

THE STATE OF DRUG ADDICTION
AND DRUG CONTROL
IN THE SLOVAK REPUBLIC

2004 Report

National Drug Monitoring Centre

The General Secretariat of the Ministerial Committee for Drug Addiction and Drug Control

Bratislava 2004

The Government Office of the Slovak Republic
The General Secretariat of the Ministerial Committee for Drug Addiction and Drug Control
National Drug Monitoring Centre

Bratislava, 2004

The State of Drug Addiction and Drug Control in the Slovak Republic
Developments, trends, and selected issues concerning the drug problem in the
Slovak Republic

2004 Report for the EMCDDA – the REITOX¹ National Focal Point in the Slovak Republic

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THE SLOVAK REPUBLIC

Developments, trends, and selected issues concerning
the drug problem

REITOX

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Introduction

Our accession to the European Union opened up a new chapter in the field of drug control in the Slovak Republic, as reflected by the establishment of the National Drug Monitoring Centre at the General Secretariat of the Ministerial Committee for Drug Addiction and Drug Control. One of the Monitoring Centre's most important tasks is to draw up an annual, national report concerning drug addiction and drug control in the Slovak Republic. This report – the very first of its kind – aims to present a comprehensive analysis of the fight against drugs up to 2004. It describes the daily fight against drug addiction, in which dozens of assorted governmental and non-governmental organisations, hundreds of experts, and thousands of volunteers, were engaged.

The current state of the anti-drug scene in the Slovak Republic and its fight against drugs has prompted a number of discussions and comparisons with other countries – above all with the original members of the European Union. With its many facts, analyses, statistical data, and outlines, the report confirms that in comparison with such developed countries in the field of the fight against drugs – such as France, the Netherlands, the United Kingdom, Germany, and other original European Union member states – we have achieved a consistent standard. The long-term work of eminent domestic and international experts, together with the extensive experience of dozens of institutions, proves that when it comes to the fight against drugs, the Slovak Republic has a high-quality professional and institutional basis, enjoying wide-ranging social and political support. Most of our problems are mainly connected to the requirement for up-to-date solutions to some of the latest trends in the area of the fight against drugs, such as implementing and developing the Early Warning System against the use of new drugs, especially synthetic drugs. Our system of monitoring and evaluating certain key indicators concerning the drug problem is still inadequate when it comes to drawing up estimates of the number of drug addicted persons, and when registering the number of deaths that result from drug addiction or abuse. We are still experiencing difficulties obtaining the materials required for the new methods of ensuring the treatment and social reintegration of drug addicts; moreover, we still lack some legislative standards that are necessary in order to attain the European level. We could certainly achieve a greater level of efficiency in the fields of preventing drug addiction and media strategy. However, these are flaws that can be eradicated; the General Secretariat of the Ministerial Committee for Drug Addiction and Drug Control at the Government Office of the Slovak Republic, in cooperation with the pertinent Ministries, regional offices, towns and cities, and non-governmental organisations, is investing the maximum amount of effort in this area, in order to attain the European standard. Specific solutions to many issues are set out directly in the National Programme for the Fight Against Drugs for 2004 to 2008, which was approved by the Slovak Government and the Members of the National Council.

Although the National Report on the State of Drug Addiction and Drug Control in the Slovak Republic is certainly not destined to become a bestseller, appealing to thousands of readers, this was never the ambition of its authors. Our objective was to present the facts and initiate a discussion as to how we should continue in the fight against drugs in Slovakia.

We hope that this discussion will be a fruitful one for the General Secretariat of the Ministerial Committee for Drug Addiction and Drug Control and its National Drug Monitoring Centre, shifting the fight against drugs into newer and more effective dimensions.

PhDr. Blažej Slabý, CSc.

Director of the General Secretariat of the Ministerial Committee for Drug Addiction and Drug Control at the Government Office of the Slovak Republic

Summary

The National Report provides an overview of institutional organisation and coordination within the framework of the state's anti-drug policies, the legislative instruments used in this policy, and the changes they have undergone since 2000. It gives an overview of developments in the drug scene and an analysis of trends based on the results of monitoring five key indicators, together with other main indicators in the area of law enforcement. The report gives details of comprehensive programmes of primary, secondary, and tertiary prevention, which were drawn up by the Ministries of Education, Health, and Social Affairs.

For the very first time on a national level, it provides estimates of the prevalence of drug abuse, and on a local level, it provides estimates of the number of drug users not participating in treatment, based upon an analysis by the syringe exchange programme.

Finally, it sums up the situation in the illegal drug market, and provides a description of three selected topics: Buprenorphine (Subutex), alternative sentences, and drugs as public nuisance.

Main findings and selected topics

The organisation and coordination of institutions has not changed since 2000; i.e., the **Ministerial Committee for Drug Addiction and Drug Control** remains an inter-ministerial institution for coordinating state anti-drug policy, as set out in the National Programme for the Fight Against Drugs, the latest version of which was approved in spring 2004 for the period of 2004 – 2008. The Committee's executive body, **the General Secretariat, is still the administrative body for implementing state anti-drug policy, as well as its control**. On 22nd May 2002, the Slovak Government passed a resolution establishing the National Drug Monitoring Centre (NDMC).

The drug scene – which, since 1992, **slowly grew to resemble the situation in Western Europe with regard to the range of drugs on offer – has undergone a qualitative change since 2000. The absolute dominance of heroin ended in 2003**, and we can expect a further shift towards the more frequent use of marijuana and synthetic drugs, especially amphetamine-type stimulants and 'party drugs', such as ecstasy.

The most marked rise occurred in the lifetime prevalence of marijuana use amongst secondary school students between 15-16 and 18-19 years of age – from 23.0% in 1999 to 35.5% in 2003 (Nociar, A., 2004). An ESPAD² study registered a similar rise in the use of ecstasy, as well as the increasing polydrug use (i.e., alcohol with tablets, alcohol with marijuana).

From the aspect of the monitored key and main indicators, this could be observed in **parallel developments in the demand for treatment – where there has been a shift from the treatment of heroin addicts towards the treatment of people dependent on marijuana and amphetamines since 2000** – and in the quantity of drugs seized and the total number of such seizures. Although the number of people undergoing treatment for heroin addiction – together with the quantity of heroin seized and the number of such seizures – rose in parallel until 2000, these figures have declined ever since (see figures 1, 4, and 5).

On the other hand, **population surveys in 2000 and 2002**, (Luha J., 2004), together with **school-based surveys in 2002 and 2003** (Bieliková M. and Pétiová M., 2003) **confirmed a conflicting trend within the indicator concerning the demand for treatment, where the declining number of heroin addicts undergoing treatment were offset by a rise in the**

² ESPAD – the European School Survey Project on Alcohol and Drugs.

number of people being treated for addiction to marijuana and amphetamines (above all, methamphetamine – also known as 'pervitine').

Data from 2003³ revealed a relatively high level of first-time treatments (41%), which was greatest amongst stimulant addicts.

The number of patients undergoing treatment almost doubled between 1994 and 2000 – from 1,189 to 2,345 patients respectively. Later, we registered a declining tendency, whereby the number of patients addicted to heroin in particular fell; the resulting graph from 2002 testified to an overall decline in the number of drug addicts being treated. In 2003, this tendency shifted towards a stabilisation in the number of patients, albeit accompanied by a significant change in the nature of the drugs used (see Fig. 1):

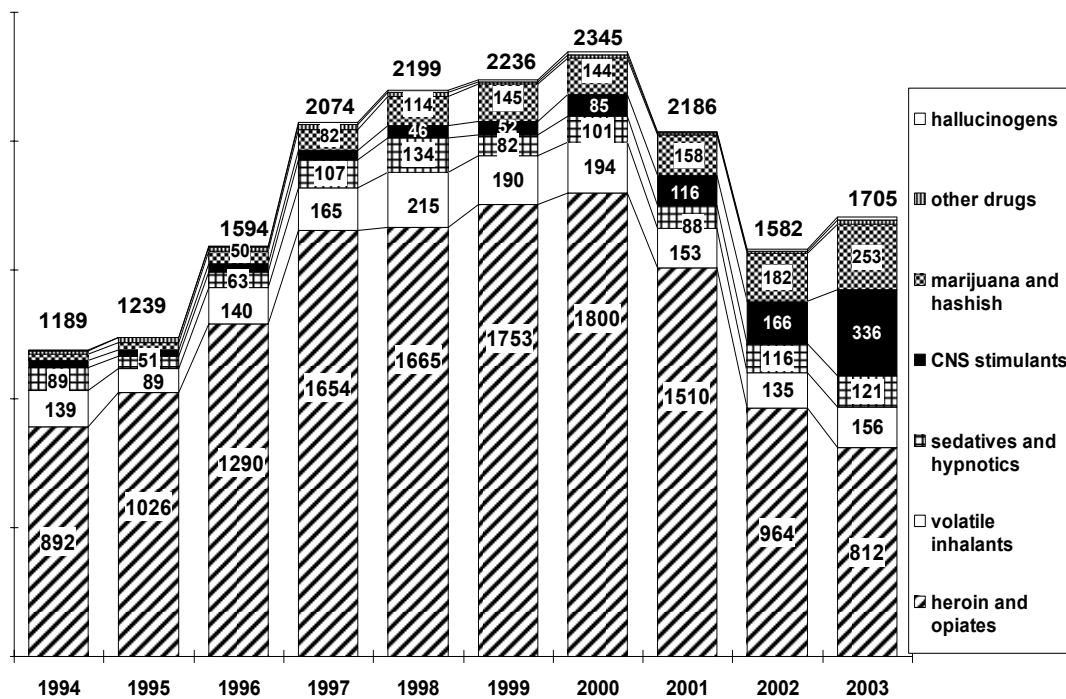


Fig. 1. Treatment demand indicator: Number of treated drug addicts in Slovakia between 1994 and 2003

Source: Institute of Health Information and Statistics. Processing and design: General Secretariat of the Ministerial Committee for Drug Addiction and Drug Control/NDMC

Although at first sight, the demand for treatment indicator appears to show that the number of drug addicts undergoing treatment is falling, it would be a mistake to conclude on this basis alone that the overall number of drug addicts and abusers is also on the decline. For example, a simple breakdown of the graph illustrates the declining trend of heroin and opiate abuse since 2000, countered by the rising trend in treatment provided to addicts of cannabinoids and certain synthetic drugs (see Figs. 2 and 3).

³ Institute of Health Information and Statistics – Health Statistics 44/2004 on Drug Addiction – the treatment of drug users in the Slovak Republic in 2003.

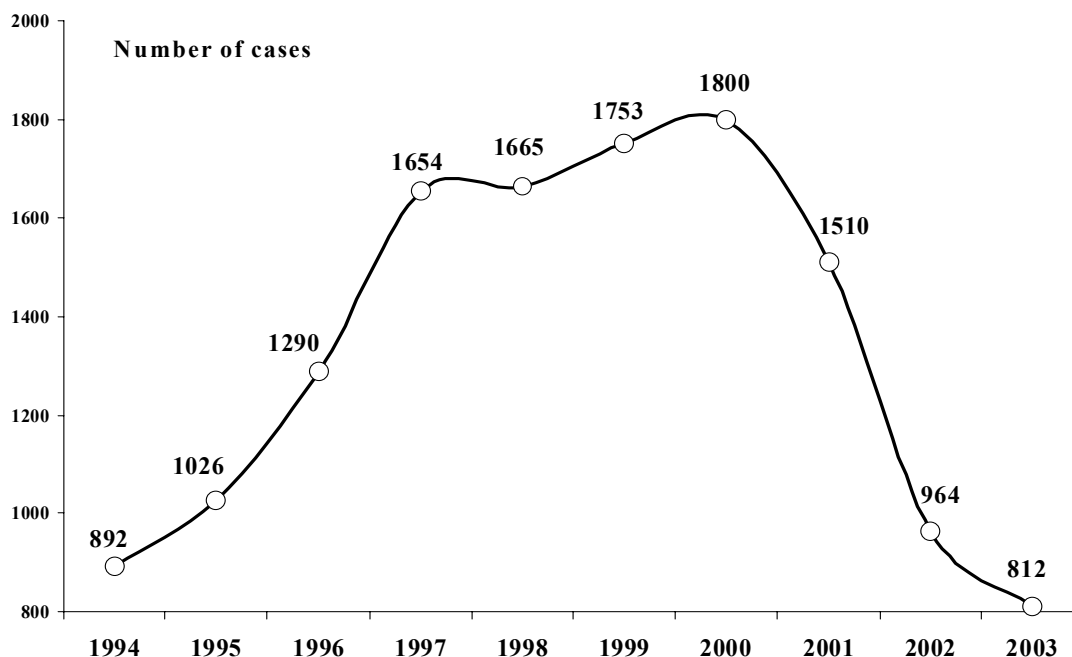


Fig. 2. Heroin as the primary drug taken by patients undergoing treatment for drug addiction in Slovakia between 1994 and 2003

Source: Nociar, A., 2004

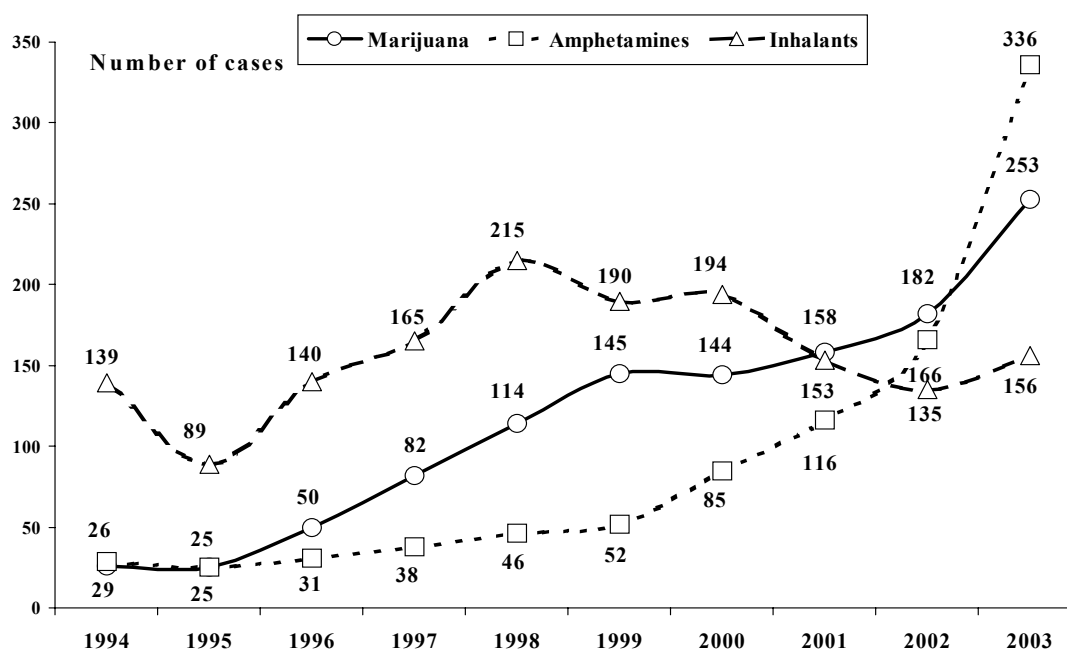


Fig. 3. Trends of primary drug use by patients undergoing treatment for drug addiction in Slovakia between 1994 and 2003

Source: Nociar, A., 2004

As a result, the fall in the number of drug addicts undergoing treatment does not mean that the extent of the drug problem has also decreased. Other data concerning the drug scene must also be taken into account – for example, the fact that the fall in the number of heroin addicts undergoing treatment was accompanied by a rise in the number of marijuana and synthetic drug addicts. Furthermore, **we cannot speak of a decline in the number of experimental or recreational users when the escalating trends in surveys of the**

population and school pupils, the increasing quantity of drugs seized, and the growing number of seizures with regard to drug type are taken into account.

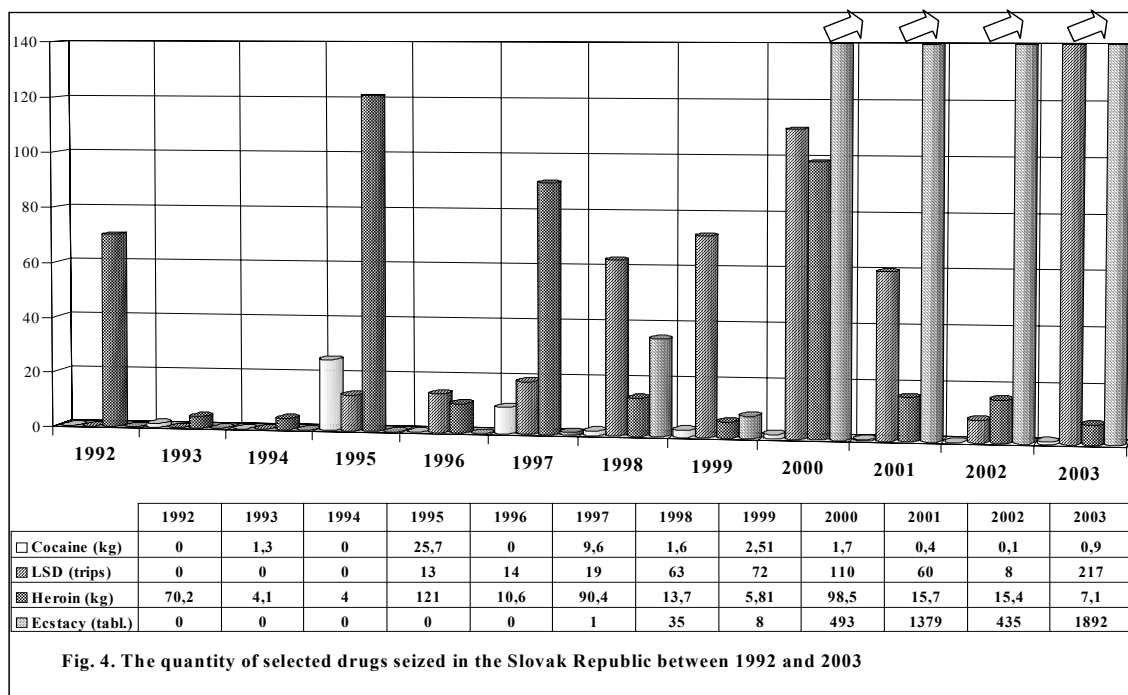


Fig. 4. The quantity of selected drugs seized in the Slovak Republic between 1992 and 2003

Source: Institute of Forensic Science of the Slovak Police Corps. Processing and design: General Secretariat of the Ministerial Committee for Drug Addiction and Drug Control/NDMC

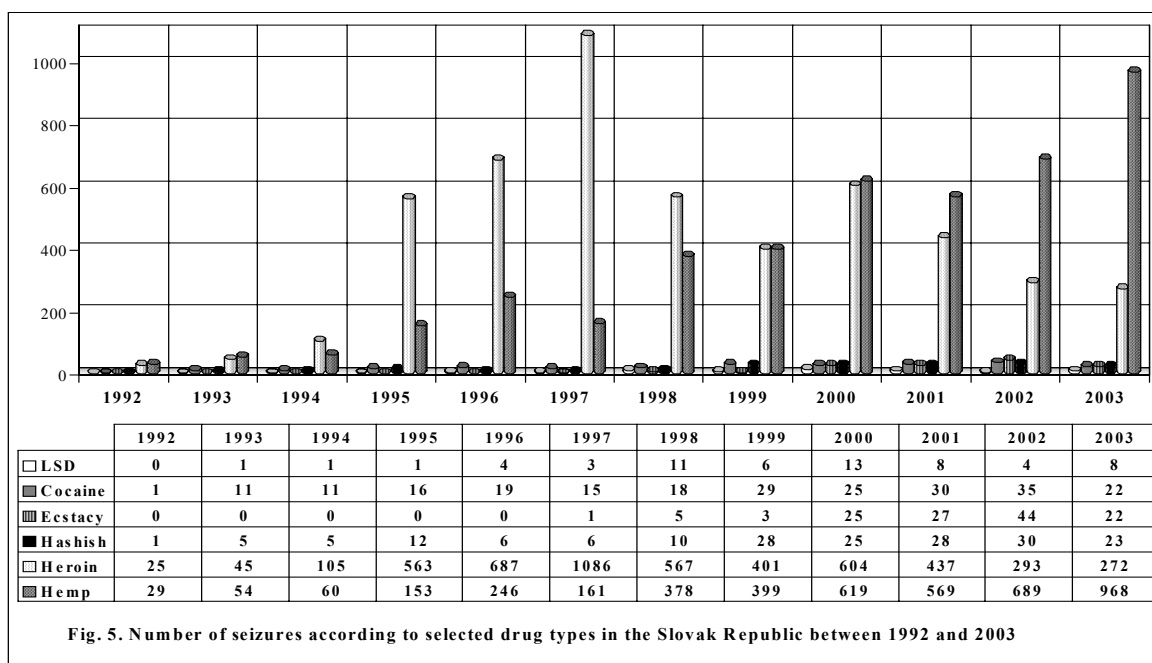


Fig. 5. Number of seizures according to selected drug types in the Slovak Republic between 1992 and 2003

Source: Institute of Forensic Science of the Slovak Police Corps. Processing and design: General Secretariat of the Ministerial Committee for Drug Addiction and Drug Control/NDMC

Having analysed the changes in the numbers of treated addicts of various drugs – beginning with an increase of heroin use in 1994 (reaching its peak in 2000), which was followed by a rise in the number of patients treated for cannabis and synthetic drug addiction – and then compare these figures with the quantity and range of drugs seized, we can perceive a link between the range of black market drugs on offer and their demand in the drug scene. In this context, it is also necessary to consider the results of surveys carried out amongst the general population and school pupils, and the trends that these studies have identified over the previous decade (Fig. 6).

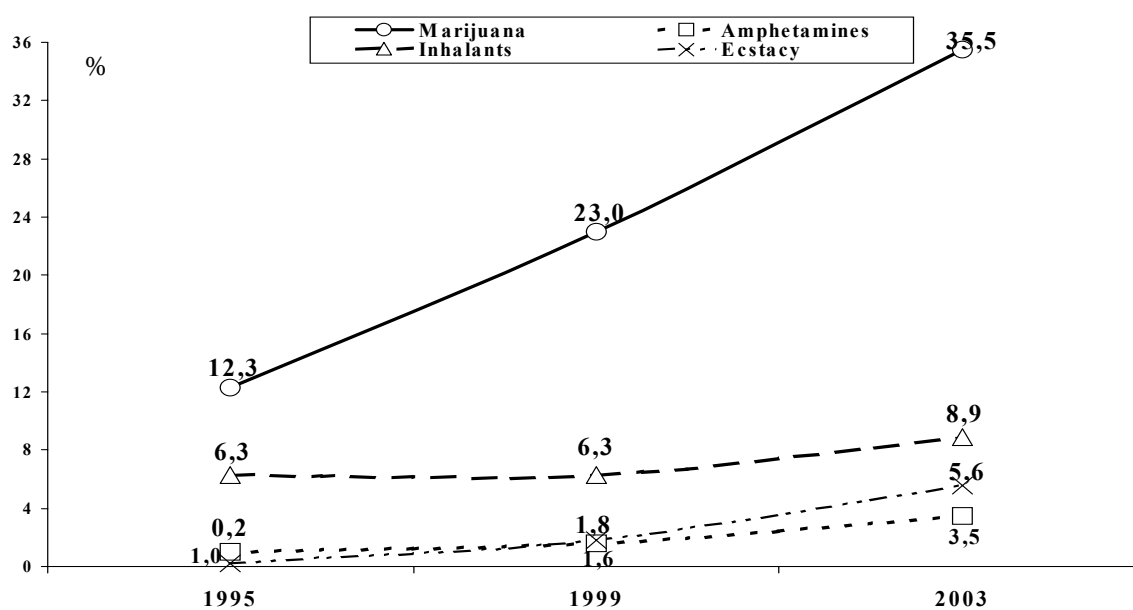


Fig. 6. Lifetime prevalence of drugs among 15 to 18 year old secondary school pupils in Slovakia

Source: Nociar, A., 2004

It is obvious that when attempting to put the monitored indicators into mutual context, and interpret them accordingly, the so-called 'triangulation' of the problem is perhaps a helpful method, as it is in the case of the indicator concerning the demand for treatment and population surveys.

No fundamental changes in the system of prevention, treatment, and social reintegration occurred between 2000 and 2003, and all of these systems developed in line with the National Programme for the Fight Against Drugs in the period of 1999 to 2003. This means that all primary prevention programmes were realised within the framework of educational and non-educational institutions under the competence of the Slovak Ministry of Education (e.g., educational and psychological prevention centres and counselling centres); mid-term treatment was assured by the state as a part of its network of centres for the treatment of drug addiction; finally, a system of social reintegration centres, generally linked to a specific health facility, was active within the framework of a network of non-governmental organisations. The Ministry of Labour, Social Affairs and Family, and the Anti-Drug Fund financed this.

From the aspect of infectious diseases contracted through drug use⁴, Slovakia succeeded in maintaining a relatively low level of infection, due to the very low prevalence of HIV in treated drug addicts, together with a relatively low number of HBV and HCV cases. The syringe exchange programme at state health facilities contributed

⁴ See Chapter 6.

to this to a great extent, as did the subsequent introduction of syringe exchange programmes in the field and other activities aimed at 'harm reduction', which were carried out by non-governmental organisations not only in the capital city, but also in selected regional capitals.

In addition to the data from standard information systems, the first studies⁵ using the Truncated Poisson Method and other 'capture-recapture' methods were employed to provide an estimate of the hidden population of drug abusers, giving an upper limit of approximately 20,500 abusers.

Since 2000, the quantity of opiates seized has declined, while the quantity and frequency of marijuana and synthetic drug seizures has increased⁶. Although a number of attempts to manufacture synthetic drugs in the Slovak Republic have been revealed, the actual quantity of drugs produced was insignificant. According to data from the National Anti-Drug Unit, the number of perpetrators of drug-related crimes rose from 1,002 in 2001 to 1,276 in 2003. There were no dramatic changes in the prices of various drugs in the given period.

With regard to the first of the three selected topics: Buprenorphine, a substitution treatment for patients addicted to opiates, was registered in Slovakia under the name of 'Subutex' in 2000. According to estimates, approximately 200 patients are currently undergoing such treatment in the Slovak Republic. More specific data obtained from research into the use and abuse of buprenorphine can be found in section 11.2.

With regard to the two other sections: **alternative sentences⁷** have been proposed as part of a revision of criminal law; however, they have yet to be applied in practice. **Disturbing the peace or causing a public nuisance⁸** is neither a relevant nor precisely defined concept in the area of drugs. Loosely interpreted, this concept could also be applied to some activities of groups promoting the legalisation or decriminalisation of soft drugs, especially marijuana.

Bratislava, December 2004

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⁵ See Chapter 4.

⁶ See Chapter 10.

⁷ See Chapter 12.

⁸ See Chapter 13.

PART A: Developments and new trends

1. National anti-drug policy and its context

Since 1996, the creation and implementation of Slovakia's anti-drug policy has been, and continues to be, the responsibility of the Slovak government. It approves the national strategy, defines its objectives, values, and principles, and creates an appropriate legislative environment.

Since 1995, Slovakia's state drug policy has been set out in the National Programme for the Fight Against Drugs (hereafter referred to as the NPDF)⁹. In its 81st session on 15th April 2004, the Slovak government approved Resolution N. 289/2004, in which it acknowledged the conclusions of the Report on the Implementation of the National Programme for the Fight Against Drugs in the period of 1999 – 2003, which was updated in 2004, and approved the third National Programme for the Fight Against Drugs in the period of 2004 – 2008.

The government's advisory body on issues concerning its drug policy is the **Ministerial Committee for Drug Addiction and Drug Control** (hereafter referred to as the MC DADC). The executive arm of the MC DADC – the General Secretariat (hereafter referred to as the 'GS MCDADC'), coordinates, directs, and controls the realisation of drug policy on central and regional levels.

The **National Drug Monitoring Centre** (hereafter referred to as the 'NDMC') began operating as a part of the GS MCDAC in 2002, and is a partner organisation of the European Monitoring Centre for Drugs and Drug Addiction (hereafter referred to as the 'EMCDDA') for the Slovak Republic. The EMCDDA monitors five key indicators¹⁰ in individual EU countries, as well as indicators such as drug-related crimes, the quantity and number of drugs seized, and the number of imprisonments. These indicators are part of the following programmes: P1 – monitoring of the situation, P2 – monitoring society's responses, P3 – the Early Warning System (EWS), and P4 – assessing national strategies.

1.1 The legal framework

Primarily the following laws form the basic legal framework for the control of drugs and drug addiction in the Slovak Republic:

- Act No. 139/1998 Coll. on narcotic and psychotropic substances and preparations as amended – the latest amendment of this act was implemented through Act No. 13/2004.
- Act no. 219/2003 Coll. on the handling of chemicals that can be used for the illegal manufacture of narcotic and psychotropic substances, and on the amendment of Act No. 455/1991 Coll. on small businesses (The Small Business Act).

⁹ See chapter 15; Annex 1: National Programme for the Fight Against Drugs for 2004-2008

¹⁰ Key indicators according to the EMCDDA

1. Population surveys
2. Prevalence estimates
3. Demand for treatment
4. Drug-related infectious diseases
5. Drug-related deaths and mortality

- Reforms of the health system were passed in autumn 2004 – in the area of **health care provision**, this was represented by Act No. 577/2004 Coll. on the scope of health care covered by public health insurance and on payments for services related to health care provision. Conditions for patients undergoing treatment for drug addiction in health care facilities will not change; in the vast majority of cases, health insurance companies will cover their treatment in full.
- **The legal framework regulating the social impacts of drug use**

Support for drug addicts in the social area is provided through social prevention (including social reintegration and rehabilitation), social and legal protection, counselling, and social services, the implementation of which is currently regulated by **Act No. 195/1998 Coll. on social assistance** as amended. (The act was amended twice in 2004 – by Act No. 45/2004 Coll. and Act No. 141/2004 Coll.)

A **bill on the social and legal protection of children and social custody**, and on amending and supplementing certain laws, was submitted in 2004. It expands the range of and regulates the methods of working with children, young people, adults, and families undergoing crises, including any problems stemming from drug abuse.

The new law aims to legally delimit as yet unregulated relations, and to amend and supplement the current legal framework, in order to create a legal basis for:

- The comprehensive protection of minors' rights and interests;
- The intensive, targeted, and systematic provision of support and assistance to children and families;
- Providing an equivalent, substitute environment for children in cases where they are not raised by their own families;
- Providing effective prevention – eliminating the causes, curbing the increase and spread, and inhibiting the recurrence, of psychological, physical, and social disorders in individuals, groups, and large social units.

Amongst other things, the bill aims to regulate **measures of social and legal protection and social prevention** related to the social issues stemming from behavioural disorders, **drug addiction**, and other sociopathic tendencies, and also defines educational and preventative measures of social custody for minors and adults who abuse drugs, or who are addicted to drugs.

Special attention is paid to the definition of **measures for providing assistance to drug addicts** – in particular, by enhancing the possibility of providing: outreach, stationary, and mobile first-contact services; advisory, educational, social, social reintegration, and assistance programmes aimed at preventing the causes, increase, and recurrence of sociopathic behaviour; outpatient care; social custody for minors and adults who abuse drugs or are addicted to drugs. The bill also creates conditions for the establishment of independent, specialist groups in borstals for children who are drug addicts. Furthermore, it sets out the requirements that 'non-state entities' must meet in order to carry out activities involving social and legal protection and social prevention; it also defines the qualifications necessary in order to perform such activities on a professional basis. The act is expected to come into force on 1st March 2005.

- **The legal framework regulating the supply of drugs - repression**

In 1999, the amendment of the **Penal Code No. 183/1999 Coll** of Laws changed Section 186 entitled "*Illicit production and possession of drugs and psychotropic substances, toxic substances and precursors and trafficking with it*" with a provision which makes it a criminal offence to unlawfully possess narcotic drugs, psychotropic substances, toxic substances or

precursors for one's own use. There is the possibility of imprisonment for up to 3 years, but here the sentencing guideline is moderated in cases of drug dependence.

Section 187 was also changed. It addresses whoever produces, exports, imports or transits purchases exchanges or otherwise procures, possesses for any length of time without authorisation narcotic drugs, psychotropic substances, toxic substances or precursors. The new amendments meant a moderation of the relevant provisions to make it more detailed and introduce the new circumstances under which shall be imposed more strict imprisonment punishment. The basic punishments are imprisonment of 2 up to 8 years, forfeiture, or pecuniary penalty. This disregards whether or not the activity was for own consumption or for another person. Nevertheless, in practice s.186 is normally used to address possession for personal use, and s.187 addresses trafficking.

In 2001, the amendment No. 253/2001 Coll. to the Criminal Code modified the construction of Section 187 in a way that increases the gravity of the offence if it is committed "in conjunction with an organised group operating in several countries", for which the amendment increased the minimum sentence of imprisonment from 8 to 10 years. At the same time, instead of "gaining considerable profit" as a circumstance justifying a heavier sentence, paragraph 1 of the amendment speaks about "handling drugs or similar substances of considerable or substantial value".

The amendment of the Criminal Code (Act 171/2003 Coll.) introduced in the new wording of the Section 43 in which includes new principle in the Slovak criminal law – the Three Strike Principle. Pursuant to this principle, if the court sentences the offender for the commission of particular type of offence, inter alia, the Illicit production and possession of drugs and psychotropic substances, toxic substances and precursors and trafficking with it (Section 187 par. 2-7) /but also the trafficking in children (216a par. 2 or 3 and 216b), the sexual violence (241a), sexual exploitation (Section 242 paragraphs 2-4), or trafficking in human beings (Section 246).../ while the offender has been sentenced for a specified category of offences two times ago and the punishment was at least partly executed, the court shall impose the life imprisonment sentence for the offender, if the specified conditions are fulfilled otherwise the court will impose the imprisonment sentence for twenty five years. The court cannot impose the imprisonment sentence less than twenty years for the offender.

The public prosecutor of the Slovak Republic supervises the legality of police conduct within pre-trial proceedings, which includes the legality of actions performed by the police outside the territory of the state insofar as such actions constitute a part of criminal proceedings.

The police authorities have been made competent to investigate criminal offences for which the Penal Code imposes a sentence of imprisonment of up to three years. In its Resolution of 31 May 2000, which endorsed the legislative plan to re-codify the Code of Criminal Procedure, the Government asked the competent services to rectify these discrepancies in a comprehensive fashion. The drafts of the re-codified version of the Code of Criminal Procedure and the Penal Code were submitted to the annotating procedure¹¹. According to the draft, the accelerated (fast-track) investigation of minor offences, as well as the regular investigation of criminal offences, will be conducted by police officers.

The re-codification assumes that in the case of less serious torts, also referred to as minor offences, a shortened investigation will be applied (simplified form of taking evidence). This category will also include deliberate criminal offences for which the Criminal Code imposes sanctions in maximum terms of not more than five years of imprisonment, as well as criminal offences committed out of negligence.

¹¹ *Second reading of the Penal Code draft is scheduled for the May 2005 Parliamentary session*

The re-codified law will clearly strengthen the position of the prosecutor, who will be authorised to decide on the merits of the case in the pre-trial proceedings as a contribution to the implementation of the EU legislation.

On the ground of the UN Convention against illicit traffic by sea, implementing Article 17 of the UN Convention against illicit traffic in narcotic drugs and psychotropic substances (1988) **the Council of Europe Agreement on Illicit Traffic by Sea was signed** in Strasbourg in 1995. Following its ratification in the National Council the Slovak Republic joined before mentioned agreement by the year 2003.

- **The legislative and institutional framework governing the activities of the Customs Directorate of the Slovak Republic in the area of drugs**

Conditions regulating the import and export of goods to and from the Slovak Republic are governed by Commission Regulation (EEC) No. 2454/93 of 2nd July 1993 laying down provisions for the implementation of Council Regulation (EEC) No. 2913/92 establishing the Community Customs Code; Council Regulation (EEC) No. 2658/87 of 23rd July 1987 on the tariff and statistical nomenclature and on the Common Customs Tariff; Council Regulation (EEC) No. 2913/92 of 12th October 1992 establishing the Community Customs Code, and Council Regulation (EEC) No. 918/83 of 28th March 1983 setting up a Community system of relief from customs duty. Under **Act No. 199/2004 Coll. on Customs** and on amending and supplementing certain other laws, the Customs Administration of the Slovak Republic oversees compliance with the measures introduced on the basis of relevant legal provisions of the European Union governing the movement of goods between the Union and third states in the territory of the Slovak Republic, and with the measures to prevent unlawful conduct of persons importing, exporting or transiting goods between the Union and third states to, from or through the territory of the Slovak Republic.

Under Act No. 652/2004 Coll. on Customs Administration Bodies as amended, the Customs Administration of the Slovak Republic fulfils or secures the fulfilment of the tasks related, *inter alia*, to combating unlawful imports, exports or transit of narcotics, psychotropic substances, precursors, radioactive substances or other dangerous materials and their precursors. It carries out these tasks through organisational units of the Customs Crime Office (hereafter referred to as 'the CCO'), namely through its drugs and dangerous materials divisions and branch offices. When necessary for the purpose of identifying persons who are engaged, in any manner whatsoever, in the commission of criminal offences involving narcotics, psychotropic substances or their precursors, the Customs Administration, acting in concert with customs authorities of other countries, organises controlled deliveries, conducts or secures customs surveillance or other types of surveillance with respect to consignments that may be reasonably suspected to contain narcotics, psychotropic substances or their precursors. When using the controlled delivery technique, it cooperates with the competent Police Corps department. Under the aforesaid law, customs officers are authorised to use the means of restraint. To enable the detection of particularly serious criminal offences against customs regulations concerning, *inter alia*, imports, exports, or transit of narcotics, psychotropic substances or their precursors, customs authorities have been granted additional competences under **Act No. 652/2004 Coll. on Customs Administration Bodies**, and Act No. 166/2003 Coll. on the protection of privacy from unauthorised use of the means of electronic surveillance and on amending and supplementing certain other laws; according to these legal provisions, the customs service is authorised to deploy clandestine operational and search techniques such as surveillance of persons or things, alarm or signalling devices, customs service agents or electronic surveillance equipment to detect, open or examine consignments and perform their forensic evaluation, to intercept and record telecommunications, or to make video, audio or other recordings. These activities are performed by the special actions division of the Customs Crime Office and by the Police Corps. Customs officers are members of an armed corps and have a service relationship

status as stipulated in Act No. 200/1998 Coll. on State Service of Customs Officers and on amending and supplementing certain other laws.

The Customs Administration of the Slovak Republic actively participates in carrying out the tasks aimed to combat drug crime, outlined in the National Programme for the Fight against Drugs. In an effort to reduce the supply of drugs, it takes measures to cut down on illegal imports, exports or transit of narcotic and psychotropic substances, and contributes to dismantling organised crime groups operating in this field, and apprehending their members.

Of growing significance for the work of units dealing with drugs and dangerous materials is cross-border cooperation with partner customs administrations on central and regional levels. Intensive cooperation is maintained mainly with customs administration of the neighbouring countries. Cooperation with other state administration authorities involved in the fight against drugs is no less important. It takes place on the basis of memoranda of understanding concluded with the Slovak Post, express delivery services, the Railways of the Slovak Republic, the Tax Directorate of the Slovak Republic, the Ministry of the Interior of the Slovak Republic, the Slovak Chemical and Pharmaceutical Industry, and with police bodies, in particular the National Anti-Drug Unit of the Police Corps Presidium. Cooperation agreements and memoranda serve as the basis for organising training courses, exchanging experience, supplying information upon request, etc.

1.2 Institutional framework, strategies and measures

The CMDADC coordinates drug control activities of all competent central state administrative authorities, other bodies, organisations and institutions at the national level. It ensures complementarity and continuity of relevant measures and activities as regards time, substance, and space and implementation methods.

The Committee coordinates, in particular

- a. The development, updating and consistent implementation of the National Programme by relevant organisations and institutions**
- b. The drafting of legislative measures in the area of combating drugs and addictions, and ensures their alignment with the legal system of the European Union.**

The executive body of the Committee of Ministers, its **General Secretariat (GS CMDADC)**, which is part of the organisational structure of the Office of the Government of the Slovak Republic, has the authority to set up special commissions – advisory and coordinating bodies.

They include, e.g., the **inter-ministerial Horizontal Group on Drug Control in the Slovak Republic**; its role is to ensure the transmission of information and data between sectors, regional authorities and specialised institutions in Slovakia and with the European Union, in particular with regard to Community projects.

The inter-ministerial Anti-Drug Action Group was created in February 2004 to address urgent problems and organise operational cooperation in dealing with acute problems on the drug scene.

Implementation of drug control measures at the regional level is coordinated by drug addiction prevention commissions set up within local state administration and self-governing authorities. Act No. 515/2003 Coll. on Regional and District Authorities and on amending and supplementing certain other laws creates organisational and personnel prerequisites for professional execution of the duties of coordinators for the prevention of drug addictions and other anti-social activities at the regional level; Section 4 paragraph 5 of the Act provides that the responsibilities of regional and district authorities include prevention of drug

addiction, crime and other anti-social activities. Regional, district and municipal commissions for the prevention of anti-social activities also include the representatives of the offices of labour, social affairs and family, centres for counselling and psychological services, and social care establishments; they secure cooperation between entities involved in the prevention of social pathologies in the regional context, and in the development and fulfilment of Action Plans for implementing the National Programme for the Fight against Drugs.

Implementation of drug policy requires coordination and cooperation. The execution of tasks, the development of an effective cooperation system, the formulation of strategies reflecting local conditions and needs – all this would be inconceivable without a system of vertical and horizontal coordination; it is therefore essential to improve coordination and cooperation at all levels of state administration and self-government.

1.2.1 National action plan and strategy

At its 81st session held on 15 April 2004¹², the Slovak Government took note of the Summary Report on the Implementation of the National Programme for the Fight against Drugs (NPF) in the period of 1999 – 2003 with update for 2004, and approved the draft National Programme for the Fight against Drugs in the period of 2004 – 2008. The NPF outlines the drug strategy that pursues the objective of developing – in harmony with the international commitments of Slovakia – a progressive and effective system of prevention, treatment, social reintegration and repression. The NPF places special emphasis on regional and local dimensions of cultural, social and economic conditions with a view to preventing further aggravation of the drug problem, especially among children and young people.

The 2004 – 2008 strategy draws on the experiences and findings from the first and second National Programmes for the Fight against Drugs¹³.

Basic premises of the NPF strategy reflect the Drugs Strategy and the Action Plan on Drugs of the EU as follows¹⁴:

1. To ensure a balanced reduction of drug demand and drug supply
2. To ensure effective coordination at the horizontal and the vertical level
3. To develop an appropriate strategy for practical communication and information exchange between public administration authorities, civil society, and international institutions
4. To address the drug problem as one of the society's priorities, in accordance with the measures adopted at the level of the EU.

Drug policy of the Slovak Republic is based on the following basic pillars:

Prevention	Treatment	Social reintegration	Repression
Activities designed to suppress the demand for drugs	Availability of the treatment of dependencies and harm reduction programmes for general public	Adequate assistance in social reintegration	Supply reduction – law enforcement – legal measures and activities aimed to suppress the supply of drugs

¹² Resolution No. 289/2004.

¹³ The first NPF for the period of 1995 – 1998

The second NPF for the period of 1999 – 2003 with outlook up to 2008.

¹⁴ The EU Drug Strategy and Action Plan on Drugs for the period of 2000 – 2004.

To be effective, the strategy must be based on a comprehensive and structured approach, in which individual drug policy actors play their unique and equal roles, on the commitment of the civil society, and on the participation of local and regional self-governing bodies; the latter should not only carry out drug strategy tasks, but also initiate new activities taking account of specific features of the communities living in the region, town or village.

The approved national strategy includes legal drugs, in particular alcohol.

Implementation of measures and strategy

Relevant sectors and regional authorities are currently working on the development of Action Plans implementing the National Programme for the Fight against Drugs until 2008 in the light of the EU Drug Strategy and Action Plan on Drugs; the CMDADC will review the plans by 31 March 2005. **The impact of measures outlined in individual actions plans will be evaluated at two-year intervals starting in 2007.**

1.3 Budget and public expenditures

The Office of the Government coordinates the National Programme for the Fight against Drugs. There is no inter-ministerial body specifically designated to coordinate the programme. Activities of individual sectors participating in the fight against drugs were evaluated in the Report on Implementing the National Programme for the Fight against Drugs in the period of 1999 – 2003 with update for 2004, which also covers the national strategy and key objectives for the period of 2004 – 2008.

Drug control activities were financed from budgetary chapters of the Government Office, of individual ministries, budgets of self-governing regions, and from health insurance and social insurance funds. Supplementary funding of approx. 50 million SKK was provided in the form of subsidies from the non-state Anti-Drug Fund¹⁵ to support projects oriented on the prevention, treatment and social reintegration of drug addicts; to a lesser extent, funding was provided also from other private sources.

For instance, funds allocated to social services establishments run by non-state entities were divided as follows: facilities for social reintegration received 130,000 SKK/person/year (i.e. approx. 30.425 million SKK for a capacity of 234 clients), crisis centres 70,000/person/year (i.e. approx. 19.460 million SKK for a capacity of 278 clients), sheltered housing 95,000 SKK/person/year (i.e. approx. 3.960 million SKK for a capacity of 44 drug addicts). **In 2003, the Ministry of Labour, Social Affairs and Family** used proceeds from games and lotteries to support several projects aimed at enhancing and expanding social prevention for persons facing the risk of socially pathological development, namely in the areas of social reintegration and occupational therapy, sheltered housing, crisis interventions and field social work. The Ministry allocated a *total of 12,474,000 SKK to support non-state entities* working in the area of social prevention, crisis intervention, field social work and social reintegration (including a subsidy of 5 million SKK from the Anti-Drug Fund). Direct financial support for drug-related activities in the social field had the form of subsidies from the *Anti-Drug Fund (ADF)*; *8,100,920 SKK* was provided to implement *45 projects* oriented on social prevention, social reintegration, sociotherapeutic movement, preventive programmes and training.

¹⁵ *In 2003, the AF provided these funds to support the financing of 237 projects.*

Source : www.protidrogovyfond.sk

More than 12 million SKK was allocated in 2003 from the ADF for **106 school prevention projects**, and the **Ministry of Education**¹⁶ provided 650,000 SKK to be used specifically for the implementation of the NPF and of the Drug Addiction Prevention Concept.

The main source for the payment of **treatment provided in medical establishments** was **non-state public funding from health insurance systems**. For instance, annual costs of 'drug-free' treatment amounted to approx. 40,000 SKK per patient; they consisted of health insurance payments of approx. 960. - SKK/day for an average stay of 30 days in specialised CTDDs and for follow-up outpatient care. **Costs of medical care provided to persons with drug problems were co-financed also from other sources which, however, accounted only for a smaller part of payments: the budget chapter of the Ministry of Health, supplementary funding from the Anti-Drug Fund, and smaller financial contributions from clients.**

The Ministry of Justice spent an average of 311,000 SKK from its budget allocation per one year of stay of inmates in penitentiary establishments (including those incarcerated for drug-related crimes).

The Ministry of Finance, the Ministry of the Interior, and the Ministry of Transport, Post, and Telecommunications combat drugs within their respective fields of competence (joint police-customs units, railway police), focusing on the monitoring of trade in illegal substances, training, fight against drug-related crime, information about the drug scene in Slovakia provided by the media, etc.; these activities are financed from their respective budget chapters. The General Prosecution Office of the Slovak Republic participates in the legislative area, the Ministry of Agriculture prevents the cultivation of drug plants on agricultural soil, and the Ministry of Foreign Affairs ensures cooperation with organisations active in the fight against drugs.

In 2002, the Anti-Drug Unit received NIK narcotic identification kits; their price of 646,800 SKK was paid from the budget of the Ministry of the Interior. Expenditures of the canine unit in 2000 (around 70,000 SKK) were covered from the budget of the Interior Ministry in the amount of around 10,000 SKK. Prevention-oriented project 'Behave normally' was allocated 537,000 SKK and 696,000 SKK from the Anti-Drug Fund in 2001 and 2002, respectively. The amount of 973,000 SKK was channelled from the state budget in 2003 to finance preventive activities of the **Ministry of the Interior**.

The 2003 activities of the **National Monitoring Centre for Drugs** in the Slovak Republic were funded through co-financing from the national budget and from Community funds, amounting in total to 6.8 million SKK. Under the Agreement between the Office of the Government of the Slovak Republic and the European Community – represented by the EMCDDA – the EMCDDA has pledged to cover 50% of total eligible costs of the NMCD.

¹⁶ Source: *Comprehensive report on the fulfilment of the NPF programme up to 2003, 2004, approved by Slovak Government's Resolution No. 289/2004 of 15 April 2004.*

1.4 Social and cultural context

In the pre-1990 period, the problem of banned or 'illegal' drugs was virtually unknown in Slovakia. Marijuana was detected only exceptionally, although the sniffing of volatile inhalants was relatively widespread among young people, and certain members of risk professions developed morphine addiction, etc. More prevalent was the abuse of certain prescription drugs, such as Diazepam or Rudotel, later Alnagon. But other illegal drugs were practically unknown in Slovakia.

A steep rise in the consumption of narcotic and psychotropic substances after 1989 was recorded in every post-communist transition country of Central and Eastern Europe. Free cross-border movement resulted in an increased availability of drugs. Inevitable economic, political and social reforms significantly increased the number of dysfunctional families and of children displaying risk behaviour, and of children or adults with behavioural disorders. Unemployment – that had been practically unknown before – also reached significant proportions. All these factors that evoked frustration in many people unable to cope with their problems, to find their place in the new social environment, became the breeding ground for a variety of drug dealers who made the business of dealing in drugs the source of their livelihood. A number of people who did not have to make an active effort before 1989 to establish their place in the society, started to gradually turn to anything that would help them forget their existential problems. Over time, the use of psychoactive substances became one of the biggest problems of the society.

While in the pre-1989 period, persons at risk would reach for various medications with psychic effects, the transformations of the society – reflecting the European-wide trend – resulted in an increased consumption of illegal drugs and escalated the trafficking in narcotics and psychotropic substances. A complete panoply of illegal drugs, mainly heroin and marijuana, were thus added after 1989 to socially accepted 'legal' drugs like alcohol and tobacco, first in Bratislava and later in the whole of Slovakia. It was reported (Nociar A., 1995) that **while in 1994 the Slovak population of 18-year old secondary schools pupils who have tried marijuana at least once in their lives was 11%, this percentage was twice as high among Bratislava students in the same year, i.e. 22%.**

The development of the drug scene in Slovakia and in the neighbouring states following the post-1989 social transformations was characterised, besides other indicators, also by a significant increase in the supply of different types of illegal drugs, which ultimately induced a gradual increase in the demand for drugs. Systematic and conceptual efforts to reduce drug supply and demand must be supported by scientific analysis and research into the drug phenomenon, dissemination of drugs, prevalence trends, and by the evaluation of effectiveness of measures adopted in the area of prevention, treatment and subsequent social reintegration. **An irreplaceable role is played in this analysis by public opinion surveys, which give a complete picture of the state of the drug problem in Slovakia.**

General population surveys were carried out by the Public Opinion Research Institute of the Statistical Office of the Slovak Republic (hereafter referred to as 'PORI SO SR') at two-year intervals between 1994 and 2002 on the following three samples:

- (a) Sample of general population of Slovakia aged 18+**
- (b) Sample of young population of Slovakia aged 15 – 29**
- (c) Sample of young population of Bratislava aged 15 – 29.**

The results of the latest survey conducted in 2004 will be published in the next National Report.

