European Monitoring Centre for Drugs and Drug Addiction

NÁRODNÉ MONITOROVACIE CENTRUM PRE DROGY
ÚRAD VLÁDY SLOVENSKEJ REPUBLIKY

2008 NATIONAL REPORT (2007 data) TO THE EMCDDA

by the Reitox National Focal Point

„SLOVAKIA”
New Development, Trends and in-depth information on selected issues

REITOX

Slovak Republic Government Office
General Secretariat of the Board of Ministers for Drug Dependencies and Drug Control
National monitoring centre for drugs

Bratislava 2008

National Report on Drugs in Slovakia for the year 2007

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From Slovak original translated by
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Acknowledgements

National Report to the EMCDDA is based on the information from institutions and professionals from the field of health, education, social affairs, justice and other relevant areas. The information will become an integral part of the 2009 EMCDDA Annual Report on drug issues in Europe.

Our acknowledgement belongs mainly to national experts and members of the working groups for key indicators who participated on relevant chapters of the National Report, standard tables and structured questionnaires. Their names and organizations as the source of information can be found in bibliographic references as well as here in alphabetical order:

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Content

Summary

Summary

In the year 2007 all three national strategies on psychoactive substances alcohol, tobacco and controlled drugs (NPFD) have been covered by the common coordination structure - the Board of Ministers for Drug Dependencies and Drug Control due its extended Statute. There is a common area of interest in prevention interventions aimed on children and young people. .

The strategy National Programme for Fight against Drugs which is the third four years´ programme will be completed by the end of 2008 and there are extensive works to evaluate the programme as well as to prepare the fourth strategy on drug problem for the period 2009-2012.

The basic legislative control tool was amended in schedule of controlled substances in 1-(meta-chlorophenyl) piperazine (mCPP) set in I. category. The next amendment controlling 1-benzylpiperazine (BZP), Oripavine and other substances based on the plant species cannabis (tincture and extract of cannabis) is expected soon.

All five key indicators of EMCDDA to monitor drug situation were implemented in 2007, moreover the different reporting statistics structure from the law enforcement bodies were launched to make the outputs of police, prosecutions and justice system more compatible

.In 2007 the fourth cycle of school survey based on ESPAD and contributing to the international ESPAD has been carried out in Slovakia. This national survey covers the broader sample size of 15-19 years old students comparing age cohort of 15-16 years for European wave. Data on alcohol consumption, smoking and experimenting with illicit drugs of 10 688 young students were obtained and compared to previous cycles. There is a rising trend in experience of any illegal drug as age increases; and growth of problems within the period from 1995 Concerning the type of drug; marijuana is the most experimented drug, and even variables defining the current use are high. The same holds true for ecstasy. Only experimentation with inhalants and solvents (sniffing) shows the declining with age. As expected, prevalence is little bid greater among boys, except the tranquilisers, sedatives and combinations of alcohol and tablets, where girls noticeably predominate. When the real dimension of young people and drugs is considered then the rising estimate of the amount real numbers is warning sign itself., Moreover the situation is modified by the demography reduction of the size of target population. Age group 15-19 years shrank by approximately a sixth between 1995 and 2007. It means that the country is facing a problem that the number of young people who do not abuse alcohol and drugs is falling faster than is indicated by the percentages measured or the estimated number of users.

The most available drug remained cannabis (marijuana/hashish), with 70% of Slovak 15-24 years old respondents saying they thought it would be fairly easy to or very easy for them to acquire it. Simultaneously the majority of convictions for drug related offences related to marihuana - 58.7% and this drug accounted for 54% of all seizures in 2007.Finally in 2007 most marijuana was home grown in “indoor cultivation” or outdoor cultivation.

According to the latest estimate in 2007 (using the same method and sources of data since 2005) there may be between 12 800 and 34 800 problem drug users in the country. A central estimate of 17 900 PDUs, represents 4.71 per 1 000 inhabitants in the age group 15-64. The majority of them use opiates, in particular heroin - the remainder use mainly pervitin. The extent of problem use in this population – clients of low- threshold (harm reduction) agencies - is underlined by the fact that almost all clients of these services are injection users. However in comparison with previous estimates of the prevalence of PDUs the situation is stabilised.

The total number of patients receiving treatment was 3% higher in 2007 than in the previous year – a total of 1 985 cases of treatment was reported, 539 persons were treated out of health sector facilities... (Within the health services of penitenciary facilities) There were no fundamental changes in the age of persons seeking treatment or the ratio of men

and women, which was 3:1. With regard to overall treatment demand by primary drug, there was no significant change in any of the studied categories[1] and the structure remained unchanged: The greatest demand was for treatment for opiates – nearly one half, and almost one third of patients accounted for amphetamine-type stimulants treatment and then cannabis – 18% of patients. The positive trend is the continual decline of the proportion, and absolute numbers of injecting drug users receiving treatment in medical facilities.

The drug treatment system is well developed, the medical care is provided free of charge and is accessible and affordable without redundant delays. The dominating demand is for the drug free treatment (inpatient or outpatient). It is partly the result of the significant changes in the diagnostic structure of people requesting treatment in the last five to ten years (the shift from the dominance of people dependent on opiates, to people who are problem/dependent users of cannabis and methamphetamines. Moreover neither the dependence on cannabis nor on methamphetamines has to be intervened by the medicines.

Specialised centres for the treatment of drug dependencies treated approximately 500 patients using methadone and buprenorphine substitution maintenance treatments in 2007. In addition an unspecified number of patients (estimated to be a few dozen) attended psychiatric outpatient clinics for buprenorphine treatment. Last year there was a sharp reduction in the distribution and prescription of Subutex (buprenorphine).what was replaced by Suboxon (a combination of buprenorphine with the opiate receptor antagonist naloxone) which has lower potential for abuse.

The change in the structure of the clientele is reflected not only in the specialised medical services provided by psychiatrists and specialists in addiction but also in the facilities for follow-up care – in social reintegration facilities. Among clients of social reintegration facilities whose primary problem substance was an illegal drug, the most common substances were methamphetamines followed by opioids .The use pattern of illegal drug users in social reintegration facilities differs in some respects from that of patients in medical facilities and it is closer to the structure of younger patients treated in medical facilities for the first time in 2007 (34% for addiction to amphetamine type stimulants, 30% for addiction to opioids and 27% for cannabis). Ten years ago there were smaller differences between patients in treatment and the clients of social reintegration facilities as regards the primary drug used. Heroin was the main drug everywhere. Currently the clientele of social reintegration facilities come mainly from the younger generation of users where the most popular drugs are pervitin and marijuana. They are users with a shorter history and a lower rate for injecting drug use.

Compared to 2006, there has been a fall in total reported drug-related direct or non-direct deaths in 17%. Most such deaths are due to pharmaceutical drugs, in particular benzodiazepines, 17 persons died directly on polysubstances with (8) or without opioids

It is important to note that the rate of infections/antibodies for the HIV virus/AIDS remains low and non-epidemic. Only one new case of positive HIV in 2007 was disclosed in population of drug users despite quite massive testing. The belief that this situation will continue in future is supported by the clear decline in intravenous drug use amongst users entering treatment.

Even the relatively high levels of hepatitis C antibodies in this sub-group are not surprising. A negative factor is the increase in rates for the HBc antibody although this is less sharp in absolute numbers, as shown relevant statistics. Significant improvement is expected in near future due to the universal vaccination of children against hepatitis B.

In the last five years there have been increases in psychiatric co-morbidity amongst drug users in Slovakia. An increase in the use of methamphetamines and cannabis is causing more frequent incidence of toxic psychoses with clinical symptoms of paranoia. The paranoid and hallucinatory states following the use of MDMA, cocaine and marijuana were referred by young Slovaks working abroad and asking for advice via Internet in online counselling service.

[1] Only from medical treatment facilities

There is sufficient scientific evidence to establish that medically assisted long term maintenance treatment reduces the risk of overdose and blood transmitted infections in patients addicted to opiates. Currently applied Suboxon presents a lower risk for non-lege artis intravenous use moreover the presence of naloxone there is a lower risk of overdosing on other psychotropic substances in combination with buprenorphine. Every maintenance treatment programme includes education for intravenous users.

Consumption rooms for users or the free distribution of naloxone to avoid the consequences of overdosing of drug user mate are methods which don't comply with the current legal framework.

Needle and syringe exchange programmes are provided by the low threshold agencies in outreach programmes. The same function is performed by designated employees of the CTDD in a "come in" settings. The first ever needle and syringe exchange programme in Slovakia was established at the Centre for Treatment of Drug Dependencies in Bratislava 1994 at the start of the epidemic of intravenous drug use – primarily the use of heroin. Since its foundation this programme has given out more than 500 000 sterile needles and syringes. The programme operates in an institution focussed on treatment, whose patients include 400 recipients of daily methadone maintenance treatment. In 2007 all low threshold programmes and CTDD Bratislava gave out over 400 000 sterile needles and syringes. Another response that should not be overlooked is the sale of sterile needles and syringes for intravenous drug users for accessible prices and without prescription in the dense network of pharmacies

The rise in the number of drug-related offences continued in 2007.most drug crimes was committed in relation to marijuana, methamphetamine (pervitin) and heroin. Among drugs seized most frequently were marijuana first, followed by methamphetamine (pervitin) – seizures of later stimulant drug rose in over 30% comparing 2006 and this growth is continuous since 2004. In generally the most widespread drug after marijuana was pervitin, which reinforced its position in the drug market in 2007. Pervitin production was expanding and spreading to other regions – Eastern Slovakia. According to police reports there is an increase in the availability of ecstasy.

The prices of drugs remained relatively stable in 2007 with .some regional differences.

Bratislava – capital of Slovakia and Bratislava region is the leader in all key indicators and in law enforcement data too. Problem drug users were over the other regions of Slovakia (app. 20%). The greatest demand for treatment in 2007 was in the Bratislava region. Almost two fifths of patients seeking treatment for the first time were treated in medical facilities in this region, in patients seeking repeated treatment the percentage was 50.2%. The region established the most accessible and extensive network of services for people with drug related problems. On the other hand Bratislava was the centre of drug related crime in terms of quantities of drugs seized and numbers of drug offenders.

Part A: Development and new trends

This part of the national report gives an overview of the situation in 2007 based on the key indicators and also current development and trends in 2008, especially in chapter 1.

1 National policy and its context

The anti-drug policy of the Slovak government is based on the United Nations treaties on drugs, the political declaration on guiding principles of drug demand reduction of the special session of the general assembly of the United Nations, the EU strategy and the current action plan on drugs.

The government is responsible for achieving the objectives of anti-drug policy. It cooperates with parliament to draft relevant legislation to support the main pillars of the strategy: prevention, treatment, social reintegration and law enforcement.

2007 was the third year of the implementation of the third National Programme for the Fight against Drugs (hereinafter “NPFD”), which are always programmed for a four year period. The medium term achievement of the goals and objectives of the NPFD was evaluated in 2007.

A full evaluation of the NPFD and the drafting of the next, fourth, programming document on government anti-drug strategy for the period 2009–2012, is scheduled for spring 2009.

1.1 Legal framework

1.1.1 Laws passed in 2007 and 2008

Two acts amending Act No. 139/1998 of Coll. on narcotics, psychotropic substances and preparations, as amended, were passed in 2007.

Act No. 455/2007 of Coll. added the substance 1-(meta-chlorophenyl) piperazine (mCPP) to the first category of psychotropic substances in annex no. 1.

Act No. 330/2007 of Coll. on the criminal register and the amendment of certain acts specifies that in order to dispose of narcotics and psychotropic substances the blameless reputation of applicants, specialist representatives and persons who are statutory bodies must be documented by an extract from the criminal register.

Another act passed in 2007 was Act No. 254/2007 of Coll. on the dissolution of regional authorities and the amendment of Act No. 515/2003 of Coll. on regional authorities and circuit authorities and the amendment of certain acts, as amended by ruling of the Constitutional Court No. 263/2006. The powers and responsibilities of the regional authorities were transferred to the circuit authorities or ministries according to the character of the power or responsibility. The effect on the area covered by this report was the cancellation of the regional coordinators. Legislation in preparation includes a bill on the prevention of crime and other anti-social activity, which proposes the appointment of coordinators for the fight against drugs and drug addiction in circuit authorities in regional capitals.

On 1 September 2008 Act No. 245/2008 of Coll. on education and training (the Schools Act) and the amendment of certain acts came into force. The act replaces the previous act, Act No. 29/1984 on the system of elementary and secondary schools (the Schools Act), as amended, and Act No. 279/1993 of Coll. on educational facilities, as amended. Education in schools and educational facilities is thus regulated by a single legislative instrument. Changes introduced by the act include a comprehensive framework for schools for children or students with special educational needs, educational facilities (including school hobby

centres and free time centres – chapter 3.1.2), special educational facilities (diagnostic centres, educational reintegration centres, therapeutic educational sanatoria – chapter 3.2) and facilities for educational advice and prevention (centres for educational and psychological counselling and prevention, centres for special educational counselling - chapter 3.2).

In 2008 Act No. 93/2008 of Coll. Amended Act No. 475/2005 of Coll. on imprisonment and the amendment of certain acts, and Act No. 127/2008 of Coll. amended Act No. 221/2006 of Coll. on custody. These amendments strengthened the legal framework to reduce the risk of narcotics and psychotropic substances entering prisons by prohibiting the acceptance of food and drink sent to prisoners in packages if such food and drink is not in the original packaging in which it was stored or if it was packed in the home environment (See also the 2007 Report, chapter 1.1.1).

1.1.2 Bills in the legislative process

A bill to amend Act No. 139/1998 of Coll. on narcotics, psychotropic substances and preparations, as amended, and to amend Act No. 308/2000 on broadcasting and retransmission and the amendment of Act No. 195/2000 on telecommunications, as amended.

The bill specifies conditions for the growing of certain varieties of cannabis sativa (with a THC content less than 0.2 %) to allow them to be grown without a licence if the producer receives direct payments in accordance with EU law. Conditions have also been relaxed for providing licences to dispose of narcotics and psychotropic substances for applicants who wish to cultivate opium poppies or cannabis.

The amendment adds a new psychotropic substance to schedule 1 of this act - 1 - benzylpiperazine (BZP), which is to be made subject to control measures and criminal provisions in accordance with Council Decision 2008/206/JHA. Oripavine and other substances based on the plant species cannabis (tincture and extract of cannabis) will also be added to the schedule.

The bill also increases the competence of self-governing regions in state administration in relation to narcotics and psychotropic substances, in particular the supervision of the destruction of narcotics and psychotropic substances.

The bill also includes an amendment to Act No. 308/2000 on broadcasting and retransmission and the amendment of Act No. 195/2000 on telecommunications, as amended, which establishes a duty to ensure that no broadcast programme refer to narcotics, psychotropic substances or the trade names of medicines that contain such substances other than programmes on current affairs or programmes of an educational character.

A bill to amend Act No. 219/1996 of Coll. on the prevention of the abuse of alcoholic beverages and the establishment and operation of sobering-up stations and on the amendment of Act No. 372/1990 on misdemeanours, as amended. The purpose of the bill is to increase the effectiveness of legislation to determine the presence of alcohol, narcotics and psychotropic substances in the organism of an affected person in accordance with EU strategic tasks and the tasks set by the NPFD and at the same time to regulate the establishment and operation of sobering-up stations for persons under the influence of alcohol in order to ensure public order in towns and villages in accordance with the National Action Plan for Alcohol-related Problems.

A bill to amend Act No. 305/2005 of Coll. on the socio-legal protection of children and social supervision (*social guardianship* - *sociálna kuratela*) and the amendment of certain acts, as amended. The amendment of this act is necessary to address a number of situations in practice. The amendment applies to provisions that are open to various interpretations or whose interpretation is problematic (e.g. education measures, diagnostic groups and the like)

or that were found to be impractical or useless in practice (proposals for adoptability, measures of a financial character in the section on the obligations of municipalities, the creation of priorities and the system for the provision of grants). The amendment adds new provisions that increase the quality of socio-legal protection and social guardianship.

A bill to amend Act No. 301/2005 of Coll. the Code of Criminal Procedure, as amended has been submitted to the legislative process outside the government legislation plan based on an initiative responding to requests from the professional community, in particular judges, prosecutors, lawyers and police officers, which indicate the need to amend a number of provisions. The Ministry of Justice (MJ) has submitted to the government an extensive amendment of the Code of Criminal Procedure that responds to suggestions based on the experience of the authorities responsible for criminal proceedings and the courts. The amendment also responds to the urgent need to amend the provisions on protective treatment and to secure persons for the purposes of decisions on institutional treatment in cases where a person cannot currently be taken into custody, for example, in the case of a convicted person who has completed his or her sentence of imprisonment and is required to continue institutional treatment, or a person who must be placed in protective treatment even though he or she is not criminally liable and who must subsequently be placed in institutional treatment etc.

A bill on the prevention of crime and other anti-social activities and the amendment of Act No. 575/2001 on the organisation of the activity of the government and central state administrative bodies, as amended, has been submitted in accordance with the government manifesto and based on Government Resolution No. 681 of 15 August 2007 on the draft strategy for crime prevention in the Slovak Republic 2007 - 2010.

1.2 Institutional framework, national strategies and policies

1.2.1 Coordination and institutional framework

1.2.1.1 Coordination at the national level

As the most senior executive authority, the government performs tasks relating to programming and strategy for reducing demand for drugs and limiting the supply of drugs, which are incorporated into the comprehensive programming document[2], the strategy for anti-drug policy. The content is the definition of priorities and objectives for a period set by the government and the method for achieving them.

One of the priorities is coordination of the performance of tasks and plans of the government anti-drug policy. Responsibility in this area is assigned to the Ministerial Board for Drug Addiction and Drug Control *(hereinafter „Board of Ministers"*), which is the body that provides advice, coordination, initiatives and control on drug issues for the government of the Slovak Republic. The members of the committee are the ministers of key ministries and the prosecutor general. The drug agenda incl. Board is headed by vice premier for

The Board of Ministers prepares and submits to the government reports and information on the performance of tasks in the area of anti-drug policy based on the National Programme for the Fight against Drugs (*hereinafter „NPFD"*).

In June 2008 (11.06.2008) the government discussed and took note[3] of an information report on the implementation of government anti-drug policy in 2007. The report was prepared using material provided by the relevant ministries and the General Prosecutor ´s

[2] The current National Programme for the Fight against Drugs is the third comprehensive programme in this area
[3] http://www.rokovania.sk/appl/material.nsf/0/1FCE562F9CB1FFB3C125745E00466824/$FILE/Zdroj.html

Office and presents information on the activities of the ministries in the area of drug and alcoholism policy[4].

Since 1995 the general secretariat of the Board of Ministers (hereinafter "the general secretariat") has been responsible for the coordination and methodological performance of preparation, implementation, monitoring and evaluation of implementation of the NPFD. The general secretariat is an organisational unit of the Government Office and acts as the executive body of the Board of Ministers. The general secretariat cooperates with individual ministries, in particular the Ministry of Interior, within the third pillar of the EU, Justice and Home Affairs (JHA) to ensure the connection and coordination of the NPFD in Slovakia and its action plans with the European drugs strategy and its Action plans.

In 2007 the general secretariat concentrated its activities on preparing conditions necessary for the performance of demanding tasks in 2008 including:

- implementation of the first stage of the European drug strategy 2005 - 2012 and the European drugs action plan for 2005 - 2008,
- the preparation and production of a comprehensive evaluation of the implementation of the third NPFD in the Slovak Republic for the period 2005 to 2008 and the submission of the evaluation to the government and parliament in the first half of 2009,
- the planning and preparation of the fourth strategy on drugs - National Programme for the Fight against Drugs in the Slovak Republic and the Action Plan for 2009 to 2012 in accordance with the second stage of the EU Drugs Strategy 2005 - 2012.

In order to manage these tasks, the Board of Ministers established a special inter-ministerial and specialist work group (WG) in 2007 for the preparation of the NPFD in the Slovak Republic for 2009 to 2012. The WG is made up of authorised representatives of ministries and the General Prosecutor Office, the higher territorial units (self-governing regions), the Association of Towns and Villages of Slovakia and non-governmental organisations.

Since 1 May 2008 the General Secretariat has also included the National Monitoring Centre for Drugs, which acts as the national focal point of the international information network on drugs REITOX under the decentralised agency, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

The other organisational units of the General Secretariat are: the department for the coordination of national anti-drug policy and the international cooperation department.

1.2.1.2 Coordination at the local and regional levels

The regional coordinators in the eight regional authorities proved their worth during the period in which the function existed[5]. They were successful in adapting the basic principles of the national anti-drug strategy (prevention, treatment and reintegrating people with drug addictions into society) to the specific conditions and needs of their region. Methodological Instruction No. 4/2006-GSVMDZKD of the Government Office defined the activities of the regional authorities and standardised the procedure for establishing regional coordination commissions to carry out these activities. In 2007, Government Resolution 165 of 28 February 2007 approved the dissolution of the stated regional authorities with effect from 30 September 2007, thereby cancelling the position of regional coordinator. It is likely that the position of the coordinators and their regional responsibilities in relation to drugs will be restored in 2009 in the act on crime prevention.

[4] In February 2007 the government approved expansion of the mandate of the MC DADC to include legal drugs in accordance with the Statute of the MC DADC

[5] Since 1.1.2004

1.2.2 National strategic documents

1.2.2.1 National anti-drug strategy (NPFD)

The current National Programme for the Fight against Drugs is the third to be implemented. The report on medium term implementation stated that a number of measures had been activated and implemented a number of measures, especially in the area of health care and social services, to assist people with addictions and vulnerable groups and also to reintegrate people who have completed treatment into society; anti-drug education has been introduced in teaching material for schools; a network of specialised prevention centres have been established with the support and sponsorship of non-governmental organisations. Various forms of judicial cooperation were supported including training staff in the enforcement of the law and the sharing of information in relevant fields with the aim of developing safe and effective means of communication in accordance with domestic legal systems. Legislation has been improved and there is better control over legal production of narcotics and psychotropic substances to prevent illegal dealing in such substances. Measures have been introduced to combat money laundering. There has been active development of international cooperation with other EU member states. The report also assessed risks and negative trends in drug use. The report highlighted rising cannabis use among young people and increasing numbers of crimes committed in relation to the production, distribution and consumption of drugs, and also increased numbers of arrests. It stated that the current model for the financing of anti-drug policy must be reorganised and a stable system for financing the strategy and programmes of anti-drug policy must be developed taking into consideration the reform of the state administration and the transfer of administrative responsibilities to self-governing authorities. It underlined the need for cooperation and coordination between players in the area of drugs policy in the state administration, self-governing authorities, civil society and the academic and research communities. In a resolution on this topic, parliament requested the government to carry out the objectives of the NPFD for 2005 - 2008 in accordance with the EU strategy and the EU drugs action plan and to submit a report on the comprehensive evaluation of implementation of the NPFD and the draft of the new strategy for 2009 - 2012 to parliament by 30 April 2009.

1.2.2.2 The national action plan for problems with alcohol (NAPPA) for 2006 - 2010

The action plan was adopted in Government Resolution No. 974 of 29 November 2006 and is managed by the Ministry of Health (MH). Performance of tasks[6] under the NAPPA is evaluated every two years in the form of a report presented to the government by the MH. The first evaluation process in 2008[7] underlined the importance of prevention especially as regards protection against the damage that alcohol causes to children and young people, in transport, in the workplace and it also recapitulated activities towards the two main objectives – to change people's social attitudes to the consumption of alcohol and to change the attitudes of health workers to people who consume alcohol (patients who are addicted to alcohol). The traditional tolerant attitude to consumption should gradually be replaced by an acceptance of "situational abstinence". Part of the objective here is to change the social stereotype under which there are certain social circumstances in which drinking alcohol is the rule and not drinking is an eccentricity and to make it socially unacceptable to pressure and repeatedly offer alcohol to someone who has once refused it.

[6] Details are given in the 2007 Report, part 1.2.2.3
[7] http://www.rokovania.sk/appl/material.nsf/0/94CADB2953B29E37C1257435002C04CC/$FILE/Zdroj.html

1.2.2.3 The National Action Plan for the Control of Tobacco in the years 2009 to 2010

The National Action Plan for the Control of Tobacco in the years 2009 to 2010 was approved by the government in 2008. **The action plan[8] is based on the strategy of the National Programme for Tobacco Control** (approved by the government in May 2007) and defines specific tasks, the timetable, the responsibility of the different players and financing. The key areas covered by the national action plan are health education, support for health and protection of non-smokers, counselling and treatment for people who are addicted to tobacco and advertising and information for consumers.

1.2.2.4. Concept of counselling services in the areas of labour, family and social affairs

Conceptual material for this sector[9] is based on the action plan for the implementation of the NPFD in the area of responsibility of the MLSAF. The drafting of the material was preceded by an analysis of the activity of the specialised facilities of the former psychological counselling service centres for the prevention of drug addictions and other addictions and reintegration into society[10].

The conceptual material defines basic terms in the area of prevention for the purposes of offices of psychological counselling services (OPCS), analyses their current role in the prevention of drug addiction, characterises the target groups of specialised psychological and counselling services and the conditions for the performance of prevention activities, basic prevention programmes, methods and their content, the conditions for the implementation of programmes and methods in OPCS including financial calculations, the necessary qualifications for employees who will implement the conceptual material. The final part of the conceptual material presents measures and the timetable for implementing the objectives.

The approved timetable for the implementation of the objectives of the concept is in two stages. Stage 1 covers the years 2007 - 2008 and stage 2 covers the years 2009 - 2012. Stage 1 is currently being implemented with the aim of elaborating and implementing the objectives of the concept for eight offices of labour, social affairs and family. This task will be carried out by new appointees - specialists. Training and education for specialists will be provided by the psychological counselling service methodology department in cooperation with other institutions. Their training and education will begin on their entry into the OPCS.

1.2.2.5 No new information on strategy documents on doping

1.3 Implementation of policies and strategies

The official conclusion of the project "Support for the implementation of the 2004 – 2008 National Programme for the Fight against Drugs in the Slovak Republic" was marked by the submission of the final report in April 2007. This project was supported by EU funding and national co-financing. Implementations of the recommendations was monitored and coordinated by the General Secretariat. From the project's seven recommendations, the only one to be implemented so far is the recommendation to establish the position of "drug policy coordinator" in those ministries that do not yet have such a position, in order to create a flexible network and strengthen personnel capacity at a central level. This function has been assigned to the employees who are currently members of the inter-ministerial commission for the preparation of the new national strategy.

[8] NPTC http://www.rokovania.sk/appl/material.nsf/0/293409DB3A05F559C125747400236B10/$FILE/Zdroj.html
[9] approved by the MLSAF
[10] Hambálek,V.2008 : Report for the NMCD

Other recommendations - financing through ministerial budgets, strengthening of the role of NGOs in the creation of a stable financing system and quality standards (for quality standards for services for reintegration into society see chapter 9.1) - are in the process of implementation. In the longer term, research is being conducted for the application of qualified assistance at the level of selective prevention for young first-time offenders involved in drug crime.

"Improving and broadening the care for the re-socialisation and rehabilitation care for persons addicted to psychoactive substances".

This project of the Government Office under the 2006 Transition Facility, using EC funds amounting in total to EUR 950 000 and national co-financing of EUR 200 000, was approved in 2006 and began officially in August 2007. The aim of the project is to develop quality standards for the provision of professional assistance to addicts and use them to increase the quality of personnel and institutional resources in re-socialisation facilities by improving their professional readiness and skills for working with persons addicted to psychoactive substances in order to raise the standard of the provided services. The partners are France (senior) and Finland (Junior). Cooperation with other member states, especially Poland, developed during the implementation of the project and the process for developing quality standards and best practice for RC.

The twinning section involves three activities and the output of the first activity is two reports: a report on the current situation in the reintegration into society of persons addicted to psychoactive substances in Slovakia (see Chapter 8.1) and a report describing the approach to reintegrating drug addicted persons into society in 11 EU countries. The two reports lay the foundations for the drafting of quality criteria (quality standards) for reintegration into society in the second activity. An interdisciplinary work group composed of representatives of the state administration, self-governing authorities, social reintegration professionals, the academic community and foreign experts has developed a manual of quality standards and best practice for facilities for social reintegration in Slovakia, which was discussed and approved at a conference attended by representatives of the project's partner institutions. The standards (and examples of good practice serving as recommendations) were aimed at two basic target groups - clients, especially young people – and therapists and others working in this area (see Chapter 9.1). The last activity is training in social reintegration. A series of training seminars for employees in social reintegration began in October 2008.

Technical assistance is used in the project to provide local support for the requirements of training activities in the twinning part of the project. EUR 380 000 is provided under the grant scheme for the projects of non-governmental organisations and self-governing authorities for the reintegration into society and rehabilitation of persons addicted to psychotropic substances. In order to qualify for financing under the grant scheme, projects must lead to the improvement and broadening of the services provided by social reintegration facilities, including assistance in returning to normal life. The maximum grant is EUR 25 000 (including national co-financing).

During the year the National Monitoring Centre for Drugs took part in one of the sub-studies in the project **Evaluation of the implementation of certain sections relating to drugs in the Slovak Criminal Code.** The sub-study is an analysis of the epidemiological situation, the trends in drug use, their availability, use patterns and trends in the enforcement of drug law based on statistical data published by the authorities responsible for criminal proceedings and the courts (2007 Report, chapters 1.1.2 and 13.2.1).

1.4 Budget and financing of anti-drug policy

In the 2007 Report, chapter 11, Public Expenditure, gave a detailed analysis of the problems involved in determining the overall volume of public expenditure (direct and indirect) on drugs policy.

There is no specific *top down* study or findings on expenditure in 2007 but such research is planned as part of the full final evaluation of the 2004 - 2008 NPFD.

Direct expenditure in 2007 included e.g.:

State budgetary funds allocated to the Anti-drug Fund amounting to SKK 45 000 000 (EUR[11] 1 332 149), of which SKK 41 672 086.80 (EUR 1, 262712) was used to finance for projects to prevent drug addiction, research, public education, treatment and reintegration into society.

2) Two rounds of grants in the project Support for the implementation of the 2004 - 2008 National Programme for the Fight against Drugs in the Slovak Republic supported a total of 25 projects with the same objective for a total of EUR 920 304.

1.5 Social and cultural context

The European Values Study[12] in 2008 revealed a number of trends in development that can be summarised (with some simplification) as *a gradual privatisation of individual life, less participation in addressing problems that affect society as a whole and a shift in emphasis from public space to the safety of family and friends.*[13] The most important value for 90% of respondents continues to be family, as it has been for a long time, and the second most important is work. Friends and acquaintances (46.3%) increased in importance as, to some extent, did leisure time. Although values linked to religion are highly stable, most people had a negative opinion of the church's ability to solve social problems in our country (57.6%). There is a positive trend towards an increase in people's declared tolerance for selected social categories (ethnic minorities, people with AIDS, homosexuals, immigrants).

1.5.1 Opinions on drug use and related problems

Slovaks are below the European average in their condemnation of certain acts that can have serious consequences. There was a fall, for example, in the proportion who strongly condemned driving under the influence of alcohol and nearly a fifth of respondents did not condemn it. People are also less concerned about the smoking of marihuana and hashish. While 85% of people were opposed to the use of *soft drugs* in 1991, in 1999 it was the proportion was 11% less and in 2008 it was only 64%. This may be due to undervaluing of the health risks[14] of cannabis and also alcohol and tobacco. Half the Slovak respondents to the 2008 EVS were not concerned about casual sex.

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[11] 1 EUR = 33,78 SKK an average exchange rate in 2007, according National Bank of Slovakia (NBS) www.nbs.sk

[12] The European Values Study is the oldest comparative research into values in Europe. It is carried out in European states at nine-year intervals (in Slovakia, since 1991) and investigates change and continuity in values in the most important areas of human life. The Sociology Institute of the Slovak Academy of Sciences has supervised the European Values Study in Slovakia since 1999. The research carried out in 2008 had the following parameters: 2 700 addresses, 1 525 questionnaires returned; 1 509 valid questionnaires, return rate: 56.48%. The research is representative for the population of Slovakia aged 18+ in terms of sex, age, education, nationality, place of residence/size category of villages and regions

[13] Búzik,B.,Tížik,M,Kusá Z.: Commentary on EVS 2008 In comparison to EVS 1991 a EVS 1999 www.sociologia.sav.sk www.europeanvalues.sk

[14] In Eurobarometer Flash survey, a majority of Slovak respondents aged 15 - 24 years declared that tobacco (72%); alcohol (75%) and cannabis (65%) represented only a moderate or low risk

The availability of six psychotropic substances including alcohol and tobacco was tested by another European survey[15]. There is no difficulty in obtaining legal drugs such as alcohol and tobacco, even for the 15 - 18 age group on whom there is - or should be - a strict age ban. 95.2% of Slovak respondents (compared to an EU average of 95.9%) report no problem in obtaining cigarettes. In the case of alcohol the proportion is 94.7% (EU 27, 96.3%). The most widely available illegal drug is cannabis (marihuana, hashish), which nearly 70% of Slovak respondents think would be fairly easy or very easy to obtain. The most difficult drugs to get hold of are heroin, cocaine and ecstasy, however 41% of young Slovaks would find fairly easy /very easy to obtain the later drug. The effect of their use on health continues to be seen as a high risk and the majority thinks they should continue to be prohibited. An interesting finding was that a fifth of young people would outlaw tobacco in our country (SR 22%; EU 27 18%) and 15% alcohol (EU 27 9%).

1.5.2 Opinions on the solution of drug problems

There is a well established preference for repression and law enforcement. This approach based on repression and law enforcement ("*strict laws*", *increased police and customs activity*) has for a long time been considered the most effective form of solution in Slovakia[16]. These are measures relating to the supply of drugs (dealing, production and trafficking), which is seen on the level of threat to the country's security. Young people aged 15 - 30 saw drugs as second only to organised crime in a list of 14 potential security risks for Slovakia (illegal migration, natural disasters, infectious diseases, neo-fascism, nationalism, pollution, radical religious movements, conflicts elsewhere in the world, invasion, international terrorism, poverty, unemployment, drugs and organised crime)[17].

31% of respondents (aged 15 - 24) in the Eurobarometer Flash survey said that they thought officials and politicians should take measures against drugs trafficking to resolve the drugs problem. A further third thought that information and prevention campaigns were the most effective while a fifth emphasised treatment and reintegration into society. Severe measures against drug users and the legalisation of drugs were not widely supported (6% and 7% respectively) while the least supported method was elimination of poverty/unemployment (5%).

