consequences of drug use in Slovakia in the year 2013. The main reasons were the high risk of the further transmission in the subpopulation of drug users and possible serious public health consequences in the case of their spill over from the subpopulation of drug users into the general population.

Other sexually transmitted diseases such as syphilis, and other serious infections such as tuberculosis, tetanus, botulism, were also under the surveillance, because of the possibility of their transmission mainly due to sharing of the injections and injecting paraphernalia in the association with drug taking behaviour. The gathered information was consistent and based on the harmonised methods, on the EMCDDA protocol for the collection of the data on drug related infection disease (DRID) indicator. The spectrum of potential infectious agents, which were focused on, and the numbers of people tested for their presence differs according to their up to date prevalence in the general population and specifically in the sub-population of drug users. So as it was already mentioned the knowledge of the prevalence of blood-borne infections among drug users is the health correlate with high priority. HIV data are collected within the health sector. The database exists at the National Centre for Reference on HIV/AIDS. The centre is using European harmonised methodology of data collection. It is also collecting data on the route of transmission. The sharing of the used needles and syringes is one of the risks of HIV transmission.

The Centre for Treatment of Drug Dependencies (CTDD) in Bratislava is a sentinel and the main source of data on the incidence and prevalence of hepatitis C, HIV, syphilis and other infections transmitted by the use of shared injection paraphernalia among drug users. The CTDD was selected because it is centrally located in the capital city, where is the highest occurrence of drug use with its longest history. The centre has the largest patient case record register in the country and the longest time series of collected aggregated data derived from its databases of drug users who were seeking treatment due to drug use problems.

The Office of Public Health is collecting notifications on new infections on national level. The main tasks are testing of biological samples and behavioural data collection by self-reporting questionnaires. Use of qualitative information is sporadic.

Some-times the additional sources provide some data, but they are not systematically collected, and are mainly from the 'ad hoc' surveys and studies, predominantly from the preselected populations treated in the health institutions. This approach can provide some information on the occurrence of psychiatric and somatic co-morbidities. The studies are focusing on the emerging health problems in the clinical practice, which are frequently

associated with drug use. Most of them are quantitative, clinical and retrospective with simple, predominantly descriptive statistical analysis.

Fatal overdoses are reported from the departments of forensic medicine. All the autopsies should be conducted on all deaths caused by suspected drug intoxication in Slovakia. The other retrospective study, research of the mortality of the former patients treated for drug related problems in the CTDD is using its case record register for the comparison with the date of the national register of the people who are registered in Slovak health insurance system. The more detailed information on fatal overdoses is limited by the numbers referred by the coroners for the autopsies and by technical equipment of the forensic – toxicological laboratories.

6.2. Drug related infectious diseases

The priority of monitoring infections among drug users focuses on HIV and hepatitis C infections. As it was already mentioned above, the reason is that regular drug users, especially those who are injecting drugs are at higher risk of contracting these infections and their treatment is difficult and expensive. Less emphasis was on the screening of the other infections among drug users, such as hepatitis B, STDs, tuberculosis, because they are less frequently transmitted by the route of injecting drugs in the country. The numbers of the drug users infected with hepatitis B virus are for several years on low level due to continuous vaccination of all new-borns.

6.2.1 HIV

HIV testing is voluntary and signed informed consent is required. It takes place in the doctor's office during the admission procedure. Patient can refuse testing without any sanctions. Pre-test and post-test counselling are parts of the process. Firstly, the front line immunoassay testing is conducted in the on-site laboratory and then in the case, if the sample is reactive, follows confirmatory testing with ELISA and Western Blot in the central laboratory. Because of different causes of cross-reactivity of immunoassay, only approximately 1 in 10 reactive samples were confirmed as positive for HIV infection in Slovak National Reference Laboratory for HIV/AIDS.

HIV testing is also offered to the people who are visiting health facilities for the prevention or as the patients in Slovakia. Especially high coverage has been achieved among pregnant women. High response rate was also in testing, which is offered to the patients prior to the surgeries.

There is national register of all HIV cases tested positive in the Slovak health services since the year 1982. The register is exhaustive. Only the positive findings are recorded, and only from the people who were tested in Slovakia, who are known to the Slovak health system. Negative HIV test results are not collected on the national level.

Two steps of HIV testing were common in the general health practice: the front-line immunoassay and more specific Western-Blot methodology, which is used only for front-line positive samples. Blood banks do not use front-line testing for the blood from blood donors. INSTI HIV-1/HIV-2 Antibody Test Kits are available for professional use in the pharmacies. Availability for self-testing is limited. But anybody can buy them via internet

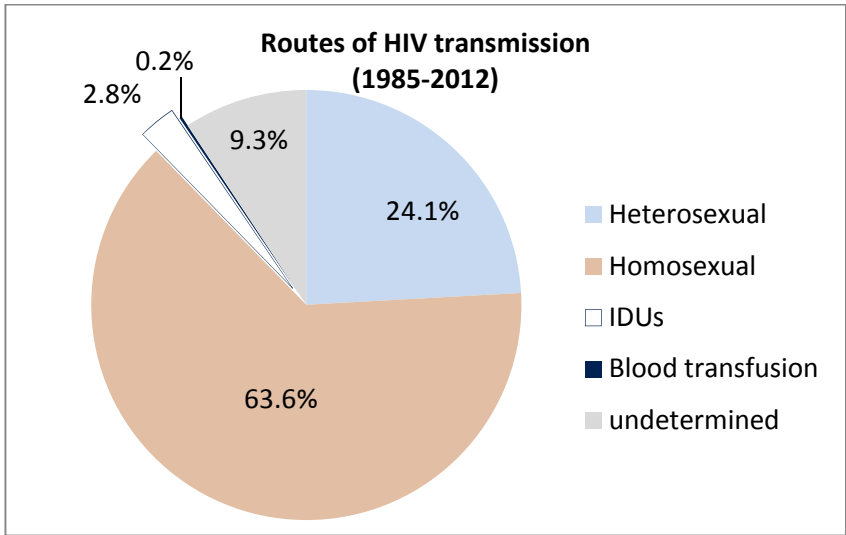
pharmacies. Indices on decline of HIV testing were observed in the past years: 190 thousands in 2010, dropping to 183 thousands tests in 2012.

Specialized addiction services are providing testing with special focus on injecting drug users. HIV testing is done from the blood of the patients, who asked for the treatment in the addiction facility, which was selected for sentinel monitoring of the incidence and prevalence of blood-borne infectious diseases. Here the screening is exhaustive, with the exception of those cases, where it was not possible to take blood, because of their bad skin, scars condition and from the negligible fraction of those, who refused the testing.

No significant change has been registered in the incidence and prevalence of HIV infection in general population, or among problem drug users in Slovakia in the year 2013. It did not achieve the level of the epidemic. However, the prevalence in general population is on slow, but continuous increase, because of the effective medical treatment of the people, who were already infected. There were 50 new cases detected with positive anti-HIV antibodies in the year 2012, but at the beginning of the decade it was only 25. 60 new cases of HIV infection were detected in Slovakia from the 1st of January till the 30th of September in the year 2013. 57 out of them were Slovak citizens and 3 were the foreigners, who were temporary residing in the country. Four new AIDS cases have been reported among Slovak citizens in the same time-period. There were 512 cases of HIV infection detected among Slovak citizens since the beginning of HIV testing in the year 1985 till the end of the year 2013. The AIDS condition developed in 74 patients and 41 died. The majority of the infections were recorded in the population of the men who had sex with men. Altogether 639 cases of HIV infection were registered in Slovakia since the start of the HIV testing in the year 1985. This figure includes Slovak citizens as well as tested non-citizens of the Slovak Republic, who were tested in this country.

Prevalence of HIV infection in the general Slovak population was deep below 0.001%. The highest percentage, 45%, of the reported cases of HIV were from the Western regions of the country, mostly from Bratislava and its surroundings, and the lowest prevalence was in the Eastern parts of Slovakia.

Figure 6.1: Routes of HIV transmission in tested persons in Slovakia. Source: National Reference Centre for HIV/AIDS Prevention



Occurrence of 12 cases among drug users in 2013 indicated HIV prevalence 0.01% according TDI, 0.1% among PDU and 0.3% among known injecting drug users in the treatment. There was no new case of HIV recorded in Slovakia, which was contracted by injecting drugs among drug users in the year 2013. The infection spread among those who were detected as infected during the whole period of HIV testing from 1985 till the end of 2013 as it follows: by homosexual intercourse 65%, by heterosexual intercourse 24%, via injecting drug use 2% and undetermined way of transmission was in 9% of the cases (Figure 6.1).

6.2.2 Hepatitis C (HCV)

The study conducted by the National centre for viral hepatitis revealed the prevalence of 0.6% anti-HCV and 0.2% of positive HCV-RNA samples among the patients in the mixed group of 1,588 voluntary healthy subjects and the patients from general health services in Slovakia. In the same study, there were occurrences of anti-HCV antibodies and HCV RNA in two selected groups of patients on dialysis and with the history of injecting drug use (IDUs) as it follows: 20% and 16% in patients on dialysis; 42% and 26% in patients with drug use history, respectively. The highest prevalence was found among the people incarcerated in the prison: in 49% of them was found anti-HCV antibody positivity and in 39% of their samples were positive findings of HCV RNA. There was large, non-specified proportion of former drug users among the persons in the sample from the prison, which could explain its high HCV prevalence.

Because of the treatment perspective it is important to know the genotype of the HCV virus in the infected person. Generally, better treatment response, clearing of the virus, could be achieved, if the patient is infected with genotype 3. Interesting were the findings of the above mentioned prevalence study in Slovakia. While IDUs had HCV genotype 1 in 52% and genotype 3 in 32%, among incarcerated it was 32% and 65%, respectively; and all the patients on dialysis 100%, had only genotype-1 of the HCV virus.

HCV testing is required from blood donors and is standard for patients on dialysis, for drug users in treatment and other patients with higher risk of HCV infection. No consent is required. It is fully covered by the health insurance. Testing might be done also on the patient's request. The testing is conducted with ELISA test of IV. generation (Innotest HCV IV Ab), quantitative test for HCV-RNA using PCR method (Cobas Amplicor Monitor HCV Test, version 2.0 Roche Diagnostic Systems), and for genotyping (INNO-li PATMHCV).

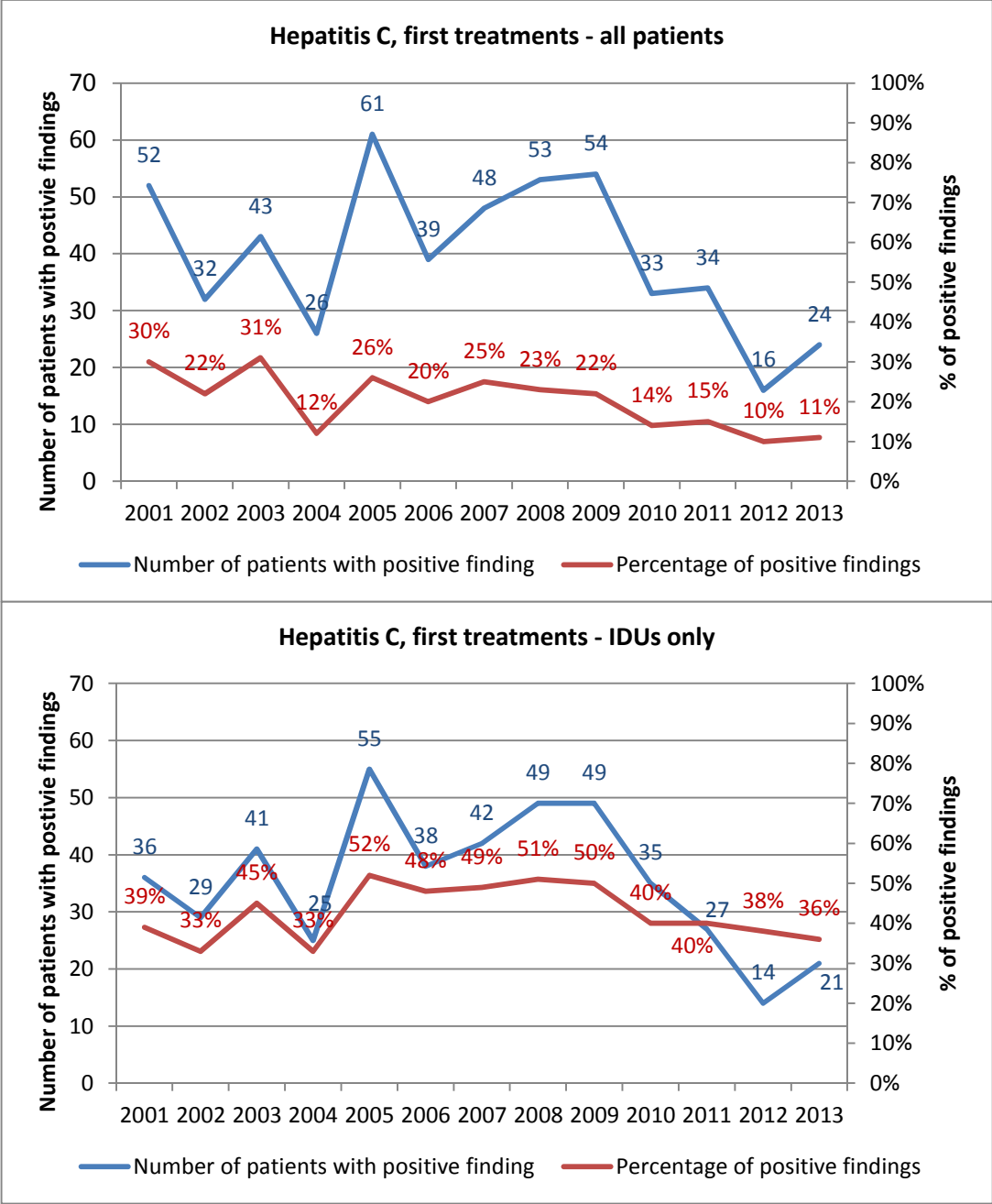
The most frequent route of hepatitis C virus transmission is by sharing of used injecting paraphernalia among IDUs in Slovakia. This is in the contrast with HIV, where the most frequent is by MSM contraction. There is epidemic of hepatitis C (HCV) infection among problem drug users in Slovakia, which is lasting now for more than decade. The findings do not support the hypothesis of the co-occurrence of the spread of HIV together with HCV in this subpopulation. This is supported by several findings all over the world. Despite of the high prevalence of HCV among IDUs, the prevalence of HIV is still very low.

Similar clinical protocol was implemented for the testing of HCV antibodies, as it was in the case of HIV at the Centre for Treatment of Drug Dependencies in Bratislava. The

testing of HCV antibodies in the serum from venous blood was conducted on the request of clinical addiction centre in the medical laboratory with confirmatory testing in the case when positive HCV antibodies were detected. The RNA testing and genotyping was not done. The patients tested positive for antibodies, were advised during the post-test counselling to visit specialist in hepatology or in the infectious diseases for further diagnostic specification and treatment. There was performed more detailed virology testing. All the procedures were voluntary with informed consent and on voluntary basis.

The prevalence of HCV infection among IDUs in the first treatment admissions in our sentinel sample dropped to 36% in 2013 in comparison with 38% in 2012, 40% in 2011 and with 50% in 2009.

Figure 6.2: Prevalence of HCV among the first admissions – all patients and IDUs in CTDD Bratislava. Source: CTDD Bratislava



As it was expected the rates of patients with HCV positive test results correlated with the age of injecting drug users, the rates were rising: from 8% in the age group below 25 years to 44% in the age category between 25 to 34 years old and to 50% in the age category of the patients, who were 34 years old and older. However, validity of these findings is not very strong, because of the small sample size. A little bit more convincing is data on the evidence of the higher rates of HCV infection, which are growing with the length of the time from the first injection. While there were 17% and 13% of anti-HCV positive patients among the injectors, who injected drugs for the first time in their life less than 2 years ago, and from 2 to 5 years ago, respectively; it was already 55% and 78% of positives for HCV in the group with history of the first injecting from 5 to 10 years ago, and more than 10 years, respectively.

No change has been observed in comparisons with the previous year. Still, the higher rate - 50% of HCV infections was found among injecting drug users, who were dependent on opioids, and only 35% among the others, whose primary drug was other substance, mostly methamphetamines – pervitin. But in absolute figures there were four times more HCV positive findings among injectors of other drugs, who were not on opioids. It was due to declining and small numbers of opiate users entering treatment.

This finding together with the findings of decline in all PDUs and IDUs and in HCV infected patients among them since the beginning of sentinel monitoring in 2008 is suggesting recession of HCV epidemic among drug users. One should be careful concerning the possibility to generalize the data. The results are from small samples and from the sentinel monitoring. However, they are from central, the largest, specialized treatment institution and cross referencing with some other indicators, especially TDI, is pointing in the same direction. Same incidence trend has been observed in other countries in the association with decline of the new injectors and the numbers of new opiate users.

6.2.3 Hepatitis B (HBV)

Similar protocol concerning medical office procedure was used as it was in the case of testing on HIV and HCV infections. The presence of hepatitis B serum antigen HBsAg was tested as the indicator of current infection and anti-HBc hepatitis virus core antigen as marker of hepatitis B viral infection, which is indicative for the past HBV infection in the tested person.

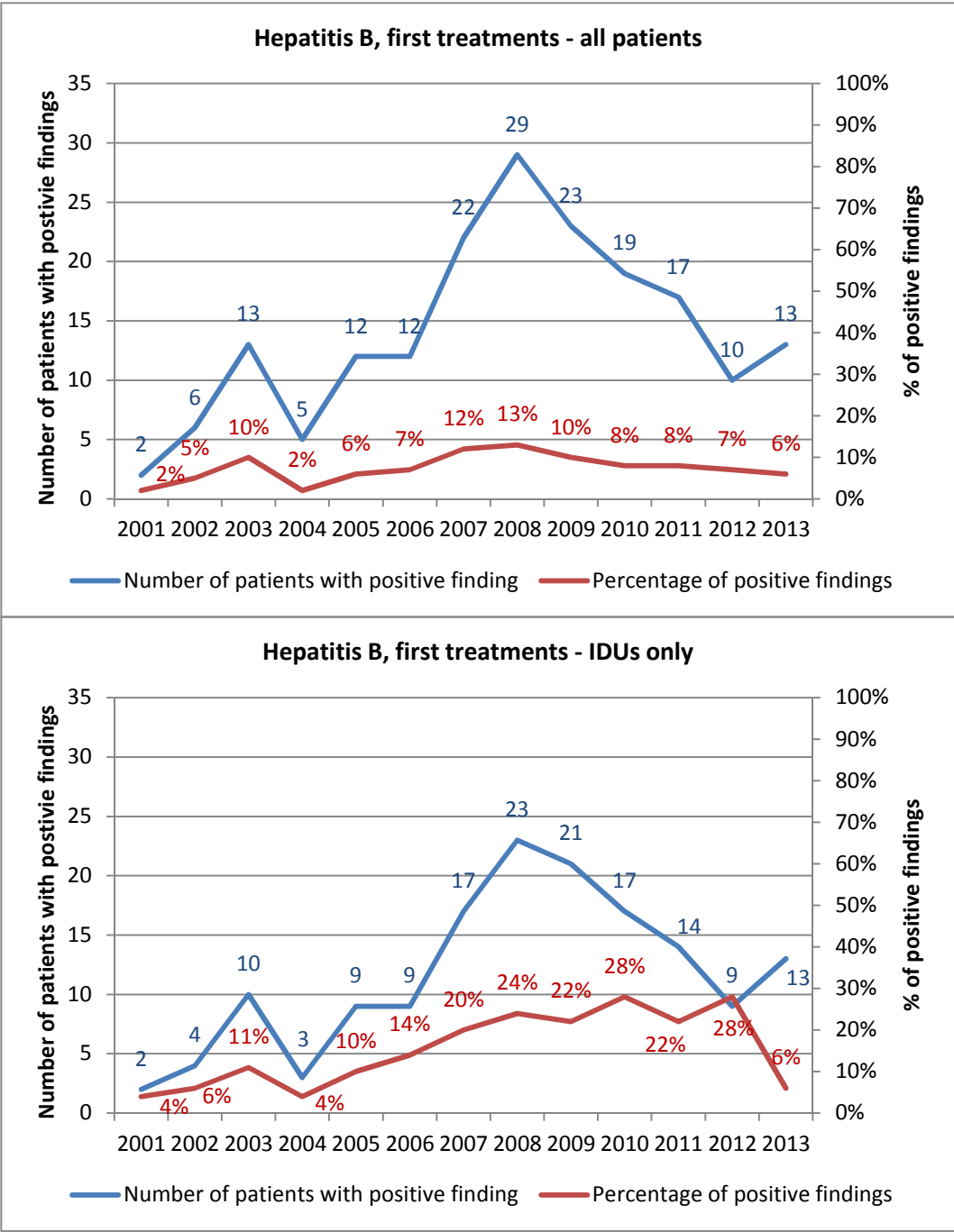
There was only one patient with HBsAg positivity, prevalence was 3%, among the new admissions of IDUs in 2013, the same as it was detected among IDUs entering the treatment at CTDD Bratislava for the first time in the year 2012. But it was only one IDU in the absolute figure. So, the new lowest level of the infection has been achieved.

The overall prevalence of anti-HBc positive cases was 17% among IDUs admitted for the first time to CTDD Bratislava in the year 2013, in comparison with 28% in 2012, which again was decrease. The trend which is expressed in total number of persons with the marker is systematically declining from 23 in the year 2008 to 14 in 2011, going down to 9 cases in 2012 and 7 in 2013. 25% of anti-HBc positivity was found in the group with

the longest history of injecting, 10 or more years, and the lowest 13% in the group of patients who injected from 5 to 10 years before the treatment entry. However, this breakdown is not very informative, because of the small figures of the positive cases in the age categories.

In contrast to the situation of HCV antibodies, the prevalence of HBV did not exceed 50% in any group of IDUs, if we relate it to the duration of injecting. The most probable explanations could be the availability of vaccination, which is not available in the case of HCV infection.

Figure 6.3: Prevalence of anti-HBc among the first admissions – all patients and IDUs in CTDD Bratislava. Source: CTDD Bratislava



Again, the similar trend was detected as with hepatitis C, which is continuous decline in the occurrence of hepatitis B infection among drug users. But in the contrast to HCV, the numbers of IDUs HBV infected are so small, that we are coming to the 'bottom' prevalence. Here, the offer and availability of the vaccination is playing a major role.

Other viral hepatitis

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

6.2.4 Syphilis

According to national health statistics there was decline of new cases diagnosed with syphilis infection in general population. There were 252 new patients detected with the infection in 2013, which was less of 50 new cases in comparison with the previous year 2012. The higher incidence was in Bratislava and Kosice regions, lower in the countryside. National centre for health information and statistics does not collect data of syphilis incidence and/or prevalence among newly infected in relation to the presence of the diagnosis of drug-related problems among them.

The prevalence of syphilis among the first admissions of injecting drug users was 6% (3 out of 47) versus 10% (4 out of 40) in the Centre for Treatment of Drug Dependencies in Bratislava in the year 2013 and 2012, respectively. It was less, but still it remains higher than in 2011 – 1.5%, and 3% in 2008. These fluctuations are very probably due to small sample sizes. The number of new patients positive for syphilis was oscillating from 1 to 7 cases during the years of monitoring.

6.2.5 Other STDs

1,055 new patients with sexually transmitted diseases were reported to the National centre for health statistics from the general population approaching the health services in Slovakia in the year 2013. This was lower in comparison with the year 2012, mostly due to lower number of the new cases with syphilis. The increase was observed only in the number of newly diagnosed gonorrhoea cases. They were typically more frequently diagnosed among younger people.

Clinical practice is showing that also sexually transmitted diseases (STDs) are frequently occurring among drug users. Syphilis, gonorrhoea and trichomoniasis are found especially among those drug users, who are earning money in the sex business. But, there are not available quantitative statistical data on it, because the screening of other STDs among drug users, except of HIV and syphilis, was not conducted.

6.2.6 Tuberculosis

There is no information and no the evidence on the cases with tuberculosis among drug users. Country belongs to the group of developed countries, where tuberculosis is not medical or public health problem. There was no known case of HIV and TB co-infection in the country in 2013. Vaccination of general population was stopped because of its low prevalence.

6.2.7 Other infections

There was no registered any case of tetanus infection among drug users in the country for decades. Other infections, such as abscesses, endocarditis is not systematically registered in relation to drug use, despite of the anecdotal clinical evidence. Even in specialized addiction treatment facilities we can see very few patients with abscesses these days, than it was the case in the past. Lower drug injecting, good availability and good access to medical care are the main reasons.

The recent DRID trends cross-referenced with TDI data seems to suggest the reduction in the risk of the epidemics of blood-borne infection diseases among drug users in Slovakia. Still, the smaller proportion of IDUs is at high risk. Even if it was lower, the spread of HCV in this group is a persisting problem. There is overall decrease in the incidence of drug related infectious diseases among the patients who were entering treatment. Very important is the fact, that it was zero in the case of HIV infection among drug users. Also decrease in the prevalence of HCV infection among injecting drug users is a trend. These two blood-borne infectious diseases are the main targets of the harm reduction activities in the field of public health among drug users.