It is evident that **increased supply** and the ensuing improved availability of illegal drugs became one of the reasons for an **overall rise in the percentage of drug users in the population.** This increase in the number of users, problem users and drug addicts

subsequently increased the public perception of the threat posed by drug addiction – to oneself, one’s children, family, or the society as a whole.

1.4.1 Public opinion concerning the drug problem

After an initial increase in the perception of drug risk between 1994 and 1998 and its decrease in 2000, the share of respondents who reported that they consider drug addiction to pose a great or moderate risk to them personally or to their families gradually stabilised at the level of around seven out of ten persons. At present, **more than one fifth of the population consider the drug addiction to pose a major risk for their immediate circle, while almost one half of the population perceive a certain risk but, on the whole, are not very concerned. More than one fourth of the Slovak population – 27%, the same percentage as in 2000 – do not consider drug addiction to pose any risk either to them personally or to their families.**

Like in 2000, **the percentage of young people aged 15 to 29, who perceive drug addiction to pose a great risk to them personally, their children or their families, is slightly lower** than the average for the whole of Slovakia. A similar tendency is apparent also among young people of Bratislava. Both at the level of Slovakia and in the city of Bratislava, young population includes a significantly higher percentage of persons who have certain concerns about the risk of drug addiction to themselves or their families, but do not consider this risk to be significant. Like two years before, the number of Slovak nationals aged 15 to 29 who did not subjectively perceive any risk of drug addiction is lower than the nation-wide average. Table 1.4.1 gives an overview of opinions of young people of Slovakia as a whole and those of Bratislava concerning the risk posed by drug addiction to themselves or their families.

What is your perception of the risk of drug addiction to yourself, your child, or your family? (Data in %)										
	Young population of Slovakia					Young population of Bratislava				
	1994	1996	1998	2000	2002	1994	1996	1998	2000	2002
I feel a great risk, I am concerned	13	22	22	17	16	21	27	32	21	20
There is a certain risk, but I am not very concerned	51	50	49	53	55	47	49	48	57	57
There is no risk, I am not concerned at all	33	22	23	25	25	26	19	15	20	21
I don't know	3	6	6	5	4	6	5	5	2	2

Table 1.4.1 Perception of drug addiction risk

Source: Public Opinion Research Institute et Statistical Office of Slovak Republic

1.4.2 Discussions and initiatives in Parliament and in the civil society

The broadest public discussion in Slovakia related to drug issues in 2004 concerned the legalisation of marijuana; the citizens’ association ‘Freedom of Choice’ launched it. Most members of the public, media and political representations took a critical view of the proposals presented.

Another issue discussed by the public and in the media was connected with the recodification of the Criminal Code and the Code of Criminal Procedure, namely of the

provisions concerning drug offenders. The Minister of Justice argued that the Ministry's proposal was aimed to introduce harsher sentences for persons involved in the production, distribution and in the selling of drugs, and softer sentences for drug users found to possess drugs for their own consumption. The polemics about the real impact of the proposed draft law on drug users has not been yet resolved; according to some opinions, possession of drug for own consumption should be decriminalised, while others suggest that it should be considered as a misdemeanour rather than a criminal offence.

While the discussions concerning the above two topics continue, **the passage of health reform laws by the National Council of the Slovak Republic in October 2004 ended the debate on whether drug-addicted patients should cover their treatment in medical establishments in full.** The version that was eventually adopted reflects the opinion of most specialists and politicians, and was passed even in spite of the opposition of a certain part of the public demanding that these patients pay for their treatment in full. There will therefore be no change in the insurance coverage of drug treatment, which, for the most part, will be fully covered from health insurance.

1.4.3 Media coverage of drug issues

The situation concerning the presentation of Government drug policy in the media was and continues to be unsatisfactory. There is practically no media strategy¹⁷; electronic or print media – except for public radio and partly also public TV that have the obligation under the law to broadcast programmes in public interest – are covering drug issues in a news-like fashion, i.e. **most of their reports create or reinforce the stereotypes about the link between drug addiction and crime.**

Government policy on drug addictions and drug control attracted more significant media attention only during the 'Week of the Fight against Drugs'¹⁸ campaign, and in connection with the presentation of the annual report of the European Agency on Drugs and Drug Addictions¹⁹ and of the results of the ESPAD²⁰ school-based surveys.

The institution that has the ambition to carry out longer-term educational and preventive activities in the health sector is the Public Health Institute – the Institute, joined by the representatives of other health organisations and NGOs, held a major press conference on the occasion of the World Day of the Fight against Drugs. As regards other activities of the Health Ministry's sector, the only organisation that **worked systematically with the media was the Institute of Drug Dependencies at the Bratislava CTDD which made over 40 media appearances or presentations concerning health aspects of drug issues in 2004**, and organised 3 press conferences on this topic. Media presentations, especially those concerning the themes related to the treatment of drug addictions and psychiatry, were also delivered by specialists from the CTDD Predná Hora, the CTDD Banská Bystrica, the CTDD Žilina and by other experts.

¹⁷ Slabý B., Urmanič M: *Media Strategy Proposal - June 2004, internal document of GS CMDADC.*

¹⁸ 15 – 22 Nov. 2004.

¹⁹ 25 Nov. 2004.

²⁰ 15 Dec. 2004.

2. Drug use amongst the population

According to population surveys, the most widely available drugs in Slovakia are still marijuana and hashish; these drugs have been offered to a fifth of all Slovak respondents at some point in their lives, and to a tenth of such respondents in the past year²¹. 49% of young people in the Slovak Republic as a whole, and 53% of young people in Bratislava, have been offered these most prevalent drugs. The supply of other illegal drugs in Slovakia is much smaller. Of those available, the most accessible is ecstasy. 6% of respondents in the Slovak Republic, 19% of young people throughout Slovakia, and 27% of young people in Bratislava have been offered ecstasy at some point in their lives. In comparison to the figures for 2000, the availability of ecstasy has increased slightly amongst young people between the ages of 15 and 29. Amphetamines, cocaine/crack, heroin, or LSD/other hallucinogens have been offered at some point to 2% – 3% of respondents in the Slovak Republic; however, this figure was over 10% for young respondents living in Bratislava (of which most – 13% – had been offered amphetamines).

The places where illegal drugs could be most easily obtained were primarily discos, concerts, pubs, and bars; in comparison to 2000, there was a significant decline in the amount of drugs offered in public spaces – on the streets or in parks.

In 2002, there was a significant rise in the number of people who admitted that they had tried illegal drugs. 23% of respondents in the Slovak Republic as a whole stated that they had tried drugs at some point in their lives, which represents a rise of 11% since 2000; 36% of young people in Slovakia stated the same, which represents a rise of 10% over a two-year period, while 39% of young Bratislava residents admitted that they had tried drugs at some point, which represents a rise of 11% since 2000. The majority of respondents who had personally come into contact with illegal drugs were aged between 15 and 29. A blurring of the differences between various levels of education is gradually occurring – above all, due to a significant increase in the number of university-educated respondents who have used drugs. **Experimenting with drugs is, to a great extent, linked to people's family situations; a large proportion of respondents who have tried drugs – 46% – also have bad relations with their parents.**

Almost a quarter of the adult population currently perceive drug addiction as posing a great threat to themselves, their children, or their family, as do one-sixth of young people in the Slovak Republic, and one-fifth of young respondents between the ages of 15 and 29 in Bratislava. The threat of drug addiction to themselves, their children, or their family, is most feared by middle-aged persons; concern amongst the youngest and oldest age groups is significantly lower²².

People believe that the greatest threat posed by drug addiction is a rise in the crime rate²³. Slovak citizens also associate drug addiction with the spread of HIV/AIDS and hepatitis B, drug users' loss of personality, the danger of dying from an overdose, and financial detriment to society as a whole.

In the area of drug policy, **Slovaks are still more inclined towards repression than towards tolerant policies concerning the use of narcotic and psychotropic substances. They believe that stringent drug policies would be most effective – 56% of respondents would welcome such policies, while 55% of respondents would like to**

²¹ In: Statistical Office of the Slovak Republic. *Public opinion: The extent of drug use in Slovakia and people's opinions concerning problems related to drug addiction, Bratislava 2002, p. 8.*

²² *Ibid*, p. 5-6.

²³ *Ibid*, p. 40-41.

see an increase in the activities of the police and customs officials²⁴. However, support for the application of both methods is gradually declining, which may indicate a change of public attitude towards the drug problem. Almost **three-fifths of Slovaks are convinced that drug addicts should undergo compulsory treatment**, while over a third favour treating addicts only if they are willing to do so. The majority of respondents (52%) are convinced that addicts should not receive needles and sterile syringes free of charge or for a small fee, even in the interests of preventing the spread of viruses and diseases; 30% of respondents state the opposite. **The legalisation of drugs as a solution to the drug problem is by no means perceived favourably. As many as 77% of respondents stated that all drugs should be prohibited²⁵.** Young respondents throughout the Slovak Republic and in Bratislava are more inclined towards a partial or total legalisation of drugs; most of them were in favour of legalising the use of marijuana, albeit with certain restrictions, such as its provision solely on prescription.

The socio-demographic structure of respondents throughout Slovakia who have used drugs has not changed significantly, according to data gathered in the October 2002 survey. As in former surveys, experience with drug use was significantly higher amongst respondents in the largest agglomerations with a population of over 100,000 (34%), and amongst people living in the Bratislava (33%) and Trnava (31%) Regions. Table 2.0.1 presents the trends identified with regard to one-off, occasional, or regular drug use, as categorised by age.

Drug use according to age (expressed in %)										
Age:	have taken drugs					have never taken drugs				
	1994	1996	1998	2000	2002	1994	1996	1998	2000	2002
15 to 17	8	25	24	27	43	92	75	76	73	57
18 to 24	12	22	20	26	35	88	78	80	74	65
25 to 29	7	15	22	28	38	93	85	78	72	62
30 to 39	7	11	11	10	19	93	89	89	90	81
40 to 49	4	6	7	13	23	96	94	93	87	77
50 to 59	5	5	3	4	19	95	95	97	96	81
Over 60	2	3	2	1	14	98	97	98	99	86

Table 2.0.1: Experiences with drug use according to age between 1994 and 2002. Source: Public Opinion Research Institute at the Statistical Office of the Slovak Republic

The largest group of illegal drug users is still composed of young people aged between 15 and 17 (of which 43% had used drugs), 18 and 24 (35%), and 25 and 29 (38%). In comparison to 2002, there was a sharp increase in the number of respondents who had tried drugs in all age categories. The most significant rise was registered amongst people aged between the ages of 15 to 17 and 50 to 59, by 16% and 15% respectively (although in the latter age group, most cases of such drug use involved drugs prescribed to these people in hospital, this nevertheless represents a significant increase in the use of various sedatives, hypnotics, and barbiturates).

²⁴ *Ibid*, p. 54.

²⁵ In: Statistical Office of the Slovak Republic. *Public opinion: The extent of drug use in Slovakia and people's opinions of problems linked to drug addiction, Bratislava 2002*, p. 54.

Since 1998, there has also been a gradual **change in the education level of people who have tried illegal drugs**. In 1998 and 2000, a significantly higher proportion of persons who had tried drugs only had primary school qualifications, or had studied at secondary school without passing their exams – this applied in particular to young people in Slovakia and Bratislava. More recent data indicate that a gradual blurring of the differences between groups with various levels of education is currently taking place – above all, due to a significant increase in drug use (one-time, occasional, or regular) amongst university graduates. Amongst young people in the Slovak Republic, there has been an increase in the number of university students who have tried drugs – from 16% in 2000 to 56%. Amongst young people in Bratislava, this figure rose from 11% to 39%; i.e., there has been a 40% and 28% rise respectively.

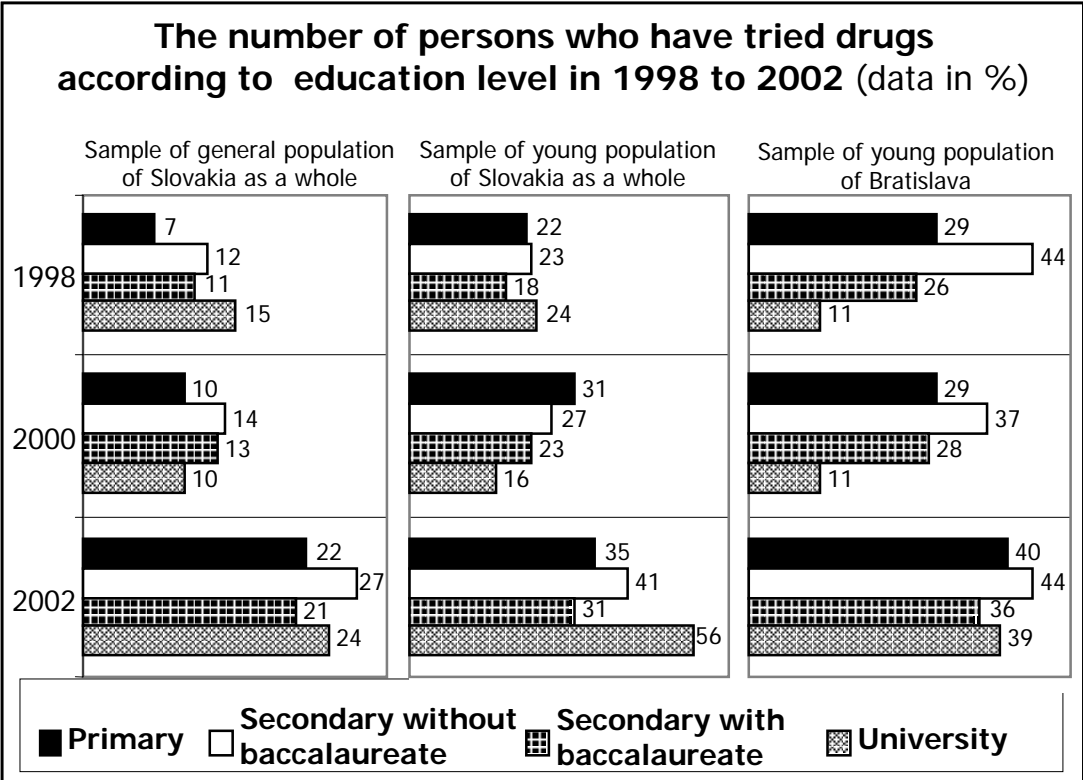


Fig. 2.0.1. The number of persons who have tried drugs, by education level
 Source: Public Opinion Research Institute at Statistical Office of Slovak republic

To a certain extent, the socio-economic situation of citizens affects their way of life – in this case, their inclination towards the use of narcotic and psychotropic substances; however, on the basis of available research data, we can state that this is not a determining factor influencing the likelihood of experimenting with drugs. The differences in drug use amongst individual socio-economic strata (as categorised by subjective responses to such use in the survey) are insignificant. A slightly higher proportion of respondents who have tried drugs was seen amongst those who described themselves as belonging to the wealthy, reasonably wealthy, and the poorest classes. This shows that not only socially deprived people, who perceive drugs as ‘an escape from the real world’, but also citizens from the wealthiest classes, are turning to drugs. For the latter, drugs are often a way to alleviate boredom, or help them achieve a certain status amongst a particular group of youths, due to a lack of friends of the same age.

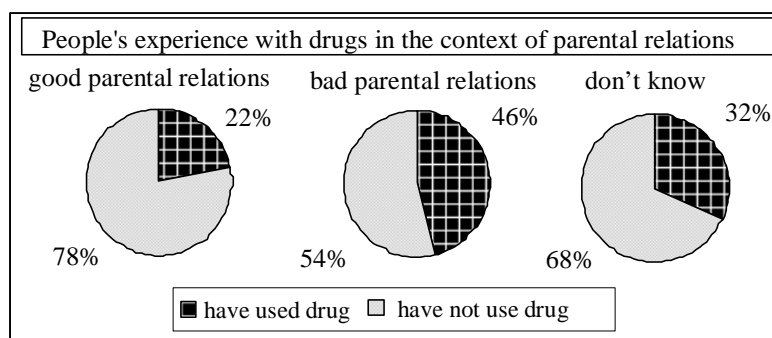


Fig. 2.0.2. People's experience with drugs in the context of parental relations
 Source: Public Opinion Research Institute at the Statistical Office of the Slovak Republic

Comparing the experiences of respondents with drug use and relations with their parents shows that **the inclination of people towards the use of narcotic and psychotropic substances is significantly linked to their family situation²⁶ – much more than to their socio-economic status.** The cited comparison demonstrated that while around one-fifth of those people who characterised their relationship with their parents as 'good' had used drugs, this figure rose to approximately one-half in the case of respondents who described their relationship with their parents as 'bad'. The link between family background and excessive drug taking is also proved by a comparison of drug use and the relations between respondents' parents: **At the time the field survey was conducted, 19% of respondents who declared that relations between their parents were harmonious had tried drugs – as compared to 32% of those who stated that relations between their parents were generally disharmonious. This proportion is even more pronounced amongst people whose parents were divorced – as many as 45% of such respondents stated that they had tried illegal drugs. These data clearly confirm the close relationship between family situation and drug use.** (See Fig. 2.0.3)

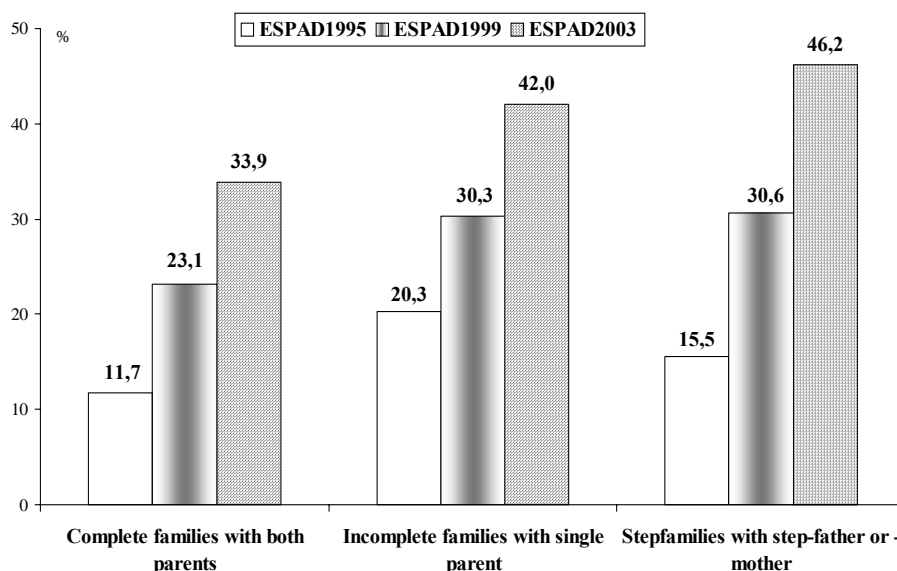


Fig. 2.0.3 the one-off or repeated use of any illegal drug during people's lifetimes according to family completeness
 Source: Nociar, A. 2004

²⁶ In: Statistical Office of the Slovak Republic. Public opinion: The extent of drug use in Slovakia and people's opinions of problems linked to drug addiction, Bratislava 2002, p. 19

Age of first-time drug users

In comparison with 2000, the average age of first-time drug users has not changed significantly; there has only been a slight increase in Slovakia as a whole:

- Within the Slovak Republic as a whole, the average age of first-time drug users was 25 in 2002 and 23 in 2000
- Amongst young people in the Slovak Republic, the average age of first-time drug users (according to the 2002 survey) is 18 – the same as in 2000
- **The average age of first-time drug users is the lowest amongst young people in Bratislava (17) – once again, this figure is the same as it was in 2000.**

Around one-seventh (14%) of respondents who regularly use illegal drugs began doing so before they reached the age of 15; the majority (57%) began doing so between the ages of 15 and 20, while 29% of regular users started to take drugs after reaching the age of 21.

The age at which people begin to use illegal drugs on a regular basis demonstrates the special status of Bratislava within the framework of the drug problem in Slovakia. Although the data only serve as an outline – due to the low number of people who admitted to regular drug use in the survey – it is nonetheless clear that:

- **A third of young people in Bratislava who regularly use drugs start doing so before they reach the age of 15;**
- Just over a fifth of young people in Slovakia who regularly use drugs start doing so before they reach the age of 15;
- Almost a third of respondents from Slovakia as a whole who regularly used drugs at time the survey was carried out began using them after the age of 20.

2.1 The use of drugs among the overall population

The extent of illegal drug use in Slovakia has been monitored since 1994, when surveys began determining²⁷ whether respondents knew someone who was addicted to illegal drugs. Population surveys revealed that until 2000, there was a steady increase in the number of people stating that they knew such people in all monitored environments – amongst their family members and friends, in their towns, and at their workplaces. This increase was perceptible in all three groups; the number of respondents who stated that they did not know anyone addicted to illegal drugs declined accordingly. The 2002 survey revealed a certain amount of stagnation, because no significant changes were recorded in comparison to the findings of 2000. Only a slight rise was recorded in the number of young people living in Bratislava who have, or have had, a drug addict in their family, or who know a drug addict at their workplace. This is shown in Table 2.1.1:

²⁷ Note: Regular surveys of the Public Opinion Research Institute at the Statistical Office of the Slovak Republic in cooperation with the General Secretariat of the Ministerial Committee for Drug Addiction and Drug Control, which have been carried out at two-year intervals since 1994.

Do you know a person who is, or has been, addicted to drugs such as marijuana, hashish, cocaine, heroin, LSD, or ecstasy? (Expressed in %) ¹⁾															
	1994			1996			1998			2000			2002		
	Slovakia	young people Slovakia	young people Bratislava	Slovakia	young people Slovakia	young people Bratislava	Slovakia	young people Slovakia	young people Bratislava	Slovakia	young people Slovakia	young people Bratislava	Slovakia	young people Slovakia	young people Bratislava
yes, in my family	1	1	3	3	2	7	2	2	7	3	3	5	3	3	8
yes, in my circle of friends	6	13	21	13	25	33	10	25	31	13	29	34	12	28	36
yes, in my town	12	16	29	18	24	50	18	26	41	22	29	47	23	32	45
yes, in my workplace	6	7	8	8	8	12	7	8	10	9	8	11	7	8	16
no	78	68	50	66	51	29	69	49	31	62	43	32	62	43	29

1) As the possibility of answering more than one question was available, total percentages exceed 100

Table 2.1.1 Acquaintance with drug addicts

Source: Public Opinion Research Institute at the Statistical Office of the Slovak Republic

An important indicator when determining the extent of drug use through population surveys is the personal testimony of respondents as to whether they have ever used an illegal drug. The readiness of respondents to reply to questions, together with the ability of pollsters to explain that the survey is anonymous and that respondents' answers will not be misused (their ability to win over peoples' trust), is of vital importance when using this type of survey concerning the extent of illegal drug use. For this reason, empirical data may be imperfect to a certain extent; however, this does not diminish their value, because an overall summary of the monitored period provides a flexible overview of changes and trends in drug use in Slovakia. These data can then be compared with the findings of similar surveys carried out in neighbouring countries, thus enabling better international cooperation in the fight against the illegal drug trade. In this context, however, we must not forget one of the key aspects – when it comes to the use of various psychoactive substances, every society has its boundaries. Over the years, every country has formed its own, specific view of drugs and their use, on the basis of cultural traditions and experiences. Nevertheless, this does not reduce the need for close cooperation within the international community.

Since 1994, there has been a steady rise in the number of citizens who have used drugs at some point. But in comparison to the survey carried out two years ago, we are currently²⁸ experiencing the greatest ever rise since records began in all selected groups – amongst Slovaks as a whole, amongst young people in the Slovak Republic, and amongst young people in Bratislava.

In Slovakia as a whole, the number of people who have tried drugs has risen by 11% since 2000 – from 12% to 23%. Since 1994, this figure has all but quadrupled – from 6% to 23%. This means that almost a quarter of Slovak citizens have tried drugs at some point.

²⁸ Note: Data from 2002. In: Statistical Office of the Slovak Republic. Public opinion: The extent of drug use in Slovakia and people's opinions of problems linked to drug addiction.

In comparison to data from 2000, the number of young Slovaks aged between 15 and 29 who have tried drugs rose by 10% – from 26% to 36%. This figure increased by 26% between 1994 and 2002 – from 10% to 36%. In the latest survey, every third respondent aged between 15 and 29 in Slovakia declared that they had taken some kind of illegal drug. While the number of young people in Slovakia as a whole who admitted experimenting with illegal drugs gradually drew level with that of young people in Bratislava between 1994 and 2000, this trend stagnated in 2002. Only subsequent surveys will reveal whether this is a permanent or merely temporary phenomenon.

Young inhabitants of Bratislava have long formed the greatest proportion of young drug users as a whole. Almost two-fifths of such respondents admit to having taken drugs. Since 2000, their numbers have risen by 11% – from 28% to 39%, while in comparison to 1994, this figure has increased by 23% – from 16% to 39%.

It is interesting that the greatest increases were recorded during two individual two-year periods – between 1994 and 1996, and 2000 and 2002 – while the number of drug users remained relatively constant between 1996 and 2000. However, we must add that the number of people who have tried drugs includes not only regular users, but also those who have tried drugs once, or who have used or use prescription drugs.

The overall findings cited above are summarised in table 2.1.2, which presents the estimated number of people who have tried drugs during their lives, together with the total growth of illegal drug use expressed in percentage terms:

Any illegal drug during one's lifetime	1994 %	1996 %	1998 %	2000 %	2002 %	TREND	Group
Slovakia (Around 1400 respondents in 1994, '96, '98, 2000)	6 <i>Estimate: 228,000</i>	10 <i>Estimate: 389,000</i>	10.2 <i>Estimate: 407,000</i>	12.4 <i>Estimate: 504,000</i>	23.3 <i>Estimate: 956,000</i>	Increase>>>9 4-96 increase: 1998 Increase>> 2000 Increase>> 2002	18 and over
Young Slovaks (Around 900 respondents in 1994, '96, '98, 2000)	10 <i>Estimate: 121,000</i>	19 <i>Estimate: 243,000</i>	21.3 <i>Estimate: 273,000</i>	26.3 <i>Estimate: 353,000</i>	36.2 <i>Estimate: 490,000</i>	Increase>>>9 4-96 increase: 1998 Increase>> 2000 Increase >> 2002	15-29
Young people in Bratislava (Around 300 respondents in 1994, '96, '98, 2000)	16 <i>Estimate: 14,000</i>	28 <i>Estimate: 27,900</i>	29.0 <i>Estimate: 28,700</i>	28.2 <i>Estimate: 29,800</i>	39.0 <i>Estimate: 41,800</i>	Increase>>>9 4-96 increase: 1998 Increase: 2000 Increase>> 2002	15-29

Table 2.1.2 Trends in the lifetime use of any illegal drug as shown by a series of representative population surveys carried out in the Slovak Republic
Source: Public Opinion Research Institute at the Statistical Office of the Slovak Republic

The structure of drug use in Slovakia is presented as the proportion of use (regardless of whether this involves one-off, occasional, or regular use) of individual types of narcotic and psychotropic substances amongst all selected groups – i.e., not merely amongst respondents who have used drugs at some point. The prevalence of individual drugs used over the monitored periods is presented in tabular form. This form was chosen in the interests of greater intelligibility, especially in view of the low number of such drug users.

In October 2002, over a tenth of all Slovak respondents declared that **they had used marijuana or hashish** – 13%; almost a third – 30% – of young Slovak respondents stated the same, as did 32% of respondents aged between 15 and 29 living in the Slovak capital. The cited figures include persons who had used one of these drugs over the previous 30 days, over the previous year, or at some other point in the past.

In comparison to figures from 2000, the greatest increase in the number of people who had tried marijuana or hashish was seen amongst young people in Slovakia as a whole – a rise of 8% – and in Bratislava – a rise of 7%. This was primarily caused by a rise in the number of people who stated in the 2002 survey that they had last used marijuana or hashish over a year before the survey was conducted.

Approximately one-tenth of Slovak citizens had used prescription drugs – i.e., various sedatives, barbiturates, or hypnotics – at some point before October 2002 (**12% of all respondents to the survey**). In contrast to other types of narcotic and psychotropic substances, no significant differences were registered between individual groups when analysing the extent of prescription drug use. The number of respondents who admitted using prescription drugs is almost identical amongst Slovak citizens as a whole, amongst young Slovaks, and amongst young people living in Bratislava.

In comparison to the Slovak average, **ecstasy is again the most widespread drug amongst young people in Bratislava - almost one-tenth (9%) of them has used it at some point. This figure is only 5% amongst young Slovaks, and 2% amongst the Slovak population as a whole.** In comparison to 2000, the greatest rise in its use was seen amongst young people in the capital (by 4%) – particularly amongst those who had last used it over a year before.

In contrast to marijuana and hashish, the proportion of persons who have tried **solvents or other volatile substances** has not risen since 1996; their numbers have either stagnated or gradually declined, especially amongst young people in Bratislava and Slovakia as a whole. In comparison to data from 2000, the number of young respondents (aged between 15 and 29) living in Bratislava who have tried solvents fell by 4%. Amongst young people in Slovakia as a whole, and amongst the Slovak population in general, this figure fell by 1%.

Table 2.1.3 presents the experiences of Slovak citizens with other types of narcotic and psychotropic substance; in view of the very low number of respondents who have tried such drugs, presenting the data in the form of a graph would not have provided a sufficiently clear overview.

Have you ever used any of the following drugs? If so, please state the type of drug and when you used it. (Expressed in %)		1996			1998			2000			2002		
		Slovakia	Young people	*Bratislava	Slovakia	Young people	*Bratislava	Slovakia	Young people	*Bratislava	Slovakia	Young people	*Bratislava
Solvents	Yes, in the past 30 days	0	1	0	0	0	1	0	1	0	0	1	0
	Yes, in the past year	0	1	2	1	1	2	0	1	3	1	1	1
	Yes, less recently	3	4	5	2	4	2	1	3	5	1	2	3
	No	97	94	93	97	95	95	99	95	92	98	96	96
		Slovakia	Young people	Bratislava	Slovakia	Young people	Bratislava	Slovakia	Young people	Bratislava	Slovakia	Young people	Bratislava
LSD/other hallucinogen	Yes, in the past 30 days	0	0	0	0	0	0	0	0	1	0	0	1
	Yes, in the past year	1	1	1	0	1	0	1	1	1	0	1	0
	Yes, less recently	1	1	1	1	1	1	0	1	1	1	1	1
	No	98	98	98	99	98	99	99	98	97	99	98	98
		Slovakia	Young people	Bratislava	Slovakia	Young people	Bratislava	Slovakia	Young people	Bratislava	Slovakia	Young people	Bratislava
Cocaine/ Crack	Yes, in the past 30 days	0	0	0	0	0	0	0	0	0	0	0	0
	Yes, in the past year	0	1	2	0	1	1	0	1	2	0	1	1
	Yes, less recently	1	0	1	1	1	2	1	1	2	1	1	1
	No	99	99	97	99	98	97	99	98	96	99	98	98
		Slovakia	Young people	Bratislava	Slovakia	Young people	Bratislava	Slovakia	Young people	Bratislava	Slovakia	Young people	Bratislava
Heroin ¹⁾	Yes, in the past 30 days	-	-	-	0	1	0	0	0	2	0	0	0
	Yes, in the past year	-	-	-	0	1	2	0	0	1	0	1	1
	Yes, less recently	-	-	-	1	1	1	1	2	2	1	1	2
	No	-	-	-	99	97	97	99	98	95	99	98	97
		Slovakia	Young people	Bratislava	Slovakia	Young people	Bratislava	Slovakia	Young people	Bratislava	Slovakia	Young people	Bratislava
Anabolics ¹⁾	Yes, in the past 30 days	-	-	-	0	1	1	0	0	1	0	0	1
	Yes, in the past year	-	-	-	1	0	1	1	1	1	1	2	2
	Yes, less recently	-	-	-	1	1	1	1	2	2	2	2	2
	No	-	-	-	98	98	97	98	97	95	97	96	95
		Slovakia	Young people	Bratislava	Slovakia	Young people	Bratislava	Slovakia	Young people	Bratislava	Slovakia	Young people	Bratislava

Tab. 2.1.3 continued

		Slovakia	Young people	Bratislava	Slovakia	Young people	Bratislava	Slovakia	Young people	Bratislava	Slovakia	Young people	Bratislava
Ampheta- mines	Yes, in the past 30 days	0	0	0	0	0	0	0	0	0	0	1	
	Yes, in the past year	1	1	2	0	0	0	0	1	2	0	1	
	Yes, less recently	0	1	1	1	2	1	1	1	2	1	0	
	No	99	98	97	99	98	99	99	98	96	99	98	98

1) The use of heroin and anabolics was not included in the 1996 survey

* Bratislava – Young people in Bratislava

Table 2.1.3 Slovak citizens' use of other types of narcotic and psychotropic substances between 1996 and 2002

Source: Public Opinion Research Institute at the Statistical Office of the Slovak Republic

2.2 Drug use amongst school pupils and young people

Social changes have led to an increase in social pathologies, of which the use of, and addiction to, illegal drugs amongst young people is of great significance. The **Department of Youth and Sports at the Institute of Information and Prognoses of Education²⁹ in Bratislava has been concentrating on this exceptionally serious problem since 1995. Its ongoing research** is aimed at providing an analysis of the issue, and through regular surveys, identifying the most significant problems in the area of drugs, as well as overall trends in young people's attitudes towards drug use. **The basic research method employed each year involves the answering of a modified questionnaire; the selected group of young people aged between 15 and 26 living in the Slovak Republic consistently meets representative criteria.**

The lowest number of respondents who admitted to having tried illegal drugs was recorded in 1998 (15.4%), while the highest proportion was registered in 2002 (20.7%). In 2003, only 16.1% of all respondents declared that they had tried illegal drugs; however, in comparison to previous years, there was an increase in the number of people who did not answer the question (5.0%). On the basis of these data, we can state that **since 1995, young people have demonstrated a growing tendency towards experimenting with illegal drugs.**

<i>Respondents who have tried illegal drugs</i>									
Year	1995	1996	1997	1998	1999	2000	2001	2002	2003
%	18.0	15.4	17.5	15.5	19.6	17.8	17.3	20.7	16.1

Table 2.2.1 Respondents aged between 15 and 26 who have tried illegal drugs

Source: Institute of Information and Prognoses of Education

When the findings of the surveys are compared, it is evident that men have greater experience with illegal drug use, especially respondents aged between 18 and 22. The

²⁹ *Bieliková, M., Pétióvá, M.: Drugs and young people's lifestyle in the Slovak Republic – a study by the Institute of Information and Prognoses of Education, Bratislava 2003.*

highest level of drug use was seen amongst employed respondents, and students at universities and grammar schools. Respondents resident in large cities and young people living in the Bratislava and Žilina Regions are also more inclined towards experimenting with illegal drugs. Respondents who have tried drugs are more likely to come from incomplete families and stepfamilies, and from families where good mutual relations are lacking. Such young people generally smoke and drink alcohol to a much greater extent; they get drunk more often, and are more likely to play slot machines. In addition, they are much more likely to maintain friendly contacts with people who have tried illegal drugs, which has a negative impact on their opinions concerning this issue³⁰.

Since 1995, there has been a significant increase in the number of respondents who have experimented with injecting drugs. There has also been a slight rise in the number of respondents who have smoked illegal drugs; in contrast, the number of people inhaling drugs or swallowing them in tablet form has fallen. The worst situation with regard to drug injection was seen in 2000 and 2003; the data for 2003 were the worst since records began. The number of people inhaling drugs peaked in 1997 and 2001, while the worst situation with regard to drug consumption in tablet form was seen in 2001. The highest number of young people smoking drugs was recorded in 2002.

	<i>Method of drug use</i>								
	1995	1996	1997	1998	1999	2000	2001	2002	2003
intravenous injection	0.2	0.5	0.9	0.6	0.6	1.0	0.9	0.6	1.4
inhaling	3.3	2.5	4.1	2.5	3.6	3.8	4.2	3.8	2.7
swallowing	3.5	1.4	4.5	3.1	4.4	3.3	4.6	4.1	2.5
smoking	14.8	14.0	16.3	14.5	18.0	15.9	16.6	20.0	15.5

Table 2.2.2 Method of drug use

Source: Institute of Information and Prognoses of Education

a) School pupils

An analysis of three phases of surveys³¹ using the TAD1 ('Tobacco, Alcohol, and Drugs') scale for primary school pupils and TAD2 for secondary school pupils – which were carried out in 1994, 1998, and 2002 – revealed a steady increase in problems with alcohol, tobacco, and other drugs (Nociar, A., 1995 and 2003).

Adults (parents, older relatives, and other adults) are still passing on their rituals, attitudes, and habits to younger generations with regard to alcohol, and somewhat less so with regard to tobacco.

Despite the effectiveness of this transfer – for example, three-quarters of young people have been tipsy at some point – over 20% of the group are disturbed by over-drinking in the family (although boys are less troubled, over a quarter of girls responded negatively).

³⁰ This finding corresponds to the findings of population surveys and the ESPAD survey – Figs. 2.0.2 and 2.0.3.

³¹ State Health Institute, Institute of Information and Prognoses of Education, National Drug Monitoring Centre

The age of first time tobacco and alcohol use as main legal drugs is generally constant (fluctuating around the age of 10); despite the existence and implementation of many prevention programmes, a rise in this age has not been achieved (see Fig. 2.2.1).

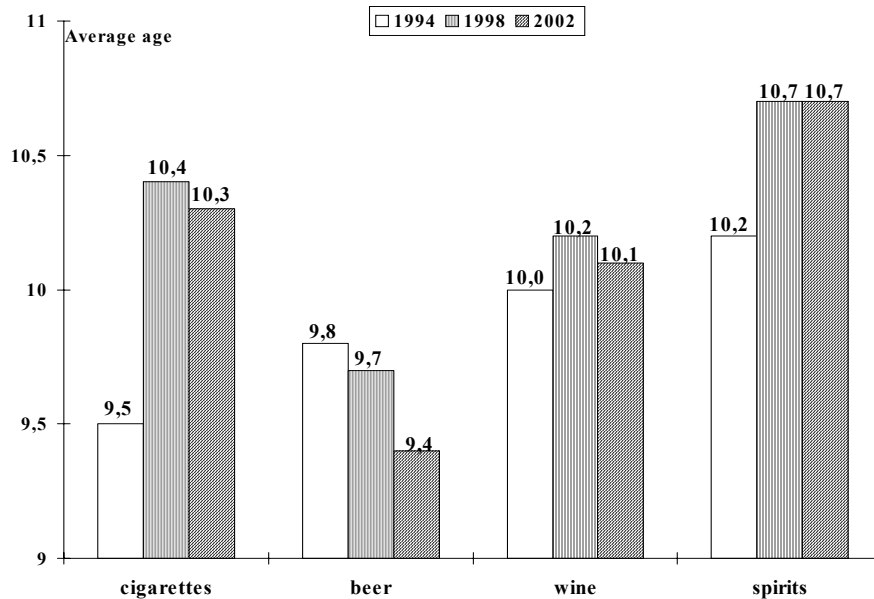


Fig. 2.2.1 TAD1: First time use of tobacco and alcohol by 11 – 14 year old primary school pupils in Slovakia between 1994 and 2002

Source: Nociar, A., 2003

The incidence and extent of first time use of tobacco and three types of alcoholic beverage, as well as the direct effects of alcohol (in the form of tipsiness or drunkenness) amongst 11 – 14 year old primary school pupils is rising steadily (see Fig. 2.2.2).

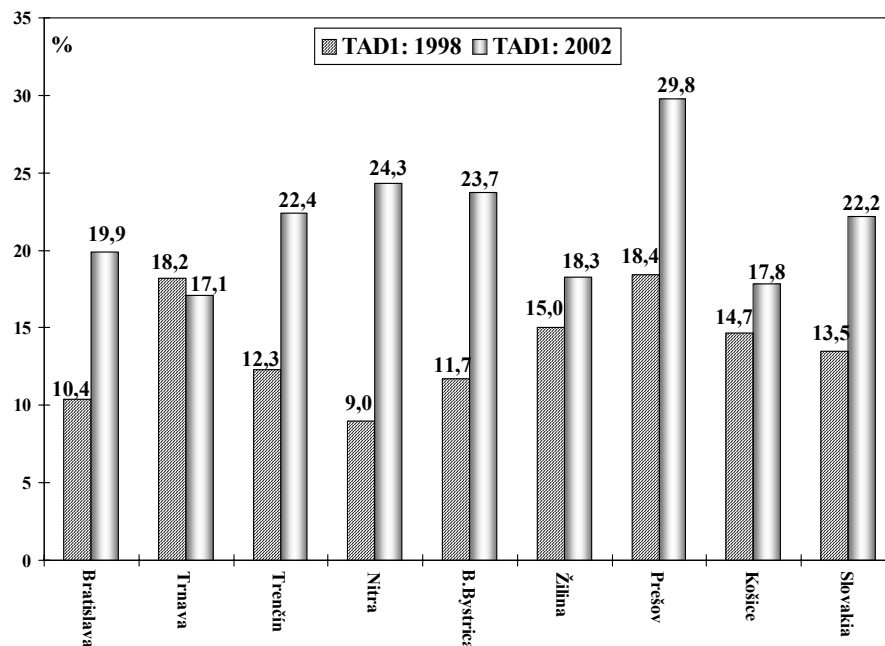


Fig. 2.2.2 11 – 14 year old pupils between 1998 and 2002: Have been tipsy at least once in their lifetimes

Source: Nociar, A., 2003

The ever more favourable climate for legal drugs is leading to a change in young people's attitudes and behaviour towards them, and also towards illegal drugs as a result. Young people perceive alcohol and tobacco as part of the image of men and women, which influences their level of smoking and drinking amongst their peers.

Over an eight-year period, occasional and regular smoking amongst school pupils and students has more than doubled; alcohol consumption amongst some young people is becoming ever more problematical, and drinking as a whole is still a routine social phenomenon.

The perceived availability of almost all illegal drugs, especially marijuana, is increasing, while at the same time, the perceived risk linked to their use is on the decline.

The rise in perceived availability, the increase in the knowledge of drugs, and the decline in their perceived harmfulness represent part of a wider process, whereby drugs are permeating the overall social environment. Awareness of individual types of drug, including their names, characteristics, etc., has risen in recent years – especially with regard to marijuana and new synthetic drugs such as ecstasy, hallucinogens, and amphetamine-type stimulants.

There is also growing approval of experimenting with or using drugs, particularly in the case of marijuana and ecstasy, which indicates an increase in young people's pro-drug orientation.

These facts, stemming from habits and culture, and changes in the availability of alcohol, tobacco, and other drugs, are reflected in an ever-increasing number of children and teenagers who smoke and drink, accompanied by a growing willingness to experiment (see Fig. 2.2.3), and actual experimentation with illegal drugs. Some young people are therefore exposed to a greater risk of becoming addicted to an ever-wider range of illegal drugs.

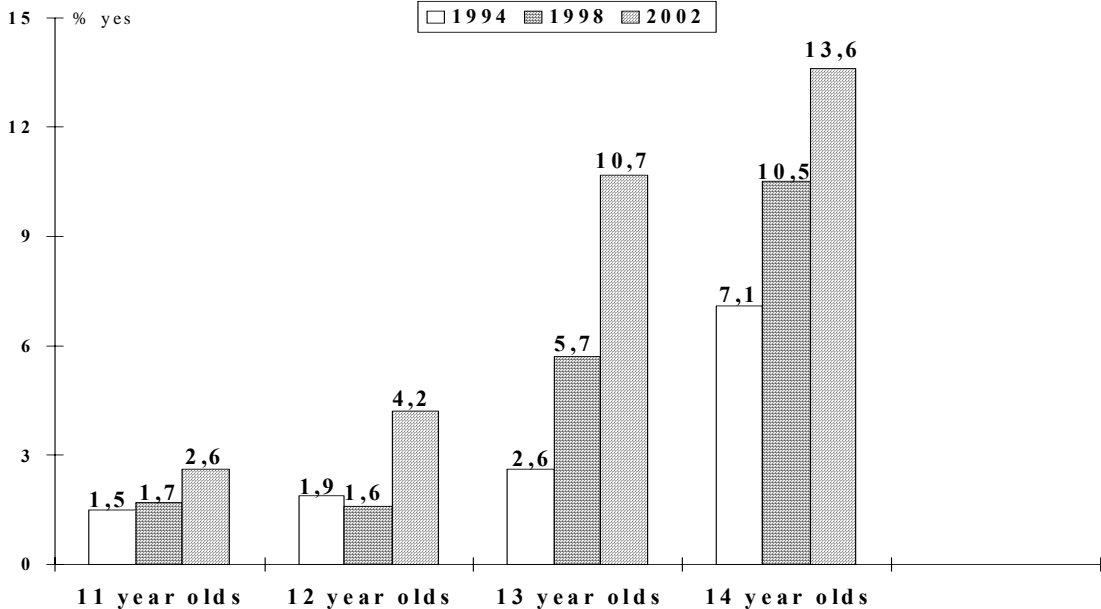


Fig. 2.2.3. Findings of TAD1 among 11 – 14 year olds: could be persuaded to try marijuana
Source: Nociar, A., 2003

The findings among secondary school pupils are based on three phases of ESPAD surveys³².

Previous school-based surveys showed a rise in the use of legal and illegal drugs with age, and also revealed a difference according to gender. It transpired that the knowledge of illegal drugs had risen over the past four to eight years, and attitudes to the most prevalent of these – marijuana – had changed. While students generally perceived the occasional smoking of marijuana to be relatively risky in 1995, this was not the case in subsequent years. This is shown by graphs on the perceived risks linked to the occasional and regular use of various drugs, in Slovakia's three largest cities:

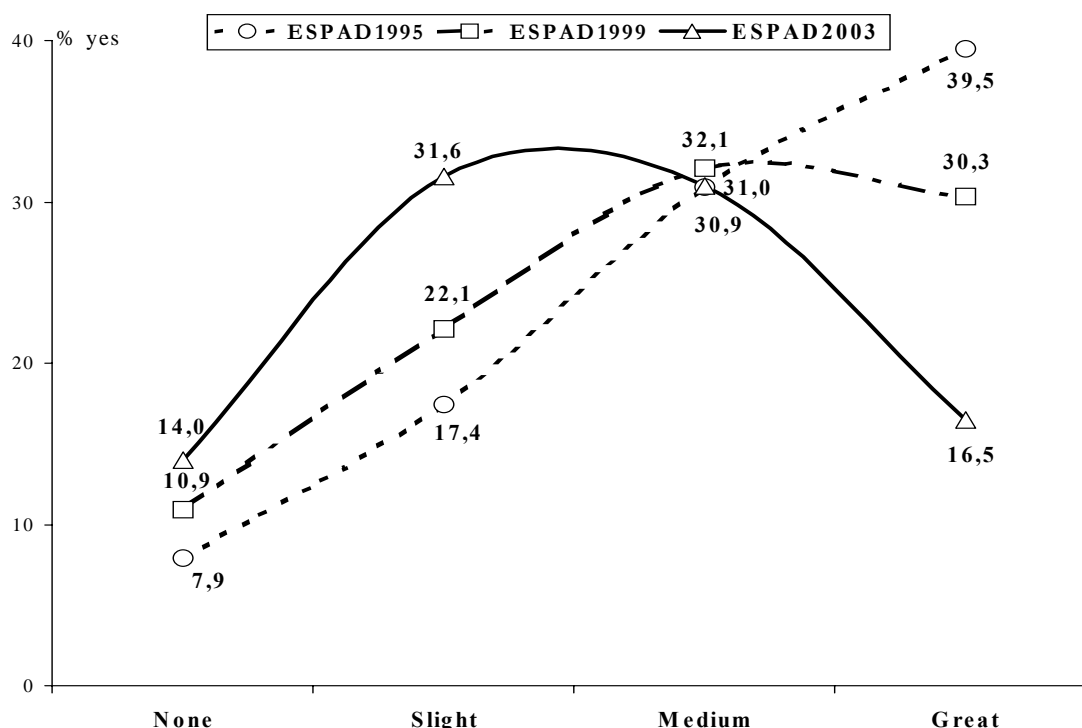


Fig. 2.2.4 A comparison of ESPAD surveys from 1995, 1999, and 2003 among 1st – 4th grade secondary school students in Bratislava – the perceived risks linked to occasional marijuana smoking
Source: Nociar, A., 2004

This situation was most evident in Bratislava, where we can see how over each four year period, the line depicting the perceived risk linked to marijuana use gradually changes from a straight line to a normal distribution curve. In other words, **the standard perception (at least from a statistical point of view) is a slight to medium level of risk.**

In the case of practically all types of legal and illegal drugs, there has been a slight to very significant increase in use since 1995, with the exception of stagnation in the use of inhalants in 1999. However, even in this area, there has also been a rise in use by both genders over the past four years.

When sorted by age, the data show a steady rise in the consumption of all drug types; the **greatest increase according to age was seen in the case of marijuana, where the difference between 15 and 19 year olds was almost threefold in 2003.**

³² European School Survey Project on Alcohol and other Drugs.

Comparing regions according to former administrative divisions revealed a situation typical for the beginning of a gradual spread of new drugs (marijuana and heroin) from the capital to the three other parts of the country, while two traditional drugs (inhalants and sedatives) were dispersed relatively evenly throughout the country (see Fig. 2.2.5).

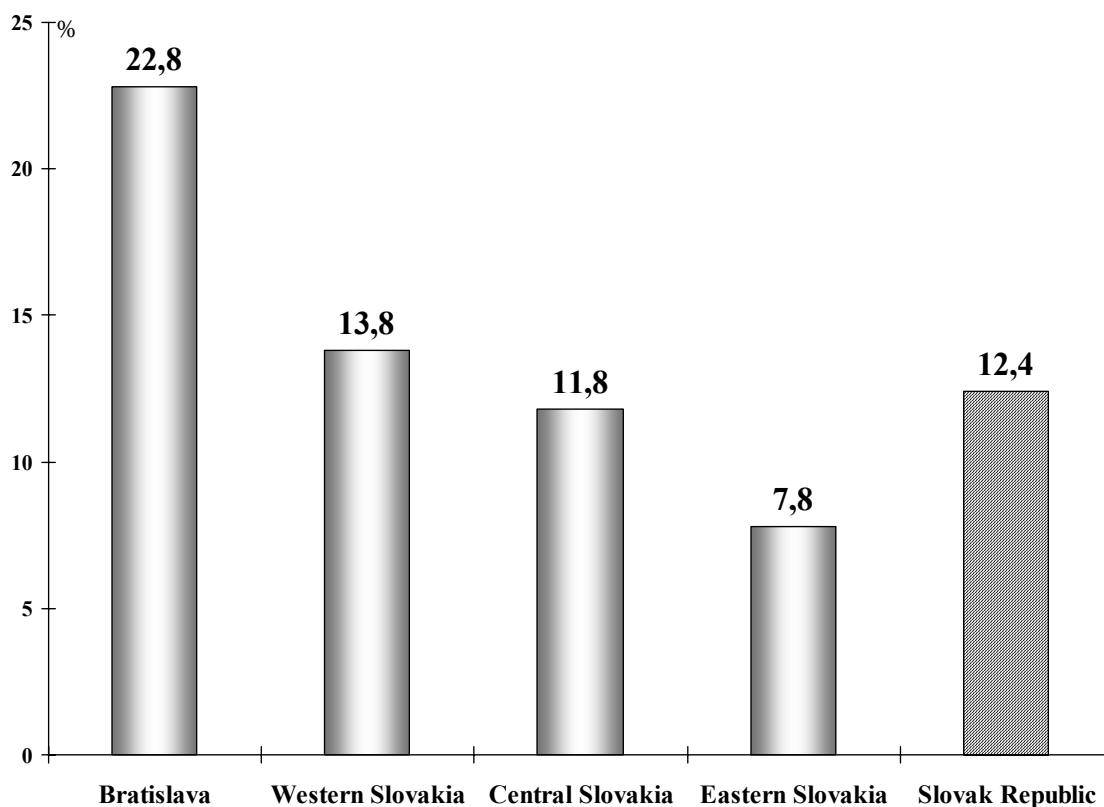


Fig. 2.2.5. Findings of ESPAD95 in Slovakia for 1st – 4th grade secondary school students, according to region. (Once or more in their lifetime: Marijuana or hashish).
Source: Nociar, A., 2004

With regard to Slovakia's current administrative division: over the past four years, there have been considerable changes in the availability of marijuana, as well as experimentation with it and its recreational use or even abuse. This was reflected in a rise in the lifetime prevalence of marijuana, and especially in a balancing out of the problem among various regions. For example, regions such as Prešov* and to a certain extent Košice*, which were markedly below the national average in 1999, had almost reached the average level by 2003 (fig. 2.2.6).