1.5.3 Sources of information on drugs and drug risks

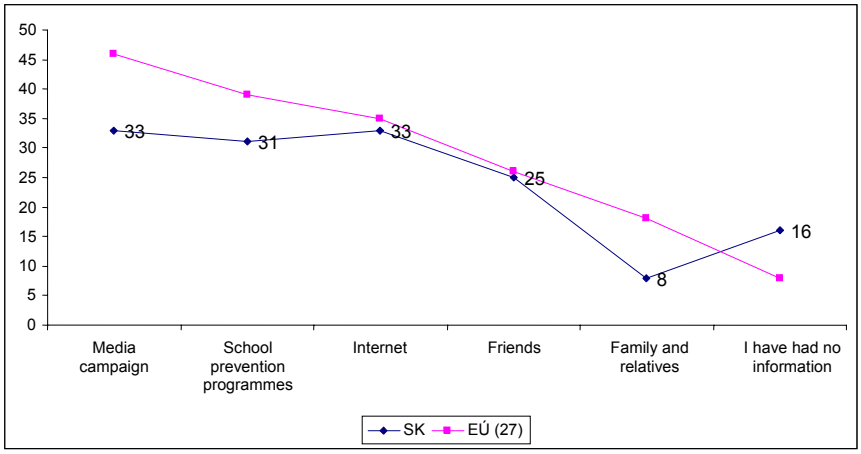
People's preferred source of information is the Internet. Over two thirds of respondents would seek information there (69%). 32% of respondents aged 15 - 24 would ask friends for information and just under a fifth would ask their parents (27% in the EU 27). Only a small minority would ask for information in school or in their place of work (8.9%, compared to around 14% in the EU 27) and only one in ten respondents would ask the police for information. The dominance of the Internet as a source of information fell when young people were asked from which sources of information they had actually received information on the effects and risks of drug use in the last year. In first place came information campaigns in the media, followed by school prevention programmes (further information is given in Chapter 3.1.1) with the Internet in third place. This was followed by friends and then parents and relatives.

[15] Eurobarometer Flash 2008 Young people and Drugs Analytical report, May 2008, Flash Eurobarometer 233 – The Gallup Organisation Hungary, 102 pp. http://ec.europa.eu/public_opinion/flash/fl_233_en.pdf

[16] According to research by the Public Opinion Research Institute of the Statistical Office, since 1995 supply reduction measures in the form of increased activity by the police and customs authorities and strict anti-drug laws have been in first place, also in a comparable age group of 15–29 year olds in Bratislava (55% and 47% respectively) SO PORI (2006) Distribution of drug use in Slovakia and public opinion on problems related to drug addiction

[17] "Attitude of young people in Slovakia to the Army", published in January 2008

Fig. 1.1: Proportion of actual channels used by young people to find out about health risks of drug use in the last year (data source: Eurobarometer Flash 2008, No.233 Young people and Drugs)



The figure also includes data on those who "had not been informed at all". In the EU 27 only 8% of respondents had such an impression, while in Slovakia it was the opinion of 16% of respondents and in Slovenia 17%, which were the two highest values for this item in all 27 states and also a challenge for further measures in the area of prevention.

1.5.4 Parliamentary initiatives

During 2007 the media and the public paid attention to legal drugs, which relates to the good communication of both national programmes and action plans (see parts 1.2.2.2 and 1.2.2.3). Attention was also created by an MP's bill[18] to prohibit people under the age of 17 years from drinking alcohol and also to create legislative conditions not only for the punishment of those who sell or serve alcohol in their business but also for children and young people who consume alcohol and/or those who are responsible for them (family, school). Municipalities would be responsible for monitoring compliance with the law and they would be given the power to impose sanctions (cautions) and fines for breach of the proposed rules. The bill proposed a "duty of notification" for head teachers and managers in schools and health care facilities. Parliament did not pass the bill.

[18] Amendment of Act No. 219/1996 of Coll. on the protection of young people against the abuse of alcoholic beverages

2 Drug use in the population

Drug use in the general population is one the five key indicators used by the EMCDDA to describe the situation in the use of legal and illegal substances in a country. The extent and the pattern of consumption of different drugs in the general population (usually aged 15 - 64, or high-risk age groups and/or cohorts), the attitudes of different population groups towards drug use are determined through surveys using standard sociological methods (standardized questionnaires, interviews) based on a representative sample of the population. The data is then used to assess the situation, identify priorities and to plan responses, in particular at the level of universal and selective prevention19. Surveys of drug use in the population provide indirect information on the availability of illegal drugs in the market. Survey results are combined with information from law enforcement sources to give a comprehensive image of the black market in drugs.

To ensure comparability of data in Europe and also globally[20], the EMCDDA recommends that the GPS indicator should include the core items formulated in the European Model Questionnaire (2002). The following information is obtained on each drug (including tobacco and alcohol): use of the drug at some point in life, in the past - lifetime prevalence - LTP; use of the drug in the last 12 months, in the last year - last year prevalence - LYP; use of the drug in the last 30 days, the last month - last month prevalence - LMP, age of first contact with the drug, frequency of use (or the quantity of the drug consumed). In countries where the use of such a structure of indicators is well established, the basic module has recently been extended by sets of questions on the more intensive use of certain drugs, in particular marijuana, and associated problems, or findings on increasingly frequent polyconsumption.

This chapter is based on data from the available representative surveys conducted in Slovakia in 2007. The target groups were young people in age starting from 15 to max. 26 years and all surveys included the consumption of alcohol and tobacco. Except ESPAD survey the other two comply to EMQ only partially, however the context is to bring some additional interesting information, and all youth surveys showed an increase of experimentation and decline of those young people who don't have experience with controlled drugs.

2.1 Drug use in the general population

No surveys focussing on the general population aged 15 - 64 were conducted in Slovakia in 2007. PORI at SR SO plans to carry out another survey in autumn 2008 based on the requirements of the NMCD to harmonise the module *"illegal drugs"* with the EMQ and to increase the number of respondents in the key age sub-groups 15 - 24 and/or 15 - 34 in the overall 15+ sample.

2.2 Drug use in the school population and among young people

2.2.1 ESPAD

The organizer of the fourth data collection for ESPAD is the Research Institute for Child Psychology and Pathopsychology (Ministry of Education). The national coordinator of the survey for international comparison is Alojz Nociar. The largest school survey of this type is financed from a number of sources, including the National Monitoring Centre for Drugs. It complies with the GPS indicator structure laid down by the EMQ.

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[19] E.g. specific preventative interventions intended on girls aged 15–19 who are catching up with boys in drinking alcohol, smoking and using illegal drugs

[20] Annual and biannual statistical reporting for the UNODC (United Nations Office on Drugs and Crime)

Methodology

Field research for the school survey based on the ESPAD international survey was carried out from 19 to 23 March 2007. In Slovakia the survey has been carried out every four years since 1995 using a sample of secondary school students aged 15 to 19. For the purposes of international comparison within the European School Survey Project on Alcohol and Other Drugs (in which around 35 European countries took part in 2007), the group (cohort) of respondents born in 1991 (i.e. those who reached the age of 16 in 2007) was selected from the sample 10 688 respondents. 120 schools were selected by means of stratified random selection from the total of 2 366 schools. The results are representative for around 350 000 secondary school students (Nociar, A 2007 p.16)

Data is always collected by means of anonymous questionnaires administered in class. Students seal their completed questionnaires in empty envelopes, which professional employees of the regional public health office pack by class and school and send for central processing, thereby ensuring the anonymity of individuals, classes and schools.

Results relating to illegal drugs

Lifetime prevalence (LTP) is understood to include experience and/or experimentation with illegal drugs. This data is important bearing in mind the age of the respondents.

Table 2.1: LTP for individual drugs in each age cohort (Source: Nociar, A. 2008, ESPAD 2007, in SR data for ST 02)

Year of birth	**1992** (*15 years*)			**1991** (*16 years*)			**1990** (*17 years*)			**1989** (*18 years*)			**1988** (*19 years*)		
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
1.Any illegal drug*	7.1	4.7	5.9	10.0	7.7	8.9	11.0	7.6	9.4	10.9	9.7	10.3	15.9	12.0	14.0
2. Cannabis	23.5	16.8	20.1	36.8	27.6	32.1	47.0	33.5	40.6	49.2	38.7	43.9	59.0	44.1	51.5
3. Opioids (total)															
4. Heroin	1.3	0.9	1.1	2.0	0.9	1.4	1.5	1.7	1.6	1.8	1.3	1.5	1.5	0.9	1.2
5. Other opioids															
6. Cocaine	1.5	0.8	1.1	2.6	2.5	2.6	1.9	2.0	1.9	2.3	1.3	1.8	2.5	4.3	3.4
7. Cocaine – powder															
8. Crack	1.6	0.6	1.1	2.0	0.7	1.3	1.2	1.0	1.1	2.3	1.0	1.6	1.9	1.5	1.7
9. Amphetamines	1.1	1.9	1.5	1.8	1.7	1.7	1.8	2.2	2.0	3.1	2.3	2.7	3.4	2.8	3.1
10. Ecstasy	3.6	2.0	2.8	6.7	4.4	5.6	6.8	4.3	5.6	6.6	6.3	6.4	11.6	8.4	10.0
11. GHB	1.0	0.3	0.6	0.7	0.3	0.5	0.9	0.4	0.6	1.1	0.3	0.7	0.4	0.1	0.2
3. Hallucinogens (total)															
13. LSD	3.3	2.2	2.7	4.1	3.1	3.6	5.0	4.6	4.8	6.1	5.3	5.7	8.2	5.0	6.6
14. “Magic mushrooms”	3.9	1.4	2.6	6.1	3.6	4.9	6.4	3.0	4.8	9.1	4.2	6.6	10.7	4.7	7.7
15. Tranquilizers or sedatives	2.9	5.8	4.4	3.3	7.1	5.2	3.2	5.6	4.4	5.6	6.8	6.2	4.9	8.5	6.7
16. other medicines															
17. solvents and inhalants	14.4	13.4	13.9	13.2	13.2	13.2	10.1	8.2	9.2	11.7	6.8	9.2	9.6	7.7	8.7
18. anabolic steroids	3.5	0.5	1.9	4.1	0.6	2.3	4.5	0.4	2.5	5.2	0.7	2.9	6.2	0.4	3.2
19. Alcohol and tablets	4.9	10.7	7.9	8.5	15.6	12.1	11.1	19.9	15.3	13.7	19.9	16.8	7.7	20.1	18.9
20. Alcohol and cannabis															
21. Other: Pervitin R	3.8	2.5	3.1	5.9	4.6	5.3	6.8	5.0	6.0	7.3	6.5	6.9	10.4	7.9	9.1
Sample size (N)	614	643	**1257**	1218	1251	**2469**	1171	1052	**2223**	1017	1038	**2055**	851	858	**1709**

* Use of any illegal drug other than marijuana.
Note: The cohort born in 1991 is highlighted – the sample for international ESPAD survey

The data documents a rising trend in experience of any illegal drug[21] as age increases. The same applies in the case of specific drugs, including the drug with which young people

[21] (not including marijuana)

most often experiment – marijuana. The same holds true for cocaine, amphetamines, ecstasy, LSD, magic mushrooms, tranquilisers and/or sedatives, alcohol in combination with tablets, anabolic steroids and pervitin.

Experience of heroin is highest amongst boys aged 16 (2.0%; N=1218) and 18 (1.8%; N=1017).

Experimentation with inhalants and solvents (sniffing) was most often declared by the youngest boys in 2007, those born in 1992 (14.4%; N=614) and 1991 (13.2%; N=1218); the trend is declining numbers with age. The greatest use of GHB (liquid ecstasy) was in the cohort of 18-year-old boys (born 1988), where LTP was 1.1%.

As expected, prevalence is greater among boys, except in the case of tranquilisers, sedatives and combinations of alcohol and tablets, where girls noticeably predominate. Certain difference for the *benefit of girls* is in cocaine LTP prevalence. In age cohort of 17 yrs (2, 0 % vs1, 9 %) and 19 years (4, 3% vs2, 5%). On the other hand, girls have only minimal experience of anabolic steroids.

LTP for certain drugs and gender differences based on data from the ESPAD 2007 survey in Slovakia are given in the following figures.

Fig. 2.1a: LTP marijuana / Boys and Girls

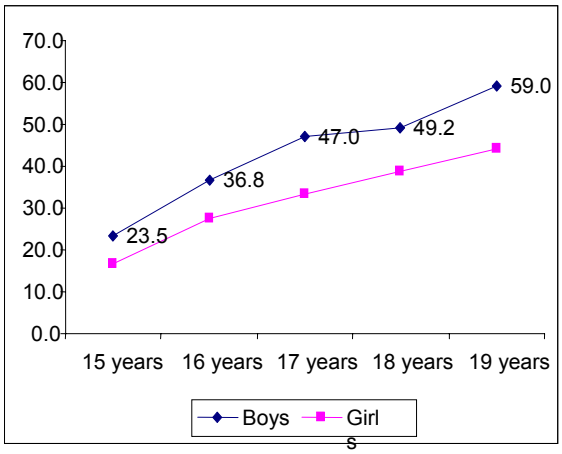


Fig. 2.1b: Alcohol and tablets / Boys and Girls

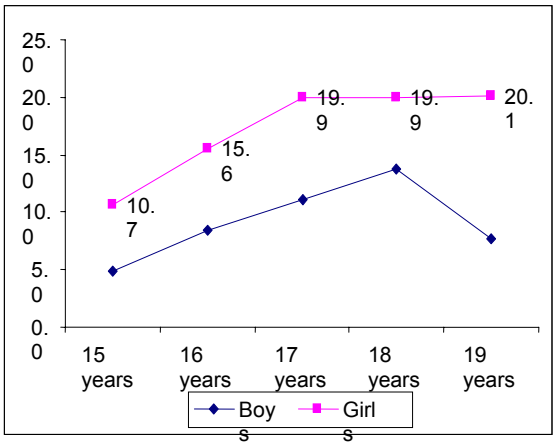


Fig 2.1c: LTP pervitin / Boys and Girls

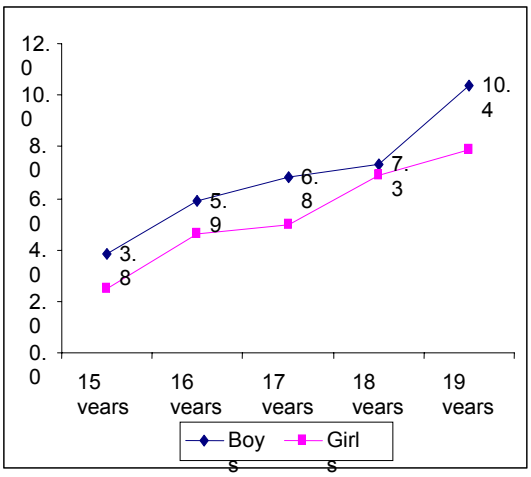
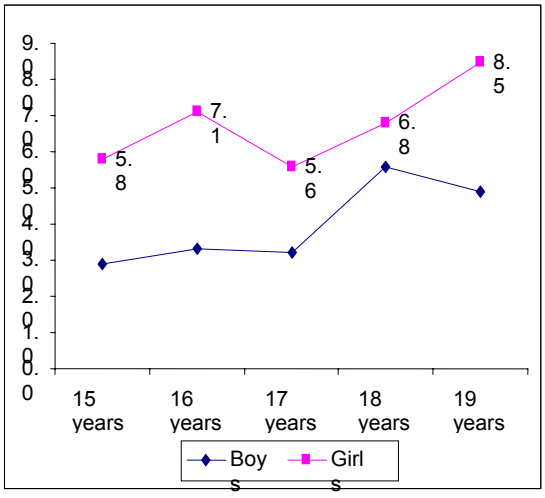


Fig 2.1d: LTP Tranquilizers and/or sedatives/Boys and Girls



(Data source: Nociar, A., 2008, ESPAD 2007 data for ST 02)

The ESPAD 2007 survey also determined other levels of prevalence: last year prevalence (LYP) and last month prevalence (LMP) for cannabis, ecstasy and volatile

substances. Both values are taken to indicate current usage of drugs. “Current” cannabis use is declared significantly more frequently (table 2.2 a) than ecstasy or volatile substance use.

Table 2.2 a: (Data source: Nociar, A., 2008, ESPAD 2007 data for ST 02)

Year of birth	1992 (15 years)			1991 (16 years)			1990 (17 years)			1989 (18 years)			1988 (19 years)		
Cannabis	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
LTP	23.5	16.8	20.1	36.8	27.6	32.1	47.0	33.5	40.6	49.2	38.7	43.9	59.0	44.1	51.5
LYP	18.1	13.3	15.6	27.5	21.3	24.3	33.7	22.1	28.2	36.4	23.3	29.8	41.0	24.5	32.7
LMP	7.3	5.9	6.6	12.9	9.9	11.3	16.4	8.8	12.8	16.5	7.3	11.8	20.2	8.1	14.1

Table 2.2 b:

Year of birth	1992 (15 years)			1991 (16 years)			1990 (17 years)			1989 (18 years)			1988 (19 years)		
Ecstasy	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
LTP	3.6	2.0	2.8	6.7	4.4	5.6	6.8	4.3	5.6	6.6	6.3	6.4	11.6	8.4	10.0
LYP	2.1	1.4	1.8	3.8	2.5	3.1	4.4	2.7	3.6	4.2	3.5	3.9	7.1	4.8	5.9
LMP	1.3	0.6	1.0	1.2	0.9	1.1	1.4	1.0	1.2	1.4	1.4	1.4	2.1	1.3	1.7

Table 2.2 c:

Year of birth	1992 (15 years)			1991 (16 years)			1990 (17 years)			1989 (18 years)			1988 (19 years)		
Solvents and inhalants	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
LTP	14.4	13.4	13.9	13.2	13.2	13.2	10.1	8.2	9.2	11.7	6.8	9.2	9.6	7.7	8.7
LYP	7.3	6.4	6.8	1.7	1.3	1.0	4.4	2.9	3.7	6.7	2.7	4.7	2.7	2.1	2.4
LMP	2.8	2.3	2.5	0.3	0.7	0.5	1.5	1.4	1.5	3.4	1.0	2.1	1.2	0.9	1.1

The ESPAD 2007 survey included 6 questions from the CAST (Cannabis Abuse Screening Test)[22] scale, which is designed to allow quick screening to identify users who may have certain psychological or social problems. 1 946 respondents aged 15 - 19 who reported using cannabis in the previous year answered the CAST scale questions. In an unpublished analysis of this data[23], Nociar states that the inclusion of the supplementary scales ADS and CAGE for problem drinking and the Fagerström scale to screen for nicotine dependency, and in particular *“the CAST questions for screening more problematic cannabis use”* in ESPAD are *useful for determining the relative risk of use of other psychoactive substances. Those who have experience of marijuana and reached score 3 or more in CAST have a relatively much higher risk of using ecstasy, LSD and hallucinogens, opioids and pervitin…”*

[22] For comparison, the NMCD used an identical set of questions in a population survey on the use of marihuana. (A telephone survey of 3039 respondents aged 15–64 (CATI). Respondents in the 15–34 subgroup (N=2020), who declared that they had used the drug in the last month (LYP = 3.6%) also responded to 6 CAST questions. 1,6% of all respondents (n=2020) was found at the risk edge to face some problems. (Further information in the 2007 Report part 2.1.1.2)

[23] Nociar.(2008b) Report for NMCD, October 2008, unpublished study

Table 2.3: Relative risk of consumption of other drugs related to CAST score > 3 (Data source Nociar.(2008b) Report for NMCD, October 2008, unpublished study)

Experience of drugs:	marihuana	**Rel. risk**	Opioids and amphet.	**Rel. risk**	LSD, haluc.	**Rel. risk**	Ecstasy	**Rel. risk**	Pervitin	**Rel. risk**
Marihuana LTP YES plus CAST > 3 : NO			14.3% 0.2%	**71.5**	26.8% 0.3%	**89.3**	39.6% 0.3%	**132.0**	44.9% 0.7%	**64.1**

According to the author, the scale and intensity of problems with illegal drugs are higher than in previous cycles of the survey in Slovakia. The real scale of marihuana use (current use, LYP, LMP) and experimentation with other drugs can be estimated[24] as follows:

Table 2.4: The estimate of real high schools population in four cycles of ESPAD survey (Source: Nociar, A, 2008 a: Presentation of results for Slovak sample in ESPAD 2007 survey)

Year of survey	**1995**	**1999**	**2003**	**2007**
LYP and LMP for cannabis	33 000	59 000	85 000	99 000
LTP for any drug (individually or at the same time and in combination ecstasy, amphetamines, LSD, hallucinogens, crack, cocaine, heroin).	10 000	21 000	29 000	37 000

These projections, which are based on the simple increase in the frequency of use in a population of unchanging size ((what is assumed to be), are complicated by the reduction in the target population, which shrank by approximately a sixth between 1995 and 2007 (December 2006). This means that Slovakia is facing a problem that is increasing its scope in a shrinking youth population, which means that the number of young people who do not abuse alcohol and drugs is falling faster than is indicated by the percentages measured or the estimated number of users. (Nociar A., 2008a).

2.2.2 The ways of spending free/leisure time in relation to the self-assessment of young people and attitudes to extremism

Another school[25] survey was conducted by the Ministry of Culture under the name "The ways of spending free/leisure time in relation to the self-assessment of young people and attitudes to extremism"[26]. The survey was largely psychological in orientation but included questions on addictions (smoking, alcohol, drugs, gambling) in the context of the ways for spending free time, level of satisfaction, self-assessment and socio-demographic characteristics of secondary school students. In terms of the GPS indicator structure it assessed on *quasi* LTP.

Methodology

The survey is based on a selective sample of students in the second and third years of secondary schools (aged approximately 16–19 years) in 18 secondary schools (high schools - preparing for university, technical and vocational schools) from Eastern, Central and Western Slovakia. The questionnaire was completed by 1201 respondents, 1198 questionnaires were statistically processed. (Research was carried out in the same schools as in 2003 plus 4 additional ones). Data, in the form of class questionnaires, was collected by the professional staff of the NOC Cultural Observatory in Bratislava during May - June 2007.

[24] by extrapolation to the full population of students in the year in which the ESPAD survey was conducted in Slovakia

[25] Conducted in classes, in groups

[26] Hradiská,E. Ritomský,A - (2007) http://www.nocka.sk/uploads/0w/Fm/0wFmQeI8papKPHJy4qk8Dw/Volny-cas-mladez-07.pdf

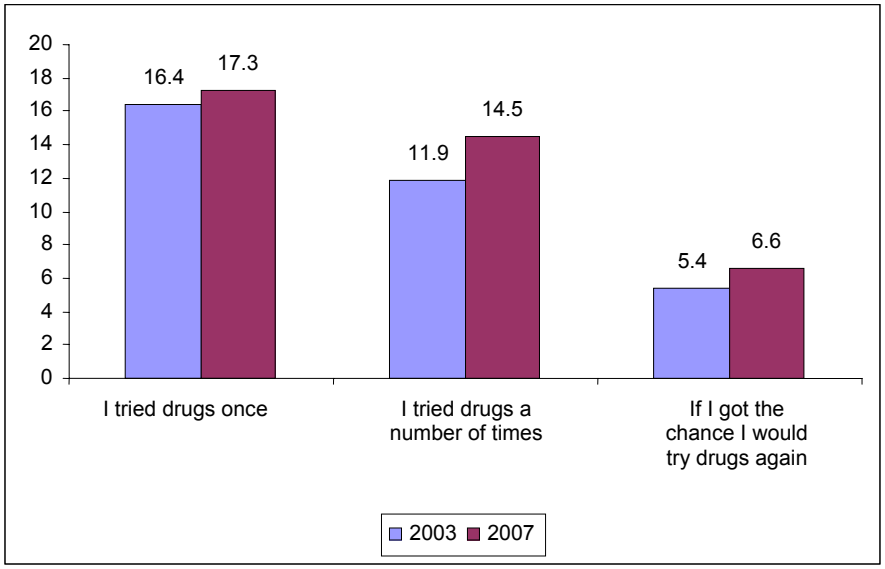
For historical comparison, the results were compared with the results of the survey carried out in 2003[27]. This survey was based on a socio-demographically comparable sample using the same questions, which makes it possible to make a more detailed comparison of possible changes in the experience of young people with smoking, alcohol consumption, drug use or playing gambling machines.

Results

In comparison with 2003, there was an increase in the percentage of young people who had tried illegal drugs (LTP), tried it several times, and who will use them again if an opportunity arose (Fig. 2.1.2.1). This *"psychological"* variable indicates an interesting dimension in the motivation for use - opportunity.

The proportion of respondents who had not tried any sort of drug (including marihuana) fell by 2.3% (65.1% in 2003 and 62.8% in 2007).

Fig. 2.2: The comparison of the four years development in three "variables" (Data source: NOC/Cultural Observatory Survey, 2007)



Traditionally drugs have been more closely associated with boys, but a third of girls (compared to half of boys) had experience of drugs. This survey also found that with increasing age respondents were more likely to have experience of drugs. Drug use was also correlated with size of place of residence. Respondents were most likely to come into contact with drugs in large towns.

The survey confirms connections between attitudes to substance addiction and experience of illegal drugs and predominant free time activities. The largest percentage of those who had tried drugs once and also more times were categorised as sociable, communicative and likely to spend free time at parties (so-called type A). This group also contained the smallest numbers who had no experience of drugs. Less sociable individuals (type B) and also sports participants and respondents with broad interests and fewer social contacts were most likely to try drugs again if given an opportunity. Drugs are associated with social activities in free time – in particular spending time with friends, clubbing and the like – and also with artistic interests. There is also a relationship between the overall satisfaction of young people and their active attitude to smoking and drugs – the more satisfied young people are, the less likely they are to smoke, but the more likely to try drugs.

[27] Hradiská, E, Ritomský, A (2003) Suitable methods of spending free time for young people as a prevention of various kinds of addiction (Bratislava, National Culture Centre, 2003) – unpublished study

An inclination to try drugs is associated with satisfaction with friends – they often encourage young people to try drugs.

*If we compare attitudes to certain extremist groups or groups like ecological pressure groups – the primary purpose of the research – we find that young people are most likely to try drugs if they are sympathetic to "punks", anarchists, anti-globalists or if they agree with any of their attitudes. Young people who are sympathetic to the idea of conservation are frequently opposed to drugs. Respondents who agree with the ideas of the skinhead movement, sects and nationalist groups are least likely to say that they smoke; alcohol appeals to young people who spend most of their free time in cafés, pubs or discos. (*Hradiská, E., Ritomský, A. 2007)

2.2.3 Youth (15 - 26) surveys

The IIPE has studied the consumption of illegal drugs by young people aged 15 -26 as part of its broader research since 1995 (see Report 2007, part 2.2.2, Report 2006 etc.). The regular last year survey in June 2007 was focussed on the theme of "Free time as an important factor in the prevention of youth drug addiction". In terms of the EMQ basic module, it determined LTP and the age of first contact with drugs A LMP variable is likely to construct.

Methodology

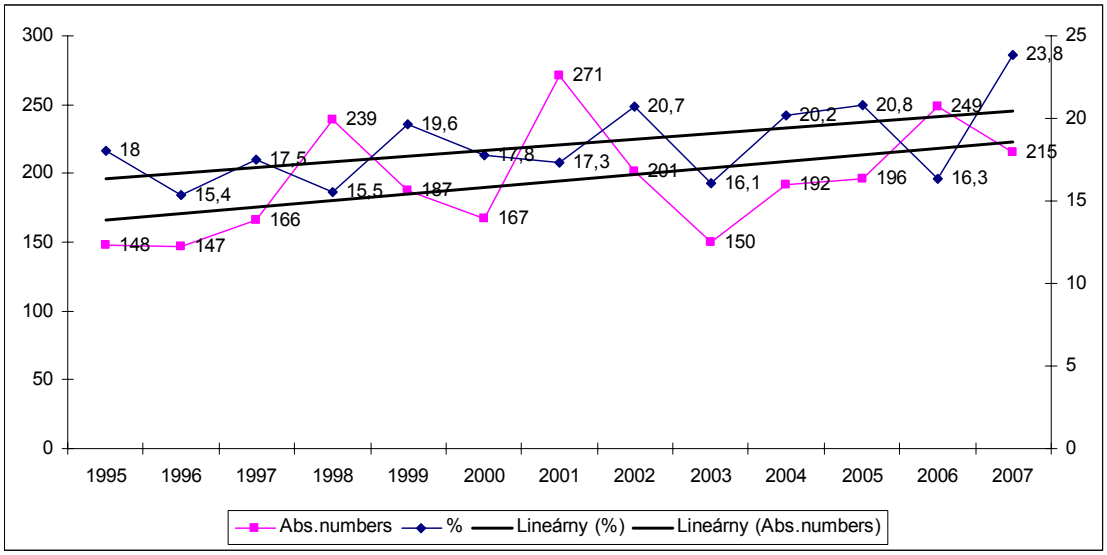
The questionnaire is completed by an interviewer during a face-to-face interview with the respondent in their home. Statistics were collected from 904 questionnaires in 2007.

Results

23.63% of respondents (N=215) reported experience with at least one type of illegal drug (quasi-variable LTP) in 2007, with a bias towards men (29.4% of all male respondents and 18.3% of all female respondents).

The percentage of 23.6% for 2007 was the largest observed in 13 years (fig. 2.3). In absolute terms, higher numbers[28] of people experimenting with drugs were recorded in 1998 – 239, in 2001 – 271 and in 2006 – 249.

Fig. 2.3: The rising linear proportion and numbers of young respondents who declared experience with drugs in surveys of IIPE (Data source: IIPE data reports for NMCD)



[28] Depending on the sample size

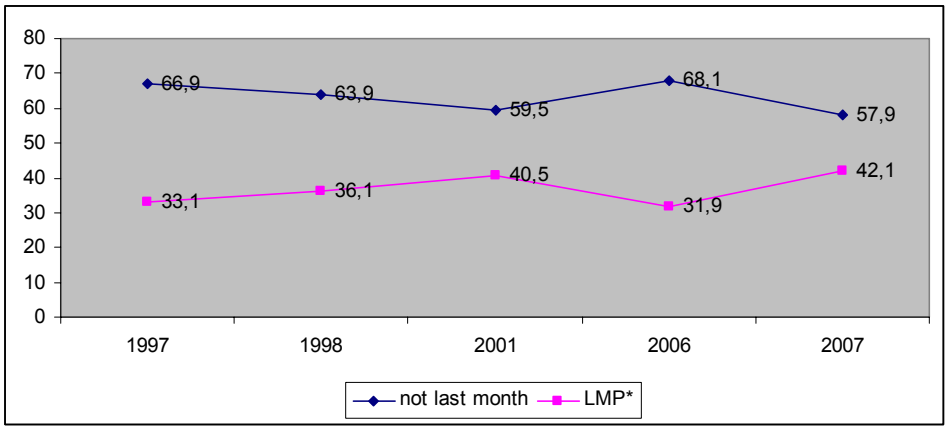
In 2007 the greatest numbers were found to have experimented with cannabis - as in the ESPAD survey - in this case, approximately 20% of respondents. The long-term monitoring offered by this sociological survey shows a clear rising trend in the proportion of young people aged 15 - 26 who have tried an illegal drug and a fall in the proportion of people who have never tried an illegal drug.

In addition to LTP, the survey identifies the frequency of use in the last month through the question "How many times have you used an illegal drug (other than alcohol and nicotine) in the last month". Respondents can choose from the following answers: not once, less than 5x, more than 5 xs and "don't know". From data supplied by the IIPE for other purposes[29], last month prevalence (LMP) could be estimated from the sum of those who declared that they had used a drug less than 5x, more than 5x and those who could not say how many times.

In 2007 such answers were given by 91 respondents (42%) from subgroup where experience with drugs was declared (215 respondents) and approximately 10% of the total of 904 respondents aged 15-26 olds. There was also a fall in the number of those who had not used any drug even once in the last month.

In a historical perspective of 10 years, this *constructed* variable for LMP shows a clear rising trend. (Fig 2.4)

Fig. 2.4: Ad hoc LMP* the falling proportion of people who had not used an illegal drug in the last month and the rising proportion of those who had used drugs in some extent in the last month. Ad hoc LMP* construction by NMCD, 2008 (Data source: IIPE data report 2008 for sub-study 3 in the NOS-OSF Evaluation of Sections 171 and 172 of the Penal Code)



The IIPE survey for 2007 "*Free time as an important factor in the prevention of youth drug addiction"* used an inventory of free time activities to map the way in which young people spend their free time and study the relationship between such activities and smoking, alcohol consumption and experimentation with illegal drugs. The data was compared with data from a similar survey on the use of free time conducted in 1997; 4 new activities were added compared to 1997: *"work with the internet", occasional work (part time jobs), vegetating and visiting large shopping and entertainment centres (shopping malls)*.

Comparison with data on the use of illegal drugs has shown that young people who have tried illegal drugs (23.8%) have more free time, are less satisfied with the way they spend that time – usually passive recreation, occasional work, work with a computer or the internet, meetings with peers, visits to discos, shopping and entertainment, pubs and restaurants or vegetating.

Young people who did not report experience with illegal drugs were more likely to report activities like watching television, listening to music, reading books and magazines, studying

[29] For sub-study 3 in the NS-OSF Evaluation of Sections 171 and 172 of the Penal Code

and developing interests, doing active sport, visiting relatives, spending free time in shopping centres and going to church services. Pétiová (2008)[30] concludes that developing interests, sports, reading books, and education can be a protective factor against illegal drug use though it is necessary to improve conditions for making good use of free time both directly in schools, home and at community and to make activities financially accessible for young people.

2.3 Drug use in specific population groups

During 2007 Prešov Region[31] (hereinafter PV) carried out research into the drug use situation in its territory. The research was part of a project entitled Concept for using regional resources in the creation, implementation and evaluation of anti-drug policy in the Prešov region. (2007 Report, part 1.2.1.2)

The objective was to provide an overview of the situation in drug use in Roma communities in the Prešov region and create a background of basic information to serve for future research. The characteristics of the target group made usual sociological methods difficult to employ and so field research was based more on cultural and anthropological principles. Researchers contacted a *focus group* in the community and carried out semi-guided interviews with the aim of acquiring information on the following areas (working hypotheses): the presence of hard drugs in the community; predominance of substances based on organic solvents and inhalants; gender differences in the consumption of alcohol and tobacco, differences between the majority population and minority groups as regards alcohol and smoking; incidence of the use of ether; excessive use of medicines; abstinence from alcohol and tobacco; inter-communal differences (urban type, village type, segregation, integration). On the basis of these and other data, the researcher prepared a summary report for each community. Research was carried out in 70 Roma communities with a total population of 56 906, which is 65.7% of all Roma in PV.

Findings

Some evidence of hard drugs[32] Roma communities was found, but they are rare. These are individual cases that have not achieved a wider distribution and use continues only for a limited period. Where they do occur, they have an increasing trend, primarily in the urban environment. Cannabis use is increasing also outside towns. According to sources of information for the research, such drugs are widely available and it is possible to obtain them without particular problems. A paradox is that the more integrated a person is in majority society, e.g. through work abroad, the more likely they are to have experience of "*hard drugs".*

Toluene is even used (inhaled) in public in some Roma communities. They are communities with a very low social status, not only in comparison with the surrounding majority but also in comparison with the general Roma population. Users of toluene have many characteristics in common. They belong to the weakest social class in their community and are judged there very negatively.