One of the principal causes is a change in the behaviour of the drug users, their change in the selection of drugs they are preferentially using. We have observed decrease in the injecting drug use, and the shift from use and injecting of opiates to use and into proportionally smaller injecting of methamphetamines in the last decade. Among those, who are starting to use drugs is much higher number of methamphetamine users, than those who are starting to use opiates, now days. Thus exposition and risk is lower of contracting the infections.

6.3. Other drug-related health correlates and consequences

Several studies on drug-related health correlates focused on selected psychiatric comorbidity and few dealt with co-occurrence of somatic disorders, others than infections in the past years. Selected focus on the health problems in aging drug users initiated by EMCDDA attracted our attention to the topic. Typical aging population of the ongoing drug users are the patients in methadone opiate substitution treatment (OST) program. The rationale to study this group from the perspective of long-term health correlates and consequences is that they are more or less in the continuous treatment and under the medical observation for quite a long time, which gives the opportunity to observe the changes of their health status. Secondly, this group with dependence on the opioids is the oldest with respect to the diagnosis of drug related problems. While patients with dependence on methamphetamines, where is the highest incidence of the new patients entering the treatment due to problems with drugs, are much younger, as well as the patients who are seeking treatment because of their problems with cannabis use.

Short, transversal, descriptive study was conducted among the patients in the largest OST methadone program in the Centre for Treatment of Drug Dependencies in Bratislava. The survey was exploring the prevalence of the problems in accordance with the WHO main preventable health determinants, which are: tobacco smoking, excessive alcohol drinking, lack of physical activity and insufficient nutrition. Out of 253 OST patients with the mean age 37 years were 64% males and 36% females. 94% were regular smokers, only 1%

manifested alcohol use disorder according to the results of MAST test, 99% had suboptimal physical activity and 57% had not good nutritional status. Besides those problems 79% were infected with hepatitis C virus, but nobody was HIV-positive in this sample.

The other typical and wide spread health consequences among drug users, especially among injectors are dental problems, teeth decays resulting in the loss of them. Here are also the focuses of bacterial inflammation, which can then circulate by blood and reach different organs. Non visible, but latent chronic endocarditis is one of the consequences, and anecdotal evidence of this condition exists. Which is surprising and good is the observation that the number of patients with skin necrosis after the use of infected needles and syringes declined and has only sporadic manifestation now days. This is probably due to significant decline of drug injecting, as mode of drug intake, and also probably due to better education and provision of sterile needles and syringes among drug users. Here, besides the pharmacies, the important role is played by the street-workers from the low-threshold harm reduction programs.

There was no significant change in the occurrence of toxic psychosis mainly due to the use of methamphetamines ("pervitín"), the most of the patients recovered with few days of the continuous abstinence.

6.4. Drug related deaths and mortality of drug users

52,089 people deceased according to the official statistics in Slovakia in the year 2013. Medical sections were performed in 7,248 cases, which was 14% of all recorded deaths.

6.4.1 Drug-induced deaths (overdoses/poisonings)

The departments of forensic medicine reported 52 cases of direct fatal drug-induced poisonings. The medicines were cause in 48% (25 cases) and in 52% (27cases) the overdoses were caused by illicit psychoactive substances and inhalants. Opioids were present in 23 (44%) and benzodiazepines in 6 (11%) of the deaths. The males dominated over the females by 66%. 71% of the deaths occurred in the older age group, in the age of 40 years and above.

6.4.2 Specific causes of mortality indirectly related to drug use

The departments of forensic medicine reported 47 deaths indirectly related to drug use in the year 2013 in Slovakia. Among them dominated males with 87%. The suicides represented 45% of the causes of deaths, followed by the accidents 32% and by drug related diseases in 19% of the cases. Benzodiazepines were in 38% of the cases, followed by amphetamines and methamphetamines in 23%, cannabinoids in 21% and opioids in 11% of the deaths. The most remarkable was the increase in the participation of cannabinoids, in which case, it is difficult to conclude on their direct role on the fatal poisoning. But, it might be the indirect evidence of their higher availability and higher consumption in drug using population in Slovakia.

6.4.3 Mortality and causes of deaths among drug users (mortality cohort studies)

Retrospective, naturalistic study on mortality among the patients treated at the Centre for Treatment of Drug Dependencies in Bratislava covered period of thirteen years from 1999 to 2012. The sample was formed by 3,316 patients with average age 24 years at the time of their treatment entry; 74% were males. 158 deaths were identified till the end of the year 2013. The overall mortality rate was 6.6 per 1,000 persons/year. The highest mortality rate was among the patients with dependence on inhalants 28.6 person/years, followed by sedatives 16.0 person/years. On the opposite side, the lowest death rate had the patients with dependence on cannabis 2.2 persons/years. However numbers of patients treated due to dependence on inhalants and sedatives were small in comparison with opioid and methamphetamine users. Because of that, the most of the deaths in absolute figures were among the patients treated due to dependence on opioids 97 deaths, which was 8% of all patients with this diagnosis, followed by 32 deaths, which was 5% among the patients with diagnosis of polytoxicomania. This is clear indication, that the most vulnerable are the patients with opioid dependence and use. It is also because of the fact that many polysubstance users, who in treatment were former or are also current users of opiates.

7. RESPONSES TO HEALTH CORRELATES AND CONSEQUENCES

7.1. Introduction

The changes on drug scene led to the considerations of the necessity to redesign our responses to health correlates and consequences of drug use. The changes in responses have already started as a reaction on demand from the field. All this is driven by wider spectrum of available psychoactive substances and due to appearance of new psychoactive substances (NPS) and also by the changes in the quantity and quality of traditional drugs, which is reflected in their consumption and by the fact, that people who are using drugs are getting older.

Needle and syringe programs (NSPs) are providing sterile needles and syringes and other equipment to drug users, to prevent health related harm. This is targeted especially to prevent the transmission of blood borne infections, with the priority focus on human immunodeficiency virus - HIV and hepatitis C virus - HCV. But also bacterial infections should be minimized and avoided their pathologic consequences, such as the abscesses, endocarditis, sepsis, etc.

The access to the sterile needles and syringes for injecting drug users is possible by three options: (1) they can be bought, (2) or exchanged for used ones, (3) or to be obtained via free distribution of sterile equipment.

The low-threshold programs are assisting drug users without any high demands,, they might be entered without high requirements imposed on the clients as preconditions for their admission. Several types of the programs exist, such as free of charge NSPs, outreach street work, low threshold substitution treatment for people with dependence on opioids. The provision of the programs is realized either by public, or by not for profit health institutions, or by pharmacies, which are in the private business, as well as by non-governmental organizations. Most of the services, which are provided by the low-threshold programs, can be approached anonymously, without personal identification of their clients. Only opioid substitution treatment requires patient's identification, but the identity of each person is strictly secured and guarded by the law.

Blood borne infections, their prevention is primarily focused on viral hepatitis C, B infections and HIV, which can be transmitted from person to person by blood, either by sharing of non-sterile needles, syringes, or by other injecting paraphernalia, or by blood transfusion, or tattooing. This is an important public health issue.

Co-morbidity, the co-occurrence of medical and/or mental disorders together with drug dependence is also in the focus of the efforts for prevention and reduction of drug-related harm done to the users. Prevention of bacterial infections, abscesses, endocarditis, sepsis caused by the use of non-sterile paraphernalia has the main goal to increase the individual health and quality of life of the injecting drug users.

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

The Early Warning System (EWS), which is in the country located at the National Focal Point at The Ministry of Health, is playing an important role in the prevention of fatal and non-fatal overdoses among drug users. It is assisting not only in the detection and in warning against the new psychoactive substances (NPS), but is also signalling the outbreaks of new epidemics of already known drugs. That was the case of higher occurrence of fentanyl abuse, which was associated with overdoses two years ago. Health and other official authorities adopted preventive and repressive measures and the police acted swiftly, which resulted in decrease of temporarily increased drug overdoses. There were no registered fentanyl associated fatal overdoses in the year 2013. Prevention is based on the health education focusing mainly on young people, who are at higher risk of drug use, selective prevention is targeting drug users. The aims are different. In the case of primary, general prevention the main goal is to avoid drug use, especially by the youngsters and in the case of drug users, it is an effort to change their behaviour, to motivate them to enter drug treatment programs, or at least not to combine drugs, and in the same time try to shift them 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 programs' to prevent spread of infectious diseases; targeting chronic opiate users with dependence with the provision of opioid substitution treatment with methadone or buprenorphine-naloxone; securing the availability and the access to specialized addiction treatment facilities and to treatment in general. All these measures are working together. Some can be used in combination, some of them are used solely, which is for example in the case of so called drug-free residential treatment. Demand on opiate substitution treatment has stabilized, even little bit increased in the year 2013. Still, it is far behind the situation which was during heroin epidemics in Slovakia in the nineties in the twentieths century. The most prevalent injecting drugs were methamphetamines in 2013, so as it was in the previous years. There is no substitution medication for methamphetamine users. Therefor the recent challenging task is to find the effective responses to prevent spread of infections by methamphetamine users who are injecting Czech invented methamphetamine – "pervitín".

7.3.1 NSP

Needle and syringe programs are organized in different ways, which is: exchange of used needles and syringes by street-workers; the exchange for used ones, or just provision of new for free in specialized addiction treatment health facilities; or inexpensive sale of the sterile needles and syringes in the pharmacies. Public pharmacies are the main source of the sterile injecting equipment. Their advantage is that they are covering the whole country, so it means that the accessibility, and also the availability of paraphernalia for injecting drug users is good in general.

7.3.2 HCV and HIV testing

Estimations by some experts are as high as 35 thousand of infected persons with HCV in the Slovak population, and only about 10% of them are aware of their infection. According to the chief expert for infectious diseases with the Ministry of Health, there is about 20 thousand persons infected with hepatitis C virus who are not aware of their infection in Slovakia, and only about one thousand is in the treatment. Despite of the fact, that the prevalence of HCV antibodies among the first admissions of IDUs in sentinel monitoring has declined from 50% in 2009 to 38% in 2013, the overall prevalence in this group is still remaining very high. Of those, who are in the methadone maintenance treatment, in the same institution, more than three quarters were infected. It is important that up to 20% of infected is able to clear the virus spontaneously without any treatment. Such cases were also observed in the addiction services in Slovakia. IDUs tested in the past as positive for HCV infection have become negative after some times without any specific treatment.

Testing for HCV, HIV is free of charge for drug users and is provided in all in-patient treatment programs in the health facilities, which are in the mental hospitals, in the specialized addiction centres, or for patients with drug related problems in the psychiatric wards in general hospitals in Slovakia. The testing of out-patients is less regular. The out-patients who are treated in the programs in the specialized Centres for Treatment of Drug Dependencies are also tested on regular basis for the antibodies against the above mentioned blood-borne infections. However, most of the private psychiatric clinics around the country do not provide the testing for the out-patients. Limited testing is also conducted from time to time by the street-workers in Bratislava, Trnava and Nitra. Even in the case of testing for HIV, where informed consent from the person is required, the refusal rates are very low. The crucial issue is to get the drug users into the touch with the addiction services and motivate them to agree to be tested. According to The National reference centre for the prevention of HIV/AIDS there is a trend of decline in the number of HIV tests conducted in Slovakia in the past years. It might be the indication of lower HIV risk awareness in the general population.

7.3.3 HCV and HIV treatment

HCV and HIV treatment for drug users, who are Slovak citizens and are insured by Slovak health insurance companies, is available, because it is fully covered by their health insurance.

HCV. The combination of pegylated interferon with ribavirin was a standard treatment for hepatitis C infection in the past. The latest standard treatment approach, especially for the non-responders infected with HCV genotype 1, is the combination of pegylated interferon and ribavirin with the new direct acting antiviral medications from the protease inhibitor group – telaprevir and boceprevir (Kristian P. et al., 2011). Treatment duration is 6 or 12 months, if it is necessary, which is based on the detection of virus. Also the patients on opiate substitution treatment have access to treatment of HCV infection without payment. Treatment is not covered by health insurance only for those, who are active problem drug users. Such barrier does not exist in the prison and so it is available there for all those, who are in the need of it.

HIV treatment is also free of charge for all drug users. It is fully covered by the health insurance companies. The antiretroviral treatment with combination of medicines starts according to detected viral load. Standard is high acting antiretroviral therapy – HAART in the country. Four health facilities are provided prophylactic treatment on the request in the case that someone was in the high risk of being infected with HIV. This is possible to obtain it in Bratislava, Kosice, Banska Bystrica and Martin. Treatment of blood borne infectious diseases is for drug users voluntary. But many times the problem is the patient's hesitation in a decision-making process to start treatment and afterwards the adherence with it.

7.4. Responses to other health correlates among drug users

7.4.1 Toxicology/Urinalysis

Toxicology of biological samples has important role in the diagnostic processes at emergency departments and also in the treatment of the people with drug use disorders in clinical practice. Especially, it is important in the era of polysubstance use and during the emergence of the new psychoactive substances. Standard method is toxicological urinalysis. Immunoassays are used as standard in clinical toxicology providing the information on the presence of traditional drugs, such as morphine, amphetamines, methamphetamines, THC, cocaine, benzodiazepines and barbiturates. This first step of drug screening, which is enough to satisfy clinical routine. As second stage is used testing of the biological samples in the specialized toxicological laboratories with GC/MS methods. Here, wider variety of substances can be detected and this is also standard for forensic toxicology. Detecting the NPS or their metabolites in the biological samples is a new challenge. This is not a problem which is specific for Slovakia, only. We can expect further development of drug toxicology in the future. It can make it less costly and more available. Some problems concerning reliability of the testing could be created by the expanding market of drug tests for at home testing. The tests are sold for non-professionals in the pharmacies. Here, the most problematic is the interpretation of the results. Road-side drug testing from saliva has been considered by the police.

7.4.2 Surveys on availability and access to treatment

The access to and the availability of the treatment is based on the principles of solidarity and health insurance with general coverage of all Slovak citizens, which is guaranteed by the law. No systematic surveys have been conducted on the issues in the year 2013. Even, if the spectrum of the services is wide and it seems to be within recent world standards, some-times not everywhere all of them might be accessible. One of the reasons is that about half of the Slovak population is scattered around and is living in the countryside, which is not so in the majority of the other EU countries. Still, the alternatives do exist. For example, methadone maintenance treatment is available only in two places in Bratislava and Banska Bystrica. Low-threshold out-reach programs are also only in the few cities. But buprenorphine-naloxone substitution is available everywhere and cheap sterile needles and syringes for injection could be bought in hundreds of pharmacies without medical prescription all over the country. According to newspaper article, there was conducted not strictly, methodologically rigorous survey by HIV positive patient, who

was asking for treatment by phone calls or via emails about thousand medical doctors, dentists, out of which only about 10% were willing to accept him. The number of rejections was higher going from the West to the East of the country, and younger doctors were more frequently willing to accept him than the older ones. The main reason given in the article was insufficient equipment in the out-patient clinics for treatment of HIV infected patients. Despite of the low validity and reliability of the survey from the scientific point of view, its results should be taken into the consideration in the education of the health personnel from the field medical practice. Because, if we consider geographic and age differences of the doctors, it seems that prejudices more likely than insufficient technical equipment could be the main reason for possible patient refusal. However, all HIV infected people can get proper medical treatment elsewhere.

7.4.3 Education and training

No changes were in the system of education and training for the medical, nurse, pharmacy students in the field of drug use disorders, either was it in the undergraduate, or in the postgraduate studies. Articles with the educational purpose were published for wide spectrum of health professionals in the professional journals, such as: 'Lekársky monitor', 'Lekárnik', 'Zdravotná sestra' and also in highly specialized Slovak professional journal 'Alkoholizmus a drogové závislosti'. All members of health personnel should undergo life-long education, to update their knowledge with the latest scientific evidence based information. Besides the self-education efforts, several other, structured forms of learning are required from health personnel: regular attendance of teaching, professional, scientific seminars and conferences, presenting and writing professional papers, conducting research. This is obligatory for every individual health worker registered with the Slovak Medical Chamber, Slovak Chamber of Nurses, Slovak Psychological Association. In the year 2013, a special support and grant was provided by the Slovak Ministry of Health for the post-graduate education of mental health workers, medical doctors specialists in psychiatry, to learn about the latest developments in OST.

7.4.4 Quality Assurance

Quality of the health services is supervised by the Ministry of Health, Health Departments of The Offices of the Regional Governments and by The Office on the Control of Health Care, which is institution independent from the state. These authorities are responsible for the control of the health care providers, supervising their clinical practice compliance with the health laws, with methodological recommendations, guidelines on diagnostic and treatment processes, with the requirements of the quality, type and numbers of the personnel. Internal and external forms of control are implemented. The feed-back from patients/clients is playing an important part in the assessment of the quality of the care provided for the patients with drug use disorders. The external quality evaluation is using ISO 9001:2000. We could observe also enhanced public control of the care in mass-media, on the internet, by bloggers, or in the portal, where are patients, clients anonymously scoring their satisfaction with the care provided by the individual medical practitioners.

8. SOCIAL IMPLICATIONS OF DRUG USE AND SOCIAL RE-INTEGRATION

8.1. Introduction

Drug use and drug dependence in particular can be considered a cause of social exclusion resulting from the shortage of income, loss of job, worsened housing conditions, and even homelessness. Vice-versa, social exclusion in combination with other factors may be a reason why individuals at risk of social exclusion start using psychoactive substances.

Social reintegration is considered an essential component of a comprehensive drug strategy. Generally, social reintegration aims at seeking and developing capacities of individuals and/or groups of individuals at risk of exclusion, enhancing their social skills, facilitating and encouraging employment, and securing or improving their accommodation. With respect to individuals with drug-related problems, social reintegration services support treatment and prevent relapse by addressing key aspects of the social exclusion of drug users⁸⁰.

The most recent national drug strategy for 2013-2020⁸¹ has emphasised the need to adopt such integrated care models that address mental and/or physical health problems, rehabilitation and social assistance to improve health and social conditions, social inclusion and treatment of problematic drug users and addicts.

Even though certain signs of integration in the treatment and post-treatment care of persons with drug problems are already visible, they cannot be considered an integrated system. Medical treatment is provided in specialised health care facilities operated by the Health Ministry (or the Justice Ministry) and financed from public health insurance funds. The status of patients, including their rights and obligations, is clearly defined in applicable legislation. Post-treatment (primary, in some cases⁸²) long-term inpatient care is mainly provided by non-government facilities, including church communities and non-official communities led by former drug users. A majority of them (their current number is 19, including one funded by a municipal authority) are officially recognised as rehabilitation (re-socialising) facilities accredited by the Ministry of Labour, Social Affairs and Family to provide services in the area of social and legal protection of children and social custody. However, even they face problems with ensuring sufficient funding for their services.

No major changes have occurred in the labour, social affairs and family sector, responsible for the prevention of social exclusion and encouraging social inclusion, with respect to classification of persons who have problems with drugs and/or psychoactive substances (alcohol), chronic dependence on psychoactive substances, or non-substance addiction. These individuals are not explicitly classified as being at risk of social

⁸⁰ European Drug Report - Trends and developments. Luxembourg: Publications Office of the European Union, 2014. Pg. 61.

⁸¹ http://www.infodrogy.sk/ActiveWeb/c/6323/narodna_protidrogova_strategia_na_roky_2013_2020.html

⁸² According to the NMCD surveys, the share of clients coming to rehabilitation facilities from health care facilities gradually fell from over a half to roughly one third between 2007 and 2013.

exclusion. Provided they meet the conditions defined for other groups of population at risk of social exclusion (unemployment, socially disadvantaged background, families with multiple children on low incomes, etc.), they qualify for measures the Labour and Social Affairs Ministry introduced and introduces to prevent social exclusion and support social reintegration. This chapter is based on the information provided by the Ministry of Labour, Social Affairs and Family of the Slovak Republic and on summary data obtained from NMCD surveys conducted between 2007 and 2013.

8.2. Social exclusion of drug users

8.2.1 “Young homeless in Bratislava: Help within one year is crucial”

This is the title under which the results of a survey entitled “Specific needs of young homeless people in Bratislava”⁸³ (one of the few such surveys conducted in Slovakia) were published in the media. The survey was designed to identify the existing needs of young homeless people living in the Slovak capital city. Among other things, the survey tried to measure their social exclusion, identify their strategies for living and their impacts on resolving this situation.

The survey was conducted through semi-structured interviews in places with an increased concentration of homeless people (night shelters, places where meals are given out to the homeless) on a sample of respondents aged 18-29, with a slight prevalence of male respondents, who have been homeless for several weeks up to ten years. A majority of respondents had elementary education only, though some cases of incomplete elementary education, as well as secondary education also occurred.

The survey did not primarily focus on issues related to the consumption of psychoactive substances among socially excluded young people, but they mentioned these problems when talking about relationships with their partners - young people tend to stay in dysfunctional relationships, often affected by alcohol and drugs. A number of the young homeless also admitted to suffer from mental problems. This group may be even larger, since not all respondents acknowledged to have such problems.

The first year of living on the street is crucial for the homeless; a majority of those who fail to escape in the first year remain living on the street. Identifying young homeless people shortly after they end up on the streets may therefore help increase possibilities for their social inclusion. Helping them find a stable job to pay for their accommodation seems crucial in this respect.

However, a significant majority of young homeless people do not expect any official assistance in their efforts to escape their homelessness; they believe they have to do it on their own. Nevertheless, they would appreciate individual social counselling and specific

⁸³ Špecifiká potrieb mladých ľudí bez domova v prostredí Bratislavy (*Specific needs of young homeless people in Bratislava*), **Iuventa, Slovenský inštitút mládeže** Mgr. Alena Rochovská, PhD., RNDr. Anna Hrabovská, PhD., Mgr. Miriam Miláčková, Mgr. Ivana Brezovská),

Survey identification sheet ID: DAVM47, Project implementation period: September 2012 – December 2012 .
Data files are not accessible to the public.

assistance, but they do not know where to look for such services. People who think social counselling could be helpful consider it important even if it would only provide psychological support.

8.2.2 Social characteristics of drug users undergoing treatment

Except for the aforementioned survey that dealt with social exclusion of homeless people, studies and surveys on the social exclusion of drug users do not exist.

Statistical data on unemployment, highest level of education attained and stable (unstable) accommodation are available from annual surveys conducted by the National Health Information Centre (hereinafter only referred to as the "NHIC") for drug users undergoing treatment in a particular year.

In 2013, a total of 2,484 drug users (2,077 men and 407 women) were treated in health care facilities.

Of the total, 1,714 individuals were treated in health care facilities run by the Health Ministry (1,501 in 2012), and 770 in facilities run by the Justice Ministry (692 in 2012). The principle of voluntariness, i.e., patients themselves seek the treatment, is the crucial factor under the Treatment Demand Indicator (TDI). This cannot be generally said about persons treated in the facilities run by the Justice Ministry.

Unemployment - the high unemployment rate at 57.6% (58% in 2012) among drug users undergoing treatment is largely affected by the fact that nearly one third of them - 31% (31.55% in 2012) are persons reported by the Justice Ministry who are serving their term in prison, including those treated in the ministry's specialised health care facility in Trenín. The unemployment rate has been moving around the 57% level since 2004 (including prisoners undergoing drug treatment in the Justice Ministry's health care facilities).

Of the total of 1,448 unemployed drug users in treatment⁸⁴ in 2013, clients treated for perritin dependence accounted for the largest share at 40.5% (587 persons, 469 men and 118 women), followed by those treated for opiate addictions at 25.5% (273 persons were heroin addicts).

The share of people with **elementary education** again moderately fell in the entire population of drug users in treatment. Clients with incomplete elementary education accounted for 3.5% of drug treated people in 2013. By contrast, the share of people with secondary education among patients in drug treatment is continuously growing, reaching its highest level at 67.3% in 2013 (54% in 2012 and 51.7% in 2011).

The **share of people who lack stable accommodation gradually increased** over the past ten years - from 7.6% in 2004 to 13.5% in 2013.

Table 8.1 shows development in some social characteristic of people in drug treatment from 2004 to 2013 (see also Chapter 5).

⁸⁴ NCZI 2014 : Drogová závislosť - liečba užívateľa drog v SR 2013 (*Drug dependence - Treatment of drug users in Slovakia in 2013*) – ZŠ-44/2014, Year 2014, pg. 42-43.

Table 8.1: Overview of people in drug treatment disaggregated by selected social characteristics, 2004-2013. Source: NHIC, ZŠ-44/2014.

Year	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Total number of people in drug treatment in Health Ministry and Justice Ministry health care facilities	2,315	2,078	1,927	1,985	2,056	1,909	2,266	2,313	2,193	2,484
Without stable accommodation (%)	7.6	8.9	8.6	9.6	7	10.6	11.9	11.2	na	13.5
Unemployment rate (%)	54.2	54	55.2	56.5	53	63.2	59.7	56.3	58.0	58.3
Highest education attained - elementary (%)	43	39.1	38.5	40.3	39.5	39	41	37.8	36.2	35.5
Without education and/or with incomplete elementary education (%)	na	na	na	na	na	2.5	2.6	1.3	3.8	3.5

8.3. Legal and institutional framework governing social reintegration measures

Drug addicts and/or people who had/have problems with substance or non-substance addiction are generally not classified as persons at risk of social exclusion; therefore, they are not monitored by the Ministry of Labour, Social Affairs and Family and/or by individual offices of labour, social affairs and family. On the other hand, they are not excluded from social measures designed for other specific groups at risk of social exclusion as far as assistance in search for employment and accommodation, as well as education and training for labour market are concerned.