* Prešov, Košice = Eastern Slovakia

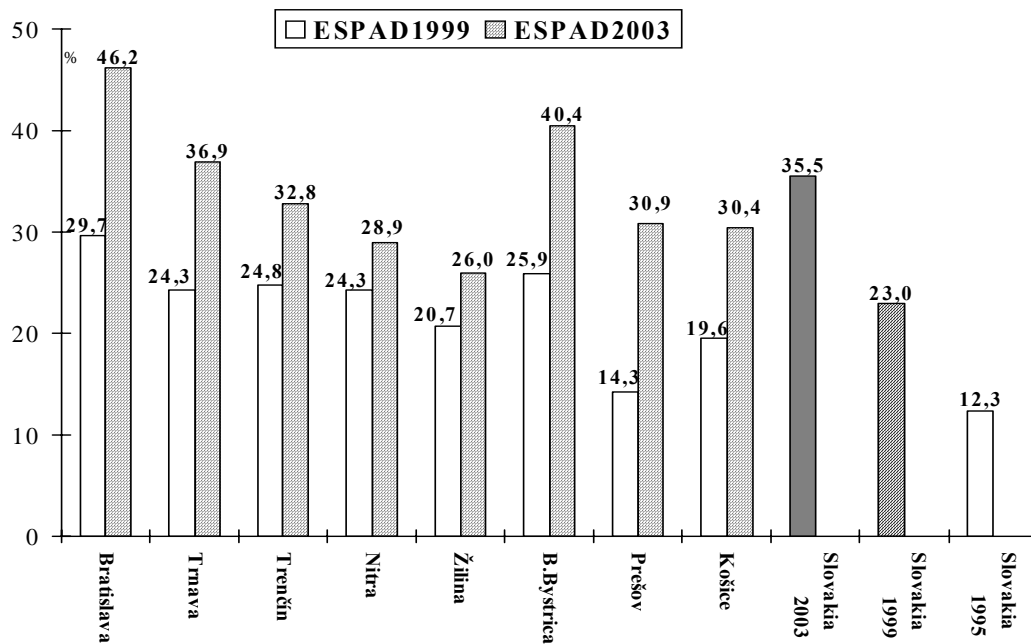


Fig. 2.2.6 ESPAD surveys carried out in Slovakia in 1999 and 2003 for 1st – 4th grade secondary school students, according to region. (Once or more in their lifetime: Marijuana or hashish).

Source: Nociar, A., 2004

The findings for 2003 showed that marijuana use is dominant among both boys and girls. Volatile inhalants were in second place amongst boys, and tranquillisers and sedatives amongst girls; combining alcohol with tablets came third amongst both genders.

In comparison, the situation with marijuana was the same in 1999 – its lifetime use almost doubled (from 12% to 23%), and a greater increase was registered amongst girls than amongst boys. Combining alcohol with tablets was in second place in 1999, while volatile inhalants were in third place amongst boys, and tranquillisers and sedatives amongst girls – these had previously held second place.

When comparing the findings of individual ESPAD surveys, it becomes clear that the incidence of smoking among young girls between the ages of 15 and 19 has changed most unfavourably: practically the same number of girls admitted smoking regularly as boys had four years previously.

Girls consume more legal and illegal drugs than their peers did four and eight years previously; at the same time, they use slightly less drugs than boys, with the exception of tranquillisers and sedatives, as well as combining alcohol with tablets.

In the case of practically all types of legal and illegal drugs, there has been a slight to very significant increase in use since 1995, with the exception of stagnation in the use of inhalants in 1999. However, even in this area, there has also been a rise in use by both genders over the past four years.

When sorted by age, the data show a steady rise in the consumption of all drug types; the greatest increase according to age was seen in the case of marijuana, where the difference between 15 and 19 year olds was almost threefold in 2003. A similar rise was registered in the case of ecstasy and amphetamines (see the following figures).

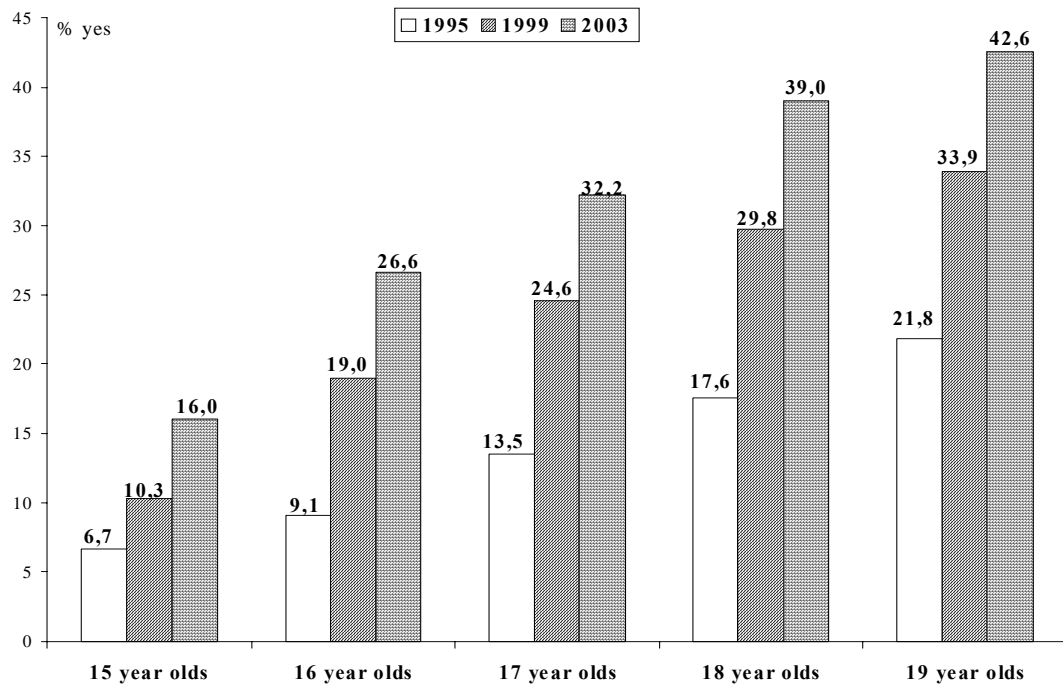


Fig. 2.2.7. Comparison by age: Marijuana or hashish used once or more in a lifetime
Source: Nociar, A., 2004

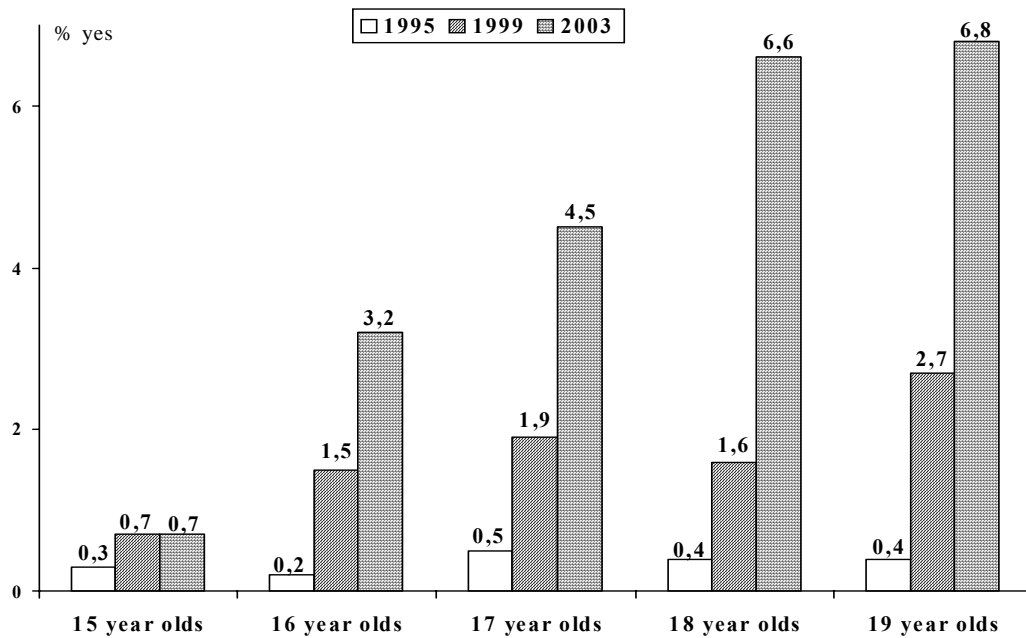


Fig. 2.2.8 Comparison by age: ecstasy taken once or more in a lifetime
Source: Nociar, A., 2004

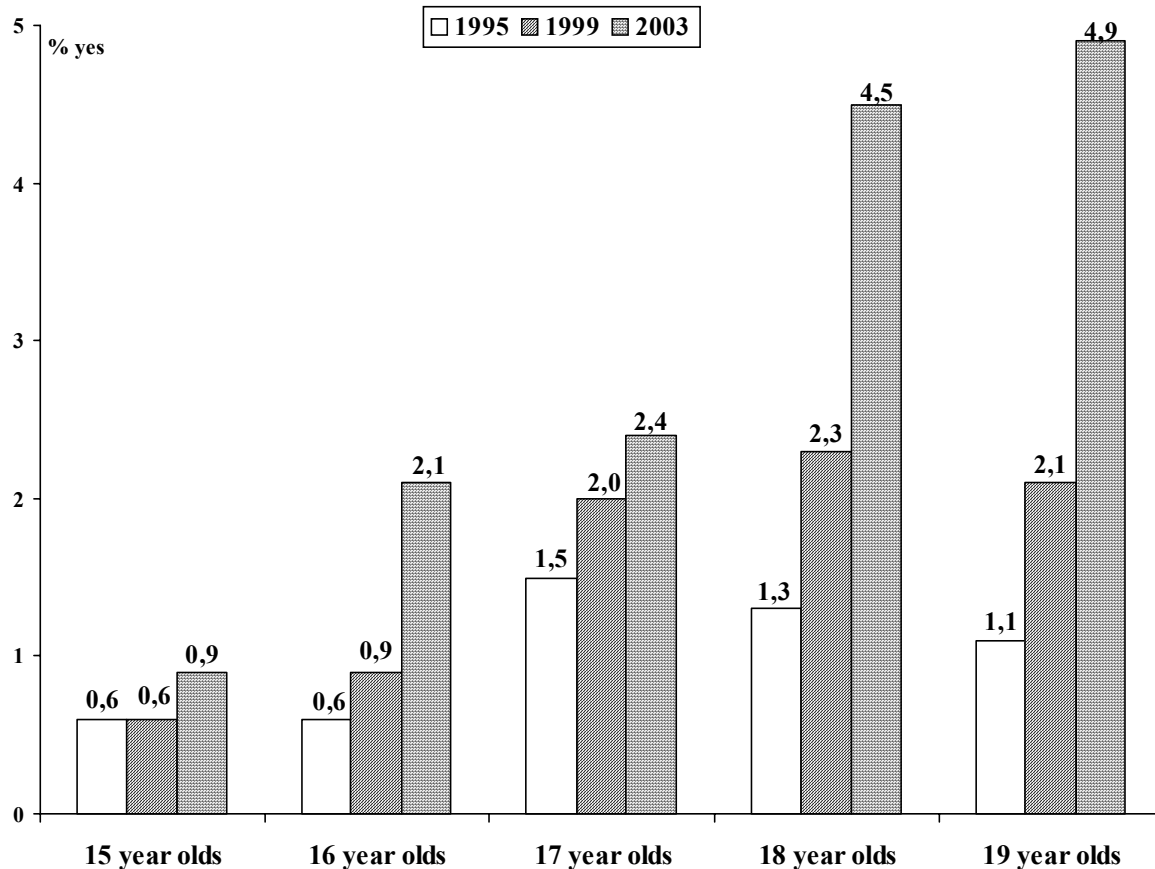


Fig. 2.2.9 Comparison by age: Amphetamines taken once or more in a lifetime
 Source: Nociar, A., 2004

Survey findings were also processed according to the consumption of legal and illegal drugs in relation to the estimated socio-economic situation, parents' education levels, and the completeness or incompleteness of families. Comparisons according to drug type showed that in the case of more expensive or fashionable drugs, such as cocaine, LSD, anabolic steroids, and ecstasy, there is a slight but perceptible trend towards greater usage among those students who stated that they were very satisfied with their family's financial situation, as well as among those who stated that their family was much better off compared to other families in Slovakia (Figs. 2.2.10 and 2.2.11).

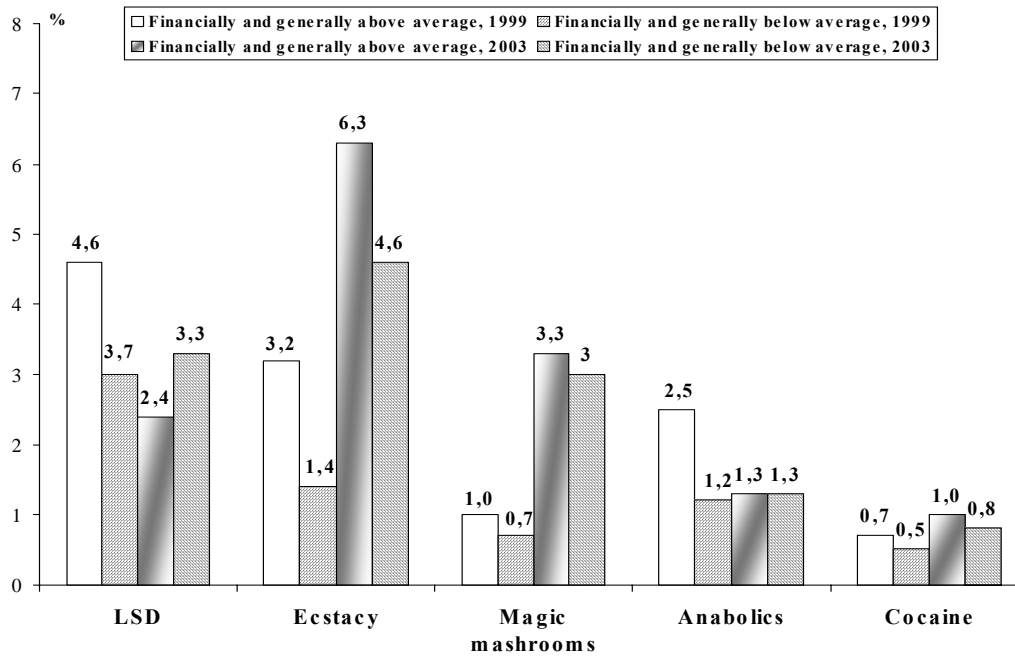


Fig. 2.2.10 Drug use among students according to the financial and socio-economic status of their families.
Source: Nociar, A., 2004

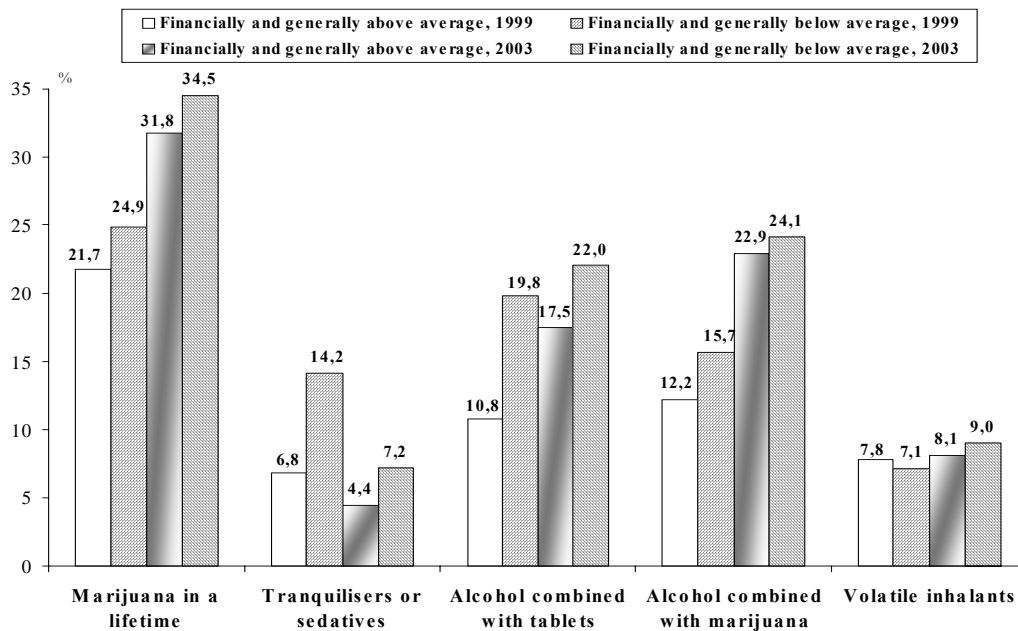


Fig. 2.2.11 Drug use among students according to the financial and socio-economic status of their families.
Source: Nociar, A., 2004

Analysing the findings according to supplementary criteria concerning the socio-economic status of parents, their level of education, and the completeness of families therefore revealed that apart from parents' education levels – which had a very low impact on drug consumption – the completeness of families, together with other characteristics linked to their financial and overall socio-economic status, had a significant influence.

Other analyses confirmed the benefits of young people living in complete families, as well as the disadvantages of living in incomplete families or stepfamilies. Although, after eight years, even complete families had not resisted changes in the drug situation, and the consumption of illegal drugs had once again risen, complete families have continued to be least affected by drugs (see the following figures).

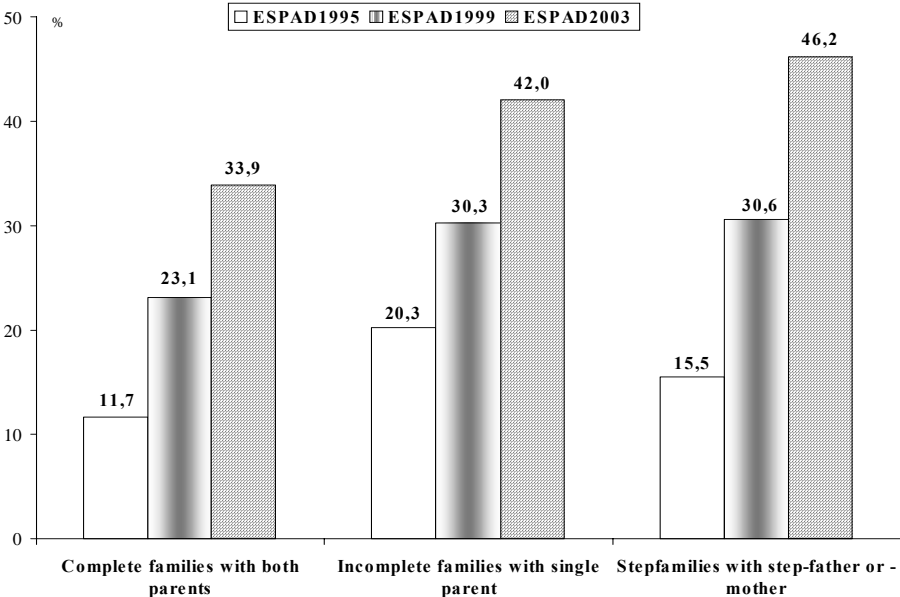


Fig. 2.2.12 The use of any illegal drug once or more in a lifetime. Source: Nociar A., 2004

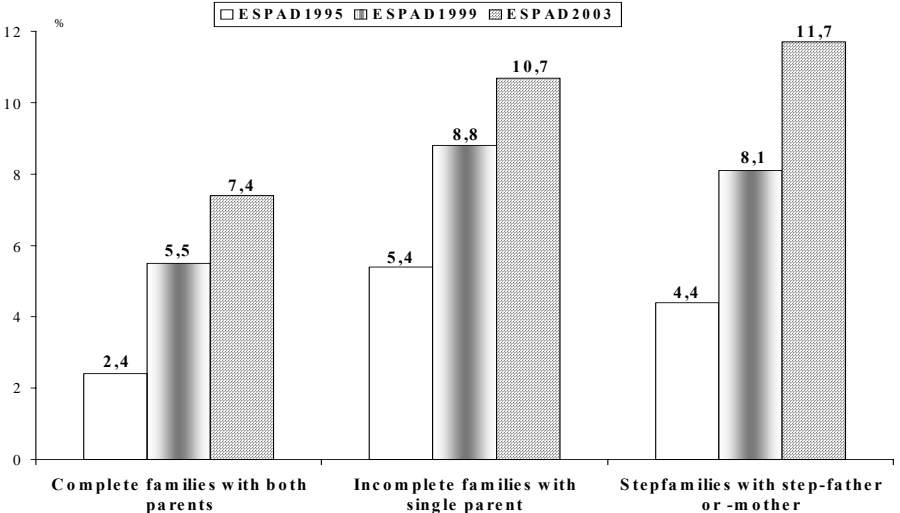


Fig. 2.2.13 The use of any illegal drug (except marijuana) once or more in a lifetime, according to family completeness. Source: Nociar, A., 2004

b) Drugs and youth

When carrying out a series of population surveys, drug use amongst young people was continually monitored in two groups – young people in Slovakia, and young people in Bratislava; both groups were composed of young people aged between 15 and 29. The findings of the 2002 survey were as follows:

People who have taken drugs at some point are much more likely to know someone who is, or has been, a drug addict. As is evident from fig. 2.2.14, this phenomenon is most marked amongst young people in Bratislava, where as many as 90% of respondents who have tried illegal drugs know someone who is, or has been, a drug addict; amongst young people in Slovakia, this figure is 74%, compared to only 59% amongst the Slovak population as a whole. 69% of Slovak respondents who have not tried drugs do not know anyone who is, or has been, a drug addict; however this figure is just 41% amongst young people living in the capital.

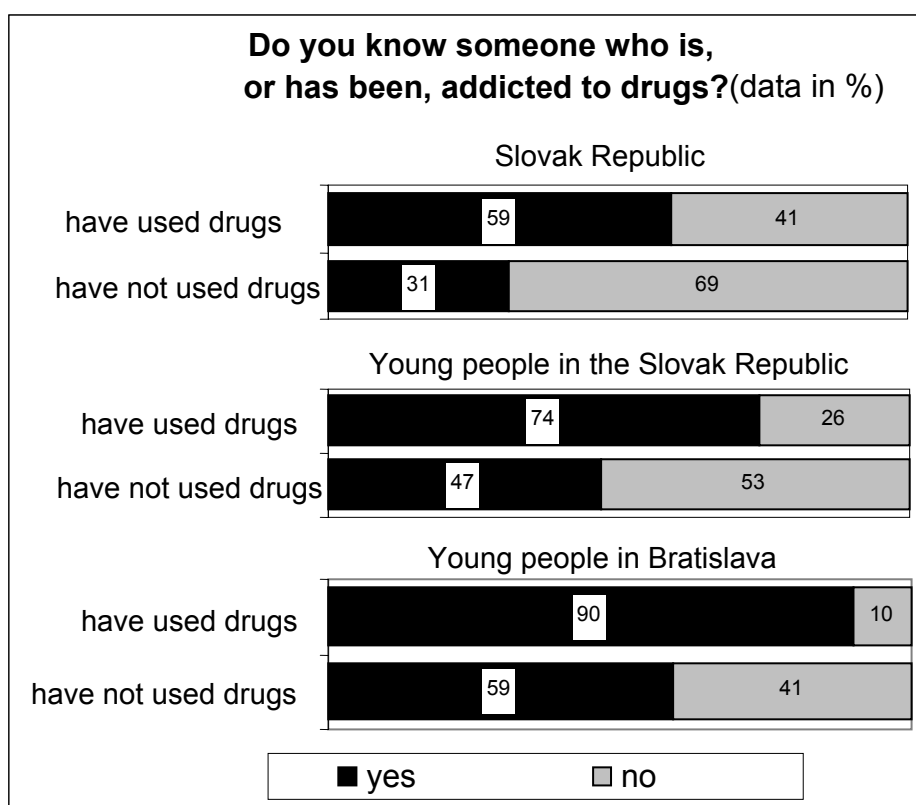


Fig. 2.2.14 Acquaintance with drug addicts (see also table 2.1.1)

Source: Public Opinion Research Institute at the Statistical Office of the Slovak Republic

In comparison to 2000, significant changes were seen in 2002 in the places where drugs were available to people, especially young people aged between 15 and 29. The greatest decline in drug supply was seen in public spaces, in the streets and in parks, which is evidently linked to the increased monitoring and control of such places by the police and other bodies involved in the fight against drug use and dealing. This decline was most marked in Bratislava; at the same time, the capital registered a significant, parallel increase in the availability of drugs in bars, restaurants, and cafes, and particularly in various clubs frequented by young people. From this it is clear that **the supply of drugs is steadily moving from public spaces into enclosed areas, where there is less chance of detecting this illegal activity and more anonymity – and consequently a greater opportunity to experiment with illegal drugs.** State anti-drug policy must therefore

gradually shift its orientation from the most commonly applied methods of monitoring and checking drug dealers in public spaces towards the more systematic, precise, and above all, demanding detection of places where young people gather in particular, and where they have the opportunity of coming into direct contact with various narcotic and psychotropic substances. In comparison to the national average, the most marked differences in the availability of drugs are found amongst young people aged between 15 and 29.

- Young people obtain drugs much more often at discos, concerts, schools, and in dormitories
- In comparison to the overall adult population of Slovakia, young people aged between 15 and 29 are slightly less likely to come into contact with drugs in various bars and pubs
- Young people in Bratislava are significantly more likely to obtain drugs at friends' and acquaintances' flats, and despite a marked decline, also in public spaces, in streets and parks.

When appraising the number of different drugs that respondents have tried, it is clear that in comparison to 1995, the number of respondents who have used only one drug is on the decline, while the number of young people stating that they have tried two or more types of illegal drug is increasing; 2003³³ in particular saw a rise in the number of respondents who had tried more than four types. From this it is clear that the number of young people switching from one type of illegal drug to another is rising. Men and respondents from large cities in particular have tried a number of types of illegal drug.

The most common age at which young people begin to experiment with drugs is between 15 and 18 years of age; however, the lowest age at which experimentation began was between 10 and 12. In 2003, 8.9% of young people first tried drugs aged 14 or less; 60.1% of respondents began experimenting between the ages of 15 and 17, and more than a third of respondents first experimented at the age of 18 or over. Boys begin experimenting with drugs earlier than girls, especially in the age category of 14 or less.

When first experimenting with drugs, young people most often obtain drugs from a friend or fellow pupil; this indicates the powerful influence of peer groups. A more thorough analysis of the data reveals the fact that since 1999, there has been a fall in the number of peers who supply drugs to their friends (1997: 84.2%, 1999: 89.6%, 2001: 82.6%, 2003: 81.8%); it was revealed that young people are more frequently obtaining drugs themselves (i.e., purchasing or growing them).

The most commonly tried drugs in Slovakia are marijuana, volatile substances, hashish, ecstasy, tablets (often in combination with alcohol), methamphetamine ('pervitin'), and LSD³⁴. Only a small number of respondents experiment with other drugs (heroin, cocaine, and crack).

Marijuana remained the primary drug throughout the monitored period (1995-2003) and in all the monitored groups of respondents. In 2003, volatile substances were the second most popular type of drug amongst men, while women preferred hashish. In addition, men also consumed more LSD, methamphetamine ('pervitine'), and crack, while women admitted to taking more cocaine and tablets.

The findings of the survey reveal that there has been a decline in the use of volatile substances and marijuana since 1999, while the use of tablets has fallen by as much as 50.0%. There has been an increase in the consumption of ecstasy, methamphetamine ('pervitine'), hashish, and crack; in the case of ecstasy and crack, the rising trend in their use since 1999 could be described as significant. However marijuana is the most frequented drug

³³ *Institute of Information and Prognoses of Education: Drugs and young people's lifestyle in the Slovak Republic, Bratislava 2003.*

³⁴ *This fact corresponds to information and data in the ESPAD 2003 survey.*

for the whole period reported. Tablets and volatile substances „gained“ second and third place in 1999 and in 2001. In the year 2003 volatile substances were second most commonly used drug, while hashish was in third place.

Young people who obtain drugs from their friends or fellow pupils consume them in greater amounts. Together with the increasing frequency of drug use, the number of respondents declaring pleasurable and very pleasurable feelings associated with drug use is also on the rise. Respondents who did not experience any special feelings when using drugs, or who described their feelings as unpleasant, most often stopped taking illegal drugs after these first experiments. Most respondents experimenting with illegal drugs are not concerned about drug addiction or the transmission of various contagious diseases; young people greatly underestimate these serious problems.

When encouraging the right opinions and attitudes, it is important that young people have access to enough objective information, according to which they can make a choice. Survey findings³⁵ for 2003 show that 67.2% of respondents are sufficiently well informed about drugs; however, 17.4% feel that there is a certain lack of information. 15.4% of young people between the ages of 15 and 26 are not interested in the issue. Women, the oldest respondents, grammar school pupils, and university students are the most satisfied with their level of knowledge; pupils at secondary technical colleges are the least satisfied. When comparing the data, it becomes clear that since 1999, the number of young people who have sufficient information about drugs is falling, while the number of respondents who lack information is increasing, as is the number of respondents who are not interested in the issue. One negative finding is the fact that respondents who have begun to take an interest in the issue do not have enough information.

Enough information about drugs	1999	2001	2003
Yes	71.7	67.5	67.2
No	15.6	14.0	17.4
I am not interested in the issue	12.7	18.5	15.4

Table 2.2.3 Perceived availability of information about drugs
Source: Institute of Information and Prognoses of Education

Respondents who have sufficient information about drugs are more likely to obtain it from newspapers and magazines, or to look for it themselves; however, respondents who lack information are more likely to consult their friends or parents. The objectivity and correctness of information depends to a great extent upon its source. **The primary source for all respondents is the television and radio;** however, boys/men more often obtain information from friends, while girls/women read it in newspapers and magazines, ask their teachers for advice, or seek information in specialist publications. Respondents aged between 15 and 17 most often receive information from their teachers. **One negative finding is the fact that people in all three monitored categories are least likely to obtain this important information from their parents.**

According to respondents, the most common reasons for young people experimenting with drugs are peer pressure, curiosity, escaping from one's family situation, and boredom. Young people regard heroin, cocaine and LSD to be the most dangerous drugs; one in ten respondents were unable to name three types of drug that are most harmful to the human body. Respondents most often specified discos and concerts,

³⁵ *Institute of Information and Prognoses of Education.*

social establishments and amusement arcades, and schools and dormitories as the places where it is easiest to buy or obtain drugs³⁶.

When asked **whether, in their opinion, society pays enough attention to the problem of drugs and drug addiction, only 22.5% of respondents answered in the affirmative in 2003; over a third of young people consider the amount of attention paid to be insufficient.** Almost half of respondents were unable to state an opinion. From the findings, it is clear that respondents aged between 15 and 26 are least satisfied with the level of attention society pays to the drug issue. In particular, respondents aged between 23 and 26, respondents living in large cities, and young people who believe they have sufficient information about the illegal drug issue regard the amount of attention paid as inadequate.

Over half of respondents believe that the current spread of drugs in society is a problem for society as a whole, which must be solved immediately; a fifth of respondents feel that it is a big problem, which has been left too late to solve. Only 2.5% of young people feel that the current spread of drugs in society is a small problem, to which attention need not be paid; 22.2% of respondents were unable to answer the question.

In comparison with findings from 1997, we can see that the number of respondents who play down this serious problem and do not see a need to address it is increasing, as is the number of respondents who are unable to state an opinion. The number of respondents who believe that the current drug epidemic is a large and insoluble problem has fallen slightly, as has the number of young people who believe it to be a problem affecting society as a whole, which must be addressed immediately.

Young people believe the most important measures in the fight against drugs to be: limiting the flow of drugs into the country, approving more stringent laws punishing drug dealers and producers, increasing police powers when apprehending drug dealers, and improving cooperation with parents, schools, and centres for the prevention of drug addiction. Respondents feel the following measures to be of intermediate importance: including prevention in compulsory school curricula, presenting regular programmes with an anti-drug message in the mass media, promoting the activities of information centres, training volunteer workers in the area of drug prevention, and providing high-quality training to pedagogues in this field. **Respondents believed the following measures to be the least effective: training peer groups to work with youth ('peer programmes'), publishing information leaflets, posters, and brochures, expanding health care to include drug addicts, and establishing special treatment centres solely for children and young people.**

The findings clearly demonstrate that young people are drawing attention to certain legislative shortcomings, and place emphasis on those measures where, in their opinion, the correct functioning of legislation would lead to an improvement in the situation. They attribute a medium level of importance to measures aimed at caring for drug addicts, but underestimate the effectiveness of measures aimed at prevention. Measures aimed at training volunteer workers in the area of drug prevention, and activists for work with youth ('peer programmes') have long been underestimated; in practice, they can achieve very good results under the systematic leadership of drug prevention coordinators at primary and secondary schools.

The same survey shows that over half of all respondents throughout Slovakia do not personally know a drug addict; young people living in large cities are much more likely to come into contact with drug addicts than respondents living in small agglomerations.

Young people most commonly regard drug addicts as people suffering from an illness, which should be treated, or as people who are unable to solve their own personal problems. 14.2% of young people believe that addicts are dissatisfied with their lives to date, and 7.5% of respondents perceive them as posing a threat to other people.

³⁶ See also data from population surveys, p. 23.

3.7% of respondents believe that these people are suffering from inferiority complexes; the same percentage feels that they are not afraid to try something new. 6.0% of respondents do not have an opinion on the subject, and 1.5% of young people see them as people who should be treated the same as others.

When meeting drug addicts, young people most often feel pity or indifference, or condemn them for their actions. Approximately one-tenth of respondents are afraid of drug addicts, and 3.7% hate them. 4.7% of respondents had no particular feelings when encountering drug addicts; these young people believe that drug addicts are a part of modern society, and that they should not be paid any special attention by others.

In comparison to the findings from 1997, it is evident that the number of respondents who fear drug addicts has remained at approximately the same level. The number of respondents who feel hatred, curiosity, or indifference when encountering these people has fallen. At the same time, the number of respondents who pity, condemn, or hate drug addicts has risen. Comparing the findings reveals the fact that over the entire monitored period, young people are ceasing to be indifferent towards drug addicts; they are more often pitied, but also condemned and hated.

In the event of a partner being addicted to drugs, young people would most often visit experts at pedagogical/psychological advisory centres, consult their parents, or use a crisis hotline. A fifth of respondents would not know what to do in such a situation. Since 1997, there has been a rise in the number of respondents who would consult experts at pedagogical/psychological advisory centres; the number of young people who would ask their parents, friends, or fellow pupils for advice has fallen. The number of respondents who would use a crisis hotline or turn to their teachers for help has remained at approximately the same level. In 1997, most people would have turned to their parents; since 2001, most young people would seek help and advice from experts at pedagogical/psychological advisory centres. Evidently, many young people now understand that problems with drug addiction can only be tackled in cooperation with experts.

A determining factor in drug use is, as in previous surveys, **people's religious orientation**. People of no religious persuasion, or who have no specific opinion on the issue of religion, display a greater tendency towards experimenting with illegal drugs; conversely, **there are much fewer religious believers who have tried illegal drugs (fig. 2.2.15)**. Most Slovak citizens who, according to their own testimonies, are religious believers and have tried illegal drugs are young people throughout Slovakia (26%), followed by young people in Bratislava (22%), while the lowest proportion of such persons is found amongst Slovaks as a whole (18%). In comparison to young people in the Slovak Republic and Bratislava, the Slovak population as a whole contains a significantly higher proportion of people who have no religious persuasion, or no specific relationship to religion, and have never used a narcotic or psychotropic substance.

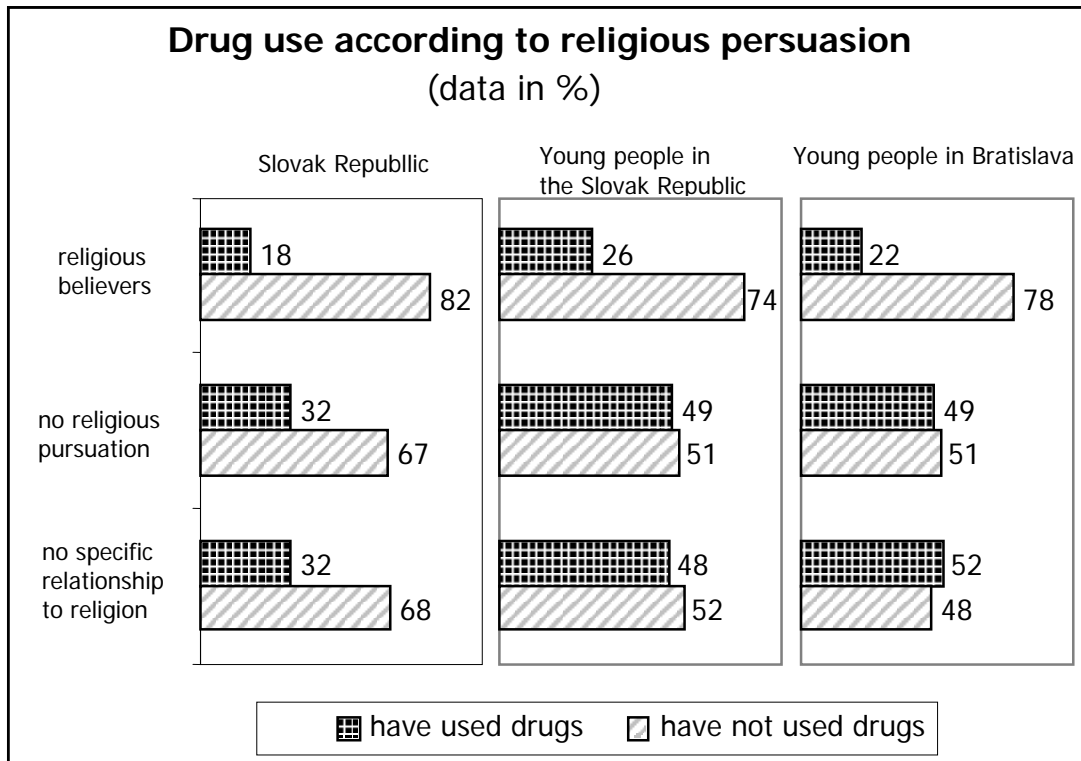


Fig. 2.2.15 Drug use according to religious persuasion
Source: Public Opinion Research Institute at the Statistical Office of the Slovak Republic

The issue of religious belief is also a significant factor-affecting people's personal acquaintance with drug addicts – as it was in previous surveys. In general, citizens with no particular opinion on the issue of religion and non-believers are more likely to know people who are or have been addicted to illegal drugs. Amongst citizens (throughout Slovakia) with no specific relationship to the issue of religion, almost a half (48%) know someone who is addicted to drugs; amongst non-believers, this figure is 45%, while **less than a third (32%) of religious believers** know such a person.

2.3 Drug Use among specific groups

Sex workers. While the general picture of the sex worker in the media, as well the general public is a drug using person, until now there was not done any rapid assessment focused on the community of the sex workers, neither on the drug use in this specific community. Therefore all the data are based on the knowledge of the outreach workers from the projects, which are also reaching the street sex workers. The drug use among the sex workers Odyssey reaches in two projects – outreach project and the low-threshold club is significantly higher than in the general population. The number of sex workers, which are injecting drugs, varies among 5% – 53% depending on the place of the contact³⁷.

As street sex workers, the women and men find themselves in a particularly vulnerable position, at a considerably higher risk of physical and sexual abuse from clients, partners and pimps than indoor workers. Being a sex worker, and possibly a drug user, Roma and/or homeless in the same time, closes many doors, evokes prejudices and denies the access to information and services to which they have a fundamental human right.

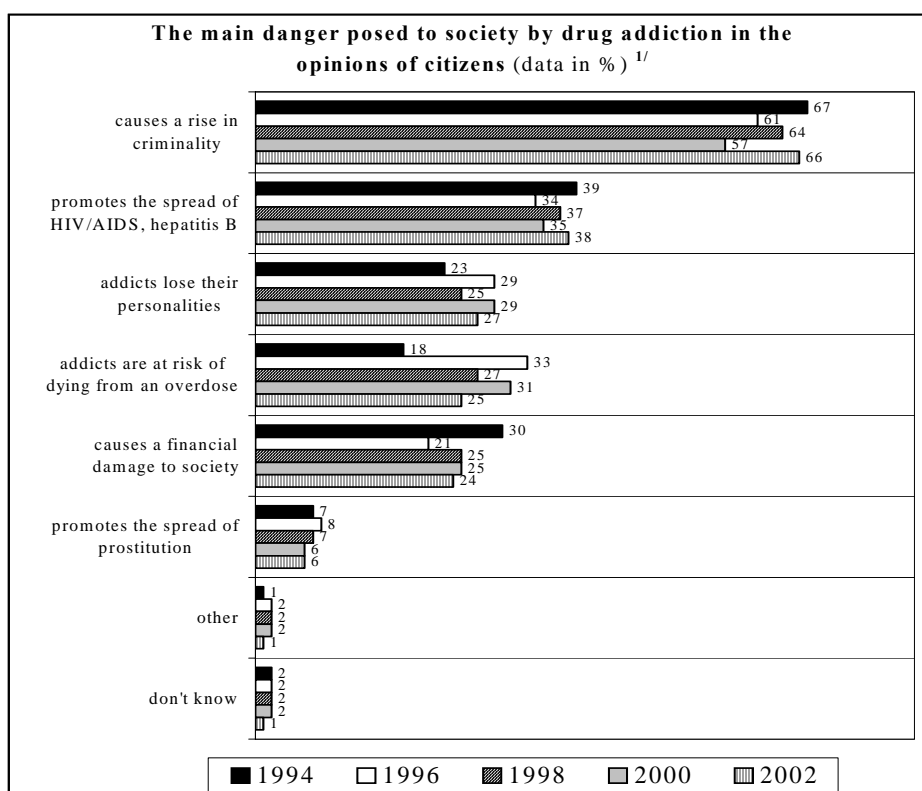
³⁷ As presented by Katarína Jirešová, M.S.W. at UNOCD Meeting on lessons learned on women-specific drug abuse treatment services, 15-17 December 2003, Vienna, Austria

2.4 Attitudes towards drugs and drug users

Drug use causes problems in various areas of society. It is accompanied by negative phenomena such as criminality, the spread of HIV and hepatitis, and above all, it causes financial damage to society as a whole.

As a society-wide problem, drug use cannot be solved in the short term; an appropriate, long-term strategy targeted at the highest-risk population groups is necessary. In addition to prevention, reducing the drug supply, enforcing the law in the fight against drugs, and effective mass media policy, treatment and subsequent reintegration are also an essential part of the fight against drug addiction and dealing. It is precisely the final phase of treating drug addicts, i.e., their social reintegration, that most often encounters opposition from a large section of the public, who often have deeply-rooted prejudices that are not backed up by satisfactory arguments. This public opposition often leads to renewed experimentation with drugs on the part of cured drug addicts.

From this it is clear that the problem of drugs and drug addiction cannot be understood solely from the viewpoint of the individual, but rather in the wider context of society as a whole. The following graph shows people's opinions on the main dangers posed to society by drug addiction according to the latest survey³⁸, as well as a comparison with the findings of previous surveys.



1) As the possibility of answering more than one question was available, total percentages exceed 100

Fig. 2.4.1 Trends in citizens' perceptions of the danger posed by drug addiction between 1994 and 2002

Source: Public Opinion Research Institute at the Statistical Office of the Slovak Republic

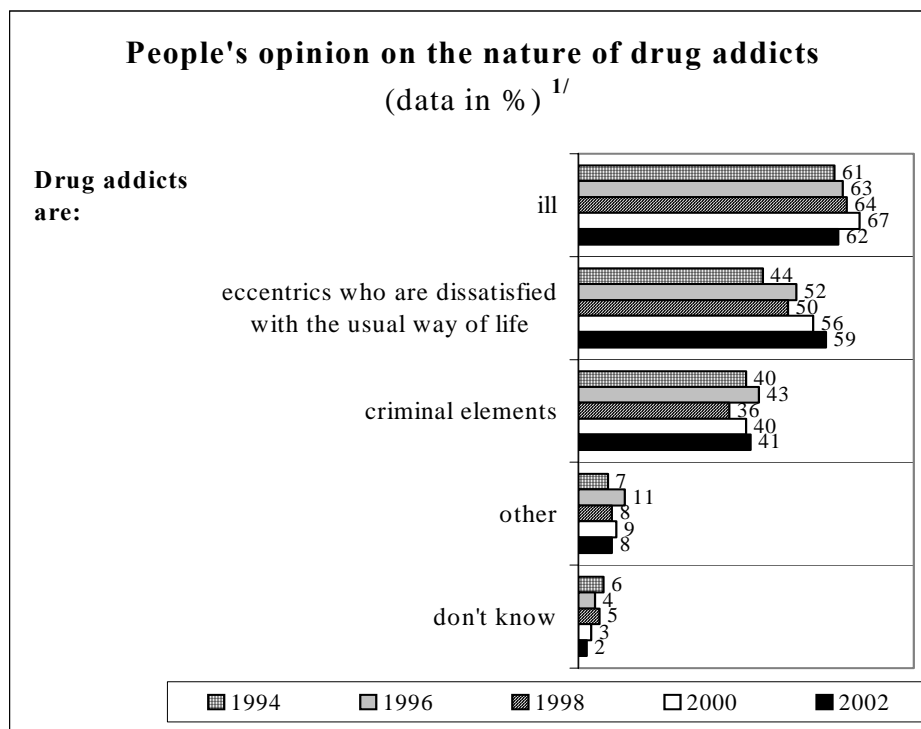
³⁸ Statistical Office of the Slovak Republic. *Public opinion: The extent of drug use in Slovakia and people's opinions of problems linked to drug addiction*, Bratislava 2002.

Compared to 2000, there has been a 9% rise in the number of people who believe that one of the primary dangers that drug addiction poses to society is a **rise in criminality**. Two-thirds of respondents feared a rise in crime connected with drug addiction. In comparison to the previous survey, there was also a rise in the second most common danger posed by drug addiction in the opinions of citizens – the spread of HIV/AIDS and hepatitis B – by 3%. In comparison to 2000, citizens were less inclined in 2002 to perceive the possible death of addicts by overdosing on narcotic or psychotropic substances as one of the primary dangers posed by drug addiction.

Throughout its development, and upon the basis of its individual cultural traditions, every society forms its own, specific attitude towards people who stand out from the majority population due to their lifestyle. This group also includes people who are addicted to drugs, because despite the steady increase in their numbers, they still form a small minority. Even the attitude of the public towards drug addicts differs from country to country, because every society has undergone its own historical development, which is reflected in diverse national traditions.

The public's attitude towards drug addicted fellow citizens can be analysed using various indicators. Surveys concerning the drug problem therefore contain certain questions, of which:

- Some chart the overall public attitude towards drug addicts;
- Some gauge people's opinions on individual forms of addiction;
- And some concentrate on attitudes towards drug addicts from the aspect of relations with colleagues and partners.



1) As the possibility of answering more than one question was available, total percentages exceed 100

Fig. 2.4.2 People's opinions of drug addicts

Source: Public Opinion Research Institute at the Statistical Office of the Slovak Republic

Comparing the 2002 survey with previous findings from 1994 onwards reveals that there have been no significant changes in the public's attitude towards drug addicts over an eight-year period. **There was only a rise in the number of people who believe that *drug addicts are eccentrics who are dissatisfied with the usual way of life*, by a total of 15% since 1994 and by 3% in comparison to the preceding survey, which was carried out in 2000. A stable, and indeed the greatest, proportion of Slovak citizens believe that drug addicts are ill – over three-fifths of respondents stated this in the survey.**

Other answers included the following opinions concerning drug addicts, for example: 'people whose education has been neglected', 'desperate people', 'a product of society', 'individualists', 'people of weak character', 'people escaping from the real world', 'people who need help, but do not know where to find it', 'children from rich families, who do not know what to do with themselves', 'people who cannot find their place in life', 'people who terrorise those around them', etc.

Respondents who believe that **drug addicts are ill** were found to a greater extent than the Slovak average amongst people of Hungarian nationality (77%), university educated people and employees (65% each), people living in agglomerations with 2,000 to 10,000 inhabitants (66%), respondents from the Banská Bystrica and Prešov Regions (67% each), and from the aspect of family status, amongst divorced people (70%).

Respondents who believe that drug addicts are **eccentrics** who are dissatisfied with the life led by most people in society were found to a greater extent than the Slovak average amongst people with a university education (65%), manual workers (63%), students (66%), people living in the Žilina (63%) and Košice (65%) Regions, and again, from the aspect of family status, divorced people (64%). Of the two-fifths of people who believe that drug addicts are **criminal elements**, a greater proportion than the Slovak average was found amongst respondents aged 60 and over (52%), people with only basic qualifications (47%), manual workers (46%), people living in the Trenčín Region (49%), and widows/widowers (50%).

Since 1996, **surveys on drugs have included questions aimed at determining the opinions of Slovak citizens concerning the need for priority measures in anti-drug policy.** When answering these questions, citizens declare which measures they feel would be most effective in halting the spread of drug addiction. Data obtained in 2002, and their subsequent comparison with the findings of previous surveys, revealed the following facts:

- As in previous surveys, in 2002, citizens believed that the most effective measures in the fight against the spread of drug addiction are **strict anti-drug laws and an intensification of activities on the part of the police and customs officials** with regard to drugs. Despite a slight decline in the likelihood of these measures being regarded as priority measures in the fight against drugs, over half of Slovak citizens still believed them to be the most effective – in 2002, 56% of respondents highlighted the effectiveness of strict anti-drug laws (in 1996, this figure was 63%), while 55% of respondents (64% in 1996) regarded the increased activity of state law enforcement authorities to be an effective measure in the fight against drugs.
- Over two-fifths of respondents to the survey once again cited prevention measures against the spread of drug addiction as being the most effective in the fight against narcotic and psychotropic substances – **school drug education programmes.** It is interesting that exactly 41% of respondents highlighted the effectiveness of these programmes in every single survey.
- The proportions of other measures cited for the fight against the spread of drug addiction hardly changed at all in comparison with preceding surveys.

One interesting aspect is the differentiation of individual anti-drug measures with regard to their categorisation among various methods of fighting against narcotics – **in the opinion of citizens, the two most effective measures in the fight against drugs essentially**

concern law enforcement; measures in the field of prevention took second place – in addition to the cited drug education programmes in schools, these included campaigns targeted at the risks posed by drug use; these were followed by measures aimed at treating drug addicts – their compulsory or voluntary treatment, together with financial and social aid for addicts. **Only 5% of respondents believed the legalisation of soft drugs to be an effective method of fighting against the spread of drugs**, a proportion comparable to that found in previous surveys.

Table 2.4.1 presents an overview of the opinions of individual groups of respondents on the most effective methods employed in the fight against the spread of drugs. They are compared with data gathered in previous surveys concerning the drug problem, which included a question aimed at ascertaining the effectiveness of individual anti-drug measures.