It was confirmed that alcohol and cigarettes are widely used in Roma communities but consumption varies from community to community. It was not possible to demonstrate a relationship between alcohol use and the degree of segregation/integration or the social level

[30] Pétiová, M.: Free time as an important factor in the prevention of youth drug addiction – summary for NMCD, 2008, based on results of IIPE research, 2008

[31] Prešov Region was established by the act on the territorial and administrative organisation of the Slovak Republic on 24.07.1996. It has an area of 8974.5 km2 (the second largest region in Slovakia after Banská Bystrica) with a population of 798 596 as at 31.12.2005, Prešov Region also has the largest population of any Slovak region. It also includes the largest number of districts (13) and the largest number of municipalities (666 – 23 towns and 643 villages). There are 86 659 people in the region whom the surrounding population regard as Roma living in 252 municipalities.

[32] Opiods,stimulants, amphetamines, marijuana

of the community. Nor was the hypothesis confirmed that alcohol use in Roma communities is always higher than in the surrounding majority community.

The lower the social level of the community is the lower the age at which alcohol and smoking is generally tolerated. There is greater tolerance for smoking than for the regular use of alcohol, even strong intolerance for the regular consumption of alcohol by women. An exception can be found in the weakest levels of the community or socially weak communities as a whole. In nearly every community there are people that the community considers to be alcoholics and this applies even in cases where there are persons who have received treatment for addition to it.

Declared abstinence does exist in Roma communities but is rare. Exceptions are respondents who have stopped using alcohol and tobacco for health reasons or members of the Jehovah's Witnesses church. Women and older people are most likely not to drink or smoke. There is an increase in the number of young people who claim that they do not smoke because of the high cost of this bad habit. The same situation exists with regard to alcohol. In this context the likelihood of non-smoking is proportionate to the social and educational level of the individual. In socially weak communities people are more likely to smoke tobacco than cigarettes for financial reasons.

In some areas (in 6 municipalities) in North-East Slovakia the chemical substance ether is used directly. This substance, popularly referred to as "Hoffman Drops" (*Hoffmanské kvapky*) was formerly imported from Poland and is now obtained from pharmacies where it is freely available (though it is also significantly more expensive).

In nearly all Roma communities there is a high level of use of freely available medicines, also in combination with alcohol. The drugs used most frequently are analgesics, antipyretics and benzodiazepine.

The hypothesis that there would be significant differences in drug use between town and village Roma communities was only partially confirmed. It is not generally the case that the situation in town is significantly worse than in villages. On the other hand it is significantly easier to buy drugs in towns.

2.4 Drug use in recreational environments and recreationally

The NMCD does not have information on research specifically targeting drug use in recreational[33] environments in 2007.

Data from the surveys cited above indicates that drugs are available in recreational settings. Mušinka et al. (2007) state that young Roma in Prešov can obtain ecstasy and marihuana in discotheques that are either Roma´s establishments or Roma are allowed to admit. In other research for the same project[34] 39.17% of 600 respondents (141) stated that they had been offered drugs, usually at clubs, discos, concerts and parties, less often in the street, school accommodation facilities and at work.

Experience with drugs (at the level of experimentation) is associated with free time social activities - meetings with friends, visits to clubs, pubs, and cafés and discos (Hradiská, 2007). Respondents to the IIPE survey who had experience of drugs also prefer to spend their free time with their peers, visiting discos, amusement arcades, restaurants and clubs. (Pétiová 2008)

[33] Recreational drug use – usually involving illegal drugs – in a social or relaxing context, without consequences, i.e. without drug addiction or other problems. The term recreation use (WHO, 1994) is expanded by the EMCDDA to cover drug use in nightclubs for entertainment purposes (2002) and UNODC even adds a social motivation to the term – drug use amongst friends in a sociable and accepting environment. Source: Young People and Drugs, 006

[34] Bača,M.et all.(2007)

3 Prevention

Prevention, with a specific emphasis on children and young people is one of the four pillars of the national strategy. The main responsibility in the area is shared between the Ministry of Health, the Ministry of Education, the Ministry of Labour, Social Affairs and Family, with the involvement of the Ministry of Interior and Ministry of Justice in the prevention of drug crime.

In terms of the key indicators on the drug situation, prevention takes the form of policies or interventions aimed at target groups.

The primary objective(s) and target groups determine the content35 and the appropriate forms of implementation of prevention policies with professional support from existing "infrastructure" (institutions and the helping professions).

This chapter is organised according to EMCDDA requirements and a table is provided in the introduction to guide readers. The horizontal axis of this table specifies the group that is targeted (from the general population or school population through at-risk groups (selective prevention) to at-risk individuals) and the vertical axis specifies the environment (school, community, family) in which prevention activities are implemented.

This structure for the monitoring of prevention interventions or categories of prevention activities/programmes is not used in Slovakia in practice. The Institute of Information and Prognoses of Education acts as the central statistical repository for information on prevention such as the activities/programmes of key centres for educational and psychological prevention (CEPP) and pedagogical and psychological counselling centres (PPCC) and reports on the activities of other special education facilities and processes information on projects supported by grants from the Anti-drug Fund in the given year.

Environment	**Environmental strategy**	**3.1. Universal prevention**	**3.2 Selective prevention**	**3.3 Indicated prevention**
School	school policies, health promotion and school climate	3.1.1 interventions for pupils and students	Interventions for pupils/students with academic or social problems, truants	3.3.1 Interventions for pupils with ADHD, conduct disorder
Community	Policies and regulations on legal drugs (taxes, bans, advertising restrictions), cultural norms on legal drugs, cannabis and antisocial behaviour	3.1.2 Interventions for young people in alternative leisure time programmes, youth programmes outside school, sports clubs	3.2.2 Interventions for young offenders, clubbers, ethnic groups, experimenting youth	3.3.2 Follow-up interventions for paediatric patients with ADHD, depression or CD
Community – family	Education styles (laissez-faire, authoritative)	3.1.3 interventions for families in general	3.2.3 interventions for families at risk	3.3.3 Help and support for families with children at risk or a member with a drug problem

Source: EMCDDA

[35] According to analysis by the EMCDDA (2006) Slovakia is one of 11 countries where illegal and legal drugs are linked for the purposes of prevention (and treatment).

3.1 Universal prevention

3.1.1 School – Interventions for pupils and students

Primary objectives: To prevent drug addiction and raise the age of first contact with drugs through health education, health promotion (alcohol, tobacco, illegal drugs and sexual health), and reduction in antisocial behaviour.

Target group: 940 022 pupils and students[36]

The environmental strategy for the achievement of the objectives is formulated in the teaching and organisational rules of the Ministry of Education. This document is updated every year and specifically reflects the basic legislative framework (the schools act, the Declaration of the Rights of the Child), individual national strategies (and/or action plans) for health promotion, the National Program for Problems with Alcohol (NAPPA), the Programme for Tobacco Control (NPTC), prevention of HIV/AIDS and the National Programme for the Fight against Drugs. According to Kopányová (2008)[37] primary (universal) prevention involves the creation of optimal conditions for the physical, mental and social development of children and young people. In particular this means the integration of the prevention of drug use and drug addiction into the educational process and the creation of the position of a prevention coordinator.

3.1.1.1 Evaluation of universal prevention in schools

During the school year 2006/2007 the state school inspectorate[38] studied the situation with regard to the prevention of drug addiction as part of the educational process in 36039 schools (245 elementary schools and 87 secondary schools) by means of questionnaires sent to prevention coordinators. The data obtained was compared with the results of similar research carried out by the SSI in school year 2002/2004 (2004 Report .

In most cases women perform the function of prevention coordinator in schools (89%). There has been an increase in the number of coordinators with one to five years of experience (they are younger). 94% of coordinators had a complete prevention plan for the school year and were interested in their work even though it was not their only activity. They gave a positive assessment of cooperation with professional educational facilities and there was much better cooperation with pupils, class teachers and parents than at the time of the previous survey. The coordinators are interested in professional development.

Prevention is most often incorporated as a component in compulsory subjects – Ethics, Civics and Social Studies. There was an improvement in the provision of supplementary text books to pupils but on the other hand fewer teachers had a guide for using the text books.

The text book currently in use “Nenič svoje múdre telo” (Don’t mess up your clever body) “Ako poznám sám seba” (How to know yourself) and “Ako byť sám sebou” (How to be yourself) are connected in terms of content and cover different age groups at different levels of education. In 2007 the text books were joined by a multimedia format for the education of teachers and students of elementary and secondary schools on the prevention of alcoholism[40] and the implementation of the “Vieme, že...” (We know that…) programme.

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[36] www.uips.sk/statistics

[37] Kopányová, A.: Tertiary/indicated prevention in education, Prevencia 1/2008 p. 5–10

[38] Report of the SSI of 9.10.2007 as the part of Ministry of Education report. Submitted to the meeting of the Ministerial Board on Drug Dependencies and Drug Control – March 2008.

[39] around 10% of schools in Slovakia

[40] A project of the State Pedagogical Institute as part of MGS – Methodological guide for the (effective) use of the DVD "Alkohol – skrytý nepriateľ" (Alcohol – the Hidden Enemy) in schools

3.1.1.2 Selected programmes and projects implemented in 2007

The national Smoke Free Class competition 5 484 pupils in 230 classes in 66 schools took part in the second year of this competition during school year 2006/2007. Over a six month period, 149 classes (64%) in 41 schools all over Slovakia did not break any of the basic rules of the competition. The competition also included art and literature contests and a contest to find the most creative school activity on the topic of non-smoking.

"Normálne je nefajčit'" (It's normal not to smoke) is the message of the website www.nefajcite.sk maintained by the Evangelical Lyceum secondary school in Banská Bystrica. (Project of the Ministry of Education, Health in Schools)

Another project implemented within the same Ministry of Education project was "Červené stužky" (Red Ribbons)41 which was intended for secondary school students aged 14 - 18 years. This was a national campaign against AIDS organised by students of the St. Francis Gymnasium secondary school in Žilina with the support of regional authorities and expert supervisors42. The students presented the message of the campaign to their peers and used a questionnaire to get feedback from participants on possible solutions to the problem. These young people considered technical information about HIV/AIDS and drug prevention to be the most effective means of fighting AIDS.

The interactive prevention programme "the Anti-AIDS game" (aimed at the 14 -18 age group) was implemented schools under the supervision of the Public Health Authority of the Slovak Republic and its regional offices. According to published information43, 4 194 pupils in 30 schools (elementary and secondary) in the Košice area had taken part in the programme to the end of 2007.

The Evangelical Youth Association carried out the MGS 2007 project, a primary prevention project focussing on risk behaviour in elementary schools and eight-year gymnasia (academically oriented secondary schools), with the aim of obtaining a picture of drug use and drug awareness among children aged 12 -15 years, to stop the reduction in the age of first contact and to test a programme to increase resistance to negative influences.

The aim of the prevention programme "Vieme, že..." (We know that…) is to reduce antisocial behaviour and prevent youth crime.44. The programme began as a pilot survey of 530 respondents in Nitra carried out in 2002 - 2003 and has now grown into a full programme that was used in 223 schools by 4 876 pupils aged 13 - 17 in school year 2006/2007. The programme (which is planned in the form of fifteen or eighteen lessons) satisfies MUSTAP (Multi–session, Standardized Printed) requirements45; it is supported by textbooks and guides for pupils and a methodological guide for the programme leader. Input and output tests/scales measure knowledge, attitudes and self-assessment. The programme studies in which areas attitudes are changed and where knowledge of an issue increases. (2007 Report, part 3.1.1.2)

The programme "Cesta k emocionálnej zrelosti" (the Way to Emotional Maturity).

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[41] www.cervenestuzky.sk

[42] The National Reference Centre for the Prevention of HIV/AIDS and the Centre for the Treatment of Drug Dependencies in Bratislava

[43] Schnitzerová, E., Masica ,I.: The "Anti-AIDS game" project as an alternative form for prevention of drug addiction Prevencia 1/2008

[44] Source: http://www.minv.sk/swift_data/source/policia/prevencia/viemeze.doc

[45] MUSTAP = a coordinated set of activities with the necessary support of printed materials (procedural instructions, manuals, work books for participants). MUSTAP programmes require training for instructors who go on to implement the programme.

A long term, national prevention programme46 intended for pupils aged 12 - 15 years (the sixth to ninth year of elementary school or the first year of secondary school). It develops and strengthens psychological and social skills which can act as a protective factor. This programme also complies with MUSTAP criteria for prevention programmes. The quality of the "Way" programme is appraised by teachers and participants every two years (2007 Report, 3.1.1.2). Quantitative data is also collected. Data is collected on the number of participating schools, the number of pupils and the number of teachers who have received special training. 511 schools (of which 498 were elementary schools) took part in this prevention programme during school year 2006/2007. In numerical terms, the fewest participants in this prevention programme came from the Bratislava Region (2 208) and the most came from the Košice and Nitra regions (5 163 and 4 489 respectively). 33.79% of the total number of elementary schools (state, private and church schools) took part in the prevention programme, which represents an increase of 1.2%. A total of 28 617 pupils in the second stage of elementary school took part (compared to 27 735 in 2005/2006). This number represents 9.89% of all pupils in education (Slovíková, 2008).

3.1.2 Universal prevention in the community

Interventions for young people in alternative leisure time programmes, youth programmes outside school, sports clubs

The environmental strategy involves the banning of the sale and consumption of alcohol and cigarettes by young people (under 18 years), the implementation of controls to prevent young people from obtaining and consuming alcoholic beverages and other addictive substances in clubs during the evening and night. Despite regulations to the contrary, there is widespread availability of alcohol and tobacco47 even though the price of alcoholic beverages is set relatively high in comparison with the purchasing power of the population. Slovakia is one of the countries with the highest number of retail outlets and sales hours for alcohol in the EU. Slovakia is not one of the countries that has achieved optimal measures for the control and regulation of alcohol advertising (sponsorship). The environments of sport and recreational activities, which are central features of the social space of young people, are strongly associated with the drinking of alcohol through a variety of marketing practices[48].

Statistical data are available on school facilities used for children's and young people's leisure activities (IIPE, 2008). The number of facilities for active leisure where it is possible to pursue interests regularly (school hobby centres) and occasionally (leisure time centres) increased compared to 2006 (from 257 to 304)[49]. The most activity was in the area of physical exercise and sports (3 058 groups) and art and culture (2 541 groups). 80% of the 153 701 participants in regular interest activities were children aged up to 15 years. There were 1 193 968 participants in occasional events, mainly in the area of art and culture (336 098) and physical exercise and sport (299 072). 776 summer camps were organised in Slovakia in 2007 (729 in 2006). They were attended by 25 956 children and young people. Children aged up to 15 years accounted for 85.7% of participants (Slovíková, 2008).

There are close relations between the alternative leisure time facilities and the network or regional public education centres, selected libraries and other cultural institutions for which the Ministry of Culture is responsible. The ministry takes part in universal prevention in two forms – leisure activities and the satisfaction of the cultural needs of the population, including children and young people. Examples of public education centre projects in the area of

[46] Over an eight year period 306 775 pupils have taken this programme in schools (307 598 pupils, if secondary school students are included) in 18 956 classes. The programme was mainly used in Ethics classes (41.5%) and other lessons during the teaching hours. Outside teaching hours, pupils followed the programme in class hours (22.2%) and seminars

[47] Eurobarometer Flash 2008 - over 90% of respondents aged 15–24 years said that they would have no problem to obtain alcohol or cigarettes.

[48] Reference to NAPPA

[49] Slovíková M., 2008

universal prevention supported from the Anti-drug Fund in 2007 include a project in Galanta Young People and Healthy Lifestyle – prevention of drug addiction in organisations and informal groups of children and young people, The Fairy Tale Tells Us – for children in nursery school, Let's not be Afraid of Prevention, for children in elementary school (education on healthy lifestyle for children including drug prevention, Žiar nad Hronom). In Bardejov – No to Drugs for Secondary School Students – a seminar with an expert on the topic and workshops to support communication skills and social skills.

A specialised unit in the area of culture – the Cabinet of Social Prevention of the National Cultural Centre – carries out a range of projects[50] involving education, publications and advice in the area of "*social prevention*". A key project in the prevention of dependencies on alcohol, tobacco and illegal drugs is the national art competition and travelling exhibition "Why I am happy in the world". Since 1995, when the competition attracted entries from 292 young artists in its first year, the number of entries has increased fivefold to 1 498 in 200751.

In Sládkovičovo a project financed by MGS52 created an interdisciplinary and effective system for drug prevention in the town.

Since 1995 the city of Bratislava has provided annual funding and support for NGO projects focussed on crime prevention, the prevention of drug addiction and the prevention of other antisocial phenomena, and also to create opportunities for leisure activities for children and young people. In 2007 Bratislava provided support with a total value of SKK 2.5 million (EUR xxx) to 111 projects.

The project Zodpovedne.sk[53] (a national project within the community programme Safer Internet plus www.SaferInternet.org) aimed to increase awareness of responsible use of the Internet, mobile communications and crime prevention. Amongst information on a variety of antisocial and psychopathological phenomena it provides information on self harm caused by drugs and provides links to other specialised internet resources such as www.infodrogy.sk and www.drogy.sk.

3.1.3 Universal prevention in the family

Currently this is a type of community prevention (family = community) and it is rare in practice, despite efforts by experts to introduce it – the reason being lack of interest on the part of parents. The register of projects kept by the Anti-drug Fund records only one project in this area in 2007, in Dunajská Streda. My Borders – a continuation of a weekend training meeting for the whole family (social and psychological exercises for pre-school children and their parents).

3.1.4 Infrastructure

All the prevention programmes and projects listed here were implemented directly or in close cooperation with counselling, pedagogical and psychological services in the area of education, which are available in every district centre. PPCC and CEPP provide professional supervision of prevention activities and programmes at a local level in cooperation with many

[50] profile of cyclical education projects – educational events focussing on the specific prevention of addiction; education through targeted publication activities (whose scope affects the whole area of responsibility of the ministry and wider) e.g. the informational and educational bulletin for the area of culture "Sociálna prevencia"(Social Prevention); the occasional publication "Kultúra a prevencia závislosti" (Culture and addiction prevention)

[51] Hupková, I.,2008

[52] MGS

[53] The project is implemented by the Ministry of Interior, the Slovak UNICEF committee and the civil association eSlovensko with financing from the EU, the Ministry of Interior, eSlovensko and the commercial sector. The project runs from August 2007 to April 2009. The main media campaign began in January 2008.

other bodies. They provide training54 for teachers and drug prevention coordinators. Nationally (Slovíková, 2008), CEPP implemented a total of 325 prevention programmes55 in school year 2006/2007, of which 53 were for at risk groups (around 16%), including 2 for parents. The majority were of a long term or medium term character.

PPCC initiated 313 prevention programmes, of which 59% were community programmes, in particular school programmes (134). More than half of programmes were short term in character (162). The largest target groups of prevention programmes were elementary school pupils.

With the exception of peer programmes, there are no standards for prevention programmes and only a small proportion of programmes undergo evaluation (according to IIPE statistics 37 programmes were evaluated in school year 2006/2007, i.e. 11.38%). This is usually on a descriptive level, with evaluation of the process being rare.

3.2 Selective prevention

3.2.1 School – Interventions for pupils/students with academic or social problems, truants

Within the area of responsibility of the Ministry of Education, the PPCC network (with the CEPP) carries out diagnosis (identification) of risk factors in clients, who in most cases are referred as a result of a recommendation to parents from the school. These services also carry out follow up interventions that may be selective (for groups) or indicated (for individuals). The IIPE analyses the statistical reports of these educational facilities (see 3.1.4) to monitor reasons why clients contact the services, which are recorded in a number of categories (all of which may represent a risk or a contributing factor of drug addiction): 1. conduct disorder, 2. personality and mental problems and 3. antisocial behaviour.

Antisocial behaviours include smoking, use of alcohol, medicines and illegal drugs, compulsive gambling. Such behaviour was recorded in 228 cases in school year 2006/2007, which was 14% of the total 1 608 cases.

Table 3.1: Antisocial behaviour as a reason for referral of clients to PPCC and CEPP in school year 2006/2007 (Source IIPE , Slovíková M., 2008)

	drugs	asocial and antisocial behaviour	compulsive gambling	membership of a cult or sect	other	total
PPCC total	133 [56]	143	3	2	228	509
CEPP total	95	183	10	2	809	1 099
Total	228	326	13	4	1037	1 608

The Centre for Educational and Psychological Prevention57 provides specific social, psychological and therapeutic care for children at risk of antisocial behaviour in close

[54] including the specialisation of their own professions. For example, the project Effective Prevention – a Good Investment (MGS project) studied the increase in professionalism and motivation of employees of the counselling centre who work with children and young people in the area of prevention and provide the parents of children at risk with basic information on antisocial behaviour, prepare them for possible risks and, if necessary, guide them to where they can obtain help

[55] The largest target group of prevention programmes was elementary school pupils. According to IIPE statistics on 37 programmes (11.38%) were evaluated

[56] The largest number (96) were found in the case of the PPCC in Trebišov

[57] Source: http://www.uips.sk/preventivne-programy/ accessed 20.05.2008

cooperation with the family and the natural social environment, usually in outpatient form. It participates in outreach work and supervision of the education of children at risk, including children who have been released permanently or on a suspended basis from compulsory institutional care. In providing assistance it cooperates with relevant institutions and civil society organisations. It provides a continuous emergency service for children and families in critical life situations. This service may involve short term accommodation.

3.2.2 Interventions for young offenders, clubbers, ethnic groups, experimenting youth, groups at risk

Intervention for first offenders involved in drug crime based on the FreD model is at the research and preparation stage. (FreD goes net – 2007 Report, Chapter 3.2.3)

The prevention of crime in prisons is described in more detail in part 9.2.

This part concentrates only on the prevention of drug addiction and the prevention of additional crimes among young offenders aged 14 -18 years placed in the Young Offenders Institute (Ústav na výkon trestu pre mladistvých) at Sučany. In 2007 the institute[58] housed 331 young offenders of whom 34 (around 10%) said that they had used drugs before being sentenced. A drug free zone with a capacity of 18 places is available[59] and the psychiatric department has 10 beds (from a total of 33) where drug addicted offenders can receive treatment. In 2007 the institute carried out a very large number of activities (333) that the prison service defined as prevention activities (lectures, seminars, socio-psychological exercises, relaxation training, counselling).

Drugs and prevention - a project within MGS monitored the increase in knowledge of drugs among children and their parents from socially disadvantaged backgrounds, the creation of opportunities for meaningful leisure activities and improvement in cooperation between schools and the Roma community in Zvolen District.

Cultural centres implemented a number of projects (creative workshops for at risk (vulnerable) groups). Young people and healthy lifestyle - drugs prevention - creative workshop Target group - children in children's homes.

The existing low threshold facilities (2007 Report, chapter 12.2.5) were joined by a new low threshold centre "Prijatie" (Acceptance) run by the humanitarian society of the same name as a centre for the prevention of drug use that also provides treatment for conduct disorders through group socio-psychological exercise (MGS project, Spišská Nová Ves and Gelnica).

In 2007 the Anti-drug fund provided continuing support (2007 Report, chapter 3.3) for a broad range of projects aimed at high risk groups, including day residential camps for children with behaviour disorders and ADHD[60], summer camps for children from socially disadvantaged backgrounds and also year-round creative workshops, low threshold clubs such as Klub Maják in Poprad, Klub M in Košice, the continuation of the Mirroring project, focussed on prevention and re-socialisation of emotionally and socially disturbed girls in a re-education home.

The national project "Hľadané deti" (Missing Children) also continued in 2007 under the slogan "Let's bring children back where they are safe." (Slovak UNICEF committee, the police force and the TESCO stores supermarket chain. (2007 Report, chapter 3.3).

[58] Slavkovský,A .,2008
[59] (one of six – capacity is 367 places)
[60] Kežmarok - Therapeutic camp for children with ADHD. The project builds upon previous camps for children with ADHD and their parents, aimed at developing core educational skills, strengthening concentration and so on

3.2.3 Selective prevention - Family

An infrastructure exists to provide qualified assistance and counselling to families at risk (for various social reasons, including families in which a member has an addiction problem). The previously independent network of centres for psychological counselling services (CPCS) were incorporated into the offices of labour, social affairs and family (OLSAF) in 2005 as offices of psychological counselling services (OPCS) within the department for socio-legal protection of children and social supervision. At this time there was a reduction in specialist staff – especially psychologists, which lead to a considerable reduction in the selective prevention of addiction. In 2007 the OPCS carried out only a minimal number of such activities.

In 2007 the OPCS provided psychological counselling on the topic of addiction problems clients in 143 cases. (compared to 135 cases in 2006 and 313 cases in January to September 2005). In 2007 assistance was mainly provided to families in which addiction, motivation for an experimenting user or addiction to medicines had arisen. The topic of alcoholism is often part of other types of problems (problems between partners, family problems, divorce etc.)[61]

3.2.4 Other forms of selective prevention and measures[62] for at risk groups

The website www.infodrogy.sk, which is operated by the NMCD, the GS MCDADC has permitted anonymous access to medical professionals and lawyers since the end of 2005. Nearly 1 000 questions have been answered in four areas focussing on the general effects of drugs, medical aspects of use and treatment for drug problems and assistance for parents and teachers and legal issues relating to the consequences of the production, growing, possession and consumption of drugs. Most questions for the experts were asked by parents, relatives and friends. 387 questions were answered in 2007, which was 27% more than in the previous year[63].

Three of the five specialised centres for the treatment of drug dependencies currently provide advice over the internet (CTDD Bratislava – www.drogy.sk, see also chapter 7.3), the specialised psychiatric treatment facility at Predná Hora and CTDD Žilina).

3.3 Indicated prevention

3.3.1 Interventions for pupils with ADHD, conduct disorder

Infrastructure

The Ministry of Education provided full care for the different problems of individuals that cannot be managed by outpatient means (CEPP) in 32 special education institutions in 2007 (31 institutions in 2006). These institutions comprised 8 re-education children's homes, 9 re-education homes for young people, re-education homes for mothers with children, 8 therapeutic-educational sanatoria[64], 3 diagnostic centres for children and 2 for young people. A total of 1 333 children were placed in these facilities (1 335 in 2006). 43.14% (575) were children aged up to 15 years, slightly more than in the previous year (Slovíková, 2008).

Most of the children, out of the total of 1 333 were placed in re-education facilities (813 - 61%). 30% were girls, including 25 young mothers with their children.

The preventative intervention programme in the therapeutic-educational sanatorium in Bratislava and three selected regions of Slovakia set a goal of eliminating the risk of drug or

[61] Hambálek V.,2008
[62] 2007 Report, chapter 12 – Vulnerable groups of young people
[63] Frančík,J.(2008) Third unniversary of www.infodrogy.sk, In Čistý deň 3,2008 p.17
[64] Also in relation to ADHD clients

other addictions for clients of the sanatorium, participating in an improvement in the social climate of the primary environment of the client and their family, inducing and observing possible changes in clients' conduct and developing acquired experience into a methodology for preventative interventions (MGS project).

3.3.2 Follow-up interventions for paediatric patients with ADHD, depression or conduct disorder –

no new information compared to the 2006 Report, chapter 11.3

3.3.3 Help and support for families with children at risk or a member with a drug problem

At the level of indicated prevention social supervision (social guardianship- *sociálna kuratela*)[65] measures become important alongside the work of education services. Such measures were applied in relation to 338 children in cases involving drug problems or experimentation with drugs in 2007 (30 more than in 2006). Special educational measures were imposed in the case of 15 children – treatment in specialised outpatient facilities, and education measures in the form of compulsory residence in a social reintegration facility for people with drug problems were imposed for 24 children.

Problems related to drug use were also dealt with in crisis centres[66], which provide outpatient and inpatient care for drug problems and other addictions. In the case of 8% of the total of 2 870 clients, children or parents had such problems, mainly children (128).

[65] The Act on the socio-legal protection of children and social supervision (sociálna kuratela) created conditions for the use of a variety of methods for working in an open environment and applying educational measures (e.g. an order for a minor to live in a social reintegration centre for people with drug problems, compulsory participation of a child in special outpatient treatment, an order for the child to take part in an educational programme or a social programme); the possibility to establish an independent specialised group for children with drug and other addiction problems in children's homes, the introduction of accreditation and so on.

[66] E.g. the specialised crisis centre UNICORNIS (in 2006 Report Chapter 11 Drug use and related problems among very young people (< 15 years))

4 Problem drug use

Estimates of the prevalence and incidence of drugs in Slovakia and the collection and analysis of data for this report is based on a definition of problem drug use corresponding to the EMCDDA's operational/pragmatic definition for the indicator Problem Drug Use: Injecting drug use or long duration/regular use of opioids, cocaine and/or amphetamines in the 15 - 64 age group in the given year[67].

One deviation in the content of the definition in Slovakia relates to cocaine users, of whom there are few in Slovakia according to current indicators and who are therefore excluded from estimates. Opiate use is represented primarily by heroin use. The dominant form of amphetamines is methamphetamine in the form known as pervitin.

Information on problem users in treatment is also based on EMCDDA definition, in this case the key indicator demand for treatment[68]. Data collection uses ICD -10 diagnostic categories at the level of the four-character subcategories.

According to the latest estimate in 2007 there may be between 12 800 and 34 800 problem drug users in the Slovak Republic based on the above definition, with a central estimate of 17 900, which represents 4.71 per 1 000 population in the given age group[69]. The majority of them, approximately 55% of the estimated population of problem drug users, use opiates, in particular heroin. The remainder use mainly pervitin.

The extent of problem use in the given population is underlined by the fact that 100% of the clients of low threshold centres are injection users.

In regional terms, there has been no substantial change in the prevalence lead that the capital city, Bratislava, has over the other regions of Slovakia (approximately 20%).

In comparison with previous estimates of the prevalence of problem use made using the same method[70] the situation could be stated as stabilised.

4.1 Prevalence and incidence estimates

No estimate of the incidence of problem drug use in Slovakia has been made in the last period.

The estimate for the prevalence of problem drug use in 2007 used a multiplication method from data on the clients of low threshold services – non-governmental organisations providing harm reduction services. This estimate is based on the methodology used to produce the estimates for 2005 and 2006, which used the same method and the same source of data 4. The basis for the multiplier in all three consecutive estimates was the proportion of problem drug users who were in contact with low threshold services in 2005 (the "in treatment rate", ITR).

The results of the estimates are given in table 4.1.

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[67] EMCDDA: Key epidemiological indicator: Prevalence of problem drug use. EMCDDA recommended draft technical tools and guidelines. Lisbon, EMCDDA, 2004

[68] EMCDDA: Treatment demand indicator standard protocol 2.0. Scientific report. Lisbon, EMCDDA, 2000

[69] Kiššová, L.: Estimate of problem drug users Monitoring study, 2008, unpublished

[70] NMCD: Estimate of problem drug users for 2006, National Monitoring Centre for Drugs 2007, unpublished Mravčík,V., Kiššová,L.: Prevalence estimate for problem drug users in Slovakia, Alkoholizmus a drogové závislosti (Alcoholism and drug addiction), 41, 5 (2006), p 259 – 272

Table 4.1: Estimate of problem drug users in the 15–64 age group in the Slovak Republic in the years 2005–2007 (Source: Kiššová, L.: Estimate of problem drug users monitoring study, 2008, unpublished)

	Year	Central estimate of PDU	Lower limit	Upper limit	Central rate/1000
Total in Slovakia excluding BA	2005	14 800	10 300	28 100	4,18
	2006*	14 700	10 100	29 300	4,29
	2007	13 900	9 300	30 300	4,03
Total in Slovakia	2005	18 300	13 500	32 200	4,76
	2006*	18 400	13 400	33 500	4,89
	2007	17 900	12 800	34 800	4,71

* The Annual Report for 2006 gave an estimate for PDU in relation to the population as a whole. The estimate here is for the population aged 15 - 64.

The data for the last year could indicate a slight fall in the prevalence of problem drug use in Slovakia because the lower limit is also below the estimate for previous years. Other indicators showing stagnation and a slight fall in the use of opioids in Slovakia in recent years and a corresponding decline in intravenous use[71] support such an interpretation. On the other hand, 2007 was the first year after a long period of decline (since 2001) when there was an increase in patients receiving first treatment for opioid problems, not only as a percentage of all first-time patients but also in absolute numbers. Furthermore, the upper limit for the estimate of problem use was higher than in the previous year. With such a broad 95% confidence interval, the reported fall in the median value for prevalence is only relative and the ambiguous supporting data suggests that what is being observed is fluctuation around a stable level rather than a real trend.

We should also avoid placing too much emphasis on movements in estimates of problem use at the regional level, where estimates suggest possible gradual growth in problem use in the region of the capital city Bratislava compared with the other regions since 2005 – even here the given confidence interval means that it is not possible to draw an unambiguous conclusion that a trend has been observed. It should also be borne in mind that the information on the number of problem users who are clients of non-governmental organisations providing harm reduction services that was used in making the estimate is sensitive to the availability of such services and that slight deviations in such availability (for example, as a result of worse conditions for financing, which is not guaranteed for such organisations in Slovakia, or a fall in interest in voluntary outreach work) can have a significant effect on the resulting value after multiplication.

Another important factor in the method used is the estimate of the population that do not remain hidden in problem drug use and get in contact with organisations providing services to drug users (the “in treatment rate”)[72]. In this context the fact that the same ITR multiplier was used for all the estimates from 2005 to 2007 could be a stabilising factor. On the other hand this can limit the interpretation of the data because it does not reflect the current situation in the use of harm reduction services by clients.

The proportions of the various sub-groups of the problem drug user population also appear to be stabilised (table 4.2).

[71] Šteliar, I., Okruhlica, Ľ.: Decrease of Drug Injecting Associated with Changes on Drug Scene, presentation at the international conference EUROPAD, 2006

[72] Šteliar, I., Okruhlica, Ľ.: Contribution on issues relating to the estimate of problem drug use using Bratislava as an example, Alkoholizmus a drogové závislosti (Alcoholism and drug addiction), 42, 3 (2007), p. 129 - 144

Table 4.2: Estimate of sub-groups of drug users satisfying the definition of PDU (Source: Kiššová, L.: Estimate of problem drug users monitoring study, 2008, unpublished)

Year	Opioid users			Pervitin users			Injecting users		
	Median	Interval	Rate	Median	Interval	Rate	Median	Interval	Rate
2005	10 200	7 500 - 18 000	2,7	8 100	6 000 - 14 200	2,1	18 000	13 300 - 31 600	4,66
2006*	10 100	7 400 - 18 400	2,6	8 200	6 000 - 15 000	2,1	18 374	13 400 - 33 400	4,74
2007	9 800	7 000 - 19 000	2,5	8 000	5 700 - 15 700	2,1	17 900	12 800 - 34 800	4,71

* The Annual Report for 2006 gave an estimate for PDU in relation to the population as a whole. The estimate here is for the population aged 15-64.