In the social affairs sector, the issue of drug addicts is specifically governed by Act No. 305/2005 Coll. on social and legal protection of children and social custody, as amended, which also contains a provision that specifies activities of social rehabilitation facilities and measures of social custody (for children and adults). Social rehabilitation is a synonym to social reintegration. The function of social rehabilitation centres/facilities is defined as follows: "Activating capacities of children and adults to overcome psychological, physical and social impacts of drug or other types of dependence and to reintegrate into their natural environment".

8.3.1 Social custody interventions for adults in 2013

Social custody interventions for adults were provided to 6,275 people in 2013 (down by 2,713 on the previous year).

The interventions were provided to 67 drug users - 1% of the total (to 80 clients in 2012).

Housing as a social service is provided by regional and local government authorities (public providers) and non-profit organisations, civic associations, church communities,

etc. (non-public providers). Social housing is provided in low threshold facilities (night shelters), crisis centres and similar facilities. Long-term accommodation - or assisted/social housing - is legislatively governed by Act No. 443/2010 on subsidies for housing development and social housing, but is rarely used in practice. The assistance provided in connection with a search for accommodation fell from 663 cases in 2012 to 230 in 2013. Social service facilities (homes) are not specifically designed for clients undergoing a drug treatment programme; persons with drug problems or those suffering from other types of dependence are provided accommodation if they meet other conditions defined in the Act on Social Services⁸⁵.

Rehabilitation facilities provide information about accommodation of persons with drug problems through statistical surveys. They register clients who have gone through the entire prescribed rehabilitation programme and were placed, as part of post-rehabilitation care programme, in sheltered homes or a half-way house facility. Thirty three adult persons were placed in this type of facilities in 2013 (37 adults in 2012). Another 126 clients returned to their families after they had completed their rehabilitation programmes (118 persons in 2012), and 21 persons (16 persons in 2012) went living on their own.

With respect to ensuring access to education and employment under the Act on Employment Services⁸⁶, requalification courses or educational projects are also provided to persons with drug problems if they meet general requirements applicable to registered unemployed job seekers.

Social custody services and interventions are also provided to convicts serving their prison term, and after their release from the prison. These services are delivered by local offices of labour, social affairs and family in a place of habitual residence of such persons. Of the total number of 6,275 social custody interventions provided in 2013, 5,226 were provided to adults released from prisons, including those released on parole.

In 2009, specialised counsellors for drug dependences were established at eight regional offices of labour social affairs and family⁸⁷. This specific agenda within psychological consultancy services which are organisationally linked with the agenda of social and legal protection of children and social custody covered interventions for persons experimenting with, or at risk of alcohol and/or drug use or other types of addiction, for persons abstaining after drug treatment, and for persons serving a probationary sentence. For the 2010-2012 period⁸⁸, a total of 842 persons (including 108 family persons) were reported to have used these services. According to the most recent information available to the Slovak Ministry of Health, these specific professional services were not provided in 2013.

The key element in the process of social rehabilitation of drug addicts delivered in the field of labour, social affairs and family are residential rehabilitation centres for people

⁸⁵ Act No.448/2008 Coll. on social services and on amendments to Act No. 455/1991 Coll. on licensed trades (the Trades Act), as amended.

⁸⁶ Act No. 5/2004 Coll. on employment services and on amendments to certain acts, as amended.

⁸⁷ Trnava cancelled the position of specialised counsellor as part of austerity measures in 2011.

⁸⁸ Mardaková 2013 : Činnosť referátov poradensko-psychologických služieb (RPPS) v oblasti prevencie drogových a iných závislostí v roku 2012 (*Activities of psychology and counselling services departments in the prevention of drug and other dependences in 2012*. - Report prepared for the Ministry of Labour, Social Affairs and Family.

suffering from drug addictions. The establishment of rehabilitation centres falls within the competence of higher territorial units - eight regional self-governments, towns and municipalities. They are operated by non-governmental organisations (non-profit organisations and civic associations) which are required to obtain an accreditation from the Ministry of Labour Social Affairs and Family, under conditions prescribed by the law, to provide services in the area of social and legal protection of children and social custody. Rehabilitation centres are not considered facilities providing social services under the Act on Social Services.

A uniform quality standard in the provision of social services is ensured by the standards adopted in 2008⁸⁹ which have been, to a greater or lesser degree, also incorporated in an amendment to the Act on Social and Legal Protection of Children and Social Custody. These standards did not change until 2013.

The funds for the operation of rehabilitation centres come from multiple sources: a portion of funds is provided by their founding entities (municipalities, self-governing regions, towns), a portion of funds is provided by the offices of labour, social affairs and family to finance implementation of measures for social and legal protection of children and social custody, and some part of the costs are paid by clients themselves. In 2013, the operation of rehabilitation centres was supported by subsidies granted under subsidy schemes run by the Ministry of Labour, Social Affairs and Family and the Government Council for Crime Prevention. The operators of such facilities can also apply for a 2% contribution from income taxes every year. The question of stable financing - especially by founding entities - has for several years been subject to a public debate⁹⁰. The rehabilitation centres form the Association for Rehabilitation Centres and Post-rehabilitation Care.

According to a survey conducted in 19 RCs (18 accredited RCs and one municipal facility run by the Bratislava City Council), and from 2013 in 20 RCs (19 accredited by the Ministry of Labour, Social Affairs and Family and one municipal facility), the following numbers of clients were served by such facilities (Table 8.2):

Table 8.2: Reported numbers of RC clients – statistical report by the Ministry of Labour, Social Affairs and Family) (Czuczorová 2014)

Year	2010	2011	2012	2013
Number of RC clients reported in the statistical system of the Ministry of Labour, Social Affairs and Family	528	632	373	410
Number of new clients	280	369	288	270

Effectiveness of a rehabilitation programme is measured as a successful completion of the entire programme which is specifically designed to meet individual needs and motivations

⁸⁹ Kolektív autorov (2008): Kvalita resocializačných stredísk pre drogové a iné závislosti - Štandardy a dobré skúsenosti (*Quality of rehabilitation centres for drug and other dependences - Standards and good practices*). <http://www.infodrogy.sk/index.cfm?module=Library&page=Document&DocumentID=645>

⁹⁰ Conference entitled “Quo vadis resocializácia” (*Quo Vadis, rehabilitation*) – Association for Rehabilitation Centres and Post-rehabilitation Care, www.arsps.sk, 20 August 2014.

of a client. Based on the data provided by the Ministry of Labour, Social Affairs and Family⁹¹, 180 clients completed their individual programmes in 2013. (Table 8.3)

Table 8.3: Number of clients who completed rehabilitation programmes - statistical report by the Ministry of Labour, Social Affairs and Family (Czuczorová 2014)

	Number of clients in 2010	Number of clients in 2011	Number of clients in 2012	Number of clients in 2013
Successful completion of the entire programme (12 months at least)	153 (19 children)	156 (26 children)	171 (26 children)	180 (51 children)
Programme early terminated by clients	216 (18 children)	193 (17 children)	203 (11 children)	241 (8 children)
Programme early terminated by RC (due to a breach of community rules, etc.)	66 (1 child)	64 (1 child)	25	45
Other reasons	32 (10 children)	24 (4 children)	24 (children)	21 (7 children)

Group-based social work with clients, in-house occupational therapy, individual social counselling, advisory and first-contact services and mediation of post-rehabilitation care were prevailing types of services provided by RCs. An average length of stay of a client in an RC is 8.92 months for adults and 6.72 months for minors. (Czuczorová 2014)

8.4. NMCD surveys on the structure of clients and services in rehabilitation facilities

The National Monitoring Centre for Drugs conducted the seventh statistical survey on the structure of clients and services in rehabilitation services in 2014. Aggregated data are obtained through a questionnaire completed by an RC officer; RCs receive financial remuneration for the provision of data. Originally, the NMCD introduced surveys in RCs in order to determine the structure of their clients by the type of psychoactive substance used by clients, and/or other non-substance addiction, that led them to seek rehabilitation services. Another important aspect examined by the survey was the effectiveness of rehabilitation programmes which ideally result in client's social reintegration.

⁹¹ Annual reports on the implementation of measures for social and legal protection of children and social custody for rok 2013 - V(MPSVR SR) 13-01; V(MPSVR SR) 12-01; V(MPSVR SR) 5-01

Table 8.4: Primary structure of RC clients in 2007-2013 (Data: Surveys on the structure of clients and services in rehabilitation facilities - NMCD 2014)

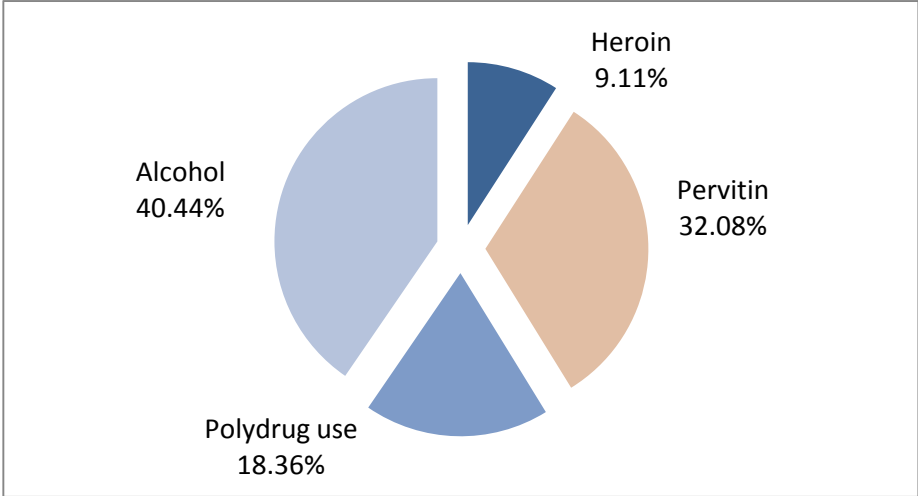
	2007	2008	2009	2010	2011	2012	2013	total	%
number of all clients	614	741	857	802	842	807	893	5,556	100
new clients admitted in a given year	382	470	521	448	452	441	497	3,211	57.8
men	420	487	531	426	445	468	532	3,309	59.5
clients under 18	50	80	106	97	95	106	145	679	12.2

The first NMCD surveys carried out before 2009⁹² indicated trends that have since prevailed and enabled to draw several general observations after the seven years of conducting those surveys:

1. Number of RC clients is increasing (having grown almost by half - 45.4% - since 2007)
2. A majority of RC clients are men - their share keeps moving around the 60% level (nine RCs are exclusively designed for male clients)
3. The number of RC clients under 18 years of age is also growing. The share of the under-18 clients doubled over the seven years (from 8% to 16%); their total number nearly tripled (from 50 to 145). Within this age group, the number of RC clients under 16 is also on the rise - from 5 children in 2007 to 21 children in 2013.
4. The share of clients with a history of injection use oscillates around one fifth, but dropped from 27% in 2007 to 15% in 2013
5. A majority of clients are people with drinking problems
6. The structure of RC clients by the most frequent primary drug the use of which brought them to an RC did not change over the seven-year period: clients with drinking problems are most numerous, followed by users of illicit methamphetamine (pervitin), polydrug users, and heroin addicts.
7. As many as 5,037 RC clients (90.6% of all RC clients) had problems with a substance from one of the following four groups (Figure 8.1)

⁹² NMCD surveys concerning the structure of clients and services for rehabilitation - social reintegration 2007-2009; internal report prepared by: Eleonora Kastelová, NMCD, September 2010 - <http://www.infodrogy.sk/index.cfm?module=Library&page=Document&DocumentID=871>

Figure 8.1: Shares of clients by individual primary substances (NMCD 2014)



The share of clients with cannabis as their primary problem drug is between 4 and 5%, but their number is slowly growing.

Table 8.5: Cannabis as primary drug - the number and share of RC clients having problems with cannabis. NMCD 2014

cannabis, RC clients: number / share	2007		2008		2009		2010		2011		2012		2013	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
	27	4.4	15	2.1	36	4.2	38	4.7	46	5.5	35	4.3	46	5.1

8.4.1 Basic data from the NMCD survey in rehabilitation centres – 2014 (data for 2013)

In 2013, another rehabilitation centre was established and the total capacity was increased to 482 places which was utilised by 893 clients in 20 RS. Majority of them⁹³ were men – 60% (58% in 2012). In 2013, 497 new clients were admitted to rehabilitation centres. Of this number, there were 145 clients below 18 years of age (16.2%), of which 21 were children aged 16.

The criminal history of clients in rehabilitation centres is monitored since 2009. In total for the entire period, the services of rehabilitation centres were provided as a form of post-penitentiary care only to 55 persons who attended a rehabilitation programme after serving a custodial sentence. In the individual years of the survey, the share of these clients was less than 2% of the total number of clients in the given year.

Since the 2011 survey, a new aspect is monitored – the criminal history of clients – (prosecuted, sentenced, serving a suspended sentence, troubles with the police). In the current survey, this aspect was monitored by 16 RCs which reported 132 clients that have

⁹³Of 20 rehabilitation facilities, nine are for men only.

already had dealings with law enforcement bodies. (In 2012 and 2011, 17 rehabilitation centres reported 205 clients and, respectively, 121 clients with such experience.)

Table 8.6: Number of rehabilitation centre clients with “criminal” history – 2009-2013 (NMCD 2014)

Year	2009	2010	2011	2012	2013
Post-penitentiary care	12	17	9	10	7
"Criminal history" of clients	na	na	121	205	132

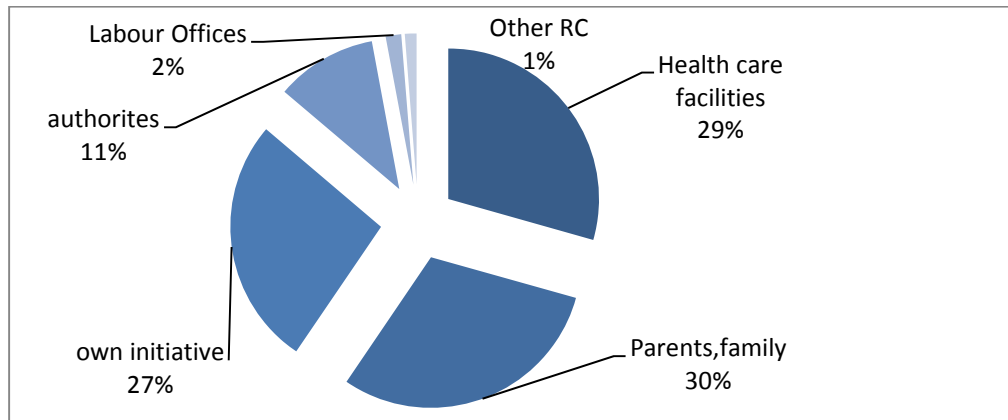
Table 8.7: Overview of the structure of clients and the primary reason in individual years of NMCD surveys (NMCD 2014)

Year / number / %	2007		2008		2009		2010		2011		2012		2013		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Number of clients	614		741		857		802		842		807		893		
Of which	New clients	382	62.2	470	63.4	521	60.7	448	55.9	452	53.7	441	54.6	497	55.6
	Men	420	68.4	487	65.7	531	62	426	53.1	445	52.8	468	58	532	59.6
	Minors below 18 years of age	50	8	80	10.7	106	12.3	97	12.1	95	11.3	106	13.1	145	16.2
	Of which: clients aged 16	5	0.8	5	0.6	14	1.6	18	2.2	9	1.1	17	2.1	21	-
	Clients with a history of injection use	168	27.3	150	20.2	184	21.5	113	14.1	140	16.6	155	19.2	131	14.7
Of that:	Heroin as primary drug	74	12	60*	8.5	77	9	70	8.7	66	7.8	59	7.3	54	6
	Methamphetamine (pervitin)	159	25.8	229*	32.4	270	31.5	232	28.9	240	28.5	231	28.7	260	29.1
	Cocaine	2	0.3	4*	0.5	7	0.8	3	0.3	3	0.3	1	0.1	2	0.2
	Polydrug use	101	16.4	117*	16.6	139	16.2	127	15.8	117	13.9	140	17.3	184	20.6
	Cannabis (THC)	27	4.4	15*	2.1	36	4.2	38	4.7	46	5.5	35	4.3	46	5.1
	Ecstasy	0	-	2	0.2	0	-	1	0.1	1	0.1	0	0	5	0.5
	Volatile substances	5	0.2	6	0.8	13	1.5	9	1.1	11	1.3	9	1.1	9	1
	Buprenorphine	6	0.9	4	0.6	4	0.4	4	0.4	3	0.3	2	0.2	2	0.2
	Methadone	0	-	1	0.1	1		2		0	0	0	0	0	0
	Alcohol	211	34.4	259	36.6	293	34.2	303	37.8	353	42	307	38.0	311	34.8
	Non-substance addiction (F 63, PC, gambling, bulimia)	29	5	9	1	17	1.7	13	1.6	11	na	20	2.5	19	2.1

8.4.1.1. Reasons/motives for contacting rehabilitation centres

In 2013, 29% of clients were referred to rehabilitation centres from healthcare facilities (in 2012, their proportion was 36%). In the long term, this reason is the most prevalent. In 30% of cases, the clients were compelled by their parents and family to undertake treatment in rehabilitation centres. The positive thing is that the proportion of the "own initiative" motive is increasing, from 18% in 2012 to 27% in 2013. An overview of reasons for using the services of rehabilitation centres is shown in the Figure 8.2 below.

Figure 8.2: Overview of reasons for using the services of rehabilitation centres in 2013 (NMCD 2014)



8.4.1.2. Effectiveness of the rehabilitation programme and services rendered

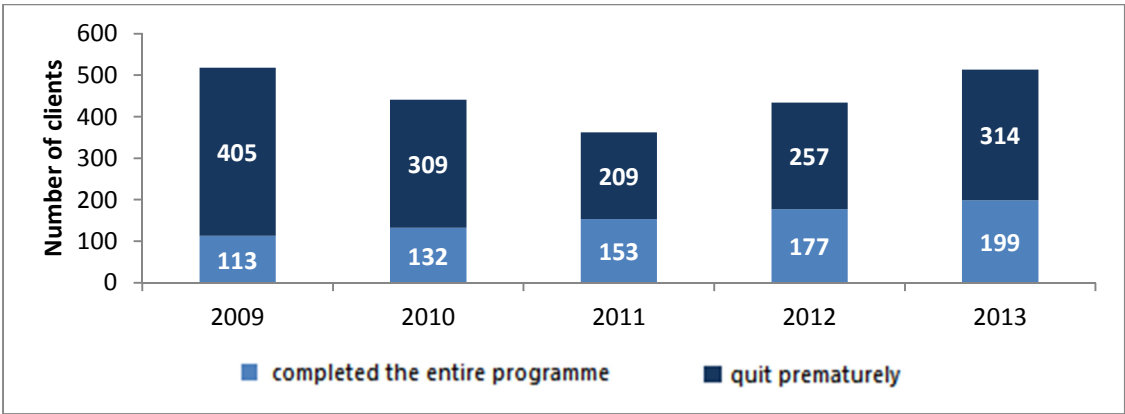
Abstinence from primary drug after one year

Based on data from 18 RCs which are monitoring the progress of their clients after one year (those who completed the programme in 2012), there were at least 164 such clients in 2013 (for 2012, 14 RS reported to have supervised 131 clients; in 2011, the number of such clients was 119 clients) as regards abstinence from primary drug after one year. Such supervision is performed by means of objective surveying (test) by five RCs, primarily combining – as is the case with other RCs - telephone contact, personal visit and additional information gathered from the family, school or place of residence. Post-rehabilitation activities – such as weekend community, fieldwork therapy, fieldwork family therapy, AA clubs – represent another source of information about the situation of a former rehabilitation centre client.

The entire rehabilitation programme was completed by 199 clients, the highest number since 2009 or 2008.

On the other hand, majority of clients quit the programme prematurely (and most of them while still in the adaptation phase) which is a long-lasting trend. For the above period, this proportion is 1:2 on average to the detriment of completing the entire programme. Even in 2013, there were 314 clients who quit the treatment in a rehabilitation centre prematurely.

Figure 8.3: Number of those RC clients who quit the social rehabilitation programme prematurely and those who completed the entire programme (NMCD 2014)



Monitored social rehabilitation criteria

Education - 18 RCs provided this data about 52 former clients.

In 2013, the majority of such clients were from the udovítov Community rehabilitation centre (18) where the average age is the lowest – 20.7 years. The absolute number of clients who continue their studies at the respective levels has increased from 42 to 52 since 2011.

Table 8.8: Education of RC clients (NMCD 2014)

Year	2011	2012	2013
Number of RC reporting data	12	14	18
Total number of clients – education	42	50	52
Continued or successfully completed their studies	21	30	35
Entered a new level of education	11	13	11
New short-term course/training	10	7	6

Employment - In 2013, out of 153 former clients, 93 were economically active, of whom 57% (53 clients) reported having a permanent employment. Permanent employment of former RC clients can be regarded as positive attitude, even if their proportion in 2013 declined and the number of unemployed increased.

Table 8.9: Employment of former rehabilitation centre clients (NMCD 2014)

Year	2011	2012	2013
Number of RC reporting data	12	14	18
Number of supervised clients – economic activity/inactivity	124	120	153
Unemployment	19	5	24
Casual jobs	19	17	32
Permanent employment	66 / 78.5%	73 / 77.6%	53 / 34.6%
Self-employment	0	4	8
Receiving pension/social benefits	20	21	36

Housing - In 2013, 181 former RC clients had a place to live. Most of the former clients were, even according to the data from the seventh cycle of the NMCD survey – returning home and staying with their parents or families (62%). In 15.5% of cases (or 16% in 2012), the former clients found a place to stay in sheltered homes.

Table 8.10: Housing of former rehabilitation centre clients (NMCD 2014)

Year	2011	2012	2013
Number of RC reporting data	12	14	18
Number of clients - housing	144	144	181
In sheltered homes, halfway houses	14	9	28
Dormitory, rooming house	18	14	22
parents, family	99	101	113
living in their own apartment, house	13	20	18

Quality of provided services in 20 accredited rehabilitation facilities

In the long term, there have been quantitative differences between the statistical surveys of the Ministry of Labour, Social Affairs and Family and the NMCD surveys which have an impact on interpretation of data. Several partial trends are identical.

1. alcohol prevails, with approximately two fifths of clients on average - followed by illicit drugs.
2. the number of new clients in the given year represents more than a half
3. the share of those who did not complete the entire rehabilitation programme is always higher than the share of those who completed it.

There are still differences between the monitored RCs, as implied by the structure of clients and the ensuing offer of services (more possibilities and services can be typically found in RCs with younger clients which, in turn, affects the selection of any particular facility, in particular by parents). RCs with older clients who have, for the most part, problems with alcohol, are focusing on work therapy and the provision of basic social services – food and housing.

In this context, the rehabilitation facilities which cooperate with healthcare facilities or were established with direct or partial involvement of medical specialists can be considered a part of comprehensive care provided to people with drug dependence⁹⁴. The structure of RC staff by qualification was reported in 2012 for the first time (for 2011) with a particular focus on the share of medical professionals in RCs. (Table 8.11)

In 2013, 11 RCs reported 13 psychiatrists (two RCs have signed contracts with two specialists), whereas only 9 RCs have employees in other medical professions. Social workers are the most represented profession, with each RC employing 2-3 such workers, (for a total of 63), 19 RCs employ 35 psychologists, and 14 RCs employ 29 pedagogues and therapeutic pedagogues. In 2013, five RCs employed workers from all of the professions specified above.

Table 8.11: Structure of employees in rehabilitation facilities between 2011 and 2013. NMCD 2014

Profession / Year	2011	2012	2013
Number of RC reporting data	19	19	20
Psychiatrists	12	11	13 (11 RCs)
Psychologists	27	28	35 (19 RCs)
Other medical professionals	17	14	14 (9 RCs)
Social workers	58	54	63 (20 RCs)
Pedagogues and specialised/therapeutic pedagogues	19	23	29 (14 RCs)

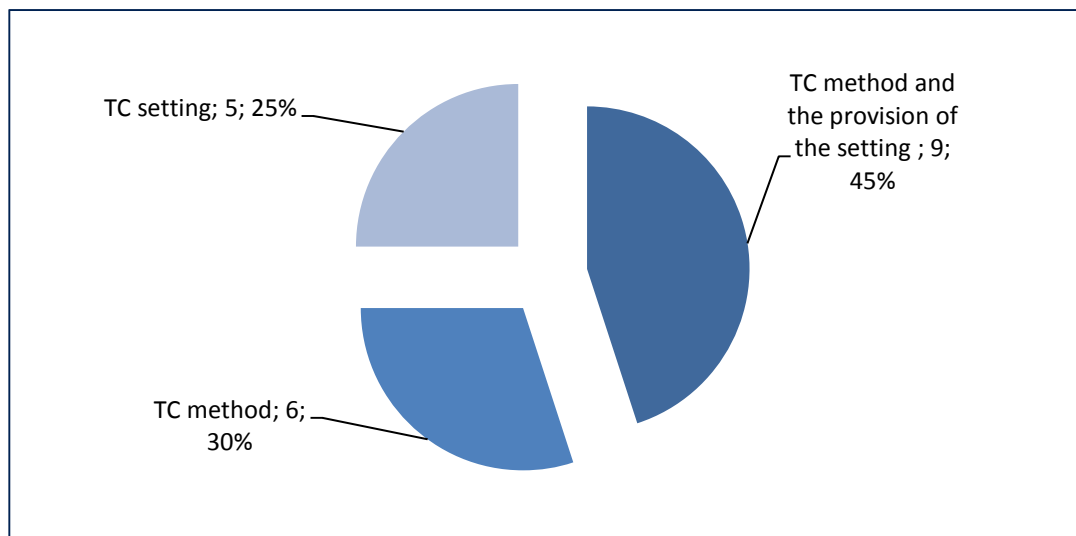
Therapeutic community – The survey has been carried out, since 2012, whether a particular rehabilitation centre is operated in the therapeutic community mode, be it as a method of treatment or as a provider of the setting. The question was answered by all 20 RCs in the current survey (for 2013).