Measures that should be taken to prevent the spread of drug addiction, according to public opinion (expressed in %) ^{1,2}					
		1996	1998	2000	2002
Increased activity on the part of the police and customs officials	Slovak Republic	64	63	57	55
	Young Slovaks	58	55	50	48
	Young people in Bratislava	58	64	50	51
Stringent anti-drug laws	Slovak Republic	63	62	58	56
	Young Slovaks	51	54	47	47
	Young people in Bratislava	51	57	53	45
Drug education programmes in schools	Slovak Republic	41	41	41	41
	Young Slovaks	46	44	46	41
	Young people in Bratislava	48	41	45	43
The compulsory treatment of drug addicts	Slovak Republic	30	28	29	29
	Young Slovaks	26	26	25	27
	Young people in Bratislava	25	29	29	27
Campaigns highlighting the risks associated with drug use	Slovak Republic	22	21	27	25
	Young Slovaks	27	27	28	30
	Young people in Bratislava	31	31	29	33
The voluntary treatment of drug addicts	Slovak Republic	14	13	13	13
	Young Slovaks	18	15	16	18
	Young people in Bratislava	16	16	17	15
Financial and social assistance for drug addicts	Slovak Republic	10	11	8	8
	Young Slovaks	16	15	14	11
	Young people in Bratislava	17	13	11	12
The legalisation of soft drugs	Slovak Republic	5	4	6	5
	Young Slovaks	8	8	11	10
	Young people in Bratislava	11	10	10	14

Continue Tab. 2.4.1

Other	Slovak Republic	2	2	2	1
	Young Slovaks	5	3	3	4
	Young people in Bratislava	2	2	2	3
Don't know	Slovak Republic	2	2	2	3
	Young Slovaks	1	3	2	3
	Young people in Bratislava	1	2	1	1
No measures are needed	Slovak Republic	1	1	2	2
	Young Slovaks	1	1	2	3
	Young people in Bratislava	2	0	1	2

1) As the possibility of answering more than one question was available, total percentages exceed 100

Table 2.4.1 People's opinions on ways of solving the drug problem

Source: Public Opinion Research Institute at the Statistical Office of the Slovak Republic

Other responses included, for instance: 'the need to control young people's leisure activities', 'to provide examples by organising meetings with drug addicts', or 'to provide work to drug addicts, so they have no time to take drugs', etc.

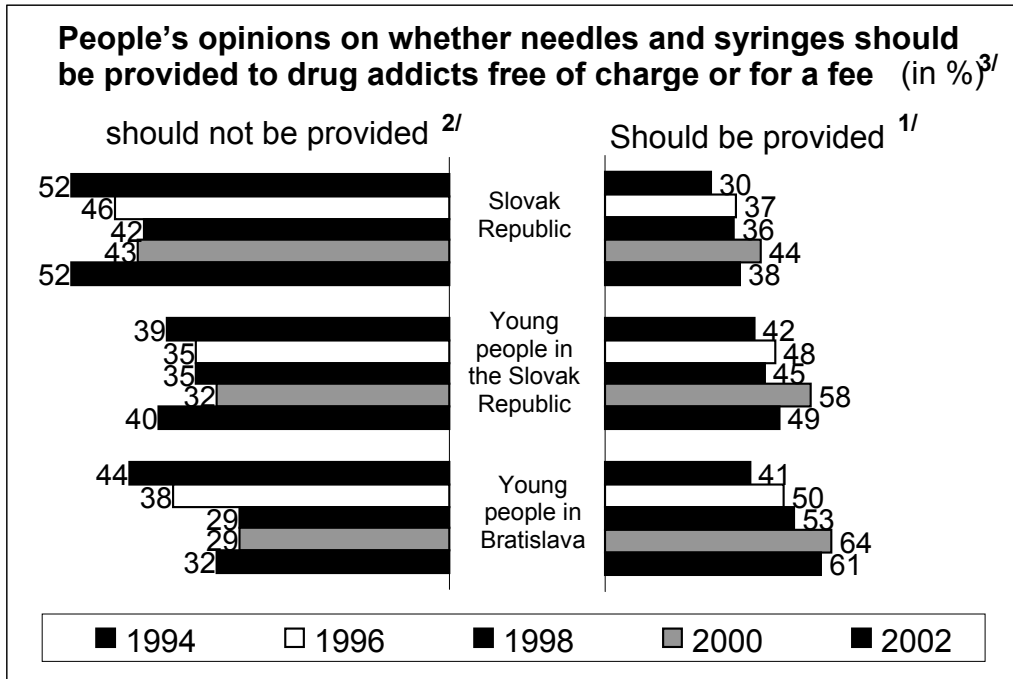
Two contrasting views are held in society with regard to the treatment of drug addicts: one part of the population believes that drug addicts should be compelled to undergo treatment, while the other is convinced that addicts should only be treated if they truly want to undergo such treatment. Both of these attitudes concerning the treatment of drug addicts were registered in the Slovak population when determining people's opinions towards state drug policy.

People's opinions on the treatment of drug addicts (expressed in %)				
		Slovak Republic	Young Slovaks	Young people in Bratislava
1994	Should be compelled to undergo treatment	60	53	52
	Should only be treated if they want to	32	41	39
	Don't know	8	6	9
1996	Should be compelled to undergo treatment	56	45	45
	Should only be treated if they want to	34	46	49
	Don't know	10	9	6
1998	Should be compelled to undergo treatment	58	47	49
	Should only be treated if they want to	32	42	43
	Don't know	10	11	8
2000	Should be compelled to undergo treatment	59	47	47
	Should only be treated if they want to	36	47	48
	Don't know	5	6	5
2002	Should be compelled to undergo treatment	59	49	49
	Should only be treated if they want to	36	46	48
	Don't know	5	5	3

Table 2.4.2 People's opinions on the treatment of drug addicts

Source: Public Opinion Research Institute at the Statistical Office of the Slovak Republic

- The 2002 survey once again confirmed the fact that young people in the Slovak Republic and Bratislava are more likely to believe that drug addicts should only undergo treatment if they truly desire to do so. The ratio of those supporting compulsory treatment to those favouring non-compulsory treatment is almost equal amongst young people in Bratislava. The belief that drug addicts should be compelled to undergo treatment is much more widely held amongst the adult population in Slovakia as a whole.
- With regard to the treatment of drug addicts, there is a significant amount of public **debate as to whether drug addicts should be provided with needles and sterile syringes free of charge, or for a minimal fee**, in order to prevent the transmission of HIV/AIDS, hepatitis, and other diseases. Again, two conflicting opinions exist – while one section of society is convinced that they should be provided to addicts, another part is *a priori* opposed to this measure, which is implemented in order to reduce the harm caused by drug addiction.



1) The responses 'they should be provided' and 'they should probably be provided' have been amalgamated

2) The responses 'they should not be provided' and 'they should probably not be provided' have been amalgamated

3) The response 'don't know' forms the remainder

Fig. 2.4.3 People's opinions on the provision of needles and syringes free of charge or for a fee

Source: Public Opinion Research Institute at Statistical Office of Slovak Republic

- In comparison to 2000, the number of people who believed in 2002 that drug addicts should receive needles and sterile syringes free of charge or for a small fee fell relatively sharply – by 6% in Slovakia as a whole, by 9% amongst young people in Slovakia, and by 3% amongst young people living in Bratislava. There was a corresponding increase in the number of respondents opposed to drug addicts receiving needles and sterile syringes free of charge or for a small fee, in order to prevent the transmission of HIV/AIDS, hepatitis B, and other contagious diseases.

In addition to the findings of surveys by the Public Opinion Research Institute at the Statistical Office of the Slovak Republic presented above, **the Institute of Information and Prognoses of Education have also ascertained the attitudes and opinions of young people towards drugs in regular surveys³⁹.**

³⁹ See Part 2.2 Drug use amongst school pupils and young people.

3. Prevention

Central role in the drug demand reduction is played by prevention at different levels – universal/primary prevention, secondary prevention and tertiary prevention – depending on the target groups concerned.

Universal prevention is aimed at the general (usually young) population, e.g. school population, without focusing on specific risk groups, while selective prevention targets vulnerable groups, and indicated prevention is focused on vulnerable individuals.

In general, **measures taken in the drug prevention area pursue the objective of reducing the number of persons that come into contact with the use of drugs or – more frequently – aim to defer the use of drugs and thus to at least mitigate the drug problem⁴⁰.** Drug prevention also includes education about drugs and their dangerous effects, but is not limited to it. In fact, the focus on specific drugs constitutes only a smaller part of drug prevention. In an ideal case, prevention policy, planned and implemented from the public health perspective and designed to secure essential and cost-effective universal prevention for a large target population, should be complemented with more intensive tailor-made interventions, focused mainly on vulnerable groups and individuals. Drug policy of the Slovak Republic pursues essentially the following objectives: Prevention of drug addiction and improvement of availability, quality and effectiveness of healthcare for drug users; construction of preventive facilities, centres for the treatment of drug dependencies; implementation of various preventive programmes such as those for children and young people, women and mothers with children, or persons serving imprisonment sentences; reduction of negative social and health impacts; surveys and gathering of data on the prevention of drug addictions; training of qualified personnel, etc. **Implementation of drug prevention activities in the Slovak Republic is pursued as a priority by three sectors – education; labour, social affairs and family; and health.**

No substantial changes took place in the period of 2000 – 2003, when all the above systems were developed in conformity with the National Programme for the Fight against Drugs in the period of 1999 – 2003. **This means that primary prevention programmes were carried out through the network of school and out-of-school establishments under the competence of the Ministry of Education (such as Educational and Psychological Prevention Centres, counselling centres); medium-term treatment continued to be guaranteed by the state through centres for the treatment of drug dependencies; and, finally, a system of social reintegration centres attached in most cases to a treatment facility, operated within the network of NGOs supported partly by the Ministry of Labour, Social Affairs and Family and by the Anti-Drug Fund.**

3.1 Prevention in the field of education

Specific tasks were set out for the education sector in the **Concept of Drug Prevention in the Sector of Education until 2003** (hereafter referred to as 'the Concept'), approved in 1999 by the Minister of Education and subsequently by the Committee of Ministers for Drug Dependencies and Drug Control in 2000. In 2003, the tasks arising from the **Concept** were evaluated and submitted for approval to the Minister of Education with a view to proposing new measures for the period of 2004 – 2007.

⁴⁰ EMCDDA Rhodes, T.-Lilly, R.-Fernández, O. et al.- www.emcdda.eu.int

The concept of prevention in the sector of education covers all aspects of the problem:

- Education and instruction (in pre-school education, in the school system, in extra-curricular activities)
- Active protection of children from social pathologies within the meaning of the Convention on the Rights of the Child – Article 33
- Professional psychological and counselling assistance
- Cooperation with families
- Re-education and social reintegration.

The prevention of drug dependencies and of social pathologies comprises activities implemented at three basic levels:

Universal (primary) prevention at schools and educational establishments aimed to create optimum conditions for healthy development of children; implementation of a system of pedagogical and psychological measures with a view to eliminating the causes of disturbed psychosocial development of children; and activities oriented at an early elimination of emerging problems among children and young people;

Selective (secondary) prevention in the form of special care activities, i.e. professional work with children suffering from problems of psychosocial development or behavioural disorders, programmes designed to prevent the fixation of sociopathic behaviour, cooperation of schools and educational establishments with families and competent institutions with a view to addressing root causes of problems, outpatient and sanatorium-type care, potentially involving short-term placement of children in a diagnosis centre or a therapy/education sanatorium for the purposes of diagnosis or therapy combined with education;

Indicated (tertiary) prevention, i.e. provision of comprehensive professional care to children displaying serious behavioural disorders and symptoms of asocial development, placed in institutional care upon a court's order; it involves re-education and therapeutic approach to children, matching the type and aetiology of disorder.

Prevention of drug dependencies in the school sector focuses on:

- **Monitoring the situation** in drug use among children and young people, carrying out surveys and research
- Ensuring **primary drug prevention** in schools and educational establishments within the process of education and instruction
- **Fostering** the system of **long-term, continuous prevention activities**, which is to be preferred over less effective one-off actions such as lectures, discussions, public education events, moralising or intimidation
- **Professional training** of pedagogical and non-pedagogical staff of educational establishments
- **Organising and extending the range of leisure-time and sports activities**, promoting the work of leisure-time instructors
- **Providing educational and professional assistance to problem children**, children with special educational needs, and children with behavioural disorders
- Ensuring **complementarity between the work of various institutions in the sector of education and their cooperation with institutions in other relevant sectors** (health and social services, police authorities with a view to actively protecting children from negative influences)

- **Establishments of the education sector providing prevention and counselling services** (educational and psychological prevention centres – EPPCs, pedagogical and psychological counselling centres – PPCCs, diagnosis centres – DCs, therapy/education sanatoria – TESs, re-education homes, etc.), with emphasis on the provision of professional assistance, mainly of psychological and re-education nature
- **Completing the development of prevention information system in the sector of education – monitoring, generation, collection and updating of information, preparing national analyses and background documents for the development of new prevention strategies**
- Implementing prevention-oriented projects with emphasis on evaluation in accordance with EMCDDA guidelines
- **Developing and implementing comprehensive prevention programmes both as regards legal and illegal drugs.**

Act No. 279/1993 Coll. on Educational Establishments as amended **provides for the creation of special educational prevention establishments** (educational and psychological prevention centres, diagnosis centres, therapy/education sanatoria) and **counselling services** (educational and psychological counselling centres and special-pedagogy counselling centres).

Although the number of educational establishments – EPPCs, PPCCs, TESs and DCs – did not increase in 2003, the number of their staff grew by 15.4%, especially among the positions of psychologists and social workers. Of 42 EPPCs that operated in Slovakia in 2003, 7 were independent educational establishments (EPPCs) and 35 departments were part of the PPCC structure. They provided prevention of social pathologies, including prevention of drug addiction, and professional educational and psychological assistance to children, teachers and parents.

Each district town of Slovakia has an educational and psychological counselling centre (there are 78 district and 8 regional centres).

The number of clients registered with counselling centres in the 2002/2003 school year was 138,498; they were offered counselling or professional services at single or repeated sessions on an individual or group basis. Of the total number of clients, 19.2% were from kindergartens, 46.6% from primary schools (including special primary schools), 25.6% from secondary schools (gymnasias, vocational schools, secondary vocational apprentice centres, special secondary schools), and 6.4% belonged to the category of others (families, etc.). In the drug prevention field, counselling centres carried out various activities (for more detail see Table 3.1.a). **The number of clients registered with EPPCs in the 2002/2003 school year was 11,406, of which 8,854 (77.6%) were children:** 554 of pre-school age, 2,548 past the age of compulsory school attendance, 5,752 at the age of compulsory school attendance, and 2,552 (22.4%) were parents and other persons (Slovíková, M., Földes, T., 2004).

Drug prevention activities and participants		PPCCs		EPPCs	
		Number of activities	Number of participants	Number of activities	Number of participants
Group activities with clients		2,080	35,395	3,865	49,737
of which	<i>training groups</i>	932	4,135	2,386	14,884
	<i>lectures, discussions</i>	1,148	28,260	1,479	34,853

Services for the teaching staff		2,534	8,236	3,054	8,617
of which	<i>methodology consultations</i>	2,224	3,277	2,694	3,660
	<i>courses, seminars</i>	310	4,959	360	4,957
Training of prevention workers		90	1,052	385	3,407
Other specialised activities		301	8,388	809	23,096
of which	<i>publishing and professional activities</i>	191	4,228	504	6,998
	<i>publicity and information events</i>	90	3,657	258	15,212
	<i>residential-type events</i>	20	503	47	886
Total		5,005	53,071	8,113	84,857

Table 3.1.a Drug prevention activities and participants
Source: IIPE

The cases of pupils experimenting with drugs are followed on the basis of case histories of pupils who contact educational and psychological prevention centres (hereafter referred to as 'EPPCs') for family problems, behavioural disorders, experimenting with drugs, pathological gambling, asocial and antisocial problems, personality or psychological problems, or truancy. In the 2002/2003 school year, experimentation with drugs was present in 2.7% (281) of cases (Table 3.1.b).

	Client's own initiative	Referred by legal guardian	Referred by another person	Referred by school	Referred by a public authority	Total
Family problems	308	507	33	168	56	1,072
Behavioural disorders	104	732	140	1,483	25	2,484
Experimenting with drugs	60	114	9	97	1	281
Pathological gambling	4	20	1	2	0	27
Personality and psychological problems	293	303	45	227	1	869
Asocial and antisocial activities	1	16	8	66	40	131
Truancy	12	64	34	277	11	398
Other	1,917	107	285	2,890	78	5,277
TOTAL	2,699	1,863	555	5,210	212	10 539
%	25.6	17.7	5.3	49.4	2.0	100.0

Table 3.1.b Reasons for seeking assistance of an EPPC
Source: IIPE

Binding Pedagogical and Organisational Instructions, issued by the Ministry of Education for schools and educational establishments and for state and public school administration authorities in the 2002/2003 school year, provide guidance in the area of preventing drug addictions and other social pathologies, and lay down the obligation of schools and educational establishments to observe changes in the behaviour of children and to provide them active protection. Under an agreement concluded with the parents, many schools are authorised to conduct permanent control and monitoring of pupils in the classroom. Moreover, random controls were performed by means of diagnostic tests. In acute cases, parents were summoned to schools, or visits were made to the families of children. Attention was attached to ensuring compliance with the law on the protection of non-smokers in school premises, to the need to appoint one teacher in every fully organised school as a coordinator of prevention responsible for year-round and school-wide preventive measures and activities and for cooperation with other entities and parents, to the duty of schools to incorporate drug prevention measures into their school rules, and to the measures designed to protect children from negative phenomena (in conformity with Article 33 of the Convention on the Rights of the Child). Stress is laid on ongoing and permanent monitoring of pupils and identifying changes in their behaviour (in case of reasonable suspicion, action is taken in conformity with internal instructions and legislation on schools). Problems with experimental use of drugs have usually been addressed as violations of school rules – and dealt with in cooperation with parents. Where appropriate, school management recommended contacting a preventive or counselling centre, examination by and interview with a psychologist, or medical examination. Gross violations of school rules are punished by sanctions, which are graded according to the gravity of violation, the most severe being expulsion from school. In cases of suspected criminal activities, school management cooperates with the police. It has been recommended to carry out preventive actions and programmes based on effective prevention principles (moralising, intimidation, simplified information are counterproductive), and to apply a holistic approach, strengthen education to health and to healthy lifestyle, ethical standards, humanistic attitudes, etc. An essential role has been played by cooperation between schools and educational and psychological prevention centres, and pedagogical and psychological counselling centres; prevention specialists in these centres (psychologists, social workers, special pedagogues) are conducting prevention work and comprehensive prevention programmes for children and pupils, applying a differentiated approach to target groups (preschool children, prepubescent children, pubescent children, adolescents, university students). Preventive activities and approaches include specific focus on working with groups of children and young people at risk, and on applying re-education and psychotherapeutic approaches. This type of work has been conducted by specialised educational establishments – educational and psychological prevention centres (EPPCs), diagnosis centres, therapy/education establishments, pedagogical and psychological counselling centres (PPCCs), and re-education homes for young people.

Drug prevention has been incorporated into mandatory school curricula, mainly into the subjects of biology, ethics, study of society, Slovak language, civics, religious education, etc. Several school-based peer programmes were carried out in 2003, and a number of local or regional events and activities were organised in connection with the European Week of the Fight against Drugs, the World Day of the Fight against Drugs, the World Non-Smoking Day, the Health Week, etc.

These tasks and topical issues of school-based prevention were addressed in the ‘General Information’ and ‘Special Educational Establishments’ sections of the Ministry of Education’s Pedagogical and Organisational Instructions for Schools and Educational Establishments and Public School Administration Authorities in the 2003/2004 school year (hereafter referred to as ‘POI’). Pedagogical and organisational instructions (updated for every school year) are available on the Ministry’s website (www.education.gov.sk).

For illustration, we present excerpts from POI sections related to the development and implementation of prevention activities.

Part I General information and instructions

Information about education and instruction activities of schools and educational establishments

Point 5) *In keeping with the Convention on the Rights of the Child, which entered into force on 6 February 1991 the following measures are recommended:*

- a) *In the drug prevention area, to continuously perform the tasks set out in the Concept for the Prevention of Drug Dependencies in the Sector of Education until 2003, and in the Updated National Programme for the Fight against Drugs in 2003. Directors of schools and educational establishments have a duty to incorporate measures to prevent the dissemination of drugs in the school environment into the school rules. Teachers notify such measures to the parents of their pupils. The management of schools and prevention coordinators continuously inform parents about preventive activities of the school and about the possibilities of helping children at risk, the possibilities of effective prevention, and about prevention and counselling centres located in their territorial area.*
- b) *To organise discussions at primary and secondary schools with a view to teaching children and young people about crime prevention. In keeping with the tasks arising from the Crime Prevention Strategy for the school sector, it is recommended to conduct activities aimed to prevent risk behaviour; to continue applying crime prevention approach as an integral part of the process of education and instruction at all levels and in all types of schools; to lay emphasis on education to legal awareness, democracy, moral values and pro-social feelings.*
- c) *To create conditions for promoting prevention programmes with the aim of eliminating sexual violence, designed for children attending kindergartens, primary and secondary schools.*
- d) *To create conditions enabling children to develop interests, talents and gifts.*
- e) *To provide information about key provisions of the Convention on the Rights of the Child, its principles and objectives, by means of extracurricular and leisure-time projects.*

Point 6) *Under the Convention on the Rights of the Child, schools and educational establishments have a duty to ensure active protection of children against sociopathic behaviour. It is recommended to apply the principle of early prevention also by means of permanent and on-going monitoring of changes in the behaviour of children. In case of emerging problems, it is recommended to resolve them in cooperation with school psychologists, pedagogical and psychological counselling centres, and/or centres for educational and psychological prevention.*

Point 7) *To participate in the fulfilment of tasks arising from the National Health Promotion Programme, in particular in connection with implementing the WHO project on Health-Promoting Schools, in conformity with the conclusions and recommendations of the 3rd National Conference on Health-Promoting Schools.*

Point 8) *In implementing the tasks resulting from the National Health Promotion Programme and in harmony with Council of Europe's Resolution No. 5418/2002 on school-based prevention of drug addiction, it is recommended to promote public health, prevention against civilisation diseases and against threats to public health, to encourage healthy lifestyle of pupils, and to carry out health promotion programmes in all schools.*

Point 9) *In accordance with the principles of the World Health Organisation, it is recommended to continue implementing the project of Health-Promoting Schools, and to organise activities to mark the World Nutrition Day, the Health Week, the World Mental Health Day, the World Day of the Fight against AIDS, the European Week of Work Safety and Health, the European Week of the Fight against Drugs, etc.*

Point 9) *If there are reasonable grounds to believe that a child is exposed to physical or psychological maltreatment, bullying, or risks to moral development, the school headmaster is obliged to immediately raise the problem with the management of the school. If the legal guardian of a child fails to fulfil the measures imposed by the school, the headmaster has a duty to report this fact to the competent social affairs department, to the attending physician – paediatrician, and to the competent police department.*

Point 10) *Directors of schools or educational establishments, as well as heads of state and public school administration authorities, have a duty to ensure the application of Act No. 67/1997 Coll. on the protection of non-smokers in school premises.*

Point 11) *It is recommended to create positions of prevention coordinators (to prevent drug addictions and other social pathologies) in all schools; their tasks will include initiating prevention activities in cooperation with school management, and coordinating prevention as an integral part of the process of education and instruction. In cooperation with the management of the school, prevention coordinators should coordinate and provide methodological guidance in the area of drug education and information to the teaching staff of school. They should prepare school-based prevention programmes and play the role of intermediaries between schools and prevention, counselling and other specialised establishments. They should closely cooperate with educational and psychological prevention centres in the territorial area of the school.*

Point 12) *It is recommended to implement preventive and educational programmes in cooperation with the centres for educational and psychological prevention, respecting and adhering to the principles of effective prevention (because moralising, intimidation, oversimplified information are counterproductive, it is necessary to apply a positive and holistic approach, promote education to health and healthy lifestyle, adequate value system, ethical norms, humanistic attitudes, and assuming responsibility for one's own conduct).*

Point 13) *Prevention of and dealing with problem cases of bullying can be consulted as necessary with trained specialists in the centres for educational and psychological prevention or, in an interactive manner, on the website of the citizens' association Child Protection Centre (www.ochranadeti.sk).*

Educational and psychological prevention centres should:

1. *Continue providing professional psychological and psychotherapeutic assistance to children, parents and teachers of children coming from educationally or socially disadvantaged environment, and to children with disturbed psychosocial development; address their problems through early psychological intervention and, if necessary, cooperate with healthcare and social care establishments.*
2. *Educational and psychological prevention centres should guarantee professional and effective prevention programmes in their territorial areas. They are recommended to focus on the prevention of all social pathologies (prevention of behavioural disorders, drug addictions, bullying, aggressiveness, suicidal behaviour, sexual abuse, truancy, etc.).*
3. *It is recommended to implement drug prevention programmes with focus on the evaluation of projects in accordance with EMCDDA's Guidelines for the evaluation of drug prevention.*
4. *It is recommended to implement peer programmes in accordance with Minimum Principles for Implementing Prevention Programmes, developed by the Research Institute for Child Psychology and Pathopsychology.*
5. *Educational and psychological prevention centres, in cooperation with methodological and pedagogical centres in their territorial area, carry out 40-hour in-service training of teachers – prevention coordinators, and provide also other types of methodological assistance and supervision for teachers – prevention coordinators in their territorial area.*

6. *It is recommended to organise prevention activities in harmony with WHO recommendations, e.g. in the framework of the European Week of Work Safety and Health, and the World Day of Mental Health, with emphasis on stress prevention and on building mental endurance.*
7. *In conformity with Council of Europe's Resolution No. 5418/2002 on school-based drug prevention programmes, it is recommended to carry out activities aimed at promoting health, healthy lifestyles and acquisition of participation and communication skills.*
8. *In the light of Council Recommendation 2001/458/EC and in conformity with the National Action Plan for Addressing Alcohol-Related Problems, it is recommended to pay attention to Community prevention plans and activities with the aim of preventing risks connected with the use of alcoholic beverages by students, as well as the smoking prevention programme.*
9. *Methodological guidance and further training of specialised staff of educational and psychological prevention centres is provided by the Research Institute of Child Psychology and Pathopsychology.*
10. *Peer programmes should respect methodological principles for implementing peer programmes, issued for relevant authorities and NGOs working with children and young people.*
11. *A questionnaire screening method (Research Institute of Child Psychology and Pathopsychology, 2002) is recommended for identifying children with behavioural problems.*
12. *It is recommended to follow professional journal 'Prevenia' published by the Institute of Information and Prognoses of Education.*

Prevention-oriented procedures and activities incorporated into the Concept for School-Based Prevention of Drug Addiction respect the following principles:

- Provision of professional assistance in accordance with the needs of children
- Adherence to the early prevention principle
- Individual approach to children
- Improved information of children and parents about the risks of drug use and effects of social exclusion on individuals.
- Use of the positive impact of peer programmes.

As regards institutional arrangements, the following organisations that belong to the Ministry of Education's sector operate at the national level:

- **The Institute of Information and Prognoses of Education** (develops the drug information system, performs drug-related analyses, surveys and research).
- **Methodological and pedagogical centres** (train teachers in effective methods of school-based prevention).
- **The Research Institute of Child Psychology and Pathopsychology** (performs surveys and analyses, trains specialised personnel of prevention and counselling establishments).
- **The National Institute for Education** (evaluates pedagogical documents and teaching texts on the prevention of drug addictions).

At the regional level, prevention is performed in particular by: kindergartens, primary schools, secondary schools, special schools, universities – especially those providing the training of teachers, educational establishments – educational prevention centres or counselling centres; leisure-time facilities – school children's clubs, leisure-time centres.

Cooperation with NGOs, municipalities, health and police authorities. (Objectives of the education and instruction process include enhancing the quality of life, promoting pro-social orientation and healthy lifestyle of individuals, stressing mental health and importance of protection of one's own health, and meaningful leisure-time activities as an important drug prevention alternative.)

Professional counselling and prevention are offered to children, parents and teachers in district towns of Slovakia through **pedagogical and psychological counselling centres**.

There are several primary and secondary schools at each district. Every school appoints a **teacher to act as a coordinator for the prevention of drug addictions and of other social pathologies**. Teachers – prevention coordinators cooperate with school management in coordinating and providing methodological guidance to the pedagogical staff in the drug prevention and information area, and inform parents about drug prevention measures taken by the school. Coordinators cooperate with the teaching staff in the development of annual prevention programmes for every school year, and act as intermediaries between their schools and prevention, counselling or other professional establishments.

Coordinators conduct prevention activities in close cooperation and consultation with the educational and psychological prevention centre in their territorial area, with a view to applying the principles of effective prevention (positive and holistic approach, education to health and healthy lifestyle, adequate value system, ethical norms, humanistic attitudes and assuming responsibility for one's own conduct).

Active protection of children – directors of schools or educational establishments incorporate the measures designed to combat the spreading of legal and illegal drugs in the school environment into the school rules.

Cooperation with parents – parents are regularly involved in the activities of the school. **Participation in school activities takes the form of regular 'teacher-parent meetings'**. Schools, as well as prevention and counselling centres in the sector of education, organise discussions for parents. They organise also a number of activities involving both parents and children.

Teachers inform parents about the measures taken by the school. School management and prevention coordinators inform parents about preventive activities of the school and about the possibilities of helping children at risk, the possibilities of effective prevention and assistance, and about prevention and counselling centres situated in their territorial area. When a pupil displays early signs of problem behaviour, the first intervention is performed by the class teacher or the teacher – coordinator. If it is apparent that professional help is required, the school contacts the competent prevention or counselling centre in the region. Psychological intervention is subject to the consent of parents or legal guardians.

In the area of prevention of social pathologies, schools have been reinforcing the anti-drug climate using accessible means. Thus, some schools carried out comprehensive prevention programmes and projects, such as the WHO project of 'Health-Promoting Schools', the national programme on 'The road to emotional maturity', the project 'Before it is too late', 'School without alcohol, cigarettes, or other drugs', 'We want to breathe clean air', peer programmes and other projects that respected the regional specificities. Schools devoted special attention to children coming from disadvantaged social settings, children with physical or mental handicaps, and children from Roma communities. Prevention of drug addictions is an integral part of the process of instruction, especially in primary schools.

School-based prevention programmes are usually carried out throughout the entire school year during the classes of ethics, class meetings or various discussions, competitions and classroom or extracurricular activities. Peer programmes are carried out in the form of guaranteed projects. They are implemented in primary and secondary schools by the staff of PPCCs/EPPCs who also provide for the training of pedagogical staff and guarantee compliance with peer programme principles.

Primary schools

Several guaranteed prevention programmes were thus carried out at primary schools, such as 'We want to breathe clean air', 'Addiction to sweets', 'Treasure within us', 'Understanding one another', 'School without alcohol, cigarettes, or other drugs', 'Before it is too late', etc.'

In 2003, copybooks entitled 'Do not destroy your wise body', taking account of the age of pupils, were introduced at the first level of primary schools.

Schools and educational establishments (including kindergartens⁴¹) participate mainly in the WHO project on Health-Promoting Schools. This resulted in the creation and gradual expansion of the 'National Network of Health-Promoting Schools'. As of December 2003, out of a total of 2,082 schools and educational establishments participating in the project, 1,977 (96%) were awarded a HPS certificate (Table 3.1.1). Of the total number of participating schools, 979 (47.0%) are kindergartens, 960 (46.1%) primary schools, 112 (5.4%) secondary schools, and 34 (1.6%) vocational apprentice schools. The project is carried out in schools and educational establishments in all 79 districts of Slovakia (Földes, T., Slovíková, M., 2004).

	Number of schools with HPS certificate
Kindergartens	937
Primary schools	924
Secondary vocational schools	36
Gymnasia	29
Secondary vocational apprentice schools	26
Special primary schools	16
Other (educational establishments)	9
Total	1,977

Table 3.1.1 Number of schools with HPS certificates – the Health-Promoting Schools project
Source: IIPE

Computer-based prevention programmes on alcohol, tobacco, marijuana, other psychotropic substances, street drugs and cocaine developed by Prof. Thomasová were updated in cooperation with the Institute of Information and Prognoses of Education. A supplementary teaching text by authors Zelina and Uhereková and a methodology manual on – **How to be true to oneself? A road programme** – was approved for the 4th grade of secondary schools and for the 8th grade of eight-year gymnasia.

The Research Institute of Child Psychology and Pathopsychology (RICPaP) prepared a methodology material for schools and educational establishments carrying out the 'Road to

⁴¹ *Prevention programs in kindergartens*

These programs were implemented either under WHO Healthy schools project on the country level. To December 2003 there are 937 kindergartens in National health promoting Schools network.

There were several regional projects, before all pro-socially oriented educational and preventive programs under various labels – „Prevention program for children of pre-school age of "Závislosť" (Dependency) agency, „Wide-open school“, „Golden apple“, „Step by step“, „We want to breath clean air“, „Strengthening of physical and mental health of pre-school aged children“, „Sweets as an addiction“.

In various towns in the country, e.g. Košice Banska Bystrica, Liptovský Mikuláš, Poprad, Žiar nad Hronom, there were launched regional pro-social prevention educational programmes for the children in kindergartens.

emotional maturity programme'; peer programmes; a collection of papers on 'Children at risk XI: Health, social and mental state of children and young people, current state and prospects'; developed a 'Medium-term comprehensive concept of educational and psychological activities in schools and educational establishments', 'Model methodological principles for educational and psychological prevention centres', 'Draft minimum methodological rules for peer programmes involving work with children and young people implemented by the staff of relevant institutions and NGOs'. A RICPaP working group presented 'Draft rules for the use of peer programmes by prevention and counselling centres in the system of psychological and educational prevention'.

Supplementary teaching texts such as '**How do I know myself**' (a methodology manual for teachers) were also published in the reporting period. Moreover, drug prevention training was organised for pedagogical and non-pedagogical staff in the sector of education. The 'Health-Promoting Schools' project was implemented in cooperation with the Ministry of Health. Prevention programme on 'Road to emotional maturity' was experimentally verified in primary schools. Documents issued for the professional staff of the sector of education included a '**Guideline for the evaluation of drug prevention**' – a manual for the authors and evaluators of the EMCDDA project; publication by A. Nociar '**Alcohol, tobacco and drugs among university students in Slovakia**', and a '**Peer programme for older pupils**'.

A prevention and educational programme, '**Road to emotional maturity**' (author Š. Matula) continued to be carried out in primary schools also in 2003. The programme was run under professional auspices of the RICPaP, and its progress was overseen by the IPE acting as external evaluator (Slovíková, M., 2004). Training of professional project coordinators was secured at the regional level. Overall, 740 schools participated in the programme (24 of them were eight-year gymnasia); the total number of schools participating in the 'Road to emotional maturity' prevention programme in the four years of its implementation was 3,524. In the 2002/2003 school year, the programme was run in 2,280 classrooms; during the four-year period it was implemented in a total of 9,943 classrooms. **Overall, 176,087 pupils participated in the 'Road to emotional maturity' programme. The number of pupils who took part in the programme in 2002/2003 was 42,504 and the number of teachers implementing the programme was 1,149.**

The 'Road to emotional maturity' programme consists of 10 topics, structured in accordance with the principles of group dynamics. The programme is designed to not only contribute to the gradual building of self-awareness of children, but also to making children gradually experience the most important aspects of emotional maturity. In June 2003, the IPE conducted a survey among the teachers undergoing training for the implementation of the programme. The objective of the survey was to identify the reasons for the teachers' decision to participate in the training organised by a PPCC or a CVPP, as a precondition for implementing the 'Road' programme at their respective levels. Most of the 311 teachers who participated in the survey were class teachers, or prevention coordinators/class teachers. Teachers who participated in the training were motivated by the desire to learn something new, as well as by their specific interest in the given problem area.

Secondary schools – all types of schools (gymnasia, vocational secondary schools, vocational apprentice schools)

Teaching materials used in secondary schools and in eight-year gymnasia include **supplementary teaching texts (STT)** on '**How to be true to oneself?**' written by authors Zelina and Uhereková for grades 1 to 4 of secondary schools and gymnasia, and approved by the National Institute for Education.

Prevention-oriented computer programmes developed by Prof. Thomasová (for alcohol, tobacco, marijuana, other psychotropic substances, street drugs and cocaine) are distributed to all secondary schools in Slovakia, and are also available to primary school pupils.

However, their use in the teaching process is **limited due to the lack of computer equipment in schools**. Several regions published their own methodology materials, didactic aids, publications and videotapes.

Schools and educational establishments conducted prevention-oriented activities throughout the entire school year. Schools are building prevention issues into their annual prevention plans, thematic action schedules, plans of prevention coordinators, and into the plans of subject commissions. Prevention issues are addressed mainly through the following subjects: ethics, civics, natural history, chemistry, biology, and also at classroom meetings. Pupils and their parents are regularly informed about the measures taken by the school to counter the dissemination of drugs. Schools inform parents about the possibility of using the services of leisure-time, prevention or counselling establishments. In the reporting period, secondary schools implemented a **Pupils' Personality Development Programme** with focus on drug prevention by author V. Hybenová. The project designed for the target group of secondary school students was carried out by professional staff of regional pedagogical and psychological counselling centres (hereafter referred to as RPPCCs) by means of training teachers – prevention coordinators in secondary schools, and subsequent implementation of individual components of the programme, in particular in the teaching of ethics. The programme received a positive response, especially because of the diversity of topics bearing on drug addiction and the mode of its presentation – pupils appreciate the substantive character of the programme, because they are often over-saturated with information.

In 1999 and 2002, the **State School Inspection Service (SSIS)** performed targeted inspections in primary schools to identify the level of drug prevention. Inspection reports concluded that the prevention of drug addiction is gradually becoming an integral part of the process of education and instruction in primary schools. The standard of primary prevention was evaluated as good in most and as satisfactory in a few districts. The education sector devotes adequate attention to combating drugs by means of drug prevention activities.

Various activities were performed with the participation of self-governing authorities, NGOs, parents, municipal representatives, and sponsors.

The Ministry of Education approved the following supplementary teaching texts for primary schools and secondary schools in the drug prevention area:

- For the 1st level of primary schools – C. Raynerová: 'Do not destroy your wise body'
- For the 2nd level of primary schools (grades 5 to 9) – supplementary teaching texts by authors Kašparová, Houška, Uhereková: 'How do I know myself?'
- For secondary schools and eight-year gymnasias – texts by Zelina and Uhereková: 'How to be true to oneself?' The texts are used in a comprehensive manner, in particular in such subjects as biology, ethics, Slovak language, civics, history, classroom meetings and/or optional subjects for secondary schools (oncology education), or in the framework of special-interest groups – extracurricular activities.

Professional training of pedagogical and non-pedagogical workers in education sector

The task of organising training activities and special courses is performed **mainly by methodological and pedagogical centres (MPCs), the Research Institute of Child Psychology and Pathopsychology (RICPaP), the National Institute for Education in cooperation with regional centres for educational and psychological prevention (EPPCs), and various non-governmental organisations** (in-service training of approx. 40 hours; specialisation training of 1 to 3 years; thematic blocks for managerial staff; workshops; social and psychological training, supervision, etc.). **The RICPaP in cooperation with Anti-**

Drug Fund organises training for regional coordinators of peer programmes; participants come from all regions of Slovakia.

In-service training (designed mainly for teachers – coordinators for the prevention of drugs and of social pathologies) of 40 – 60 hours is split into two blocks.

- **Theory block** (work of coordinators in schools, psychological aspects of their work, creation of favourable social climate in schools, healthy lifestyle, psychological characteristics of individual stages of personal development, the most frequent development disorders, differentiation of drugs, criminal law aspects, information about well-tested prevention-oriented programmes in the sector, prevention of violence, bullying and aggressiveness)
- **Experiential block** – training of practical skills (child self-expression and self-development techniques, communication, assertiveness, empathy and pro-social skills, controlling aggressiveness, coping with stress and with difficult life situations, practical steps to prevent smoking, alcohol, drug addiction).

Further in-service training is organised for teachers – prevention coordinators, managers (school directors and their deputies). Further specialised professional training is organised for the staff of prevention, counselling and educational establishments.

Residential training courses and educational events are also organised for regional coordinators of peer programmes from all regions; employees of prevention and counselling services in the education sector attend courses of several days devoted to universal or selective drug prevention, courses on using group forms in prevention activities involving children and young people, etc. Emphasis is laid on providing quality training to teachers – prevention coordinators, management staff of schools, teachers of the subjects of ethics, civics, religion, educators in youth homes, kindergarten teachers, vocational training instructors, and educational advisors.

In 2003, the Methodological and Pedagogical Centre (MPC) in Prešov carried out a 40-hour project of continuous education for coordinators. The project comprised a block of theoretical information about coordinator's work, and an experiential learning block aimed to train practical skills that coordinators need for working with pupils and young people. The continuous training programme is updated and supplemented with new information arising from practical experience of schools and educational establishments.

Methodological sheets and materials for coordinators include, e.g. 'Information for coordinators of drug and other social pathology prevention' (Nos. 11 and 12), Blahutková, M.: 'Psychomotorics for everybody', 'Healthy school: Collection for 8th grade', Bosá, M.: 'How to prevent violence in gender and couple relations?' Team of authors: 'Helping hand'.

In the reporting period (2003), the training was provided to 145 prevention coordinators of primary, secondary and special primary schools from the Prešov and Košice regions, and to 26 coordinators of health-promoting kindergartens. This type of basic training is provided to all coordinators.

The Methodological and Pedagogical Centre at Tomašíkova Street in Bratislava conducted the following training activities:

Specialised innovations study for drug prevention coordinators under the project 'Tomorrow will be too late'. The training was provided to three groups: Trnava (32 applicants), Piešťany (30 applicants), Topoľčany (31 applicants). The number of trainees in December 2003 was 86; 8 participants completed the training in 2003 (3 – Topoľčany and Piešťany, 5 – Trnava); the total number of those who completed the training to date is 19.

Continuous training for kindergartens aimed to prevent sociopathic behaviour in the society was provided under the project 'I like me, I like you'. This training includes the following topics: Emotional self-awareness; Development of communication skills; Creating realistic self-perception; Building self-confidence and self-awareness; Empathy; Creativity;

Creating atmosphere of security and comfort; Personal integrity. Training was offered in the 2002/2003 school year to 2 groups at Levice and Piešťany; 51 of 60 participants completed the training. The project comprises 80 teaching sessions.

A discussion group on problems of young people met on 31 July 2003 at the MPC Training Centre of Budmerice; during the 2-hour session, its 30 participants received methodological instructions for using the drug-prevention CD ROM.

In 2003, the **MPC of the city of Bratislava** organised specialised innovation training of 200-hour on 'Before it is too late' for 41 participants, continuous training for 452 participants, and specialised skill training for 12 vocational training supervisors of secondary apprentice schools, for 25 educators of educational establishments. In all, it organised 577 training events for 1,325 participants. The Methodological and Pedagogical Centre of the City of Bratislava published the following methodological materials on the relevant topics:

Kováčik J., 'The right to life', MPCMB, 2nd edition, 2003

Kováčik J., 'Refugees in the today's world', 2nd edition, 2003

Vargová D. - Pilátová N., 'How to teach environmental ethics', MPCMB, 2003

Special pedagogy counselling – information bulletin VII, MPCMB, 2003

Bratská M., 'Communication: advantages and barriers, or art of communication', MPCMB, 2003

Team of authors, 'Observation: One of the forms of diagnosing the child's development', MPCMB, 2003

Team of authors, 'Child personality development: Strategies and methods', MPCMB, 2003

The Methodological and Pedagogical Centre in Banská Bystrica carried out the following training activities in 2003: Drug prevention using computer-assisted instruction programmes in classes of ethics for 43 participants, specialised skill training on ethical education for 23 participants, cyclic training of drug prevention coordinators for 24 participants, cyclic training on pro-social education for 82 participants, pro-social role of teachers in coping with stress situations in the school system for 39 participants, coordinators of sociopathic behaviour prevention for 43 participants, street law for 21 participants.

The **RICPaP** organised two residential training courses in 2003 for regional coordinators of peer programmes from all over Slovakia; 3 and 4-day supervisory training courses for school sector employees (mainly those of EPPCs and PPCCs) on universal and selective drug prevention; training courses on group forms of prevention work with children and young people for new staff of PPCCs and EPPCs.

At the university level, drug prevention issues have been incorporated into several study programmes. Prevention of addictions is an increasingly frequent topic of seminar papers. **Drug prevention issues are incorporated into core subjects for all 1st and 2nd year master students of teaching.** Special efforts were made last year to update the broad offer of educational activities contained in the 'Catalogue of further training activities for teachers of primary, secondary and special primary schools'.

Leisure-time activities

Attention is devoted also to special-interest activities, enhancement of creativity and talents of pupils through extracurricular activities, school children's clubs, special-interest centres, and leisure-time centres. Leisure-time activities are offered to children and young people **in the Slovak Republic by specialised educational establishments: leisure-time centres (LTC) and school centres for special-interest activities (SCSIA)**; their status is defined in Act No. 279/1993 on educational establishments as amended. **At the end of 2003, 155 active leisure-time facilities were registered with the Ministry of Education (134 LTCs and 21 SCSCIAs).** Leisure-time centres and school centres for special-interest activities

offer a range of activities for children and young people in regular special-interest groups (5,507 groups and 72,151 registered members), occasional special-interest events (27,602 events attended by 1,564,255 children and young people), and school holiday camps (788 camps with 22,280 participants). Leisure-time facilities thus create a number of opportunities for meaningful ways of spending free time, and constitute an effective instrument for education and primary prevention of negative phenomena in the society.

The offer of these facilities attracts mainly children younger than 15 that make up 84% of membership of regular special-interest groups, 75.5% of participants in occasional special-interest activities, and 83.3% of camp participants. Most children and young people are interested in the activities and events involving physical education and sports, closely followed by events in the area of culture and arts – approximately one fourth of children and young people participating in the activities organised by leisure-time facilities choose one of these two areas. Language training takes up a prominent position among regular special-interest activities (11.8%); moreover, the offer has been expanded to include social sciences, natural sciences, science and technology, environmental education and activities involving both children and their parents organised on a regular or occasional basis.

Considerable attention continued to be given to educating children and young people through sports. The Ministry is taking steps to make physical education and sports an integral part of a broader education to health protection. In line with the global trend towards healthy lifestyles, the Ministry started to devote considerable attention to creating conditions for physical education and sports activities – with the aim of involving as many children and young people as possible, including pupils with disabilities, in regular sports activities and events. In an effort to create favourable conditions for special-interest activities, the Ministry approved the following projects: ‘Let’s return sports to schools’, ‘Open school in the area of sports’, ‘Sports in schoolyards during holidays’, ‘Unity for pupils’, ‘School milk league’, and financially supported their implementation with approx. 30 million SKK. The objective of these projects was to open schools, gyms and schoolyards for children, young people and general public throughout the year and enable them to actively fill their leisure-time with sports. Many schools and educational establishments carried out a number of events and activities in the framework of the European Week of the Fight against Drugs, the Health Week, the World Day of the Fight against Drugs, etc.

In 2003, the ‘Sports for all’ project received a subsidy of 38,955,000 SKK and citizens’ associations a subsidy of 62,381,000 SKK; 650,000 SKK was allocated to implement the NPF and the Concept.

In the same year, 47 citizens’ associations for children and young people received a subsidy of 56,121,000 SKK.

The Anti-Drug Fund established under Act No. 381/1996 Coll. is a non-state special-purpose fund designed to raise and allocate financial resources in the areas of drug prevention, treatment and social reintegration of drug addicts. In 2003, it provided a subsidy of more than 12 million SKK for 106 school-based prevention projects.

Research

Systematic research in this field is conducted by the Youth and Sports Department of the Institute of Information and Prognoses of Education, and the Research Institute of Child Psychology and Pathopsychology. The IIPE has surveyed opinions and attitudes of young people concerning the use of legal and illegal drugs since 1995 (focusing on children and young people aged 15 to 26 – representative national data). Smoking habits of pupils of primary and secondary schools have been studied since 2001 (a repeated study was made in 2003) and quantitative (as well as qualitative) data concerning truancy have been collected since 2001. Research projects in this area include ‘Truancy as an expression of problem behaviours in selected districts’, ‘Current status of drug prevention in universities’, and other

research and analysis projects such as ‘Social pathologies among young people in Slovakia’, and others.

The RICPaP monitors the incidence of behavioural problems and possibilities of psychological intervention in risk groups of children and young people. Comenius University in Bratislava – Faculty of Education – is also involved in the development of teaching texts and preventive programmes.

The IIFE is also building a school drug information system (DIS), processes data concerning the implementation of prevention programmes and activities by institutions in the sector of education, develops the content, structures, data collection and relevant software for the registration of data, creates the register of entities and compiles drug prevention statistics.

In 2003, the **IIFE** published several papers based on its research and surveys, papers concerning activities of prevention and counselling establishments, the ROAD prevention programmes, prevention programmes conducted by PPCCs and EPCCs, projects submitted by educational establishments to support their applications for funding from the ADF, etc.

The National Institute for Education (NIE) conducted a representative survey of appropriateness and adequacy of supplementary teaching texts for primary drug prevention in grades 5 to 9 of primary schools. The supplementary teaching text on ‘How do I know myself’ were translated into Hungarian and distributed to schools providing instructions in the Hungarian language. The NIE carried out a survey on ‘Primary drug prevention in secondary schools’ aimed to obtain opinions of students and teachers concerning supplementary teaching texts on ‘How to be true to oneself’.

In 2003, the RICPaP continued to monitor the incidence of behavioural problems in the population of children and young people of Slovakia. The percentage of problem pupil population is 3 to 14%; these children represent approx. 10% of children of the population surveyed. The behaviour of problem pupils is characterised by impulsiveness, propensity to joining problem groups, emotional instability and negativism.

The Institute also carried out a grant project on ‘Psychological prevention and psychological intervention: phases of integrated care for children and young people with behavioural disorders’.

Risk groups of school goers

Quantitative data concerning **truancy and problem behaviours of pupils** of primary and secondary schools are gathered by the **IIFE**, which has been assigned with carrying out long-term monitoring of the situation in this area.

According to IIFE data, the number of unexcused classes per one primary school pupil in 2003 was 3.1: 2.5 unexcused classes were reported for 1st level pupils (aged 6 to 10), and 3.6 for 2nd level pupils (aged 11 to 15). This percentage was 0.9 point (by 22.0%) lower than in the previous year.

	1998	1999	2000	2001	2002	2003	Index 2002/2003	Index 1998/2003
1 st level	1.3	1.7	2.2	2.1	3.0	2.5	0.83	1.92
2 nd level	2.9	3.2	4.4	4.3	4.8	3.6	0.75	1.24
Primary schools – total	2.1	2.5	3.4	3.3	4.0	3.1	0.78	1.48

Table 3.1.2 – Evolution of the number of unexcused classes per 1 pupil of primary school
Source: IIFE

The highest number of unexcused classes was recorded among fifth graders (5 unexcused classes per pupil) of primary schools (0.9 point less than in the preceding year). The situation in this area reflects wide regional disparities. **Extremely high values are reported for the districts of Trebišov (19.4), greater Košice (13.2), and Michalovce (9.99). All these districts are characterised by a very unfavourable social and economic situation, high unemployment, and a high proportion of Roma pupils.**

The number of unexcused classes in secondary schools is also quite variable, ranging from a low value for gymnasium students (0.42 classes), through a higher value for students of secondary vocational schools (1.17 classes), see Table 3.1.3, to a very high value of 8.04 classes for students of secondary vocational apprentice schools (in the latter case, students aged 15 to 19). The value of this indicator also varies among administrative regions: its highest value for secondary vocational schools was recorded in the Bratislava region with 1.72 unexcused class per one student (0.55 higher than Slovakia's average) and for secondary vocational apprentice schools in the Košice region with 11.29 classes (3.25 higher than Slovakia's average). Equally high values were found in the Bratislava region (10.65 classes, i.e. 2.6 more than the Slovak average).