It would seem that injecting use is not declining in the population of problem drug users, as can be seen in users entering treatment. This stable trend can be explained in part by the definition of problem use – the estimate relates to the prevalence of long term/regular use, which is frequently associated with injecting drug use, especially in the case of opiates. Another contributing factor is that the data source – NGO-provided low threshold harm-reduction services are aimed primarily at injecting drug users as a high risk group (exchanging/providing needles and syringes).

Despite a slight reduction in the central estimate, problem users of opiates and pervitin continue to represent a stable proportion of the population of problem drug users, which is in line with the stable number of (long term / chronic) users of these drugs who receive repeated treatment.

The character of estimates of the prevalence of problem drug use is highly dependent on the method used. It can be said that the use of the method chosen herein produces consistent results for estimates in Slovakia that largely correspond with other estimates 71,[73] and the indicated trends correspond to findings for other indicators.

4.2 Problem drug users in treatment

Problem drug users have for a long time made up a large part of the population in treatment although the proportion has fallen gradually from a peak of around 83% in the 1990es to the still relatively high level of 70% in recent years. A classification criterion for inclusion/exclusion was the use of the diagnoses F11.2 or F15.2 and the group also included all those who said that they had injected any drug in the last 30 days.

Users of opioids and amphetamine type stimulants are most significant for problem use. Patients receiving treatment for the first time provides the best reflection of the situation in use receiving repeated treatment, who include a high proportion of chronic users with a higher probability of problem use is another considerable group. The method of primary drug use is also important, especially as regards injecting use of the stated drug but also other risk behaviours are significant characteristics such as current injecting use of another drug (not only the primary drug), daily use and the like.

4.2.1 Profile of the treatment demand population

The total number of patients receiving treatment was 58 higher in 2007 than in the previous year - a total of 1 985 cases of treatment was reported.

Monitoring continued to use the category of multidrug users. These are users who use more than one drug at a time and it is not possible to determine which of them is primary according to the protocol. A large proportion of such patients are concurrent users of heroin and pervitin and under the original method they would be highly likely to be divided between

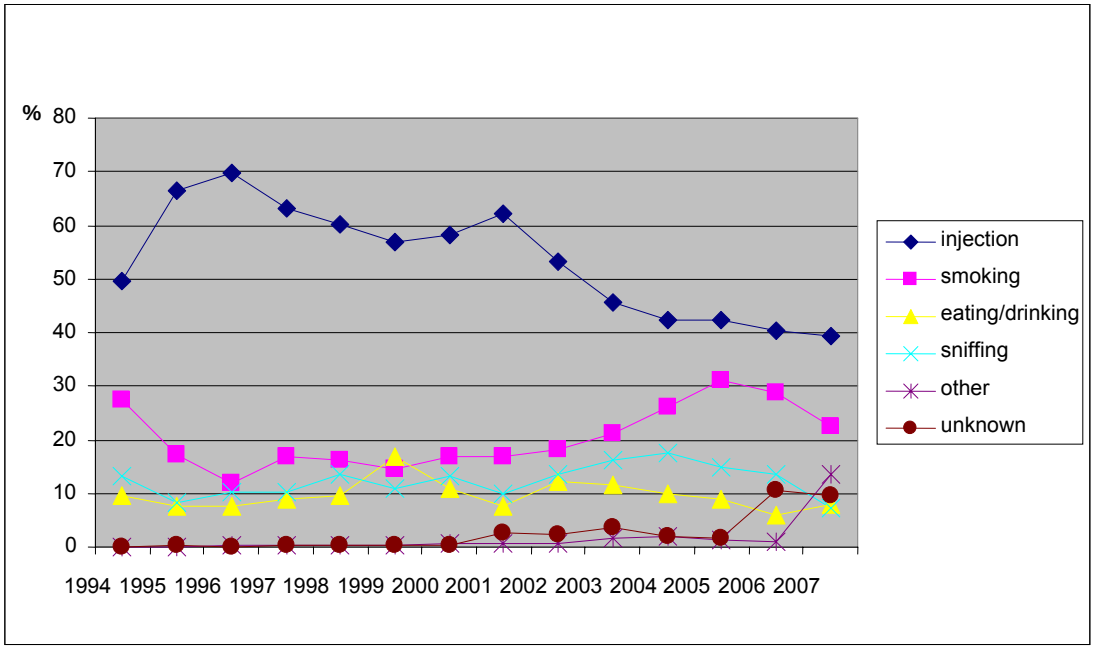
[73] Klempová, D.: problem drug use In: The situation in drug addiction and drug control in Slovakia (national report for REITOX) Bratislava 2004, p. 76 - 82

the groups of opiate users and patients who use amphetamine-type stimulants. Multidrug users represented 9.4% of patients seeking treatment for the first time in 2007 and 10.4% of patients seeking repeat treatment. In neither case was the proportion lower significantly than in the previous year (down from 9.7% and 11.6% respectively).

The ratio of patients seeking repeated treatment to first time treatment was 1.3:1 in 2007, which indicates a higher rate of chronic / long term users compared to new, short term patients. The difference is not highly significant however and may be due to the character of the disorder, since people with repeated / long term problems related to drug use have a greater tendency to remain in therapy. The general ratio does not apply to all groups of drugs – while in the case of opioids the ratio has for a long time been on the side of patients repeating treatment (in 2007 it was 2.5:1), in the case of amphetamine-type stimulants (pervitin) the ratio is reversed and is 1:1.3 in favour of patients in first treatment.

With regard to the method for taking drugs, the number of injecting drug users receiving treatment in Slovak medical facilities continued the downward trend that began in 2001 (Fig. 4.1). More detailed analysis of the data shows that the trend continued in 2007 only in the group of first time patients. There was an increase in the percentage of returning patients who were injecting users, from 43% in 2006 to 49% in 2007, and there was also an increase in absolute numbers as the total number of patients fell (348 such patients in 2006, 397 in 2007). As this is a single rise and the overall trend is downward, it would be premature to take this data as indication of a change in behaviour.

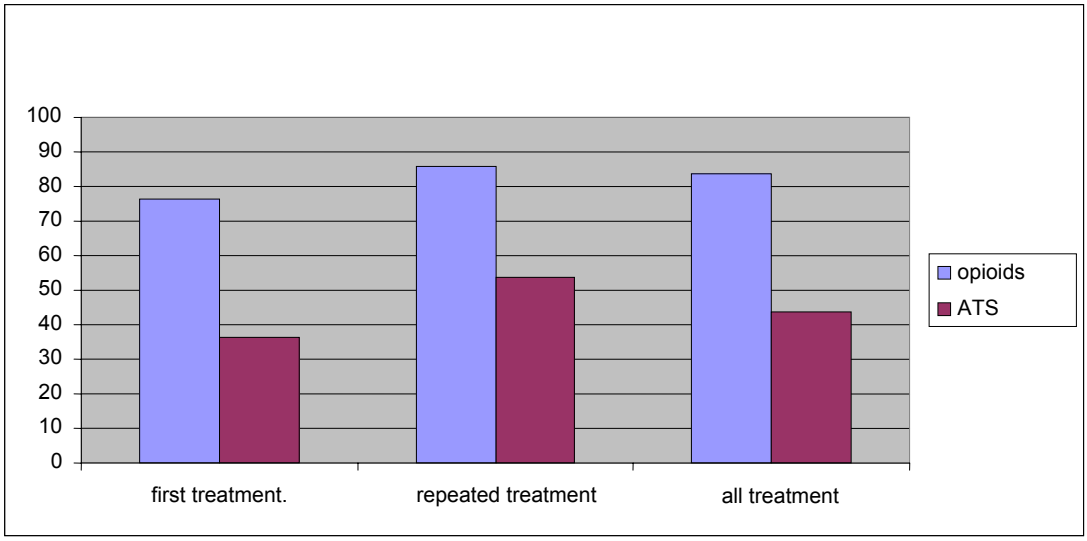
Fig. 4.1: Percentage of patients in treatment in Slovakia who are injecting users of their primary drug - Trends in the method for the use of the primary drug reported by patients (Source: National Health Information Centre)



76% of users of opioids seeking treatment for the first time and 86% of returning patients are injecting users of their primary drug. The percentage of all opioid-using patients who are injecting users of their primary drug is 83%.

As expected, the percentage of amphetamine (pervitin) users who inject is lower: 36% of first time patients, 54% of returning patients and 44% overall (fig. 4.2).

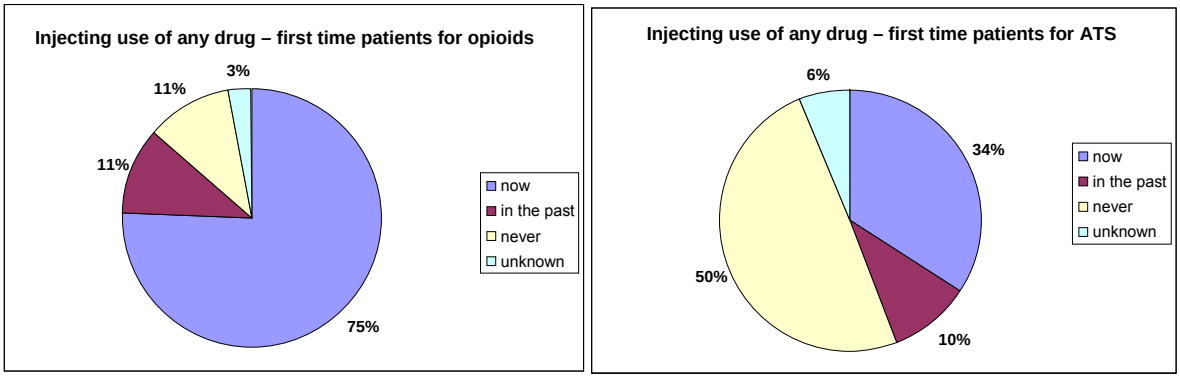
Fig. 4.2 Injecting drug users as a percentage of first time patients, returning patients and all patients whose primary drugs are opioids and amphetamine type stimulants - Percentage of users who inject their primary drug (Source: National Health Information Centre)



When patients enter treatment, information is also collected on whether they inject other drugs in addition to the primary drug. There is a high prevalence of injecting drug use amongst patients treated for opium use - only 5% claim never to have used a syringe/needle; a considerable 80% are currently injecting (last 30 days). The proportion is only a little smaller among patients being treated for opioids for the first time - 76%.

The situation is better amongst patients receiving treatment for amphetamine (pervitin) use, where the proportion who currently use an injection need/syringe (40%) is approximately the same as the proportion who have never injected (39%). Among persons receiving first treatment for amphetamine type stimulants the proportion who have never injected any drug is even higher - nearly 50% (Fig. 4.3)

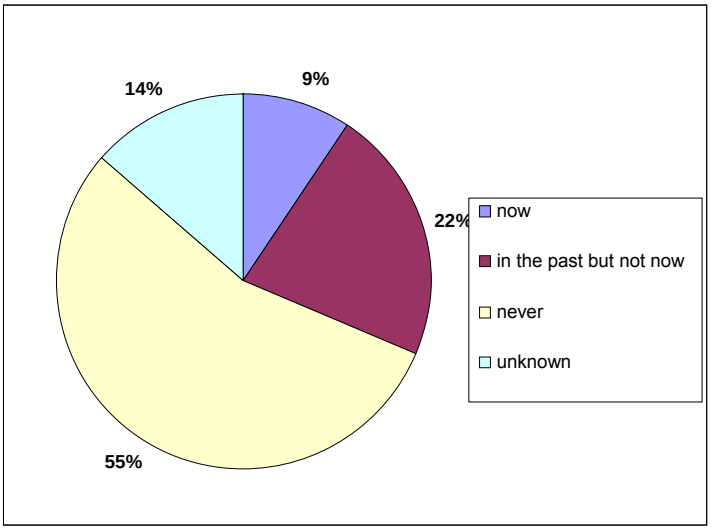
Fig. 4.3a-b: Comparison of life time prevalence of injecting any drug for first time patients using opioids (left) and amphetamines (right) (Source: National Health Information Centre)



An important risk factor is the sharing of injecting (equipment) paraphernalia - syringes or needles. Even though on the one hand nearly a quarter of drug users receiving treatment admit to having shared needles/syringes with other drug addicts in the past or present and it is highly likely that a large proportion of patients whose answer to this question is unknown have probably also shared a needle or syringe, it is gratifying that more than half of the

patients in treatment (55%) claim never to have shared a needle or syringe in their life (Fig. 4.4).

Fig 4.4: Sharing of needles and syringes with other drug users (Source: National Health Information Centre)



As regards frequency of use, nearly three quarters of patients treated for problems with opioid use (73%) were in the highest risk daily use category. In the group of patients treated for amphetamine type stimulant (pervitin) use, the most common category was daily use (40% of users) while the second most common was use 2 - 6 times per week (nearly 30%). As expected, first time patients were less likely to used drugs every day and this held true for both opioids and stimulants.

With regard to first use of the primary drug, the highest risk age group was 15 -19 age group, in which 51.4% of first time patients began to take opioids and 60.6% of first time patients began to take amphetamines.

Geographic data can be looked at from two points of view: in terms of the geographic distribution of services, i.e. the location of the medical facilities in which patients are treated and in terms of the permanent residence of the users.

The greatest demand for treatment in 2007 was in the Bratislava Region. 36.4% of patients seeking treatment for the first time were treated in medical facilities in this region. In the case of patients seeking repeated treatment the percentage was 50.2%. This may be a result of the epidemic of heroin use that first struck the capital city and its surroundings and left more people with chronic health problems comparing with other regions, or it may be a sign that in response to this epidemic the region established the most accessible and extensive network of services for people with drug dependence.

In terms of the patient's permanent address, the largest number of patients seeking treatment also came from the Bratislava Region. In the case of first time patients the percentage was 30.1% and in the case of returning patients 46.3%. It is interesting that the second most numerous group of patients seeking treatment for the first time had their permanent residence in Banská Bystrica Region, while in the case of repeated treatment Nitra Region was in second place and Banská Bystrica was fifth.

It is also a little surprising that the region with the second largest city in Slovakia, Košice, did not achieve a leading position in the regional rankings either in terms of treatment in facilities in the region or in terms of the number of patients with permanent residence in the region.

A somewhat surprising socio-demographic characteristic of patients in all areas is the equal - even slightly higher - proportion of men in the group of first time patients compared to all patients (around 80%).

The unemployed continued to be the largest group of patients by social status in 2007 (56%). People who performed regular work - employees and students - made up 19% and 13% respectively. This is probably a group for whom use has not become so problematic as to threaten their social functioning - whether due to the type of drug used, personal disposition or use which has still only been for a relatively short period - or they may be people with a good response to treatment even in the event of heavy use.

4.3 Problem users in facilities other than health care facilities

The most important source of information on problem use besides direct field studies and estimates is information from low threshold outreach programmes that have contact with the largest part of the problem drug use population including that which remains concealed from other sources.

4.3.1 Problem drug users attending needle and syringe exchange programmes

Information on patterns of use amongst the clients of outreach programmes are available thanks to the cooperation between all NGOs and the NMCD. Data was collected using a special questionnaire on the use habits of clients and the kinds of service provided to them. Double-counting cannot be excluded in the data given in this chapter.

Analysing the information from these organisations, it should be borne in mind that although the information covers a wide range of areas in Slovakia, the resulting image is more of a mosaic because the activities and range of such organisations tends to be tightly bound to the region (usually a single town) in which they operate.

94% of the clients are drug users, who tend to be injecting users based on the character of the programme. 35.2% of clients for whom a primary drug was identified were heroin users, 34.5% were pervitin users and in 19% of cases the specific primary drug could not be identified, usually cases where the client used a combination of heroin and pervitin. Users of pentazocine (Fortral) in Košice made up 2.8% of the total number of clients in Slovakia and Subutex users made up nearly 3%, as in the previous year.

Table 4.3: Patterns of use among the clients of harm-reduction organisations

	2005	2006	2007	Percentage in 2007
Clients	3979	3 957	4023	-
of whom, users	3773	3722	3812	100
of whom, injecting	3576	3560	3658	96,0
Heroin	1430	1452	1341	35,2
Cocaine	0	7	6	0,2
Pentazocine (Fortral)	247	162	107	2,8
Pervitin	1418	1403	1314	34,5
Combination of heroin and pervitin	436*	437*	722	18,9
Subutex	109	109	102	2,7
Volatile substances	5	5	22	0,6
Ecstasy	10	10	-	-
Cannabinoids	6	6	-	-
Others (e.g. alcohol etc.)	112	131	198	5,2

* Estimate

A rise in the number of problem drug user clients can be seen in Bratislava - 2 657 in 2005 and 2 913 in 2007 while the number of PDUs who are clients of harm reduction organisations outside Bratislava has fallen - 873 in 2005 and 747 in 2007.

Table 4.4: Problem drug users in contact with low-threshold organisations (Source: NMCD, 2008a)

Year	Number of clients	Number of clients classified as PDU	of whom, injecting users	of whom opioid users	of whom, pervitin users	of whom, polydrug users (mainly heroin and pervitin)
2004	3 401	-	-	-	-	-
2005	3 979	3 640	3 576	1 786	1 418	436
2006	3 957	3 571	3 560	1 724	1 403	437
2007	4 023	3 660	3 658	1 596	1 314	722

The relatively high numbers of problem users reported by low threshold organisations in comparison with the number of problem users in treatment is the result of the different focus of the services. The provision of harm reduction services (e.g. needle exchanges) is generally simpler in comparison with procedures in medical & preventive care , which are subject to legal regulation and strict controls, and the low threshold organisation is able to serve more clients in the same period of time. Furthermore, people often visit a low threshold facility who does not feel a need to consult a doctor, especially in recent years when there has been a fall in the use of opioids and an increase in the consumption of less addictive drugs. Thus some of the clients of the low threshold facilities may satisfy the conditions for problematic drug use as it is defined but not be dependent. There is also another part of the population for whom drug use - regardless of how problematic it is - has become a life style that they neither can nor want to change and who make use of low threshold outreach services in order to reduce the impact of such a lifestyle.

Another possible factor is that outreach workers in low threshold centres actively seek out drug users.

5 Drug-related treatment

5.1 Treatment system

The treatment system in Slovakia for patients who are addicted to controlled psychotropic substances is based on a voluntary form of treatment with an emphasis on outpatient treatment, though inpatient treatment is also an important component of the overall system. There is currently also a system for compulsory, court-ordered treatment. Costs for all forms of treatment are fully covered from public health insurance. An exception is some co-payment for certain medicines in outpatient treatment. In inpatient care all medicine costs are fully covered by the health insurance. At the proposal of the Ministry of Health (MH) the law was amended so that any consultation with a specialist doctor for diagnosis and treatment requires written referral by a general practitioner. The objective of the amendment was to reduce costs for the provision of health care while retaining patients' ability to choose a doctor freely. The primary objective was to ensure that specialists are not burdened with health problems that can and should be dealt with by general practitioners. Treatment provided by specialists is more expensive for health insurances. On the other hand, if this procedure was required for all patients with dependencies, it would make their access to treatment more difficult because general practitioners in Slovakia are not allowed to treat persons with dependencies without cooperation with a specialist psychiatrist. They do not satisfy the institutional or professional requirements for such treatment. Following negotiations between the representatives of specialised health care providers in the area of mental health and representatives of the MH, a consensus was reached on the treatment of patients with mental disorders. It was decided that active users of addictive substances who request treatment for dependence should be treated as patients requiring immediate medical attention. Such patients are not subject to the requirement for referral by a general practitioner. We have not yet received reports of any serious problems relating to such matters in the field. Patients who had problems as a result of the use of psychoactive substances had and they continue to have the same access to treatment as in the past.

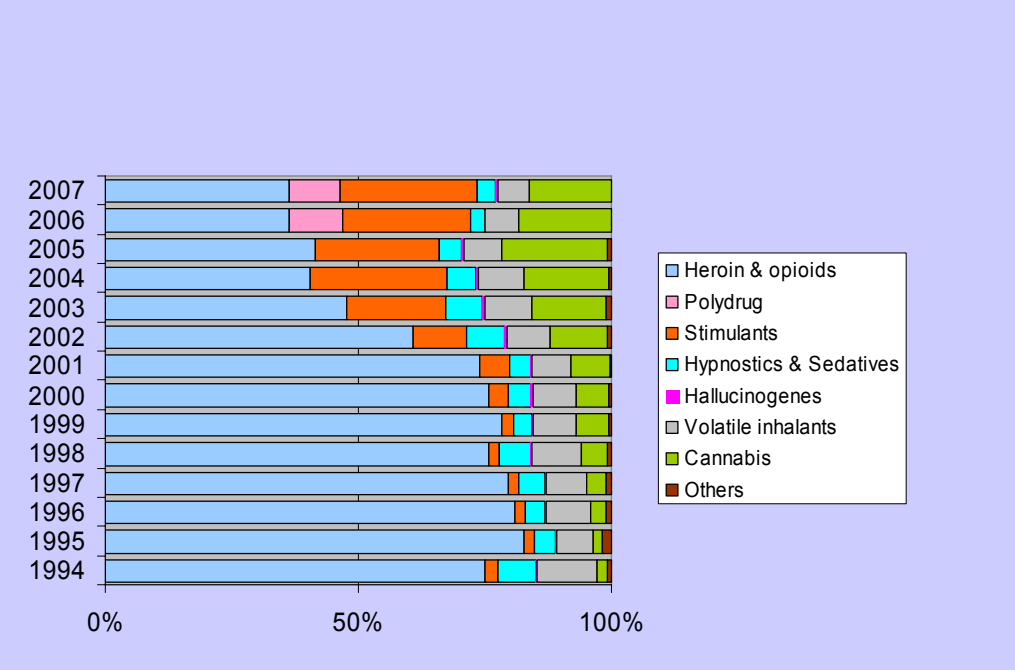
Significant progress has been made in improving the quality of provided health care through the implementation or the start of implementation of an ISO 9000 quality standards control system in specialised inpatient facilities for the treatment of patients with dependencies. Health insurances have also carried out quality audits of health care facilities. In the published national ranking for 2007 the largest specialised facility for the treatment of drug dependencies in the capital city shared first place in quality in the ranking of all the specialised health care facilities in Slovakia. This facility also carries out the country’s only and the largest prospective evaluation study of the results of the treatment out-comes of its patients in the country. The study is carried out every three years. No results from such studies became available in 2007 because it was an intermediate year for the studied cohort. This is third cohort of patients undergoing treatment for a diagnosis of dependence to be studied.

Social reintegration into society has a special place in the system of continuing care for people who have been treated for drug dependence. In the accordance with the NPFD it is defined as the completion of patients’ aftercare, which follows previous treatment in the inpatient health facilities, it is in cooperation with a medical doctor who specialises in dependencies, but it is primarily oriented towards the full reintegration of former drug users into society in a way that minimises the risk that they will fall back into prior habits in response to social triggers.

5.1.1 Characteristics of patients in treatment

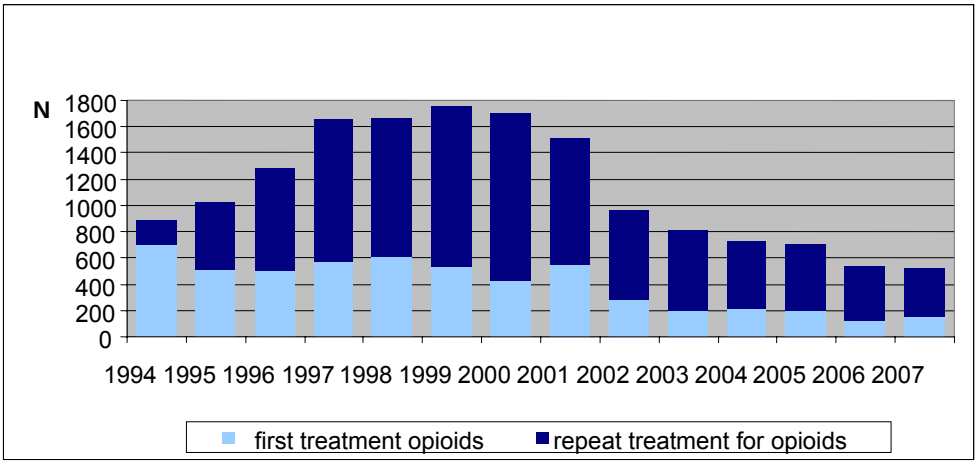
TDI results (Fig.5.1) show only small changes in the overall number and profile structure of patients in treatment in 2007, which indicates that there has been no change in the availability and affordability of treatment.

Fig. 5.1: Trends in overall numbers receiving treatment for drug problems in Slovakia and patterns of primary drug use (Source: CTDD-IDD,2008)



The total number of persons treated for drug-related problems was slightly (3%) higher than in the previous year. This increase was primarily due to an increase in the number of patients receiving treatment reported by the Ministry of Justice (MJ), where there are certain methodological deviations from the protocol and therefore patients are excluded from the evaluation of the main trends. There has been in fact a fall in the number of patients treated in the health sector which is of responsibility of the MH, but this was only slight (2%) and numbers can be seen as stabilised. The overall fall in the first treatment demands does not apply equally to all groups of drug users according to primary used psychoactive substance. An increase of 6% in the first treatment demand in life related to opioid use has been observed after a long period of reduction (Fig. 5.2). But all first treatment demands (also with those treated in the past) in 2007 due to the opioids under the MH actually recorded a decline. These slight movements could indicate a strengthening repressive approach to drug users. The structure remained unchanged: the greatest demand was for treatment for opiates - 46%, in the second place were amphetamine-type stimulants - 27% and then cannabis - 18% of patients.

Fig. 5.2: Proportions of patients receiving first treatment and repeat treatment for opioids in medical facilities in Slovakia 1994-2007 (Source: CTDD-IDD,2008)



There were no fundamental changes in the age of persons seeking treatment or the ratio of men and women, which was 3:1. The age group from 20 to 24 years had the highest number of patients. According to primary drug, cannabis users in treatment with the average age of 22 years belonged to the youngest and users of opiates with the average age of 29 to the oldest groups of patients.

A positive trend, and the most significant change, was in the number of current intravenous drug users who requested treatment. This group shrank not only relatively from 46% in 2006 to 41% in 2007 but more importantly there was a decline in absolute numbers from 883 to 815 patients. According to the TDI data, the reduction was higher among those, who in requested treatment repeatedly, while number of injecting drug users who asked for the treatment for the first time in their life also fell, but less steeply, from 32% to 28%.

The majority of the patients were the inhabitants from Western regions of the country - Bratislava, Nitra and Trnava, with the highest concentration in the capital city Bratislava. Not so the access to the services or density of young population seems to be playing a dominant role in the geographic distribution of drug using patients entering treatment, as are probably the differences in the economics. Bratislava with the highest per capita income has much higher number of drug users in treatment in comparison e.g. to Kosice in the East, the second largest city, with younger population and with well developed specialized services for patients.

5.2 Drug free treatment

In Slovakia demand for this form of treatment remains dominant, partly as a result of the significant changes in the diagnostic structure of people requesting treatment in the last five to ten years. A major part of this is the shift from the dominance of people dependent on opiates, the main diagnosis for patients in treatment at the end of the twentieth century to people who are problem/dependent users of cannabis and methamphetamines. The change in the structure of the clientele is reflected not only in the specialised medical services provided by psychiatrists and specialists in addiction medicine, but also in the facilities for the aftercare - in social reintegration facilities. There too the situation has changed and the majority of clients have other types of dependence than on opiates. In the case of dependencies on cannabis or methamphetamines there are fewer opportunities for major interventions using medicines, which has heightened the predominance of drug free treatment.

5.2.1 Outpatient and inpatient treatment

Outpatient and inpatient treatment are complementary elements of the unified health care system. The expected minimum length of treatment is 12 months from the start of treatment. Where inpatient treatment is indicated, it usually takes place in the first stage of treatment. For most patients, most of their treatment is provided as outpatients. In addition to individual therapy programmes, group and family psychotherapy are also widely used.

5.2.2 Outpatient treatment

Outpatient treatment is free of charge. It is provided through general psychiatric clinics, specialised clinics for the treatment of drug problems and specialised centres for the treatment of drug dependencies. Outpatient care is provided not only in the patient's home environment but also in prisons and in a limited extent in residential programmes for the social reintegration of abstaining drug users. Neither outpatient nor inpatient treatment makes use of so-called dry treatment. Medications are prescribed during treatment to mitigate withdrawal symptoms, especially in the detoxification phase.

5.2.3 Inpatient treatment

Except in the case of court ordered inpatient treatment, the specialized inpatient facilities in the health care system are operating with the capacity, which enables them to admit the patient for requested treatment with maximum waiting time lasting up to 2 - 3 weeks. Inpatient facilities provide both detoxification treatment during acute withdrawal as well as inpatient treatment for dependence, in which case it is usually planned for a period of three months. If one facility has a longer waiting time for inpatient treatment for drug problems, the patient can always choose to go to another specialised facility in Slovakia with no or a shorter waiting list.

According to MJ statistics, courts ordered compulsory treatment for drug problems in 247 cases in 2007. 124 cases involved outpatient care and 123 orders were for inpatient care. Treatment was then provided either in facility under the responsibility of the MJ while the client was serving a sentence of imprisonment or in the civil health system. Court ordered treatment in prison was provided in a total of 428 cases in 2007. It was also possible to enter treatment for drug problems voluntarily during imprisonment. This is provided to a lesser extent but is used primarily by young people. 19% of court ordered treatment in Slovakia was not provided due to lack of treatment capacity by the December 31, 2007. The shortage mainly affects inpatient treatment ordered in medical facilities outside the prison system. It should be borne in mind that even in cases where a convicted offender has to wait longer for court ordered inpatient treatment; he or she still has the option to enter voluntary treatment with the short waiting time mentioned above. Patients who successfully complete voluntary inpatient treatment can ask the court to cancel the order for compulsory inpatient treatment if it has not yet been possible to begin treatment for capacity reasons. Because of these treatment options available to patients we do not see that sometimes existing long waiting lists for court ordered treatment, as a critical problem for patients who want to enter treatment.

5.3 Pharmacologically assisted treatment

5.3.1 Detoxification treatment

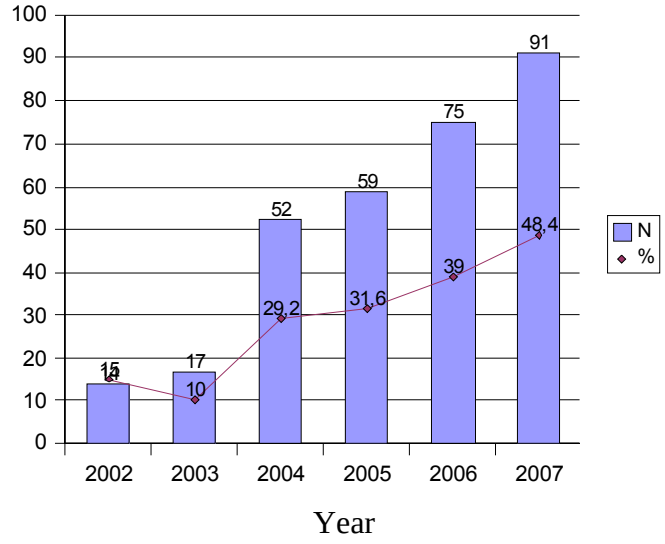
The most developed programme in Slovakia is pharmacologically assisted detoxification for opioid dependencies. It is provided on both an inpatient and outpatient basis. It uses both agonists of opiate receptors: methadone, buprenorphine, codeine and also other psycho pharmaceuticals, especially benzodiazepine and non-benzodiazepine sedatives and hypnotics. Neuroleptics are used, but less frequently. Antagonists of opiate receptors are not

used. Detoxification treatment for other frequently treated forms of dependencies, such as methamphetamines and cannabis, is provided on ad hoc basis. This is limited mainly to sedatives and/or antidepressants where symptoms indicate a need in the first days and weeks of treatment. Only a psychiatrist can prescribe such treatment. The same applies in the case of substitution treatment.

5.3.2 Substitution treatment

Specialised centres for the treatment of drug dependencies treated approximately 500 patients using methadone and buprenorphine substitution maintenance treatments in 2007. In addition an unspecified number of patients (estimated to be a few dozen) attended psychiatric outpatient clinics for buprenorphine treatment. During this period there was no significant expansion or reduction in the number of patients receiving maintenance treatment. Guidelines issued by the MH require that substitution treatment should be provided in the form of a combination of pharmacotherapy, and psychotherapy in structured program regiment. There is an emphasis on supervision of the use of medication and toxicological urinalysis. Pre-treatment urinalysis in methadone maintenance programmes at the Centre for the Treatment of Drug Dependencies (hereinafter CTDD) in Bratislava revealed a continuing sharp increase in the number of patients using combination of both opiates and methamphetamines. The proportion of such patients entering methadone maintenance treatment increased from 39% to 48% from 2006 to 2007 (Fig. 5.3).

Fig. 5.3: Trend in prevalence of positive tests for methamphetamines in urine in patients of CTDD Bratislava starting methadone maintenance treatment



At the same time demand for substitution treatment was unchanged and there has also been a stable level in demand for treatment for methamphetamine problems both in the CTDD and at a national level. This discrepancy in trends is probably largely the result of the drifting of patients with chronic opiate dependency and increasing multidrug use into methadone maintenance treatment.

Many of these users are able to give up methamphetamines during the methadone programme without any additional therapy, but a not insignificant proportion of them are dependent on both opiates and methamphetamines and require not only substitution treatment but also treatment to help them end their dependence on stimulants. Patients in Slovakia probably prefer amphetamine type stimulants over cocaine because of the lower price. Cocaine is many times more expensive and patients in substitution treatment are only rarely found to have used it. Substitution treatment is free of charge in Slovakia.

In 2007 there was a sharp reduction in the distribution and prescription of Subutex (buprenorphine) in Slovakia. It was replaced by Suboxon (a combination of buprenorphine with the opiate receptor antagonist naloxone) which has lower potential for abuse. This was more important as a psychological momentum with a preventative effect because except in isolated cases, Slovakia had had relatively small problems with the abuse of buprenorphine as a primary drug in an international context. The TDI data supports this.

5.3.3 Other pharmacologically assisted treatment

Because naltrexone is not a registered in Slovakia and rapid (ultra-rapid) detoxification with naloxone is not a procedure recognised by the MH, opiate antagonists are not used in pharmacologically assisted treatment. There is no other than the provision of sedatives, antipsychotic and/or antidepressants or mood stabilisers when indicated by symptoms, other pharmaceuticals are not used in treatment.