Nine RCs (six RCs in 2012, seven RCs in 2011) apply the therapeutic community method and also provide the therapeutic community setting.

Therapeutic community is applied as a method in six RCs (13 in 2012) and five RCs apply the therapeutic community principles in the provision of the setting.

⁹⁴ Health Ministry’s Journal of 26 July 2006 – Concept of Health Care in the Field of Drug Dependence Treatment

Figure 8.4: Resocialisation centres as treatment communities: criterion; number of RCs, proportion. Source: NMCD



Client satisfaction – 13 RCs are gathering feedback from clients (“client satisfaction”), which is more than the figure from the previous client satisfaction survey about services rendered (10 in 2012). Such surveys are predominantly conducted in the form of an anonymous questionnaire, or by means of individual interviews at post-rehabilitation weekend meetings or other sessions.

Cooperation with other supporting services and satisfaction of the RCs

RCs consider healthcare facilities (16) and the families of their clients to be the most important partners upon the admission of clients. Upon their release, the most important partners are families and probation officers.

As regards other entities within the framework of the existing supporting services, as well as other entities (in terms of organising work therapies, such as municipalities or local entrepreneurs), cooperation is in many cases informal (13 RCs) and based on long-term personal contacts. Formal contracts have been signed in four cases.

As with the previous survey (2012), 17 RCs said they were completely satisfied (9) and almost completely satisfied (8) with their position as regards supporting services (15 RCs in 2011). Two RC were dissatisfied for the third time already – “non-cooperation of local governments and responsible authorities; no interest in addressing the issue at hand; nobody is interested in what is going on and how non-profit organisations, which help people and are not corrupt, can exist and survive; medical institutions do not treat us as partners... (NMCD 2013).

8.5. Other surveys

The Institute of Social Studies and Therapeutic Pedagogy of the Faculty of Education at the Comenius University in Bratislava is conducting a study entitled “Evaluation of the outcomes in reintegrating the clients of rehabilitation centres in the Slovak Republic” under project VEGA No.1/0221/11. This is the first prospective cohort study aimed at mapping the outcomes of the process of reintegrating the clients of rehabilitation centres

in Slovakia. In October 2013, the first results of the project were presented during the conference entitled "Rehabilitation centre vs. therapeutic community". Within this project, a publication⁹⁵ of project researchers is available under the title "Client profile on admission to a rehabilitation centre" which offers an insight into selected aspects of the profile of dependent clients when being admitted to rehabilitation centres. It describes the level of seriousness in the following areas: health condition, situation of dependency (alcohol or drug use), employment/ livelihood, family and social relationships, legal status and mental condition in the context of adult clients' motivation to handle their situation upon admission to the rehabilitation centre. Also addressed are several effective factors that are playing an important role not only during, but also a long time before the rehabilitation process.

8.6. Social integration of problem drug users or high-risk drug users⁹⁶

The consulting services are provided to high-risk drug users undergoing treatment (health care facilities) or those who have completed rehabilitation programmes in rehabilitation centres by qualified social workers in these facilities.

Problem (high-risk) drug users who are recipients of low-threshold "harm reduction" services provided by agencies can make use of social assistance when interacting with local authorities (ID cards, health insurance, social benefits, information on accommodation options and on day care centres for homeless people, etc.) or with health care facilities, if they decide to undergo treatment.

Additional information on the possibilities of reducing social impacts on patients undergoing treatment is also specified in Chapter 5.

⁹⁵Pavelová Ľ.a kol. (2014): Profil klienta pri vstupe do resocializačného strediska. Bratislava (*Client profile on admission to a rehabilitation centre*), IRIS, 2014. ISBN 978-80-89239-96-5, 167 pg,

⁹⁶High Risk Drug Use – this category includes injection drug users, high-risk opioid users, at-risk cannabis users (daily and several times a week). The category also applies to high-risk users of cocaine, amphetamines, synthetic cathinones and the risky use of other drugs, in case such data on drug use are collected.

9. DRUG-RELATED CRIME, PREVENTION AND DRUGS IN PRISONS

9.1. Introduction

In Slovakia, "drug-related crime" covers law offenders arrested, prosecuted and convicted of the following crimes: possession of drugs⁹⁷ for personal use (§171 of NTZ⁹⁸/§186 of STZ⁹⁹); production, trafficking or possession of drugs in a quantity larger than ten usual single doses (hereinafter referred to as "dealing") (§172 of NTZ/§187 of STZ); production or procurement of articles¹⁰⁰ intended for drug production (§173 of NTZ/§188 of STZ) and promotion of drug use (§174 of NTZ/§188a of STZ). Since some law offenders were convicted of drug-related crimes in accordance with the old Criminal Code (STZ) in 2012, the overall picture of drug-related crime in Slovakia also needs to take into consideration relevant provisions of the STZ. In addition to drug-related crime, this chapter also provides a detailed description of drug-related crime prevention measures, criminal justice interventions, the issue of drug use in prisons, as well as social reintegration of the accused/convicted persons following their release from prison.

Drug-related crime development in 2013 was characterised by the stabilisation in the numbers of prosecuted and convicted persons at a level similar to the previous year's level, and a change in its structure.

The share of people convicted of drug production, dealing and trafficking (51.6%) exceeded the share of people convicted of the possession of drugs for personal use (45.1 %) for the first time since 2006 when the new Criminal Code (Act No. 300/2005 Coll.) entered into force. The change was primarily driven by a rapid increase in the number of people convicted of drug trafficking, with their number having increased nearly fivefold since 2009 (from 46 in 2009 to 220 offenders convicted of this crime in 2013). The number of people convicted of the possession of drugs for personal use, which had kept at approximately constant levels since 2009 (n=620), dropped to 535 in 2013 (mainly due to the lower number of people sentenced for the possession of less than three doses of a drug).

From the drug-type perspective, the structure of drug-related crime did not change significantly. Similarly to previous years, more nearly three quarters of offenders were convicted of cannabis and pervitin related crime, 47.5% and 25.6%, respectively, in Slovakia in 2013.

Two thirds of the total number of offenders convicted of drug-related crimes (n=1191 persons) were given a suspended sentence and/or suspended sentence with probation. The aforementioned alternative punishments were most frequently imposed for the possession of drugs for personal use. By contrast, the share of offenders sentenced to a

⁹⁷ Pursuant to the Criminal Code (Act No. 300/2005 Coll.), a drug is defined as any narcotic substance, psychotropic substance, poison or precursor.

⁹⁸ Abbreviation referring to the *new* Criminal Code effective from 1 January 2006 (Act No. 300/2005 Coll.).

⁹⁹ Abbreviation referring to the *old* Criminal Code effective until 31 December 2005 (Act No. 140/1961 Coll.).

¹⁰⁰ An article that is usually a key component in the production of a narcotic and/or psychotropic substance, poison or precursor; these articles usually involve apparatuses/devices and other equipment, as well as ingredients intended and designed for their production (Čentéš, J., 2007, pg.116).

term in prison for drug-related crimes fell to 22.4%. More than 80% of the offenders given a suspended sentence had committed crimes related to drug supply (drug trafficking in particular). The share of juvenile drug offenders decreased in 2013. A majority of juvenile drug law offenders (79%) in Slovakia were sentenced for the possession of and trafficking in cannabis. More than three quarters of juvenile drug law offenders were given suspended sentences (n=34). No juvenile drug law offender was sentenced to immediate custody in 2013.

In 2013, a significant increase occurred in the percentage of registered drug users in prisons - to the historically highest level at 21%. The share of prisoners in whom random screenings detected the prevalence of drugs also increased. The most common positive test results were for benzodiazepines, followed by amphetamines and opiates.

A total of 770 convicts underwent drug treatment in prison in 2013; a majority of them were treated for methamphetamine-related problems.

Viral Hepatitis C was the most widely spread blood-borne infection among the Slovak prison population in 2013. The share of HCV seropositive prisoners nearly doubled (20.9%), while the number of screening tests conducted was roughly the same as in the previous year. A moderate increase - to 21.8% - was also observed in the share of the convicts in whom HCV prevalence was confirmed by PCR testing. Viral Hepatitis A was an infectious disease with the second highest prevalence among the prison population in Slovakia in 2013.

The number of cases where social custody measures were provided to persons released/conditionally released from prison increased in 2013.

9.2. Drug-related crime

This section of the Report is mainly based on the statistical data provided by the Ministry of the Interior¹⁰¹ (hereinafter only referred to as the "MI"), the General Prosecutor's Office (hereinafter only referred to as the GPO), and the Ministry of Justice (hereinafter only referred to as the "MJ"). Since the statistical systems operated by these law enforcement institutions are not interconnected, their cross-comparison is impossible.

In order to make the Slovak criminal statistics easier to compare with equivalent data from other EU countries and to ensure compatibility of the data included in ST11, the Report contains categories of criminal offences adjusted in line with EMCDDA directives. Therefore, drug-related offences are divided into the following three categories:

1. possession of drugs for personal use (covers offences under §171 of NTZ and §186 of STZ);
2. production, trafficking or dealing in drugs (covers offences under §172 of NTZ and §187 of STZ);
3. other criminal offences related to drug supply include production or possession of articles intended for drug production and promotion of drug use (i.e., §173+§174 of NTZ and §188 + §188a of STZ).

¹⁰¹ Involves statistical data obtained from the Police Presidium and other specialised police units (Organised Crime Authority).

9.2.1 Persons prosecuted for drug-related crimes

The MI keeps statistical information on offences and prosecuted offenders classified by individual articles and paragraphs of the Criminal Code.

In 2013, a total of 1,732 individuals were prosecuted for drug-related crimes and a total of 1,926 drug-related offences were recorded in Slovakia, a situation similar to the previous year.

The MI introduced the statistical monitoring of criminal offences and law offenders disaggregated by types of drug in 2007, but a number of technical issues have still not been removed (data inconsistency, inaccurate classification of drugs included in the other precursors category) which distort the resulting data to a large degree. Therefore, the Report does not contain statistical information about persons prosecuted for drug law offences structured by the type of drug.

9.3. Drug law offences

Convicts and juvenile convicts sentenced for drug law crimes

In 2013, the Slovak courts sentenced a total of 1,191 persons for illicit drug possession, production, trafficking and/or other crimes related to drug supply. Due to the suspension and discontinuation of criminal proceedings (for example, due to the lack of evidence, etc.), some law offenders were prosecuted in accordance with the “old” Criminal Code (Act No. 140/1961 Coll.), in force until the end of 2005, even as late as 2013 (n=42).

9.3.1 Structure of convicts, by individual types of drug law criminal offences

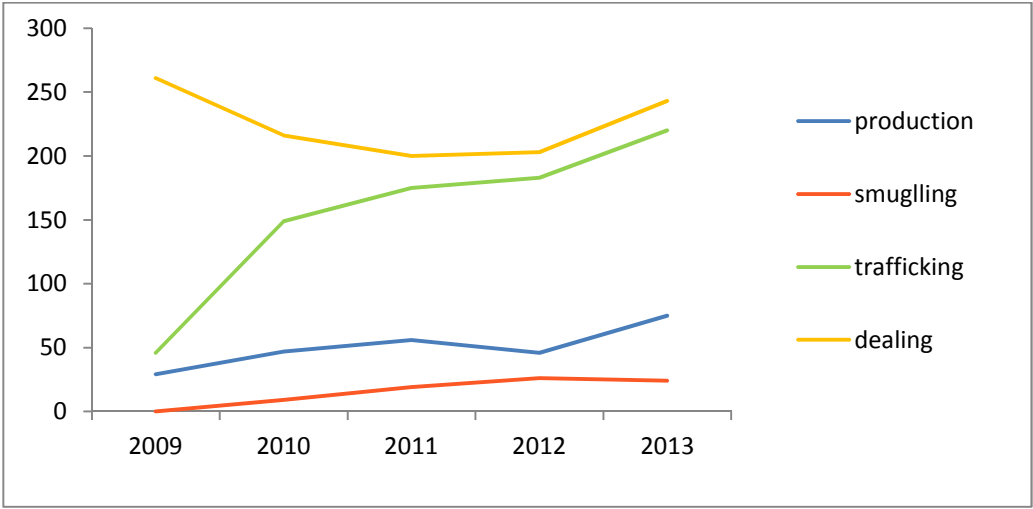
In 2013, the structure of drug law offences departed from the trend observed since 2006 when a majority of offenders were convicted of the possession of drugs for personal use. For the first time since the amended Criminal Code had entered into force (in 2005), the year 2013 saw the number of persons sentenced for illicit drug production, trafficking or dealing (n=615 persons) exceeding the number of those sentenced for the possession for personal use (n=537) in 2013. A similar trend was not observed in the statistics concerning persons prosecuted or charged in 2013; therefore, the rise observed for offenders convicted of drug production, trafficking and dealing might have considerably been influenced by cases from previous years that were concluded as late as 2013 (e.g., due to suspension of criminal proceedings).

The most considerable increase was observed for persons convicted of dealing (n=243) and trafficking in drugs (n=220) in 2013. Even though it is only a short-term trend in the case of dealing in drugs, as far as trafficking is concerned, a continuous growth has been observed since 2010 - see Figure 9.1.

The growing trend could be driven by several factors: amendments in criminal laws (2006), the lack of heroin on the market (2010), and an increased demand for stimulants, methamphetamine in particular.¹⁰²

¹⁰² Confirmed by growing numbers of patients entering drug treatment with methamphetamine as a primary drug.

Figure 9.1: Structure of convicts sentenced for drug production, smuggling, trafficking and dealing in Slovakia (2009-2013). Source: MJ,2014

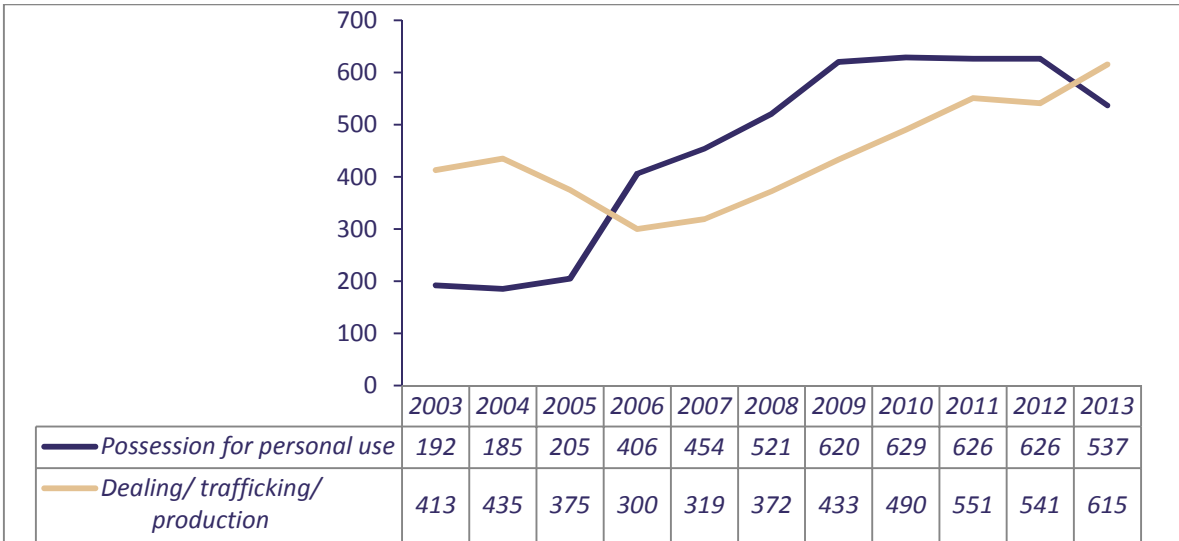


The 2006 amendment to the Criminal Code, under which the upper limit for the possession of drugs for personal use increased (from a usual single dose to as much as ten times the usual single dose), has resulted in an increase in drug law crime and change in its structure¹⁰³. The amendment to the Criminal Code reflected the most in a sharp increase in the number of persons sentenced for the possession of drugs for personal use, but also affected the rise in crime related to drug supply. According to the operative information obtained by law enforcement authorities, it was mainly small pervitin dealers who adapted to the new situation, carrying maximum ten doses of the drug on them, while burying larger quantities in the ground, in so-called “dead drops”, and sending to customers GPS coordinates of their location - for more details see Chapter 10.1 and 10.2.

In 2005, nearly two thirds of drug law offenders were sentenced for the production and trafficking in drugs. This criminal offence also covered dealing in drugs, which had before also applied to persons having two doses of drug in their possession. Even though the number of persons sentenced for production, dealing and trafficking in drugs was exceeded by those sentenced for the possession of drugs for personal use after 2006, their numbers continued growing. Similarly as before 2006, a majority of offenders were sentenced for illicit production, dealing and trafficking in drugs in 2013 - see Figure 9.2.

¹⁰³Confirmed by the statistics on offenders sentenced for drug-related crime, as well as by seizures of drugs and precursors and numerous cases of production laboratories dismantled.

Figure 9.2: Development in drug-related crime by number of persons sentenced for possession of drugs for personal use and for drug dealing/production/trafficking in Slovakia (2003-2013). Source: MJ 2014



9.3.2 Convicts by type of drug

The MJ statistical system records the types of drug solely with respect to drug-related crimes (§171, §172, §173 and §174 of NTZ, in force from 1 January 2006). Even as late as 2013, 42 persons were sentenced according to the STZ (in force until 31 December 2005). The type of drug was reported in 93% of offences in 2013 (n=1107).

More than two thirds of law offenders sentenced for drug-related crime in Slovakia in 2013 had committed cannabis and pervitin related crimes. For cannabis, the 2013 saw a considerable decline in the number of persons sentenced for its possession; this is in line with an overall decrease in the number of persons sentenced for this criminal offence in the given year. An opposing, growing trend can be seen with respect to law offenders sentenced for methamphetamine related drug crimes, particularly in relation to criminal offences related to methamphetamine supply. Nearly 62% of the total number of persons sentenced for methamphetamine related drug law crimes were convicted of production, trafficking or dealing in this particular type of drug. The most likely cause of this rise in methamphetamine supply related crime is the increased demand for the drug among Slovak drug users. According to the operative information provided by the National Drug Unit, methamphetamine is currently the “most profitable article” on the Slovak black market.

Table 9.1: Numbers and shares of persons sentenced for drug law crimes, by type of drug (2012-2013)
Source: Standard Table 11 / 2012

	Possession for personal use		Dealing/trafficking/production		Other drug supply offences*	
	2012	2013	2012	2013	2012	2013
Cannabis	397	278	286	278	9	9
Heroin	36	32	29	32	0	0
Cocaine	2	3	5	6	0	0
Methamphetamine	111	112	117	189	4	4
Amphetamines	44	44	34	37	5	5
Ecstasy	0	1	1	2	1	0
LSD	0	0	0	0	0	0
Other drugs**	24	32	25	31	24	12
Total	614	502	497	575	43	30

* illicit production/possession of items intended for drug production and promotion of drug use.

** includes other unspecified kind of drugs and prescription drugs

9.3.3 Juvenile convicts

In 2013, forty-two juveniles were convicted of drug law offences in Slovakia, accounting for 3.5% of all drug law offenders convicted that year. Broken down by Slovak regions, the highest number of juvenile convicts were reported in the Košice region (n=12) and Žilina region (n=8), while the lowest number was reported for the Bratislava region (n=2), a region with a long track history of the highest drug-related crime rates. A likely reason could be a different approach taken at the regional level to out-of-court resolution of less severe drug law offences. The share of juvenile offenders convicted of possession for personal use decreased in 2013 compared to the previous year (this type of criminal offences made up 52.1% of total drug law crimes in 2012, and fell to 38% in 2013). By contrast, similarly as in the case of adult offenders, the share of juveniles sentenced for production, dealing and trafficking in drugs increased in 2013 (to 35.8% of all drug-related crimes).

More than three quarters of juveniles (n=33) were sentenced for cannabis-related drug law offences; the number of those convicted of its production, trafficking and dealing rose year-on-year (45.4%). Five juvenile offenders were sentenced for the promotion of drug use in relation to other amphetamines.

9.4. Other drug-related offences

This section is based on the data obtained from criminal law enforcement institutions: the Ministry of the Interior (the Police Force Presidium), the Prosecutor General's Office and the Ministry of Justice.

9.4.1 Crimes committed in order to obtain financial resources to buy drugs

Reasons for committing crimes are monitored by an MJ system in the form of statistical sheet T¹⁰⁴ (item 30, paragraph 11 - under which drug addiction is given as a particular reason for committing a crime).

In 2013, "drug addiction" was most frequently given as a reason for committing a crime by law offenders sentenced for production, trafficking and dealing in drugs (n=180) and for possession of drug for personal use (n=148).

The drug addiction was also reported as a reason for the following crimes: theft (15); causing public menace under the influence of addictive substances (4); stalking (3); unauthorised manufacture and use of means of payment (2); robbery (2); breaking and entering (2); hooliganism (1); murder (1); killing (1); torture of a close and dependent person (1); illegal possession of arms and arms trafficking (1); assault on a public authority (1); credit fraud (1); damage to property (1); blackmail (1); fraud (1); drunkenness (1); evading the alimony or maintenance obligation (1); endangerment of moral formation of youth (1) and obstruction of the execution of an official decision (1).

Source: MJ, 2014

9.4.2 Crimes committed under the influence of drugs

Both the Prosecutor General's Office (PGO) and the Ministry of Justice keep special records in their statistical systems of whether a crime has been committed under the influence of alcohol or other illicit drug. While Slovakia has yet not introduced tests for car drivers for psychoactive substances other than alcohol, it is impossible to compare the data on offenders prosecuted for having committed a crime under the influence of other psychoactive substances and alcohol.

In 2013, the Prosecutor General's Office prosecuted 562 persons who had committed a crime under the influence of a psychoactive substance other than alcohol - their share in the total number of persons prosecuted in 2013 was 1.04%. The PGO prosecuted 6,936 people for alcohol (up by 163 compared to 2012). The PGO prosecuted a total of 4,343 juvenile law offenders (approx. 18% more than in the previous year) in 2013; 1% of those (n=45) were prosecuted for a crime committed under the influence of a psychoactive substance other than alcohol. The share of juvenile offenders prosecuted for a crime committed under the influence of alcohol moderately fell in 2013, to 4.7% (n=203 juvenile offenders).

Source: Statistical Year Book of the Prosecutor General's Office, 2014

According to the data provided by the MJ, 528 law offenders were sentenced for having committed a crime under the influence of a psychoactive substance other than alcohol (their number more than doubled over the past two years). Since this trend was only

¹⁰⁴ It is a standard record sheet completed for every law offender convicted in Slovakia that provides comprehensive information about offenders (a crime for which they were sentenced, the sentence and/or type of a preventive measure imposed, as well as the reason for having committed the crime).

observed with respect to convicted offenders, we assume it could be affected, to a certain degree, by more frequent preventive police operations focused on drugs in drivers, as well as improvements in the reporting in this area. Their share in the total number of sentenced persons (n=36079) rose to 1.46% in 2013 (from 1.3% in 2012 and 0.85% in 2011). Similarly to previous years, drugs had the largest impact on crime in the Bratislava region (4.3%). A growing trend continued also with respect to the share of persons sentenced for crimes committed under the influence of alcohol - from 7.9% in 2011 to as much as 19.1% in 2013.

Source: Ministry of Justice, 2014

9.4.3 Drugs and driving

In Slovakia, driving under the influence of drugs is prosecuted pursuant to §289 of the Criminal Code - causing public menace under the influence of an addictive substance. Since the statistical system of the Ministry of the Interior does not differentiate between alcohol and other illicit drugs with respect to this type of a criminal offence, it is impossible to specify how many persons were prosecuted for causing public menace under the influence of alcohol and how many for causing public menace under the influence of illicit drugs.