Year	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Slovakia – total	0.42	0.38	0.40	0.43	0.42	0.39	0.35	0.43	0.42	0.46	0.42

Table 3.1.3 Unexcused classes per one gymnasium student
Source: IIPE

Year	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Slovakia – total	0.78	0.75	0.74	0.83	0.80	0.79	0.79	1.04	1.09	1.56	1.17

Table 3.1.4 Unexcused classes per one secondary vocational school student
Source: IIPE

The incidence of problem behaviour is reflected in the number of pupils who received an unsatisfactory conduct grade. In 2003, their number was as high as 14,123 (i.e. 2.4% of all pupils); this is less than the year before, although it should be noted that the 2003 school attendance rate was lower because of the decline in the overall number of school-age children. These figures are higher for pupils at the 2nd level of primary schools (12,150, i.e. 86.0% of pupils); for more details see Table 3.1.5

	2001		2002		2003	
	Number of pupils	% of the total number	Number of pupils	% of the total number	Number of pupils	% of the total number
1 st level	2,192	0.8%	2,555	0.9%	1,973	0.8%
2 nd level	13,599	3.8%	13,690	3.9%	12,150	3.7%
Primary schools - total	15,791	2.4%	16,245	2.6%	14,123	2.4%

Table 3.1.5 The number of primary school pupils in Slovakia who received an unsatisfactory conduct grade
Source: IIPE

The percentage of gymnasia students who received an unsatisfactory conduct grade in 2003 was 1.1 %. This figure is even higher for students of secondary vocational schools (see Table 3.1.6 below).

<i>Region/year</i>	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Slovakia – total	2.3	2.1	2.3	2.5	2.3	2.3	2.3	2.8	2.8	3.1	3.2

Table 3.1.6 Evolution of the percentage of secondary vocational school pupils who received an unsatisfactory conduct grade
Source: IIPE

These data suggest that the **most problematic is the conduct of pupils of secondary vocational apprentice schools, as many as 12.3% of whom received an unsatisfactory conduct grade in 2003** (most of them in the Bratislava, Banská Bystrica, Trnava and Košice regions). Compared with 2002, the number of pupils who received an unsatisfactory conduct grade displayed a downward trend; a moderate increase was reported only in secondary vocational schools (by 0.1%) and a slightly higher increase in secondary vocational apprentice schools – by 0.6% (Slovíková, M., Dugovičová, M., 2004).

3.2 Social prevention – the sector of labour, social affairs and family

The role of the state – among other important tasks – is to **adopt measures with a view to creating preconditions for preventing the occurrence and negative consequences of adverse life situations encountered by families and their individual members, and to create the mechanisms for providing support and assistance in such life situations.** The system of **state social support** has been introduced to address certain life situations of individuals and families with children. If individuals or families find themselves unable to deal with their adverse social situation, the state guarantees that they be provided **social assistance.**

Social assistance is provided to persons in social distress (including individuals abusing or addicted to drugs) especially in the following forms:

- **Social prevention, defined as a professional activity whose aim is to prevent and avert the occurrence, aggravation or recurrence of problems in the mental, physical or social development of individuals.** It is provided mainly to help minor children whose education is seriously endangered or impaired, children with behavioural disorders, and children or adults exposed to the risk of drug addiction and other sociopathic behaviour, or persons with impaired health. **Social prevention carried out within the sector of the Ministry of Labour, Social Affairs and Family has mainly the form of secondary or tertiary prevention measures. Social prevention activities are performed, besides self-governing bodies, mainly by social affairs departments of the offices for labour, social affairs and family – by a total of 46 offices with 124 social prevention workers for minors, and 64 social prevention workers for adults.**
- **Social protection** aimed on the protection of the rights and legally protected interests of citizens, especially of minor children, includes:
 - 1) Educational activities
 - 2) Organisation of foster family care
 - 3) Decisions about immediate placing of a child in care that substitutes for the parental care if there is nobody to take care of a child, or if the existing environment poses a serious threat to the life or health of the child; decisions concerning educational measures if

parents or other persons responsible for the child's education or other persons endanger or jeopardize such education, or seriously violate their rights and responsibilities mainly by failing to create conditions as necessary for education, upbringing and all-round development of a child in accordance with the child's abilities, or if the child displays behavioural disorders,

- 4) Other activities, including the role of 'collision guardians' of minor children; acting as legal guardians of minor children; filing motions with courts seeking injunctions to impose or discontinue institutional education, to lift educational measures, to restrict or withdraw parental rights; monitoring the development of children placed under institutional or protective care, taking part in legal proceedings against juveniles; implementing measures taken to protect interests of minor children who are not Slovak nationals; writing motions and proposals related to upbringing and maintenance of minor children; implementing tasks arising from international conventions on the rights of children. A total of 332 employees of social affairs departments of local state administration authorities were assigned with the above tasks in 2003.
- **Social counselling** focuses on the identification of the extent and nature of social distress and of its root causes, on the provision of information about the means that are available to address material or social distress, and on providing guidance concerning the choice and use of various forms of social assistance; social counselling is provided mainly to families. Of the total of 9,456 counselling interviews conducted in 2003, approximately 6% concerned problems rooted primarily in the abuse of alcohol and other drugs.
 - **Social services** are specialised activities designed to help deal with social distress, provided in the natural family environment of beneficiaries or in social services establishments. Social prevention, crisis intervention and social reintegration are mainly provided by crisis and social reintegration centres, shelters and sheltered housing facilities.

Basic social prevention activities include: **identification** (in cooperation with schools, families, police, communities); **remedial actions** (long-term actions designed to remedy educational situation of minors); **rehabilitation and social reintegration activities** (creation of conditions for integration into the society, placement on the labour market, restoration of family relationships, mitigation of the consequences of drug consumption). Social prevention also includes the organisation of educational and recreational activities, and post-penitentiary care for ex-prisoners.

Social prevention has also **other forms** such as:

- **Work in the open environment** – working with clients in their natural social environment, rehabilitation of families, working with homeless drug addicts, prostitutes, etc.
- **Outpatient forms of work** – mainly the work of counselling and psychological services centres with individuals, couples, and families (46 regional and 14 branch offices),
- **Residential services** – provision of care mainly in *social reintegration centres for drug addicts* (there are 16 registered social reintegration centres with a capacity of 236 places), *crises centres* (24 centres with a capacity of 278 'crisis' beds), *shelters* (60 shelters with a capacity of 1,130 places for homeless persons, victims of family violence, and young people after the completion of institutional or protective education), and *sheltered housing facilities* – the so-called 'half-way houses' (6 facilities with a capacity of 44 places).

Of a total of 30,786 *children* who benefited from social and legal protection or social prevention activities performed by social affairs departments in 2003 (compared with 29,581 children in 2002), *social prevention was provided to 21,729 children* (compared with 21,999 children in 2002) with the aim to address their sociopathic behaviour or behavioural disorders (i.e. 70.1% of the total number of children). **As regards children targeted for social**

prevention mainly because of primary drug abuse, social affairs department provided assistance to 285 minors (91 of them younger than 15).

In the area of field social work, *80,021 investigations in families* were performed in 2003 (*in connection with 51,888 cases*), and *19,461 clients visited the establishments* in connection with 14,467 cases (in 2002 – 80,393 and 20,732, respectively); on the average, *1.54 investigation visits in the client’s natural environment were effected in connection with one case (compared with 1.87 in 2002)*, and the average number of clients’ visits to establishment in connection with one case was 1.34 (compared with 1.67 in 2001).

A number of non-state entities are also active in the area of prevention of drug addictions; they operate on the basis of authorisation to perform social prevention, provide social counselling or carry out specific social prevention protection activities. On the whole, out of 131 applications submitted last year, the authorisation was granted to 94 applicants.

Risk groups and family

An important role in social prevention, social counselling and therapy is played by *46 regional CPSCs and 14 branches* (counselling and psychological services centres for individuals, couples and families) that worked mainly in the area of indicated or selected prevention of drug addictions and other sociopathic behaviour – in particular through cyclic events targeting young people from primary and secondary schools, risk groups and endangered families and social groups, and addressing personality and social consequences of sociopathic behaviour. **CPSC services represent the instrument by means of which the state (or the sector of the Ministry of Labour, Social Affairs and Family) provides assistance in the areas of:**

- Preventive psychological and psychosocial care for mental health of citizens;
- Prevention of sociopathic behaviour in the society;
- **Support and assistance to families, including therapy provided to families that have a family member with addiction.**

CPSCs have a special, almost unique position in the area of marital/partnership, family, and divorce counselling. They provide both psychological counselling and therapy in individual, marital, family, and other relationship problems. They focus on population groups that face an increased risk of partner or family problems, unemployment, addictions, social exclusion, etc. The issue of drug prevention and treatment (focusing on individual, group and family therapy) represented an important part of CPSC activities besides personality-related, partner, family, divorce or post-divorce problems, or foster care issues.

Specific problems	2003	2002	2001
Manifestations of violence in families	776	771	830
Alcoholism in families	746	688	569
Other drugs	113	173	253
Gambling	8	138	91

Table 3.2.1 Occurrence of social pathologies among CPSC clientele
Source: MLSAF SR

Short-term activities in 2003:

- Implementation of activities in the framework of the comprehensive project approved by the Anti-Drug Fund: '**Child and family in the centre of prevention of addictions II.**' The project focusing on the prevention of addictions, in particular primary and secondary addiction consisted of 22 partial projects carried out by specialists from several regional CPSC offices in Slovakia. Partial projects were organised into 3 blocks:

Block 1 – projects involving the training of specialists on work with families facing problems related to addiction, domestic violence or other sociopathic behaviour, or on family co-addiction problems,

Block 2 – projects aimed on carrying out primary prevention in the field; main target groups were children and young people, and

Block 3 – projects oriented on training peer activists, work with peer groups, programmes for children and educators in children's homes, etc. *Preventive and educational activities* focused on various target groups included lectures, discussions or regular club meetings addressing such topics as education to parenthood, primary drug prevention and prevention of other addictions, healthy lifestyle, and development of personality. In 2003, CPSCs organised a total of 2,113 events for 39,428 participants, 71% of whom were young people (27,917 participants), and the rest were adults.

3.3 Healthcare

The tasks of primary drug prevention and stressing adverse health consequences of drug use are systematically implemented by public health authorities⁴² and general practitioners; primary prevention in the groups of young people facing an increased risk of drugs is also performed by specialised centres for the treatment of drug addictions.

Specialised healthcare personnel systematically participate in joint training and educational activities for pedagogical and educational workers from the Ministry of Education's sector involved in primary prevention of drug addictions. This mainly applies to the training of drug prevention coordinators in schools.

Prevention in risk groups

The Institute of Drug Dependencies of the Bratislava CTDD thus carried out:

(1) A 2003/04 project of primary drug prevention **among the Roma population**, 'Roma Anti-Drug Forum' in Bratislava, carried out on a request of the citizens' association of Wallachian Roma of Slovakia and in cooperation with the association. These activities were mainly oriented on young Roma and their families.

(2) **Over 2,000 pupils of primary and secondary schools of the capital city of Bratislava and the wider region took part in anti-drug education organised by the Bratislava CTDD in 2004.** They came from schools whose teachers perceived a potential risk of drugs for young people and the need for improving information about adverse health consequences of drug use.

In the course of its outreach activities, the CA Odyseus had 7,258 contacts with the target group of drug users and sex business workers; 1,097 persons used outreach services at least once (600 men and 497 women). Although outreach services are provided only in the districts of Bratislava I, II and III, other persons regularly seek them also with permanent residence in Bratislava and by clients from outside the capital. There is,

⁴² <http://www.uvzsr.sk>

however, an increased need to expand outreach activities in the area of syringe exchange also to the fourth district.

145,645 sterile syringes and needles were thus distributed and 119,108 used syringes and needles collected through the exchange service. 11,847 condoms were distributed in the framework of prevention of sexually transmissible diseases.

4. Problem drug use

The goal of the problem drug use indicator is to provide us with as comparable as possible, science-based estimates of more severe patterns of drug use, which are not reliably measurable by surveys. Projects, which would produce this kind of estimates, can be realized on the local, as well as on the national level. The role of this kind of studies is to determine a measure of need for treatment in the population of our country, but also a study to estimate societal costs related to drug-related problems can be based on these estimates. (Wiessing, 2004)

Although these estimates are not very costly, their quality depends on the quality and existence of data entering analyses. The first limitation of our efforts is the fact, that data collection for certain indicators is only in the state of development in our country (e.g. drug related deaths). In Slovakia, there hasn't been any study conducted which would, with the use of verified methods, estimate the population of problem drug users.

Therefore, to work out this estimate, we used all available data that are rather scarce at the moment.

EMCDDA operationally defines problem drug use as:

- Injecting use or long-lasting/ regular use of opiates, cocaine or amphetamines,
- This use has taken place within the last year before the data collection, and
- It has taken place in the age group of 15-64-year-olds.

To get an estimate, which would be more useful for services planning for persons with problem substance use we have broadened this definition to the use of other substances than opiates, cocaine or amphetamines, in case when the person, who is using them experiences problems, and would benefit from some form of professional care.

4.1 Prevalence and incidence estimates⁴³

An estimate of injecting drug users population in the capital Bratislava in the years 1997 – 2001

To estimate the extent of the population of injecting drug users we have used the Truncated Poisson Estimator method based on data from a programme for provision of sterile needles (PPSN) at the Centre for Treatment of Drug Dependencies in Bratislava. This programme was established in 1994. Clients of the programme might have been provided with up to three sterile needles per day and it the programme was open at least 16 hours a day, 7 days a week. For the purpose of estimation, we have used data only from 1997 on, as the programme has been supposedly fairly established and known to injecting drug users (IDU) since then. **Truncated Poisson Estimator is a quite simple method based on the Poisson distribution**, which would, according to frequency 1 and frequency 2 (which are the numbers of persons who have attended the program only once or only twice), estimate the number of „potential programme visitors“ - persons, who attended zero times, which is the hidden population (Hay and Smit, 2003, Hay, 2004).

This method is based on a number of assumptions about which we know that in practice they cannot be fully fulfilled (an assumption of a closed population of IDUs, assumption of the homogeneity of this group, assumption of a perfect identification, which means an impossibility of double counting in different categories, unchanging probability of capture/recapture) and therefore it is necessary to keep in mind a possible erroneousness of this estimate. As it is reminded by Hay and Smit (2003), although the Zelmer estimator has a proved quite good robustness, especially heterogeneity within the studied group can result in an underestimate of the estimated number. Our estimate should be interpreted as summing up the number of

⁴³ Klemková, D., 2004

those, who have a latent probability to visit the PPSN, from which we have computed the estimates. This can be automatically decreased by e.g. establishing a new needle exchange programme that is for example situated closer to the place of residence of an IDU. Table 4.1.1 shows the estimates of the total IDU population as well as the numbers of real visitors to PPSN in 6-month periods from January 1st 1997 to December 31st 2001 and confidence intervals of the estimate.

<i>year</i>	<i>Number of PPSN visitors</i>	<i>Total IDUs population estimate</i>	<i>Hidden population</i>	<i>Confidence interval of the total population estimate</i>
1 st half of 1997	617	771	152	770-772
2 nd half of 1997	859	1466	603	1465-1466
1 st half of 1998	881	1315	431	1314-1315
2 nd half of 1998	877	1210	333	1209-1210
1 st half of 1999	861	1194	333	1193-1196
2 nd half of 1999	842	1295	450	1294-1296
1 st half of 2000	891	1263	369	1262-1263
2 nd half of 2000	827	1102	272	1101-1103
1 st half of 2001	722	1099	376	1072-1100
2 nd half of 2001	537	841	303	838-844

Table 4.1.1 The number of real visits to PPSN, the estimate of the total size of the IDUs population, the estimate of the hidden population and the confidence interval of the estimate of the total IDUs population (without stratification)

Further analyses with stratification have shown that stratification according to gender almost wouldn't change the estimate at all, while stratification according to age (up to 29 years and over 30 years) would slightly shift it. We have also seen during analyses, that „older“ clients had a lot more visits per person on average. That's why we show estimates for age groups, „younger“ and „older“ and their sum in Table 4.1.2.

<i>Year</i>	<i>Age group</i>	<i>Number of visitors to PPSN</i>	<i>The total population estimate</i>	<i>The hidden population estimate</i>	<i>The total IDU population after adjusting for age groups</i>
1 st half of 1997	Younger	551	659	108	838
	Older	66	179	113	
2 nd half of 1997	Younger	769	1235	466	1499
	Older	90	264	174	
1 st half of 1998	Younger	785	1204	419	1322
	Older	96	118	22	
2 nd half of 1998	Younger	788	1068	280	1216
	Older	89	148	59	
1 st half of 1999	Younger	753	1000	247	1239
	Older	108	239	131	
2 nd half of 1999	Younger	740	1097	357	1326

Year	Age group	Number of visitors to PPSN	The total population estimate	The hidden population estimate	The total IDU population after adjusting for age groups
1 st half of 2000	Older	102	229	127	1261
	Younger	754	1087	333	
2 nd half of 2000	Older	137	174	37	1104
	Younger	685	930	245	
1 st half of 2001	Older	142	213	71	1097
	Younger	580	884	304	
2 nd half of 2001	Older	87	174	87	853
	Younger	450	679	229	

Table 4.1.2. Estimates of the population of injecting drug users in Bratislava with the Truncated Poisson method after stratification according to age groups

The time trend of visits to PPSN and estimates of the total population of IDUs in Bratislava is obvious on Fig.4.1.1.

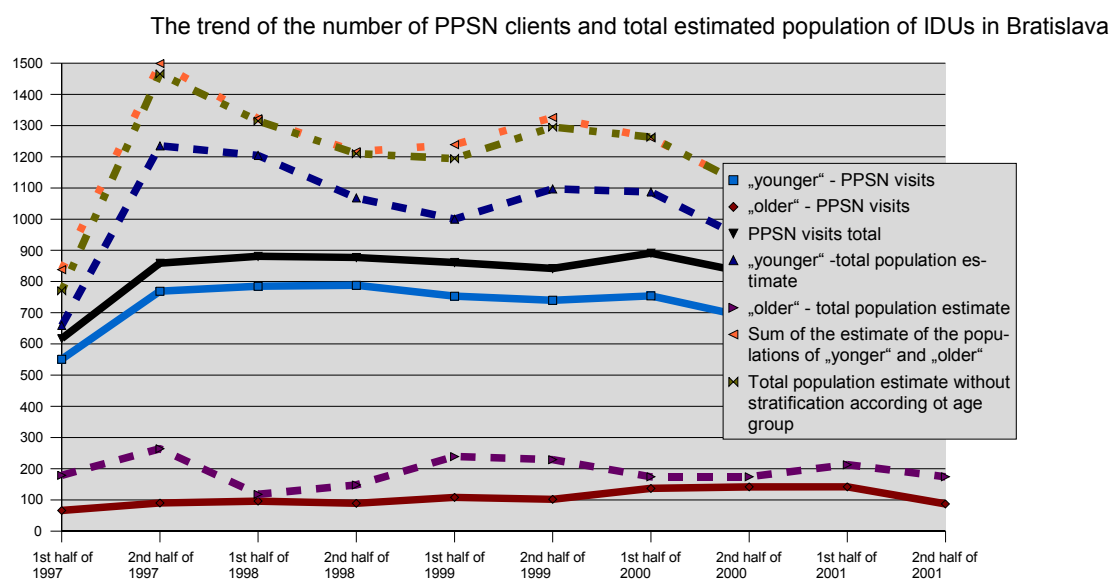


Fig.4.1.1 Trends of PPSN visits, contacted and estimated total population of IDUs

The peak of the number of visits to PPSN appears only after the peak of the first admission to treatment of the patients with opiate dependence, which was in 1994-1995. Although intuitively we would expect it the other way around, it could be caused by the fact that the PPSN has been only in the process of establishment since 1994, but even more could be due to the fact that the most frequently used drug (>90%) of treated patients as well as the PPSN visitors – heroin – used to be smoked from the beginning, and only later they

have switched to injecting (Okruhlica, 2004). Another interesting trend is the decrease of the total number of PPSN visitors since 2000. This could be caused by at least two known factors – in the year 1999, there was established a street-based needle exchange programme, to which some clients who lived closer to it could transfer. We can also observe a general decrease in heroin use and first admissions to treatment due to this substance, in accordance with a similar trend in other EU countries.

Weaknesses of the used method:

The Truncated Poisson Method of the hidden estimation is based on a number of assumptions. Among them is the assumption of a closed studied population. This assumption is obviously not realistic. To ensure a lower migration we have decided to use the 6-month intervals. Another disadvantage is a relatively smaller sample of „older“ IDUs, which is obvious from a more variable estimates compared to the real trend of visits to PPSN.

Multivariate indicator method

This estimation method is based on extracting one factor (latent factor of problem drug use) from various indicators of problem drug use, and its scores are put into a regression equation in order to estimate a problem drug use in particular regions with the help of the so-called anchor points, which should be some estimates from at least two regions. Because of the data availability, we have chosen the year 2002, and we have used these indicators of problem drug use:

The number of drug-related offences (person-based)

The number of patients in treatment in the health sector

The number of clients in prisons who required treatment for substance use problems

The number of persons per 100 000 inhabitants who admitted the use of heroin, amphetamines or cocaine in the last year in the national population survey conducted by the Statistical Office of the Slovak Republic in 2002.

As the units of analysis we have chosen regions, and „anchor points“ were numbers, based on capture/ recapture method, of people with substance use problems (excluding alcohol) in treatment and prison in the Bratislava region, where according to all indicators substance use is the most prevalent, and Presov region, where substance use is obviously the least prevalent. We have decided to use the total number of users with problems requiring treatment, because we have supposed, that there is one common factor of drug use in the society and when one substance is not available any more, it will be replaced by another available at the moment, as it is illustrated by historical examples e.g. from Japan, Thailand, etc.

As the population at risk we have used the population of 15-54-year-olds (in economically active age) in the particular regions. The numbers were used according to census on December 31st, 2001.

After converting all data to rates per 100 000 inhabitants and their standardization, we have extracted the drug use factor. Based on this factor, we have computed estimates of the numbers of problem drug users in the particular regions using linear regression.

Results are summarized in Table 4.1.3 and on Fig.4.1. 2.

Region	Regression factor score of the drug use factor	Estimated population of problem substance users
Bratislava region	2,3376	7496
Trnava region	0,3003	2859
Trencin region	-0,2707	1858

<i>Region</i>	<i>Regression factor score of the drug use factor</i>	<i>Estimated population of problem substance users</i>
Nitra region	-0,3238	2043
Zilina region	-0,4137	1751
Banska Bystrica region	-0,2676	2021
Presov region	-0,9010	611
Kosice region	-0,4611	1798

Table 4.1.3. Regression factor score of the drug use factor in the particular regions and the estimates of the number of problem substance users

That would mean, that there are roughly up to 20 500 substance users in Slovakia with or without dependence (and this is not only heroin, amphetamines or cocaine users, but also users of marijuana, sedatives and hypnotics, inhalants and others), who would benefit from some kind of intervention. **The estimate would be lower, if it would include only persons with dependence, since the definition of problem drug use is a broader concept.**

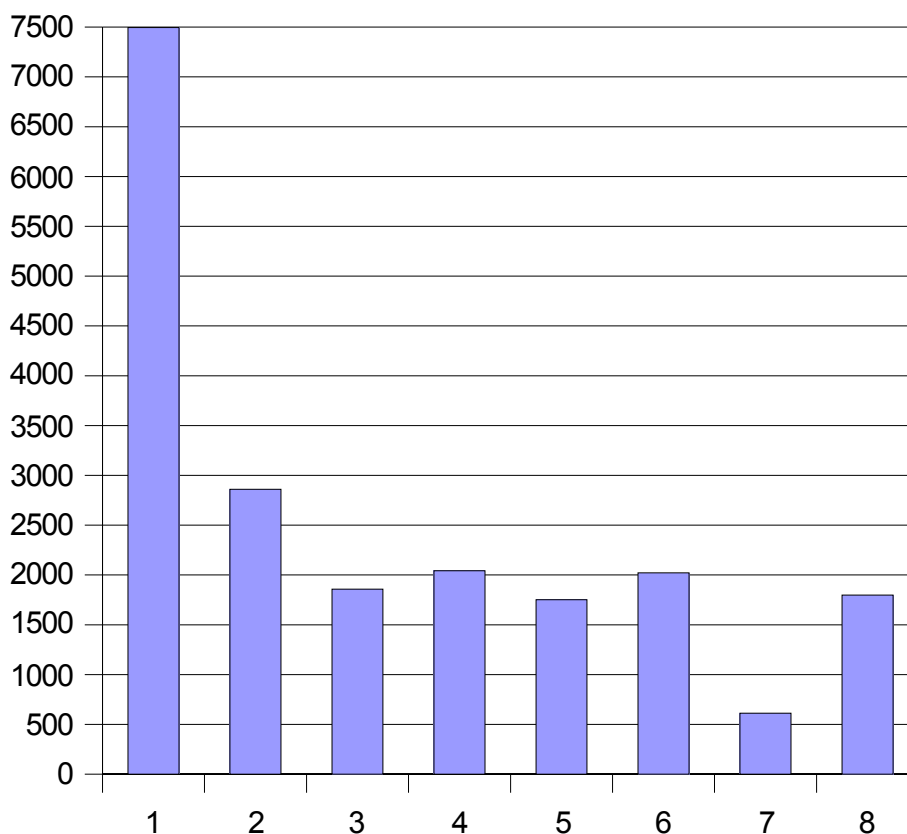


Fig. 4.1.2. estimates of problem substance users in particular regions

Legend:

- 1 – Bratislava region
- 2 – Trnava region
- 3 – Trencin region
- 4 – Nitra region
- 5 – Zilina region
- 6 – Banska Bystrica region
- 7 – Presov region
- 8 – Kosice region

Limitations of the estimate:

We should consider the above-mentioned estimate as very approximate. In the capture/recapture method used to construct the anchor points we suppose that appearing in prison decreases the probability of appearing in treatment outside prison, and therefore we suppose, that the acquired estimate is only an upper limit and the real number of problem substance users besides alcohol will be anywhere underneath this limit. A very important aspect with a high risk of bias is, that alcohol was excluded from the analysis, because it also substitutes for drug use in case of drugs' unavailability and that way it participates as the factor of substance use. Another weakness of the method is an assumption of homogeneity of drug use in particular regions, for this obviously cannot be realistic. Therefore we warn, that the acquired estimate is very rough and it needs to be made more precise using also other methods when conducting further studies.

4.2 Profile of clients in treatment

Thanks to a system of reporting of drug users' treatment in the Slovak republic, that is realized through mailing „Reports of drug user treatment“ to the Institute of Health Information and Statistics, there are more or less reliable data without double counting about the number and kind of treated substance users with the exception of alcohol.

There is a trend of decrease of the number of opiate (predominantly heroin) users among the treated patients and increase of stimulant users (predominantly methamphetamine). This trend has started after 1999 and in the first half of 2004 the number of treated stimulant users is almost the same as the number of treated opiate users and it is even higher in the first treatments.

In the year 2003 there were 2136 treated drug users reported, which is stabilization in accordance with the year 2002 after the decrease since 2000. The treated patients were mostly men (75%). 431 patients were treated in the Ministry of Justice sector.

The most frequent age group was in the health sector the age group of 20-24-year-olds, while in the Ministry of Justice sector it was the age group of 25-29-year-olds.

The most frequent primary drug was opiates (predominantly heroin – 52% of patients); in 19% it was stimulants, in 14% cannabis, 9% volatile agents and 6% hypnotics and sedatives.

Patients, who had been using opiates were injecting in 81% of cases.

5. Drug related treatment

The most significant change on the drug scene over the last year was the increase in the number of patients seeking treatment for dependency on amphetamine-type stimulants (methamphetamines), and a lower number of those seeking treatment for opiate addiction. In spite of efforts to provide all-round and accessible medical care, without the need for waiting lists of drug-dependent patients, a complete range of treatments is not yet available. This mainly applies to the systemic introduction of substitution maintenance treatment. Thus, methadone maintenance treatment is provided only in one programme in Bratislava, buprenorphin treatment is limited to a maximum of 2 months, i.e., a sub optimal duration of treatment, and naltrexone is not available at all, because it is not registered in Slovakia. A separate and as yet unresolved question is the more effective implementation of court-ordered withdrawal treatment. A certain number of drug treatment facilities should change their focus with a view to introducing and expanding drug-free withdrawal programmes for patients with methamphetamine dependency, for which there is no known effective biological preparation – medicament – as is the case with opiates. Repeated evaluation studies of the history of drug-dependent patients in Bratislava show that most patients have abstained from drugs for considerable periods of time.

5.1 The treatment system in the Slovak Republic

The treatment system in the Slovak Republic in 2003 was, just as it is today, based on an approach to drug use and drug addiction that makes a clear distinction between health and sickness, between a purely social phenomenon and a biological, medical phenomenon. **The core treatment procedure was medically assisted treatment, which, in strict compliance with ICD-10, defines the line between drug users without a diagnosis of health damage and those suffering from drug-related health damage.** These official criteria of the World Health Organisation were and are being used to diagnose the 'harmful use' of drugs and 'drug dependency', and/or other health disorders related to such diagnoses. **The system of treating drug addiction is based on scientifically verified approaches. Drug addiction issues are tackled within the field of psychiatry; methodical guidance is provided by the chief specialist of the Ministry of Health of the Slovak Republic on drug addiction. The Institute secures the systematic implementation of research-based, scientific methods of diagnosis and treatment for Drug Dependencies, attached to the Centre for the Treatment of Drug Dependencies in Bratislava. It is a state health institution.** The key background document for the development of drug treatment programmes is a research manual published in 1999 by the U.S. National Institute on Drug Abuse, "Principles of Drug Addiction Treatment", which was translated and published in the Slovak language by the Institute for Drug Dependencies in 2000.

Drug treatment services are concentrated under the umbrella of the Ministry of Health and the Ministry of Social Affairs and Family; to a lesser extent, they are provided under the competence of the Ministry of Justice (especially in relation to prisons) and the Ministry of the Interior.

In the above, medically-oriented, model of diagnosing harmful use and drug addiction, **most persons seeking treatment are referred to healthcare facilities, whose work is complemented by that of organisations providing social assistance and, where necessary, facilitating social reintegration.**

As in previous years, the predominant form of treatment was voluntary treatment, where patients themselves sought treatment for their drug problems; less frequent was involuntary treatment ordered by a court that had established drug addiction in criminal proceedings. The diagnosis in such cases is made, and drug treatment recommended, by a court expert on medical issues – a psychiatric doctor. Although there are no statistics about the relative

proportions of voluntary applications for treatment and court-ordered referrals, practical observations indicate that involuntary, court-ordered treatments accounted for a smaller and non-decisive part of referrals for treatment, and that their share has tended to decline in recent years. The moderate decrease in their number could be ascribed to changes in drug consumption on the drug scene and, to a lesser extent, changes in the approach of law enforcement bodies. No significant systemic change occurred in the recent period in the area of involuntary, court-ordered treatments provided on an outpatient or inpatient basis. **Relevant proposals were put forward by Health Ministry's experts in connection with the envisaged recodifications of the Criminal Code and the Code of Criminal Procedure: they propose, *inter alia*, that there should be a possibility to change the court-ordered inpatient treatment to outpatient treatment without the need for a new court ruling, in order to enable the health establishment to respond rapidly to the actual health condition of the patient. Given the high number of drug withdrawal treatments ordered by courts several years ago that have yet to be completed, it will be necessary to introduce a systemic approach in the near future, in order to address this issue at the national level.**

In quantitative terms, the availability of treatment in Slovakia has had, and continues to enjoy, a high standard. Treatment is both available and accessible. This also applies to the quality and range of treatment programmes and services on offer as far as the Slovak capital, Bratislava, is concerned; the availability of a complete range of treatment programmes and services is also ensured throughout the country, albeit to a lesser extent. In a way, this is understandable, because the capital city has the highest concentration of people with drug-related health problems; nevertheless, there is both the opportunity and the need to expand the availability of certain treatment programmes throughout Slovakia. In his reports, the chief specialist on drug dependencies at the Ministry of Health has repeatedly pointed to the necessity of systematically introducing medically and socially assisted methadone maintenance treatment in places outside of Bratislava. Specific prevention aimed at harm reduction for drug injectors outside the capital city is only sporadically available.

Medical treatment is provided to drug addicts through a combination of private, non-state, and state medical facilities on an outpatient or hospital basis. While non-state physicians provide most outpatient care, hospital care is mostly provided by state medical facilities. Healthcare reform laws passed by the Slovak Parliament at the end of 2004 envisage, *inter alia*, that hospital care for drug-dependent patients **is to be provided only in non-state medical facilities.**

Treatment provided in establishments that fall under the competence of the Ministry of Health is covered by health insurance companies on the basis of contracts concluded with the providers (physicians with a private practice, medical facilities). Patients entering treatment are required to pay only a nominal handling fee. Every citizen has statutory health insurance and is entitled to medical care. **In essence, treatment for drug-related health problems in the reported period was available to every citizen of the Slovak Republic.**

From the systemic point of view, individual, mutually overlapping stages of healthcare provision to drug users in Slovakia may be formally categorised as follows:

- Pre-clinical care (counselling, harm reduction, treatment/abstinence motivation programmes);
- Detoxification treatment;
- Drug free withdrawal programmes;
- Maintenance treatment for patients with chronic, recurring opiate dependency;
- Follow-up care programmes.

As regards the organisation of healthcare provision to patients with drug-related mental disorders within the competence of the Slovak Ministry of Health (MH SR), a *Professional*

Guideline introducing standards for the diagnosis and treatment of drug dependencies was issued in 2003 and promulgated in the Official Journal of the Ministry of Health, Title 12-15 Vol. 51, 2003. Another important document published in the Official Journal of the Ministry of Health, Title 21-27 Vol. 2004, was the organisational guideline for introducing methadone maintenance treatment: *Methodological instruction concerning the introduction of methadone maintenance treatment*. At the end of 2003, the Ministry of Health issued its Measure No. M/5649/2003, according to which the payment for Subutex (buprenorphin) used in the treatment of opiate-dependent patients, is fully covered by health insurance, with effect from 15th November 2003. Previously, patients had had to pay the full price of medicines prescribed by their physicians. As a follow-up to this Measure (18th Nov. 2003), the largest health insurance company in Slovakia – the General Health Insurance Company – issued an instruction to its contractual healthcare providers concerning the prescription of Subutex.

The range of programmes for providing healthcare and treatment to persons with drug-related health damage includes low-threshold drug programmes ('street work') that provide pre-medical care, the exchange of sterile needles and syringes, health advice, and referrals for treatment.

Referrals for treatment include "self-referrals" to specialists and/or referrals by social workers or general practitioners. The treatment of drug-dependent patients is provided primarily on an outpatient but also on a residential – hospital – basis, depending on the condition, needs, and wishes of the patient. **The system of treatment for drug-related problems provided within the competence of the Ministry of Health comprises general practitioners who perform diagnostic screening and make the first diagnosis of the problem, medical specialists – psychiatric doctors with general psychiatric practice who treat patients either on an outpatient basis or in a hospital, while the best targeted healthcare is provided by a network of specialised drug treatment centres and by psychiatrists specialised in treating alcohol or substance abuse. There are currently 8 such centres in Slovakia, of which only 4 operate as independent legal entities.** According to a decision of the Ministry of Health, all drug treatment centres are expected to become independent legal entities by the end of 2004, with independent management and economic operation, and to be transformed into non-profit organisations.

The existing bed capacity for the withdrawal treatment of drug-dependent patients in specialised drug withdrawal centres or departments of psychiatric hospitals and psychiatric medical facilities is adequate.

Follow-up care consists of medically assisted treatment and social reintegration programmes. The latter take the form of clubs, which bring together persons who remain clean of drugs, and are founded either on an outpatient basis in medical facilities, or externally, with or without the support of specialists – for example, "NA" ('Narcotics Anonymous').

Another form of follow-up care is that of **'therapeutic communities and half way houses'**, aimed at the social reintegration of persons who stay clean of drugs after medically-assisted withdrawal treatment. **The Ministry of Social Affairs and Family and the Ministry of the Interior, and by self-governing regions and municipal councils provide methodological guidance.** Except for one state-run social reintegration facility, all of them are non-state entities – mostly not-for-profit organisations established by non-governmental organisations, citizens' associations, or church-based organisations. Under the law on social assistance, social programmes run by therapeutic-community type establishments are financed – depending on the number of their clients – from taxpayers' money through regional authorities and self-governing regions. Clients of social reintegration facilities also contribute towards the cost of their stays. The amount of financial contributions from clients varies, and is a factor restricting the use of social reintegration services. In Slovakia as a whole, the number of places in facilities for the social reintegration of drug-dependent persons – therapeutic communities – was around 200; total capacity adequately met the

demand for this type of care. As regards halfway houses, their number and development are limited. They are almost non-existent outside Bratislava, and their number should be increased.

On 11th September 2004, the Institute of Drug Dependencies (IDD) attached to the Centre for the Treatment of Drug Dependencies (CTDD) in Bratislava organised a seminar on the economic aspects and evaluation of drug treatment. The UNODC manual on "*Investing into drug abuse treatment*" – a discussion document for policymakers – and an abstract of the WHO publication "*Neuroscience of psychoactive substance use*" were also published and distributed in the Slovak language in 2004. Because of changes on the drug scene and a rise in the use of amphetamine-type stimulants and polydrug use, reflected in the structure of profiles of patients seeking treatment, the Institute of Drug Dependencies organised a training course and prepared a translation of the manual for the "MATRIX" instrument of NIDA (USA) for publication, with a view to introducing new treatment programmes for this type of patients.

The staff of drug treatment services comprises medical doctors, nurses, orderlies, social workers, psychologists, and laboratory and support personnel. Accredited forms of specialised training and education for health professionals in the area of drug treatment, except for pregraduate education, are provided by the Slovak Health Academy in Bratislava at a university level, and are complemented by a training course on drug counselling run by the Institute of Drug Dependencies in Bratislava, and by training in cognitive-behavioural psychotherapy provided at an accredited facility in Liptovský Mikuláš.

Due to the continually declining trend in the demand for treatment (both in relative and absolute terms) by persons with opiate dependencies, as confirmed by data from the Institute of Health Information and Statistics concerning the first half of 2004, **recent years have witnessed a shift in the methods of treatment – the number of persons undergoing medically-assisted treatment is falling in favour of those receiving 'drug-free' treatment.**

However, the age structure of persons undergoing treatment remains stable – most of them (around a third of persons in treatment) belong to the 20-24-age bracket (compared with 34% in the first half of 2004). No major differences have been observed in gender composition, either – the ratio is approx. 3:1 in favour of men, although the proportion of women increased slightly by the first half of 2004 in comparison with 2002 (21.5% vs. 24.0%).

After the first years of drug epidemics – especially the use of heroin in the mid 1990s, when the number of persons entering treatment for the first time was higher than that of persons in repeated treatment – in recent years, the proportions of the two categories in medical establishments have stabilised. Approximately one-third of all patients are those entering treatment for drug dependency for the first time, while approximately two-thirds of patients are undergoing repeated treatment.

These statistics indicate that the number of drug-dependent patients in Slovakia is not increasing. This means that there has been no sharp increase in the number of new cases of drug-dependent persons and the above statistics concerning the demand for treatment indicate that no dramatic and significant increase in the number of persons with chronic drug dependencies is to be expected, either. We can only speculate as to the degree to which this reflects the actual situation in the general population, and to what extent these data can be associated with the impact of preventive treatment programmes and other factors. **However, it is a fact that no significant increase in the demand for this type of treatment has been recorded in the capital city of Bratislava, which offers immediately available drug treatment services, with no capacity limitations.**

The above findings are supported and complemented by those of a **cyclic evaluation study, performed in order to follow up the history of persons that have undergone treatment**

at the Centre for the Treatment of Drug Dependencies in Bratislava. The study of the first cohort of 1997 and the study concerning the history of patients in the second cohort, who entered treatment for the first time in 2001, **indicate a steadily high proportion (55%) of persons who stay clean of drugs** after 1 and 3 years (only findings concerning the first cohort of patients are available at this time).

5.2 Drug-free treatment

In our system, drug-free treatment usually combines residential treatment with outpatient treatment, and outpatient treatment is often combined with residential treatment within a single, continuous treatment process.

Drug-free treatment is the prevailing form of withdrawal treatment for drug dependencies in Slovakia.

- ***Inpatient/residential types of treatment***

In Slovakia, residential withdrawal treatment is provided either with or without a preceding medically-assisted detoxification, usually in a specialised medical facility, i.e., (1) at the inpatient department of a drug treatment facility or (2) a specialised, inpatient withdrawal ward of a psychiatric hospital or specialised psychiatric establishment; less frequently, (3) an alternative to medically-assisted residential treatment is withdrawal treatment in therapeutic-community type social reintegration establishments, where patients, although receiving residential treatment, have an outpatient status from the aspect of medically-assisted treatment. Health Ministry standards issued in 2003 recommend that the duration of withdrawal treatment for drug-dependent patients should be up to 3 months. On average, the duration of individual episodes of withdrawal treatment was around four weeks, depending on the type of treatment programme and facility; for some patients, however, it exceeded the recommended 3-month duration, especially in the case of patients with psychiatric co-morbidity.

Besides the initial episode of residential withdrawal treatment, at least one episode of the so-called reinforcement residential treatment of one to two weeks fully covered by health insurance is recommended, usually in the second half of the first year of abstinence. However, only a small percentage of patients take advantage of this form of residential treatment during the abstinence phase.

Therapeutic procedures applied during residential withdrawal treatment are based on the principles of regime treatment and cognitive behavioural psychotherapy. They include the use of supportive, motivational, and family psychotherapy methods, logo therapy, relapse prevention techniques, art therapy, psychodrama, or confrontations. This is a combination of individual and group psychotherapy sessions. Depending on the type of establishment or programme, residential hospital treatment programmes include, to a greater or lesser extent, the elements of therapeutic community regimes. Some establishments also make limited use of the elements of dynamic, non-directive psychotherapeutical schools.

Drug-free withdrawal treatment is also combined with the comprehensive diagnostics and treatment of somatic diseases, with a focus on blood and sexually transmitted diseases.

The entire residential withdrawal treatment in a health establishment is fully covered by the solidarity fund of health insurance companies. The patient must pay for part of the board and accommodation costs, but only during the first 14 days of individual treatment episodes, to a total of SKK 50/day (around EUR 1.2); the remainder of the stay in the health facility is fully covered by health insurance.

A certain number of patients with a significant social and economic deficit follow up their residential withdrawal treatment with a stay in a social reintegration facility, most often of the

therapeutic community type. Even residential establishments that provide follow-up care and are not part of the healthcare system apply withdrawal programmes to some of their clients, who may or may not have undergone detoxification, as an alternative to medically assisted, residential withdrawal treatment. They apply regime treatment, therapeutic-community system, counselling, support and motivational treatment, spiritual therapy, group or individual psychotherapy, acupuncture, art therapy, occupational therapy, vocational training and education.

From the aspect of the therapeutic approaches used, social reintegration services can be divided into: (1) communities applying the U.S. "Day Top" method, which form a minority in Slovakia, (2) communities of the so-called "humane", or less authoritative type, which represent a majority, and (3), a smaller number of church-based therapeutic communities with predominantly spiritual and religious themes. Spiritual therapy and logo therapy are among the most frequently used therapeutic approaches in non-health system, residential, church-based, treatment establishments. According to the law on social assistance, the clients of these establishments have an outpatient status, are assigned an educator, and are overseen by a medical specialist – a psychiatrist.

Nonetheless, many of these establishments still base their treatment methods on non-medical approaches, and apply the social model of the perception of drug addiction. Their total capacity of some 200 beds is not fully utilised, partly due to the fact that clients are required to make a substantial contribution towards the costs of their stay.

Most staff members of social reintegration services are psychologists, social workers, or employees recruited from groups of abstaining former alcohol or drug addicts, who do not meet the university education requirement, but have received relevant training in psychotherapy and counselling for the treatment of patients with dependencies.

- ***Outpatient treatment***

Alongside residential treatment, health or non-health providers, mostly in the 'drug-free' form, offer outpatient treatment.

All specialised medical establishments provide systematic outpatient care as a follow-up to residential treatment; this is true in the case of centres for the treatment of drug dependencies (CTDD) except for one CTDD (Predná Hora); in some, outpatient care is the prevailing form of treatment. While most patients receive outpatient treatment at the beginning of and/or after their residential treatment, a large proportion of patients receiving outpatient withdrawal – drug-free – treatment never enter residential treatment.

The importance of drug-free outpatient treatment in Slovakia has grown in recent years because of changes on the drug scene, such as a decrease in the number of heroin addicts and an increase in the number of those seeking treatment for addiction to amphetamines or cannabis.

Such treatment is provided as follows: (1) In medical facilities by physicians, psychologists, trained nurses, special pedagogues, and educational therapists with adequate training in psychotherapy and the treatment of drug addiction. Their methods and methodologies include those of cognitive behavioural psychotherapy, didactotherapy, family psychotherapy, relapse prevention technique, and motivational and support psychotherapy, applied in the form of individual or group sessions; (2) Outpatient, drug-free, withdrawal treatment – in particular for non-opiate dependencies – is often offered as an alternative to medically-assisted treatment, in the form of individual or group psychotherapy at psychological counselling facilities falling under the competences of the Ministry of Education or the Ministry of Labour, Social Affairs, and Family; (3) An alternative form of treatment, particularly in large towns, are self-help groups of former addicts – Narcotics Anonymous.

While the number of persons receiving outpatient treatment in the health sector can be ascertained from the statistics of the Institute of Health Information and Statistics, it is practically impossible to establish the number of persons participating in outpatient treatment programmes offered as an alternative to outpatient, medically assisted treatment. However, practically every therapy-resistant client ends up, sooner or later, in a healthcare programme – either by his or her own choice, or as a result of referral by a therapist.

A significant, new trend has started to emerge over the last 2 – 3 years in Bratislava (the only city in Slovakia that has a large-scale programme of substitution methadone treatment), represented by an increase in the number of opiate-dependent patients undergoing methadone maintenance therapy who, because of an accompanying dependency on methamphetamines, are simultaneously treated in residential and/or outpatient withdrawal programmes for dependency on stimulants.

5.3 Medically-assisted treatment

- ***Detoxification treatment***

Detoxification treatment is provided in medical facilities, either on an outpatient or residential basis. This type of treatment is traditionally provided under the assistance of healthcare specialists to most opiate-dependent patients who seek treatment and want to stop using opiates or opioids; i.e., those who either do not have the choice of, or are not interested in, substitution treatment.

Another group is represented by patients with other diagnoses of primary substance abuse, in particular those addicted to sedatives or hypnotics (mainly benzodiazepines), or to volatile inhalants.

In recent years, an increase has been observed in the number of patients undergoing detoxification treatment for addiction to psychoactive substances in combination with poly-substance abuse.

The most frequent form of medically assisted detoxification is detoxification for opiate dependency. Detoxification is commonly performed by means of administering decreasing doses of opiate receptor agonists such as codeine, ethyl morphine, buprenorphin, or methadone and slow-release morphine.

The recommended, first-choice medication is buprenorphin; however, medically assisted detoxification for opiate dependency is sometimes performed even without the use of antagonists, using benzodiazepines or neuroleptics.

The detoxification inventory lacks one antagonist of opiate receptors – naltrexone – that is not registered in Slovakia, and is therefore unavailable for use in treatment.

- ***Substitution maintenance treatment***

This type of treatment can only be provided to persons addicted to opiates. Its availability in Slovakia is limited.

The only programme of **methadone maintenance treatment**, provided to an average of 300 to 350 patients, is available in Bratislava. Although the Ministry of Health issued a methodological guideline on methadone treatment in 2004, methadone maintenance programmes have not been systemically introduced in other locations due to the shortage of funds for their financing.

Buprenorphine maintenance treatment: The medication is fully covered by health insurance, but since the coverage is limited to three months from the onset of treatment, a

wider-scale, long-term substitution treatment with buprenorphine is practically impossible. Nevertheless, it can be applied in medically assisted detoxification.

Both forms of the existing substitution treatment with opiate agonists are combined with programmes of psychosocial assistance. They include the regular toxicological monitoring of urine, and include psychotherapeutic programmes. The expected outcomes include, besides the primary objective – i.e., abstinence from illegal opioids – social reintegration, employment, and life in a drug-free and proper household. However, because this is a healthcare programme, its primary objective is staying clean of illegal opiates. Although other anticipated outcomes are also significant, they are attached only secondary significance in the medical evaluation of the effectiveness of treatment. The most significant secondary impacts include a decrease in drug-related crime.

The only criterion that must be met by a patient prior to being referred for substitution treatment is a diagnosis of opioid dependency established by a physician. Another relative precondition for referral is, however, legal age – i.e., the attainment of 18 years of age. **Substitution methadone treatment is not limited, either as regards the dosage or the length of administration. However, the medically recommended, minimum duration of substitution treatment is 12 months.** The programme of medically-assisted substitution treatment in Slovakia is primarily a therapeutic programme with emphasis on the individualisation of doses, the process of treatment, and its objective; i.e., staying clean of illegal drugs. Its objectives also include the secondary effects of harm reduction, such as the prevention and reduction of infectious, blood transmissible diseases among the users of opiates and opioids. Moreover, only the Bratislava programme of substitution methadone treatment includes the regular monitoring of patient compliance and retention one year after the beginning of treatment.

Because morphine sulphate and diacetylmorphine are not medically registered preparations, they cannot be legally prescribed for substitution treatment in Slovakia.

Medically assisted **naltrexone antagonist maintenance treatment is not applicable** either, because naltrexone is not a registered medication in Slovakia. No company has manifested interest in its registration and import to the small Slovak market.

- ***Other types of medically-assisted treatment***

No other form of medically assisted treatment is used in Slovakia, with the exception of neuroleptics used to treat acute toxic psychoses, which have witnessed a significant increase in recent years as a result of the increased use of methamphetamines.

6. The health implications and consequences of drug use

No systematic monitoring of drug-related deaths is carried out in Slovakia. However, certain secondary findings of other studies indicate that the number of drug-related deaths among drug users who had undergone treatment is significantly higher than that of their peers. **The system of monitoring drug-related infectious diseases is more advanced, even though it only has the character of sentinel surveillance.** The country has one of the lowest incidences of HIV among drug injectors in Europe. On the other hand, a type A hepatitis epidemic broke out among drug users in Bratislava at the turn of 2002/2003. The greatest problem continues to be a persistent and expanding epidemic of type C hepatitis. According to sentinel surveillance data, its proportion among drug injectors who first entered treatment at the Bratislava Centre for the Treatment of Drug Dependencies is as high as 42%. In spite of a good response to the treatment of genotype 3a of type C hepatitis, which prevails among two-thirds of drug users, the number of those who seek treatment is relatively low, due to the strict elimination criteria set out by health insurance companies for covering such treatment. The incidence of other infectious diseases such as syphilis or rare tuberculosis among drug users has not reached significant proportions. Patients with a dual diagnosis of serious mental disorder combined with a drug-related diagnosis have access to standard and fully covered psychiatric care; there are no waiting lists for treatment. Patients with dependencies also have full access to adequate treatment of other drug-related physical health problems.