5.4 Social reintegration

In contrast to health care providers, facilities for social reintegration (SRC) in Slovakia are in the area of responsibility of the Ministry of Labour, Social Affairs and Family (hereinafter MLSaF). The majority of such facilities operate residential programmes. They also differ from inpatient health facilities in that, except for a few exceptions, they are not established by state, and most often are operated by not for profit, non-governmental organisations. As in specialised care in the health care system for patients who have psychoactive substances related problems, the facilities for social reintegration are looking after the patients with all types of substance dependence, though the majority of clients are addicted to illegal psychoactive substances.

5.4.1 Clients in social reintegration facilities

The MLSaF collected information on the clients of social reintegration facilities in 2007 by means of an activity monitoring form. On this statistical form some questions on a number of epidemiological parameters were included (NMCD, 2008b). Such information was provided by a total of 19 social reintegration facilities/centres (SRC) whose programmes had a total capacity of 299 places. In 2007 a total of 614 patients took part in programmes at these facilities - 68% were men. The majority of these social reintegration facilities accept users of legal and illegal substances in their programmes. Alcohol was the primary problem substance for 35% of clients.

Among clients of social reintegration facilities whose primary problem substance was an illegal drug, the most common substances were methamphetamines (40%) followed by opioids (19%). The use pattern of illegal drug users in SRCs differs in some respects from that of patients in medical facilities. It is closer to that of the younger section of patients treated in medical facilities for the first time in 2007: 34% for dependence on amphetamine type stimulants, 30% due to dependence on opioids and 27% due to cannabis. Despite recent falls, opioids are still the most common type of drug amongst those receiving treatment in medical facilities (46%), followed by amphetamine type stimulants (27%) and cannabis (18%).

Ten years ago there were smaller differences between patients in treatment and the clients of SRC as regards the primary drug used. Heroin was the main drug everywhere. At this time the clientele of social reintegration centres come mainly from the younger generation of users where the most popular drugs are pervitin and marijuana. They are users with a shorter history and if, with a lower rate for injecting drug use. On the other hand patients in treatment in medical facilities tend to be older and are more likely to be suffering from chronic dependency on heroin, with repeated treatment episodes and to be drug injectors. They often prefer substitution treatment, which is not available in social reintegration facilities.

There are also interesting regional differences between clients. In Western Slovakia users are fairly evenly distributed in terms of the substances they use; in central regions amphetamine stimulants have a slight lead and in Eastern Slovakia 82% of clients have problems with alcohol and only the remaining 18% are illegal drug users of illicit psychoactive substances.

5.4.2 Clients in follow-up outpatient aftercare

Little attention is given to the long term abstaining former patients of medical facilities and former clients of residential social reintegration facilities who complete their treatment and are in the need of the outpatient social reintegration. After the phase of treatment in medical facilities, those who do not continue with treatment in residential social reintegration facilities (SRC), and do not lose contact with their place of treatment, they can join clubs or self-help groups for abstainers. SRC also offer outpatient programmes for their clients who have completed residential treatment.

Limited financial resources mean that there is no standard solution for housing problems for those who have nowhere to go after completing treatment for their dependence or a social reintegration programme. In most cases questions of housing and suitable employment exceed the current abilities of social reintegration facilities.

6 Health correlates and consequences

6.1 Drug related deaths and mortality[74] of drug users

The collection of data on deaths related to the use of psychoactive substances in Slovakia in 2007 was carried out by employees of the Health Care Surveillance Authority (HCSA). Continuous data collection was introduced in the year 2007 and relevant cases were reported using electronic forms on the internet portal www.infodrogy.sk., which is operated by the NMCD. Cases are reported after the diagnostic closure of the case on completion of the laboratory toxicological examinations. Data are collected from all nine forensic medicine offices of the HCSA. The offices in Nové Zámky and Nitra have been merged to create a single office based in Nitra. Likewise, the performance of autopsies in Bratislava was rationalised into a single office during the year. An overview of the numbers of cases identified by each office and the category of death is given in Table 6.1.

Table 6.1: Drug related deaths in Slovakia in 2007 by office and category of death (Source: HCSA, 2007 (prepared by Šidlo, J.))

Office /Category of death	Direct	Indirect	Total	Percentage
Bratislava	15	21	36	42.35
Nitra	2	2	4	4.7
Žilina	2	6	8	9.4
Martin	4	10	14	16.5
Banská Bystrica	2	7	9	10.6
Lučenec	1	3	4	4.7
Poprad	-	2	2	2.35
Prešov	1	4	5	5.9
Košice	1	2	3	3.5
Total	28	57	85	

6.1.1 Direct drug related deaths (overdoses, poisoning)

28 deaths caused by the direct effects of psychoactive substances were reported in 2007. In 11 (39.3%) cases the cause was an overdose of generally available medicines and in 17 cases the cause was an overdose of psychoactive substances in other groups. Identified substances were mainly combinations of different substances including combinations with opioids - 8 cases or 28.6% - and without opioids - 8 cases (28.6%). In one case an 11 year old boy overdosed with methadone alone.

Benzodiazepines were the main medicines involved in overdoses. They were implicated in 12 cases (42.9%) either individually or in combination with other substances. More cases involved men than women. Men made up 71% of all reported cases. 67.8% (19 cases) of deaths were in the 20 - 34 age groups. A detailed summary of the detected cases by groups of psychoactive substances, age groups and sex is given in Table 6.2.

[74] Anonymous data that permits this aspect of the DRD indicator to be tracked is currently being collected from the NHIC, the Statistical Office (General Mortality Register) and the General Register of the population. Such data will serve in the study coordinated by the Czech monitoring centre (NMS) to check the methods of monitoring the mortality of drug users in accordance with EMCDDA procedures.

Table 6.2: Deaths caused by an overdose of psychoactive substances in Slovakia in 2007 by groups of psychoactive substances, age groups and sex (Source: HCSA, 2008 (prepared by Šidlo, J. ST 05/ ST 06)

Psychoactive substance/ age group	under 14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	over 65	Total (M/W)
Opioids alone (excluding methadone)	-	-	-	-	-	-	-	-	-	-	-	-	-
Methadone alone	1/-	-	-	-	-	-	-	-	-	-	-	-	1 (1/-)
Multiple substances including opioids	-	-	3/-	1/1	1/1	-	-	-	-	1/-	-	-	8 (6/2)
Multiple substances excluding opioids	-	-	2/-	1/-	3/-	-	2/-	-	-	-	-	-	8 (8/-)
Psychoactive medicines	-	-	-	1/2	-/1	3/-	-	1/-	-	-/2	-	-/1	11 (5/6)
Unspecified substances	-	-	-	-	-	-	-	-	-	-	-	-	-
Total (M/W)	1/-	-	5/-	3/3	4/2	3/-	2/-	1/-	-	1/2	-	-/1	28 (20/8)

Note: The age groups with highest numbers in controlled drugs are indicated by the highlighted columns

6.1.2 Deaths under the influence of psychoactive substances

In 2007 a total of 57 deaths were reported in this category. Medicines were detected in 24 cases, 42.1% of the total. The most frequent medicines were benzodiazepines, which were implicated in 21 cases, i.e. 87.5% of deaths under the influence of medicines. Men were involved in an even larger percentage of cases than in the case of deaths linked directly to the use of psychoactive substances, 79% of recorded cases. The most frequent cause of death was an accident (50.9%) followed by suicide (26.3%) and disease (19.3%). 19 cases (65.5% of all accidents and 33.3% of all indirectly caused deaths) involved traffic accidents. A detailed summary of detected cases by categories of substances detected, cause of death and sex is given in Table 6.3. A detailed summary of detected cases by categories of death, age group and sex is given in Table 6.4.

Table 6.3: Deaths under the influence of psychoactive substances in Slovakia in 2007 by categories of substances cause of death and sex (Source: HCSA, 2008 (prepared by Šidlo, J. for ST 05/ST 06))

Psychoactive substance/ cause of death	Natural/ internal	Accident	Suicide	Murder	Unidentified	Total (M/W)	Percentage %
Opioids	-	1/-	-	-	-	1 (1/-)	1.75
AMT/MAMT	1/-	13/2	1/2	-	-	19 (15/4)	33.35
MDMA	-	1/1	-	-	-	2 (1/1)	3.5
Cannabinoids	-/1	5/-	3/-	1/-	-	10 (9/1)	17.55
Solvents	-	1/-	-	-	-	1 (1/-)	1.75
benzodiazepines	5/1	3/1	5/1	-/1	-	17 (13/4)	29.8
Other medicines	2/1	1/-	2/1	-	-	7 (5/2)	12.3
Total (M/W)	11 (8/3)	29 (25/4)	15 (11/4)	2 (1/1)	-	57 (45/12)	

Note: AMT - amphetamine, MAMT – methamphetamine, MDMA – ecstasy

Table 6.4: Deaths under the influence of psychoactive substances in Slovakia in 2007 by category of death, age group and sex (Source: HCSA, 2008 (prepared by Šidlo, J. for ST 05/ ST 06))

Cause of death / age group	under 14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	over 65	Total (M/W)
Natural/ internal (24)	-	-	-	2/-	-	3/1	1/-	1/-	-/1	-	1/-	-/1	11 (8/3)
Accident (25)	-	1/1	9/-	5/1	4/1	5/1	-	-	1/-	-	-	-	29 (25/4)
Suicide (26)	-	-	4/2	2/-	1/-	3/-	-	-/1	-/1	-	-	1/-	15 (11/4)
Murder (27)	-	1/-	-	-	-	-	-	-/1	-	-	-	-	2 (1/1)
Unspecified (28)	-	-	-	-	-	-	-	-	-	-	-	-	-
Total (M/W)	-	2/1	13/2	9/1	5/1	11/2	1/-	1/2	1/2	-	1/-	1/1	57 (45/12)

Note: The code identifying the categories of death 24, 25, 26, 27, 28 is based on the EMCDDA standard tables.

The highlighted columns indicate the age groups in which there was the greatest number of indirect deaths - 77% fall in the 20 - 39 age groups.

6.1.3 General information

According to data from the Statistical Office of the Slovak Republic 53 856 people died in Slovakia in 2007. Autopsies were carried out in 8 978 cases, giving an overall autopsy rate of 16.7% of total deaths in 2007. This was 0.4% less than in 2006.

6.2 Drug-related infectious diseases

It is important to note that the rate of infections/antibodies for the HIV virus/AIDS remains low and non-epidemic. The belief that this situation will continue in future is supported by the clear decline in intravenous drug use amongst users entering treatment. Even the relatively high levels of hepatitis C antibodies in this sub-group are not surprising. A negative factor is the increase in rates for the HBc antibody though this is less sharp in absolute numbers, as shown in table ST 09. We expect that in the near future there will be a significant improvement in this area due to the universal vaccination of children against hepatitis B.

6.2.1 HIV/AIDS among injecting drug users in Slovakia

According to data from the National Reference Centre for HIV/AIDS, as at 31.12.2007 there were 323 HIV positive persons in Slovakia, of whom 99 were foreigners. Of the 224 Slovak citizens, 180 were men and 44 were women. 50 patients developed AIDS and 32 died of AIDS.

135 Slovak citizens were infected through unprotected sex, 67 through heterosexual intercourse, and 4 by injecting drugs and 17 by other (unknown) causes. One patient was infected with HIV through a blood transfusion received abroad. 13 HIV positive women gave birth in Slovakia in 2005. 9 babies are HIV-negative, 1 child left Slovakia with its mother immediately after birth and 3 children are still under observation.

To the end of 2007, only 4 people had become infected through intravenous drug use in Slovakia: 1 woman in 1995, 1 man in 1996, 1 pregnant woman in 2006 and 1 man (a foreigner who had obtained Slovak citizenship) in 2007. According to the Regional Public Health Authority for Bratislava 8 411 tests for anti-HIV antibodies had been carried out amongst drug users to the end of 2007. Of these, 123 tests were carried out in state and private drug treatment clinics in 2007. The NGO Prima also carried out tests for anti-HIV antibodies on 72 users who were not in treatment throughcontacted through its outreach programme. Even so, only one new case of infection amongst intravenous drug users was detected in 2007. At present, the professional guidelines for the prevention of HIV infections in Slovakia as the National Programme for the Prevention of HIV/AIDS in Slovakia, which ended in December 2007, are being updated at the instigation of the chief hygiene officer of the Slovak Republic, doc. MUDr. I. Rovný PhD, MPH.

Fig. 6.1: Cumulative incidence of HIV infections in Slovak citizens (2000 – 2007) (Source: National Reference Centre for HIV/AIDS,2008)

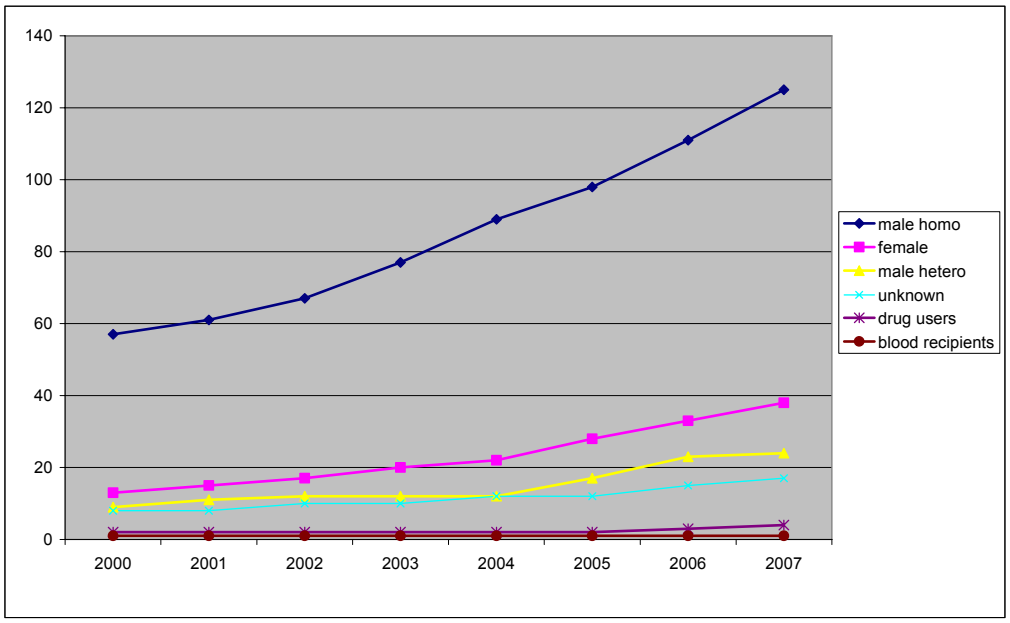
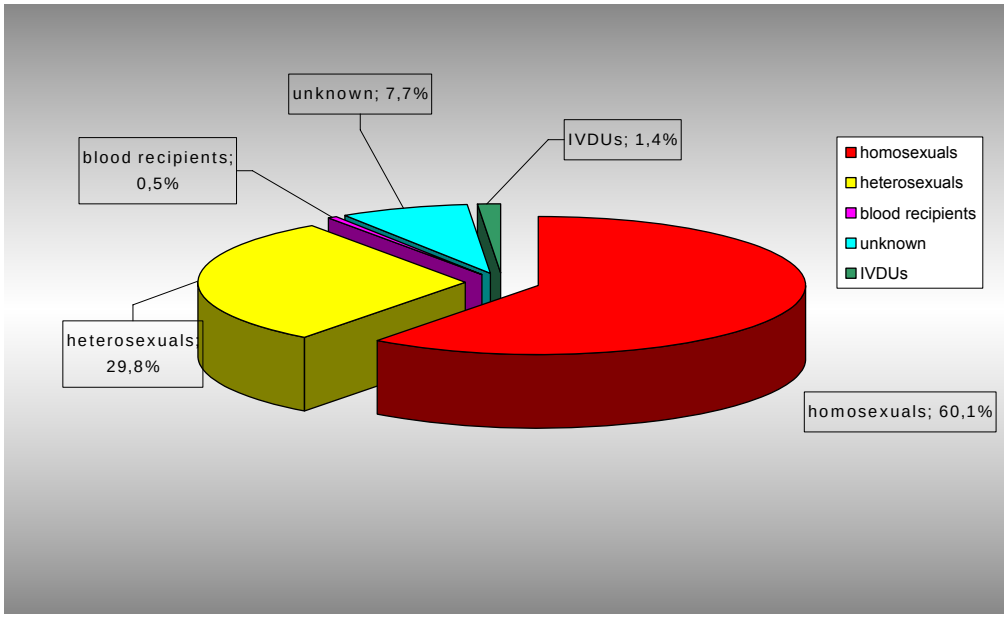


Fig.6.2: HIV positive cases (only Slovak citiziens) according the way of transmission (Source: National Reference Centre for HIV/AIDS,2008)



6.2.2 Viral hepatitis among injecting drug users

6.2.2.1 Information from the National Register of Infectious Diseases

The regional public health authority in Banská Bystrica maintains the National Register of Infectious Diseases, which records infectious diseases at a national level.

Hepatitis C

38 acute cases of hepatitis C were reported in 2007, of which 6 involved intravenous drug users (4 men and 2 women, 5 under the age of 25 years). There was also an increase in reports of chronic hepatitis C from 239 in 2006 to 367 in 2007. The increase was very probably caused by reporting bias as a result of increased reporting of the people with chronic HCV infection. 115 reported cases involved injecting drug users (91 men and 4 women; 39 under the age of 25 years). 4 injecting users had been injecting for less than 2 years.

Hepatitis B

In comparison with the previous two years, 2005 and 2006, there was a slight decline in the number of reports of acute cases of hepatitis B, from 123 and 124 to 103.

Of these 14 involved injecting drug users. 40 cases of chronic hepatitis B were reported in 2007.

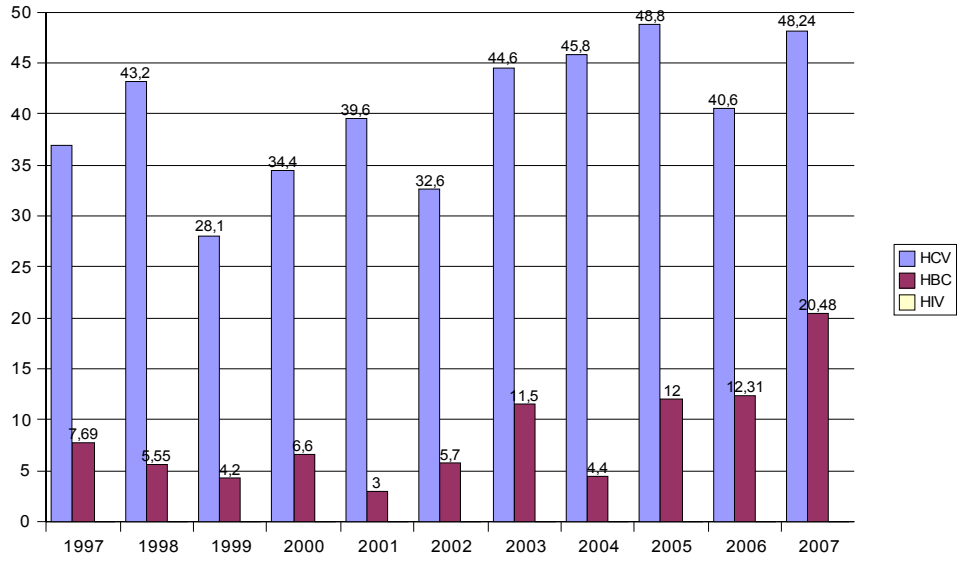
Other

The National Register of Infectious Diseases did not record any notified cases involving types of hepatitis or any other infectious diseases in addition to the above mentioned, where there was an indication of blood-borne transmission between injecting drug users or a relation to a history of drug use.

6.2.2.2 Results of testing in the CTDD – IDD in Bratislava

The department of the Institute of Drug Dependencies in the Centre for the Treatment of Drug Dependencies (CTDD) in Bratislava monitors trends in the incidence of blood-borne infectious diseases amongst drug users who request treatment for the first time in a given year and who have been injecting drug users (Fig. 6.3). 68.4% of injecting drug users were men in 2007 and 31.6% were women. The average age of injecting users who had been injecting for less than 2 years declined from 26.3 in 2006 to 25.9 in 2007.

Fig. 6.3: Trends in the prevalence of blood-borne infections among intravenous drug users in CTDD Bratislava (Source:CTDD,2008)



HIV/AIDS infections

98 patients were tested for HIV antibodies in CTDD Bratislava in 2007 without any positive results.

Hepatitis C

A comparison with results recorded in the past shows that the trend in the incidence of antibodies against hepatitis C in injecting drug users entering treatment in CTDD Bratislava for the first time in their lives has been relatively stable since 2003. The sequence is 2003 - 44.6% of valid tests, 2004 - 45.8%, 2005 - 48.8%, 2006 - 40.6% and 2007 - 48.3%. 95 patients were tested in 2007. The annual average is around 100 patients. Men tested positive for hepatitis C antibodies in 44.8% of valid tests and women in 55.6% of valid tests. Patients under the age of 25 years tested positive in 42.9% of cases. Patients over the age of 34 years tested positive in 50% of cases. 62% of tested patients whose primary drug was opioids received positive results.

Hepatitis B

Patients were found to have antibodies for the hepatitis B virus - anti-HBc (core antigen) in 20.5% of valid tests. This represented a slight increase in such antibodies compared to 12.3% in 2006. Hypothetically, this may indicate more frequent immunodeficiency in this specific sub-population which means that they do not respond adequately to vaccination against hepatitis B. In the past there has already been a case in Bratislava where an intravenous drug user entered treatment and tested negative for contact with the hepatitis B virus. Despite a complete vaccination they he failed to respond and did not develop a sufficient immunity and after they he took up drug use again later, hethey wasere diagnosed with acute hepatitis B.

15.8% of valid tests on men and 30.8% of valid tests on women produced positive results for the presence of the HBc antigen. The significantly higher proportion of women suggests a hypothesis that infection is transmitted sexually as well as via blood especially in the sub-population of female drug users. This form root of infection is also more likely for men than in the case of the hepatitis C virus, because that virus is transmitted sexually to a much lesser extent. Patients under the age of 25 years tested positive in 25.6% of cases. Clients with opiates as their primary drug tested positive for anti-HBc antibodies in 18.9% of cases.

Other

No other types of hepatitis were detected in patients treated in the CTDD in 2007.

In addition to monitoring of the above blood-borne infections, drug users entering treatment in CTDD Bratislava underwent systematic monitoring of antibodies for treponema pallidum (syphilis). Processing and trend results will be presented in the future when analysis is complete.

Because of the low, non-epidemic prevalence of tuberculosis in the general population in Bratislava Region and also in the sub-population of drug users and the almost complete absence of HIV, CTDD Bratislava did not carry out routine tests of drug users for these infections in 2007. No case was clinically diagnosed among patients and universal screening of the clientele in the past had not revealed any infection.

In line with the fall in injecting drug use in the last decade, clinical practice encountered hardly any cases of serious bacterial infections such as abscesses at the site of injection that required medical attention in 2007. These types of infections were not systematically monitored nor, for reasons of diagnostic difficulty, were bacterial endocarditis or other clinically non-manifest potential bacterial infections in injecting drug users.

6.2.2.3 Infectious diseases among drug users entering prison

In prisons a project of the National Centre for the Management and Treatment of Chronic Hepatitis began with the aim of determining the incidence and prevalence of the blood-borne infectious diseases: HCV, HBV and HIV during imprisonment and to determine factors that influence infection before and during the sentence. The first preliminary results are expected to become available at the end of 2008 after the publication of this national report.

6.2.2.4 Infectious diseases among clients of outreach programmes

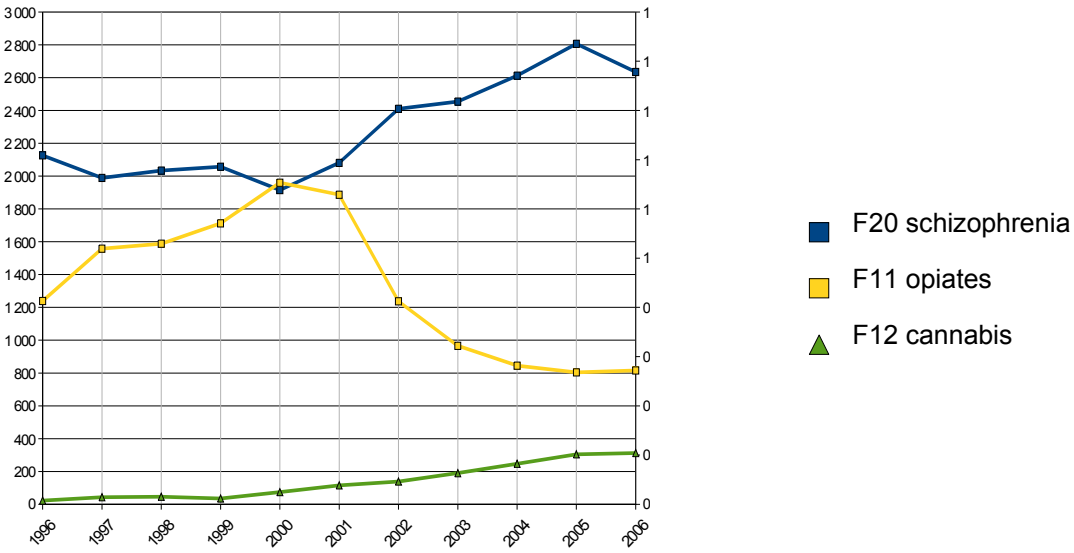
No major difference was found in the last year between the prevalence of blood-borne infections, in particular HIV and HCV, among tested clients of low threshold needle exchange outreach programmes for drug users and among patients entering treatment for drug problems. The most likely explanation for the higher prevalence of clients reactive to syphilis antibodies is that the syphilis was transmitted sexually because the outreach programmes pay increased attention to women in the sex business, working on the streets with higher exposure to this infection. Due to the current conditions required by the hygiene standards of the Ministry of Health, which are difficult to adhere to when collecting and handling infectious biological material during field testing, it was recommended that such testing should not continue in its current form in 2007.

6.3 Psychiatric co-morbidity

A problem which is coming to the foreground of attention is co-morbidity of diagnoses of substance dependenceaddiction and a serious mental disorder – usually of a schizophrenic character. This is due to the increased use of cannabis and methamphetamines by illicit drug users. Theis comment is based on a clinical impression without a quantitative evaluation. There are no trends based on monitoring in previous years. The same applies to affective disorders. There has not been a noticeable remarkable increase in such disorders but they are continuously present in a part of the treatment population.

The Institute of Drug Dependencies has prepared and presented preliminary results from the TDI material and treatmenthe register of treatment for the diagnosis of schizophrenia in the Slovak Republic (Fig. 6.4). An interesting feature is the high negative correlation between the trend in treatment for schizophrenia and for addiction dependence to opiates (r= -0.921) and the high positive correlation between the development in the numbers treated for schizophrenia and treatment for problems with cannabis (r=0.878) and stimulants (r=0.936). A rough preliminary analysis of results suggests a number of unverified hypotheses and clarification of the identified effect will require additional more detailed research in future (Okruhlica, L. EUROPAD, Sofia, 2008).

Fig. 6.4: Comparison of prevalence trends among patients treated for schizophrenia and problems with opiates and cannabis in Slovakia, 1996–2006



6.4 Other health correlates and consequences

There have been occasional cases of chronic drug users with cirrhosis of the liver. These users began injecting drug use at the time of the epidemic more than a decade ago and became infected with the hepatitis C virus. They have not received effective treatment for this infection and consume excessive quantities of alcohol. In view of the epidemic of hepatitis C infections amongst intravenous drug users in Slovakia we expect in future an increase in the prevalence of severe liver disease (cirrhosis, hepatocellular carcinomas) in the future. There is a continuousing problem with the compliance of drug users in prenatal care. In view of the high rate of traffic accidents in Slovakia, which also involve drug users, the Ministry of Health has begun work in cooperation with the Ministry of Interior on a new act to allow the routine testing of drivers for the presence of drugs. The act is expected to enter into force in 2009.

7 Responses to health correlates and consequences

Discussion of health correlates and consequences of drug use in this part of the National Report is limited to measures for the prevention of physical harm caused by drugs. We do not deal here with mental health issues such as the creation of addiction because this core health problem resulting from the use of psychotropic substances is dealt with in chapter 5 - Drug-related Treatment. The majority of measures to reduce the physical harm caused by drug use are implemented by:

- providers of specialised health care facilities
- the staff of low-threshold “harm reduction” field programmes
- pharmacies.

State institutions, non-governmental organisations, professional health workers, graduates in social work, students – volunteers and (former) users also participate in such activities.

Our efforts and measures are graded according to a well established scheme:

- primary prevention to reduce the number of people who start to use drugs, especially young people;
- efforts to prevent those who have become regular drug users from becoming injecting users and to encourage them to seek treatment to end their drug use at the earliest opportunity;
- intravenous users are urged and encouraged to enter treatment without delay and if they do not stop using drugs intravenously, we try to get them to reduce intravenous use or to use sterile equipment and to use procedures that prevent them from infecting themselves or other and from taking a fatal overdose.

7.1 Prevention of drug-related deaths

An important role in this area is played by maintenance treatment for patients who are addicted to opioids. Substitution is achieved either through methadone maintenance treatment or buprenorphine maintenance treatment (currently Suboxon). There is sufficient scientific evidence to establish that medically assisted long term maintenance treatment reduces the risk of overdose and blood transmitted infections in patients addicted to opiates.

Two small but important changes have been made to maintenance therapy in this direction: in the case of methadone treatment, since 2004 the treatment modality in the largest substitution treatment programme in the CTDD in Bratislava which requires “clean” urine checked by regular tests has existed in parallel with a second harm reduction modality that emphasises not abstinence but the prevention of further damage to the user’s health and seeks to ensure that the user does not lose contact with health services in spite of their current inability to abstain entirely from drugs.

In 2007 the buprenorphine substitution treatment programme changed from using the pure buprenorphine preparation Subutex to using Suboxon. Suboxon not only presents a lower risk for non-lege artis intravenous use but also thanks to the presence of naloxone there is a lower risk of overdosing on other psychotropic substances in combination with buprenorphine. Every maintenance treatment programme includes education for intravenous users.

Some of the less frequent measures that have been implemented elsewhere in the world, such as consumption rooms for users or the free distribution of naloxone for use if a friend is having an overdose would not be acceptable in Slovakia in the current legal framework.

7.2 Prevention and treatment of drug-related infectious diseases

7.2.1 Needle and syringe exchange programmes

In addition to education provided to drug users by means of leaflets, in person during treatment and through the channel of the mass media, a successful means for making contact with continuing intravenous drug users is a system for the exchange or the distribution of sterile equipment for drug administration. In this a primary role is played by the staff of low threshold organisations in outreach programmes. The same function is performed by designated employees of the CTDD in an office setting.

The first sterile needle and syringe exchange programme in Slovakia was established at the Centre for Treatment of Drug Dependencies in 1994 at the start of the epidemic of intravenous drug use - primarily the use of heroin. Later, for technical and organisational reasons the programme changed from the compulsory exchange of sterile material for used equipment handed in by drug users to distribution and users' voluntary deposit of used needles and syringes in containers for infectious waste. A special characteristic of the oldest programme for the provision of sterile needles and syringes to drug users is that operates in an institution focussed on treatment, whose patients include 400 recipients of daily methadone maintenance treatment. In the 10 years since its foundation the programme has given out more than 500 000 sterile needles and syringes.

In 2007 all low threshold programmes for drug users gave out a total of 420 627 sterile needles and syringes and collected over 319 000 items of used equipment. Another programme that should not be overlooked is the sale of sterile needles and syringes for intravenous drug users for accessible prices in Slovak pharmacies, though we do not have numbers for this programme. There is a dense network of pharmacies covering the whole of Slovakia. Needles and syringes can be bought there without a doctor’s prescription.

Fig.7.1: Trends in the issuing and collection of needles and syringes in low threshold facilities (Source: NMCD,2008a)

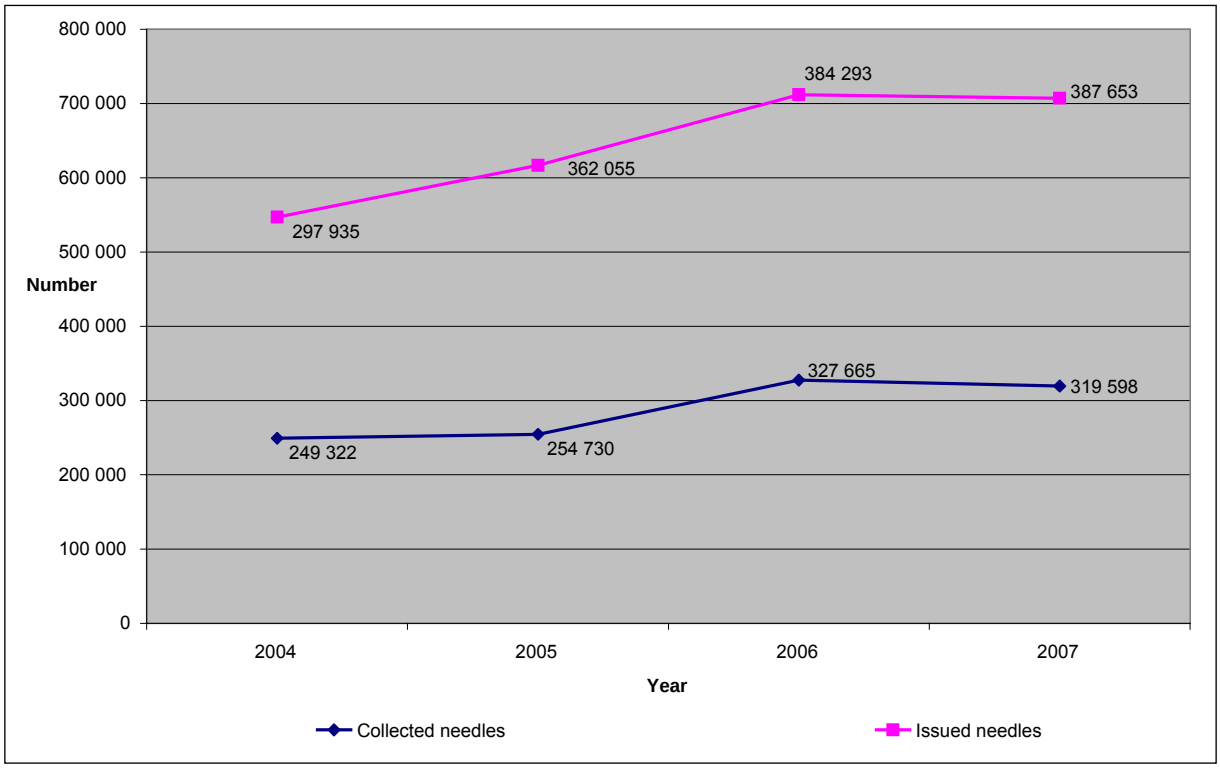


Table 7.1: Needle and syringe exchanges in outreach programmes, (NMCD and CTDD IDD, 2008)

Year	Number of needles / syringes collected	Number of needles / syringes issued + CTDD Bratislava	Number of exchange programmes for which information is available	Number of exchanges	Number of persons
2004	249 322	297 935 + 26 829	8		
2005	254 730	362 055 + 43 663	10	7 333	1 658
2006	327 665	384 293 + 66 154	13	9 784	1 965
2007	319 598	387 653 + 32 974	12	10 485	2 248

7.2.2 Testing and vaccination for drug users

Drug users have access to free testing (including anonymous testing) for blood-borne infections in medical facilities. This is useful not only with regard to screening for undetected infections but also an indirect form of prevention to reduce the incidence of such infections. Professional counselling is provided before and after testing. A large project has begun in prisons to test for blood-borne infections and offer follow-up treatment.