The police prosecuted 5,669 persons for causing public menace under the influence of an addictive substance (§289 of the Criminal Code) in 2013, down approximately one tenth compared to 2012 (n=6306 prosecuted persons), but three times more than in 2011 (n=1369 prosecuted persons). A total of 5,879 crimes involving public menace under the influence of an addictive substance were recorded in 2013. **(Source: Ministry of the Interior, 2014)**

According to the statistics kept by the PGO, 6,070 persons were prosecuted for this criminal offence; 58 of them were juveniles (aged 14-18). More than two thirds of the total number of persons prosecuted for having caused public menace under the influence of an addictive substance were prosecuted for alcohol. Only 12 persons were prosecuted for having caused public menace under the influence of an addictive substance other than alcohol, accounting for a tiny share of 0.2% of all such crimes. In most cases, the criminal proceedings resulted in criminal charges brought against such persons (82.5%), followed by plea bargain with a prosecutor (16.3%), conditional discontinuation of criminal prosecution (0.4%) and other forms of discontinuing criminal prosecution (0.8%). **(Statistical Year Book of the Prosecutor General's Office, 2014, pg. 95)**

The Ministry of Justice of the Slovak Republic reported a total of 5,619 people sentenced for causing public menace under the influence of an addictive substance in 2013, up 6.7% compared to 2012.

9.4.4 Legalisation of incomes from drug-related criminal activity

The measures aimed at preventing the legalisation of income derived from drug-related criminal activities are covered by Act No. 297/2008 Coll. on the protection against legalisation of income from criminal activity and on the protection against terrorist financing.

The police did not reported any law offender prosecuted for legalisation of income from drug-related criminal activity (§233(4b)) in 2013. Also, no law offender was sentenced for this criminal offence in 2013.

9.5. Prevention of drug-related crime

The prevention of drug-related crime is one of the main priorities of the Slovak Government Council for Crime Prevention which is incorporated, at a system level, in a strategy on the prevention of crime and other anti-social activities in Slovakia for the 2012-2015 period, and in measures¹⁰⁵ aimed at crime prevention. In crime prevention, the Council cooperates with local public authorities, self-governments, business entities, NGOs and civic associations, etc. In 2013, the Council provided subsidies from the state budget to finance crime prevention projects in the total amount of € 1,328,000.00.

9.5.1 Police priorities and projects focused on prevention of drug-related crime

As part of its drug crime prevention measures, the police concentrate on educating children and young people, and on raising their awareness of drug use and related social risks, while they primarily focus on causes and symptoms of this type of crime.

The main crime prevention projects targeted at school populations in 2013 included:

“Správaj sa normálne” (Behave Normally) A nation-wide projects for five and six graders at elementary schools aimed at building mutual confidence and trust between the police, schools, children, families and the public. The project had not only an information/awareness raising arm (delivering information on the tasks performed by the police, on prejudices and racism, traffic issues, hot-lines, etc.), but it particularly focused on prevention (advising children on how not to become victims of crime, how to cope with certain stressful situations, where to look for help, etc.)

“Póla radí deťom” (Póla Advises Children) The goal of this project was to teach children how to behave safely in risky situations, teach them towards responsibility for their own health and property, and provide them with information to raise their legal and social awareness. The project taught children in an appropriate way about the risks they may encounter in their everyday life. Implemented from November 2013 throughout the whole of Slovakia, the project was targeted at children in kindergartens and first graders at elementary schools.

“Správame sa normálne a miesto drogy športujeme” (Let’s Be Normal, Do Sports, Not Drugs). A drug prevention project for elementary and secondary school students implemented in the Eastern Slovakia region. Its goal was to show the causes, risks, social and legal consequences related to the consumption of alcohol and other psychoactive substances (by minors and juveniles) and familiarise them with their obligations to observe the Act on the Protection Against the Misuse of Alcoholic Beverages and on the

¹⁰⁵ Act No. 583/2008 Coll. on the prevention of crime and other anti-social activities.

Establishment and Operation of Sobering-Up Rooms (Act No. 219/96 Coll.), and to encourage them to spend their free time meaningfully.

“Drogy a zákon” (Drugs and the Law)

The project objective was to provide second-level elementary school and secondary school students with the basic information and advice on the prevention of drug addictions, with a special focus on the prevention of drug-related criminal activity. The project was carried out in the Western Slovakia region.

“Droga a ja” (Drug and Me)

A project designed to provide preventive and educational information to elementary and secondary school students about drug use, and to raise their legal awareness in the area of drug-related crime. The project was carried out in the Western Slovakia region.

“Rozhodneš sa správne?” (Will You Make the Right Decision?)

The aim of the project was to eliminate criminal activities committed under the influence of psychoactive substances and to provide information about harmful effects of drug use (with a special focus on tobacco, alcohol and cannabis) in order to discourage children from taking drugs. Carried out in the Central Slovakia region, the project primarily targeted students aged 9-10.

“Falošné vedomie” (False Consciousness)

Targeting elementary and secondary school students in Western Slovakia, the project's content focused on drug-related crimes committed by juveniles and on reduction of occurrence and use of drugs at schools.

Preventive activities and programmes designed for specific population and implemented in 2013:

“Viem čo chcem a čo smiem” (I know what I want and what I am allowed)

In cooperation with the Public Health Authority and the police, the Centre of Leisure Time in Žiar nad Hronom prepared preventive programmes for children and adults from the Roma community. Implemented between January and June 2013, the project focused on prevention and on strengthening the ability to defend oneself against socio-pathologic phenomena. The lectures and discussions were tailored to the specific needs of the participants, providing all kinds of promotional materials and educational activities. The individual activities were organised with active participation of field staff and social workers of the Žiar nad Hronom municipality, and the municipal police.

“Dobrá rada” (Good advice)

This project was targeting pedagogical staff and parents of primary school children who participated in discussions with a focus on raising legal consciousness of pedagogical staff and on providing assistance in handling situations involving problem children.

“Polícia v éteri” (Police on the air)

The period between September 2012 and June 2013 saw the implementation of a project in which members of the police provided the listeners of the public radio station Radio Regina with information and advice on the most topical and problematic issues

which they are frequently dealing with (such as bullying, addictions, thefts, extremism and risky online behaviour, etc.); the public were allowed to ask questions and provide feedback to the topics covered in the programme.

Source: NAKA (Bučková,I), 2014

9.5.2 Prevention and assistance to drug users in prisons

In 2013, the Corps of Prison and Court Guard (CPCG) organised outreach events and educational activities on drug use for accused and convicted persons. The outreach and educational activities focused on universal and harmonious development of the personality of prisoners while promoting healthy lifestyle without drugs and emphasising the importance of primary prevention of drug addiction by offering alternatives such as sports, fine arts, literary art, as well as lectures, discussions and group forms of work. These activities were organised for the accused and convicted persons by the police, pedagogues, psychologists and medical staff.

In 2013, a total of 8,827 convicted persons and 1,306 accused persons were held in prison. In the individual facilities, a total of 4,694 activities were carried out (focusing on primary prevention and the prevention of the psychoactive substance abuse), with approximately one seventh of convicted persons and a half of accused persons participating. An overview and comparison of the individual activities for the accused and convicted persons (2012-2013) is shown in Table 9.2.

Table 9.2: Overview of the types of implemented activities involving convicted/accused persons in the CPCG facilities in 2012 and 2013. Source: Corps of Prison and Court Guards, 2014

No.	Type of group activity	Number of activities (2012)	Number of activities (2013)	Difference
1.	Discussion	123	173	+50
2.	Outreach activity	119	215	+96
3.	Lecture	308	449	+141
4.	Educational activity	45	176	+131
5.	Social-psychological training group	36	220	+184
6.	Social advisory group	41	23	-18
7.	Therapeutic group	307	748	+441
8.	Discussion and advisory group	53	118	+65
9.	Watching educational films on the given subject	94	121	+27
10.	Educational concerts	16	9	-7
11.	Sporting events	176	1697	+1,521
12.	Competitions	395	703	+308
13.	Publications in in-house magazines	17	42	+25
Total		1,730	4,694	+2,964

When complying with the tasks under the National Anti-drug Programme, narcotic and psychotropic substances were searched by detection dogs in all CPCG facilities. The most searched items in terms of narcotic and psychotropic substances were as follows: correspondence (362,327 pieces), baggage and garments (62,582 pieces) and packages (34,937 pieces). Prison cells and rooms were searched in 11,256 cases and motor vehicles in 1,583 cases.

9.6. Interventions in the criminal justice system

The system of penalties in the Slovak Republic does not permit convicted drug-addicts to voluntarily choose between prison and therapy. The Criminal Code and the Criminal Procedure Rules regulate only the possibility of imposing the so-called protective (court-ordered therapy), either independently or in addition to a penalty or in case of remission. A judge can order such a therapy to an offender who committed an offense under the influence of a drug (alcohol or illicit drug) or as a result of drug addiction (e.g. theft for the purpose of purchasing drugs, or any of drug-related crimes).

9.6.1 Sentences statistics – alternatives to prison sentences

In the Slovak Republic, criminal prosecution may be discontinued with a final decision by a prosecutor or a judge. The Prosecutor's Office keeps a record of the cases where prosecution has been terminated by: conditional discontinuation of criminal prosecution, approval of reconciliation, plea bargain or an indictment. The Ministry of Justice registers the cases of those persons sentenced with finality to serve immediate custody, a suspended sentence, a suspended sentence with probation supervision, home curfew, community services, fine or disqualification. The General Prosecutor's Office keeps the records of those prosecuted drug offenders for whom criminal prosecution has been discontinued. The Ministry of Justice maintains a statistics of sentences imposed by judges for drug-related crimes.

In 2013, 2,084 persons (of whom 152 were juveniles) were prosecuted for drug-related crimes. In most cases, the criminal proceedings conducted by the prosecutor have lead to bringing charges against such persons (44.9%) followed by plea bargain (32.7%), conditional suspension of criminal prosecution (14%) and other¹⁰⁶ non-specific forms of discontinuing the criminal prosecution (8,4%). Based on statistical data of the prosecution, almost one of ten offenders was repeatedly prosecuted for a drug-related crime in 2013. More than half of the total number of repeat drug offenders (n=241 persons) were prosecuted for the possession of drugs for personal use. (Statistical Year Book of the General Prosecutor's Office, 2014, pg. 95).

In 2013, the Slovak courts convicted a total of 1,191 persons for drug-related crimes; of this number, 1,184 persons were convicted with a final decision (seven offenders were discharged by a judge without punishment). During the reporting year, the number of people sentenced to immediate custody has declined and the number of those who received an alternative sentence to imprisonment has increased. In 2013, the most prolific group of punishments for drug-related crimes includes suspended sentence and

¹⁰⁶ Dismissal, transfer of case, suspension or adjournment of criminal proceedings: all of these forms of discontinuing criminal proceedings are described in Annual Report 2008, Chapter 11).

suspended sentence with probation supervision which were imposed by judges on two thirds of offenders (66.7%), which is up 5.5% against 2012. In most cases, the suspended sentence was imposed on offenders possessing drugs for personal use. Of the total number of 530 offenders given this sentence, as many as 92.6 % of offenders received a suspended sentence or other alternative sentence to imprisonment (community service work or fine). The observed trend could be related to the Government's declared intention to address prison service issues¹⁰⁷ by systemic measures aimed at depenalisation and a wider use of alternative penalties (Report on compliance with the tasks under the Prison Service Strategy for 2011-2020). The past three years (2011-2013) saw a decline in the proportion of offenders sentenced to immediate custody for drug-related crimes (from 30.6 % in 2011; 26.1 % in 2012 to 22.4 % in 2013). As much as 85.4 % of immediate custody sentences in 2013 had been imposed on offenders for drug supply crimes (in particular drug trafficking).

A detailed breakdown of sentences received by offenders for the possession of drugs for personal use or for drug supply crimes¹⁰⁸ is shown in Table 9.3.

Table 9.3: Number and percentage of offenders, sentenced for possession, drug trafficking and other drug law offences in Slovakia (2013). Source: MJ, 2014

Punishment	Possession for personal use		Dealing/trafficking/production		Other drug law offences	
	n	%	n	%	n	%
Immediate custody	39	7.35	220	35,8	8	20.5
Alternatives to imprisonment						
Suspended sentence	360	67.92	104	16.9	30	76.9
Suspended sentence with probation	10	1.9	290	47.1	0	0
Fine	51	9,6	1	0.2	0	0
Home curfew	0	0	0	0	0	0
Community services	57	10.75	0	0	0	0
Other	13	2.45	0	0	1	2.6
Total	530	100	615	100	39	100

* including other non-specified and non-reported types of punishment (such as confiscation of property).

Sentences imposed on juveniles convicted of drug-related crimes

Of the total number of 42 juveniles convicted of drug-related crimes in the Slovak Republic in 2013, 39 young offenders received a final sentence (three offenders were discharged by the judge without punishment).

More than three quarters of offenders aged 14-18 received suspended sentence for the possession of drugs for personal use and for illegal production/trafficking/dealing (n=34). Community service work was imposed on two offenders for the possession of

¹⁰⁷ One of the current problems associated with prisons is their overcrowding (due to excessively high number of prison sentences, as a result of which the capacity available in prisons has been exceeded)

¹⁰⁸ this includes illicit production, trafficking and dealing as well as other drug supply crimes – see the beginning of this chapter

drugs for personal use. The remaining three offenders received other non-specified, alternative sentences. No juvenile offender was sentenced to immediate custody in 2013. (Source: MJ,2014)

9.7. Drugs in prison

9.7.1 Drug use among prison population

In 2013, the service of custody (hereinafter the "SoC") and the service of a term of imprisonment (hereinafter the "SoTI") was served in 18 facilities of the Corps of Prison and Court Guards.

For the purposes of the Corps of Prison and Court Guards, the persons qualifying as "drug users" meet any of the following criteria: history of drug use before admission to prison (as part of initial medical examination of an accused/convicted person), random drug screening with a positive result, and seizure of a drug found with the accused/sentenced person).

In 2013, prison population in Slovakia was 9,723 accused and convicted persons, of whom 2,046 were drug users. For the past five years, the number of drug users in held in prison almost has nearly doubled – from 11.65 % in 2008 to as many as 21.04 % in 2013.

9.7.2 Drug use before admission to prison

During initial medical examinations in 2013, a total of 785 individuals (of whom 701 were men) reported using illicit drugs before entering prison. The highest number of such persons was reported by the facility for SoC and SoTI Bratislava (28%).

According to data from anamnesis questionnaires¹⁰⁹, the most frequently used drug was pervitin, which was reported as the primary drug by almost half of prisoners (43.7%). Heroin and cannabis followed with 22.8 % and, respectively 20.6 %.

Of the total number of 785 accused/convicted persons who reported using drugs prior to their admission to prison, 337 were injecting drug users (42.9%).

9.7.3 Drug screening

In 2013, a total of 1,881 screening examinations were performed to test for the presence of selected types of drugs¹¹⁰. In order to determine the presence of drugs in urine and saliva, multi-detection cassette drug tests were used.

In 277 cases, which accounts for 14.7 % of all screenings, the tests were positive. The prisoners subjected to the screening were most frequently tested positive for benzodiazepines (n=94 cases), amphetamines (n=77 cases), morphine/opiates (n=60 cases), barbiturates (n=25 cases), other substances (n=18 cases) and THC (n=3 cases). For the past year (2012-2013), the number of prisoners whose urine tests were positive for amphetamines (in particular methamphetamine) has increased considerably. To allow comparison, the share of prisoners who reported the use of methamphetamine as the

¹⁰⁹ Prisoners completed the questionnaires on admission to the prison as part of their medical examination.

¹¹⁰ benzodiazepines, THC, barbiturates, amphetamines, morphine/opiates, etc

primary drug prior to admission to prison has increased as well (from 36.1% of convicted persons in 2012 to 43.7 % of convicted persons in 2013). The highest number of tests positive for amphetamines was reported in 2013 by the Facility for SoC in Žilina (n=39 cases), followed by the Facility for SoC in Banská Bystrica (n=26 cases).

9.7.4 Drug-free zones

In 2013 drug-free zones were operated in seven prisons¹¹¹ and their total capacity was 376 places (44 places more than in 2012).

All activities involving prisoners placed in drug-free zones were designed to help them handle difficult life situations without alcohol and drugs. In the drug-free zone, the focus is on group forms of treatment oriented at preventive anti-drug programmes. An overview of the above group activities implemented in 2013 is shown in Table 9.4.

Table 9.4: Group activities oriented at drug addictions and performed in drug-free zones in 2013

No.	Type of group activity	Number of activities	Number of convicts
1.	Discussion	55	887
2.	Lecture	150	1,846
3.	Educational activity	6	67
4.	Social-psychological training group	141	417
5.	Social advisory group	25	335
6.	Therapeutic group	66	533
7.	Discussion and advisory group	49	1,095
8.	Watching educational films on the given subject	25	411
9.	Sporting events	555	2,940
10.	Competitions	43	453
11.	Publications in in-house magazines	2	2
Total		1,117	8,986

Placed in open units, the convicted persons were able to engage in their interests even outside the wards – at cultural, religious, educational and sporting events, by moving freely around even outside the open unit.

The facility also organised¹¹² educational activities for juvenile prisoners assigned to drug-free zones. In 2013, juvenile prisoners attended apprenticeship programmes primarily in the fields of painting, bricklaying and wood-working.

¹¹¹ Facility for SoC in Bratislava, Facility for SoTI in Košice – Šaca, Facility for SoTI for juveniles in Sučany, Facility for SoTI in Nitra – Chrenová, Facility for SoTI in Želiezovce, open unit in Opatovce and open unit in Prešov.

¹¹² In cooperation with the Stredná škola sv. Jozefa Robotníka (Secondary School of Saint Joseph the Worker) in Žilina, Combined School in Turany

9.8. Measures in response to health implications arising from drug use in prisons

9.8.1 Inpatient treatment

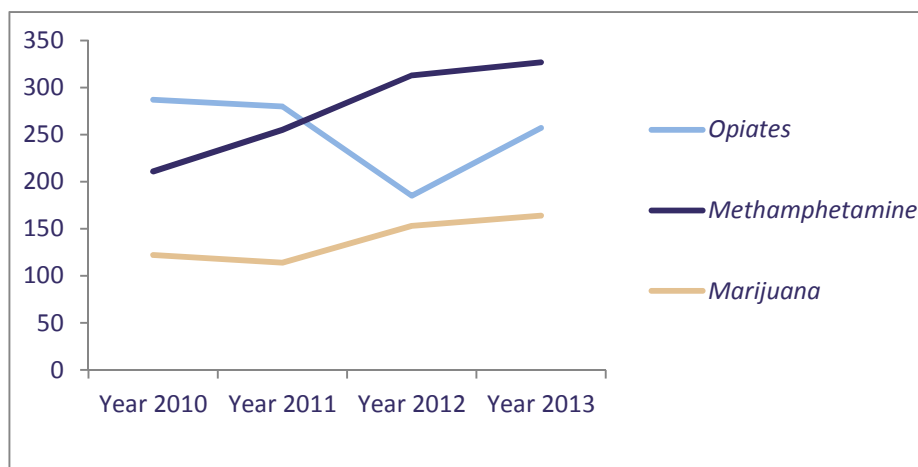
As regards drug use, the quality of the provided inpatient care is determined by framework standards drawn up by the Ministry of Health of the Slovak Republic and the chief expert of the Slovak Republic in the field of psychiatry. The court-ordered therapy undertaken within the remit of the Corps of Prison and Court Guards is regulated by §§80–88 of Decree No. 368/2008 Coll. of the Ministry of Justice of the Slovak Republic establishing the Rules for the Execution of Prison Sentences. Healthcare is provided on the basis of public health insurance.

In 2013, a total of 431 convicted persons underwent court-imposed protective treatment in the psychiatric wards of four facilities¹¹³. Of this number, 60 % underwent inpatient treatment. Voluntary treatment of alcohol or drug dependences was provided only by one facility for SoTI for juvenile offenders in Su any where 25 juvenile convicts underwent such treatment in 2013.

Based on the TDI data (2013), a total of 40 health facilities of the Corps of Prison and Court Guards reported and/or provided information about inpatient treatment (28 in 2012). These were, in particular, facilities providing outpatient healthcare (general practitioners and psychiatric wards within the remit of the Corps of Prison and Court Guards) and one inpatient facility (the hospital for accused and convicted persons in Trenčín). A total of 770 convicted persons underwent anti-addiction therapy in prisons (an increase by 78 persons against 2012). Even though the share of sentenced persons undergoing treatment more than once (41.8 %) has increased, the number of those who underwent anti-addiction therapy for the first time remains higher (57.3 %). Less than one percent of persons undergoing treatment (0.9 %) did not indicate the above parameter.

¹¹³ Facility for SoTI in Hrnčiarovce nad Parnou, Facility for SoTI in Košice - Šaca, facility for SoTI in and SoC in Leopoldov, Facility for SoTI and the Hospital for Accused and Convicted Persons in Trenčín

Figure 9.3: The number of treatments¹¹⁴ by three most frequent primary drugs in treatment units in prison (2010-2013). Source: TDI data, 2011, 2012, 2013, 2014



In 2013, the majority of convicted persons underwent anti-addiction therapy due to problems with methamphetamine (n=327 of convicted persons). Following methamphetamine, the most frequent treatment underwent by convicted persons was due to their abuse or dependence on opiates¹¹⁵ (n=257) and cannabis (n=164). Following a sharp decline in 2012, the number of convicted persons who entered treatment due to opiate problems started increasing again in 2013 (n=185). However, while their proportion in 2012 was almost 92% of all convicted persons undergoing treatment due to drug-related problems – heroin users, this share dropped to some 72 % in 2013 – which, in absolute terms (n=185), is on par with the figure for 2012. A significant increase in the number of convicted persons who underwent anti-addiction therapy due to opiate problems can primarily be attributed to an increase in the number of convicted persons undergoing treatment due to problems with other opiates¹¹⁶ (28 %) in 2013.

9.8.2 Measures to prevent the spreading of infectious diseases in prisons

The treatment provided to persons in custody or serving a prison sentence is determined by framework standards drawn up by the Ministry of Health of the Slovak Republic and the chief expert of the Slovak Republic in the field of psychiatry. At the same time, internal standards for nursing, diagnostic and therapeutic procedures are being continuously prepared with due account taken of the specific prison settings. Substitution treatment is not applied as part of treatment procedures.

During medical examinations underwent by prisoners, screening tests for selected infectious diseases – HAV, HBV, HCV, HIV/AIDS and syphilis – were performed on the basis of their medical history.

¹¹⁴ Including first treatment and previous treatment

¹¹⁵ including opioids

¹¹⁶ in particular in derivatives of pethidine and dolsin.

In 2013, a total of 5,555 screening tests for the presence of blood-borne infectious diseases were performed, with 462 samples being positive. In comparison with the previous year, the number of positive screenings has increased (from 5 % in 2012 to 8.3% in 2013). Because the mode of infection transmission is not examined in the case of positive tests, it is not possible to determine the impact of injecting drug use on the prevalence of the individual infectious diseases.

Viral hepatitis C remains the most widely spread blood-borne infection among the Slovak prison population. In 2013, the share of HCV seropositive prisoners nearly doubled (20.9%), with the number of screening tests conducted being roughly the same as in 2012 (n=1512). One of the reasons behind a sharp increase in HCV-positive cases is the better targeting of prisoners during their selection for tests. Confirmatory PCR tests for HCV were conducted in 193 cases in 2013. There was a slight increase in the share of those convicted persons in respect of whom the presence of HCV virus has been confirmed by a PCR test – rising to 21.8% against 2012, which implies an ongoing and increasing trend in the prevalence of this blood-borne infection in the prison population. Occurring in 18 cases out of 60 tested prisoners, viral hepatitis A was the second most prevalent infectious disease – however, considering the low number of screening tests performed, this data is not very relevant in terms of the entire prison population (n = 9,723 accused/convicted persons).

Table 9.5: The number and the results of performed screening tests for the presence of selected infectious diseases in the prison population in the Slovak Republic in 2013. Source: Directorate General of the Corps of Prison and Court Guards, 2014

Test	Number of tests	Negative result	Positive result
HIV	1,170	1,169	1
HCV	1,515	1,198	317
PCR HCV	193	151	42
HBsAg	1,409	1,364	45
HAV	60	42	18
BWR	1,224	1,85	39
Total	5,555	4,962	462

As part of preventive measures aimed at halting the spread of infectious diseases in prisons, some 10,000 leaflets about the prevention of drug-related infectious diseases have been distributed to the accused and convicted persons.

9.8.3 Measures to prevent and eliminate the risk of overdosing in prison

The Corps of Prison and Court Guards have no special standards in place for preventing the risk of overdosing. The focus is primarily on measures preventing the entry of drugs into prisons.

In 2013, no extraordinary case of life-threatening condition or death of an accused/sentenced person due to overdosing has been reported.

9.9. Social reintegration of drug users after their release from prison

9.9.1 Cooperation with stakeholders in post-penitentiary care:

The assistance provided to the convicts upon and following their release from prison covers social custody measures implemented by labour offices in the place of their habitual residence. In practice, this includes the following measures, in particular:

- staying in touch with the person held in custody or serving a prison term, either in writing or personally, and providing assistance in educating such person and in resolving his/her personal, family and social problems (in particular as regards maintaining and reinforcing family ties),
- involvement in preparing such person for release from SoC and SoTI,
- helping the individuals after their release from SoC/SoTI, in particular as regards returning to their families, finding a job and a place to live, or options to continue their training, and resolving personal and relationship problems,
- motivating people to undergo drug treatment or treatment of other addictions,
- referral and mediation of assistance provided by specialised facilities,
- offering adult prisoners to take part in social reintegration and other programmes organised by other government authorities, municipalities, higher territorial units and accredited entities;
- motivating the adult persons to take part in self-help groups focused on addressing personal and relationship problems,

The implementation of the above measures for the target group of drug- and substance-dependent clients following their release from SoC and SoTI is not specifically monitored for statistical purposes.