6.1 Drug-related deaths and drug user mortality

Efforts aimed at introducing a uniform system for the monitoring of drug-related deaths at the national level have not brought the desired outcome. There is a problem with the collection of data at the national level, particularly because of a low number of autopsies, reluctance on the part of relatives of deceased young persons, especially their parents, to grant permission for an autopsy, or because of the unwillingness of bereaved relatives to disclose any history of drug use.

Because of the relatively young age of persons facing the risk of drug-related death in Slovakia – most of them are in their twenties – there is a lower probability of death due to chronic hepatitis C and/or HIV/AIDS, which has a low prevalence among drug users in Slovakia.

The only source of statistical data available in connection with drug-related deaths in Slovakia is represented by findings concerning small cohort samples from a longitudinal study of the history of patients who had been treated for drug dependency for the first time at the Bratislava CTDD. While the difference between mortality of 1997 and 2001 patient cohorts was not very significant, representing 1.8% and 1.5% respectively, only 3.2% of patients in the 1997 cohort died in the three years from the beginning of treatment compared with the cohort of patients who first entered the treatment in 2001, where as many as 6.2% of former patients had died after 3 years.

As regards the possibility of deriving more general interpretations from these data, it is subject to important limitations. The data were obtained from relatively small samples of 200 to 300 subjects, whose exact cause of death was not established, and most of who came from the same locality – Bratislava. Another limitation to making generalisations is represented by the fact that **the subjects in all cases were drug addicts who sought treatment.** It is therefore not possible to estimate the mortality rate for a wider group of drug users with or without dependency who did not seek the help of a medical establishment.

6.2 Drug-related infections

The Slovak Republic **has not introduced systematic monitoring of the incidence of drug-related infectious diseases among drug users.** Nevertheless, centres for the treatment of drug dependencies serve as sentinels for epidemiological surveillance. The largest of them, the CTDD centre in Bratislava, has conducted the most consistent studies of this issue over the longest period – since 1997. Moreover, specialised medical establishments that provide residential detoxification or withdrawal treatment to drug-dependent patients routinely perform blood tests for antibodies to blood-borne transmissible diseases in all patients, in connection with basic medical tests. The only exceptions are persons from whom it is not possible to collect a blood sample, and a small group of patients who refuse to be tested for HIV.

- ***Type A hepatitis***

The most notable development in the incidence of infectious diseases **among drug users** in the recent period **was a microepidemic of type A hepatitis in Bratislava at the turn of 2002 and 2003**, which broke out in the situation of a relatively low HAV incidence in the general population of the capital city. Based on the compulsory notification of clinical cases of type A hepatitis, 144 cases of the disease were recorded in Bratislava by May 2003, 42% of which concerned drug users of 23 to 24 years. This figure was markedly higher than the reported incidence of type A hepatitis in Bratislava in 2001, when – as in previous years – it was as low as 26 cases, mostly among younger school children, compared with 45 cases in 2002 and 98 patients during the first 5 months of 2003 alone, most of them young adults in their twenties.

The vaccination of the entire population against type A hepatitis, or the free vaccination of drug users that could help prevent the occurrence and spread of such epidemics, is not performed in Slovakia.

The sentinel surveillance of other blood-borne transmissible diseases among drug users treated for the first time at the Bratislava CTDD did not reveal any major changes in trend.

- ***Type B hepatitis***

In 2003, the Bratislava CTDD recorded **a moderate increase in the marker of hepatitis B virus infection** – the core antigen (HBc) – from 5% in 2002 to 9% among all injectors, and from 6% to 10% in the subgroup of injectors treated for the first time. This change can hardly be ascribed merely to the discontinuation of the vaccination of drug users treated for the first time at the Bratislava CTDD, which resulted from the termination of full health insurance coverage for the vaccination of drug-dependent patients against type B hepatitis (HBV) that existed until 2002. Such a hypothesis could only be supported by a continued increase in the incidence of HBV infection in the sub-population of drug-dependent patients. It would therefore not be correct to speak about an HBV epidemic in Slovakia, because the observed incidence is of a sub-epidemic nature. The marker of acute infection, the HBsAg antigen, is only rarely detected among drug users at the Bratislava CTDD; similar findings were made in the multicentric study of monitoring blood-borne diseases among drug users in treatment, conducted with the participation of 3 more centres for the treatment of drug dependencies in other regions.

- ***Type C hepatitis***

The type C hepatitis virus (HCV) is the only blood-borne transmissible infection whose incidence has the character of an epidemic in the subpopulation of patients treated for drug dependency in Slovakia. This was also confirmed by the 2003 findings of other CTDDs and in patients from other regions of the country. Epidemic incidence was recorded, however, **only among persons with a history of drug injection.**

The observation of the HCV incidence trend among intravenous drug injectors treated for the first time at the Bratislava CTDD revealed that the proportion of patients with detected

antibodies against HCV increased between 2002 and 2003 from 33% to 43%. Yet the share of HCV positive patients among all first contacts was 28%, roughly the same as in 2001; this, however, was only due to a fall in the absolute number and relative proportion of drug injectors treated for the first time in Bratislava. The partial results of two probes into PCR prevalence are also available.

Besides screening for infectious diseases, special attention in treatment programmes is paid to the consequences of these diseases, such as liver damage; this is done by monitoring the dynamics of liver tests in HCV positive patients, and their referral for treatment in cooperation with hepatologists, immunologists, or infectologists.

Full health insurance coverage of combined treatment with Interferon and Ribavirin is provided to drug-dependent patients only if they demonstrate that they have abstained from drug use for at least six months, confirmed by a specialist in psychiatry, and supported by toxicological evidence. Health insurance companies refuse, as a rule, to reimburse the costs of treatment for type C hepatitis, even for patients who have been fully stabilised under methadone maintenance treatment.

- **HIV/AIDS**

In spite of epidemics of intravenous drug use, Slovakia belongs among the small group of countries with a rare incidence of HIV infection among drug injectors. The incidence of HIV/AIDS infection has been consistently among the lowest in the world; moreover, in 2003, the proportion of demonstrated cases of HIV positive patients among **drug injectors in treatment was lower than 0.1%**. At this time, there are 2 patients with demonstrated HIV transmission through intravenous drug use. However, these drug users contracted the infection during stays abroad. Anonymous surveys conducted in the past in connection with needle and syringe exchange programmes did not reveal an increased incidence of HIV infection, either.

- **Other infections**

Syphilis was repeatedly found among drug users. However, according to the monitoring performed by the Bratislava CTDD, its incidence did not exceed 1%. It is more frequently found among drug-dependent sex workers who offer sexual services in the streets. The situation is probably similar in the case of other sexually transmissible diseases, the incidence of which among drug addicts in Slovakia has not been specifically studied.

In Slovakia, tuberculosis among drug users is not monitored, and was not diagnosed in patients treated for drug dependency in 2003. Consequently, the rate of incidence of this infection in the relevant subpopulation can be characterised as low.

Apart from the abovementioned infections, no information was reported about an increased incidence of other infections among drug users.

6.3 Psychiatric comorbidity (dual diagnosis)

In spite of a higher incidence of depressive manifestations during the use of opiates and at the beginning of the withdrawal treatment, **surveys into the incidence of major depressive disorders among patients treated for opiate dependency conducted by the CTDD demonstrated the presence of a primary depressive disorder only in approximately 8% of patients. Other cases of depression involved secondary depression accompanying the primary diagnosis of opioid dependency.**

Current observations from clinical practice indicate an increased **incidence of, in particular, paranoid persecution and hallucinatory syndromes accompanying toxic psychoses among methamphetamine ('pervitín') users. Even in patients who stay clean of drugs, such psychotic disorders, whose clinical picture is reminiscent of schizophrenia, may last several weeks and take a longer time to subside. More accurate statistical data are not yet available.**

Similarly, several cases were recorded of co morbidity between the diagnosis of harmful use of, and addiction to, cannabis and the diagnosis of schizophrenia.

Older clinical works pointed to an increased incidence of personality disorders among patients treated for heroin addiction.

Another form of dual diagnosis is the diagnosis of the parallel occurrence of two types of dependencies on psychoactive substances. According to older surveys conducted by the Institute of Drug Dependencies, 98% of opioid-dependent patients also displayed a diagnosis of addiction to tobacco, which persists, although to a lesser degree, among most patients even after they have ceased using opioids. A decreased rate of this type of comorbidity was also recorded with respect to a combined addiction to benzodiazepines and primary addiction to opioids.

An opposite trend was observed in connection with a combined dependency on opioids and amphetamine-type stimulants (methamphetamines), whose number increased in particular among intravenous drug users; a mini-epidemic of methamphetamine dependency was recorded among patients who had been stabilised for a considerable period of time under methadone maintenance treatment.

As noted above, systematic attention in the process of diagnosing patients treated for drug dependencies is attached to the occurrence of other primary or secondary mental disorders and diseases. **Where necessary, patients treated for dependencies are simultaneously provided treatment for depressive disorders, anxiety states, or schizophrenic disorders. The treatment of these mental disorders is free and available.**

6.4 Other health consequences of drug use

As in other countries, the population of patients with a diagnosis of drug dependency displays, compared with other persons in their age bracket, an **above-average incidence of other types of health impairments requiring more frequent medical attention**, such as more frequent tooth cavities, abscesses, necroses of skin and muscle tissue due to infections caused by non-sterile needles, infectious endocarditis, phlebitis and thrombophlebitis, infectious and toxic hepatitis and hepatopathies, kidney damage, and others. **Drug users tend to postpone the treatment for such health problems and when they eventually visit a medical facility, their untreated somatic diseases have often attained an advanced stage and caused more extensive health damage. A comprehensive and accurate evaluation of this category has yet to be made in the context of Slovakia.**

Drug users in this age group, in particular those with dependency, also display a higher incidence of accidents, fractures sustained in traffic or other accidents, and health damage caused by physical violence.

Even in the absence of more detailed studies, these claims are corroborated by clinical experience and indirectly confirmed by the results of a probe into the life history of patients treated for drug dependency, which indicate a higher mortality rate compared with the expected mortality of their peers without a drug-addiction diagnosis.

- **Traffic and other accidents**

Based on the clinical findings concerning patients treated for drug problems, the **frequency** of traffic and other accidents and injuries experienced during the period of drug use was estimated to **exceed that found in a comparable group of the same age. No data are available and no specialised morbidity studies focusing exclusively on this issue were carried out in Slovakia.**

7. Measures addressing the health implications and consequences of drug use

Public education and targeted programmes for drug users aimed at preventing drug overdoses are carried out by non-governmental organisations performing social fieldwork and by health services specialised in drug treatment. Besides personal communications, drug users are provided printed materials. However, the coverage of the Slovak territory is not satisfactory, and several studies indicate that the impact of these activities falls short of expectations. Mortality among drug users continues to be relatively high. **More successful is the implementation of programmes for preventing the spread of infectious diseases transmissible by blood among intravenous drug users. The exchange and free provision of sterile needles and syringes in combination with the fact that they are readily available to drug users in pharmacies for a relatively low price have helped prevent the spread of HIV/AIDS epidemics.** A sustained decline in the number of drug injectors was recorded among patients treated for the first time in 2003, and a survey carried out in Bratislava indicates a decreased occurrence of high-risk behaviour, such as the sharing of non-sterile needles and syringes. **As a result of vaccination against type B hepatitis, its incidence among drug users has been maintained at a sub epidemic level.**

On the other hand, efforts to contain the spread of hepatitis C epidemics among drug injectors have not been successful, and no available measures seem to be effective.

Treatment for HIV and hepatitis, but also for other infectious diseases, is available to drug users under the same conditions as to other patients, except for the treatment of hepatitis C infection, where a medically documented abstinence of at least six months is required prior to treatment. In Slovakia, drug users have access to the same standard of treatment for other somatic diseases in the healthcare system as other citizens. This also applies to standard procedures in the treatment for dual diagnoses at psychiatric wards in hospitals.

7.1 The prevention of drug-related deaths

The systematic education and training of drug users on techniques for the safe application of drugs and measures designed to prevent fatal overdoses and/or for providing emergency assistance to fellow drug users, has been offered in Bratislava for a number of years now. These activities are carried out primarily by **non-governmental organisations**, the CA (Citizens' Association) Odysseus and the CA Prima, which focus primarily on harm-reduction programmes targeting drug users, and the **Centre for the Treatment of Drug Dependencies in Bratislava** in the course of didactotherapy. The training is provided either in the form of direct communication with users, or by means of pertinent brochures or leaflets published by these organisations.

Another non-governmental organisation focusing on harm reduction and the training of users in overdose prevention was revitalised last year in Banská Bystrica, and the CA Odysseus helped create a similar NGO in Púchov and in another regional capital, Nitra, which also covers the town of Hlohovec.

However, these activities are not sufficiently developed across the board in Slovakia, as demonstrated by frequent media reports about fatal drug overdoses. On the other hand, no accurate statistics are available. There are no supervised consumption rooms in the country, and drug users do not have Naloxone antagonist kits at their disposal to be used in the event of overdose. While the introduction of consumption rooms is impeded by the prevailing opinions of the population, the availability of kits is hindered by the lack of funding.

Overdose prevention

Besides drug treatment centres and several other medical facilities, which, however, reach only a limited number of drug injectors, key players in overdose prevention are non-governmental organisations performing social work that targets drug users.

7.2 The prevention and treatment of drug-related infectious diseases

The targeted prevention of blood transmissible diseases among drug users in the form of needle and syringe exchange is performed by non-governmental organisations through 'street work', and by specialised drug treatment centres in Košice and Bratislava where, however, needles and syringes are distributed rather than exchanged.

Moreover, volunteers working for non-governmental organisations distribute condoms to drug users, especially to women engaged in prostitution in order to obtain money to support their drug habit. The free provision of sterile needles and syringes to drug injectors is adequate, in terms of territorial coverage, only in the Bratislava region, and in regional capitals such as Košice, Banská Bystrica, and more recently, Nitra.

Surveys show that the proportion of drug injectors who entered drug treatment for the first time in their lives dropped from over 70% in 1998 to less than 50% in 2003. **Repeated cross-sectional probes into the occurrence of high-risk behaviour among the clients of the needle exchange programme carried out by the Bratislava CTDD in 2004 found a significant decrease in the occurrence of high-risk behaviour – the sharing of non-sterile needles or syringes.**

The main source of sterile needles and syringes for other drug users living outside the above geographical areas are pharmacies. Pharmacy prices being relatively low, injection paraphernalia are available to users. However, a problem lies in the negative attitude of certain pharmacists towards the sale of sterile needles and syringes to drug users, even though the law allows it. The Institute of Drug Dependencies therefore carried out a telephone survey among 97 pharmacies in the capital city of Bratislava, and in 83 pharmacies in selected towns across the country in September 2004. Its results showed that, compared with as many as 54% of respondents in other parts of the country, only 21% of respondents in the capital city were willing to sell sterile needles and syringes to drug users. As a practical follow-up measure, the Institute ran an educational media campaign focused both on pharmacists and the general public.

The vaccination of drug users against type B hepatitis, which was provided free until 2002, when it was fully covered by health insurance, came to a virtual standstill for economic reasons. Very few users entering the treatment can afford, or are willing to pay for, vaccination against HBV. On the other hand, we can expect that the protective impact of the large-scale, free vaccination of all newborns and children under 12 years of age will manifest itself in the future in the form of preventing HBV infection among drug users.

As demonstrated by the epidemics of type A hepatitis in 2002 and 2003 in the capital city of Bratislava, the introduction of affordable vaccination for drug users against this type of viral hepatitis would also have a practical effect.

- **Harm prevention counselling is provided to drug users** by all organisations participating in harm-reduction programmes. The anonymous testing of blood and saliva for syphilis and HIV among drug users is carried out in the streets of the capital city by the citizens' association Odysseus. Counselling and testing for blood transmissible diseases are invariably offered as a voluntary option by specialised CTDDs, as well as by the psychiatric wards of hospitals and psychiatric establishments, and by specialised outpatient facilities for the treatment of alcoholism and substance addiction. Slovak legislation does not contain provisions enabling the testing of synthetic drugs prior to their use.

• **Under the Constitution, drug users are entitled to free treatment for infectious diseases; thus, in essence, it is available to all of them.** In reality, this only applies to those who are infected with the HIV, HBV, and HAV viruses, and not to all persons infected with HCV. The criteria governing the coverage of treatment for type C hepatitis, set out by health insurance companies, exclude active drug users, all former drug users who have stayed clean of drugs for less than 6 months, and patients undergoing substitution treatment with opiate agonists. **Professionals working in the drug addiction field are trying to achieve a change in these criteria, in order to provide free treatment for HCV infection to patients who are adequately stabilised under the methadone maintenance treatment programme.** Given the high proportion of the genotype 3a virus and the young age of infected patients, the prognosis and outcomes of their treatment are very favourable. The overwhelming majority of patients who completed combined Interferon and Ribavirin treatment do not display the presence of the virus. Interferon treatment compliance is also very good.

The prevention of the health-related, physical consequences of drug use is carried out by specialised medical establishments and indirectly by public pharmacies, as well as by field social workers and volunteers from non-profit non-governmental organisations – citizens' associations. **While vaccination, the supply of sterile needles and syringes, and informative and educational materials in medical establishments are limited only to drug users who actively contact these facilities, non-governmental organisations can also reach users in the field, even if the users do not show any interest in or the need for treatment, or if they do not contact medical establishments. NGOs therefore play a decisive and essential role in this respect.**

The non-governmental organisations that have the longest history and the most extensive experience with fieldwork among drug users in Slovakia are the CA Prima⁴⁴ and the CA Odysseus.

The target group of **CA Prima** is the hidden population, living mainly in the streets. CA Prima works with active drug users, prostitutes, homosexual prostitutes, and the homeless. Most of these clients are not registered anywhere, either, because they have no identity documents, no insurance policy card, or because they are not sufficiently motivated to seek professional help.

CA Prima therefore tries to ascertain their health status and motivate them towards the lower-risk use of drugs and safe sex. **To reach this objective, CA Prima runs three programmes oriented towards the health of clients:**

1. **A programme of basic medical treatment in the field** – this treatment is provided by outreach workers in the streets, in strict compliance with hygienic principles. This mainly involves the treatment of abscesses, phlegmonas, or less serious injuries;
2. **A programme of field visits by physicians** – twice a month (every other Tuesday), the team of CA Prima staff is joined by a physician who provides professional treatment or counselling to clients and, if necessary, arranges follow-up examinations and further treatment outside the street environment;
3. **A programme of social assistance** – street workers accompanying clients when in contact with the authorities, physicians, the police, etc.

⁴⁴ *The PRIMA citizens' association is active in the area of harm reduction and prevention in specific groups of drug users, prostitutes, and the homeless since its creation in 1998.*

In 2003, CA Prima tested clients for HIV and hepatitis, provided health counselling, accompanied clients to medical facilities under the social assistance programme, helped them arrange detoxification and subsequent treatment, but, for the most part, provided treatment directly in the field. The number of these interventions is shown in Fig. 7.2.1

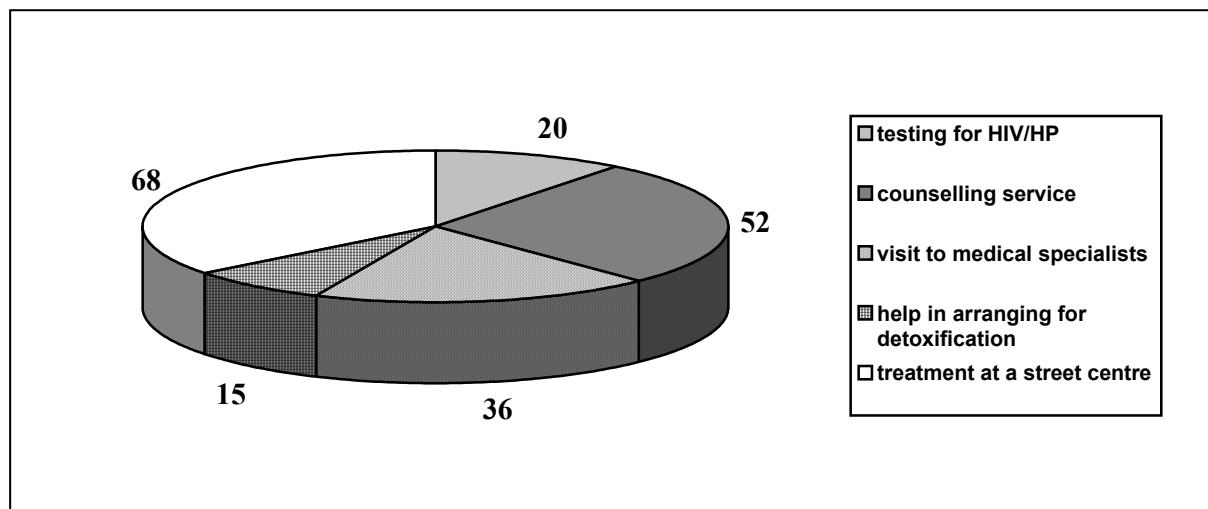


Fig. 7.2.1 Proportion of the individual 'harm-reduction' activities of CA Prima

Since CA Prima does not have the funds necessary to arrange for the vaccination of clients, the most it can do is to have them tested for antibodies to hepatitis A, B, and C. CA Prima focuses mainly on needle and syringe exchange and on the provision of other medical material that active users need for the safe application of drugs. Sterile kits contain, besides syringes, alcohol tampons to disinfect skin prior to injection, dry tampons to stop bleeding after injection, filters to trap impurities when pumping the drug in the syringe, injection liquids for mixing drug solutions and rinsing syringes, ascorbine – vitamin C used for processing heroin (the environment must be acidic), adhesive plaster, bandages, and condoms.

In 2003, CA Prima collected 47,709 used needles and syringes from intravenous drug users. In the same period, workers of this non-governmental organisation distributed to drug injectors: 67,161 disposable sterile needles and syringes, 3,954 doses of ascorbine, 23,823 alcohol tampons, 19,684 dry tampons, 15,157 filters, 12,244 ampoules of liquid for intravenous application, 2,228 condoms, and 324 sterile gloves.

In 2003, CA Prima published the following **educational leaflets and brochures for clients**:

- *How to obtain identification documents and what if I lose them?*
 - The leaflet is intended to help people obtain new identification documents (personal ID card or a travel document, i.e., a passport), advise clients what to do if they lose their ID, or if it is stolen, and on the expiry of their ID's validity
- *How to behave when in contact with the police!*
 - The leaflet describes, in a concise and clear manner, the powers of police officers vis-à-vis citizens, what they can and cannot do, and the rights and obligations of citizens vis-à-vis the police

- *Hepatitis, jaundice*

- The leaflet describes three types of hepatitis (A, B, and C), how they are contracted, the symptoms of individual types, possible treatments, and hepatitis prevention

- *HIV, AIDS*

- The leaflet explains HIV and AIDS, how the virus can be transmitted, how to protect oneself, the evolution of the disease, and how and when to seek an HIV test

- *Where can I seek treatment?*

- The leaflet focuses on treatment facilities, social reintegration facilities and narcotics anonymous clubs, contacts and conditions of entry to individual facilities

- *Sexually transmissible diseases*

- The leaflet describes the transmission and evolution of the most frequent diseases that CA Prima has observed among its clients in the streets, such as syphilis, candidosis, gonorrhoea, herpes genitalis, scabies, chlamydiae, etc.

The 'Protect Yourself' Project of CA Odysseus is an in-the-field social project involving syringe exchange, where social prevention in target groups takes place directly in the streets of Bratislava. **The project was officially launched in October 1998, and was the first of its kind in Slovakia. Since 2003, the association has also conducted a successful field social work project involving needle exchange in Púchov.**

Needle exchange is performed by two fieldworkers, specially trained in outreach social work, who work regularly four times a week on a precisely determined route in the streets of Bratislava at times when potential clients can be expected to be reached; i.e., in the afternoons and evenings. Under the project, the mobile exchange of syringes/needles is carried out every Thursday in sections of the city with a considerable concentration of injecting drug users, and another two times a week, in addition to testing for syphilis and HCV antibodies.

As a part of its outreach activities, CA Odysseus distributes sterile syringes to clients and, in the form of exchange, organises the safe collection and liquidation of used syringes, provides condoms, lubricants, and healthcare materials and materials for safe injection application (alcohol tampons, filters, ascorbine, injection liquid, dry tampons to stop bleeding, Stericup plugs). An inseparable part of counselling are informative and educational materials intended to attract the attention of clients (HIV/AIDS; Hepatitis; Condoms and Lubricants; What to Do If a Condom Bursts; Syphilis; Rights and Obligations of Clients at the Police, a Public Authority, or When Claiming Social Benefits; Safety in Sex Work (special leaflets for women and men); Safe Drug Use; and informative material on social assistance, providing practical information about the assistance network, opening hours of offices, etc.

As regards prevention, great importance during the counselling in outreach work is attached to educating the target group in harm reduction, especially in the safer application of drugs, safer sex, and safer sex work.

CA Odysseus has started once again to involve an active user from the drug injecting community, a so-called peer-exchanger⁴⁵, in a syringe exchange programme in Bratislava. Peer-exchangers, thanks to their established relationships and contacts, are very useful intermediaries in motivating clients towards the safer injection of drugs. Active drug users who are involved in the needle exchange programme have access to other injectors, are experts in the given field, and may conduct fieldwork in those sites that are inaccessible to a team of professional workers, especially for reasons of subculture, time, and space. In

⁴⁵ A peer-exchanger – active drug user – worked in the field in 2002 as part of a project of CHSS-Bratislava.

addition to distributing sterile syringes and materials, their role also includes the dissemination of information about the safer use of drugs and safer sex.

The 'Protect Yourself' Project in Púchov is one of the activities implemented by CA Odysseus since 2003. In view of the specific characteristics of a small town environment, fieldwork employs a number of different methods. Two outreach workers carry out Field social work targeting drug injectors, each of whom has telephone duty on specified days. Clients can arrange appointments with the outreach worker, at which the latter exchanges needles/syringes for them, distributes condoms, medical material, informative or educational materials, in combination with counselling and individual "face to face" consultations, or mediates contacts with the network of healthcare and social institutions. For over a year, the project has also included the services of contacted peer-exchangers recruited directly in the drug injector community.

Printed materials on prevention are available under the needle/syringe exchange programme and, as regards outpatient treatment, they are also available and provided to all the patients and clients visiting specialised medical facilities for the treatment of dependencies – centres for the treatment of drug dependencies – who have not yet stopped using drugs.

Public pharmacies are important points of contact with intravenous drug users in Slovakia because, unlike the cited, specialised organisations, a network of approximately 200 public pharmacies covers the entire territory of the country. For this reason, the Institute of Drug Dependencies in Bratislava (CTDD) conducted a survey in September 2004, followed by a media campaign with the aim of informing pharmacists about the need to sell sterile needles and syringes to drug users and pharmacies in the capital city; at the same time, it provided pharmacies an information leaflet intended to serve as a methodological guideline for drug users buying sterile syringes in pharmacies.

Counselling and testing

Counselling and public education about the consequences of drug use and testing for blood transmissible diseases among users are routinely performed through specialist medical facilities. They are provided free of charge, including the possibility of anonymous, free testing for HIV. In addition to counselling through personal contacts, an important role is played by the dissemination of information leaflets and the provision of information by means of Internet counselling. **An important and irreplaceable part of work in this area is carried out by non-governmental organisations performing social, outreach work among drug users in the streets of cities. Examples of such NGOs include CA Prima and CA Odysseus.**

CA Prima is also helping its clients through the Social Assistance programme, designed primarily for clients who do not possess adequate social skills and are not capable of seeking out the necessary assistance to help them deal with their problem. Street workers involved in this programme accompany clients and help them in contacts with various authorities, the police, or hospitals. It is important to motivate clients to cope with their problems within the limits of their own abilities and possibilities; street workers therefore only help them help themselves, rather than doing things for them. This requires cooperation between such institutions as the police, hospitals, and the authorities.

Street workers' tasks also include teaching clients about the safer use of drugs, or safer sex. To this end, CA Prima provides educational materials explaining various types of infectious diseases, how they can be contracted, and how to behave in order to avoid infection.

In 2003 CA Prima tested 20 clients for hepatitis and HIV, and provided health-counselling services to 52 clients.

Under the CA Odysseus 'Protect Yourself' project, clients are given counselling with the aim of identifying the roots of their problems, information is provided about the possibilities of

alleviating their material or social distress, and clients are guided in choosing and benefiting from various forms of social assistance. Counselling also includes recommending and mediating contacts with specialised institutions active in the area of drug dependencies, with the network of institutions and facilities providing follow-up social and health services, and/or with accommodation facilities and shelters.

Because persons from the target group are often marginalized, stigmatised, and excluded from the social system, and are afraid of or have negative experiences with the authorities (although this often applies to the other side as well), CA Odysseus offers social assistance by personally accompanying clients when visiting institutions (in addition to the time for performing outreach work) to suit the needs of clients.

Since August 2004, specially trained outreach workers have provided social assistance. The advantage of this new method of work is that it "lowers the threshold" for clients, because it gives them the opportunity to agree on social assistance services (accompaniment to the police or a doctor, HIV testing, etc.), directly in the field, with an outreach worker who has already been informed of their problem (the same outreach worker will accompany them to every relevant institution). Contacts with clients are oriented towards social counselling, which is specifically focused on the needs of individuals, the extent and character of these needs, and on improving the client's orientation within the social network, with a view to inducing positive changes.

Since 2002, CA Odysseus has conducted regular field tests for syphilis antibodies as part of its outreach work in selected places and at selected times. Specially trained outreach workers carry out regular weekly testing, in combination with client identification and needle and syringe exchange, on predetermined days, in addition to mobile needle/syringe exchanges directly in locations frequently visited by clients. From July to September 2004, CA Odysseus administered tests for antibodies to type C hepatitis (HCV); it will continue the testing from the end of 2004 and in the future.

However, clients who were tested in the field face difficulties when seeking repeated tests and treatment at a healthcare establishment (health insurance covers treatment only for those who have abstained from drugs for at least six months).

There is both a need and demand on the part of the target group for HIV antibody testing directly in the field, due to the existence of high-threshold testing for HIV antibodies in Slovakia.

In 2003, CA Odysseus administered 391 field tests for syphilis antibodies.

The treatment of infectious diseases

The treatment of all infectious diseases that are or could be found among drug users in Slovakia is free and available for this group of people. The only significant limitation exists in the provision of antiviral treatment for persons infected with type C hepatitis, where health insurance companies request at least 6 months of abstinence from drugs and do not even cover the costs of methadone maintenance treatment, irrespective of the duration of one's abstinence from the use of illegal addictive substances.

Treatment is provided in specialised, outpatient departments of medical facilities.

Infectologists, immunologists, and hepatologists, who cooperate with medical specialists on the treatment of dependencies, treat patients with blood transmissible infectious diseases. To increase compliance, the Bratislava CTDD has recruited an immunologist to provide care to this group of patients.

However, what remains problematic after successful withdrawal treatment is maintaining contacts with and motivating patients who have been free of drugs for longer periods of time

to seek antiviral treatment; in particular, treatment for hepatitis C virus infections that they contracted while on drugs.

7.3 Interventions connected with psychiatric comorbidity

Patients with pronounced psychiatric comorbidity are admitted for treatment in psychiatric departments of hospitals, where they are provided standard psychiatric care, without any obstacles to accessibility or waiting lists.

7.4 Interventions connected with other health implications and consequences

Drug-dependent patients who suffer from other drug-related health problems do not face any obstacles when seeking health care, just like any other citizen. They are not discriminated against or disadvantaged in the provision of healthcare.

Special attention should be devoted to the issue of driving under the influence of drugs. It can be assumed that many drug users drive cars under the influence of drugs, presenting a danger to themselves and to their surroundings. This is confirmed by case histories of patients entering treatment for drug dependency. Nevertheless, a system of monitoring the use of drugs by drivers in road traffic, similar to the one commonly used for alcohol, has not yet been introduced in Slovakia. This issue was also addressed in 2004 by an inter-ministerial commission composed of the representatives of the Slovak Health and Interior Ministries.

Somatic comorbidity

The most frequent diagnoses of drug-related health problems have been addressed above. Their treatment in the healthcare system is available to, and free for, drug users.

Overdoses without fatal consequences and medical care

The medical emergency service, emergency doctors visiting patients on call, or the medical staff of hospital emergency departments treat dozens of emergencies connected with the use of drugs every year, most often **unintentional intoxication after intravenous application. There are no accurate records about the number of patients treated in connection with drug use. Medical care in these cases is accessible and free.**

Equally accessible is treatment for general health problems occurring among drug users, secured through the network of healthcare providers in Slovakia. The occurrence of severe long-term health impairments, except for hepatitis C infection, is relatively low in Slovakia because of the comparatively young cohort of users, the low HIV prevalence, and a generally good level of free healthcare provision.

The prevention and reduction of drug-related traffic accidents

New legislation is envisaged concerning the testing of car drivers, with a view to identifying people driving under the influence of drugs. A joint expert committee was set up for this purpose in 2004 at the level of the Interior and Health Ministries. This legal measure has not yet been enacted.

8. Social implications and consequences of drug use

8.1 Social exclusion

Measures aimed to **prevent social exclusion** are outlined in the Joint Memorandum on Social Inclusion and in the *National Action Plan of Social Inclusion*. By Resolution No. 1156 of 2 December 2003, the Slovak Government adopted a draft Joint Inclusion Memorandum (JIM). Subsequently, a draft National Action Plan of Social Inclusion was drawn up for the period of 2004 – 2006 (*hereafter referred to as 'Social Inclusion NAP'*); after its approval by the Slovak Government in July 2004, it was submitted to the European Commission. Key measures addressed by the Social Inclusion NAP are:

- Promoting employment and employability of population groups facing increased risk of social exclusion
- Preventing exclusion through promoting labour adaptability and mobility
- Guaranteeing necessary means for leading a decent life, while enhancing people's motivation for independence, facilitating access to legal aid, proper housing, healthcare services, education, transportation and cultural values
- Creating conditions to foster family solidarity and prevent social exclusion – access to information and communication technologies by population groups facing the risk of poverty and social exclusion
- Promoting social inclusion of the most vulnerable population groups
- Comprehensive approach to addressing exclusion of Roma communities.

The above key areas are addressed through specific measures with well-defined content and timetable of implementation. **The Social Inclusion NAP focuses on the most vulnerable groups of the population, which include mainly the long-term unemployed, low-income families with children, persons facing the risk of addiction, crime and other social phenomena, members of segregated Roma communities, persons with disabilities, elderly persons requiring long-term care, persons facing difficulties in connection with access to housing, or homeless persons.**

Homeless

The most vulnerable groups include the homeless. The concentration of homeless individuals is particularly high in the capital city: according to the findings from a police action carried out in 2003 on the initiative of the city council, 90 % of around 600 checked homeless persons report having their permanent residence in Bratislava. Approximately the same numbers of homeless live in Košice and in other cities of regional significance, attracted by such factors as anonymity of a big city, higher level of migration, etc. **The total number of homeless living in Slovakia is around 2000.** However, according to non-governmental organisations working with the homeless community, the number of individuals affected by homelessness, i.e. being deprived of home (not identical with the loss of housing), is around two to three thousand in Bratislava alone. **Care for the homeless at the local level is currently provided in cooperation between municipal self-governing bodies and NGOs and charitable organisations. They provide assistance in the form of food, hygienic facilities or, in some cases, temporary accommodation.** Self-governing regions and municipalities are gradually expanding the network of *shelters for people without home* in the framework of their social programmes; **60 such shelters that currently operate in Slovakia have a capacity of 1,130 places.** The Bratislava self-governing region intends to create a network of shelters throughout the region with the help of the European Union. The shelter network has the objective to provide emergency assistance to persons without home and to facilitate their social inclusion.

The groups that are at the highest risk of social exclusion and poverty due to a combination of factors include *non-integrated Roma communities* living in rural or urban settlement units; the number of these settlements in Slovakia is estimated at several hundred. They have around 100,000 Roma dwellers, i.e. less than 2% of the total population of Slovakia and 28% of the estimated Roma population in Slovakia (according to expert demographic estimates, it is around 350,000). On the one hand, Roma live in marginalized regions where they have extremely few job opportunities, and thus a very little chance to become independent on the social net; on the other hand, due to a number of reasons, they are virtually unemployable on the labour market, or their entry on the labour market is more difficult (e.g. because they are disadvantaged by their lower skill level or social exclusion). This situation gave rise to the phenomenon of ethnically specific Roma unemployment whose extent and social implications are broader and deeper than in case of the unemployed members of the majority population. The unemployment rate in certain Roma settlement units is close to 100%. Due to the character of job supply and inability of a part of the Roma population to take up available jobs, a large group of people continue to rely exclusively on assistance in material distress. The situation is further complicated by certain specific factors such as ethnic discrimination or sociopathic behaviour in segregated Roma communities, e.g. growing abuse of alcohol, volatile substances, medications, pervitine and marijuana in the recent period.

Unemployment

The number of the unemployed continued to fall in 2003 as a result of a decrease in the unemployment rate by 1.1 percentage point. The average rate of registered unemployment went down from 17.8 % in 2002 to 15.2 % in 2003. However, unemployment rates display wide regional disparities, ranging from 6.9% in the Bratislava region to 23.8% in the region of Banská Bystrica. As regards the age structure, the most numerous age brackets were those of 35–49 (34.8%), 15–24 (26.9%), and 25–34 (25.2%).

In 2003, the unemployment rate of young people (under 25) decreased by 15.6 percentage points. As many as 37.6% and 32.9% of young people under 25 years of age were out of work in 2002 and 2003, respectively. Young people continue to be the hardest hit by long-term unemployment. Data concerning the registered unemployment show that young people aged 15 to 29 accounted for as many as 28.2% of the total number of long-term unemployed. **The prospects of finding a job were especially bleak for uneducated registered unemployed who represented up to 83.4% of the long-term unemployed.**

The unemployment rate of registered drug addicts in 2003 was about 66%.

Persons with disabilities accounted for 5.4% of all registered unemployed persons in 2003. In that year, the number of the registered unemployed per one job vacancy dropped from 33 to 22.

	Registered unemployment											
	January	February	March	April	May	June	July	August	September	October	November	December
1998	13.4%	13.6%	13.4%	13.2%	12.9%	13.5%	14.1%	13.8%	13.8%	13.9%	14.5%	15.6%
1999	16.3%	16.5%	16.7%	16.4%	16.5%	17.7%	18.3%	18.2%	17.8%	17.7%	18.3%	19.2%

	January	February	March	April	May	June	July	August	September	October	November	December
2000	19.5%	19.5%	19.3%	18.8%	18.6%	19.1%	19.4%	17.4%	16.6%	16.1%	16.7%	17.9%
2001	19.8%	19.7%	19.2%	18.3%	17.5%	17.7%	17.9%	17.8%	17.4%	17.3%	17.7%	18.6%
2002	19.7%	19.6%	19.1%	18.1%	17.7%	17.6%	17.6%	17.2%	16.6%	16.4%	16.8%	17.4%
2003	17.7%	17.1%	16.5%	15.4%	14.8%	14.6%	14.5%	14.3%	13.9%	13.7%	14.2%	15.6%
2004	16.6%	16.5%	16.0%	15.3%	14.5%	13.9%	13.7%	13.2%	13.1%	12,7%	12,6%	13,0%

Table 8.1.1: Registered unemployment rate - by months, from 1998

Source: www.employment.gov.sk

In 2003, employment rate in the Slovak economy recorded a year-on-year increase of 1.8%; employment grew for both genders and in all the regions. The most significant increase in the number of workers was observed in population groups with university-level education (by 9.3%), and with complete secondary vocational education with baccalaureate (by 8.5%). The most dynamically growing age group of workers was the 55+-age category (the number of workers aged 55–59 grew by 8.6%, and those aged 60+ by 12.6%). This indicates certain positive trends in the lengthening of working life.

The overall **rate of employment** in 2003 was 57.6 %; traditionally, it was higher among men (63.0%) than among women (52.2%). An increase in the employment of young people in the 15–24 age group was also observed in 2003 (by 1.7%); the employment rate of this age bracket was 27.3%.

The favourable trend of falling unemployment was reflected also in the lower number of jobseekers among the **long-term unemployed**. The share of jobseekers registered with the offices of labour, social affairs and family for more than 1 year was 47% – a decrease by 2.2 percentage points from the previous year. However, the share of jobseekers who had been registered for more than 2 years in the total number of jobseekers increased by 2 percentage points (from 28.5% at the end of June 2003 to 30.5% at the end of June 2004).

The situation slightly changed as regards the **age structure** of jobseekers. The number of jobseekers under 25 years of age decreased, probably due to changes in registration requirements, while the raising of the retirement age started to be reflected in a higher number of jobseekers from higher age brackets (Fig. 8.1.1).

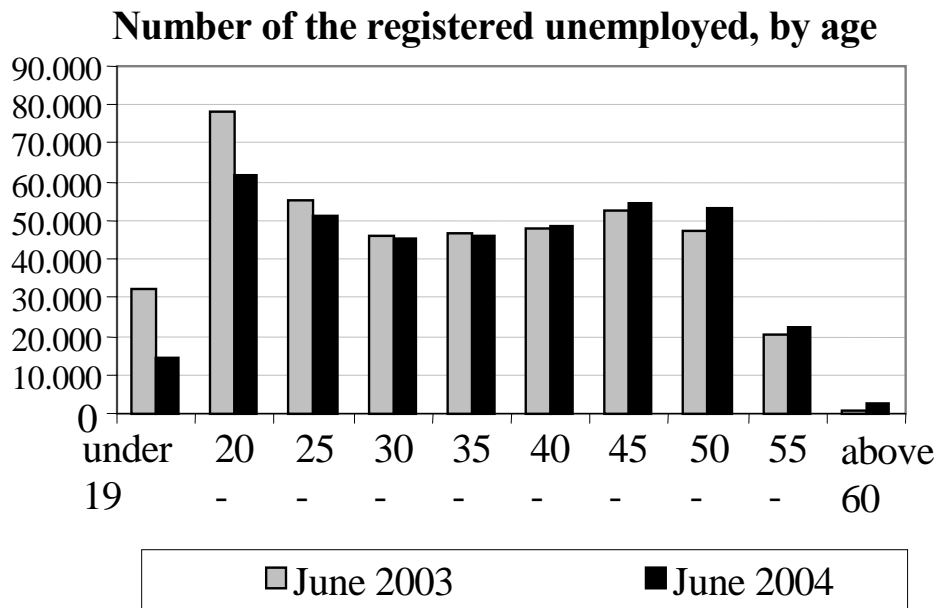


Fig. 8.1.1 - Number of the registered unemployed, by age
Source: Centre of Labour, Social Affairs, and Family (CLSAF)

As regards the **education structure**, most persons in search of employment in the first half of 2004 had low level of education. At the end of June 2004, the highest share (35.2%) in the total unemployment was represented by jobseekers with incomplete secondary vocational education, whose number also recorded the highest year-on-year increase (by 1.4 percentage points). They were followed by jobseekers with primary education that represented a 29.5% share. The share of unemployed persons who completed secondary education with baccalaureate dropped by one percentage point (Fig. 8.1.2).

Shares of the registered unemployed, by education level

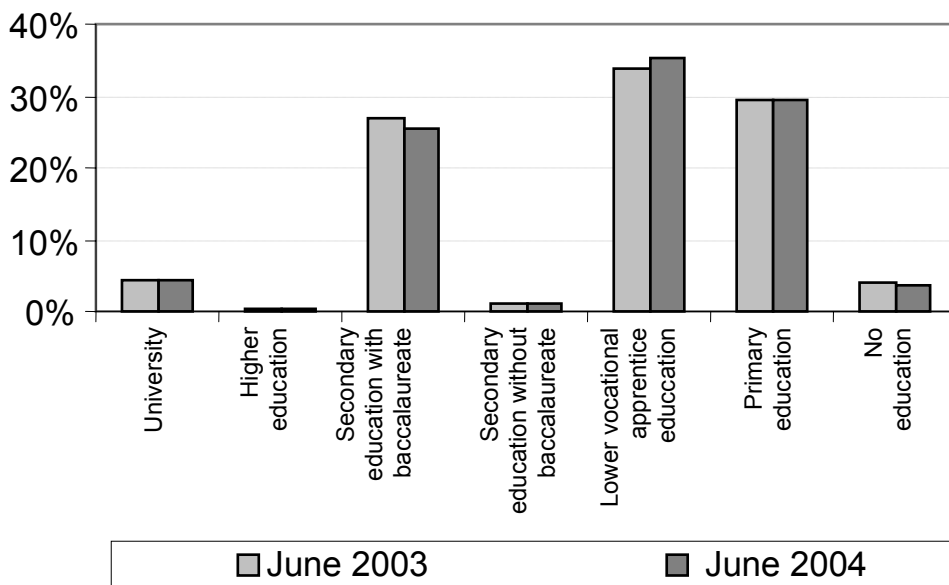


Fig. 8.1.2 Number of the registered unemployed, by education level
Source: Centre of Labour, Social Affairs, and Family (CLSAF)

Financial problems

The risk of social exclusion is, among other factors, connected with financial problems of individuals and families, and with the possibilities of citizens to obtain sufficient income above the subsistence minimum threshold. Thus, important factors that predetermine the risk of social exclusion and poverty include income and its distribution in the society. In 2002, the risk of poverty in Slovakia, expressed by the proportion of individuals living in households whose income was lower than 60% of the median of equivalent income, was 21%.

Another *national indicator of poverty in Slovakia is the subsistence minimum*, i.e. the number of the recipients of social assistance benefits (from 1 January 2004: assistance in material distress).

A person is considered to be in *material distress* if his/her income and the income of jointly assessed natural persons is lower than the subsistence minimum (current subsistence minimum is set at 4,580 SKK for natural persons of legal age, 3,200 SKK for the second jointly assessed person, and 2,080 SKK for dependent children), provided that he/she and jointly assessed natural persons are unable to obtain or increase their income through efforts of their own.

A person with no income is entitled to assistance from the state that has the form of benefits in material distress, activation and protective allowances, and housing allowance. These, however, can only be granted as a temporary substitution for income from work.

Social security

Social security in Slovakia has **three basic forms: social insurance, social assistance and social support.**

1. The role of social insurance is to protect people in different situations (such as maternity or incapacity for work), in particular as regards implications for participation in the labour force. The system of insurance is based on the employment history of persons and their income. The social insurance reform introduced a merit-based system; this means that the amount of received insurance is proportionate to the amount of contributions paid to the system (to insurance funds).

2. Social assistance schemes are designed to secure income substitution, in particular for the most vulnerable population groups in a situation of social or material distress. Persons with no income are entitled to assistance from the state, which has the form of benefits in material distress. Persons are deemed to be in a situation of social distress if they are unable to provide for their own livelihood, to run a household, to protect and exercise their rights and legally protected interests, or to maintain the contact with their social environment, mainly due to their age, poor health, social mal-adaptability, or loss of employment. Severely disabled persons who need to mitigate or overcome social consequences of their disability are also deemed to be in a situation of social distress.

3. Social support

The social support scheme, funded from the state budget, has the form of family allowances: the state provides direct support to persons facing certain situations, such as the birth of a child, maintenance and upbringing of children, death of a family member, etc. Entitlement to family allowances is not conditional on the payment of contributions or on the income situation of the recipients. Basic social support benefits are: child allowances, parental allowances, childbirth grants, and foster care grants. The table below gives the amount of individual social support benefits and the number of recipients.

Benefit	Year 2003		1 st half of 2004	
	Actual situation		Actual situation	
	Expenditures	Number of recipients	Expenditures	Number of recipients
Parental allowance – total	5,646,750	116,649	2,795,607	117,137
- in the amount of 3,790 SKK		8,350		7,887
- in the amount of 1,200 SKK		36,203		12,591
- 1,200 SKK – the other parent				
Child allowance	8,818,446	807,005	4,156,947	758,388
Child birth grant	160,092	50,892	96,753	24,934
Increased child birth grant	60	13	15	3
Grant for parents	708	95	380	51
Funeral grant	107,811	51,082	52,963	25,065
Maintenance benefit for soldier's family	2,507	205	798	133
Foster care – total	63,910		65,967	
- lump-sum grant for foster care		654		486
- repeated grant for foster care		2,098		2,165
- remuneration for the foster parent		2,499		2,578
Housing allowance	894,675	59,675	206,608	35,830
Total	15,694,959	-	7,376,038	-

Table 8.1.2 Number of recipients and expenditures on state social support benefits in thous. SKK, 200 – 2004

Source: Social Insurance Company, COLSAF Information System

8.2 Drug-related crime

Drug-related criminal offences handled by the Police Corps

As seen from Table 8.2.1, the number of drug-related criminal offences increased by 18.14% between 2002 and 2003. The corresponding increase between 2001 and 2002 was 7.78%.

Year	Drug-related crimes
2001	1002
2002	1080
2003	1276

Table 8.2.1 Number of drug-related crimes in the 2001 – 2003 period

Source: NADU (OFOC PCP)

Structure of drug offenders

As regards the age structure of offenders, most offenders belong to the 18 – 30 age group; between 2001 and 2003, their number increased by 29.1%. In the same period, the number of offenders in the 30 – 40 age group grew by 16.3%. At the same time, the number of

offenders in the 15 – 18 age group increased by 16.2%. Compared with 2001, the number of male offenders in 2003 rose by 26.7%.

- **Age aspect**

Year	Total	Men	Women	Under 15	15-18	18-30	30-40	40-50	50-60	Above 60
2001	1002	754	114	18	105	597	92	43	9	4
2002	1080	770	106	19	83	621	90	46	12	5
2003	1276	955	104	13	122	771	107	28	17	1

Table 8.2.2 Structure of drug offenders in the Slovak Republic, by age and gender: 2001 – 2003

Source: NADU (OFOC PCP)

In the breakdown by education level, most offenders belonged to the group with primary education – they accounted for 47% of all offenders in 2003. As regards offenders with secondary education, their number increased by 77.7 % between 2001 and 2003. Over the same period, the number of offenders with university-level education increased by 71%.

- **Education**

Year	Primary	Secondary	University	Other
2001	586	110	7	165
2002	526	161	14	175
2003	600	195	12	252

Table 8.2.3 Structure of drug offenders in the Slovak Republic, by education level: 2001 – 2003

Source: NADU (OFOC PCP)

The comparison between 2003 and 2001 shows a higher than three-fold increase in the number of offenders holding managerial positions. The number of offenders – manual workers increased by 57.5%. An increase of 43.3% was also recorded in the category of private entrepreneurs.

- **Social situation**

Year	Manual workers	Operations staff	Technicians	Managerial staff	Non-production	Unemployed	Other production workers	Entrepreneurs	Others
2001	40	33	6	3	4	577	103	30	175
2002	46	38	8	15	6	541	83	58	164
2003	63	49	10	10	10	665	83	43	209

Table 8.2.4 Structure of drug offenders in the Slovak Republic, by social status: 2001-2003

Source: NADU (OFOC PCP)

- **Situation by regions**

The table below (Tab.8.2.5) shows that the **drug crime is concentrated in Bratislava**. In 2003, the share of Bratislava and its surroundings in the total crime level in Slovakia was 55.5%. In the same year, the number of registered drug addicts increased by 25%. The indicator reflecting the number of drug-related crimes involving seizures of synthetic drugs in 2003 was 70% higher than in 2002. These data suggest that **there are signs of epidemics on the drug scene in the capital city, which has not yet reached its peak**.

In addition to being the capital of the country, Bratislava's geographical location makes it easily accessible from Austria, the Czech Republic and Hungary. It has a concentration of educational and cultural institutions, and is a centre of economic and business activities. These facts, in combination with the highest population density and income, create favourable conditions for latent drug-related crime. **Dominant drugs in Bratislava are heroin, pervitine and discotheque drugs. There is a growing interest in the cultivation of improved marijuana**. Cocaine, whose price went down in the recent period, is becoming an attractive and more widely accessible drug.