A special measure to prevent hepatitis B infections is universal vaccination for all new users, or at least all intravenous users who come into contact with facilities for the treatment of addiction.

7.2.3 Treatment of infectious diseases

One of the most effective means of providing users who are already infected with infectious hepatitis C with protection against progress of the disease and the onset of serious illness is to ensure that they receive treatment as soon as possible. However, it is a condition for interferon alpha treatment that the patient must abstain from drugs continuously for six months and that abstinence must be verified by 6-monlty medical and toxicological examinations. In 2007 specialists in hepatology, infectious diseases and the immune system made intensive efforts to motivate patients who were tested positive for hepatitis C to begin treatment as soon as possible and to continue with peginterferon alpha treatment in combination with ribavirin.

Low threshold programmes in the field distribute free condoms, mainly to women with drug addictions working in the sex business. Syphilis is the object of special education activities of low threshold programmes and the investigation and counselling activity of specialised programmes focussing on the treatment of addictions and the subsequent guidance of clients/patients to specialised clinics for venereal skin infections. The programmes distribute educational leaflets and also provide personal counselling.

7.3 Interventions in relation to psychiatric co-morbidity

In the last five years there has been an increase in psychiatric co-morbidity amongst drug users in Slovakia. This relates to a change in the use of drugs on the drug scene with an increase in the use of methamphetamines and cannabis which is causing more frequent incidence of toxic psychoses. The clinical picture in such cases is dominated by symptoms of paranoia reminiscent of schizophrenic psychoses. In response, cooperation is increasing between addiction services and the providers of general psychiatric treatment. An especially demanding task is work with the families of such patients. In the CTDD in Bratislava this takes the form of regular meetings of a doctor and parents and relatives in a self-help group. Of great benefit is advice provided by reputable experts via the Internet on sites like www.infodrogy.sk and www.cpldz.sk. In 2007 there were 141 messages posted to www.drogy.sk. These included requests for advice from young Slovaks working abroad who used drugs. The most frequent requests were for advice on paranoid and hallucinatory states

following the use of MDMA, cocaine and marihuana. The growth in multidrug use and the frequent consumption of stimulants means that it will be necessary to devote more attention in future to the issue of psychiatric co-morbidity. The Institute of Drug Dependencies at CTDD Bratislava is preparing a research project in this area.

7.4 Responses to Other Health Correlates and Consequences

In addition to services for the prevention of blood-borne and sexually transmitted diseases among drug users, low threshold programmes provide other services to provide for drug users' basic social, economic and health needs (table 7.2) as resources permit. These include pre-medical treatment, usually for infected wounds following injection, food services and crisis interventions, usually combined with referral for treatment. Outreach workers in low threshold programme

State authorities, including self-governing authorities are also in the process of organising other measures. Proposed legislation to create a clearer legislative framework for testing drivers for the presence of drugs while driving a motor vehicle has already been mentioned at the end of chapter 6.

A special social health problem is the inhalation of volatile substances by children and young adolescents in Roma settlements, primarily in Eastern Slovakia. This issue is important despite the fact that it has not yet become a major factor or shown growth in the treatment demand indicator monitored by specialised health services. There have however been repeated reports of sniffing, especially of toluene, in settlements from Roma and non-Roma non-profit organisations taking part in projects to improve health and raise the standard of living and quality of life in such localities. From a health perspective, intensive and continued sniffing can strongly affect young growing brains and lead to serious organic damage and disturbed mental development. Frequent sniffing of volatile substances in Roma settlements is however only one aspect of a complex socio-economic phenomenon that must be addressed by a multi-sectoral approach. The main coordination for such an approach should be provided by the Government Plenipotentiary for Roma Communities in the Government Office in cooperation with the Ministerial Committee and its General Secretariat for Drugs and Drug Addiction in the Government Office.

Responses to health correlates and consequences are extremely demanding in terms of human and financial resources and in terms of cross-sectional coordination. It is likely that they will remain extremely complex in future.

Table 7.2: Summary of numbers of persons and the services provided to them in low threshold programmes in 2007 (NMCD, 2008)

Service provided	Number of persons	Number of programmes for which information is available	Number of actions	Number of programmes for which information is available
Food service	283	2	4 635	3
Medical treatment	242	8	1 147	10
Individual counselling	150	7	1 703	8
Crisis intervention	95	2	284	2
Referrals for treatment	426	7	947	7
Referrals to substitution programmes	186	6	622	6
Social assistance	76	4	126	5

8 Social correlates and consequences

Drug use can be understood as a consequence or cause of social exclusion. On the one hand, social marginalisation can be a reason to start using drugs and contribute to problem use, and on the other hand drug use may lead to deterioration in living conditions (income, employment, housing and so on).

The National Action Plan on Social Inclusion defines the main groups of the population who are at risk of poverty and social exclusion, which is largely in line with the EMCDDA concept of vulnerable[75] groups. The unemployed, marginalised Roma communities, homeless people affected by multiple exclusion, people with disabilities, migrants, families with children (the most at risk are incomplete families and families with three or more children) and other vulnerable groups in the population such as people with drug problems, gamblers, abused children, victims of domestic violence, prison inmates and former inmates, young people who have been brought up in care.

The unemployed continued to be the largest group of patients in treatment by social status in 2007 (56%).

Involvement in crime is considered to be another serious consequence of drug use. In 2007 there was another rise in the number of crimes committed. Offences include 2 135 offences relating to the possession, production and trafficking of drugs (i.e. 413 more cases than in 2006). There was also an increase in the number of persons charged[76] from 1 256 in 2006 to 1 717 (an increase of 461).

8.1 Social exclusion among drug users

There is limited information on the social exclusion and the social problems of drug users.

Information on the social characteristics of people in treatment for drug problems is derived from health care statistics. The unemployed continued to be the largest group of patients in treatment by social status in 2007 (56%).

8.1.1 Social characteristics of drug users in treatment

The broad scope and complexity of the social phenomenon of drug use means that it is difficult to identify causal relations between use and worsened social conditions of users. Some selected characteristics of patients' social situation are also monitored in TDI data collection. These include housing conditions, the highest level of education completed, economic activity, living with other persons (including other persons with drug problems).

In general it can be said that the social situation of first time patients is not as bad as that of persons seeking repeat treatment[77].

A significant percentage of patients treated for drug problems in Slovakia are people who have completed only the first level of education (elementary school) or less. 46% of patients were in this category in 2007. (Fig 8.1) This percentage is significantly higher for female patients (53%) than for men (44%) and accounts for the majority of female patients.

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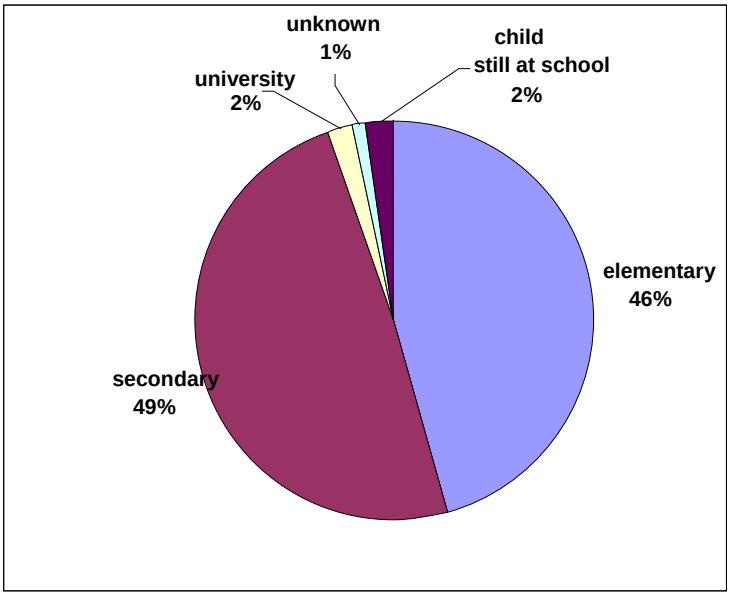
[74] 'Vulnerability' at the group level is interpreted in a purely socio-demographic sense, i.e. groups that can be described by socio-demographic or geographic characteristics with known concentrated risk factors for drug use. The use of the word 'vulnerable' indicates a group's exposure to social disadvantage or inequality that may result in limited individual choice.

[76] Statistical information on the number of offenders charged with drug related offences need not correspond with official police data because they are prepared using different methods and thus they are not comparable.

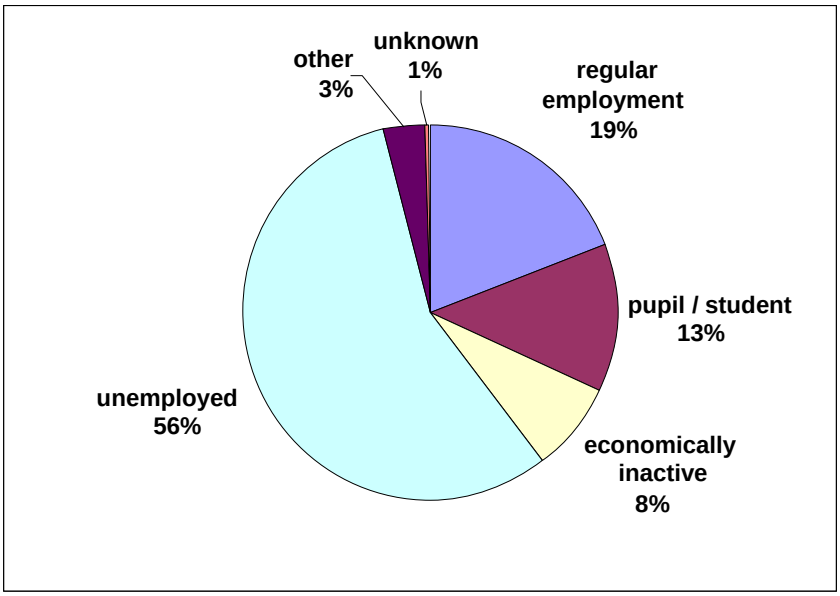
[77] NMCD: Annual Report on the drug situation in Slovakia in 2006, National Monitoring Centre for Drugs, Government Office, Bratislava, 2007

Fig.8.1: Patients receiving treatment for drug problems in 2007 by highest completed level of education (source NHIC, 2008)



In terms of economic activity, the unemployed make up the majority of patients, as was reported in chapter 4. Less than a third of patients - 32% - are economically active (i.e. in employment or studying) (Fig. 8.2)

Fig. 8. 2: Patients receiving treatment for drug problems in 2007 by economic activity (Source: NHIC, 2008)



Changes in the drug scene since the 1990es mean that the number of users under the age of 20 years has gradually declined and stabilised in recent years. In 2007 such patients represented 22% of patients in all medical facilities. A disadvantage of this seemingly gratifying result is that the increase in the proportion of patients in higher age groups increases the likelihood of problem use.

A relatively important factor for risk behaviour is whether a person lives with another person who uses drugs. In 2007 nearly 10% of all patients lived with another drug user.

The development of some social indicators since 2003 is shown in table 8.1.

Table 8.1: Selected social characteristics of drug users in treatment in % - all requests for treatment, NHIC, 2008)

	2003	2004	2005	2006	2007
Unstable accommodation	6.6	7.6	8.9	8.6	9.6
Prison/institution inmate	1.9	1.6	1.6	1.0	0.8
Unemployed	55.2	54.2	54	55.2	56.5
Highest level of education elementary	40.3	43	39.1	38.5	40.3

8.1.2 Clients in SRCs (social reintegration facilities)

Information on the socio-economic status of clients in therapeutic communities (social reintegration facilities outside the health care sector) was provided by a survey[78] carried out as part of the twinning project[79]. The research was conducted in 20 social reintegration facilities between August and October 2007 during visits of the foreign experts participating in the project to the social reintegration facilities. It collected information on 405 clients whose socio-economic status the management of the social reintegration facilities were able to identify. 5 social reintegration facilities reported that their clients come from a range of backgrounds from illiterates to university graduates. Another 4 facilities take clients from wealthy backgrounds while 7 take clients from average backgrounds (white and blue collar workers) and 4 take clients with a poor or very poor social situation. In interviews with the clients themselves, a large majority mentioned financial (debt) worries about the future (after leaving the facility). They have little or no education that would help them to get a job and nowhere to live. Clients were more likely to mention educational opportunities and opportunities to start or continue in studies the lower their level of education and work experience. They hoped for assistance and training for job interviews that they would face when seeking employment.

The foreign experts taking part in the project noticed significant social and economic differences between Western and Eastern Slovakia which also affected the area of social reintegration80 (finding a job and somewhere to live) and were linked to the economic situation: the unemployment rate in Western Slovakia is 4 - 5% while in the eastern part of the country it is 20 - 23%.

The offices of labour, social affairs and family (which cooperate closely with the social reintegration facilities) indicated that although they registered high levels of drug use in the majority of their clients, it was difficult to identify specific clients as drug users and their social problems tended to be the same as for other clients: unemployment, housing.

8.1.3 Drug use in Roma communities

A theoretically opposite order of cause and effect (social exclusion and drug use) was studied by a survey[81] of 70 Roma communities in the Prešov Region, where the Roma ethnic

[78] Social reintegration facilities for drug and other addictions in the Slovak Republic – the current situation, 10/2007 Source: http://www.infodrogy.sk/indexAction.cfm?module=Library&action=GetFile&DocumentID=643

[79] EU Twinning Project SK/06/IB/SO/02 - Improving and broadening the care for the re–socialisation and rehabilitation care for persons addicted to psychoactive substances

[80] In the area of drug problems the following difference was observed in substances used: in the east the main problem is alcohol and in the west it is pervitin and other drugs.

[81] In the project "Concept for using regional resources in the creation, implementation and evaluation of anti-drug policy in the Prešov region" - supported in 2006 from the grant scheme of the project " Support for the Implementation of the 2004 - 2008 NPFD"

group is highly concentrated. (the main findings of this cultural and anthropological research are reported in chapter 2 Drug use in specific population groups). According to the authors, the findings are paradoxical in some areas - the more that individual in these communities, which are affected by multiple forms of exclusion, became integrated into the majority environment or sought to become integrated into that environment, the higher the risk of the adoption of negative patterns of behaviour.

8.2 Drug related crime

This chapter presents information on criminal law issues: illegal production of narcotic and psychotropic substances, poisons or precursors, possessing and dealing in such substances (sections 171 - 173 of the new Criminal Code), endangerment under the influence of addictive substances (section 289 of the new Criminal Code) and drug motivated crimes (i.e. secondary drug related crime). (see the Criminal Code, Act No. 300/2005 Coll.).

Drug related crime is analysed in terms of recorded crimes and offenders. Records and statistics are kept at a national level by the law enforcement and judicial authorities – the Ministry of Interior (MI), the General Prosecutors Office (GPO) and the Ministry of Justice (MJ). The MJ and MI began to monitor drug related offences and offenders by drug type in 2007. (the GPO began to monitor types of drugs on 1.1.2008 so the first official statistics will be published in next year's Annual Report).

In the writing of this report information was drawn from the statistical system of the Presidium of the Police Force (PPF) and the Report on the Security Situation in the Slovak Republic with regard to Drug Related Crime for 200782 (MI). The statistics include information on the number of offences and persons charged under each section of the Criminal Code relating to drugs (sections 171 - 174 of the Criminal Code) and on types of drugs. The transparent image of overall drug related crime is supported by information from the statistical systems of the GPO and the MJ, which include data on the number of persons indicted/convicted under the relevant sections of the new Criminal Code[83] (171 - 174) and the old Criminal Code[84] (186 - 188a).

8.2.1 Number of offences and persons charged according to data from the MI / PPF

The statistical data of the MI (the Report on the Security Situation in the Slovak Republic with regard to Drug Related Crime for 2007) shows a continuing increase in detected drug related offences and offenders. As evidence of this there were 2 135 offences relating to the cultivation, production and distribution of drugs (i.e. 413 more cases than in 2006). There was also an increase in the number of persons charged[85] from 1 256 in 2006 to 1 717 (an increase of 461). Persons charged with drug related offences included 39 foreigners, among whom the most numerous national groups were people from the Czech Republic (17), Hungary (5) and former Yugoslavia (3).

The structure of offenders by age, gender and education did not change significantly in comparison with 2006 (see the National Report for 2006). Most drug related offences in 2007 were committed by offenders in the 18 - 30 age groups, whose share was approximately the same as in the previous year – around 70%. More young people were charged in 2007 - an increase from 98 in the 14 - 18 age group in 2006 to 162 in 2007.

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[82] The MI material was submitted to the Ministerial Committee for Drug Addiction and Drug Control in March 2008. The material includes, amongst other things, the report of the National Anti-drug Unit of the Organised Crime Office on the drug scene in the Slovak Republic in 2007, which has been used extensively in the writing of the relevant parts of this chapter.

[83] The new Criminal Code, Act No. 300/2005 Coll., has been in force since 1.1.2006

[84] The old Criminal Code, Act No. 140/1948 Coll. was in effect until 31.12.2005

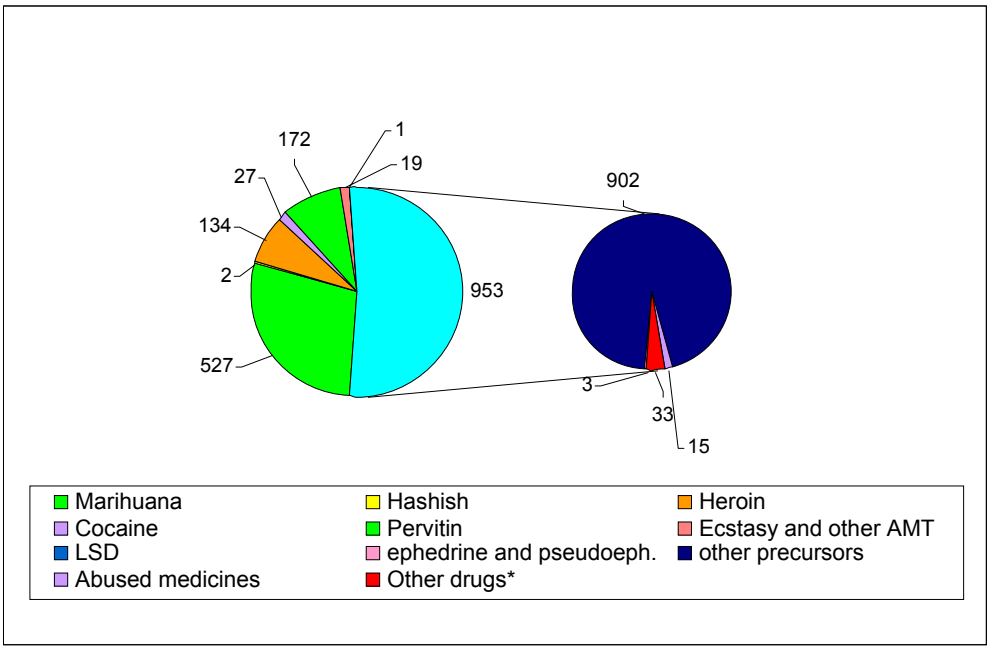
[85] Statistical information on the number of offenders charged with drug related offences need not correspond with official police data because they are prepared using different methods and thus they are not comparable.

In terms of social status, drug related offences were most frequently committed by the unemployed (73%) followed by manual and operational workers - both responsible for 5% of drug related offences. At the other end of the scale, workers in the non-production sphere (managers and technical workers) were the least likely to be involved in drug related crime, making up less than 1% of the total.

The PPF introduced a second form of statistical monitoring of drug related crime[86] in 2007: classification of offenders charged and offences (sections 171 - 174 of the Criminal Code) by drug type. The police force recorded a total of 2 160 offences and 1 861 persons charged in this structure. A specific drug type was recorded for only 1 835 offences and 1 238 persons charged[87].

In 2007 more than half of offences related to "other substances" - in total 52%. This total was due to the high number of offences (902) that related to other precursors [88] With regard to traditional drugs[89], the majority of offences related to marihuana (527), pervitin (172) and heroin (134). Further information is given in Fig.3.

Fig. 8.3: Number of perpetrators of offences under section 171-174 NCC by type of drug in 2007 (MI, 2008b)



Abused medicines: morphine, Rohypnol, Nurofen, Modafen, Clarinnese etc.
Other drugs: psilocin and other narcotic and psychotropic substances that are not recorded statistically, anabolic steroids, chemicals, poisons and equipment for the production of drugs.

The range and quantity of drugs in the case of offenders was nearly identical with that for offences (see Fig.4). In the category of "traditional drugs" the leaders were: marijuana 31%, pervitin 9.5% and heroin 7.3%.

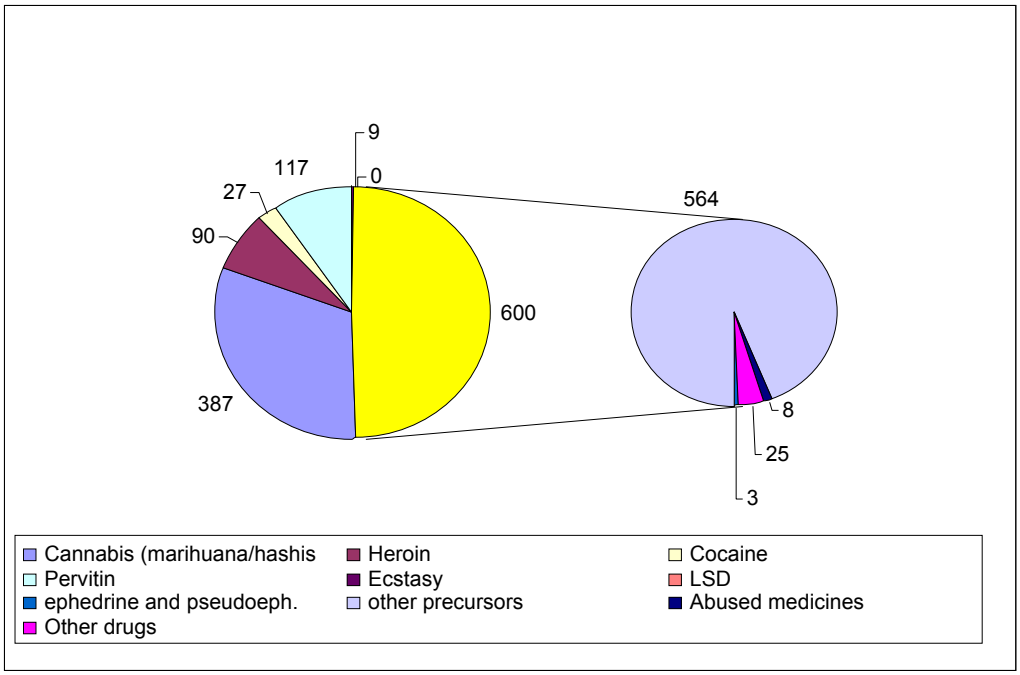
[86] Police statistics on types of drugs involved in drug related offences under sections 171 - 174 of the Criminal Code have been kept since 1 June 2006

87 In the case of 325 offences and 623 offenders the police officer who reported the case did not specify the type of drug involved because there was no clear forensic confirmation of the type of drug involved

[88] Other precursors include: diazepam, buprenorfine, bromazepam, ethylmorphine, zoldipem, midazolam, pentazocín, klonazepam, oxycodone and others which are not specifically recorded. The reason for the large number of offences and offenders relating to other precursors could be a imprecise data processing method. (the police officer reporting the crime may have reported an unknown drug type in the form for drug types as an "other precursor").

[89] Marihuana/hashish, heroin, pervitin, cocaine, LSD, ecstasy and other AMT

Fig. 8. 4: Number of offenders in drug related offences (§171-174 NCC), by type of drug, in 2007 (MI, 2008b)



Abused medicines: Rohypnol, Modafen, Nurofen, Clarinese and other medicines
Other drugs: ephedrine, pseudoephedrine, anabolic steroids, equipment for drug production (driers, pressure vessels) and other poisons and precursors.
Note: The figure shows offenders who committed an offence related to 1 type of drug. Where the offender was associated with 2 or 3 types of drug, the drug that was entered first in the record form was used in the statistics. Usually the first drug recorded was the drug of which the largest quantity was seized.

8.3 Drug-related crime in regions, according to the MI

This section is based on the Report on the Security Situation in the Slovak Republic with regard to Drug Related Crime for 2007 prepared by the MI.

2007 was characterised by a continuing increase in the number of offences committed - 2 135 (413 more cases than in 2006) and the number of persons charged - 1 717 (416 more charges than in 2006). There was an increase in drug related crime (both in terms of offences and offenders) in nearly all regions of Slovakia.

The only region that did not report a rise in drug related crime in 2007 was Banská Bystrica – the number of offenders (115) and offences (127) was approximately the same as in 2006. The development of drug related crime in 2005 - 007 shows a systemic rise in the number of offences and persons charged, especially in the Trnava and Nitra regions. (See Table 8.1). This table also shows that the lowest levels of drug related crime were in the Prešov, Košice and Žilina regions.

Table 8.2: Development of drug related crime in terms of offences and persons charged by region in the years 2005–2007 (Source: Ministry of Interior 2008 – "the Drug Scene in the Slovak Republic in 2007" - NADU OCO PPF, for the Ministerial Committee on Drug Addiction and Drug Control.)

Region	Number of offences			Number of persons charged		
	2005	2006	2007	2005	2006	2007
Bratislava	1024	1055	1222	802	750	969
Trnava	140	195	249	97	107	170
Trenčín	83	64	125	69	44	88
Nitra	119	131	218	80	116	166
Žilina	65	57	77	70	34	66
Banská Bystrica	111	131	127	96	111	115
Prešov	34	35	56	32	30	66
Košice	62	54	61	62	64	77
Total	1638	1722	2135	1308	1256	1717

8.3.1 Number of convictions according to MJ

The statistics of the Ministry of Justice (MJ) record the number of persons convicted of offences under individual sections of the Criminal Code in each year. Since 2007 the MJ also monitors specific types of drugs in relation to the relevant legislative provisions on drugs90. Due to the long time it takes to complete some cases, which can be several years, it is not possible to consider these data an accurate up-to-date reflection of trends in crime in the year under analysis.

As in 2006, the picture of overall drug related crime in terms of numbers of convictions covers total convictions under sections 171 - 174 of the new Criminal Code and total convictions under section 186, 187, 188 and 188a of the old Criminal Code.91

Drug related crime continued to rise in 2007. The number of persons convicted of drug related offences increased to 786 persons. This represents an increase of 8.9% compared to 2006 and 33, 2% compared to 2005. 80.3% of the total of 786 convictions was in cases tried under the new Criminal Code and only 19.7% were tried under the old Criminal Code. Nearly 72% of all drug related crime in 2007 was centred in the Bratislava Region. At the other end of the scale, the lowest number of convictions for drug related crime was in Žilina Region (31), less than in the regions that have for a long time had the lowest levels of drug related crime - Prešov (34) and Košice (37).

In 2007 the MJ began recording the specific drug types involved in convictions under sections 171 - 174 of the new Criminal Code. Because this is a pilot statistic, it is not possible to compare then number of convictions by type of drug (654) with the total number of convictions (786)[92]. One of the objective causes of this situation is the fact that the specification of drug types does not apply to the drug related sections of the old Criminal Code (186 - 188a) which continued to account for some of the convictions for drug related offences in 2007.[93]

The presented statistics show that the majority of convictions related to marihuana and hashish (384 convictions). Cannabis had a similar position in the PPF statistics on charges

[90] Sections 171 - 174 of the Criminal Code, Act No. 300/2005 Coll. in force from 1.1.2006 and sections 186 - 188a of the Criminal Code Act No. 140/1961 in force to 31.12.2005.

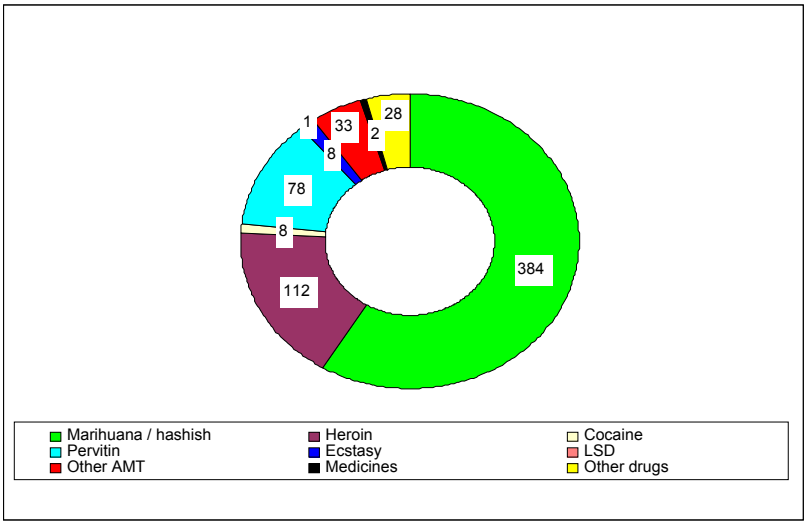
[91] Judgements in the case of people who were charged under the old criminal Code were still made under the old act in 2007.

[92] The overall number of convictions for drug crime is the total number of convictions under NCC sections 171 - 174 and the corresponding OCC sections 186 - 188a.

[93] The overall number of convictions for drug crime is the total number of convictions under NCC sections 171 - 174 and the corresponding OCC sections 186 - 188a.

(see chapter 8.2.1 of this report). The following drugs came quite a way behind marihuana: heroin (112), pervitin (78), other AMT (33) and other unspecified drugs (29). There were lower numbers of convictions relating to cocaine, ecstasy; medicines and LSD (see Fig. 8.5).

Fig. 8.5: Number of convictions under sections 171 -174 of the new Criminal Code by drug type, (MJ 2007)

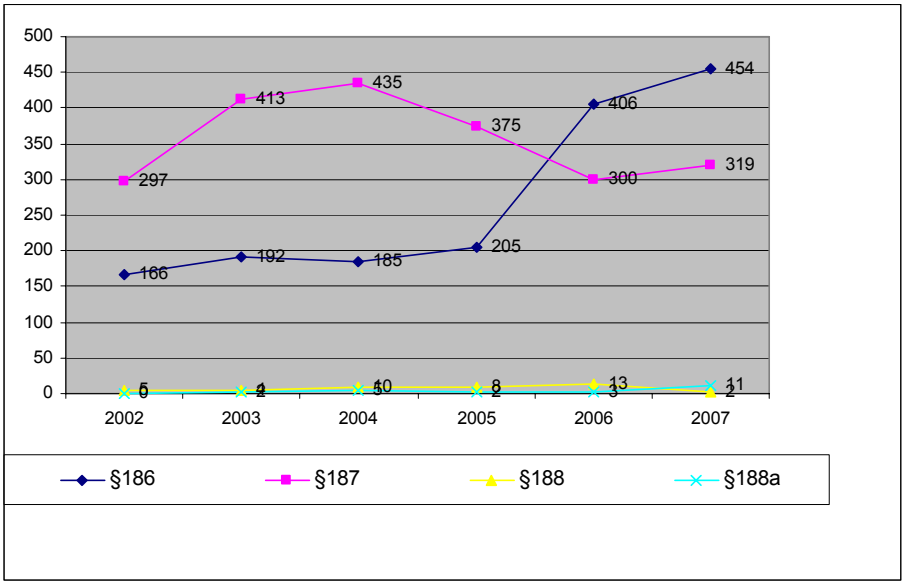


Other drugs: This category includes all drugs not otherwise specified.
Note: The number of convictions in the graph represents the total number of convictions under sections 171 - 174 of the new Criminal Code and sections 186–188a of the old Criminal Code. In the case of convictions under the old Criminal Code it was not possible to specify which type of drugs were involved and therefore the sum of convictions for individual types of drugs is not the same as the overall total number of convictions.

Another of the changes introduced by the new Criminal Code (Act No. 300/2005) was an important change in the treatment of drug users charged with the possession of drugs for personal use (section 171 of the new Criminal Code). Sentences for persons who produce, distribute and hold drugs on a large scale[94] were increased, while less severe, alternative punishments[95] were handed down to those who possessed drugs for personal use[96], with a view to their decriminalisation. These changes were reflected in a fall in the number of convictions for drug production or dealing - section 172 of the new Criminal Code - and a significant increase in convictions for the possession of drugs for personal use - section 172 of the new Criminal Code (see Fig. 8.6).

[94] More than ten times the usual single dose
[95] Section 53 - home curfew and section 54 - compulsory work, Act No. 300/2005 Coll.
[96] In quantities not exceeding ten times the usual single dose

Fig. 8.6: Development in the number of convictions under relevant legislative provisions on drugs in the period 2002 - 2007 (MJ, 2008)



Note: From 2006 (when the new Criminal Code Act No. 300/2005 Coll., entered into force) this is the sum of convictions under the provisions of the old Criminal Code and the corresponding provisions of the new Criminal Code: section 186 OCC + section 171 NCC, section 187 OCC + section 172 NCC, section 188 OCC + section 173 NCC, section 188a OCC + section 174 NCC.

The sentences handed down by courts for drug related crime in 2007 are described in more detail in chapter 11.

8.3.2 Young offenders

51 young offenders were convicted for drug related offences in 2007, which was the same as the previous year when 50 young offenders were convicted. There was a slight increase in the number of 14 year old offenders convicted from one conviction in 2006 to two in 2007, specifically one for the possession of drugs for personal use (NCC section 171) and the other for producing and dealing in drugs (NCC section 172).

In 2007 the MJ introduced the same separate monitoring for young offenders by type of drug as for overall offenders (see chapter 8.2.2). Persons in the 14 - 18 age groups were most frequently convicted for offences relating to the following drugs in 2007: marihuana (35), other AMT (3), other drugs (3) and pervitin (1)[97]

For comparison, data from the GPO records a slight fall in the number of young people charged with drug related offences - from 64 in 2006 to 56 in 2007. This decrease may be directly related to the legislative changes in this area and the use of alternative penalties.