In 2013, the total number of social custody cases dropped to 6,275 (down 2,714 cases compared to the preceding year). In 83.3% of cases (n=5,226), social custody services were provided to persons after their release from SoTI/SoC and to persons released on parole from SoTI/SoC. Social custody services were also provided in the following cases: probation/mediation (n=215), suspended sentence (n=91) and release from facility for institutional care or protective care after reaching the age of majority (n=62).

10. DRUG MARKET

10.1. Introduction

Even though cannabis and pervitin are among the most abused and most consumed illicit drugs in Slovakia in the long term, as far as cannabis is concerned, we have witnessed not only certain stabilisation of its consumption (see Chapter 2), but also a moderate decline in cannabis-related crime (see Chapter 9.1) in the recent years. A similarly positive observation cannot be made in the case of pervitin; its consumption, production, trafficking and dealing has been continuously increasing in Slovakia (the number of people convicted of committing pervitin-related crimes has nearly doubled since 2010). Its wide accessibility and high average concentration (above 70%) compared to other illicit drugs (amphetamine, cocaine and heroin) boost demand for this particular substance. The results of a project designed to analyse the presence of illicit drugs in wastewater (2013) indicate a high consumption of methamphetamine in Slovakia (in the capital city, in particular). Demand for this drug is on the rise in Slovakia, despite its relatively high price, approaching the price of cocaine in some cases (EUR 100/g).

No major changes were seen with respect to drug seizures in 2013 when compared to previous years. In 2013, cannabis products and methamphetamine showed the highest share of seizures, at 61% and 28%, respectively, which account for 89% of all drug seizures in Slovakia. Several cases of trafficking in and illicit import of larger volumes of precursor substances were detected in 2013. A total of 1.2 ton of pre-precursor PMK-glycidate was seized in an intermediate warehouse in Western Slovakia (near the Slovak-Czech border). Precursor substances ephedrine and pseudoephedrine were also seized, in respective quantities of 5kg and 12,000 tablets). In addition to the aforementioned precursors, a minor volume of pre-precursor APAAN (Alpha-Phenyl-Aceto-Aceto-Nitrile) was also confiscated, which is used to manufacture a precursor substance for amphetamine (BMK), similarly to PMK-glycidate. The law enforcement authorities warned in 2013 of the growing cross-border cooperation of organised crime groups (Czech Republic and Slovakia) that create networks among groups of ethnic Vietnamese who are involved in wholesale manufacturing and distribution of cannabis and pervitin in the Czech Republic and Slovakia, and further trafficking in these drugs to Hungary and Austria.

10.2. Supply and accessibility

The situation in reducing drug supply in Slovakia is monitored by specialised departments and units: National Drug Unit of the National Crime Agency¹¹⁷ and the Customs Department of the Criminal Financial Administration Office.

¹¹⁷ The National Crime Agency was established in 1 December 2012 through the merge of the National Drug Unit and the National Anti-corruption Unit of the Organised Crime Authority. The National Crime Agency replaced the Organised Crime Authority and currently covers activities of both separate units: the National Drug Unit and the National Anti-corruption Unit.

10.2.1 General perception of ease of access to illicit drugs

A survey was conducted in Slovakia in 2013 to find out, among other things, the perceived ease of access to selected psychoactive substances, which also covered, in addition to illicit drugs, the ease of access to new psychoactive substances (also known as 'legal highs', 'research chemical'): Flash Eurobarometer 401, 2014.

The 5th Flash Eurobarometer 401 was conducted in 28 European Union Member States (including Slovakia) in June 2014. This telephone-based survey was carried out on a sample of 13,128 respondents (500 in Slovakia) aged 15-24. The perceived ease of access to selected types of illicit drugs among young Europeans was examined by asking the following question: "*How difficult or easy do you think it would be for you personally to obtain the following substances within 24 hours: cannabis, heroin, cocaine or new substances?*"¹¹⁸

In total, nearly two thirds (63%) of young Slovaks say it is "*easy*" for them to obtain cannabis, while more than half of those two thirds say it would be "*very easy*" for them to obtain it (34%). Even though the perceived ease of access to cannabis still remains above the EU average in Slovakia (58%), we have observed a downward trend, similar to that observed in other EU Member States. By contrast, with respect to stimulant drugs (cocaine and ecstasy), more than a half of the respondents in Slovakia say it would be "*fairly difficult*" and/or "*very difficult*" for them to obtain such illicit drugs within 24 hours. In both cases, a majority of respondents said it would be "*very difficult*" for them to obtain both cocaine and ecstasy. Young Slovaks perceive heroin as the drug that is most difficult to obtain. A total of 62% of Slovak respondents say it is "*difficult*" for them to obtain heroin within 24; more than one third of those say it is "*very difficult*".

When asked about the ease of access to new psychoactive substances (NPS), more than a half of Slovak respondents (56%) said it would generally be "*difficult*" for them to obtain such substances, which is similar to the EU average at 50%. (Source: Flash Eurobarometer 401, 2014)

In 2013, a project entitled "*Occurrence of psychoactive compounds in wastewater in Slovakia*" was conducted to determine consumption of illicit drugs and medicinal products in Slovakia, as a follow-up to the pilot project by Bodík I. et al., 2013 entitled "*The drugs in wastewater – monitoring and removal on Slovak WWTPs*". This new stage of the project examined the presence of the following psychoactive substances and medicinal products in wastewater in nine Slovak towns and cities: THC, amphetamine, methamphetamine, ecstasy, heroin, cocaine, codeine, oxazepam, tramadol and methadone. Testing run from July to November 2013 on samples analysed using the HPLC MS/MS method. The results showed that methamphetamine was the most widely used illicit drug in Slovakia during the monitored period. Concentrations of this illicit drug in wastewater ranged between 63 and 953 ng/l. In the nine Slovak municipalities, the highest quantities of this illicit drug per 1,000 population were measured in Petržalka (183 mg/1,000 pop./day), Piešťany (152 mg/1,000 pop./day) and Bratislava (133 mg/1,000 pop./day). The measurements of cocaine concentrations in wastewater indicate that cocaine-users mainly concentrate in Bratislava. In the nine Slovak

¹¹⁸ Responses were given on a scale from *very difficult*, *fairly difficult*, *fairly easy* through to *very easy*, or respondents could decide not to choose any of these options.

municipalities, the highest quantities of this illicit drug per 1,000 population were measured in Bratislava (17 mg/1,000 pop./day) and Petržalka (10 mg/1,000 pop./day). The concentration of the THC-COOH metabolite in wastewater was analysed to serve as the proof of cannabis consumption. The concentration of THC-COOH in wastewater proved by analyses ranged between 2 and 250 ng/l, with the highest concentration of this metabolite measured in Bratislava's suburb Devínska Nová Ves. As far as medicinal products are concerned, the highest concentration in wastewater was observed for prescription painkiller tramadol whose concentrations exceeded even those of illicit drugs (225 to 1560 ng/l). The overall quantities of tramadol in wastewater could be influenced by the fact that it is a frequently prescribed painkiller (a portion of measured quantities could come from its permanent users, e.g. patients suffering from chronic pains in joints, muscles, etc.) Of the nine Slovak municipalities covered by the analysis, the largest quantities of tramadol per 1,000 population were measured in Zvolen (366 mg/1,000 pop./day) and Piešťany (361 mg/1,000 pop./day); spas for patients with locomotor disorders (severe fractures, arthralgia).

10.2.2 Drug supply - manufacturing and trafficking

The information given below is taken from a report by the National Drug Unit of the National Crime Agency which obtained it through its operative investigation activities.

10.2.2.1. Cannabis

In 2013, the large-scale production and distribution of cannabis was largely managed by ethnic Vietnamese living in Slovakia. A substantial volume of cannabis grown in Slovakia was intended for export abroad (Czech Republic, Hungary and Austria in particular), due to more favourable (higher) prices in those markets. Several cases of cannabis trafficked into Slovakia from the Czech Republic (from Ostrava, Brno, eský T šin and Prague) were detected in 2013. Some of the trafficked volume was distributed in Slovakia, some was re-exported to Hungary. Small volumes of cannabis were also grown, indoor or outdoor, by native Slovaks for their own consumption and/or for distribution to a small group of customers. The police uncovered one case of a so-called clandestine "box laboratory" built in a bathroom in a private flat in 2013. Self-pollinated cannabis varieties were used in outdoor growing, shorter in height (up to 1m), that yield larger buds. Outdoor cannabis growing mainly prevailed in Slovakia's eastern regions.

As early as in 2012, the police obtained information about cooperation of organised crime groups consisting of ethnic Vietnamese operating in the territory of Slovakia, the Czech Republic and Hungary. The organised groups cooperated not only in establishing production sites/facilities, but also in their funding and ensuring cannabis sales to drug customers.

Persons of Vietnamese origin having permanent residence in Slovakia served as organisers, controlling and managing financial flows, technology purchases, its repeated use in establishing new production facilities, sale of raw, as well as processed cannabis products, and distribution of larger volumes of cannabis. Organised crime members of Vietnamese origin with permanent residence outside Slovakia were responsible for growing and caring for cannabis plants. In this manner, they often paid fees for "the arrangement" of their travel from Vietnam to Europe.

10.2.2.2. Methamphetamine (pervitin)

Methamphetamine production was largely carried out in small “kitchen-based” laboratories in 2013 in Slovakia. The most frequently used precursor substance was pseudoephedrine obtained from over-the-counter medicinal products (Modafen, Trifed, Clarinase Repetabs). Methamphetamine was also produced in small mobile laboratories and in specialised, high-output laboratories (especially by persons of Vietnamese origin). The high-output laboratories used mainly pure ephedrine as a precursor substance, imported in the form of tablets or powder from Poland.

Indications of ephedrine imports from Asia, China in particular, occurred in 2013. A larger number of individuals were involved in the manufacturing process in 2013 when compared to previous years. Before 2013, methamphetamine producers usually procured precursor substances, as well. The number of persons involved in obtaining precursors increased in 2013. Cooperation between pharmacists and perpetrators of drug-related crimes was also detected, in obtaining medicinal products containing pseudoephedrine. Similarly as in the case of cannabis production and distribution, the organised crime groups built contacts with similar groups in Austria, Hungary, the Czech Republic, Poland, as well as in the countries of former Yugoslavia and/or the Western Balkans.

Several cases of illegal import of larger quantities (exceeding 1 kg) of high quality methamphetamine from the Czech Republic were uncovered in the Western Slovakia region, mainly from Ústí nad Labem, Ostrava and eský T šín.

Home-manufacturing of methamphetamine fell in the Eastern Slovakia region. Producers preferred smaller, mobile laboratories with lower drug outputs. The growing demand for this illicit drug was covered by imports from other Slovak regions and from the Czech Republic.

Methamphetamine produced in Slovakia was primarily intended to satisfy demand on the domestic market; only a marginal portion was trafficked into Austria in 2013. An Austrian citizen (of Turkish origin) was arrested during a police drug operation aimed at detaining a methamphetamine distributor.

10.2.2.3. Heroin

Slovakia is a transit country in heroin trafficking, as the major portion of heroin supply only passes through Slovakia to other EU countries (northern European states in particular). Only a smaller volume of the contraband was intended for the Slovak market, several times diluted before it got to consumers. A permanently low purity and concentration of heroin on the Slovak market could be among the reason why a decrease in demand for this particular illicit drug has been seen in the recent years. A distinct switchover from heroin consumption to methamphetamine consumption was confirmed in 2013.

Heroin was mainly distributed from suppliers to consumers through Roma families that apply a similar modus operandi as Albanian organised crime groups. In Central and Eastern Slovakia, heroin continued to be sold in minimum quantities to relatively closed groups of consumers. A majority of heroin consumers were individuals of Roma origin involved in its distribution, and/or long-term heroin addicts. The misuse of opioid

medicinal products (methadone, subutex and suboxon) was identified across Slovakia throughout 2013. An increase in the misuse of a medicinal product containing tramadol as its active substance (tramal) occurred in the Central Slovakia region.

10.2.2.4. Cocaine

Similarly as heroin, cocaine is primarily a transit drug in Slovakia. Due to the increased frequency of arrests of cocaine traffickers in European countries combined with more stringent security measures at Europe's international airports, cocaine trafficking has been re-routed. Airborne trafficking was probably replaced by automobiles and train transport across Schengen area countries. The minimum checks at internal border crossing points and the free movement of individuals have considerably complicated the work of law enforcement authorities in discovering cocaine traffickers. Cross-border trafficking of cocaine from Slovakia continued in 2013. The cocaine distributed in Western Slovakia came primarily from Austria, Hungary and the Netherlands.

A pilot project analysing the presence of drugs in wastewater, carried out in Bratislava as part of a study entitled *The drugs in wastewater – monitoring and removal on Slovak WWTPs* (Bodík I. et al., 2013), yielded surprising results, with cocaine being the third most frequently used illicit drug, after cannabis and pervitin, in Bratislava (152 mg/1,000 pop./day), outrunning ecstasy, other amphetamines and heroin. We assume that a high cocaine consumption rate in Bratislava may reflect its better accessibility in this region, and may as well result from a higher migration of people, stronger purchasing power and, last but not least, from Bratislava's geographical location (being close to other capitals such as Vienna and Budapest).

Trafficking in cocaine and illicit activities related to the distribution and import of cocaine to Slovakia was uncovered by a police operation carried out in Piešťany and its surroundings in November 2013. Two criminals, of Serbian and Albanian nationality, were arrested during the police operation that employed Slovak nationals (acting as distributors and dealers) to traffic larger quantities of cocaine from Austria to Slovakia. A total of 1 kg of cocaine was seized, with the active substance concentration between 32 and 36%.

10.2.2.5. Synthetic drugs and new psychoactive substances

Differences in control measures adopted by individual EU Member States at the national level with respect to new psychoactive substances are misused by some perpetrators who build manufacturing and processing laboratories in border regions. An example of such activities was the discovery of an organised group of Hungarian nationals who established a laboratory to process new substance 3-MMC in a Slovak border region. The necessary ingredients were first transported to Hungary via courier services and then forwarded to Slovakia by cars. An extensive network of customers was built in Hungary. The new substances were primarily destined for export abroad, only a small portion was sold on the Slovak market. The National Drug Unit seized a total of 15 kilograms of new psychoactive substances (3MMC, -PVP and MPA).

The police discovered a distributor of new psychoactive substances in the Eastern Slovakia region who ordered, via the internet, substances (under various names, such as Coco) containing MDPV and 4-MEC from a Banská Bystrica-based supplier. The supplier

sent these substances via COD letters. In addition to new psychoactive substances (MDPV), the police also seized illicit drugs (cannabis, methamphetamine) and medicinal products (Subutex and Suboxon).

Importation of new psychoactive substances was also revealed in 2013, namely from Hungary (AB-PINACA) and Poland (AB-PINACA, AKB-48, 4-MEC).

10.2.3 Precursor supply – manufacturing and trafficking

The legislative framework on control and handling of drug precursors is defined by Act No. 331/2005 Coll. on state authorities in charge of drug precursors, which also lays down the powers and competences of state authorities in charge of drug precursors. The movement of drug precursors is monitored by a joint criminal-customs department of the National Drug Unit of the National Crime Agency. All drug precursors seized in Slovakia are analysed by the Institute of the Forensic Science (IFS).

The misuse of medicinal products containing ephedrine/pseudoephedrine¹¹⁹ continued throughout 2013; these substances were used to manufacture methamphetamine in small mobile laboratories and/or in so-called “kitchen” laboratories. Ephedrine-containing medicinal products imported from Poland (Cirrus, Sudafed) continued to be used in large-scale production.

Based on a legislative measure adopted by the Ministry of Health of the Slovak Republic in 2009 (see the 2011 Report, Chapter 10.1.3. for more information) which requires that pharmacies send regular monthly reports on the sale of all medicinal products containing precursors, 36 inspections were carried out throughout 2013 in pharmacies with a history of excessive sale of over-the-counter medicinal products containing pseudoephedrine.

Two Czech citizens who established a methamphetamine manufacturing laboratory in a rented cottage near Nové Mesto nad Váhom were also involved in trafficking ephedrine/pseudoephedrine-containing medicinal products into the Czech Republic and in the distribution of cannabis. During two police operations, 14,065 pseudoephedrine tablets were seized in 2013.

An international police drug operation seized a truck transporting 1.2 tons of PMK-glycidate, piperonal and safrol in Senica (Slovakia). The substance was manufactured in China from where it was transported via Turkey, Romania and Slovakia to the Netherlands. An intermediate storage was built in Slovakia where the drug precursor was re-packaged into small packages. The re-packaged precursor was then supposed to be transported to the Netherlands.

In addition to the aforementioned drug precursors, two samples of so-called pre-precursor APAAN (Alpha-Phenyl-Aceto-Aceto-Nitrile) were seized in Slovakia; APAAN is used in the manufacturing of BMK precursor.

¹¹⁹ Nurofen Stopgrip, Modafen, Trifed, Clarinase Repetabs and ACC Long

10.3. Seizures of drugs and precursors

Qualitative and quantitative analyses of all illicit drugs and precursors intercepted in Slovakia are carried out by the Institute of the Forensic Science of the Police Force (IFS).

10.3.1 Illicit drug seizures

This chapter is based on the data provided by the IFS and the Customs Department of the Criminal Financial Administration Office which are summarised in standard EMCDDA table No. 13 on illicit drug seizures. The total number of drug seizures (illicit drugs shown in Table 13 along with seizures of other types of illicit drugs) reached 2,237 in 2013, up 2.0% against 2012, but down 14.0% compared to 2011 (as shown on the xy chart).

No major changes have been seen over the past three years as far as the percentage shares of individual illicit drugs seized in Slovakia are concerned. The highest percentage of seizures made in Slovakia in 2013 is for cannabis products - marijuana, hashish and herbal cannabis (61%) - and methamphetamine (28%), which together accounted for 89% percent of all illicit drug seizures in 2013. The seizures of new psychoactive substances (NPS) were also reported in 2013, accounting for the largest share of other than controlled illicit drugs at 6%.

Table 10.1: Number of seizures and seized quantities of illicit drugs in Slovakia (2009 - 2013), ST 13. Source: ST13,(IFS, A., Bolf, 2014)

YEAR		2010		2011		2012		2013	
	unit	number of seizures	quantity seized	number of seizures	quantity seized	number of seizures	quantity seized	number of seizures	quantity seized
Hashish (cannabis resin)	kg	12	0.21	22	0.017	17	0.705	21	0.021
Herbal cannabis (marijuana)	kg	1,156	170.945	1,512	137.02	1,242	176.798	1,307	80.999
Cannabis plants	kg	43	1,986.26	45	18.338	38	2,927 ks	32	1,039 ks
Heroin	kg	146	1.294	33	0.323	82	0.261	73	0.189
Cocaine	kg	21	0.393	30	35.265	19	1.751	23	1.463
Amphetamine	kg	12	0.031	10	13.223	7	0.118	6	0.017
Methamphetamine	kg	545	2.954	692	1.644	600	10.9	628	3.786
Ecstasy tablets	tablet	5	993	5	27	16	529	17	47
LSD	dose	3	135	2	7	1	100	2	4
Other		99		250		172		128	
Total		2,042		2,601		2,194		2,237	

*includes number of cannabis plants only

In 2013, a moderate year-on-year increase in seizures was reported for cannabis (5.2%), methamphetamine (+28), up 4.7%, hashish (+4) and cocaine (+4). Moderate drops were reported for heroin (-9), cannabis plants (-6) and other than controlled illicit drugs (-56), which represents a decrease of 25.6% compared to 2012. The number of seizures of other controlled illicit drugs remained at the 2012 level. The significant increase in the number of heroin seizures observed in 2012 did not continue in 2013, which only proves the continuing retreat of opiates from the drug scene.

Table 10.1 shows a decline in quantities of illicit drugs seized in 2013 for each controlled drug. The decline in the seized quantities of illicit drugs (from 176.798 kg in 2012 to 80.999 kg in 2013 for cannabis, from 10.9 kg in 2012 to 3.786 kg in 2013 for methamphetamine, and from 2,927 to 1,039 pieces for cannabis plants) is considerable.

10.3.2 Precursor seizures

The legislative framework on the control and handling of drug precursors is defined by Act No. 331/2005 Coll. on state authorities in charge of drug precursors. The movement of drug precursors is monitored by a joint criminal-customs department. All drug precursors seized in Slovakia were analysed by the Institute of the Forensic Science.

Table 10.2: Number of seizures and seized quantities of drug precursors in Slovakia in 2013. Source: IFS, 2014

Type of precursor/pre-precursor	Form	Number of seizures	Quantity seized
Ephedrine	Powder	1	5 kg
Pseudoephedrine	Powder	2	0.0015 kg
	Tablet	6	16,128
Hydrochloric acid	Liquid	14	8.176 kg
Iodine	Powder	1	1.823 kg
Phosphorus	Powder	1	1.909 kg
Phosphoric acid	Liquid	1	10.635 l
Sodium hydroxide	Powder	1	5.826 kg
Toluene	Liquid	24	6.29 l
PMK-glycidate, safrol	Powder	1	1.2 ton
APAAN	Powder	2	0.0039 kg

The seizures of precursors and constituents used in methamphetamine production (see Table 10.2) indicate the ongoing dominance of its production in Slovakia. In the long term, the most misused drug precursor in Slovakia is pseudoephedrine - obtained mainly from over-the-counter medicinal products. A one-off large-quantity ephedrine seizure (13,995 tablets) was reported in 2013; the contraband came from Poland in form of the Cirrus medicine. Small-output production sites were mainly discovered, in which pseudoephedrine and other constituents were seized: hydrochloric acid, phosphoric acid,

sodium hydroxide, iodine and organic solvents (such as, for example, acetone, toluene, benzene).

In addition to precursors used in methamphetamine production, pre-precursors were seized in 2013 from which precursors used in amphetamine (BMK) production can be obtained: PMK-glycidate and APAAN - see Chapter 10.3.2 for more information.

10.3.3 Drug manufacturing laboratories dismantled by the police

The police information system does not collect and keep summary statistical data on the number of illicit drug laboratories dismantled in Slovakia. Only partial data are available about illicit drug production sites dismantled by a joint police-customs task force.

The largest operations conducted by the National Drug Unit in 2013 to uncover and close down illicit drug production sites include:

- a methamphetamine production site dismantled in Central Slovakia, two Czech nationals arrested. The production site operated in a rented cottage in the vicinity of Nové Mesto nad Váhom. In addition to methamphetamine production, the two arrested individuals were also involved in trafficking medicines containing ephedrine/pseudoephedrine into the Czech Republic and in cannabis distribution. Besides methamphetamine, ten packages of Nurofen (an OTC medicine containing pseudoephedrine) and a pulpy mixture of dissolved medicines stored in several plastic bottles were also seized.
- a drug raid operation aimed at discovering perpetrators involved in manufacturing and distribution of new psychoactive substances intended to be marketed in Slovakia and Hungary. Three Hungarian nationals were arrested and 15 kilograms of new psychoactive substances - 3MMC (3-methyl-meth-catinone), α -PVP and MPA were seized. The ingredients necessary for the production of these substances were imported from Hungary and, following their processing in Slovakia, were to be re-exported back to Hungary.
- a drug raid operation to uncover an indoor cannabis production site. A Slovak national was arrested during the operation and 110 cannabis plants seized, as well as laboratory equipment.
- a police drug raid to uncover a laboratory for indoor growing of cannabis. A Slovak national was arrested, and cannabis-growing equipment and 512.2 grams of herbal cannabis, with THC concentration of 18.6%, were seized.
- a drug raid operation to uncover a clandestine methamphetamine production laboratory. Five persons were arrested and, in addition to the laboratory and laboratory equipment, 58.9 grams of methamphetamine seized.
- a drug raid operation aimed at liquidation of an indoor cannabis production site in the Eastern Slovakia region. 500 grams of herbal cannabis and laboratory equipment were seized during the operation.
- a drug raid conducted in cooperation with the Czech drug crime service. A group of drug-law offenders of Vietnamese origin was uncovered in Slovakia who cooperated with a similar group based in the Czech Republic in growing, distribution and trafficking in cannabis.

The increasing trend in cross-border cooperation between organised crime groups operating in Slovakia and neighbouring countries (the Czech Republic, Hungary and Poland in particular) continued in 2013, as confirmed by the information provided by the National Drug Unit regional officers, as well as customs authorities. The growth in organised crime activities may be driven, among other things, by different legislation applied by individual Member States with respect, for example, to new psychoactive substances, as well as by different forms and length of sentences for drug-related crimes.