The drugs of choice in western Slovakia's regions of Nitra and Trnava are marijuana and heroin. Dealers operating in these regions obtain drugs directly from Bratislava. Critical areas for pervitine production include the town of Hlohovec and its surroundings, mainly because of direct access to the ingredients at Slovakofarma Hlohovec, and the areas around the towns of Sereď, Piešťany and Galanta.

Central Slovakia, i.e. the region of Banská Bystrica, the towns of Liptovský Mikuláš and Kežmarok are known for the consumption of marijuana. The production and distribution of pervitine are in the hands of organised groups. Basic ingredients are obtained from Poland and the Czech Republic. Organisers of drug trade have contacts in Bratislava and abroad. Imports and distribution are limited to smaller quantities of 10 to 20 g. Individual groups mutually cooperate and their activities are characterised by a high degree of organisation and secrecy.

The regions of Žilina and Trenčín represent the north of Slovakia. The products in highest demand among students include marijuana and hashish. The production of pervitine and consumption of ecstasy by young people are on the rise.

Eastern Slovakia in general, and the cities of Košice, Poprad and Prešov are characterised by high unemployment. Heroin is brought from Bratislava in small quantities of 20 to 30 g. Also this region witnesses an increase in the interest in synthetic drugs, some of which are produced directly in the region. Hashish is widespread among foreign students, however cocaine is rare.

- **Number of drug-related criminal offences handled by the Police Corps, by localities**

	2001	2002	2003
Bratislava	527	498	705
Trnava	81	113	94
Trenčín	63	139	115
Nitra	92	94	81
Žilina	54	71	86
Banská Bystrica	106	92	122
Prešov	31	23	25
Košice	48	50	48
Total	1002	1080	1276

Table 8.2.5 Number of drug-related criminal offences handled by the Police Corps, by localities

Source: NADU (OFOC PCP)

8.3 Social costs of drug use

- **Social area**

Under new Act No. 599/2003, situations of material distress are addressed mainly through **benefits in material distress** (1,450 SKK for individuals), and supplements to benefits, in particular **activation allowances** (1,500 SKK for persons undergoing vocational training or participating in publicly beneficial or voluntary work), **housing allowances** (contribution to housing costs in the amount of 780 – 1,330 SKK/month), **protective allowance** (1,500 SKK for persons involved, e.g., in social reintegration programmes, persons of poor health, etc.) and **lump-sum grants** in material distress (maximum 3 times the amount of subsistence minimum, designed to cover expenditures on basic clothing, household articles, medical treatment costs, etc.). Amounts of benefits and allowances are given in Table 8.3.1 below.

Amounts of material distress benefits and supplements	
<i>Basic benefit</i>	
individual	1 450 Sk
individual with a child or no more than four children	2 160 Sk
childless couple	2 530 Sk
couple with a child or no more than four children	3 210 Sk
individual with more than four children	3 160 Sk
couple with more than four children	4 210 Sk
<i>Supplement for medical treatment</i>	50 Sk
<i>Activation allowance</i>	1 500 Sk
<i>Housing allowance</i>	
one person in material distress	780 Sk
one person in material distress + other jointly assessed persons	1 330 Sk
<i>Protective allowance</i>	1 500 Sk

Table 8.3.1 Amounts of material distress benefits and supplements

Source: MLSAF SR, Social Insurance Company

In the first half of 2004, average monthly benefits and supplements amounted to 2,742 SKK, representing an increase by approx. 5% or, in absolute terms, by 137 SKK in comparison with the same period of the previous year (1st half of 2003). In the first half of 2004, assistance in material distress was provided to an average of 400,252 persons a month. They account for 7.4% of the population of Slovakia; the size of this group decreased by 3 percentage points compared with the same period of the previous year. The highest number of beneficiaries and jointly assessed persons live in the region of Košice (13%), followed by the regions of Prešov (10%) and Banská Bystrica (11%). Conversely, the fewest beneficiaries live in the region of Bratislava (1%). The average monthly number of recipients of benefits and allowances in the 1st half of 2004 was 187,159; they were paid a total amount of 3,079.136 million SKK.

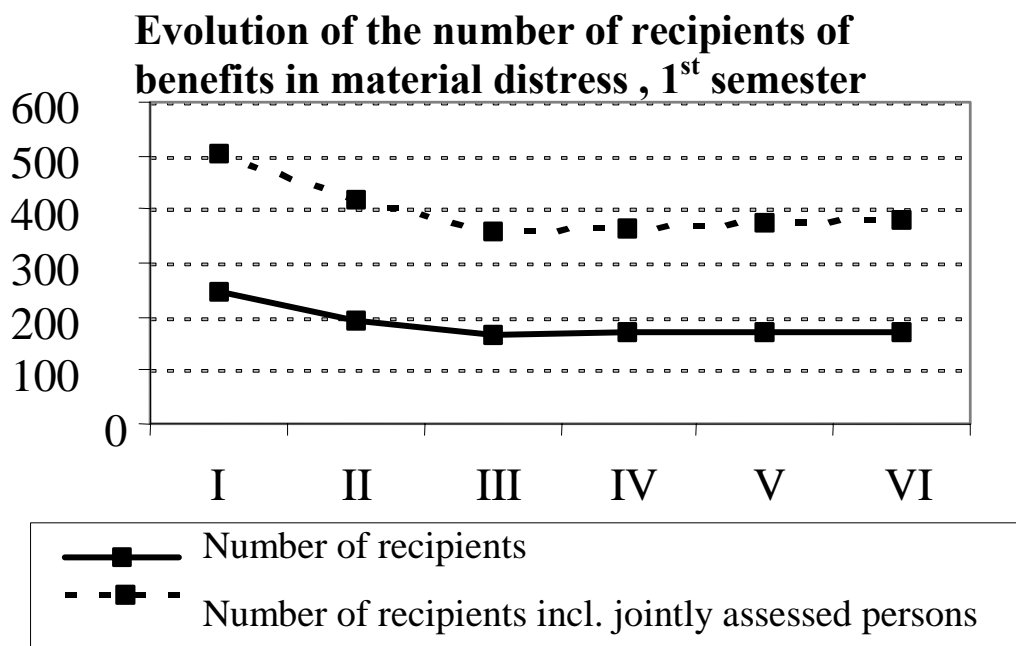


Fig. 8.3.1 Evolution of the number (in thousands) of recipients of benefits in material distress, first half of 2004

Source: MLSAF SR, Social Insurance Company

The total number of persons who were registered on 30 June 2004 as meeting the criteria of entitlement to **activation allowance** was 92,970. The most widely represented population category were jobseekers performing smaller-scale municipal services or voluntary jobs, i.e. a total of 82,625 persons. Persons unable to obtain income or to earn additional income are provided **protective allowance**; the number of these persons on 30 June 2004 was 11,125. As of 30 June 2004, **housing allowance** was granted to 52,238 persons, 37% of them individually assessed persons and 63% assessed jointly with other persons.

Basic state social support benefits are: child allowances, parental allowances, childbirth grants, and foster care grants. All types of state social support benefits provided in the 1st half of 2004 amounted to 7,376,038 thous. SKK.

Costs of treatment

Direct costs incurred by residential withdrawal treatment per one patient with drug addiction, covered from public health insurance, were around 40,000 SKK for average stay of one month. Costs of outpatient treatment, covered from the same source, were around 20,000 SKK/year, and for methadone substitution treatment around 24,000 – 27,000 SKK.

9. Measures related to social implications and consequences of drug use

9.1 Social reintegration

Housing

In an effort to improve the **housing situation of disadvantaged population groups**, the Ministry of Construction and Regional Development, in cooperation with other sectors, including the Ministry of Labour, Social Affairs, and Family, developed a **'Long-term Concept of Housing for Marginalized Groups of the Population and Model of Its Financing'**

The concept of the state housing policy sets out basic objectives and goals of housing development and, in combination with economic instruments for promoting housing development, creates conditions for improving access to housing for the population of the Slovak Republic. However, because of their educational, cultural and social circumstances, members of a certain minority population group are unable to provide for their housing through efforts of their own. The objective of the proposed measures is to define the principles and to create conditions for addressing the issue of housing for **marginalized groups of the population, including, in particular:**

- Persons belonging to socially excluded Roma communities,
- Persons experiencing social inclusion problems (homeless, ex-convicts, drug addicts, etc.),
- Former inmates of children's' homes,
- Elderly persons,
- Persons with severe disabilities.

The issue of affordable and generally available housing is especially important for socially weaker groups of population, i.e. those who are not capable of finding adequate housing on the housing market. As a result of massive sell-out of municipal rental flats in the 1990s, proportion of rental flats in the housing stock fell from 25% in 1989 to 4% in 2003. In spite of the rise in housing construction, the Slovak housing market is still short of around 250 thousand flats. To satisfy existing demand, it is necessary to step up both the pace of and support for housing construction, in particular, for the construction of affordable public rental flats.

The state supports housing construction mainly through the State Housing Development Fund (SHDF) and the Housing Development Programme.

In 2004, the state budget allocation for the SHDF was 2,519.4 million SKK. It is used to grant loans to towns and villages throughout Slovakia under favourable terms for building more than 2,300 flats.

Applicants who are procuring the housing for disabled persons may obtain a non-returnable grant amounting to 50% of the purchasing price, maximum 100 thousand SKK. Resources from the Fund are used to support around 200 barrier-free flats annually. The State Housing Development Fund may also be used to support the construction of social services establishments, renovation of residential buildings, or construction of municipal rental flats.

In the framework of the housing development programme for allocation of rental flats, it is possible to provide subsidies to villages, towns, town districts, non-profit state or municipal organisations working in the area of rental flat procurement, or to non-profit organisations

providing generally beneficial services, covering up to 30% of construction costs. These flats may be leased to tenants whose income, including the income of jointly assessed persons, is not higher than three times the subsistence minimum amount. The amount of state budget funds allocated in 2004 for the *Rental-Flat Subsidy Sub programme* of the *Housing Development Programme* was 845 million SKK.

In the amendment to the law on assistance in material distress, the Ministry of Labour, Social Affairs and Family envisages granting housing allowances to landlords renting rooms in accommodation facilities for permanent stay.

The Updated Concept of the Development of Housing Construction approved in October 2003 contains revised and more effective financial tools for supporting housing development. Because of limited state budget allocations for housing development, it was necessary to channel support mainly to social housing projects, i.e. the housing for persons with low household income – smaller flats with lower costs per 1 m² of floor area.

Education and training

Extracurricular programmes for young people

The activities of social reintegration centres (SRCs) established by the city of Bratislava (RETEST) and by a self-governing region (RS Košice I) are funded from the budgets of self-governing regions, and partly from the Anti-Drug Fund.

Long-term social reintegration facilities include: House for Life without Drugs – Ľudovítov, Road Tomky, Return – Kráľová, Koš – Provital Prievidza, Adam Adamov, Bethesda Sered, Retest Bratislava I, Social Reintegration Centre for Young Drug Addicts Košice I, SRC Hope – Bátorové Kosihy, COR Centrum Banská Bystrica, Hill Bohunice, SRC Žakovce, Charitas House Prešov, SRC Clean Day – Galanta Hody. **Social reintegration centres have currently a capacity of 236 places; they are located in all self-governing regions except the Žilina region, where a SRC is to be created next year.**

Drug addicts who have completed a social reintegration programme may be provided housing and further supervision in a sheltered housing facility – the so-called ‘half-way houses’; they were recently opened at the SRC Provital Koš, SRC Bethesda Sered, SRC Ľudovítov, SRC Charitas House Prešov, SRC Clean Day Galanta, and SRC Žakovce.

All registered social reintegration centres were provided adequate financial support during the reporting period by the relevant self-governing regional authorities, which covered 100% of the difference between revenues and expenditures on the provision of social services. **16 SRC with a capacity of 236 places were registered in Slovakia in 2003; their average occupancy rate was 84% (with an average of 197.5 clients/year).** In the course of 2003, self-governing regions provided social reintegration centres a total of 26.255 million SKK, i.e. 132,938 SKK per client/year, or an average of 11,078 SKK per person/month. **The SRC clientele comprised mostly men (77%); 62% of clients were addicted to ‘hard drugs’; alcohol addiction was the primary reason for the placement in a SRC of 23.1% of clients.**

The age structure was as follows: 3.9% of clients were minors under 18, 54.2% of clients were aged 18 to 24, 34.7 % were aged 25 to 40, and 7.2% of clients were above 40.

According to the data provided by RSCs, they employed 83 full-time workers in the reporting period; 72.3% (i.e. 60) of them were staff members in direct contact with clients (professional staff), and 27.7% belonged to auxiliary personnel. 54 % of full-time employees were men and 46% women. As regards their skill structure, 43.4% were university graduates, mostly with degrees in humanities such as psychology, social work, pedagogy, etc. The university

education requirement was fulfilled by 55% of staff members coming into direct contact with clients. Almost a half of all employees had full secondary education; they also took additional courses and/or participated in training. The comparison of the number of staff members with the number of clients in social reintegration gives the ratio of 0.45 full-time worker/client.

Employment

Social reintegration includes social re-insertion and **vocational rehabilitation of former drug users and their access to the labour market; this is a priority for the Ministry of Labour, Social Affairs and Family.** The National Employment Plan also includes active labour market policy with focus on retraining programmes for young persons and publicly beneficial works for the long-term unemployed, i.e. including for drug addicts who lost work or are not able to find a job due to inadequate skill level. The programme of 'Promoting employment of school graduates and school dropouts' includes the creation of conditions in selected regions for the training of and access to employment by young people who are disadvantaged on the labour market by their drug habit.

A project on 'Vocational and social rehabilitation of drug addicts' was drawn up and submitted with a view to improving the situation in this area; it has several parts devoted to access to employment, vocational therapy, retraining and reintegration of drug addicts into their natural social environment, and employment support for these persons. Employment policy lays emphasis on the use of new instruments of active labour policy – in particular, training and preparation for entering the labour market, allowance for employers hiring disadvantaged job seekers, allowance for employers hiring school graduates as trainees, allowance for activation activities, grant for moving in search of employment, grant to encourage the setting up and operation of a sheltered workshop or sheltered workplace, grant to encourage persons with disabilities to conduct private entrepreneurial activities, grant to encourage employment of assistants.

Development plans aimed to improve labour market access for persons from disadvantaged groups are increasingly focused on **building a network of supported-employment agencies** that provide a broad range of services designed mainly for persons with disabilities, including persons who have completed a treatment or social reintegration programme, and need special support to find or keep a job. At the same time, these agencies provide counselling and assistance to the employers who set up and operate sheltered workshops or sheltered workplaces for persons with disabilities.

A national project prepared to help fulfil the above objectives – 'Activation of the unemployed, and of jobless persons with low propensity to work, dependent on benefits in material distress' – received a support of 526.8 million SKK from the ESF. The project is mainly designed for the long-term unemployed jobseekers relying on assistance in material distress to help them maintain work habits. It is expected that by increasing the motivation of municipalities and of legal and natural persons to address local employment needs, it will be possible to improve cooperation between state administration, local government authorities and business entities in this field.

Motivation to work among the unemployed who are receiving benefits in material distress is expected to be increased by adding an activation allowance to the basic amount of material distress benefit, granted on the basis of participation in retraining programmes or smaller-scale services for the municipality, or in voluntary works organised by legal or natural persons. The purpose of organising smaller-scale municipal services is to refresh and preserve work habits by means of appropriate activities, while taking account of the age, health condition, education and length of experience.

9.2 Prevention of drug-related crime

Helping risk groups

Drug addicts receive assistance also in the form of **post-penitentiary care; mainly the offices of labour, social affairs and family in the framework of social prevention provide it for persons of legal age**. Measures in this area include working with persons serving imprisonment sentences and with remand prisoners, and with persons released from prison; they focus on social reintegration, access to the labour market, help in the search of housing and in restoring family relationships. Social rehabilitation activities that were carried out in 2003 for persons of legal age included assistance in the search for employment provided to 1,258 persons, encouragement of drug addicts to seek treatment and/or social reintegration to 253 persons, help in addressing housing problems to 1,003 persons; outreach social work was carried out for 5,668 persons in the open environment, and 2,474 persons in institutions (420 persons were visited in penitentiary establishments). Social prevention efforts resulted in a successful social reintegration of 2,014 persons of legal age.

The Ministry of Labour, Social Affairs and Family supports also harm-reduction programmes carried out in the form of field social work projects among risk populations (especially drug injectors, prostitutes, etc.); they include the provision of social and special counselling, exchange programmes, distribution of the means of protection, etc. Using the revenues from games and lotteries, the Ministry of Labour, Social Affairs and Family supported the *Protect Yourself* project, which involved 'street-work and harm-reduction' programmes carried out by the CA Odysseus Bratislava. The Ministry of Labour, Social Affairs and Family also helped publish a material on 'Harm reduction and injection use of drugs'. The Anti-Drug Fund when assessing project proposals considers the objective of supporting outreach social activities as a priority. Thus, it supported the projects of CA Prima Bratislava aimed on harm-reduction in the capital city of the Slovak Republic, and on the prevention of drug addictions and HIV/AIDS in Roma communities (under EU programme 'SASTIPEN'). Other projects that received support included those of CA HEUREKA Žilina, CA ALTERNATIVE Banská Bystrica, CA Clean Needle Košice and CA RIDZ Prešov, which include prevention of HIV/AIDS among drug users and prostitutes.

Important tools for promoting social work, social protection, social prevention and social counselling will be created by the envisaged changes to the criminal law, i.e. recodification of the Criminal Code and the Code of Criminal Procedure (containing provisions to extend the range of alternative sentences⁴⁶), the law on probation and mediation officers (laying down the institution of probation and mediation as an alternative option and as an instrument in connection with suspended imprisonment sentences), and by the envisaged or enacted changes to the family law. A significant role in implementing non-penal measures is to be played by social workers. The Ministry of Labour, Social Affairs and Family participates in the pilot project on probation and mediation service; the Ministry of Justice in the districts of Bratislava, Nové Zámky and Spišská Nová Ves verified the project in 2003.

The Ministry of Labour, Social Affairs and Family actively participated also in the drafting of the law on family; the Ministry of Justice submitted the draft for legislative processing. Since most measures involving interventions in families result from or precede court decisions, the proposed legislation on social and legal protection and on social prevention was aligned, *inter alia*, with the relevant provisions of the law on family, in particular those concerning judicial measures imposed to secure education of children, separate provisions governing adoption, wardship, guardianship, collision or property guardianship, or extending the authority to impose educational measures, including institutional education. Proposed educational measures include the authority to compel minor children and their parents to undergo social counselling or professional counselling in specialised establishments, to

⁴⁶See Part B Chapter 12 – Alternatives to custodial sentences – current state and proposals.

undergo outpatient drug treatment, or to take part in an educational or social programme. If the above measures fail to remedy the situation, the court may temporarily remove a minor from parental care or from care of another persons responsible for the child's education, and order the placement of minor child, under a separate law on social and legal protection of children and on social custody, a) in a specialised diagnosis establishment for a period not exceeding six months, b) in a medical or other specialised establishment for a period not exceeding six months, or c) in an establishment for social reintegration of drug addicts.

10. Drug market

The post-1989 drug scene in the Slovak Republic recorded dramatic changes. While in the period that immediately followed the opening of borders Slovakia could be characterised as a transit country, in the early 1990s it rapidly changed into a country with a well-developed drug market. **At the turn of the millennia, drug situation in the country is almost identical with that of other countries of the European Union. Drugs are no longer just transported through or stored in the territory of Slovakia, and the country has a developed drug market that responds to every trend.** All types of drugs are available. An increased interest in synthetic drugs was observed after 2000. These drugs are manufactured in relatively small quantities in home laboratories using simple procedures from medications or preparations containing pseudoephedrine, or from imported precursors with ephedrine content.

In 2003, certain interest groups tried to launch a public discussion in an effort to introduce provisions into the recodified Criminal Code that would decriminalise marijuana and allow a 'single dose for personal use'. The effort to decriminalise marijuana reflected, among other things, an expanding hydroponic cultivation of improved marijuana with a higher content of active substance. The fixing of the 'personal dose' is questionable, since it is different for individuals with a long history of drug dependency and first-time drug users.

The Slovak drug scene after 2000 can be characterised by:

- Steadily rising incidence of drug-related crime
- Access to all types of drugs that are available in the European Union
- Control of the drug trade by foreign organised crime groups
- Predominance of organised house sale of drugs
- Persons of Roma origin controlling the house sale of drugs
- Distribution of smaller quantities of drugs through house sale
- Rising interest of users in synthetic drugs
- Own production of synthetic drugs (production of pervitine and hydroponic laboratory cultivation of cannabis with high THC content)
- Steady increase in the number of persons using drugs
- Considerable proportion of drug users committing crimes against property
- Identification and detection of drug-related crimes almost never results in seizing proceeds from drug trade.

Joint police–customs unit

To improve the quality of the fight against crime and secure the fulfilment of obligations set out in relevant legal standards, the Ministry of the Interior of the Slovak Republic **and the Customs Directorate of the Slovak Republic signed an Agreement on Setting Up a Joint Police–Customs Unit on 18 October 1999. The Unit started to operate in March 2000.**

The joint police–customs unit has the following tasks:

- Monitoring specified substances
- Drafting and concluding Memoranda of Understanding on voluntary cooperation with industrial entities
- Analytical, information and documentation activities
- Law enforcement in the fight against illegal handling of precursors and other chemical substances that can be abused to manufacture narcotic and psychotropic substances.

10.1 Drug availability and supply

Heroin

The Kosovar Albanian community has maintained its predominant position in heroin trade. Recent findings point to the existence of links to persons from Croatia, Hungary, Albania and Turkey. Practically all of them are Kosovar Albanians operating in those countries.

The route that is increasingly used for heroin transit is the southern Balkan route, with Bulgaria and Croatia playing an important part as transshipment points. All available means of passenger and freight transport are used to smuggle drugs. The drug is currently smuggled in smaller consignments of approx. 1 to 2 kg, in order to reduce losses of the organisation in case of seizures. The concentration of imported heroin has recently recorded a marked decrease. The distribution of the drug from the producer to the consumer takes place along a chain with many links.

Ethnic Albanians form an organisation based on ethnic, religious and family principles. The structure of the group, positions of its individual members, and their tasks remain unknown to persons hired from the 'outside' to perform one-off jobs (couriers, errand boys). An increasing number of persons from the Balkans have been found to reactivate their drug smuggling operations; most of them are Albanians who respect the principle of silence and are therefore more likely to remain silent in case of drug seizures.

The Roma community controls House sale of drugs, which is a specific feature of the Slovak drug scene. Wallachian Roma who have contacts to sources in the Albanian community and abroad supplies drugs. They operate on the principle of family clans that adhere to strict unwritten rules. Violations of these rules are punished in a variety of ways – from a fine to the most brutal physical punishment, or even death. They do not hesitate to sacrifice the weakest member who voluntarily takes the guilt upon him, while the organisation continues in its operations.

Cocaine

Cocaine trade is conducted mainly by Albanian groups who benefit from a network of contacts all over the world. They import cocaine mostly from South American countries. The drug is shipped by air to Western Europe or to the capitals of the neighbouring countries because of a limited number of flights to Slovakia. The carriers thus have sufficient time to manipulate with the drug before entering our territory.

In the last few years, persons from West Africa started to play an increasingly active role in cocaine trade. For instance, Nigerians effectively use well-established structures in the neighbouring countries. Because of the closed character of that community and important language barrier (use of Edo or Ibu dialects), it is very difficult to infiltrate these groups not only in Slovakia, but also elsewhere in the European Union.

The National Anti-Drug Unit initiated the setting up of the international 'SUN' project to monitor activities of Nigerian groups. **After 1 January 2004, Slovakia had to step out of the project it initiated because of the decreased staffing quota for the National Anti-Drug Unit of the Office for the Fight against Organised Crime at the Police Corps Presidium that resulted from the new organisational structure of the Police Corps Presidium. After the withdrawal of Slovakia, the project was wrapped up.**

Cannabis and cannabis products

Organised groups of Slovak nationals started to recently show in increased interest in the hydroponic cultivation of cannabis. Products from cannabis grown indoors have a much higher THC content than cannabis grown in open nature. Cannabis can be harvested four times a year. This mode of production can yield profit, which is comparable to that from heroin sale, at a relatively lower degree of risk.

The groups involved in these activities have their own hierarchy and specific modus operandi. Their members often communicate via the Internet. Growers regularly change locations, using rented houses in the countryside. It is therefore quite difficult to carry out their undercover surveillance.

Mainly members of the Arab community sell hashish. The trade is concentrated in the hands of Arabs from Tunisia and Algerians. The drug is sold in flats, mainly in Bratislava and Piešťany. Slovakia is not the target country for the trafficking in hashish. The drug is smuggled mainly from Morocco, Lebanon, Pakistan and Afghanistan. Its target countries are the Netherlands, Switzerland and Spain. The drug is transported in caches built in the lorries and trailers.

Synthetic drugs and precursors

Slovakia has caught up with the European trend of growing interest in synthetic drugs. These substances are manufactured using a simple technology from available medications and preparations containing, e.g., pseudoephedrine. Pervitine (metamphetamine) is gaining an important position on the market. Since the National Anti-Drug Unit expects pervitine expansion to continue, there are worries that the drug might become too widespread on the market. Metamphetamine production is concentrated in the hands of Slovak nationals, with the citizens of other countries being involved in it only sporadically (for instance 'cooking' specialists from the Czech Republic). The prevailing trend today is to choose production locations that cannot be linked to the producer of the drug. Various weekend homes or remote structures rented for this purpose are quite often as far as 50 to 100 km from the place of stay of the organiser. As soon as the production of the drug is finished, the entire equipment (laboratory, chemicals) is dismantled and moved to another place.

Ecstasy is popular especially among young people. It is smuggled from the Netherlands. Importers use two methods:

- a) They import limited quantities at irregular intervals, collecting money in advance
- b) Large importers organise imports of large quantities (thousands of pills) at regular intervals. The National Anti-Drug Unit has recent information about the drug distribution system – part of the drug shipment from the Netherlands (thousands of pills with imprinted logo) stays in the Czech Republic and the rest goes to Slovakia.

Professional as well as recreational athletes are increasingly abusing substances to enhance physical performance (ecstasy etc.) or appearance (anabolics, etc). Trainers and staff of fitness centres, some of who are connected to the organised groups involved in the trafficking of other drugs, sell these substances.

NADU officers identified the following drug prices.

Drug prices

Type of drug	Drug prices in €
<i>Hashish</i>	2 - 15 / g
Marijuana cigarette	1.5 – 2.5 / pc
Cocaine	65 – 75 / g
Heroin	7.5 – 15 / dose
Ecstasy	1 – 5 / pc
LSD	4-7 / trip
Metamphetamine	55 – 60 / cubic centimetre

Table 10.1.1 Prices of drugs according to the findings of the National Anti-Drug Unit
Source: NADU (OFOC PCP)

Situation by regions

The table below shows that **the drug-related crime is concentrated in Bratislava**. In 2003, the share of Bratislava and its surroundings in overall crime in Slovakia was 55.5%. In 2003, the number of registered drug addicts grew by 25%. The 2003 indicator of increase in the number of drug-related crimes with seizures of synthetic drugs was 70% higher than in 2002. These data suggest that the drug scene in the capital city **is showing signs of epidemics, which has not yet reached its peak**.

From the geographical point of view, Bratislava is not only the capital city, but is also easily accessible from Austria, the Czech Republic and Hungary. It is the centre of educational and cultural institutions, and of economic and entrepreneurial activities. In combination with the highest population density and the highest income, it has the latent potential for drug-related crime. Dominant drugs for Bratislava are heroin, pervitine and discotheque drugs. There is a growing interest in the cultivation of improved marihuana seeds. As the price of cocaine has been going down, the drug has become more attractive and accessible to a wider user base.

In western Slovakia, i.e. the regions of Nitra and Trnava, the drugs of choice are marihuana and heroin. Dealers based in these regions obtain drugs directly from Bratislava. The area of critical importance for pervitine production is the town of Hlohovec and its surrounding; this directly reflects access to the necessary raw materials at Slovafarma Hlohovec. Other critical areas include the vicinity of the towns of Sered, Piešťany and Galanta.

Central Slovakia, i.e. the Banská Bystrica region, the towns of Liptovský Mikuláš and Kežmarok are known by the consumption of marihuana. The production of pervitine and its distribution are in the hands of organised groups. Base materials are obtained from Poland and the Czech Republic. Organisers of drug trade have established contacts in Bratislava and abroad. Imports and distribution are limited to smaller quantities of 10 to 20 g. Individual groups mutually cooperate, and their activities are highly organised and clandestine.

The regions of Žilina and Trenčín represent the north of Slovakia. The products in highest demand include marihuana and hashish among students. Production of pervitine and consumption of ecstasy among young persons are on the rise.

Eastern Slovakia, the towns of Košice, Poprad and Prešov are characterised by high unemployment. Heroin is brought from Bratislava in small quantities of 20 to 30 g. Interest in synthetic drugs is increasing also in this region, and part of them are produced directly in the region. Hashish is widespread among foreign students, however the cocaine is rare. Number of drug-related criminal offences handled by the police, by localities is set in table 10.1.2.

	2001	2002	2003
Bratislava	527	498	705
Trnava	81	113	94
Trenčín	63	139	115
Nitra	92	94	81
Žilina	54	71	86
Banská Bystrica	106	92	122
Prešov	31	23	25
Košice	48	50	48
Total	1002	1080	1276

Table 10.1.2 Number of drug-related criminal offences detected by the police, by localities, 2001 – 2003

Source: NADU (OFOC PCP)

10.1.1 Availability of drugs for users

The citizens' association CA Prima works only in Bratislava districts I (Old Town), II (Dolné Hony, Slovnaft, Vrakuňa) and V (Petržalka). Clients from district I are mostly persons who make a living by begging, while those from districts II and V are not inclined to come to the downtown area – the Old Town – either due to financial (prostitutes or homoprostitutes) or other reasons (pimps, drug dealers). In the course of 2003, CA Prima did not observe any drug availability problems in the streets of districts II and V. A different situation existed in the Old Town area, where clients found it difficult to obtain their dose, as the dealers started to move out to the periphery of Bratislava, thus reducing drug availability and supply. In 2003, **CA Prima registered 724 clients, most of them in districts II and V.** The table below gives client data indicating the district, gender and year of birth:

CLIENTS BY DISTRICTS	
I	54
II	222
III	43
IV	59
V	279
Outside of Bratislava	67
Total	724

Table 10.1.1.1 – Clients of CA Prima in Bratislava, by districts

CLIENTS BY GENDER	
Men	373
Women	351
Total	724

Table 10.1.1.2 - Clients of CA Prima, by gender

CLIENTS BY THE YEAR OF BIRTH	
1986 – 1990	43
1985 – 1981	137
1980 – 1976	278
1975 – 1971	121
1970 – 1966	67
1965 – 1960	51
1956 – 1960	27
Total	724

Table 10.1.1.3 – Clients of CA Prima, by the year of birth

10.2 Seizures

Heroin

Heroin seizures have displayed a generally declining trend also in Slovakia after 2000. This decline reflects, among other things, the current geopolitical situation of Slovakia and its EU membership – according to the Schengen Agreement, checks on internal borders of the EU

are not to be abolished before 1 July 2007. As a result, couriers seem to consider the crossing of Slovak borders to be more risky. **Heroin of South American provenience reaches Europe, and thus also Slovakia, either by sea or air. Opium and/or heroin from Afghanistan are imported to Western Europe through Baltic countries or through the silk route (e.g. through Russia).** Transit countries are Iran and Pakistan.

A growing trend of smuggling smaller quantities of drugs by couriers, mainly of Bulgarian nationality, in passenger cars or minivans has been observed since 2002 (as opposed to the smuggling of large quantities of heroin by lorries that prevailed in the past). This activity is organised by groups that have a solid base in Germany. They extensively use Turkish buses operated by persons of Turkish origin residing in Germany.

Heroin-related crime in Slovakia has two main forms – import of heroin to our territory with its subsequent distribution to dealers and then to consumers ('Balkan route' or the 'reversed Balkan route' – a courier picks up the drug in northern Germany using the Czech route. The courier then returns through Austria, thus lowering his risk since there is only one border to cross), and the organisation or co-organisation of drug transport from producer areas to markets outside of the Slovak Republic.

Criminal organisations operating in the Slovak Republic are either part of or closely cooperate with criminal groups abroad. They organise couriers, transshipment and temporary storage of drugs. Growing consumer demand drives the heroin production up (heroin made from methadone in Slovakia).

Cocaine

Since 2003, Slovak law enforcement bodies have recorded an increased demand for cocaine, in particular among well-to-do customers. This trend is reflected in the growing number of cocaine seizures in the territory of Slovakia, and even more markedly in the number of Slovak couriers apprehended abroad.

Cocaine trade is carried out by Albanian, Dominican, Italian, Lebanese, Serbian, South American organisations and organisations from former Yugoslavia. There are also indications pointing to multi-ethnic cooperation between various criminal groups operating on the market, although the mode of their cooperation has not yet been well documented.

Three recent cases of drug seizures indicate the routes that are probably used to bring cocaine to Slovakia:

- Through Germany: three Slovak citizens were apprehended for cocaine possession in May 2004 in Germany. Couriers travelled from Slovakia to northern Germany where they picked up cocaine and returned via Germany and Austria
- From South America: a courier arriving from South America who worked for an Albanian organiser was apprehended at the Bratislava airport in May 2004
- In the third case, two Slovak nationals were apprehended at the Vienna Schwechat airport for cocaine possession. They flew in from the Caribbean, i.e. used direct flights for this purpose.

Synthetic drugs

Metamphetamine

One of the most pronounced trends on the Slovakia's drug scene of recent years is the steadily growing consumption of synthetic drugs, especially of metamphetamine (pervitine), and the related increase in the supply of the substance. In the past, pervitine used to be smuggled mainly from the Czech Republic in passenger cars or buses. This has changed and, according to recent estimates, the bulk of pervitine consumed today in Slovakia is produced at home in small clandestine laboratories/production facilities.

According to certain reports, pervitine is illegally exported from western Slovakia to the Czech Republic. These, however, are only findings of local significance. It seems that the situation of pervitine import and/or export between the Slovak and the Czech Republics depends on the current availability and price of the drug at the Slovak-Czech border.

Precursors

The main precursor for pervitine production is **ephedrine or pseudoephedrine**. These substances are listed among group I precursors in Act No. 219/2003 Coll. on the handling of chemical substances that can be abused for illegal production of narcotic or psychotropic substances amending Act No. 455/1991 Coll. on Small Business (Trade Act) as amended. The share of pervitine made from medicaments containing ephedrine/pseudoephedrine started to rise in 2001. Besides the traditionally used Solutan, other medicaments registered in Slovakia – Modafen, Disofrol, Clarinase, Nurofen and others – were found to be increasingly in use. Operational findings and recent cases detected by customs or police authorities indicate that the most frequently abused preparations for pervitine production in Slovakia include US-made Disophrol Repetabs containing 120 mg (60 mg in the coating and 60 mg in the core) of pseudoephedrine sulphate per tablet. Another source of ephedrine for metamphetamine production are illegal imports mainly through the Hungarian and Ukrainian borders. Ephedrine smuggled from Hungary has mostly the form of tablets, and is of Turkish or Rumanian origin.

Attempts were recorded in the past at smuggling the Turkish preparation Efedrin Arsan, tablets containing 50 mg of ephedrine hydrochloride made by the Turkish pharmaceuticals company Bilim Pharmaceuticals Inc., Istanbul. The preparation was found also in several cases of illegal pervitine production detected by the National Anti-Drug Unit. Hungary is the transit country also for the Rumanian preparation Efedrin Armedica containing 50 mg ephedrine hydrochloride per tablet. Turkish ephedrine is smuggled mainly by Bulgarian or Serbian nationals.

It should be noted that illegally imported ephedrine tablets are not exclusively used for metamphetamine production, since a substantial amount is used as unauthorised 'training booster' in athletics and, in particular, as performance enhancer in 'recreational' physical activities, mainly by fitness centre visitors who use it to lose weight or enhance muscles. Ephedrine is often clandestinely offered and sold in fitness centres as part of preparations that are not registered as pharmaceuticals in Slovakia.

MDMA

A prominent part among synthetic drugs imported to Slovakia for the purpose of their consumption is played by synthetic dance drug 'ecstasy' containing active substance MDMA. It seems to be **is smuggled to Slovakia mainly from the Netherlands, which is its main producer**. Amphetamine imported in lesser quantities also belongs among favourite discotheque drugs, especially in the form of tablets. However, Slovak customs and police authorities have not yet been able to gain the necessary body of information concerning the smuggling of these drugs or to dismantle criminal organisations involved in their import and distribution.

LSD

In 2003, the joint Customs Directorate and Police Corps Presidium unit made what apparently amounts to the largest seizure of ergotamine – LSD precursor – in the world to that date. The substance was to be smuggled to the Netherlands, the country that according to operational findings of a number of foreign services has become the global centre of illegal trade in this precursor. No operational findings were made concerning the production of LSD in Slovakia, and the substance was imported to the country mainly from Hungary.

Other medications

Besides the continued trend of consumption of Rohypnol and other benzodiazepines, an increase was recorded in the demand for barbiturates – such as Tardyl.

10.3 Drug prices

In 2003, CA Prima noted complaints of its clients about an inferior quality of heroin, due to which many of them limited their drug consumption to pervitine or combined heroin with pervitine. CA Prima also noted that because of low-quality heroin in the street, several clients started to consider treatment.

Street price of drugs

Name of drug	Price	Comment
Marijuana	300 SKK ⁴⁷	Price per 1 gram; top quality marijuana may cost as much as 500 SKK
Hashish	60 to 100 SKK	
Heroin	1,500 SKK	Price per 1 gram
Cocaine	3,000 SKK	Due to low availability of cocaine, its price per 1 gram is very high
Pervitine	250 SKK	Price of 250 SKK is for one part
Ecstasy	Around 200 SKK	Price is variable, 200 SKK is minimum price; it also depends on the logo printed on the tablet
LSD	Around 400 SKK	The price depends on the size and logo on the paper or tablet; it can be higher or lower

Table 10.3.1 Street price of drugs according to information from CA Prima

Outreach workers of CA Odysseus and active drug users – clients of the ‘Protect yourself’ project, report street prices of drugs in Bratislava given below. Prices may vary within the reported range, depending primarily on dealers supplying the drug, quality of the product (including that of its ingredients) and, especially in case of marijuana, on seasonality.

Name of drug	Price	Comment
Marijuana	400 SKK	1 gram
Joint	50 – 200 SKK	1 pc
Heroin	800 – 1200 SKK	1 gram
Cocaine	2500 – 3000 SKK	1 gram
Pervitine	250 – 300 SKK 2000 – 2500 SKK	Line (0.010); Cube (cube = 10 lines)
Ecstasy	200 – 300 to 400 SKK	1 pc
LSD	350 SKK 200 – 300 SKK	1 pc
Crack	-	Not available in the street

Table 10.3.2 Street price of drugs according to information from CA Odysseus

⁴⁷ Average rate for one € in 2004: 39 SKK

PART B: Selected issues

11. Buprenorphine – treatment, misuse and prescription practice

Although the buprenorphine preparation designed for the substitution treatment of patients addicted to opiates has been registered and available in Slovakia since 2000, it is not prescribed very often. This is due to significant restrictions imposed on its prescription by the largest health insurance company, and also its relatively high price. Buprenorphine is prescribed mainly outside of Bratislava, since methadone maintenance treatment is not available outside of the capital city. In spite of existing restrictions, patients, doctors and police reported an increased incidence of buprenorphine abuse on the Slovak black market in 2004. Intravenous use of buprenorphine is frequently reported. No fatal buprenorphine overdosing has been officially reported in Slovakia.

11.1 Buprenorphine treatment

Slovakia has the necessary legal basis for buprenorphine substitution treatment. Buprenorphine preparation Subutex was registered for this purpose.

Buprenorphine has been prescribed for substitution treatment of patients addicted to opioids since 2000.

a) The criteria for buprenorphine treatment include medical diagnosis of opioid addiction and age of over 15. In addition, the largest health insurance company in Slovakia – General Health Insurance Company – has formulated several other conditions that must be met in order to pay for the treatment from health insurance funds. Buprenorphine may be prescribed only by psychiatric doctors who have a certificate on examination in the area of medicine of addictions, or by doctors working in a drug treatment centre. The medication is designed for the treatment of drug dependency following a previous residential detoxification treatment for heroin addiction. Maximum duration of treatment is 2 months. During the 12-month period from the first administration, treatment may not be repeated more than three times. Criteria ruling out buprenorphine substitution treatment include: hypersensitivity to buprenorphine and auxiliary substances, serious respiratory insufficiency, serious hepatic insufficiency, acute alcoholism or delirium tremens, MAO inhibitor therapy and a 14-day period following its completion, age under 15, women in lactation, presence of benzodiazepines and/or methadone in urine sample collected under supervised conditions, presence of alcohol in the breath. The guidelines of the health insurance company prescribe the following criteria for the termination of buprenorphine treatment: positive urine finding indicating the presence of benzodiazepines, positive finding of alcohol in breath of more than 0.5 per mille, three consecutive positive findings of morphine in urine, skipping three consecutive doses. Patients who fail to comply with the treatment regime and are excluded from the treatment can be readmitted for buprenorphine maintenance treatment only after 6 months.

b) According to the methodology of the Ministry of Health and guidelines of the health insurance company, general practitioners may not prescribe buprenorphine for the treatment of opioid addiction. No special accreditation or training is required for buprenorphine prescription.

c) The number of patients who are currently undergoing buprenorphine maintenance treatment in Slovakia is estimated to be around 200 or more. In essence, the only difference between these patients and those undergoing methadone substitution treatment is that most of the former live in the countryside where no methadone treatment is available.

d) The number of patients in buprenorphine substitution treatment in recent years has remained more or less constant.

No training courses are offered in Slovakia on buprenorphine administration, and no research or evaluation studies are carried out in this area.

11.2 Buprenorphine abuse

To obtain indicative information about the possible forms and extent of **buprenorphine abuse in Slovakia, the Institute of Drug Dependencies conducted a study in the second half of 2004 among psychiatric medical specialists in different locations in Slovakia and among patients undergoing methadone maintenance treatment in Bratislava.**

- a) In 2000, around one half of respondents – psychiatric doctors in Slovakia and around 2/3 of patients in methadone maintenance programme in Bratislava reported they had information about buprenorphine abuse. Because of the restrictive buprenorphine prescription policy, the extent of its abuse in the country is not very high. However, no population surveys are available in this area. It is generally believed that abuses are more frequent outside of the capital city due to unavailability of the option of methadone maintenance treatment.
- b) Over 50% of psychiatric doctors in the survey reported that they had information about intravenous abuse of buprenorphine, and around 15% of patients in the methadone programme illegally tested the drug.
- c) No specific measures have been taken in Slovakia to reduce harm caused by illegal injection use of buprenorphine.
- d) Besides benzodiazepines and methadone, some patients used buprenorphine in combination with methamphetamines.
- e) In relative terms, considering the number of patients in buprenorphine substitution programme, its diversion to the black market seems to be quite high; however, in absolute terms, buprenorphine diversion is rather low because of the general restrictions on its prescription. According to one informer from the Bratislava region, the price of one buprenorphine (Subutex) tablet in the autumn of 2004 was 150. - SKK, i.e. the equivalent of around 4 euro.
- f) Yes, patients in buprenorphine substitution treatment are also among those who abuse the medication, but they are not the only ones.
- g) Thrombophlebitis were reported in Slovakia following illegal injection use of buprenorphine, and its combination with benzodiazepines caused breathing difficulties and was suspected of causing deaths from overdose. However, these reports have not been medically documented.
- h) In a katamnestic questionnaire survey of October 2004, only 14% in the sample of 115 patients undergoing methadone maintenance treatment in Bratislava reported that they were not familiar with buprenorphine, 20% knew somebody who had used it, 10% has a past experience with it, and only one applied it intravenously.
- i) Apart from abovementioned surveys, no statistical data or results from the evaluation of treatment results, etc. is available.

Operational findings of law enforcement authorities indicate the incidence of large-scale abuses of buprenorphine-containing substitution preparation Subutex, mainly by persons dependent on opiates, most of them from southern Slovakia. **Street prices of the substance are estimated at 40 – 50 SKK per capsule.** Both injection and non-injection use of the drug is reported. **There are no confirmed findings about illegal imports or exports of the drug.**

12. Alternative imprisonment sentences

Characteristics of sentences

The Slovak criminal legislation characterises sentences as the specific consequences of the commission of a criminal offence, set out by law and enforceable by the state; they are handed down by courts in criminal proceedings and, unlike protective measures, reflect the negative assessment of the criminal offence and of its perpetrator, and inflict a certain degree of harm on the perpetrator with a view to serving the purpose of the sentence and of the Criminal Code.

The sentence is one of the legal consequences of the commission of crime. It is not the only or inevitable legal consequence, because it does not necessarily follow the commission of every criminal offence. In addition to the sentence or in lieu of the sentence, legal consequences of the commission of a criminal offence may take the form of protective measures, damage compensation, etc.

Sentences and protective measures are legal means employed to serve the purpose of the Criminal Code. This purpose is to be achieved both by the threat of sentence, and by its imposition and execution. The threat of sentence is represented by the description in the Criminal Code of the types of conduct that are deemed as unacceptable and harmful for the society, and the types of sentences such conduct may entail.

If the threat of sentence is not sufficient to serve its purpose, the court hands down a sentence. The Slovak criminal legislation provides that the sentencing must abide by the principles of humanism, legality, individualisation, personalisation and proportionality of the sentence, thus guaranteeing fair and just punishment. **These principles are very important also for delivering alternative sentences to imprisonment sentence. The Criminal Code provides that sentences may be delivered only by courts of law** and by no other state authorities, and only in respect of criminal offences (i.e. not in respect of any other – however serious – violation of the law), **and only through properly conducted criminal proceedings.**

The execution of sentence thus directly serves the purpose of the Criminal Code and of the sentence. In essence, the sentence involves a certain degree of harm to otherwise protected civil rights and freedoms of the perpetrator. However, causing harm should never be seen as the objective or purpose of the sentence. It should always be considered, including in alternative sentences, only as the inevitable means to serve the purpose of the sentence and of the Criminal Code.

The Slovak Criminal Code embodies the principle of auxiliary role played by criminal repression; this means, as far as the purpose of sentence is concerned, that criminal repression must not be harsher than what is strictly necessary, taking account of the dangerousness of the committed crime for the society and of the assessment of its perpetrator, and must be proportionate to the purpose of the sentence. **The educational impact of the sentence is not directly proportional to the intensity of repression; the opposite is not true, either – more moderate sentences are not necessarily more effective.**

Different types of sentences cannot be characterised in advance as educational or repressive. As a rule, **every sentence includes both repressive and educational elements. However, the relative weight of the two may be influenced by the sentencing rate, and by combining different types of sentences. This is also why we speak about alternative sentences substituting for unconditional imprisonment sentences rather than about educational sentences.**

The types of sentences that may be imposed by courts are laid down in Section 27 of the Criminal Code as follows: sentence of the deprivation of liberty (imprisonment sentence); sentence of stripping a person of honorary titles or awards; sentence of stripping a person of a military rank; prohibition of an activity; forfeiture of property; forfeiture of a thing; expulsion; prohibition of stay; and pecuniary sentence. The list of sentences in Section 27 of the Criminal Code cannot be extended in any way whatsoever (e.g. by means of interpretation), not even by invoking a certain reason (such as serving the purpose of the Criminal Code).

At the same time, handing down a sentence that does not entail immediate deprivation of liberty is perceived as an expression of trust in the offender; the execution of such sentence can build on positive traits and habits of the offender, and on the educational impact of professionals and of the general public.

There is a worldwide trend towards a wider use of sentences that do not involve imprisonment, and imprisonment sentences are being increasingly replaced by alternative sentences. This also applies to the offenders who committed a criminal offence under the influence of drugs or who are addicted to drugs.

The main reasons for this trend reflect the fact that alternative sentences do not have the disadvantages connected with the deprivation of liberty, are cheaper to execute, and do not stand in the way of social reintegration of the offender – just the opposite, in many cases they effectively help reintegration.

Another very important reason is that alternative sentence were found to work much better for a considerable percentage of criminal offenders than unconditional imprisonment sentences – the latter normally have the effect of deepening the sentenced persons' perception of the society as being oblivious to their fate, frustrations or feelings of injustice. Such feelings then give rise to a negative perception by these sentenced persons of the value system of the society in which they live, especially if these offenders experience damage to family and social relationships, or lose employment or housing, as it often happens with persons serving unconditional imprisonment sentences. **In contrast, alternative sentences – especially with effective guidance of a probation and mediation officer – give less disturbed offenders a new chance to deal with their problems in a manner enabling their reintegration into the society while, at the same time, safeguarding their family and social relationships.**

The most frequent alternative sentences in the Slovak Republic

Conditional imprisonment sentence

Conditional imprisonment sentence is the most frequent form of punishment; it represents an important tool for exerting educational influence on the offender and is an important alternative to short-term imprisonment sentences, especially for the perpetrators of less serious criminal offences. This type of sentence diverges from the perception of the sentence as retribution.

The basic characteristics of a conditional sentence is that the court issues a sentencing judgment involving the deprivation of liberty, and defers its execution (waives the execution of imprisonment sentence) for a probationary period during which the sentenced person must lead a law-abiding life and fulfil the conditions prescribed by court.

The rationale of conditional sentencing is that the circumstances such as criminal prosecution, negative assessment of the offender's person expressed in the judgment, potential threat that the sentence would have to be executed in the future, restrictions and requirements imposed on the sentenced person and, possibly, educational impact of the person who guaranteed the correction of or oversees the offender, may have a beneficial impact in terms of individual and general prevention, which would be absent in case of unconditional imprisonment sentence.

Conditional sentences, besides manifesting trust in the offenders, give them a chance to redress their crimes through their conduct during the probation period without being isolated from the society, and a chance to avoid the necessity to have to execute the suspended imprisonment sentence, and thus to achieve a no-sentence fiction – i.e. that the offender will be deemed as not having been sentenced.

Conditional sentencing may therefore motivate offenders to leading a law-abiding life, drawing on social, psychological and/or material assistance provided by probation and mediation officers, citizens' associations or social workers. Conditional sentencing is considered as a tool to achieve the purpose of the sentence and may therefore be used only where the purpose of the sentence allows it.

Conditional sentence means that the court finally established that an act constituting a criminal offence was committed, found the offender guilty of its commission, and handed down a deferred sentence and, at the same time, set out a probation period and appropriate obligations and restrictions with a view to motivating the offender to lead a law-abiding life, or ordering the supervision over the offender.

If the sentenced person leads a law-abiding life during the probation period, fulfils the duties related to the probation and complies with obligations/requirements, as appropriate, there may be no need to actually serve the imprisonment sentence in a penitentiary establishment. The sentence of imprisonment thus exerts its influence on the offender not through its actual execution, but through the threat that it might have to be executed should the sentenced person fail to lead a law-abiding life during the probation period, fulfil the duties related to the probation, and comply with obligations and restrictions, as appropriate.

The law provides that the key consideration in deciding on the suspension of the execution of an imprisonment sentence is, next to the facts of the case, the person of the offender. This means that the court must take into consideration mainly the profile of the offender, especially his/her personality traits, character, inclinations and preferences, work ethics, relationships within the family and with the society, and social status.

In case of offenders addicted to drugs, the courts examine mainly the family and personal situation of the offender at the time of sentencing, and the extent to which the sentence is likely to exert an educational impact on the offender.