8.3.3 Other drug-related crime

Secondary drug related crime includes a wide range of offences committed in relation to drug trafficking or in order to obtain funds for the purchase of drugs. Although this form of crime is not directly followed by the law enforcement and judicial authorities, the MJ keeps statistics on the motives for crimes[98]. According to these statistics drugs were a motive for the following crimes (other than crimes under specifically drug related provisions): theft (23),

[97] The type of drug was specified only in the case of young people who were convicted under the sections of the NCC relating to drugs and does not include convictions under the OCC.
[98] Crimes for which the offender specified drug addiction as a specific motive

robbery (9), threatened assault (8), fraud (3), embezzlement (3), endangerment under the influence of an addictive substance (2) and assault (2).

8.3.4 Crimes committed under the influence of drugs

The MI keeps also statistics on offenders who have committed offences under the influence of addictive substances (drugs)[99]. In 2007 the number of offenders who committed offences under the influence of addictive substances other than alcohol was 394 out of a total of 27 067. This represents an increase of 73 cases compared to 2006, and 154 compared to 2005. Nearly half of the stated offenders (48%) came from Bratislava Region and at the other end of the scale the fewest, less than 4%, came from the Košice Region.

8.4 Drugs in prison

At the end of 2007 there was a total of 8 049 persons in custody or serving sentences in facilities of the General Directorate of the Prison and Court Guard Force (GD PCGF). Of these, 975 were registered drug addicts. Their proportion to the total number of persons in custody or serving prison sentences was similar to that in the previous year at just under 12%. During entrance examinations, GD PCGF facilities identified 748 persons who had used primary drugs before entering prison in 2007. This was 102 persons more than in 2006. The most common of the primary drugs was heroin (313), followed by pervitin (126) and marihuana (109). Amongst methods of application, injection remained predominant. 347 persons took drugs in this way.

428 clients were treated for drug addiction by court order in psychiatric departments of GD PCGF health care facilities, which have 180 beds, in 2007. This was 7.8% fewer than in 2006. 155 were treated as outpatients and 273 received inpatient care. 53 clients underwent treatment for drug addiction voluntarily in facilities with a capacity of 22 beds. This was 1 client less than in the previous year.

Drug screening has been carried out in GD PCGF facilities since 2004. In this time the proportion of tests carried out for the presence of drugs in urine has tripled increased (from 1089 in 2004 to 3268 in 2007). The number of screening tests carried out in prisons increased again in 2007 (see Fig. 8.7) The substances found most frequently in positive tests were: benzodiazepines (BDZ), marihuana (MAH), barbiturates (BAT), amphetamines (AMT) and opioids/morphine (OP/MO). As table 8.2 shows, the main drug type each year was benzodiazepines, though in 2007 there was a sharp increase in the number of positive tests for marihuana.

[99] Section 201 of the OCC and section 289 of the NCC.

Fig. 8.7: Number of screening tests for drugs carried out in prisons in the Slovak Republic (2004 - 2007) (Source: GD PCGF, 2008)

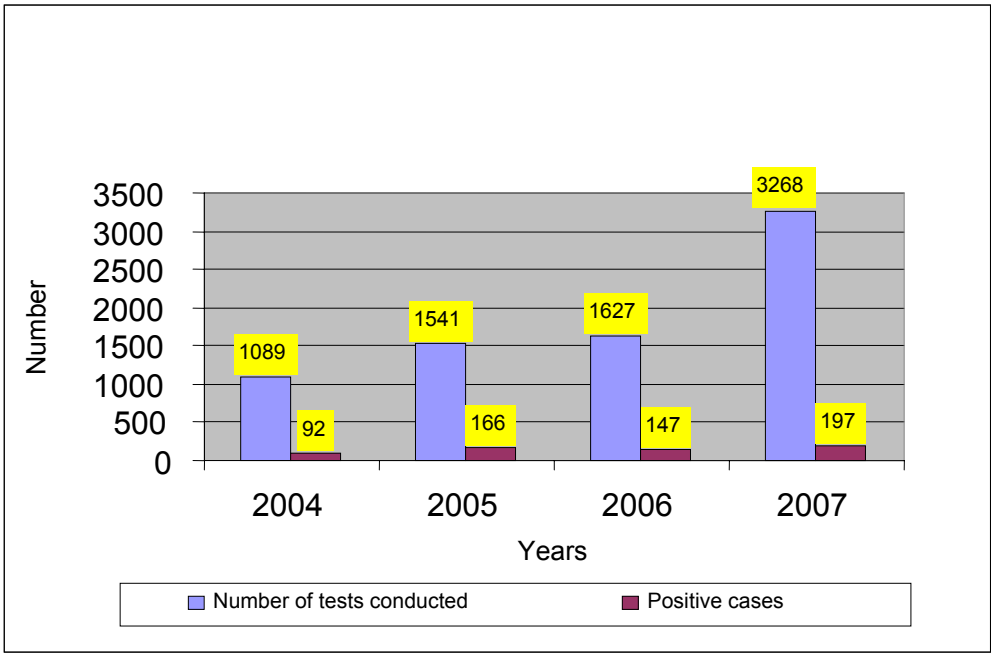


Table 8.3 Range of abused psychoactive substances detected in positive tests (Source: GD PCGF, 2008)

Year	Abused substances						Σ
	BDZ	MAH	BABT	AMT	OP/MO	other	
2004	53	9	16	2	12	0	92
2005	91	30	17	13	11	4	166
2006	84	20	7	14	21	1	147
2007	73	52	3	32	29	8	197

8.5 Social costs associated with drug use

The latest available information on social costs associated with drug use were publicised in 2007 Selected Issue on public expenditure (Report 2007).

9 Responses to social correlates and consequences

The area of labour, social affairs and family is of key importance for the implementation of measures for at risk and marginalized[100] groups. This section of the report regularly features information on the activities of social reintegration centres (SRC) that have recently begun to integrate to a large extent with social assistance and services (i.e. activities in the area of responsibility of the Ministry of Labour, Social Affairs and Family and the social activities of the self-governing regions) and have presented themselves as such though they were originally established[101], functioned and function as therapeutic communities with the objective of "activating the inner abilities of children and adults to overcome the mental, physical and social consequences of drug addictions and other addictions and to become involved in life in their natural environment." [102]

There can be no doubt that long term residence in social reintegration facilities addresses acute social problems (unemployment, housing, and finance) and the selected specialist activities (services) that it provides multiply the likelihood of an effective solution to such problems. At present SCRs represent a specific form of social assistance for people with drug problems. It must be emphasised that there is no standard solution for housing for those who have nowhere to go after completing treatment for their addiction or a residential social reintegration programme. In most cases questions of housing and suitable employment exceed the current abilities of social reintegration facilities.

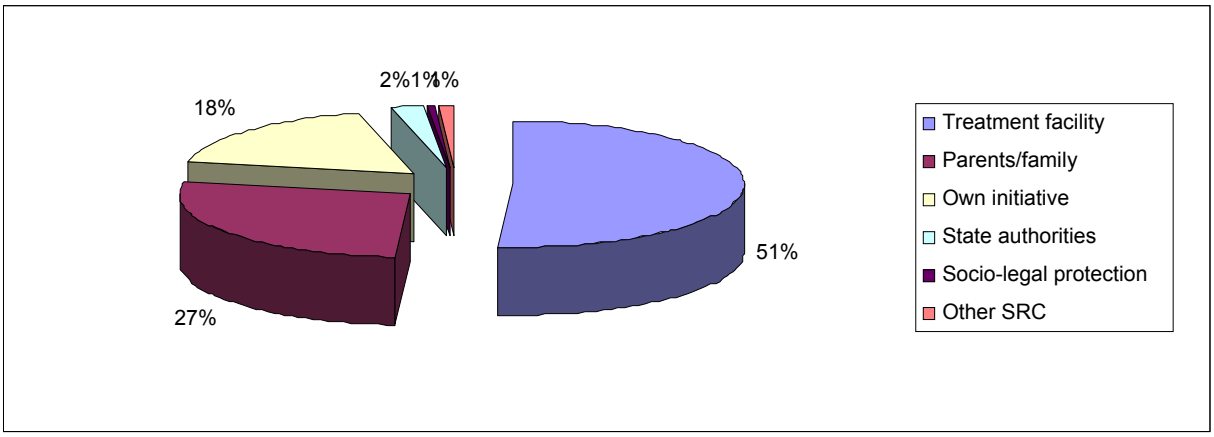
However according to the experts participating in the project "Improvement and expansion of social reintegration and rehabilitation for people dependent on psychoactive substances" (see section 8.1.1) it is necessary to make social reintegration centres for addicts an equal partner for health care in the treatment of addicts and the continuation of clients' treatment. They also suggest changing the name of social reintegration facilities to rehabilitation facilities[103]).

9.1 Solutions for the social consequences of drug use through SRCs

The SRCs do not submit information to the health care statistics system and thus there is limited access to epidemiological data. Some clients enter these facilities without prior treatment in medical facilities, though data gathered by the NMCD indicates this is still the main route through which contact with the SRCs is established. Fig. 9.1:

[100] Including drug users
[101] Including NGO, civil and not-for-profit facilities
[102] Annual Report of the "Komunita Ľudovítov" not-for-profit organisation, 2007
[103] Žemličková,J.(2007)

Fig.9.1: Source of contact with SRC in 2007 – NMCD survey, 2008 (Data source: Record on social reintegration programme of SRC , NMCD, 2008b)

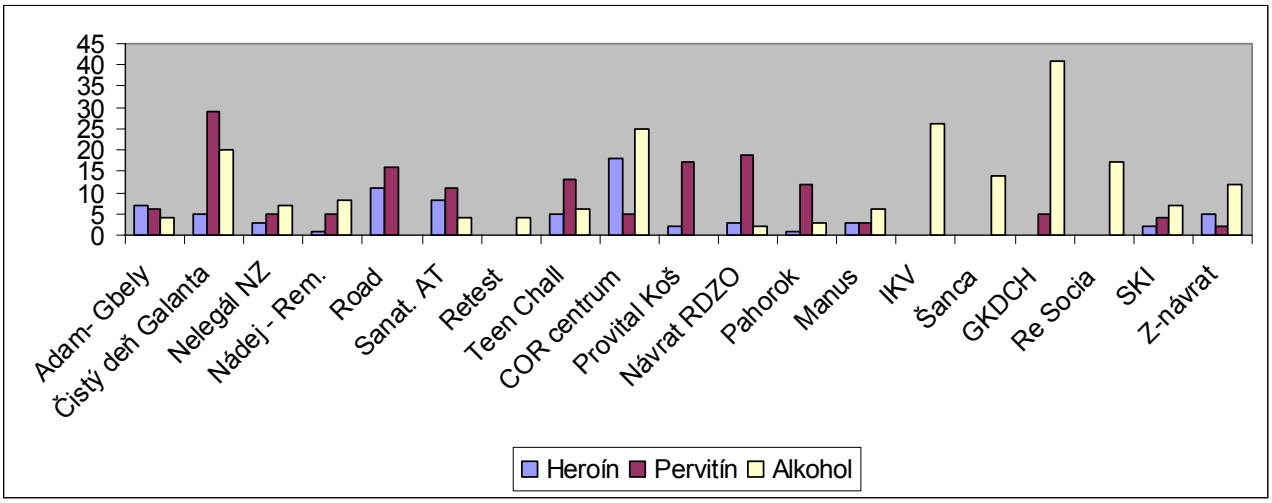


In 2008 the NMCD carried out an independent survey of the structure of clients and provided services of the SCRs in 2007. Of the 23 SCRs in operation, 19 provided information (around 83%)[104]. The total number of clients was 614, 32% were women (194) and 68% were men (420). The average age of the clients in the SCRs was 23 to 46 years. 50 (8%) of the total of 614 clients were under the age of 18 years. 8 people in SCRs were in care following release from prison.

Epidemiological data have been presented in chapter 5 - Treatment. Demand The largest proportion of clients in SCRs had problems with alcohol.

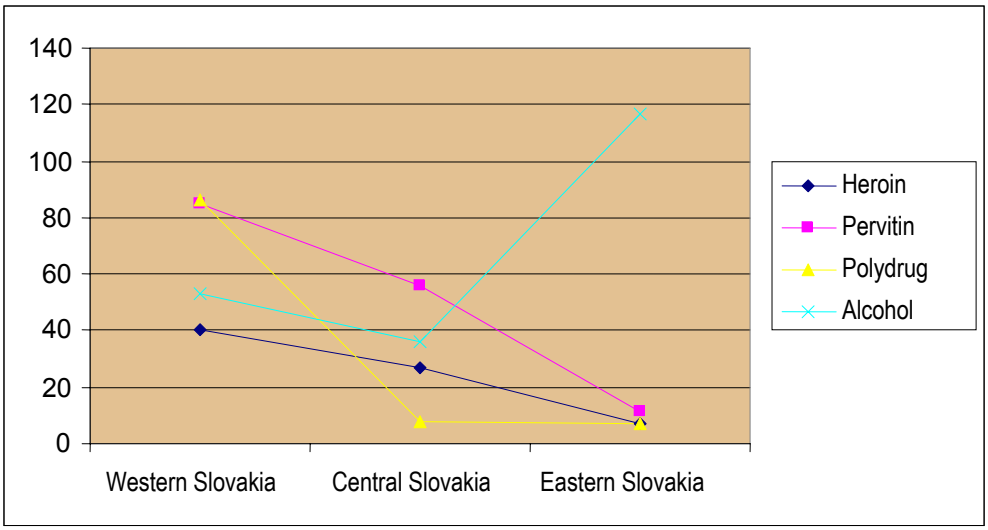
In case this finding was linked to the "geographical" distribution of SRCs from Western to Eastern Slovakia, the difference among clients in Eastern Slovakia (alcohol) and other parts of Slovakia is visible (heroin, methamphetamine (pervitin), polydrug use).

Fig.9.2: Dominating drugs in individual SRCs – set geographically from west to east (Data source: Record of social reintegration programmes, NMCD, 2008b)



[104] Excluding one of the oldest SRCs, Annual Report of the "Komunita Ľudovítov" not-for-profit organisation, 2007

Fig.9.3: Regional differences according primary drug of SRCs clients (Data source: Record of social reintegration programmes, NMCD, 2008b)



With regard to the responses to basic social problems (housing, little or no education, low job qualifications, employment), numbers of cases and activities were recorded in the following areas:

- Provision of vocational training (education, completion of secondary education or university)
- Assistance in obtaining work skills
- Assistance in finding employment
- Monitoring of the effectiveness of social reintegration
- Follow-up activities after the completion social reintegration activities (sheltered accommodation, sheltered workshops)

The proportion of clients who benefited from the above services/activities, including the sheltered accommodation service/ Half way homes, is shown in Fig. 9.2 for 18 SRCs (one did not provide information). The remaining service - so called protected workshops - was omitted from the graph because it was reported by only one SRC.

Fig.9.4: The proportion of clients who benefited from the social reintegration services provided in individual SRC. (Data source: Record on social reintegration programmes, NMCD, 2008b)

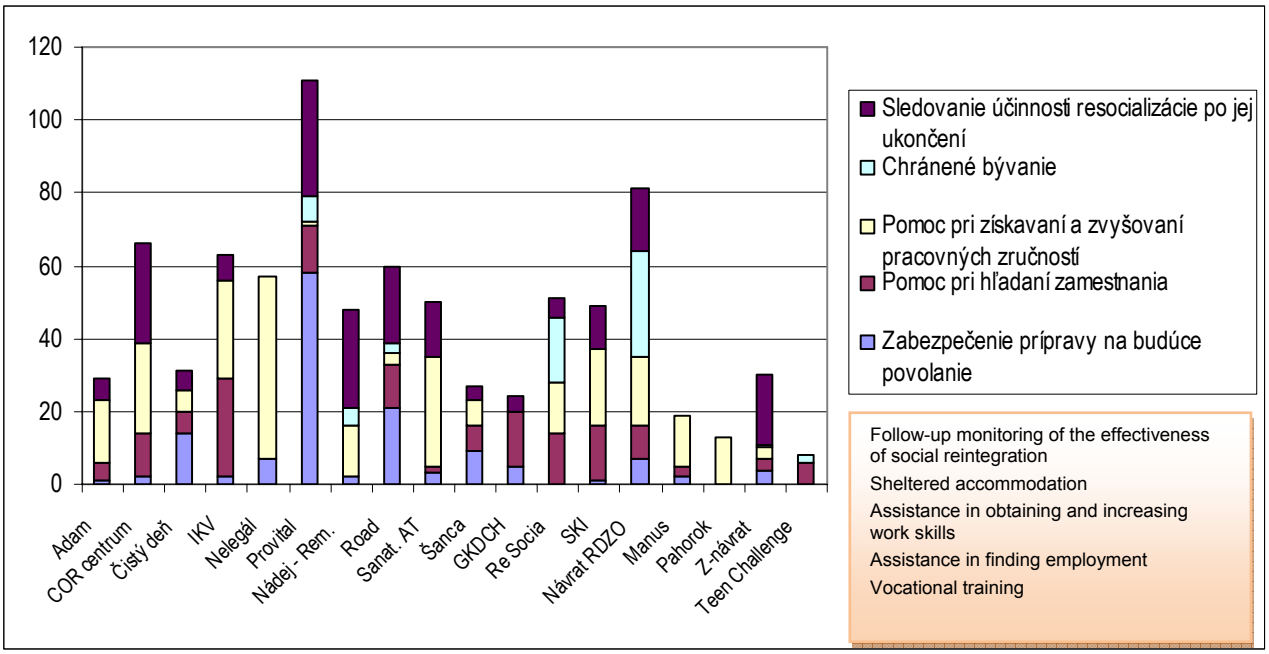
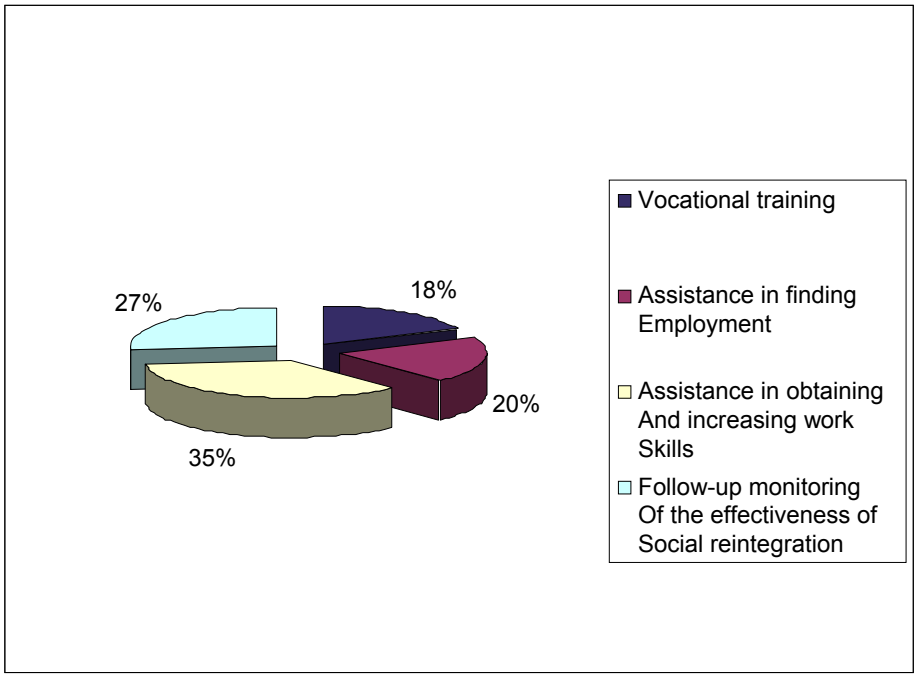


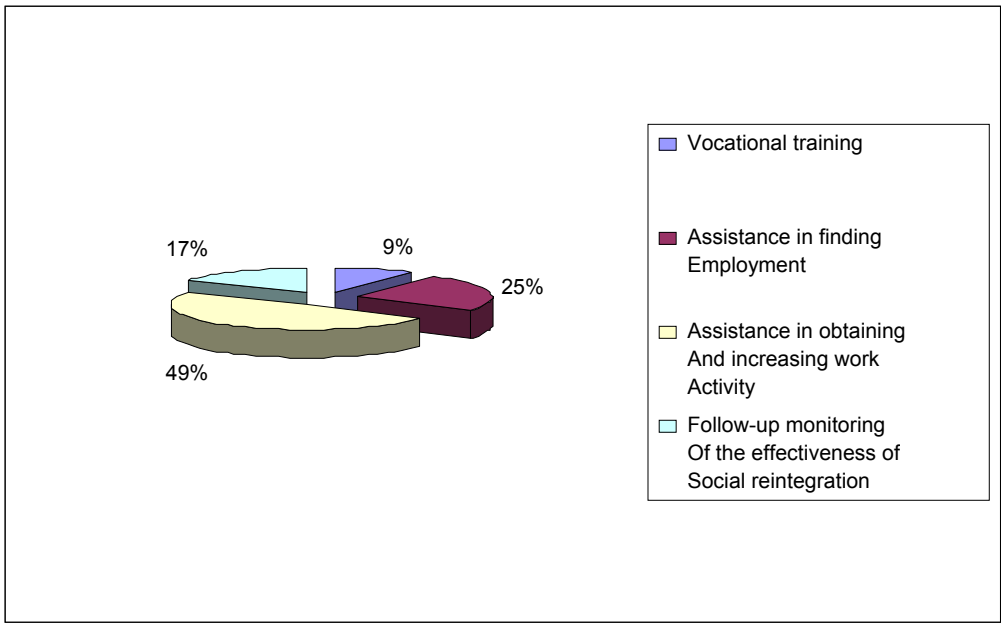
Fig. 9.5a. Share of overall activities of responses to social problems facing clients of SRCs (18) in 2007 (Data source: Record on of social reintegration programmes, NMCD, 2008 b)



The largest proportion of activities (35%) sought to provide work skills.

Similar findings were reported in data from the MLSAF (49%). A relatively small proportion of activities were directed towards vocational training (i.e. the completion of education and the acquisition of higher education) – 18% and 9% respectively.

Fig.9.5b Share of overall activities of responses to social problems facing clients of SRCs (22) in 2007 (Data source: MLSAF, 2008)



The SRCs are required to submit statistical reports to the MLSAF. These data[105] show that in 2007 professional assistance was provided to 687 clients in 22[106] centres. (Out of this total, 411 were new clients, including 46 women and 41 clients under the age of 18 years, 13 girls and 28 boys).

Clients stayed in a social reintegration for an average of 15 months, which were divided approximately equally into four phases: adaptation, "self work", stabilisation and becoming independent. Statistical reports also refer to work therapy (52% in amount of all *social reintegration services*) inside and outside facilities - see table 9.1

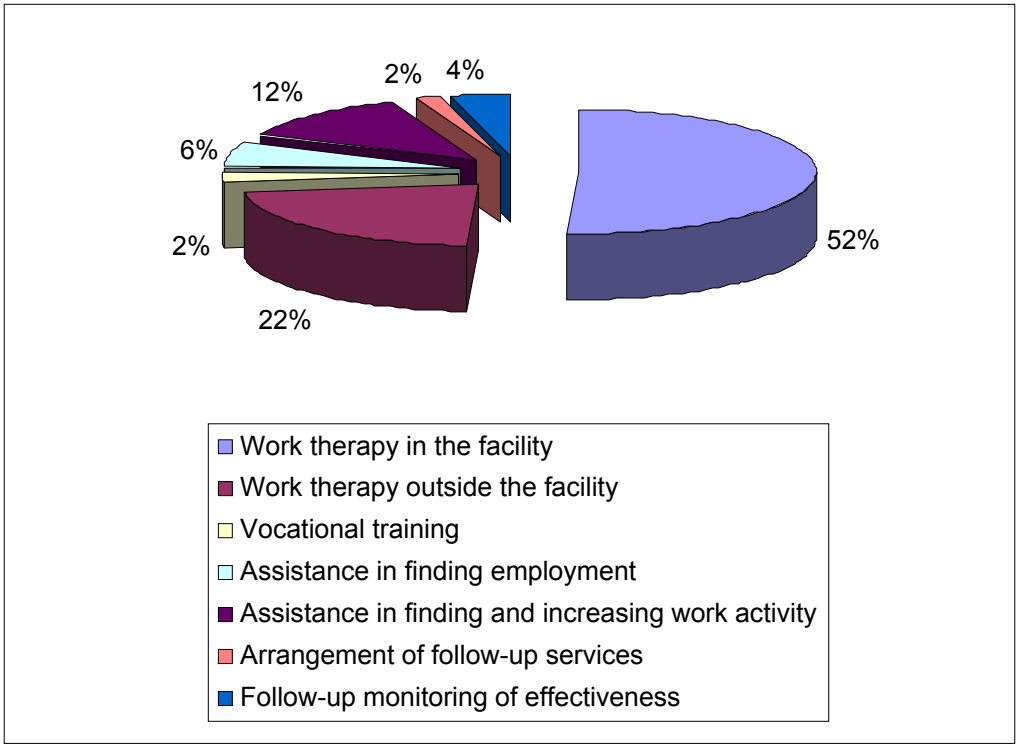
Table 9.1: Selected specialised activities carried out by social reintegration centres (Source: Statistical record for 2007 MLSaF, 2008)

Selected activities of social reintegration centres	Number of cases	By dependence			
		alcohol	heroin and other opiates	other drug types	compulsive gambling
Counselling and first contact services	1161	411	85	623	42
Individual social work	3150	1609	554	801	186
Group social work	3908	1388	726	964	159
Field social work	92	37	8	44	3
Social work with families	633	214	108	283	28
Psychotherapy	712	312	105	216	27
Work therapy in the facility	3107	1530	400	989	173
Work therapy outside the facility	1334	519	284	428	121
Vocational training	146	64	26	54	1
Assistance in finding employment	389	214	61	90	24
Assistance in obtaining and increasing work activity	758	402	97	210	49

[105] Report 13-01 of the MLSAF
[106] More than in the NMCD survey, which was carried out on a voluntary basis

Arrangement of follow-up services	102	40	17	39	6
Follow-up monitoring of the effectiveness of social reintegration	262	110	56	82	14
Other	51	20	7	22	2

Fig.9.6 Selected specialised activities carried out by social reintegration centres (Data source: MLSaF)



9.1.1 Quality of social reintegration centres for drug problems and other addictions

The output of the second activity of the twinning project are standards and good practice presented in the document of the same name which can be obtained from www.infodrogy.sk They represent a set of rules (postulates) for a number of categories of activities which are undertaken by all SRCs including the formal particulars for establishing a SRC, records and documentation on clients, external and internal diagnostics, the social and professional case history, the preparation of an individual procedure for social reintegration (conditions for entry), service and the programme for work with clients and groups, preparation of a programme for future activity, conclusion of the social reintegration programme, direction and follow-up care during integration in society after the completion of the programme. Special attention is given to children (implementation of court judgements – social supervision measures). Another large group is standards for the management and development of human resources including the managers, employees and volunteers working in the various social reintegration centres with support for continuing education and the acquisition of knowledge, abilities and skills. In addition minimum standards are proposed for material and financial conditions and resources. The section on effectiveness, monitoring and evaluation recommends as a minimum standard an annual report and regular evaluations of activities (e.g. evaluation of the programme of the SRC) and good practice includes discussing the conclusions of the evaluation of an activity with clients.

9.1.2 Measures in relation to marginalised groups

Community social work programme

187 end beneficiaries took part in the Community Social Work Programme[107] (CSW Programme) in 2007 (183 municipalities and 4 NGOs). As at 31 December 2007, 217 community social workers, 377 assistant community social workers and 17 local coordinators working in the field were employed by the participating municipal authorities under the CSW Programme[108].

The priority target groups of the programme are the inhabitants of socially isolated and segregated Roma communities. A specific feature of this target group is the accumulation of problems (problems with unsuitable housing, failure to pay rent, debt to loan sharks, unemployment, poor use of leisure time, drug and other addictions etc.)

According to information from the MLSAF the CSW programme has great potential in the area of community selective prevention represented by activities such as remedial lessons for children in community centres combined with information on drug problems, presentations and seminars on drug issues for children and young people, presentations and seminars on drug issues for adults carried out in cooperation with experts or former addicts who have succeeded in completing treatment and remaining drug free, the provision of leisure activities for children and young people in the form of creative activities or with themes relating to health education in cooperation with health outreach assistants[109] and cooperation in organising meetings of abstaining alcoholics. An activity that was recommended as good practice was regular seminars on healthy lifestyle for elementary school pupils that were directly incorporated into regular teaching hours in schools. Another good practice is requiring participation in an anti-drug seminar organised by CSW staff as a condition for admission to a disco for young people.

Outreach workers cooperate on addiction problems with health facilities (psychiatric wards, children's psychiatric wards, general practitioners, infectious disease wards, anti-alcohol treatment wards), with police officers in the local and national police forces, the offices of labour, social affairs and family, the Slovak Red Cross, crisis centres, municipal authorities and NGOs.

9.2 Prevention of drug related crime

9.2.1 Assistance to drug users in prison

Prevention in penitentiary facilities is generally organised in the form of individual and group activities. The individual approach involves counselling and/or therapeutic procedures. These comprise mainly individual interviews with convicts suffering from mental or emotional problems[110].

Group activities are categorised in the following three groups:

"Socio-psychological exercises" - these are typically focussed on convicts who have committed a crime under the influence of alcohol or drugs or who used drugs before committing a crime. The objective is, on the one hand, to increase awareness of their actions (better self-knowledge) and on the other hand to develop skills that reduce the probability that the convict will not return to drugs on release from prison.

[107] MLSaF (2008) report for NMCD by Eva Czuczorová E.
http://www.socialnainkluzia.gov.sk/si/index.php?SMC=1&id=154

[108] SKK 132 million was allocated from the state budget to the Program for the support of the development of community social work in municipalities (the CSW Programme).

[109] Health support programme for marginalised communities - Ministry of Health programme

[110] Caused by the use of addictive substances before imprisonment or the commission of a crime under the influence of an addictive substance.

"Group counselling" - educational activities conducted in the form of discussions, seminars, video screenings and lectures on anti-drug topics or the prevention of the hepatitis and HIV viruses.

"Rest and recreation activities" - these activities are not primarily focussed on convicts with drug addictions but also give such convicts an opportunity to participate in active forms of relaxation.

A long term project of the GD PCGF for the prevention of drug related crime is the operation of so-called "drug free zones" (totally 367 places in six penitenciary facilities) in response to current patterns of drug use in society. The objective of the drug free zones is to prevent drug use and to prevent convicts from becoming addicts. In its work it uses different forms of education and activities to support and develop healthy lifestyles, including the development of personal and social competences.

9.2.2 Penitentiary and post-penitentiary care

The activity of probation and mediation officers is primarily focussed on offenders, especially when serving on probation. The purpose of probation activities, especially supervision during probation, is to monitor and check the behaviour of the offender in order to ensure public safety and reduce the risk of reoffending and also the professional guidance and assistance of offenders (e.g. those who committed crimes under the influence of drugs) to ensure that in future they lead a normal life. (Mrázek, 2008).

The probation and mediation system was introduced in 2004 but became fully operation only gradually as the new Criminal code111 took effect because proceedings that began before the new Criminal Code and Code of Criminal Procedure entered into force (i.e. before 1 January 2006) were completed in accordance with regulations in force to 31 December 2005.The first relatively complete year for the collection of valid statistical data is therefore 2007.

Out of a total of 7 518 cases involving probation and mediation in 2007 the proportion that involved drug related crime112 was 8.1% (i.e. 607 cases). The most cases involving probation and mediation were in Bratislava Region (472) and the fewest were in Prešov Region (10). Values for the other 6 regions can be found in Table 9. 2.

Table 9.2: Number of involving probation and mediation for crimes under sections 171 - 174 of the new Criminal Code and sections 186 - 188a of the old Criminal Code, by region (Source: Mrázek, P.: MJ, 2008)

Regional court	Probation-mediation in 2007	
	sections 171 - 174 of NCC	sections 186 - 188 of OCC
Bratislava	422	50
Trnava	24	3
Trenčín	6	5
Nitra	14	6
Žilina	11	9
Banská Bystrica	24	4
Prešov	8	2
Košice	18	1
Σ	527	80

Note: The probation and mediation service is operated by probation and mediation officers in district courts in the Slovak Republic (45) though the statistical report is organised by region (8).

[111] The new Criminal Code (Act No. 300/2005 Coll.) and the Code of Criminal Procedure (Act No. 301/2005 Coll.) both entered into force on 1 January 2006.

[112] Under sections 171 - 174 of the NCC and sections 186 - 188a of the OCC.

10 Drug markets

Pervitin reinforced its position in the Slovak drug market in 2007. There was an increase not only in the number of users but also in the number of laboratories producing it.[113] The position of marihuana also strengthened (in terms of continuing increases in its availability). The long term downward trend in demand for heroin continued, especially in Central Slovakia, where it almost disappeared from the drug market in 2007.

The centre of drug related crime in terms of quantities of drugs seized was the Bratislava Region in 2007[114].

There was a 22, 5% increase in the total number of seizures compared to 2006. The types of drugs seized most frequently were marihuana (1 289) and pervitin (690). In the case of pervitin, this represents an increase of 50, 3% compared to 2006.

The purity of ecstasy increased (from 14.3 mg MDMA/tablet in 2006 to 63.3 mg MDMA/tablet in 2007) while the active ingredient content of other drug types (marihuana, cocaine, hashish, pervitin, AMT) was slightly lower than in the previous year.

The synthetic drug 2 - CB was seized in Slovakia for the first time in 2007.

There was a significant fall in seizures of mCPP in the studied year (from 10 368 tablets in 2006 to 2, 5 tablets in 2007).

10.1 Availability and supply

Reducing the supply of drugs and their precursors is one of the key policy fields in the strategy for anti-drug policy of the Slovak Republic, which is based on the EU drugs strategy 2005 - 2012. Reducing the supply of drugs includes law enforcement, repressive and legislative measures implemented by institutional players in the area of penal law (MI, GPO, and MJ) at different levels of the legal system.

10.1.1 Perception of the availability of drugs in the general population

The latest Eurobarometer Flash Survey mapped the availability of selected illegal drugs[115] in 27 EU states including Slovakia[116] through a telephone survey of a sample of 12 312 respondents in the 15 - 24 age group. The availability of illegal drugs was studied through the question: “how difficult would it be for you to get hold of any of the following substances if you wanted to: heroin, cocaine, ecstasy, cannabis[117]?”

This survey showed that the most available drug remained cannabis (marihuana/hashish), with 70% of Slovak respondents (average for 27 EU states – 64% of respondents) saying they thought it would be fairly easy to or very easy for them to acquire it and only 26% of young people in Slovakia saying that it would be fairly difficult or very difficult to acquire it compared to an EU average of 34%. For more than 75% of young Slovaks it would be fairly difficult or very difficult to obtain heroin or cocaine while 41% of Slovaks in the 15 - 24 age groups said that it would be fairly easy or even very easy to get hold of ecstasy. (Source: Eurobarometer Flash, 2008)

[113] The first pervitin laboratories were detected in Eastern Slovakia.
[114] Nevertheless, there was a gradual balancing of regional differences.
[115] Heroin, cocaine, ecstasy and cannabis
[116] The Slovak part of the project was conducted by the Fokus agency using a sample of 500 respondents
[117] Respondents could choose from the following options: very difficult, fairly difficult, fairly easy or very easy, respondents could also choose none of the above.