10.4. Price and purity of illicit drugs

10.4.1 Prices of illicit drugs

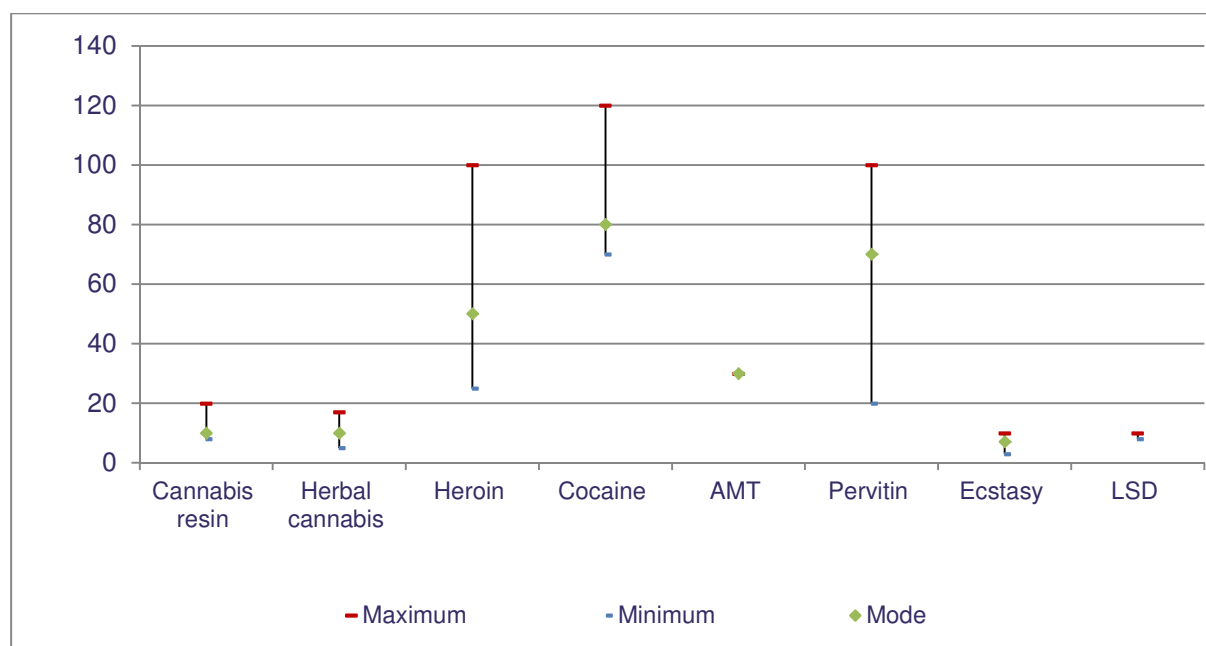
The National Drug Unit of the National Crime Agency determines drug prices through its operative investigation activities. The National Drug Unit provides the data on retail (so-called street) prices of individual kinds of illicit drugs in the form of a standard table ST16.

Prices stabilised in 2013 for the majority of controlled illicit drugs: cannabis, hashish, pervitin, cocaine and ecstasy. A price increase was only reported for heroin (from EUR 25-80/g in 2012 to EUR 25-100/g in 2013). Even though demand for this illicit drug has been falling in Slovakia (the population of heroin users is ageing and young drug consumers prefer stimulants, pervitin in particular), we assume that the increase in heroin prices could be caused by its shortage on the market, which also reflects in its low quality (heroin that enters the market is several times diluted and its concentration does not exceed 6%). The existing heroin consumers are mainly individuals of Roma origin involved in its illicit distribution, and/or long-term heroin addicts.

The price of amphetamine fell in 2013, from EUR 50/g in 2012 to EUR 30/g.

LSD prices on the Slovak market ranged between EUR 8 and EUR 10 per trip in 2013.

Figure 10.1: Minimum, maximum and average prices of selected types of illicit drugs in Slovakia in 2013, in EUR/g. Source: ST16 (NPJ NAKA, 2014)



Note: For ecstasy, the price is given per tablet; for LSD, the price is given per trip.

10.4.2 Purity and composition of illicit drugs

Illicit drugs seized in Slovakia are analysed by the Institute of the Forensic Science having its laboratories in Bratislava, Slovenská up a and Košice. The central register is kept at the IFS in Bratislava. In the case of small-quantity drug seizures (e.g., less than 1,000 mg for cannabis and less than 200 g for pervitin), no quantitative analysis is performed, hence concentration is not detected for all reported drug seizures.

In 2013, the IFS carried out 2,636 quantitative analyses of illicit drugs, up 2.9% compared to 2012.

The concentration of active substance in heroin fell under both indicators in 2013, to 6.0% for the mean concentration and to 5.9% for weighted average, but remained the second lowest since 2001.

The mean concentration for cocaine samples increased significantly to 54.1%, while the weighted average dropped slightly to 35.4%. These data indicate that samples with a higher cocaine content were seized in 2013 than in the previous years.

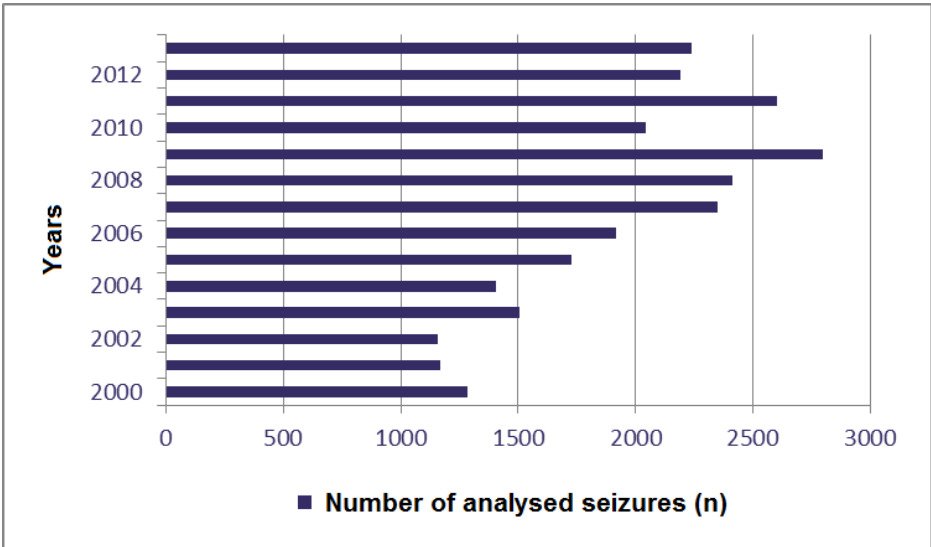
For hashish, the highest concentration of THC since 2001 was measured in 2013, with the weighted average value of 20.8% and the mean value at 15.2%.

Even though the mean THC concentration in cannabis increased moderately in 2013, no considerable changes have been observed in the recent years. On the other hand, a moderate year-on-year drop in the concentration of active substance in methamphetamine was observed in 2013, but remains stabilised in the long term. A new

ingredient, methylsulfonylmethane, was detected in methamphetamine samples in 2013¹²⁰.

For the period from January 2013 to April 2014, Odyseus NGO¹²¹ recorded eight cases where their clients reported to have the following health issues after using a regular dose of methamphetamine: face swellings, breathing problems, skin reddening and impaired motor abilities. (OZ Odyseus, 2014) All the eight reported cases occurred in Bratislava. Since the particular methamphetamine samples did not undergo a quantitative analysis, it is impossible to determine to what extent the reported health issues had been caused by unknown ingredients in the drug and/or other factors (e.g., bad health conditions, interactions with other illicit drugs, medicinal products, etc.).

Figure 10.2: Number of analysed drug seizures in Slovakia (2000-2013). Source: IFS, (A. Bolf), 2014



¹²⁰ Methylsulfonylmethane (MSM) is an organosulfur compound contained in several dietary supplements for joint regeneration.

¹²¹ A harm-reduction NGO operating in Bratislava and Western Slovakia region.

Table 10.3: Number of samples, weighted average and mean values for active substance content in selected types of illicit drugs in Slovakia, 2010-2013, ST 14, IFS (A. Bolf) 2014

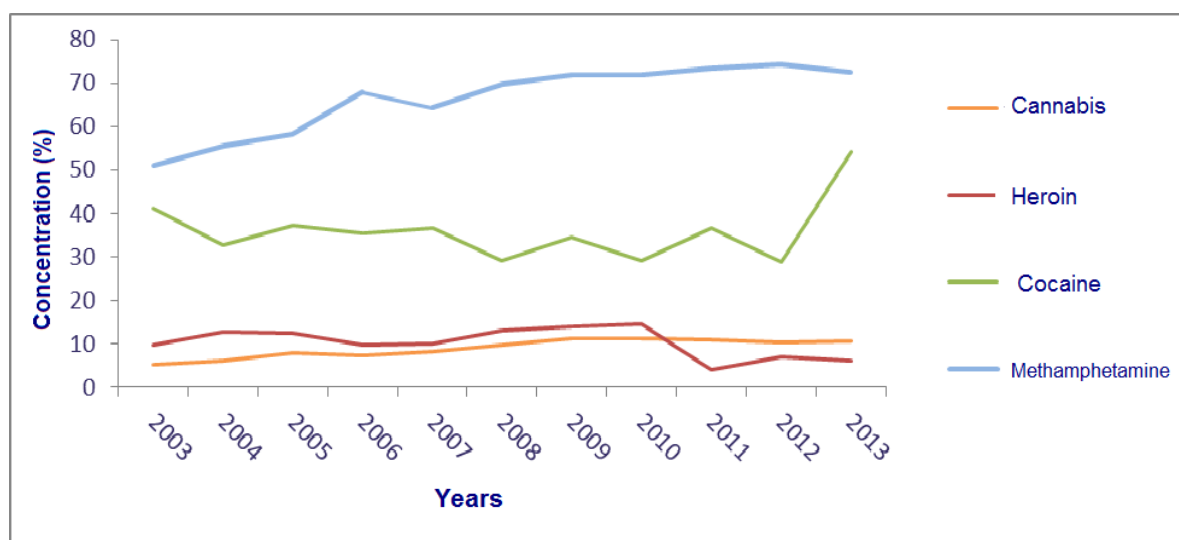
YEAR	2010			2011			2012			2013		
	A	B	C	A	B	C	A	B	C	A	B	C
Hashish (% THC)	13	9.7	7.5	24	9.6	8.1	26	10.6	14.5	23	20.83	15.2
Herbal cannabis (% THC)	1,222	7.7	11.3	1,499	7.7	11	1,496	9.2	10.2	1,555	7.1	10.5
Heroin (%)	2,878	16.2	14.6	128	4.5	4.1	260	8.9	7	258	5.9	6
Cocaine (%)	29	48.3	29.1	55	46.7	36.5	28	35.9	28.8	47	35.4	54.1
Methamphetamine (%)	561	65.7	71.8	774	69.2	73.4	748	73.4	72.2	778	69.6	72.4

A = number of samples

B = weighted average

C = mean value

Figure 10.3: Mean values for the concentration of an active substance in selected types of illicit drugs in Slovakia, 2003-2013, ST 14. Source: IFS (A. Bolf), 2014



11. BIBLIOGRAPHY

11.1. Alphabetic list of all bibliographic references used

1. Alexanderčíková, Z., Okruhlica, L., Kováčsová, E. (2013). 'Sexuálne dysfunkcie u pacientov pri vstupe do liečby závislostí', *Alkoholizmus a drogové závislosti*, Vol. 48, 1, PP 15-24.
2. Alexanderčíková, Z., Okruhlica, L., Slezáková, S. (2012). 'Mortalita pacientov so závislosťou od psychoaktívnych látok', *Alkoholizmus a drogové závislosti*, Vol. 47, Sup.1, PP 3.
3. *Alkoholizmus a drogové závislosti*. (2011). '7. Bojnické AT dni', *Obzor Bratislava*. Vol. 46, Sup. 2, PP. 40.
4. Almášiová Angela (2013) Report for NMCD
5. André, I., Izáková, J. (2013). 'Toxické psychózy a schizofrénia', *Alkoholizmus a drogové závislosti*, Vol. 48, Sup. 2, PP. 4.
6. André, I., Izáková, J., Baloghová, B., Borovská, M., Novotný, V. (2011). 'Výskyt a psychopatológia toxických psychóz na psychiatrickej klinike LFUK a UN Bratislava', *Alkoholizmus a drogové závislosti*, Vol. 46, Sup. 2, PP. 2-3.
7. Bačíková, A. ZVJS (2011): Drug-related Statistics of Prison and Court Guard Force in 2010. Part 2: Responses to Drug Related Health Issues in Prison. Report for NMCD – unpublished
8. Baldacchino, A. et al. 2011. Nature, level and type of networking for individuals with dual diagnosis: A European perspective. *Drugs: education, prevention and policy*. 2011; 18 (5): p. 393–401. ISSN 0968-7637
9. Bargerová, Z., Divínsky, B. 2008: Integrácia migrantov v Slovenskej republike: Výzvy a odporúčania pre tvorcov politik. 2008
10. Baška (2011) Risky behaviour of Pupils In *Sociálne determinanty zdravia školákov HBSC – Slovensko 2009/2010 (Social Determinants of School Aged Children Health – HBSC Slovakia 2009/2010)*, ISBN 978-80-89284-73-3, Košice 2011 Eds. Madarásová Gecková Andrea, Zuzana Veselská, Jana Kollárová
11. Bizíková J. (2011): Prevention in Elementary Schools Practice <http://www.statpedu.sk/sk/Vyskum-overovania-sutaze-a-vzdelavacie-aktivity/Vyskumne-ulohy.alej>, downloaded 18-6-2011
12. Bohonová, Š. (2011). 'K problematike komorbidity v adiktológii', *Alkoholizmus a drogové závislosti*, Vol. 46, Sup. 2, PP. 5.
13. Bolf, A. (2011): Seizures, purity and composition of illicit drugs in Slovak Republic, FEI PF, Report for NMCD, unpublished
14. Bučková, I. (2011): Drug Prevention activities under the Ministry of Interior and Police Headquarter Report for NMCD, unpublished
15. Bukvinová, P. (2014): Situácia v oblasti infekcie HIV a možnosti terapie. *Lekárske listy*, Príloha HN, . 10, PP 5-8.
16. Bušová Z, Kováčsová E, Okruhlica L. Užívanie drog v rekreačnom prostredí. *Alkoholizmus a drogové závislosti (Protialkoholický obzor) (Use of Drugs in the Recreational Environment. Alcoholism and Drug Addictions 2006; 41(4):231-242.*
17. Čentéš, J. (2007): Hmotnoprávne aspekty trestnej činnosti páchanej v súvislosti s nealkoholovou toxikomániou v SR (Substantive law on crime committed in relation to

- addictions to substances other than alcohol in the Slovak Republic), Bratislava, 2007, Slovak Republic Government office – NMCD, 116 pp. ISBN 978-80-88707-94-3
18. Chovanec, M., Dasová, K., Stanko, R., Zelman, M., Weiss, P. (2013). 'Priebežné výsledky sexuálnych dysfunkcií u závislých v PN Hronovce', *Alkoholizmus a drogové závislosti*, Vol. 48, Sup. 2, PP. 22.
 19. Coll. 305/2005 (§ 63) on Social and Legal Protection of Children and on Social Legal Guardianship, as amended.
 20. Coll. 581/2004 (§ 7) on Health Insurance Companies
 21. Concept of the field "drug addictions" of the MH SR
 22. Cook, J., Novotný, V., André, I.: Toxic psychosis , part 4. Alcoholism and Drug Addictions 2008, 43, p. 149 – 157. (*Toxické psychózy. 4. as . Alkoholizmus a drogové závislosti* 43, 2008, p. 149 – 157.
 23. Custom Criminal Office (2011): Letter 9224/2010-5006 , January 3, 2011 Regular information on seizures of narcotic and psychotropic substances in period of October – November 2010. The Report for NMCD, unpublished
 24. Czuczorová E.(2011): Selective Interventions of Social System for Vulnerable Children and Families and Social Reintegration Policies and Fulfilments, incl. Reintegration of drug users after release from prison The Ministry of Labour, Social Affairs and Family Report for NMCD, unpublished
 25. De Girolamo, G. et al. 2002. Residential care in Italy: National survey of non-hospital facilities. *BJP* 2002; 181: p. 220-225
 26. Development in Drug Use and Public Opinion Related to Drug Issue – Surveys of Public Opinion Research Institute in 1994-2006 and National Monitoring Centre for Drugs 2009-2010) edited (*Vývoj rozšírenosti užívania drog na Slovensku a názorov na drogovú problematiku - prieskumy ÚVVM 1994-2006 a NMCD 2009- 2010 , NMCD 2011 – pripravuje sa do tla e*)
 27. urove R (2013): On line Screening of Problems in Marijuana Users – Visitors of web site www.rastamama.sk , Data for NMCD
 28. Džambazovi , R. - Gerbery, D. - Sopóci, J (2013): ISSP Slovakia 2012 - Health and healthcare. source publication. Stimul, Bratislava, 2013
 29. EMCDDA (2003): Social reintegration in the European Union and Norway, by Annette Verster and Ulrik Solberg, www.emcdda.eu
 30. EMCDDA (2003): Treatment demand indicator standard protocol 2.0. Scientific report, Lisbon
 31. EMCDDA (2004): Key epidemiological indicator: Prevalence of problem drug use. Recommended draft technical tools and guidelines. Lisbon, EMCDDA, 2004
 32. EMCDDA (2010), Guidelines for the National Report 2011– unpublished www.reitox.emcdda.europe.eu
 33. EMCDDA (2010): Annual Report on the state of the drugs problem in Europe (in SK I language version - *Výro ná správa o stave drogovkej problematiky v Európe*, 2010), p.96, ISBN 978-929168443
 34. EMCDDA (2011). Directives for the National Report 2012 - internal material for REITOX members - not published
 35. EMCDDA 2011 Quality Report - Slovakia NFP. Internal document – unpublished
 36. EMCDDA, ST 34 TDI, 2012

37. EMCDDA. (2011). 'Mortality related to drug use in Europe: Public health implications', EMCDDA, Luxembourg, PP 33.
38. Flash Eurobarometer 330, July 2011: Youth attitudes on drugs – analytical report http://ec.europa.eu/public_opinion/flash/fl_330_en.pdf
39. Gazdíková K, Gazdík F, Hanzen J, Kajaba I, Okruhlica L. (2009): Incidence of HCV Infection and Distribution of the Genotype among Intravenous Drug Addicts and Clients of Re-socialization Facilities in Slovakia (October, 2009) 6. AT Conference, Bojnice, Slovakia. Lecture - unpublished
40. Gazdíková, K., Gazdík, F., Kajaba, I., Hu ková, D., Okruhlica, ., Farkašová, D. (2012). 'The seroprevalence of HCV among injecting drug users in the years 2004-2008 in Slovakia', Vnit Lé k, Vol. 58, 3, PP 179-182.
41. General Directorate of Prison and Court Force (2009,2008,2007,2006): Drug-related statistics of Prison and Court Guard Force in 2008,2007,2006,2005, Report for NMCD
42. General Directorate of Prison and Court Force (2010): Drug-related statistics of Prison and Court Guard Force in 2009, Report for NMCD – unpublished
43. General Prosecution Office (2010): Statistical yearbook of activities of Prosecution SR in 2009, GP SR, Bratislava, 249 pp
44. General Prosecution Office (2011): Statistical yearbook of activities of Prosecution SR in 2010, GP SR, Bratislava, 249 pp
45. Greenberg, B. et al. 2007: Methadone Maintenance Therapy in Residential Therapeutic Community Settings: Challenges and Promise. Journal of Psychoactive Drugs, 2007; 39:3, p. 203-210
46. Hamade J.,Janechová H (2011): Health Education and Health Promotion Activities of Public Health Authority in 2010 – Report for NMCD, published on www.infodrogy.sk
47. Hamade, J., Janechová, H. Univerzálna a selektívna prevencia – opatrenia na podporu a ochranu zdravia – Úrad verejného zdravotníctva Slovenskej republiky
48. Heretik, A. et al. (2008): EPIAF - epidemiológia alkoholizmu a fajenia na Slovensku (Epidemiology of Alcoholism and Smoking in Slovakia), Psychoprof, Nové zámky, 152 pp, ISBN: 978-80-89322-01-5
49. Interim Report on fulfilments of Antidrug Strategy in 2009-2010, publicised on <http://www.infodrogy.sk/index.cfm?module=Library&page=DocumentList&LibraryID=1&ArticleID=48> and www.rokovania.sk
50. Izáková, ., André, I., Baloghová, B., Borovská, M., Novotný, V. (2012). 'Toxická psychóza ako možná symptomatická forma schizofrénie?', Alkoholizmus a drogové závislosti, Vol. 47, Sup.1, PP 28.
51. Justh, R. D. (2011): Work in the Field of Crime Prevention, In: Social prevention, 1/2011, p.28, ISSN: 1336-9679
52. Kalina, K. a kol.: Terapeutická komunita: obecný model a jeho aplikace v lé be závislosti, Grada Publishing, vyd. 1, 2008, 400 p. ISBN 978-80-247-2449-2
53. Kalina, K. a kol.: Základy klinické adiktologie, Grada Publishing, vyd. 1, 2008, 392 p. ISBN 978-80-247-1411-0
54. Kastelová E (2011), NMCD Survey regarding Structure of Clients and Services in Resocialisation Centres – data 2013, unpublished
55. Kastelová E., Luha J. (2011 b) Annual GPS expert meeting Lisabon 21-22 June 2011 – Workshop - Presentation GPS (2010) - Results Regarding Perceiving Risk and Availability of Drugs

56. Kastelová, E.,(2010): NMCD Surveys regarding Structure of Clients and Services in Resocialisation Centres in period of 2007-2009. Internal Report – published on <http://www.infodrogy.sk/index.cfm?module=Library&page=Document&DocumentID=871>
57. Kiššová, L. (2008): Estimate of problem drug users. Monitoring study for 2007 PDU in low-threshold agencies, unpublished
58. Klobucký R. (2011): Drug Issues in Public Opinion in: Development in Drug Use and Public Opinion Related to Drug Issue – Surveys of Public Opinion Research Institute in 1994-2006 and National Monitoring Centre for Drugs 2009-2010 - edited
59. Klobucký R. Strapcová K (2010) Scientific seminar “Current problems of drug addiction in the SR and other EU countries”, NHF EU, Bratislava, April 27th 2010
60. Kolektív autorov. (2009). Projekt IATPAD. ‘Zlepšenie prístupu do lieby pre ľudí s problémami súvisiacimi s užívaním drog a alkoholu’, 2009, Bratislava, BB print, PP. 181.
61. Kolektív autorov. (2011). ‘Trestný poriadok’, In: Zbierka zákonov. Úplne znenie, Vol. 13, 10, PP 8.-116.
62. Kolesár, J., Martinove, M. (2011). ‘Zaradenie do resocializačného zariadenia ako jedna z možností alternatívnej trestno-právnej sankcie. Ochranná ústavná lieba závislosti a možnosti jej ukončenia’, Alkoholizmus a drogové závislosti. Vol. 46, 2, PP. 99-106.
63. Kolibáš, E., Novotný, V. (2011). ‘Nové drogy – II. časť – Šalvia divotvorná’, Alkoholizmus a drogové závislosti, Vol. 46, 5, PP. 257-275.
64. Kolibáš, E., Novotný, V. 2007. Alkoholizmus a drogové závislosti. UK Bratislava. 2007, 260 p., ISBN 978-80-223-2315-4
65. Kopányová, A (2011) : Report for NMCD – unpublished
66. Kopányová, A. (2008): Tertiary/indicated prevention in education, Prevencia (J. of Prevention) 1/2008 p. 5 – 10
67. Korcsog, P. (2011). ‘Závislosť od metamfetamínu a súvisiace problémy: videokazuistika’, Alkoholizmus a drogové závislosti, Vol. 46, Sup. 2, PP. 15-16.
68. Korcsog, P., Streška, P. (2011). ‘Mefedrón – nová látka na drogovej scéne’, Alkoholizmus a drogové závislosti, Vol. 46, Sup. 2, PP. 17.
69. Krajčovičová, D., Hanzelová, K. (2011). ‘Problematika komorbidít schizofrénie a užívania psychoaktívnych látok, možnosti terapeutického ovplyvnenia’ Alkoholizmus a drogové závislosti, Vol. 46, 4, PP. 207-224.
70. Kratky A,(2009): High virologic sustained response of former young intravenous drug users with chronic hepatitis C treated by pegylated interferon_ plus ribavirin. (2009), Bratisl Lek Listy magazine;110(2): p.77-84.
71. Kristian, P., Schréter I., Jarúška, P. (2011) : Triple therapy with protease inhibitors – news standard of care in chronic hepatitis C treatment’, Via practica, Vol. 8, No. 6, PP 23-26.
72. Kristian, P., Schréter, I., Jarúška, P. (2011). ‘Triple therapy with protease inhibitors – new standard of care in chronic hepatitis C treatment’, Via practica, Vol.8, 6, PP 23-26.
73. Lexmann, J., Droba, S., Kostár, A. (2011). ‘Závislosti a ich niektoré forenzně-psychiatrické súvislosti’, Alkoholizmus a drogové závislosti, Vol. 46, Sup. 2, PP. 19.
74. Macháková E., Luha J. (2011) Report for NMCD (Opinions of medics and students of Pharmacy College on Smoking - Názory študentov LF UK a FaF UK na fajenie), Excerpt from internal report
75. Matula Š., Kopányová A.(2010): Experimental examination of integrated system of prevention in city district Ružinov in 2010-2013 – Report for NMCD