These circumstances, which are not directly related to the actually committed criminal offence, thus have a significant influence on the deliberations concerning the sentence, including conditional sentences. The living and working environment of the offender may or may not have played a role in the commission of crime; however, it has a distinct bearing on the potential correction of the offender, and sometimes may play a decisive role in the social reintegration of the offender. **There is, however, one basic precondition – the offender addicted to drugs must be aware of his/her addiction and be ready and capable to overcome it.**

It will also be necessary to ascertain the circumstances of the offender's life that were relevant for the commission of crime and that could indicate, with a certain degree of probability, that the offender might continue committing criminal acts also in the future.

An irreplaceable role in this direction is played by the probation and mediation service. The court must identify, in particular, positive and negative facets of the offender's personality at the time of sentencing. The considerations that are relevant for assessing the offender's life prior to sentencing include the behaviour of the offender between the commission of the crime and the decision of the court, in particular the offender's feelings about the committed criminal offence (for instance, whether the offender tried to make the compensation for the damage caused by the commission of the offence, contacted and actively cooperated with the probation and mediation officer even before the pronouncement of the judgment, showed readiness to undergo treatment, etc.).

Imposing obligations and restrictions, as appropriate

Courts in the form of judgments pronounce conditional sentences, usually after the main trial. The key and obligatory criterion for suspending the execution of an imprisonment sentence is good behaviour of the sentenced person during the probation period. **Where the nature of the crime or the person of the offender do not give sufficient reason to believe that the probationary sentence as such, i.e. the threat of imprisonment, will be sufficient to guarantee good behaviour of the sentenced person, the court may impose also other restrictions and obligations, as appropriate.**

Such obligations and restrictions that may be imposed, as appropriate, on the offender to make him/her lead a law-abiding life, interfere with the freedom of action and decision-making of the offender during the probation period. **They may have the form of prohibition of a certain activity (i.e. obligation to refrain from an activity) or of an instruction to take a positive action.**

In practice, this means such obligations or restrictions that are conducive to the elimination of the consequences of the crime committed, and of the conditions and opportunity for committing the same crime again. Restrictions and obligations must be also appropriate with respect to the nature of probationary sentence of which they are integral part. At the same time, restrictions or obligations must be appropriate with respect to the criminal offence of which the offender was convicted.

Such obligations and restrictions that may be imposed on the sentenced person, as appropriate, may include the duty to:

- a) Undergo vocational training to upgrade one's skill level
- b) Take part in an appropriate social training or re-education programme
- c) Enter the treatment for dependency on addictive substances
- d) Refrain from visiting unsuitable places or contacting certain persons
- e) Abstain from gambling, playing slot machines and betting.

The most important obligation of drug-addicted offenders is the obligation to undergo drug treatment. The treatment may be provided on an outpatient or inpatient basis.

Alternative sentences and protective measures proposed in the recodification of penal codes

Suspended imprisonment sentence with probation supervision

Suspended imprisonment sentences with probation supervision are delivered on the basis of **probation provisions of the Code of Criminal Procedure.**

These sentences involve **institutionalised supervision** over the offender's conduct; the treatment of the offender combines penological (threat of sentence, imposition of restrictions) and social approaches (supervision and assistance). It means that the supervision may be combined with the educational impact exerted by the person who offered to guarantee the offender's correction, provided that the court accepted that guarantee. **In case of drug-addicted offenders, such supervision function is performed mainly by the closest social circle (family) of the offender, which assumes also the assistance function.**

A probation and mediation officer should perform supervision over the conduct of the offender. The court should define the supervision directly in the judgement: as regular personal contacts between the sentenced person and the probation and mediation officer, cooperation in the development and implementation of the probation programme during the probation period, and verifying compliance with the requirements imposed on the sentenced person by the court.

It comprises:

- a) Observation and control of offenders to ensure protection of the society and reduce the likelihood of repeated commission of crime
- b) Professional guidance of and assistance to offenders to ensure that they lead a law-abiding life in the future

Other obligations that may be imposed on sentenced persons include:

- a) Cooperate with and follow instructions of the probation and mediation officer in compliance with the probation programme
- b) Report to the probation and mediation officer at time intervals fixed by the court and/or the probation and mediation officer
- c) Inform the probation and mediation officer about his/her whereabouts, about compliance with court-imposed obligations and restrictions, and about other facts that are relevant for supervision purposes
- d) Enable the probation and mediation officer to enter the dwelling where the offender is staying
- e) Undergo the treatment for dependency on addictive substances, unless the offender was ordered to undergo forensic treatment.

A probation and mediation officer should as a rule, perform supervision. The probation programme, prepared jointly by the sentenced person and the probation and mediation officer, may also include the obligation to undergo the treatment for dependency on addictive substances (in case of offenders addicted to drugs).

Community service sentences

Community service sentences (referred to as 'CS' hereafter) represent **an important alternative to imprisonment sentences**. This means that if the sentenced person fails to execute such sentence by a fault of his/her own or to lead a law-abiding life during its execution, the sentence is transformed into a sentence of imprisonment.

In essence, CS sentence amounts to a certain **kind of legal forced labour performed for the benefit of a wider community**. Moreover, offenders are under supervision not only with respect to the performance of work, but also as regards their behaviour during the execution of the sentence and compliance with the applicable restrictions and obligations.

Work constitutes an important re-education element of the sentence, and should contribute to the social and work adaptation of the offender.

Conditions underlying community service sentences

CS sentences, as sentences of general type, **may be given for offences that carry a maximum sentence of five years of imprisonment**.

Furthermore, a community service sentence can be given if it can be reasonably assumed that, considering the nature of the committed offence and the possibility of correction of the offender, the purpose of sentence can be reached equally as if the offender served an imprisonment sentence. **It is open to question to what extent can this type of sentence be used for drug-addicted offenders, since most of them did not develop good work habits. Community service sentences can be considered especially for those drug-addicted offenders who underwent the drug treatment already at the pre-trial proceedings stage and whose social environment supports their social reintegration efforts.**

This is in line with the character of community service sentences as an alternative to imprisonment sentences, mainly unconditional, since the law provides that community service sentences should be considered in those cases where, in order to achieve the purpose of the sentence, it would otherwise be necessary to serve an imprisonment sentence.

The criteria for imposing community service sentences are therefore defined in a manner, which allows their imposition on the perpetrators of less serious offences where it is not necessary to give an imprisonment sentence and where, for certain reasons, a pecuniary sentence would not be sufficient or appropriate either as a separate sentence or in combination with another sentence not involving the deprivation of liberty.

The reasoned conclusion that the community service sentence will fulfil the purpose of the sentence in the same manner as an imprisonment sentence must be based on the type of the committed criminal offence and on personal characteristics of the offender. A CS sentence will therefore be given where none of the above considerations calls for delivering a sentence of the deprivation of liberty, which is incompatible with a community service sentence.

Seen from the above perspective, community service sentences are applicable mainly to criminal offences involving a lower degree of danger for the society, in particular criminal offences of public disturbance, or less serious property crimes where it is necessary to exert a public opinion influence on the offenders, since community service sentences are often executed in public, and/or the effect of a community service sentence has an impact on the broader public.

The conclusion that it is not necessary to deliver an imprisonment sentence and that the purpose of the sentence can be reached also by a community service sentence is justified mainly in case of offenders who had no previous criminal record, or who could receive also other concurrent non-custodial sentences, such as the prohibition of activity, or be imposed restrictions or obligations, as appropriate, designed to make the sentenced person lead a law-abiding life.

Community service sentences always involve a certain work duty that the offenders must execute in person, in their free time, and without entitlement to remuneration – for free. The tasks to be performed are usually of the kind that appropriately supplements the work performed under the employment relationship or involves the activities, which, for some reason, are not usually performed under the employment relationship.

Community service sentences entail a certain institutionalised control over the offenders who serve such sentences, focusing on the performance of work, behaviour of the sentenced person and/or compliance with the restrictions and obligations set out by court. Probation and mediation officers can effectively perform such control.

The execution of community service sentences includes both assistance to the sentenced person and control over the performance of community service because, rather than being a typical example of probation supervision over the sentenced person, it involves cooperation with the competent municipal authority and contacts with sentenced persons, in particular if they have problems that may have an influence on the performance of assigned work.

Possibility of working in community services teams (reflections de lege ferenda)

This model of execution of community service sentences is common in the Netherlands and involves the activities that are of a longer-term nature, such as those connected with the protection of nature and landscape, whereby it is possible to exert positive influence on the sentenced persons working in centres established for this purpose.

After they have served their community service sentence, certain former sentenced persons can be granted permanent employment contract in such centres. **These adapted clients**

can then exert a very important influence on, for instance, juvenile sentenced persons. As regards sentenced drug addicts, of special importance for them is that they work in teams consisting of persons of comparable age, and that community service can induce a change in their personal perception of drugs and the related commission of criminal offences.

This also makes it possible to exercise better control over the clients who have just started executing their community service sentence.

Approach of probation and mediation officers to sentenced persons and control of community service sentences

In cooperating with clients and overseeing the execution of community service sentences, probation and mediation officers must strive in particular to gain confidence of clients in their ability to provide them real help in life.

Probation and mediation officers must make effort to obtain as much information as possible about the clients' family and social circumstances, as well as information about their work attitudes and habits.

Supervision over the execution of community service sentences should be based on obtaining personal and voluntary information from clients concerning the execution of the sentence and their way of life directly by probation and mediation officers.

Although this type of supervision is less invasive than the control over probationary sentences, probation and mediation officers should choose the procedures that are sufficiently effective in identifying possible problems of particular clients, not only in relation to the execution of the community service sentence, but also in relation to their lives in general.

If the judgment lays down obligations or restrictions for the sentenced person, compliance is ensured in the same way as in conditional sentencing. Sentenced drug addicts should receive assistance from probation and mediation officers helping them cope with problem situations (such as withdrawal symptoms, inability to handle emotions, stress), or referring them to relevant institutions that can provide assistance in such situations.

Protective measures – forensic treatment

Courts may order forensic treatment for the offenders who committed criminal offences under the influence of addictive substances or in connection with their use. Courts may order forensic treatment also in addition to a sentence or in case of waiver of sentence.

If the court orders forensic treatment for a sentenced person who has not yet started to serve his/her imprisonment sentence, the treatment will be provided in the relevant medical establishment (institution) or on an outpatient basis. Depending on treatment options, forensic treatment may change from an inpatient to an outpatient form or vice-versa.

Probation and mediation officers supervise the execution of non-custodial sentences. Their status and competences are laid down in Act No. 550/2003 Coll. on probation and mediation officers.

The element of probation is very important especially in the work with clients addicted to drugs. For the purposes of the law on probation and mediation officers, probation means:

1. Organising and performing supervision over indicted, accused or sentenced persons,
2. Controlling the execution of non-custodial sentences, including compliance with prescribed obligations or restrictions,
3. Supervising offenders released on parole,
4. Helping offenders to lead a law-abiding life and comply with the conditions set out in the decisions of prosecutors or courts in criminal proceedings.

As of 1 January 2004, probation and mediation officers were appointed in all district courts of the Slovak Republic; their number on 30 November 2004 was 78. Between 1 April 2002 and 31 December 2003, the Ministry of Justice carried out a pilot project on probation and mediation in criminal matters at three district courts – Nové Zámky, Spišská Nová Ves and Bratislava IV District Court.

Due to excellent results of these pilot projects (the probation and mediation officer appointed to the Bratislava IV District Court became a member of the drug commission in the district), the Ministry of Justice proposed a draft law on probation and mediation officers, which was passed by the National Council of the Slovak Republic in October 2003. **However, expectations of the Ministry were not fully met, since probation and mediation is used only to a very limited degree in cases of juvenile offenders, and is almost never used in cases of drug-addicted offenders.** Adequate cooperation among all relevant services is absent, and law enforcement bodies continue to be reluctant to work with these offenders being at liberty.

The Ministry of Justice defines the policy and provides methodological guidance in the area of probation and mediation work. To this end, the Minister of Justice created the Probation and Mediation Council in March 2004, acting as the Minister's advisory body. The Probation and Mediation Council comprises representatives of state administration, probation and mediation officers, representatives of the justice system, prosecution, police, NGOs and professional community.

Probation and mediation officers are civil servants (according to Civil Service Act No. 312/2001 Coll.). The Ministry of Justice organises training courses and workshops for probation and mediation officers.

The training of probation and mediation officers focuses on the acquisition of general and specialised knowledge and skills necessary to perform the work of probation and mediation officers at courts. According to the law on probation and mediation officers, candidates for these positions must have university-level education with a master degree in law, teaching, theology or other social sciences. Because individual university programmes do not fully account for specific needs of the profession of probation and mediation officers, these officers receive specialised training in relevant fields. The criminal law section of the Ministry of Justice coordinates the training. Training activities comprise lectures, specialised seminars, workshops, discussions and practical classes in the following fields:

- Basics of law – legal system of the Slovak Republic, basics of criminal law and stages of criminal proceedings; Civil law – basics of the law of contracts; Legal regulations.
- Probation and mediation – alternative resolution of criminal matters, philosophical premises, role, historical development of alternative resolution of criminal matters by mediation, communication skills and techniques.
- Mediation – basics of mediation, principles and stages of mediation processes, types of mediation; role and task of mediators in mediation proceedings; legal framework for mediation, possibilities and forms of mediation in criminal proceedings, information of law enforcement authorities about the results of mediation
- Probation – history of probation and overview of European assistance systems; professional forms of assistance and control; probation work methods, rules and principles, substance and purpose; communication skills used in probation work; cooperation with criminal justice authorities, probation report; alternative sentences (with focus on community service sentences)

Summary

The system of sentences in the Slovak Republic is laid down in Act No. 140/1961 Coll. (Criminal Code) and Act No. 141/1961 Coll. (Code of Criminal Procedure).

The categories of sentences (under Section 27 of the Criminal Code) are as follows:

- a) Deprivation of liberty
- b) Stripping a person of honorary titles or awards
- c) Stripping a person of military ranks
- d) Prohibition of activity
- e) Forfeiture of property
- f) Pecuniary sentence
- g) Forfeiture of a thing
- h) Expulsion
- i) Prohibition of stay

Under the proposed recodification of criminal legislation, the following types of sentences will be introduced in the near future:

- a) Imprisonment sentence
- b) House imprisonment sentence
- c) Community service sentence
- d) Pecuniary sentence
- e) Forfeiture of property sentence
- f) Forfeiture of a thing sentence
- g) Prohibition of activity sentence
- h) Prohibition of stay sentence
- i) Sentence of stripping a person of honorary titles or awards
- j) Sentence of stripping a person of military or other ranks
- k) Expulsion sentence

The extension of the range of alternative sentences is intended to strengthen the principle that unconditional sentences represent only 'ultima ratio' and should be imposed only where other, less serious means of the fight against crime, including imprisonment sentences, fail.

13. 'Public nuisance'

One of the widely discussed proposals related to drug addictions, that give rise to considerable polemics, is the **legalisation of soft drugs such as marijuana and hashish**. The advocates of the legalisation of marijuana are convinced that the drug has a low addiction potential and that the risks connected with its use are very low, referring to such countries as the Netherlands where marijuana was legalised without causing major disturbances to the life of the society in the country. An example in the opposite direction is represented by Sweden, which, after decriminalising marijuana, re-criminalized its cultivation, selling and consumption.

The legalisation of marijuana/hashish would mean setting out on the road of tolerant or liberal policies vis-à-vis drug use and users. Such policies could lead to an increase in the number of drug users and in the overall drug consumption, although, on the other hand, average consumption would tend to decrease, most users would probably learn to use the drug in a controlled manner, and need for assistance by specialised treatment institutions would probably be reduced. However, because of the complex nature of national and international relations, the legalisation of drugs in the near future cannot be expected, especially since the surveys (Luha, J. 2004) indicate that the population is more in favour of radical measures against drug trafficking and rigorous actions against users of narcotic and psychotropic substances. This tendency is demonstrated in Fig 13.0.1 below, which presents the opinions of the citizens of Slovakia concerning the legalisation of drugs.

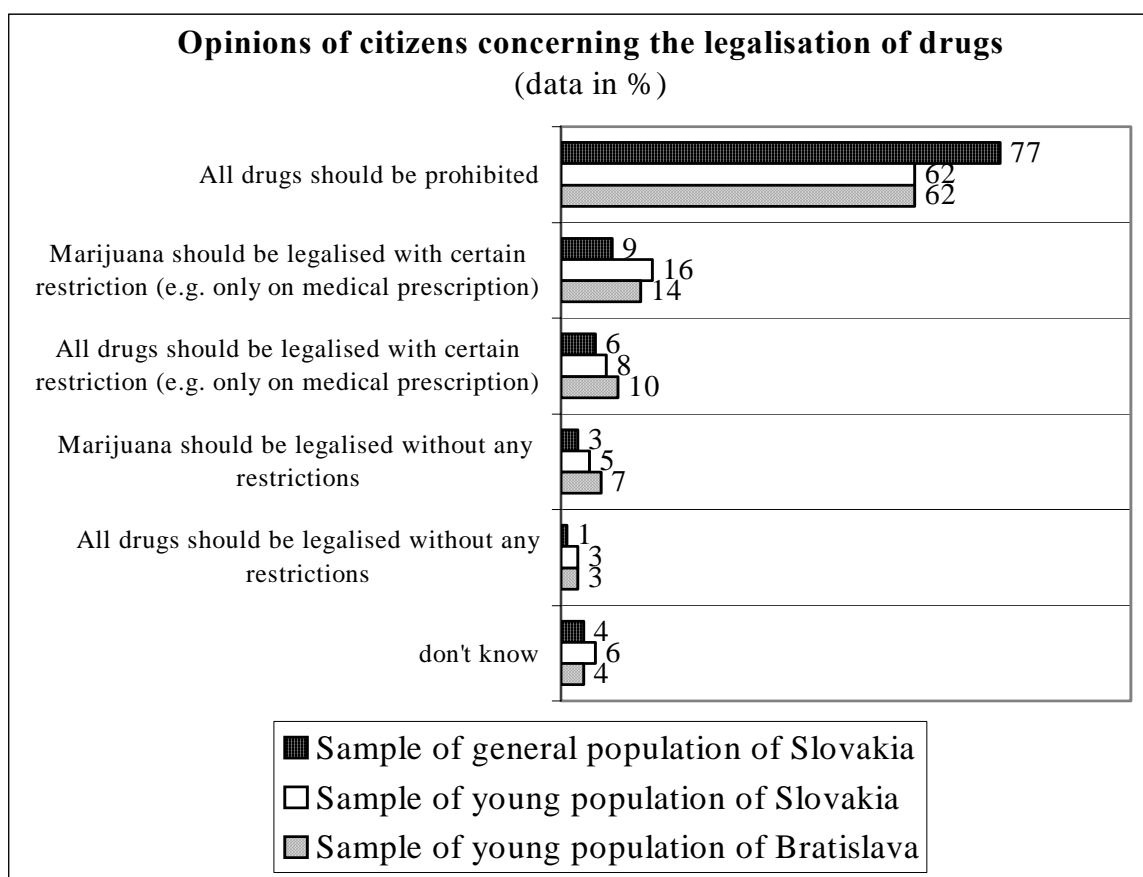


Fig. 13.0.1 Citizens' opinions concerning legalisation of drugs – 2002
Source: Public Opinion Resource Institute at Statistical Office of the Slovak Republic

The sample of general adult population of Slovakia comprises a significantly higher percentage of persons who believe that all drugs should be banned without any exception. Conversely, this sample contains a lower percentage of those who are in favour of full or partial legalisation of drugs.

Young population of Slovakia and of Bratislava in the 15 – 29 age group contains a higher proportion of those who support full or partial legalisation of drugs, namely that:

- **Marijuana should be legalised without any restrictions,**
- **Marijuana should be legalised with certain restrictions, e.g. only on prescription,**
- **All drugs should be legalised, but with certain restrictions, e.g. only on prescription,**
- **All drugs should be legalised without any restrictions.**

As regards socio-demographic characteristics of the respondents, the following findings were made concerning preference for individual drug legalisation options:

- Compared with the Slovak average, the **support for legalising all drugs without any restriction** was expressed by a relatively higher percentage of persons in the 25 – 29 age group, respondents living in the cities with more than 100 thousand inhabitants, respondents living in the Bratislava region, respondents who did not clear religious affiliations, and divorced respondents (3% in each category),
- Compared with the Slovak average, the opinion that **all drugs should be legalised, albeit with certain restrictions**, is supported by a higher percentage of persons in the 18 – 24 age group (10%), the unemployed (11%), inhabitants of the Prešov region (10%) and single respondents (11%).
- Compared with the Slovak average, **a higher percentage of respondents that would fully legalise marijuana** was reported in 18 – 20 and 25 – 29 age groups, manual workers, the unemployed, students, persons living in cities with more than 100 thousand inhabitants, respondents from the Bratislava region (5% each), and single respondents (7%),
- **Legalisation of marijuana, but with certain restrictions**, e.g. on medical prescription would be welcome mainly by persons in 18 – 24 (17%) and 25 – 29 (18%) age groups, students (18%), persons without religion (16%) or without clear religious affiliation (15%) and, as regards the family status, especially by single (17%) and divorced respondents (16%),
- Compared with the Slovak average, **total ban on all types of drugs** is supported mainly by women (82%), persons aged 50 to 59 (82%), and those of 60 and more years (87%), persons living in the Banská Bystrica region (84%).

All the options of partial or complete legalisation of narcotic substances are supported, by a higher than average margin, among persons who already had personal experience with the use of illegal drugs; in contrast, those who had no experience with drug use, are more in favour of absolute prohibition of all drugs.

Besides declaring their support for certain options of partial or complete legalisation of drugs or, conversely, absolute prohibition of the use of drugs, the position of people on the legalisation of narcotic substances could be assessed also on the basis of their opinions concerning the consequences of legalisation of drugs for the society.

- The overwhelming majority of citizens – four fifths of the Slovak sample – believe that the legalisation of drugs would result in an **increase in the number of drug addicts**. The share of respondents holding this opinion is slightly lower in the samples of young persons both in Slovakia as a whole and in Bratislava.

- More than three fifths of respondents declared that the legalisation of drugs in our society would **increase the demand for drugs**. In comparison with 2000, the share of holders of this opinion increased by 8 percentage points.
- Close to one half of citizens agree with the statement that the legalisation of drugs would **improve access to health and social services for drug addicts**; their share is identical to that in 2000.
- About two thirds of respondents agree with the opinion that the legalisation of drugs would **deepen the difference between hard and soft drugs**; this opinion is shared by a greater percentage of respondents in the sample of young persons both in Slovakia as a whole and in Bratislava.
- An approximately identical part of citizens agreed with the opinion that the legalisation of drugs would **reduce their prices and enable a more consistent control over drug trade**; like in 2000, this opinion was expressed by a higher percentage of young persons in Bratislava and in the whole of Slovakia.

Opinions of citizens regarding the consequences of the legalisation of drugs in our society (data in %) ^{1/}																		
<u>Legalisation of drugs would:</u>	Slovak-wide sample						Young people in Slovakia						Young people in Bratislava					
	2000			2002			2000			2002			2000			2002		
	A	N	P	A	N	P	A	N	P	A	N	P	A	N	P	A	N	P
Increase the number of drug addicts	78	16	6	80	16	4	75	20	5	75	22	3	73	23	4	75	20	5
Increase the demand for drugs	68	22	10	76	17	7	68	23	9	72	20	8	65	26	9	69	22	9
Improve access to health and social services for drug addicts	45	34	21	45	38	17	50	29	21	47	35	18	50	30	20	43	39	18
Deepen the difference between hard and soft drugs	38	41	21	38	44	18	42	41	17	46	39	15	45	40	15	41	44	15
Reduce the crime rate, prostitution and illegal drug trafficking	22	68	10	21	72	7	28	63	9	25	66	9	28	67	5	27	65	8
Reduce drug prices and enable control over drug trade	32	49	19	36	53	11	41	45	14	40	49	11	41	47	12	33	54	13
Increase compliance with the law and restrict activities of crime organisations	21	69	10	20	72	8	23	66	11	22	69	9	22	70	8	20	71	9

Legend:

A – yes, 'yes' answers and 'more yes than no' answers are merged in one

B – no, 'no' and 'more no than yes' answers are merged in one

P – unable to judge

Table 13.0.1 Opinions of citizens concerning the consequences of possible legalisation of drugs in our society – comparison between 2000 and 2002

Source: Public Opinion Resource Institute at Statistical Office of the Slovak Republic

Part C: – Bibliography, annexes

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15. Annexes:

15.1 National Programme for the Fight against Drugs in the Period of 2004 – 2008

I.

PREAMBLE

Being aware of the complexity and gravity of the drug problem, the Slovak Republic is approaching and tackling this problem with full seriousness. The Government of the Slovak Republic decided to adopt a new strategy of the anti-drug policy for the period between 2004 and 2008 in line with the declared principles of the anti-drug policy and international commitments assumed in the field of the fight against drugs, while taking into account the experience gained from the implementation of the national programmes for the fight against drugs between the 1995-1999 and 1999-2003 periods.

It will create an environment for the effective prevention of the spread of drug addiction and suppression of drug production, transit and trafficking and make use of a comprehensive, balanced and co-ordinated approach with emphasis on the shared responsibility of the whole society for the implementation of tasks related to the fight against the threat of drugs.

The national strategy, expressed by the National Programme for the Fight Against Drugs, is focused primarily on narcotic drugs and psychotropic substances in accordance with UN international conventions concerning drugs and psychotropic substances of 1961, 1978 and 1986 and the European Union Action Plan to Combat Drugs for 2000-2004.

Since the use of the so-called legal drugs, in particular of alcohol, is closely related to the above issue, the national strategy also deals with the abuse of these drugs and the related problems.

II

INTRODUCTION

Drug use has become a serious society-wide problem. Despite all the measures that have been adopted and taken, the number of persons experimenting, abusing or addicted to drugs is constantly increasing, while their average age is decreasing. The number of detected and prosecuted criminal acts of illicit production, possession and distribution of drugs is rising.

Drugs not only damage health and quality of life of their users, but also that of those closest to them. The risks lie in the alteration of basic values, weakening of will power, disruption of interpersonal relations and gradual disintegration of families. As a result of the negative health, social, economic and security impacts associated with drug use, the healthy development of the society, public health, general order and security in municipalities are put under threat. Changes in this unfavourable development can be achieved only through joint and co-ordinated action.

It is necessary to seek new approaches consistent with the knowledge of the developments on the drug scene in our community and improve the existing methods and forms confirmed by practice and latest findings. In the interest of a long-term and integrating effort, it is necessary to focus attention on a thorough analysis of the developments on the

drug scene, recognise the causes for the occurrence and dissemination of drugs and methods of drug use, and review the efficiency of adopted measures in the context of international experience, national specificities and expertise.

The area of demand and supply reduction is a continuous system. The system maintains and respects individual specificities. The implementers of activities must continuously improve and co-ordinate their work. They must learn to mutually co-operate and create room for the development and reinforcement of civic and society-wide responsibility for tackling this problem. They need to realise the urgency and topicality of the existing risks and determine their place and role in this process. Territorial self-government authorities – regions and municipalities – are becoming important implementers of anti-drug activities.

The key objective of the strategy of the National Programme for the Fight Against Drugs of the Slovak Republic (hereinafter referred to as the “NPFAD”) is to improve the conditions for the implementation of a progressive and quality system of prevention, treatment, re-socialisation and repression in the context of adopted international documents and experience, with emphasis on children and youth. It is necessary to make use of scientific and practical knowledge (epidemiology of drugs, medicine, pedagogy, psychology, social sciences, activities of non-governmental organisations, etc.).

One of the strategy’s important objectives is to address the health and social problems of people living in specific regional, geographic, cultural, social and economic conditions, mobilise, build and support the creation of capacity, and strengthen and increase the share of regional and local resources.

An inseparable part of the strategy will be the thorough adherence to international commitments directed at the prevention of legalisation of proceeds from illegal activities or related to drug crime. We are determined to respect and apply international conventions and principle of international co-operation within the framework of control of licit drug and precursor production. Our efforts will be focused on the reduction of illicit drug production and trafficking. Programmes for drug demand reduction, medical treatment for addicted individuals and programmes for risk groups will be implemented.

The set objectives can only be achieved by assuming responsibility for the fulfilment of the anti-drug policy tasks. The importance and position of territorial self-government authorities in the process of implementation of the anti-drug policy strategy are increasing. The role of non-governmental organisations and civic activities and the need for active involvement of the civic society in the resolution of the drug problem are becoming more important. The creation of a stable funding system is one of the conditions for the creation and implementation of the anti-drug policy and strategy objectives.

The NPFAD strategy defines objectives in a broader, society-wide context of the knowledge and experience gained in the past. Being one of the key principles of the integrated approach to the given issue, they became a basis for the strategy’s orientation for the next period.

III

STRATEGY AND KEY OBJECTIVES OF THE NATIONAL PROGRAMME FOR THE FIGHT AGAINST DRUGS

A. BASIC PREMISES AND APPROACH TO THE CREATION OF THE STRATEGY

Drug supply reduction and drug demand reduction are equally important and complement each other. The basic condition for the fulfilment of the strategy's objectives is a comprehensive and balanced multidisciplinary approach based on society-wide, inter-ministerial and inter-sectoral co-operation.

In compliance with the EU Action Plan to Combat Drugs and EU Strategy for Drugs, the following served as the basic objectives in the creation of the strategy:

- achieve a balance in the reduction of drug demand (prevention, treatment and re-socialisation) and supply (legal repression and law enforcement)
- create effective co-ordination at horizontal and vertical levels
- elaborate the corresponding strategy for communication and information between public administration authorities, civic society and international institutions
- ensure that the drug issue becomes one of the priorities in our society in the context of the measures adopted by the EU.

The creation of the strategy for the 2004-2008 period relies on the experience and knowledge gained from the implementation of the objectives and goals of the National Programme for the Fight Against Drugs for 1995–1998 approved by the Government through Resolution No. 583 of 8 August 1995 and the National Programme for the Fight Against Drugs for the 1999-2003 period with an outlook to 2008 approved by the Government through Resolution No. 298 of 21 April 1999 (see annex 1: Epidemiology of Drugs in Slovakia between 1994 and 2002).

The conclusions from the annual reports of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) for 2002 and 2003, the principles and objectives contained in the United Nations Declaration on the Guiding Principles of Drug Demand Reduction and the relevant documents of the World Health Organisation (WHO), as well as the experience from international co-operation also served as a source.

In accordance with the EU Action Plan to Combat Drugs for 2000-2004 and the documents from the Special UN General Assembly for 1998-2008, as well as on the basis of an assessment of the current situation on the drug scene and expected developments, objectives in the following five key areas will be pursued under the strategy:

A. Drug demand reduction:

Prevention

Treatment

Re-socialisation

B. Drug supply reduction:

Repressive measures

Law enforcement and fight against organised crime

Legislative area

C. Review and monitoring:

Evaluation of the national programme's impact – monitoring of effectiveness

Monitoring of social expenditure on drugs

Monitoring and implementation of the basic and key indicators (pursuant to Council Directive No. 302/1993)

Development of an early warning system for new synthetic drugs

D. Co-ordination of the anti-drug policy:

Extension of the mandate of the Ministerial Committee for Drug Addiction and Drug Control to include legal drugs

Modification of the co-ordination mechanism

E. International co-operation

This means that the Slovak Republic's anti-drug policy is formed by the following basic pillars:

Prevention

Activities aimed at reducing drug demand

Treatment

Accessibility of addiction treatment programmes to the general public and reduction of health risks

Re-socialisation

Provision of appropriate assistance in re-socialisation of individuals

Supply reduction and law enforcement

A set of legislative measures and activities directed at the suppression of drug supply.

Each of these pillars is irreplaceable, interrelated and complementary. They must be applied in a balanced manner. Otherwise, the development and stability of the system would be disrupted and the objectives of the anti-drug policy reduced. The risk of negative consequences and impacts would arise. The approach builds upon the "United Nations Declaration on the Guiding Principles of Drug Demand Reduction". It makes it

possible to influence the area of drug use, from experimentation with drugs to the reduction of negative health, social, economic and security impacts of their use.

B. BASIC PRINCIPLES OF THE STRATEGY

The constantly rising drug use preference, increased health problems and social exclusion, drug trafficking and damage caused by drug-related crime have also hit our society. The fight with the drug problem is becoming an imperative for joint action and co-operation.

Co-operation with EU Member States and regional and local co-operation with the relevant institutions and fora, in line with the global, multidisciplinary and integrated EU strategy for combating drugs, has to become a prerequisite for the strategy's implementation and efficiency.

The problems related to drug abuse must be perceived in the context of broader social disadvantages, which include poverty, deprivation, unemployment, homelessness and social exclusion. The enhancement of social welfare, mainly support for families and those who are worst off, must become an effective instrument of protection against the drug problem.

The drug problem requires a **comprehensive and structured approach**, where the individual components of the anti-drug policy play an irreplaceable and equal role. Change cannot be achieved through one-off, isolated measures.

The implemented activities must be based on valid and scientifically and practically verified data, statistics, knowledge and information. The area of research and research support and the collection, analysis and dissemination of objective, reliable and comparable data must become a condition for the implementation and application of the adopted strategies and interventions in the forthcoming period.

The creation and implementation of the anti-drug policy requires special interest and open, direct and critical discussion. **Civic participation must become an important element of the fulfilment of the strategy's objectives and ensure the transparency of the strategy's implementation.** Its role and importance is increasing, including the risk groups themselves.

The fulfilment of the strategy's objectives requires **partnership and wide co-operation** of all elements of social administration. Joint action by all of its units will require co-ordination at the local, regional, national and international levels.

The area of **planning**, definition of indicators for the **evaluation** of efficiency and **successfulness** of the fulfilment of the set objectives must become an important element of implementation of the strategy's objectives. Domestic and foreign knowledge and experience indicate that the issue of drug use can only be affected through long-term effort and long-term strategies.

C. ORIENTATION OF THE STRATEGY

Attention needs to be focused on the following:

- Creation of a system for the regular monitoring of drug abuse indicators. Monitor and analyse the epidemiological situation and development trends in drug abuse. As a follow-up, adopt targeted measures for risk groups and risk regions;

- Improvement of information of the general public on the risks associated with drug use and the changing trends in the development of the drug scene. Provide information on new types of drugs;
- Emphasis on the importance of drug use prevention, mainly among children and young people. Improve healthcare and social care and the corresponding assistance for individuals addicted to drugs with the aim of renewing their physical and mental health and ensuring their re-socialisation. Create and make use of a comprehensive preventive information system on drug endangered children and youth with the aim of providing appropriate preventive and early healthcare;
- Implementation of long-term, intervention and preventive projects. In compliance with the accepted European standards, rules and procedures, monitor their economic effectiveness and preventive, therapeutic, re-socialisation and social efficiency and benefits;
- Reinforcement of the partnership and co-operation with territorial self-government authorities. Underline their share, role and co-responsibility for the fulfilment of the NPFAD strategy objectives;
- Support for the programmes and projects of public institutions. Continuously monitor adherence to preventive, educational, treatment and therapeutic standard and principles in their implementation, including professional and financial responsibility;
- Application of methods for the reduction of health risks to young drug users, with emphasis on needle exchange and street work programmes;
- Development of international co-operation with partner institutions within the framework of implementation of the EU Action Plan to Combat Drugs and conclusions adopted by the Council of Europe, World Health Organisation (WHO) and the UN Office for Drugs and Crime (UNODC);
- Creation of an efficient system of financing of the implementation of the NPFAD strategy;

D. OBJECTIVES OF THE STRATEGY

The key objective of the strategy is to prevent further worsening of the situation in the area of drug abuse and drug addiction among the population of the Slovak Republic, with emphasis on children and youth.

Drug demand and drug supply reduction and law enforcement in the fight against drugs must be integrated into the activities of the whole society, the relevant state authorities and institutions, local and regional authorities of territorial self-government, communities and civic activities. Its success is conditional upon the creation of an efficient system of co-ordination of anti-drug policy activities at the horizontal and vertical levels, professional competence, co-operation and partnership. Emphasis needs to be placed on the gradual standardisation of quality, efficiency and professional approach to the fulfilment of the strategy's objectives. Participation in the creation and implementation of international activities and programmes directed at the suppression of drug supply and demand is also necessary.

D.1. The Area of Drug Addiction Prevention

- Make prevention a priority and use it as a room for the development of co-operation and the creation and implementation of joint strategies and actions. Reduce the increasing demand for drugs and supply opportunities by improving prevention. Pay attention to reducing the prevalence of drug use, in particular among young people below 18.

- Focus the educational process on the promotion of the quality of life, pro-social orientation of individuals, healthy life style, promotion of mental health and the importance of protection of one's own health.
- Underline the importance of leisure time education as a significant preventive alternative to drugs. Enable children and youth to use leisure time creatively. Support civic activities in this area. Pay special attention to endangered groups of children and youth and to the family.
- Concentrate attention on the creation and implementation of extensive preventive programmes covering both legal and illegal drugs. Rise the average age of first contact with drugs and minimise negative impacts of drug use on the society.
- Improve the information of the general public on the dangers and risks related to drug use and the effects of social exclusion of individuals. Focus media campaigns on the promotion of regional and local activities and practical action.
- Create society-wide conditions for the active involvement of youth in the creation and implementation of preventive programmes. Build on the adopted international documents, mainly the Youth Charter for a 21st Century Free of Drugs, oriented on the reduction of legal drug consumption. Make use of the positive impact of peer programmes.

D.2. The Area of Drug Addiction Treatment

- Concentrate the effort on the extension and quality of the medical services provided, including the treatment of drug addiction and its accessibility.
- Pay attention to the treatment of drug addicts in prison facilities.
- Promote medical care with a view to the seriousness and changes in the epidemiological situation. Focus on the completeness of the services provided and the quality of procedures oriented on the reduction of health risks and damage.
- Participate in the effort to ensure interconnectedness with re-socialisation and long-term rehabilitation of individuals on the basis of co-operation between and co-ordination of the activities of medical and social establishments.
- Gradually engage first contact physicians in the prevention and treatment process with the aim of broadening comprehensive healthcare. Create room for co-operation with healthcare establishments providing medical treatment.
- Pay special attention to the creation and development of facilities providing professional medical and psychosocial care to pregnant women addicted to drugs and their children.
- Adopt measures aimed at reducing health risks associated with drug addiction. Concentrate attention on the reduction of the incidence of health damage related to drug use, especially infectious diseases such as HIV, B and C hepatitis and tuberculosis. Support and develop medical and social care for HIV positive and AIDS patients.
- Activate the establishment of low threshold facilities and mobile units oriented on the least accessible drug users under the risk of infectious diseases.

D.3. The Area of Re-socialisation Related to Drug Addiction

- Within the framework of re-socialisation services, ensure the quality of services delivered and co-ordination between state and non-state organisations, with a view to regional differences.

- Ensure sufficient scope, professionalism and quality of activities in the area of re-socialisation work. Pay attention to the methods and means of occupational re-adaptation and gradual re-integration of afflicted individuals into the natural social environment.
- Promote the activities of the self-help social and therapeutic movement in the restoration and stabilisation of family, work and social relations.
- Improve the system of accessible and early professional assistance in the resolution of drug use related problems of individuals and families.
- Broaden the provision of services in the area of social assistance and re-socialisation of drug addicts and create a corresponding system and instruments of co-operation with the treatment process.

D.4. The Area of Demand Reduction and Law Enforcement (Repression)

- This needs to be seen as an integrated and multidisciplinary area in the context of the European Union's strategy. The aim is to achieve qualitative progress and good results in the fight against international organised crime.
- Reinforce co-operation and co-ordination of activities in the field of justice and internal affairs, directly or through Interpol and Europol, between police units, customs officers and border police, as well as judicial and other competent institutions.
- Focus the effort on the reduction of availability of illicit drugs as a source of supply, with emphasis on synthetic drugs and psychotropic substances. Restrict illicit trafficking in precursors, occurrence of drug crime and drug money laundering.
- Prosecute organised crime, street crime and the illicit organisation of the production, possession and distribution of drugs, with emphasis on children and youth.
- Promote research into the effectiveness of suppression of organised drug crime. Create criminal and police indicators for the assessment of progress in the control and prevention of organised crime.
- Concentrate on the prevention, use, detection and punishment of drug use by drivers.
- In prison and detention facilities, take measures to improve the conditions for protective and voluntary treatment of addiction in the course of imprisonment. Establish departments with elements of a drug-free therapeutic community regime in prison facilities. Support preventive and treatment measures in the army.
- Place emphasis on drug crime prevention. Make use of the active involvement of the civic society, opportunities and international experience in drug crime prevention.

D.5. The Area of Information and Review

- Improve the accessibility and quality of data and information on the drug situation and reliability and comparability of the data with key EU epidemiological indicators. Create a suitable review mechanism and the relevant review methods.
- Create the relevant databases of projects, partners, budgets, time schedules and trends in the drug area, mainly in the field of chemical precursors and synthetic drugs. Create an effective system of monitoring and review of activities in the area of drugs, in accordance with the requirements of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Complete and activate the National Monitoring Centre for Drugs (NMCD) within the framework of the operation of the General Secretariat of the Ministerial Committee for Drug Addiction and Drug Control.
- Create a system of continuous assessment of the efficiency and success of treatment methods in the context of international knowledge and experience.

- Strengthen the system of exchange of information on the situation, measures and methods aimed at suppressing unfavourable health and social impacts of drug use and preventing social exclusion of drug addicts.

D.6. The Area of Co-ordination

The Government will continue to carry the responsibility for the creation and fulfilment of the Slovak Republic's anti-drug policy. It approves and defines the objectives, rules and principles of the national strategy. It will continue to specify the tasks for public administration institutions and adopt measures aimed at suppressing the unfavourable developments in the area of combating drugs. The Ministerial Committee for Drug Addiction and Drug Control (MC DADC) is the advisory body for anti-drug policy issues and its executive body – the general secretariat (GSMC DADC), co-ordinates, methodically guides and controls the implementation of the anti-drug policy at the central and regional levels.

The system of implementation of the anti-drug policy must be based on corresponding co-ordination and co-operation. The practical fulfilment of the set tasks, the development of an effective system of co-operation and the creation of strategies taking into account local conditions and needs are not feasible without vertical and horizontal co-ordination. It will be necessary to improve co-ordination and co-operation at all levels of state administration and self-government.

Attention needs to be paid to the following areas:

- Due to its nature, the drug issue requires broad multidisciplinary co-operation at various levels and joint action by state administration and self-government organisations and institutions, educational, healthcare and re-socialisation establishments, security forces, mass media, as well as non-governmental, voluntary, interest and self-help organisations and movements.
- Public administration reform and the transfer of state administration competences to territorial self-government authorities is a chance to improve the existing system, not a threat to it.
- A quality system of co-ordination of the anti-drug policy at all levels must become a significant instrument for the implementation of the strategy's objectives. Engage the whole society into the strategy's implementation. Despite the achieved level of informal co-operation, focus the attention on the efficiency of horizontal co-operation between the relevant public administration institutions and establishments.
- Place emphasis on territorial self-government authorities so that they accept their role and responsibility for tackling the drug problem.
- At the level of the MC DADC, select responsible partners on a contractual basis. Methodically guide, support and co-ordinate the creation and implementation of regional and local programmes on drug demand reduction.
- Support the creation of a mechanism of co-ordination with the National Health Promotion Programme and the National Action Plan for Alcohol-Related Problems, in accordance with the relevant WHO documents, the European Charter on Alcohol and the European Alcohol Action Plan.
- The introduction of regional anti-drug coordinators into the structure of the transformed local state administration authorities (regional state administration offices) and territorial self-governments is a prerequisite for the creation of a new system for co-ordination of the strategy. Ensure that professional competence of the coordinators corresponds with the needs and requirements. Create rules for their professional growth and continuous training. Hold periodical meetings throughout Slovakia with participation by the relevant members of the Government and MC DADC, self-government and representatives of non-governmental organisations.
- Define and implement the methods and means of regular dissemination of data and information and regularly update them. Create and operate a system of co-operation and co-

ordination with the media with a view to the need to provide objective and reliable information to the general public.

- To ensure the fulfilment of the national strategy's objectives, it is necessary to draw up action plans for the implementation of the NPFAD at the relevant central state administration bodies, regional offices and territorial self-government authorities. These need to be elaborated in line with the NPFAD strategy and the EU Action Plan to Combat Drugs for 2005-2008.

The implementation of the strategy is not currently possible without the participation of public institutions. They do not only provide supplementary or special services. They also carry out activities and programmes, which the state provides only to a limited extent or not at all. They are active in the fields of prevention, treatment and re-socialisation. Therefore, the quality, efficiency and operational conditions and requirements on them must be the same as those on state administration authorities. One of the strategy's priorities is the promotion of those institutions, organisations and services that form part of the preventive, medical and re-socialisation care network and meet the set quality and efficiency standards for services provided. Nevertheless, the set rules, mainly in the area of delivery of services and efficiency of the use of financial resources, must also be adhered to by the relevant state organisations.

D.7. The Area of International Co-operation

The global nature of the drug problem requires that international co-operation be intensified. This is becoming an important part of the NPFAD strategy until 2008. The basis will be a balanced, multidisciplinary and integrated approach in the context of the adopted international documents, principles and the EU Action Plan to Combat Drugs.

The Slovak Republic will continue to co-operate with the Member States in the area of the anti-drug policy, including information exchange between responsible institutions and strengthening of multi-agency co-operation. It will promote international co-operation based on the principles of shared responsibility and partnership in compliance with the conclusions of the UN General Assembly Special Session on Drugs of 1998. The common threat that illicit drugs pose to our country requires that drug-related measures be dealt with in the international context.

The Slovak Republic will continue to develop co-operation with the Council of Europe's Pampidou Group in line with the Work Programme for 2004-2006, which was adopted as a binding document at the ministerial conference in October 2003 in Dublin.

It will participate on the following key goals:

- Promotion and evaluation of an anti-drug policy based on scientific evidence proved and confirmed by practice.
- Promotion of inter-ministerial co-operation and joint action in the fight against drugs.
- Promotion of multidisciplinary approaches in research and adoption of measures.
- Promotion of common standards of good practice, including ethical standards.

It will take a more active part in the work of the European Commission's advisory group – the Horizontal Working Party on Drugs (HWPD). Through representatives from sectors and the GSMC DADC, it will promote professional and political positions of the Slovak Republic in the preparation of documents for the Committee of Permanent Representatives of EU Member States (COREPER) and subsequently for the European Parliament and European Council.

The Slovak Republic will participate in projects and work of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Being part of the European Information Network on Drugs and Drug Addiction (Reitox), it will co-operate with national monitoring centres for drugs in other EU Member States.

In line with the EMCDDA's Work Programme, it will mainly carry out the following key programmes through the National Monitoring Centre for Drugs (NMCD):

- P1: Monitoring of the drug situation on the basis of standard indicators.
- P2: Monitoring of the society's responses to the drug problem.
- P3: Joint action on new synthetic drugs and the Early Warning System (EWS).
- P4: Monitoring of the national strategy and anti-drug policy programmes.

The Slovak Republic will carry out its tasks arising from ratified drug control agreements. It will see to the implementation of all UN conventions and their application in national legislation, so that they comply with the principles of the UN Charter and international law.

D.8. The Area of Funding

The set objectives can be achieved only if the responsibility for the completion of the strategy's objectives is accepted and shared at all levels of public administration.

The current method of funding needs to be rebuilt and a new system of financing anti-drug policy programmes needs to be created, *inter alia*, with a view to the state administration reform carried out and the transfer of state administration competences to self-government authorities. The amount of financial resources allocated for the anti-drug policy in the state budget is inadequate and unstable, which endangers the network's stability and development of new programmes, as well as the quality and efficiency of the services delivered.

The allocation of a corresponding amount of financial resources, creation of a financial environment with long-term stability and creation of a new system of financing of the anti-drug policy services guaranteeing the continuity of the required and delivered services is a basis for the success of the realisation and implementation of the NPFAD strategy and a condition for guaranteeing the sustainability of the activities in the field of drug demand and supply reduction.

This requires that relevant sources of funding be identified and effectively used – e.g. 3-5% contribution from excise duties on alcohol and tobacco products, revenues from forfeited and sold property originating from criminal activities related to the production and distribution of drugs and active support with the framework of the grant strategy.

It is necessary to define the financial requirements of the anti-drug policy and create instruments and mechanisms for maintaining the funding. This can only be achieved by means of a systemic solution. This will result in the creation of a long-term, stable and sustainable fund of financial resources needed for the implementation of the NPFAD strategy and a significant modification of the current system of allocation and redistribution of financial resources. The needs of self-government authorities must be taken into account in the development of the relevant system. At the same time, these authorities should participate in the generation of the necessary financial resources.

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15.3 List of abbreviations used in the text (in alphabetical order)

Abbreviation	Full text
ADF	Anti-Drug Fund
CA	Citizens' association
CCPS	Centre for Counselling and Psychological Services
CLSAF	Centre for Labour, Social Affairs and Family
CM DADC	Committee of Ministers for Drug Addiction and Drug Control
CS	Community service (sentence)
CTDD	Centre for the Treatment of Drug Dependencies
DA	Drug addictions
DC	Diagnosis Centre
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EPPC	Educational and Psychological Prevention Centre
ESF	European Social Fund
ESPAD	European School Survey Project on Alcohol and other Drugs
EWS	Early Warning System
GS	General Secretariat of the Committee of Ministers
CMDADC	for Drug Addiction and Drug Control
GPO SR	General Prosecution Office of the Slovak Republic
HBV	Hepatitis B infection
HCV	Hepatitis C infection
HEI	Health Education Institute ⁴⁷
HIV/AIDS	Human Immunodeficiency Virus Acquired Immunodeficiency Syndrome
ICD	International Classification of Diseases
IFS	Institute of Forensic Science
IHIS	Institute of Health Information and Statistics
IIFE	Institute of Information and Prognoses of Education
IUD	Injection use of drugs
LSD	Lysergic acid diethylamide (lysergid)
LTC	Leisure Time Centre
ME SR	Ministry of Education of the Slovak Republic
MF SR	Ministry of Finance of the Slovak Republic
MFA SR-	Ministry of Foreign Affairs of the Slovak Republic
MI SR	Ministry of the Interior of the Slovak Republic
MTPT SR	Ministry of Transport, Post and Telecommunications
MLSAF SR-	Ministry of Labour, Social Affairs and Family of the Slovak Republic
NA	Narcotics Anonymous
NADU	National Anti-Drug Unit
NCPH	National Centre for the Promotion of Health ⁴⁸
NDMC	National Drug Monitoring Centre
NGO	Non-governmental organisation
NPFD	National Programme for the Fight against Drugs
OFOC	Office for the Fight against Organised Crime
PCP	Police Corps Presidium
PC	Police Corps
POI	Pedagogical and Organisational Instructions of the ME SR
PORI SO SR	Public Opinion Research Institute of the Statistical Office of the Slovak Republic
PPCC	Pedagogical and Psychological Counselling Centre
PESS	Programme of exchange of sterile syringes
PCR	Polymerase Chain Reaction (used to diagnose HIV virus)
REITOX	Réseau européen d'information sur les drogues et les toxicomanies – European Information Network on Drugs and Drug Addiction

Abbreviation	Full text
RICPaP	Research Institute of Child psychology and Pathopsychology
RNA	Ribonucleic acid
RPPCC	Regional Pedagogical and Psychological Counselling Centre
SHI SR	State Health Institute of the Slovak Republic
STT	Supplementary teaching texts
SSI	State School Inspection
SIS	Special innovation study
SCSIA	school centre for special-interest activities
SHDF	State Housing Development Fund
SRC	Social Reintegration Centre
SGR	Self-governing region
TAD	Tobacco, alcohol, drugs – name of the survey

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⁴⁸ Provided in English in the course of 2004 to EMCDDA for the 2004 Annual report on the state of the drugs problem in the European Union and Norway