76. Meier, P. S., Best, D. 2006. Programme factors that influence completion of residential treatment. *Drug and Alcohol Review*, 2006; 25, p. 349 – 355
77. Methodological Guideline for the provision of methadone maintenance treatment (MMT) for patients dependent on opiates with chronic disease process. *Journal of the MH SR* 2004.
78. Ministry of Interior (2010a): Report on the Security situation in Slovakia with regard to drug-related crime in 2010. Material for session of the Government of Slovak Republic, 2011, unpublished
79. Ministry of Interior (2010b): Statistics on drug related crimes and their perpetrators by type of drug, Presidium, of Police Force, Division of Police information system), Report for NMCD – unpublished
80. Ministry of Interior (2011b): Evaluation of the project „The Right Choice“ - published on <http://www.minv.sk/?Vyhodnotenie>
81. Ministry of Justice (2007): Convictions for drug-related offences, by type of drug, Report for the NMCD by L. Bodor
82. Ministry of Justice (2008): Convictions for drug-related offences, by type of drug, Report for the NMCD by L. Bodor
83. Ministry of Justice (2009): Convictions for drug-related offences, by type of drug, Report for the NMCD by L. Bodor
84. Ministry of Justice (2010): Convictions for drug-related offences, by type of drug, Report for the NMCD by L. Bodor
85. Ministry of Justice (2011): Convictions for drug-related offences by type of drug, Report for the NMCD by L. Bodor
86. Ministry of Justice (2011a) The Conception of Imprisonment for 2011-2020 (Konceptcia väznenstva <http://www.rokovania.sk/Rokovanie.aspx/BodRokovaniaDetail?idMaterial=19500>
87. Mravčík, V., Kiššová, L. (2006): Prevalence estimate of problem drug use in Slovakia, In: *Alkoholizmus a drogové závislosti*, 41, 2006, 5, p. 259 – 272, ISSN 0862-0305
88. MZ SR. (2005). 'Vyhláška č. 366/2005 Z.z. o kritériách a spôsobe hodnotenia sústavného vzdelávania zdravotníckych pracovníkov'. www.epi.sk
89. Národné centrum zdravotníckych informácií. (2012). 'Drug Addiction – Drug user treatment in Slovak Republic 2011' NCZI, PP. 72.
90. Národné centrum zdravotníckych informácií.(2014). 'Drug Addiction – Drug user treatment in Slovak Republic 2013', NCZI Bratislava, PP. 56.
91. National strategy against drugs for the years 2009-2012 www.infodrogy.sk
92. NHIC - Drug Addictions - Treatment of drug users in the SR 2010, Year 2011, ZŠ-44/2011
93. NHIC - Health Yearbook of the Slovak Republic 2012
94. NHIC - Psychiatric care in the SR 2013, Year 2014, ZŠ-4/2011
95. NHIC - Report on drug users treated from dependence ZS (MH SR) 4-12
96. NHIC - Statistics of in-patients in the SR 2010, Year 2011, ZŠ-25/2011
97. NHIC (2011): Data for ST34 (TDI), National Health Information Centre, unpublished
98. NMCD - Annual Report on the Condition of Drugs in Slovakia 2003-2010
99. NMCD - Drug Policy Implementation by Resorts
100. NMCD - National Drug Strategy 2009-2012 (adopted by the Slovak Government by Resolution 259/2009 of 1 April 2009)
101. NMCD - National Programme for the Fight against Drugs 2004–2008

102. NMCD - Report on Medium-Term Evaluation of the Performance of National Drug Strategy 2009–2010
103. NMCD (2007): Annual report on the drugs situation in Slovakia for the year 2006, Government Office of Slovak Republic, Bratislava, ISBN 978-80-8106-000-7, 127 pp.
104. NMCD (2008) Annual report on the drugs situation in Slovakia for the year 2007, Government Office of Slovak Republic, Bratislava, ISBN 978-80-8106-007–6, 118 pp
105. NMCD (2008a): Report on low threshold programmes – needle and syringe exchange programmes, National Monitoring Centre for Drugs, unpublished
106. NMCD (2009) Annual report on the drugs situation in Slovakia for the year 2008, Government Office of Slovak Republic, Bratislava, ISBN 978-80-8106-025–0, 160 pp
107. 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.
108. NMCD (2009a): Report on low threshold programmes – needle and syringe exchange programmes, National Monitoring Centre for Drugs, unpublished
109. NMCD (2009b): Report on social reintegration programme of RCs. National Monitoring Centre for Drugs – internal report, unpublished
110. NMCD (2010) Annual report on the drugs situation in Slovakia for the year 2009 (EN version)
<http://www.infodrogy.sk/narodnasprava/index.cfm?module=ActiveWeb&page=WebPage&s=summary2009>
111. NMCD (2010b): Report on social reintegration programme of RCs. National Monitoring Centre for Drugs – internal report, unpublished
112. NMCD (2010c): Report on low threshold programmes – needle and syringe Exchange programmes, National Monitoring Centre for Drugs, unpublished
113. NMCD (2010d): Annual report on the drugs situation in Slovakia for the year 2009, Government Office of Slovak Republic, Bratislava, unpublished
114. NMCD (2011) GPS survey “Prevalence of alcohol, tobacco and illicit drug consumption in Slovakia in 2010” -
115. NMCD (2011b): Report on social reintegration programme of RCs. National Monitoring Centre for Drugs – internal report, unpublished
116. NMCD (2012a): Report on Clients and Low-Threshold Facility Programmes - Exchange Programmes. National Monitoring Centre for Drugs - not published
117. NMCD (2012b): Report on Clients and Programmes of Resocialization Centres. National Monitoring Centre for Drugs – not published
118. Nociar A. (2011) : Situation in SK concerning new syntetic drugs and population and schools surveys in 2006-2007 and 2010-2011 (Situácia v SR vzhľadom na nové syntetické drogy a výsledky populárnych a školských prieskumov z rokov 2006-2007 a z rokov 2010-2011. Bratislava November 15 th 2011
<http://www.infodrogy.sk/index.cfm?module=Library&page=Document&DocumentID=907>
119. Nociar, A. (2010) : Final Report on TAD Survey in Pupils of Elementary and Secondary Schools and Their Teachers in 2010 (Záverová správa z prieskumu TAD u žiakov ZŠ, študentov SŠ a ich učiteľov v roku 2010) . Bratislava, VÚDPaP, 2010.
120. Novotný, V., Kolibáš, E. (2011). ‘Nové drogy – 1. časť – mefedrón’. Alkoholizmus a drogové závislosti, Vol. 46, 3, PP. 161-166.

121. Okruhlica L, Mihalková, A, Klemková D, Skovayová L (2002): Three-Year Follow-Up, Study of Heroin Users in Bratislava. *European Dependence Research* 2002; 8(2):103-
122. Okruhlica, . (2014): Main medical problems among aging patients in OST. Presented at: EMCDDA conference in Lisbon, September 2014.
123. Okruhlica, ., Alexander íková, Z., Olejárová, V. (2011). 'Why is it necessary to change law about court ordered treatment', *Alkoholizmus a drogové závislosti*, Vol. 46, 1, PP.35-40.
124. Okruhlica, ., Alexander íková, Z., Slezáková, S. (2013). 'Results of periodic, out-come cohort study of the patients treated for dependence'. November 2013, ISAM Annual Conference, Kuala Lumpur (Poster presentation).
125. Okruhlica, L., Alexander íková, Z., Slezáková, S., Olejárová, V (2010): Preco je potrebné zmeniť zákon o súdom nariadených liečeniach (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
126. Okruhlica, L., Bajcarová, L., Klemková, D.(2002) : Depressions and Score of Beck's Questionnaire with Patients with Alcohol Addiction. *Alcoholism and Drug Addictions*. 2002:32 (1) p. 15-22.
127. Okruhlica, L., Klemková, D., Bajcárová, L (2002).: Depressions and Beck's Questionnaire Score for Patients with Opioids Addiction, *Alcoholism and Drug Addictions* 2002:37(4-5) p. 209-218.
128. Palkovi , P., Okruhlica, ., Kocúriková, M. (2011). 'Význam toxikológie pri diagnóze psychózy', *Alkoholizmus a drogové závislosti*, Vol. 46, Sup. 1, PP. 52.
129. Palkovi , P., Alexander íková, Z., Slezáková, S., Vojtková, D., Okruhlica, .: Combined Diagnosis: Methamphetamine Addiction and Psychosis. (Kombinovaná diagnóza: závislosť od metamfetamínov a psychóza), *Alcoholism and Drug Addictions Alkoholizmus a drogové závislosti* 46, 2011, 3, p. 175 – 183.
130. Palkovi , P., Alexander íková, Z., Slezáková, S., Vojtková, D., Okruhlica, . (2011). 'Combined diagnosis: methamphetamine dependence and psychosis', *Alkoholizmus a drogové závislosti*, Vol. 46, 3, PP.175-183.
131. Pedersen, M. U. et al. 2011. Abstinence-orientated residential rehabilitation of opioid users in Denmark: Do changes in national treatment policies affect treatment outcome? *Scand J Public Health* 2011
132. Pétiová et al (2010): Final Reports on Research Concerning Consumption of Legal and Illicit Drugs in Years 1995-2009 (Pétiová, M. a kol. Závere né správy z výskumov zameraných na problematiku konzumácie legálnych a nelegálnych drog v rokoch 1995 až 2009. Internal Report , Bratislava ÚIPŠ.2010
133. Pétiová M. et al. (2011) Illicit and Licit Drug Consumption in Youths Living in Special Educational Facilities. Internal Research Report of IIPE and Report for NMCD,2011 (Konzumácia legálnych a nelegálnych drog u mladých udí žijúcich v diagnostických a reedukáčných centrách na Slovensku, interná výskumná správa ÚIPŠ, správa pre NMCD, 2011)
134. Pétiová, M. a kol.: Consumption of licit and illicit drugs among the schoolchildren of the EC and SS. Final survey report. ÚIPŠ, Bratislava 2012.
135. Plán B. (2012). 'Závere ná správa projektu: Stav a dostupnosť substitúnej liečby na Slovensku'. Plán B, PP. 39.

136. PORI at SO (2006): Prevalence of drug use in Slovakia and Opinions of Citizens Regarding the Drug-Dependence Related Problems Public Opinion Research Institute at the Statistical Office, Bratislava
137. Quality of RCs in Slovakia – Standards and Good Practice (Kvalita resocializačných stredísk pre drogové a iné závislosti – Štandardy a dobré skúsenosti) <http://www.infodrogy.sk/index.cfm?module=Library&page=DocumentList&LibraryID=1&AreaID=48>
138. Rawson RA, Gonzales R, Brethen P. Treatment of methamphetamine use disorders: an update. *Journal of Substance Abuse Treatment* 2002; 23(2):145-50.
139. Report on fulfillments the Crime Prevention Strategy in 2007-2010 and priorities in 2011 (Správa o plnení úloh vyplývajúcich zo Stratégie prevencie kriminality v Slovenskej republike na roky 2007 – 2010 v roku 2010 a prioritách prevencie na rok 2011)
140. Šidlo, J. (2013). 'Úmrtia súvisiace s nezákonnými drogami a rozpúšťadlami v Bratislavskom a Trnavskom kraji v rokoch 1996 – 2012. 'Alkoholizmus a drogové závislosti, Vol. 48, Sup. 2, PP. 4.
141. Šidlo, J. (2014): Drug Related Deaths in 2013 – Report for NMCD, unpublished
142. Šidlo, J. (2014): ST 05 and ST 06 for REITOX Drug Related Deaths in 2013.
143. Šidlo, J., Šidlová, H., Luha, J., Šikuta, J. Kuruc, R. (2012). 'Somatické a smrteľné následky užívania opiátov a opioidov'. *Alkoholizmus a drogové závislosti*, Vol. 47, 4, PP. 271- 284.
144. Slezáková, S., Okruhlica, . (2011). 'Motivation for Treatment of HCV Infection among Drug Users', *Adiktologie*, Vol. 11, 3, PP. 142-146.
145. Slezáková, S. Okruhlica, . 'Mortalita u pacientov so závislosťou od psychoaktívnych látok', *Alkoholizmus a drogové závislosti*, (in print).
146. Slezáková, S. Okruhlica, . (2012). 'Weight changes of patients in methadone maintenance treatment during four years period', *as. Lékařská*, Vol. 151, N.8, PP 389-391.
147. Slezáková, S. Okruhlica, . (2013). 'Mortalita u pacientov so závislosťou od psychoaktívnych látok', *Alkoholizmus a drogové závislosti*, *Alkoholizmus a drogové závislosti*, Vol. 48, 2, PP. 85-94.
148. Slovíková, M., (2011): Selected statistical data of IIPE for school year 2009-2010, Institute of Information and Prognoses of Education, Bratislava – Report for NMCD
149. Somošová J, Záleský R, Pospíšil R. Amfetamíny a techno – scéna. *Alkoholizmus a drogové závislosti* (Amphetamines and Techno-scene. *Alcoholism and Drug Addictions* 2002; 37(3):147-159.
150. Sorensen, J. L. et al. 2009. Methadone patients in the therapeutic community: A test of equivalency. *Drug and Alcohol Dependence* 2009; 100, p. 100–106
151. Specialized guideline regarding standards for diagnostics and treatment in the field of drug addictions
152. Standards for minimum occupancy of residential departments of healthcare facilities with physicians (2002)
153. Statement of policy of the Government of the Slovak Republic. 2010.
154. Statistical Office of the Slovak Republic. Prevalence of Drug Use in Slovakia and the Opinions of Citizens Regarding the Problems Related to Drug Dependence, 2006.
155. Stav drogových závislostí a kontrola drog v SR 2004 (National report for REITOX – data 2003): Government Office SR, Bratislava, 2004, ISBN 80-968631-3-4, 162 pp
156. Stav drogových závislostí a kontrola drog v SR 2005 (National report for REITOX – data 2004): Government Office SR, Bratislava, 2005, ISBN 80-968631-4-2, 220 pp

157. Stav drogových závislostí a kontrola drog v SR 2006 (National report for REITOX – data 2005): Government Office SR, Bratislava, 2006, ISBN 978-80-88707-73-8, 133 pp
158. Šteliar I. (2009b) ST 7 and ST 8 for REITOX
159. Šteliar, I. (2011). 'Obraz kombinovaného užívania psychoaktívnych látok v monitoringu drogovej situácie', *Alkoholizmus a drogové závislosti*, Vol. 46, Sup. 2, PP. 32-33.
160. Šteliar, I. (2009): Estimate of problem drug users. Monitoring study for 2008 PDU in low threshold agencies, unpublished
161. Šteliar, I., Okruhlica, L. (2006): Decrease of Drug Injecting Associated with Changes on Drug Scene, a presentation at the international conference EUROPAD, 2006 Bratislava – unpublished
162. Šteliar, I., Okruhlica, L. (2007): Contribution on issues relating to the estimate of problem drug use using Bratislava as an example, *Alkoholizmus a drogové závislosti (Alcoholism and drug addiction)*, 42, 3 (2007), p.129 – 144, ISSN 0862-0350
163. Stewart, D. et al. 2000. Variation between and within Drug Treatment Modalities: Data from the National Treatment Outcome Research Study (UK). *Eur. Addict Res* 2000, 6: p. 106-114
164. Survey on NPS use in specific environments NMCD 2013
165. Tejová M. (2011): Summer festival Pohoda. Participants' Knowledge on Crazy shops and Products Sold – lecture on 7th. AT conference, Bojnice, 30. September - 2. October 2011. (Informovanos ú astníkov Pohody o Crazyshopoch, Smartshopoch a Growshopoch a ich názory na produkty v nich ponúkané – prednáška : 7. bojnická AT konferencia, Bojnice, 30. september - 2. október 2011).
166. Tejová M., Kara E. 2012 Nové psychoaktívne látky v rekreácii a virtuálnom prostredí
167. Tejová, M. (2011). 'Informovanos ú astníkov Pohody o Crazyshopoch, Smartshopoch a Growshopoch a ich názory na produkty v nich ponúkané', *Alkoholizmus a drogové závislosti*, Vol. 46, Sup. 2, PP. 33.
168. Trokanová, Z. (2011). 'Abúzus na sedatívach a hypnotikách (Kazuistické príklady z praxe ženského psychiatrického oddelenia)', *Alkoholizmus a drogové závislosti*, Vol. 46, Sup. 2, PP. 34.
169. Višnovský, E. (2011). 'Akútna intoxikácia kokaínom – kazuistika', *Alkoholizmus a drogové závislosti*, Vol. 46, 2, PP. 107-111.
170. Vráblová, ., ZVJS (2011): Drugs in Prisons in 2010 – Part 2 Using drugs in prisons, seizures, drug-free zones Report for NMCD – unpublished
171. Vývoj užívania drog na Slovensku a názory na drogovú problematiku – prieskumy ÚVVM pri ŠÚ SR v rokoch 1994-2006 a NMCD 2009-2010 – pripravuje sa do tlače (The Development in Drug Use and Public Opinion Related to Drug Issue – Surveys of Public Opinion Research Institute in 1994-2006 and National Monitoring Centre for Drugs 2009-2010) editing
172. Youth attitudes on drugs – analytical report Flash Eurobarometer 330, July 2011 http://ec.europa.eu/public_opinion/flash/fl_330_en.pdf
173. Z. z. . 305/2005 (§ 63) Zákon o sociálno-právnej ochrane detí a sociálnej kuratele v znení neskorších predpisov.

11.2. Alphabetic list of relevant databases available on internet

<http://statistics.sk>

<http://vyskumymladeze.sk>

http://www.sukl.sk/sk/databazy-a-servis/databazy/vyhľadavanie-v-databaze-registrovaných-liekov?page_id=242

11.3. Alphabetic list of relevant Internet addresses

<http://jaspi.justice.gov.sk>

<http://primar.sme.sk/c/6684320/neliecena-hepatitida-c-moze-mat-aj-fatalne-dosledky.html>

<http://www.cpldz.sk>

<http://www.cpldz.sk>

<http://www.cpldz-bb.sk>

<http://www.cpldz-kosice.sk>

<http://www.cpldz-zilina.sk>

<http://www.drogy.org>

<http://www.drogyinak>

<http://www.economy.gov.sk>

<http://www.emcdda.europa.eu>

<http://www.emcdda.europa.eu/countries/slovakia>

<http://www.emcdda.europa.eu/data/2014>

<http://www.employment.gov.sk>

<http://www.euphoria-shop.sk>

<http://www.finance.gov.sk>

<http://www.genpro.gov.sk>

<http://www.health.gov.sk>

<http://www.hiv-aids.tym.sk>

<http://www.infodrogy.sk>

<http://www.infodrogy.sk>

<http://www.isgf.ch/fileadmin/downloads/E>

[QUS Annexes to final report 1.pdf](#)

<http://www.justice.gov.sk>

<http://www.liecebnariekka.sk>

<http://www.minedu.sk>

<http://www.minv.gov.sk>

<http://www.nczisk.sk>

<http://www.nrsr.sk>

<http://www.olup-prednaha.sk>

<http://www.prima.sk>

<http://www.rastamama.sk>

<http://www.ruvzba.sk>

<http://www.sme.sk/c/7068328/ma-hiv-lekari-ho-vacsinou-vysetrit-nechcu.html>

<http://www.statistics.sk>

<http://www.sukl.sk>

<http://www.uips.sk>

<http://www.upsvar.sk>

<http://www.upsvar.sk>

http://www.upsvar-zv.sk/docs/spo_resocializac_strediska.pdf

<http://www.uvzsr.sk>

<http://www.vlada.gov.sk>

<http://www.vzbb.sk>

[http://www.zdravie.sk/obsah/29602/Hepatiitida-c-%C2%96-tichy-zabijak/.](http://www.zdravie.sk/obsah/29602/Hepatiitida-c-%C2%96-tichy-zabijak/)

<http://www.zvjs.sk>

11.4. 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 Counselling 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 Additions
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	flourophenylpiperazine
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
IPE	Institute of Information and Prognoses of Education
IPE	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	metylendioxyamfetamine
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)
PCC	Pedagogical and Psychological Counselling Centres (CPPPaP in Slovak)
PPF	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

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12.3. 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
4. Government resolution 1/2011 the draft of bill on the cancellation of the Anti-Drug Fund
5. 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.
6. Act 43/2011 Coll., which changes and amends the Act 139/1998 Coll. on Narcotic Substances, Psychotropic Substances and Preparations as amended
7. Act 575/2001 Coll. On the government activity organisation and on organisation of the central state administration
8. Act 524/2010 Coll. on state subsidies provision in authority of the Government Office of the Slovak Republic
9. Act 140/1998 Coll. on Medicines and Medical Aids.
10. Act 308/2000 Coll. on Broadcasting and Retransmission and on changes to Act 195/2000 Coll. On Telecommunications as amended.
11. Act 147/2001 Coll. on Advertising and on change and amendments of some acts as amended.
12. Act 377/2004 Coll. on the Protection of Non-Smokers and on changes and amendments to certain Acts as amended.
13. Act 36/2005 Coll. on Family and on change and amendment of certain Acts.
14. Act 300/2005 Coll. Criminal Code.
15. Act 224/2010 Coll., which changes and amends the Act 300/2005 Coll. as amended and on change and supplement of certain laws.
16. Act 301/2005 Coll. Penal Code.
17. Act 262/2011 Coll., which changes and amends the Act 301/2005 Coll. Penal Code as amended, and which changes and supplements certain laws
18. Act 305/2005 Coll. on the Social Legal Protection of Children and Social Guardianship and on changes and amendments to certain Acts as amended.
19. Act 331/2005 Coll. on State Administrative Authorities in matters of drug precursors as well as change and amendment of certain Acts.
20. Act 475/2005 Coll. on the Performance of the Term of Imprisonment.
21. Act 221/2006 Coll. on Performance of Imprisonment.
22. Act 124/2006 Coll. on Safety and Health Protection at work.
23. Act 330/2007 Coll. on Criminal Register and on change and amendment of certain Acts.
24. Act 245/2008 Coll. on Upbringing and Education (the School Act) and on changes and amendments to some Acts

25. Act 300/2008 Coll. on Organization and Support of Sports and on change and amendments of certain Acts.
26. Act 583/2008 Coll. on the Prevention of Crime and Other Anti-social Activities and on changes and amendments to some Acts.
27. Act 67/2010 Coll. on Conditions of Introduction of Chemical Substances and Chemical Compounds to the market and on change and amendment of certain Acts (Chemical Act).
28. 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
29. Resolution of the National Council of the Slovak Republic 440/2011 acknowledging the Report on Medium-Term Assessment of the Fulfilment of the National Anti-Drug Strategy for the Period 2009–2010
30. Government resolution 272/2011 acknowledging the Report on Medium-Term Assessment of the Fulfilment of the National Anti-Drug Strategy for the Period 2009–2010
31. Government resolution of the Slovak Republic Government 135/2011 about the proposal of statute of the Ministerial Council and proposal for cancellation of certain advisory bodies of the Slovak Republic
32. Government resolution No. 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
33. Government resolution No. 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
34. Government Resolution No. 610/2012 towards assignment of competencies in the area of drug policy and of drug situation monitoring in Slovakia
35. Government Resolution No. 215/2013 on the proposal of the Statute of the Government Council of the Slovak Republic for Drug Policy
36. Government Resolution No. 380/2013 towards the proposal of the National Drug Strategy for period 2013-2020
37. Acto No. 525/2010 Coll. on state subsidies provision in authority of the Ministry of Health of the Slovak Republic
38. Act No. 40/2013 Coll. – amendment of the Act No. 139/1998 Coll.
39. Act No. 43/2014 Coll – amendmend of the Act No. 139/1998 Coll.

12.3.1 List of 2013 standard tables provided

Standard Table	Title	Remarks
Standard Table 01	Basic results and methodology of population surveys on drug use	no new data
Standard Table 02	Methodology and results of school surveys on drug use	no new data
Standard Table 05	Acute/direct related deaths	
Standard Table 06	Evolution of acute/direct related deaths	
Standard Table 07 & 08	High risk drug use	No new data
Standard Table 09-1	Prevalence of hepatitis B/C and HIV infection among injecting drug users: methods	
Standard Table 09-2	Prevalence of hepatitis B/C and HIV infection among injecting drug users	
Standard Table 09-3	Voluntary results for Behavioural Surveillance and Protective Factors	Voluntary
Standard Table 09-4	Notified cases of hepatitis C and B in injecting drug users	
Standard Table 10	Syringe availability	
Standard Table 11	Arrests/Reports for drug law offences	
Standard Table 12	Drug use among prisoners	
Standard Table 13	Number and quantity of seizures of illicit drugs	
Standard Table 14	Purity at street level of illicit drugs	
Standard Table 15	Composition of tablets sold as illicit drugs	
Standard Table 16	Price in Euros at street level of illicit drugs	
Standard Table 18	Overall mortality and causes of deaths among drug users	n.a.
Structured Questionnaire 23	Harm reduction measures to prevent infectious diseases	
Structured Questionnaire 27 P1	Treatment availability	
Structured Questionnaire 27 P2	Quality assurance of drug demand intervention	
Standard Table 24	Access to treatment	
Standard Table 30	Standardised results and methodology of targeted youth and/or site setting, national or local surveys on drug use	