10.1.2 Sources of drug supplies – production and trafficking

The following information is based on the reports of the National Anti-drug Unit of the Organised Crime Office in the Presidium of the Police Force (NADU OCO PPF), which obtains information through its operations and investigations.

The drug that is most frequently abused (2007) in the Slovak Republic was and continues to be marihuana. This is shown by statistical data from the MJ according to which the majority of convictions for drug related offences related to marihuana (58.7%).

In 2007 most marihuana was grown in laboratory conditions, so-called "indoor cultivation"[118]. Plants were cultivated using seeds obtained mainly from Holland or Austria. There were also attempts to grow marihuana from grafts or shoots from high quality plants. Marihuana was grown mainly in modified family houses (cellars) or in rented buildings (warehouses) and locations were changed frequently in order to maintain secrecy.

According to information from the NADU OCO PPF, the consumption and cultivation of this drug increases every year. An alarming fact in 2007 was the incidence of marihuana in universities and secondary schools and its increasing frequency even in the second stage of elementary school. The increase in the use of marihuana/hashish amongst secondary school students was confirmed by the Slovak section of the ESPAD survey[119]. The survey was based on a sample of students aged 15 - 19 and was conducted in March 2007[120]. The survey confirmed the continuing rise in experience of marihuana (used once or more times in life) observed since 1995 (12.4%) in 1999 (23%), 2003 (35.5%) and 2007 (43.9%). (Nociar A, 2007). Declared experience of marihuana in the 2007 ESPAD survey[121] broke down as follows: 51.5% - 19 year olds, 43.9% - 18 year olds, 40.6% - 17 year olds, 32.1% - 16 year olds and 20.1% - 15year old students.

Use of hashish remains localised in the Arab community in Western Slovakia (Piešťany). The drug was mainly imported to Slovakia by citizens of states that are attractive for tourists (Spain, Egypt, and Morocco).

The most widespread drug after marihuana was pervitin. More and more people are consuming it for its stimulant effects. According to information from the NADU OCO PPF, pervitin was produced in Slovakia using the precursors of ephedrine/pseudoephedrine which are imported to Slovakia mainly in tablet form under the name Efedrin Arsan from Hungary and Turkey.

Methamphetamine (Pervitin) was produced:

- in specialised laboratories with high productivity and quality, for distribution not only to other Slovak regions but also in smaller quantities[122] to Hungary and Austria.
- in small so-called "kitchen" laboratories where the cooks can prepare batches of about 10 - 20 cm^3 of the drug (200–400 doses with a total value of around EUR 2 400 - 3 600)[123]. The production of such laboratories is lower but production took place more often. The production of pervitin very often involved abuse of medicines that are sold over the counter in our market and contain ephedrine/pseudoephedrine (Modafen, Nurofen, and Clarinase) and also over the counter medicines imported from Hungary and Austria.

When it was distributed pervitin was often diluted with Kalikor or other medicines. In 2007 the NADU OCO PPF observed an increase in pervitin laboratories, including the first

[118] This method allows several crops of high quality marihuana to be grown each year with a high THC content.
[119] http://www.infodrogy.sk/ActiveWeb/c/3272/prezentacia_vysledkov_slovenskej_casti_prieskumu_espad_2007_.html, 14.3.2008
[120] The ESPAD survey has been carried out in Slovakia every four years since 1995.
[121] Nociar, A. 2008, ST02 for REITOX
[122] The reason is the fact that the quality of pervitin decreases very rapidly and must be kept cool at all times. This prevents its subsequent transport and smuggling over large distances or its long term storage.
[123] The average exchange rate for the euro in 2007 is SKK 33.78 / EUR 1, www.nbs.sk

laboratories in Eastern Slovakia (in and around Košice), where it had previously only been imported.

The heroin on the Slovak drug market in 2007 came from 2 sources:

- natural[124], smuggled to our country from Afghanistan via the Balkan route (brown to black in colour),
- or semi-synthetic[125] (usually white).

As in previous years, sale of the drug centred on the Bratislava and Trnava regions where dealers bought it and distributed it to other parts of Slovakia. Heroin was imported to our territory by organised groups of ethnic Albanians or persons close to the Albanian community living in Slovakia (the drug was most frequently smuggled in the body of cars and lorries). Information obtained by the NADU OCO PPF shows a long-term decline in demand for heroin.

Cocaine was often taken experimentally or in combination with other drugs. Information obtained by the NADU OCO PPF indicates that like other drugs (heroin, cannabis etc.), its sale is concentrated in the Bratislava area and larger population centres where people have more money to spend. Cocaine trafficking was under the control of organised groups belonging to the Albanian ethnic group with links to organised crime in South America and the Caribbean. Increasingly citizens of Nigeria and the neighbouring African states are involved in cocaine trafficking and Slovak citizens have been exploited as couriers. The supply of cocaine imported to Slovakia was limited to a small group of wealthy customers.

Ecstasy continued to be imported to Slovakia from neighbouring states and Holland. Imports in large quantities were immediately distributed to other persons or groups (according to demand) in other regions of Slovakia. In most cases it was distributed together with pervitin[126]. It was sold mainly in discos or at events where young people got together to have fun[127]. The rising trend in experimentation with ecstasy can also be seen in the Slovak part of the 2007 ESPAD survey (students aged 15 - 19). According to Nociar (2007), 0.2% of the surveyed age group had tried ecstasy in 1995, 1.5% in 1999 and 5.6% in 2003. The 2007 ESPAD survey[128] reported that 10% of 19 year olds, 6.4% of 18 year olds, 5.6% of 17 year olds, 5.6% of 16 year olds and 2.8% of 15 year old students had experience of ecstasy (Nociar A, 2008, ST02 for REITOX).

The new psychoactive substance mCPP, which began to appear on the Slovak drug scene in 2006, has been on the list of banned narcotic and psychotropic substances[129] since 1 November 2007. Possession, production, import, export or distribution of this substance is therefore a crime.

LSD, magic mushrooms, durman and other drugs are used only occasionally in Slovakia. There is no organised market in such drugs in our country.

In 2007 the synthetic drug 2-CB began to appear in our market. It is a hallucinogen with aphrodisiac and stimulant effects (Páleníček, T et al., 2004, p. 20). It is also known in the drug market under the name “Erox”, and is sometimes sold as ecstasy in night clubs and discos.

[124] produced directly from opium poppies
[125] obtained from medicines containing morphine
[126] If dealers did not have ecstasy and there was demand for it, they knew where they could buy it or exchange it for pervitin.
[127] If dealers did not have ecstasy and there was demand for it, they knew where they could buy it or exchange it for pervitin.
[128] Nociar, A. 2008, ST02 for REITOX
[129] Act No. 139/1998 Coll. – on narcotics, psychotropic substances and preparations

10.2 Drug seizures

This section of the report is based on information from the Forensic Expertise Institute of the Police Force (FEI PF) and the Customs Criminal Office (CCO) and summarises EMCDDA standard table no.13 on drug seizures. Seizures of the following drugs were higher than in the previous year: pervitin (+231), marihuana (+185), ecstasy (+13) and hashish (+3), while there was a fall in seizures of the following drugs: cocaine (-9), AMT (-3) and heroin (-2)

The total number of seizures (the drugs specified in table ST 13 together with seizures of other types of drugs[130]) in 2007 was 2 350, which represents an increase of 22,5% compared to 2006 and 36.1% compared to 2005 (specific numerical values are shown in fig. 10.1).

The largest increase in seizures in 2007 was in pervitin (231 more seizures than in 2006). Seizures of this drug have been increasing since 2004 (see tab. 10.1).

The number of seizures of marihuana (1 269) and also the volume seized (115.27 kg) have been rising for many years. Marihuana accounted for 54% of all seizures in 2007 (fig. 10.2 and fig.10.3). Alongside the increase for marihuana and pervitin there was a slight rise in seizures of ecstasy and hashish. In the case of ecstasy there was a fall in the number of tablets seized (from 13 403 in 2006 to 2 115 in 2007)[131].

There was no very significant change in the quantities of drugs seized in 2007 (levels were approximately the same as in 2006). In addition to ecstasy, there were noticeable falls in the quantity of AMT and cocaine seized (see table 10.1).

Table 10.1: Number of seizures and quantities of drugs seized in the Slovak Republic (2005–2007), ST 13, FEI PF (A Bolf), 2008

YEAR		2004		2005		2006		2007	
Drug	unit	number of seizures	amount seized	number of seizures	amount seized	number of seizures	amount seized	number of seizures	amount seized
Hashish	kg	29	0.96	29	0.27	30	0.54	33	0.742
Marihuana	kg	786	70.68	981	34.82	1059	81.97	1269	115.27
Cannabis plants	kg	31	1474.79	58	1137.92	40	614.37	20	706.87
Heroin	kg	167	2.34	235	3.71	214	2.43	212	2.15
Cocaine	kg	12	1.98	18	0.36	25	0.96	16	0.103
AMT	kg	1	0.009	9	0.014	6	6.96	3	0.00388
Pervitin (meth-amphetamines)	kg	280	1.46	326	1.99	459	1.3	690	1.337
Ecstasy	tablet	37	2387	26	1698	34	13403	47	2115
LSD	dose	6	207	2	11	1	100	1	1
Other		58		42		50		59	
Total		1407		1726		1918		2350	

Note: Other drugs seized in 2007 include the following substances: m-CPP, 2C-B, psilocin (mushrooms), flunitrazepam, diazepam, bromazepam, ethylmorphine, zolpidem, morphine, midazolam, temazepam, pentazocine, klonazepam, buprenorphine, oxycodone, diphenoxylate and methadone.

[130] All other types of drugs that are not specified individually in the standard EMCDDA table on seizures (ST 13)

[131] The significance difference was due to a one-off seizure of a large quantity of mCPP in 2006 with a total volume of 10 368 tablets.

Fig. 10.1 : Seizures of illegal drugs in the Slovak Republic, 2002–2007, FEI PF, (A Bolf) 2008

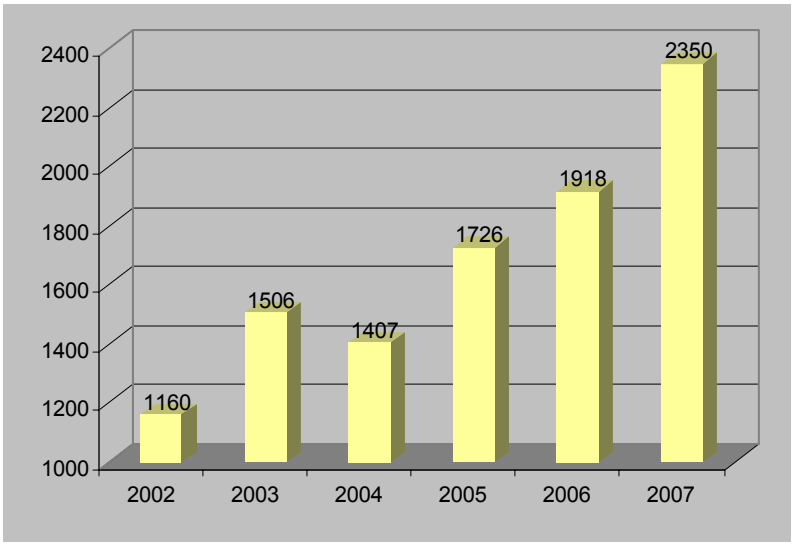


Fig. 10.2: Percentage share of seizures of individual types of drug in 2007 in the Slovak Republic, FEI PF, (A. Bolf) 2008

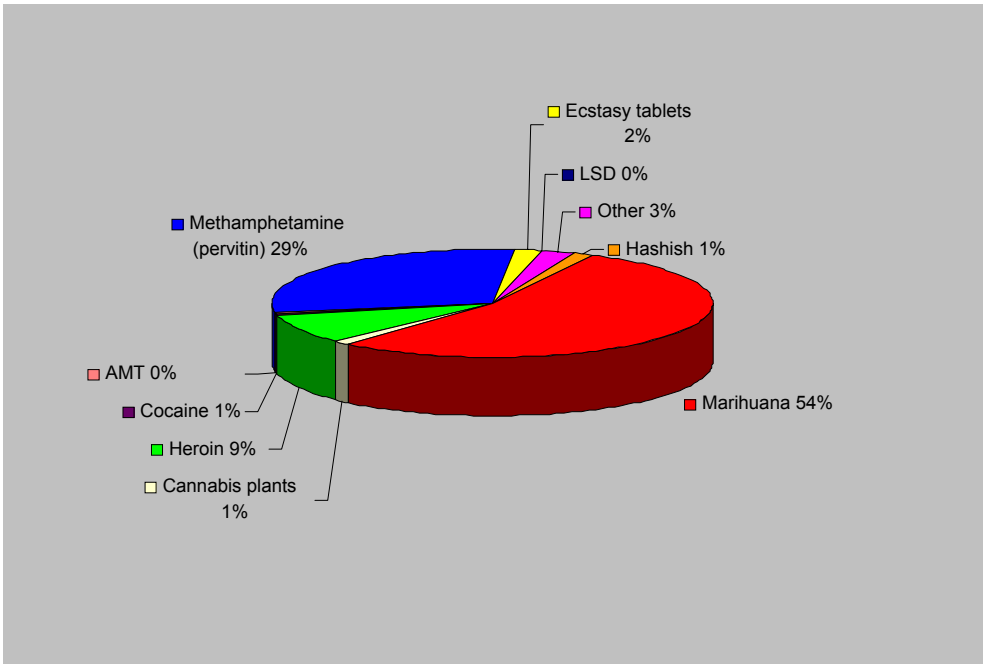
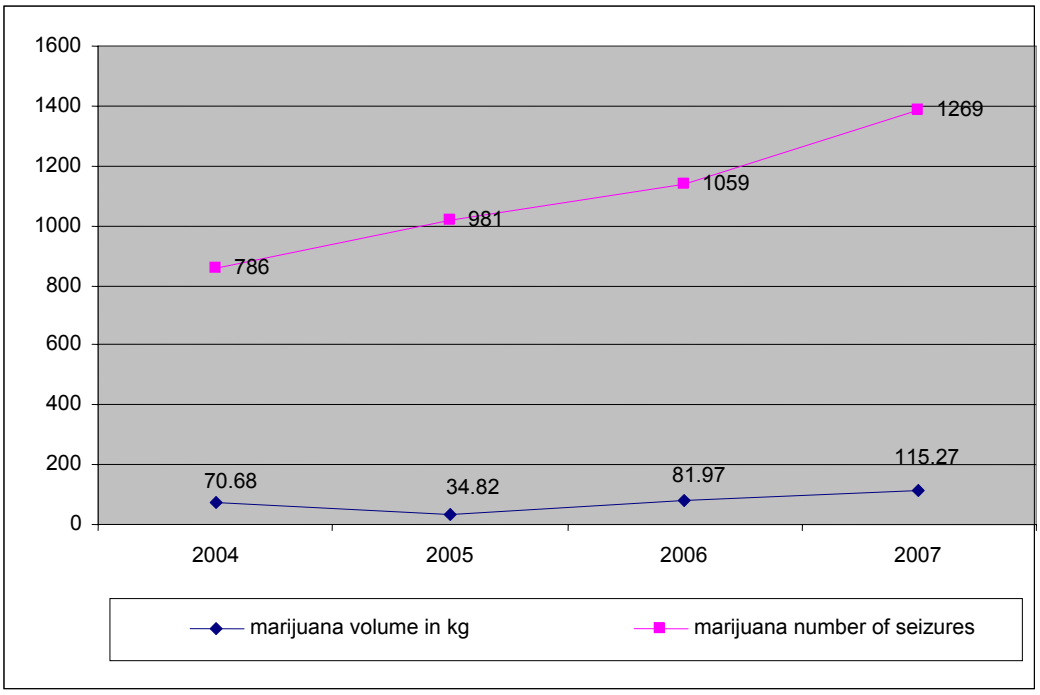


Fig. 10.3: Development in the number of seizures of marihuana and the quantity of marihuana seized (2004–2008) ST 13, FEI PF (A Bolf), 2008



10.3 Price and purity of drugs

10.3.1 Drug prices

Information on drug prices are not studied statistically or recorded in Slovakia. The following information is based on information acquired by officers of the NADU OCO PPF in the course of their operations and investigations.

In 2007 there was a sharp fall in the price of ecstasy (the bottom price was SKK 250 less than in 2006 and the top price also fell by exactly SKK 100). One of the factors in the reduction in price could be the low “dumping” price of the drug’s competitor mCPP (100 - 200 SKK/tablet), which has gradually been pushing ecstasy out of the market since 2005.

The price of marihuana varies according to the concentration of the active THC content. The lowest price was found in the lowest quality product, i.e. the lowest THC content in the dose. The higher is the level of THC in the dose, the higher the price (see Table 10.2).

Information from the NADU OCO PPF indicates that the price of cocaine has declined recently and the price of 1 g is now comparable to that of pervitin. The reason for the increase in the number of users of pervitin may be its greater availability in comparison with the availability of cocaine.

The drug mCPP was offered at a low “dumping” price (100–200 SKK/tablet) with a view to increasing sales, especially in lower income groups (secondary school and university students).

Drug prices in the regions vary according to the following factors: The quality (concentration of active chemicals), origin (organic/synthetic), supply and demand in each region and also according to the price and availability of the precursors for drug production. (See Table 10.2). In general the price of drugs is higher in regions where the population has greater purchasing power (Bratislava, Western Slovakia). Pervitin and cocaine were exceptions, being most expensive in Eastern Slovakia. According to the National Antidrug

Unit the probable reason may have been increased demand and low availability of these drugs in this region.

Table 10.2: Retail/wholesale prices of drugs by region of the Slovak Republic in 2007 (NADU OCO PPF, 2008)

Drug/region	**"Retail" price** (SKK/dose, tablet)			
	Bratislava	**Western Slovakia**	**Central Slovakia**	**Eastern Slovakia**
Marihuana	80-150	100-300	50-250	50-100
Pervitin	300	300	200-400	500
Heroin	200-300	300	200-300	NA
Cocaine	2 400–3 000/g	2 000–2 400/g	500	NA
mCPP	100-200	NA	100-200	NA
MDMA (ecstasy)	150-200	300-500	150-400	180-300
	"Large quantity" price (SKK/g, cm^3)			
Marihuana	500–700/g	500/g	700–1 000/g	300–400/g
Pervitin	1 100–1 700/cm3	900–1 500/cm^3	1 100–1 700/cm^3	1 100–1 600/cm^3
Heroin	700–1 200/g	600–1 200/g	500–1 000/g	NA
Cocaine	2 000/g	2 000/g	2 500–3 000/g	2 500–3 000/g
mCPP	–-	–	–	–
MDMA (ecstasy)	NA	NA	50–70/tablet	250/tablet

Note: There is no precise definition of the term "larger quantity". According to information from the NADU OCO PPF even quantities of tens of grams can be considered a larger quantity. In the case of cocaine and heroin it is around 200 - 300g. Pervitin "spoils" quickly (it lasts only 2–4 days) so even 50 g can be a large volume.

10.3.2 Purity and ingredients of drugs

Drugs seized in Slovakia are analysed by the FEI PF in Bratislava and its laboratories in Banská Bystrica and Košice. Central records are kept by the IFS in Bratislava.

In 2007 the FEI PF carried out 3 166 quantitative analyses of drugs, which is 22.1% more than in 2006 (2 592 analyses) and 36.3% more than in 2005 (2 323 analyses) (fig. 10.5).

In comparison with 2006 there were fewer seizures and a smaller number of seized tablets containing mCPP together with MDMA (2 seizures of one tablet), which meant that in 2007 there was a higher average MDMA content in tablets (fig.10.6).

The concentration of active chemicals in heroin was approximately the same in 2007 as in 2006.

The average concentration of active chemicals (median value) continued its long term rising trend up to 8.3% in 2007 (table 10.4).

The average concentration of pervitin decreased slightly in 2007 according to both statistical indicators - median 64.2%, weighted average 59.6% (table 10.3).

The concentration of active chemicals in hashish was lower for the third consecutive year (the median was 13.1%, which fell to 9.1% in 2007).

The concentration of active chemicals in cocaine was effectively unchanged for the fourth consecutive year, at a median level of around 35%.

Fig. 10.4: Development in median concentration of selected drug types in the Slovak Republic (2004 - 2007), ST 14, FEI PF (A. Bolf) 2008

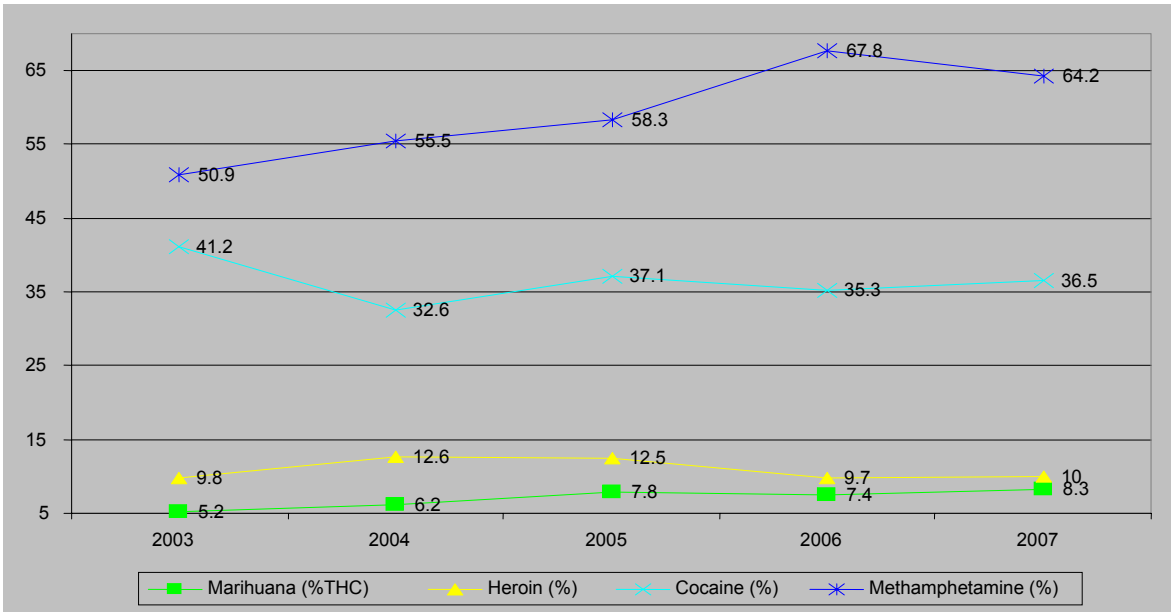


Table 10.3 Weighted average and median concentration of active chemicals in selected drug types in Slovakia 2005–2007, ST 14, FEI PF (A. Bolf) 2008

YEAR	2005			2006			2007		
Concentration of active substances in	number of samples	Weighted average	median	number of samples	Weighted average	median	number of samples	Weighted average	median
Hashish (% THC)	32	13.2	12.8	34	9.8	10.2	33	8.2	9.1
Marihuana (% THC)	1219	6.1	7.8	1379	6.4	7.4	1763	4.9	8.3
Heroin (%)	898	12	12.5	1224	8	9.7	1450	10.2	10
Cocaine (%)	20	34.8	37.1	29	45.8	35.3	28	35.2	36.5
AMT (%)	10	12.8	40.5	3	6.5	5.9	5	4.3	6
Methamphetamines (%)	386	46.7	58.3	636	61.7	67.8	867	59.6	64.2
Ecstasy (mg MDMA per tablet)	1684	52.7	54.6	13398	14.8	53.9	2115	63.3	78

Fig. 10.5: Number of quantitative analyses of drugs performed in the Slovak Republic, 2004–2007, FEI PF (A. Bolf) 2008

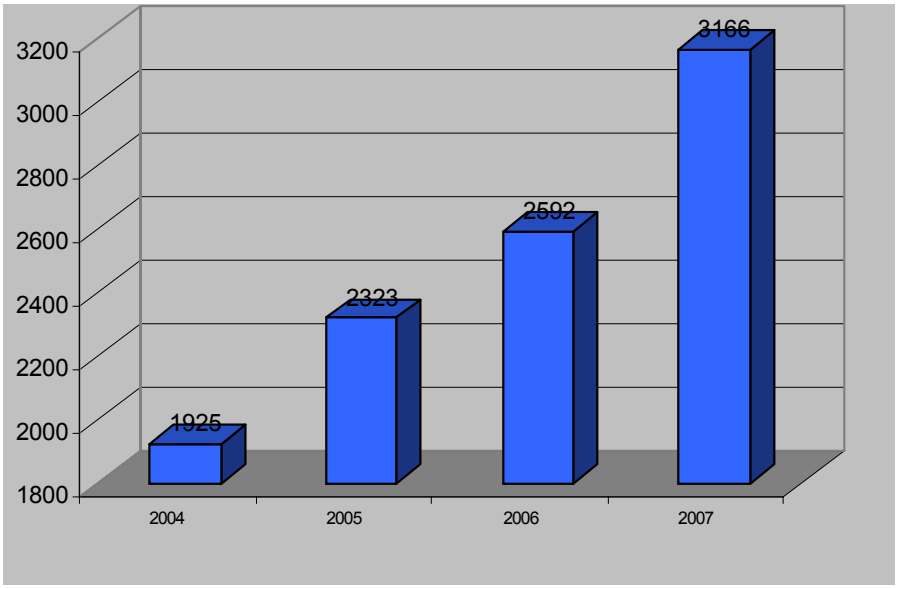
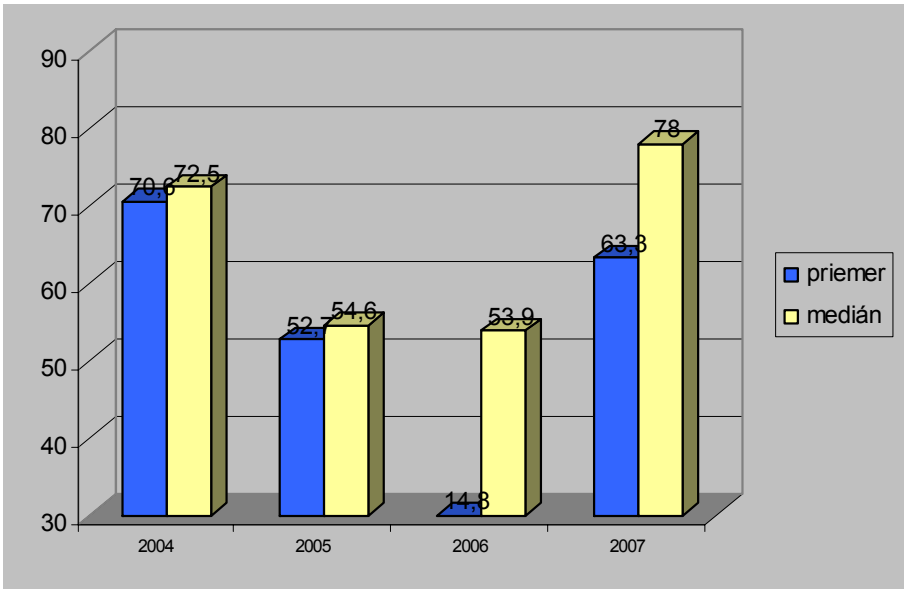


Fig. 10.6: Average MDMA content in mg/tablet, 2004–2007, ST 14, FEI PF (A Bolf), 2008



11 Sentencing statistics

The specific theme of this chapter means that it differs in structure from the other chapters in the Annual Report because it provides mainly information on the technical character of statistical records.

Summary

In the Slovak Republic criminal justice data is recorded in three independent statistical systems the Ministry of Interior (MI), the General Prosecutors Office (GPO) and the Ministry of Justice (MJ)), which are not mutually compatible. The MI system includes statistics for the whole police force [132](PPF), the military police, the prison and judicial police force, the railway police and the Customs Criminal Office (CCO). The central statistics of the GPO record data from the districts of the 8 regional public prosecution offices[133] and separately from the military prosecution offices[134]. The MJ statistical system[135] records information from the following sources: 54 district courts, 8 regional courts, the Special Court and the General Directorate of the Prison and Court Guard Force (GD PCGF).

Statistical records of offenders in relation to the possession of drugs for personal use; producing, selling or dealing in drugs and also driving under the influence of drugs are considered in the report only from the perspective of the criminal justice system because they are acts that are defined as crimes in the law of the Slovak Republic.

The legal framework for the control of drug supply in the Slovak Republic is provided through the applicable Criminal Code[136] and Code of Criminal Procedure[137]. The application of the above codes only in cases that clearly relate to a psychoactive substance that is listed as a controlled substance pursuant to Act No. 139/1998 Coll. on narcotics, psychotropic substances and preparations[138].

The general effects of the changes to drug legislation in 2005 were as follows: "there was increased differentiation and individualisation of the criminal liability of individuals; there was a change in the general philosophy of sentencing, with an emphasis on an individual approach to criminal cases based on the possible use of alternative penalties[139] and deterrents to provide positive motivation for offenders (Čentéš J., 2007, p. 70). In practical terms, the new criminal code reduces penalties for the possession drugs for their personal use (NCC section 171) and increases penalties for persons who produce, deal or traffic in drugs (NCC section 172).

Legislative provisions on drug in driving are described in detail in the 2006 Report.

[132] The following police units have responsibilities in relation to drugs: the NADU OCO PPF (which takes part directly in the investigation of grave drug crimes), FEI PF (which analyses all drugs seized and new psychoactive substances, determining their purity and composition).

[133] Regional public prosecution offices: Bratislava, Trnava, Trenčín, Nitra, Žilina, Banská Bystrica, Prešov and Košice.

[134] The higher military prosecution office in Trenčín and 3 military prosecution offices (Bratislava, Banská Bystrica and Prešov).

[135] The central statistics of the MJ do not include cases from the Supreme Court and the 3 military courts, which keep their own statistics

[136] Act No. 300/2005 Coll., in force from 1.1.2006 which modified the treatment of drug crime under Act No. 140/1961 in force to 31.12.2005.

[137] Act No. 301/2005 Coll.replaced the previous Act No. 141/1961 with effect from 1.1.2006.

[138] The act defines the conditions for the cultivation, production, control, wholesale distribution, issuing, use (for scientific research and forensic activities), import, export and transit of narcotics, psychotropic substances and preparations.

[139] The new Criminal Code introduced the following new alternative forms of punishment: community service, section 54 and home curfew section 53

11.1 Classification of drug related crimes

The monitored offences a) drug use/ personal possession, b) production, dealing or trafficking c) drug in driving are defined in Slovak law as follows:

a) possession of drugs for personal use

Because the use of drugs is not in and of itself a crime in Slovakia, the first type of crime is covered only by NCC section 171 on the unauthorised possession of narcotics, psychoactive substances, poisons or precursors for personal use. The sentence for offenders ranges from three to five years[140] depending on the quantity of drugs in the offender's possession.

b) drug production, dealing and trafficking

The equivalent section on the stated offence is NCC section 172, which includes the unauthorised production, import, export, conveyance, shipment, purchase, sale, exchange, acquisition, possession and brokering of drugs or precursors for any time. The sentence in this case is imprisonment for 4 - 10 years. An offender shall be sentenced to 10 - 15 years if: they have a previous conviction for a similar offence; the offender offers drugs to a person receiving treatment for drug addiction; the offence took a "graver" form; the offence involved a protected person[141]; the offence was on a larger scale. A sentence of 15 - 20 years imprisonment shall be handed down: if an offender is guilty of an offence resulting in grievous bodily harm or death; if an offender is guilty of an offence against a person younger than fifteen years of age or such a person is involved in the offence or if the offence is "significant" in scale. The most severe penalty of 20 - 25 years or an exceptional punishment of life imprisonment may be imposed if the offender is guilty of an offence that has caused grievous bodily harm to a number of persons or the death of a number of persons; as a member of a dangerous group or if the offence is of a "large" scale[142].

c) endangerment under the influence of an addictive substance (drug in driving)

Criminal liability for driving a motor vehicle under the influence of drugs is not specifically defined in a separate section of the Criminal Code. This act (crime) is covered only by the provisions of section 289 of the NCC "Endangerment under the influence of an addictive substance", which includes both endangerment under the influence of alcohol and other illegal drugs. Penalties are in the range of one to five years with penalties at the upper limit being imposed in the event of a threat to another person's life or health or in cases that involve public transport).

11.2 Responses to criminal offences in the Slovak Republic

The forms and level of sentences/penalties that may be imposed on offenders at different levels of the criminal justice system are laid down in the Criminal Code (Act No. 300/2005 Coll.) and the Code of Criminal Procedure (Act No. 301/2005 Coll.). Administrative penalties for driving under the influence of drugs are laid down in Act No. 372/1990 on misdemeanours.

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[140] The lower tariff is applied to offenders holding at most 3 times the usual single dose while the upper tariff is applied to persons holding between 4 and 10 times the usual single dose.

[141] A protected person is: a child, pregnant woman, relative, dependent person, a person of advanced age, a sick person, a person who is protected under international law, a public official or a person performing duties assigned by law or a witness, expert, interpreter or contractor

[142] The identification of a crime as being on a larger scale, of significant extent or on a large scale depends on the quantity NPS involved in the case and the related extent of the danger to the life and health of users (J. Čentéš, 2007 p. 103)

The following table shows the possible procedures of the authorities responsible for criminal proceedings[143] and judicial authorities in response to the offences of possession of drugs for personal use (NCC section 171), drug production, dealing and trafficking (NCC section 172) and driving under the influence of drugs, which is covered by provisions on the following offence: Endangerment under the influence of an addictive substance (NCC section 289).

Table 11.1: Procedure in response to possession of drugs for personal use

Criminal justice system	Procedure in response to possession of drugs for personal use (NCC section 171)	Statistics recorded
Police	- CCP section 197 dismissal	Yes
	- CCP section 199 opening of criminal proceedings (no later than 30 days from the submission of criminal complaint)	Yes
	- CCP section 206 bringing of charges	Yes
	- CCP section 214 transfer of case (the police officer transfers the case to another authority if the results of the investigation or shortened investigation show that the alleged offence was not a criminal offence but an act that could be classified as a misdemeanour or another administrative offence or could be dealt with through disciplinary proceedings.)	Yes
	- CCP section 215 suspension of criminal proceedings (if charges were not brought)	Yes
	- CCP section 215 adjournment of criminal proceedings (if grounds for prosecution were not found)	Yes
		- rejection of the case - transfer of the case - adjournment - transfer - acceptance
Prosecution office	- CCP section 197 dismissal (if prosecution would be ineffective, the police or the prosecution office may dismiss the case before the start of criminal proceedings).	Yes - after cancellation of a resolution on inauguration. - effective remorse - rejected after cancellation of a resolution on the start of proceedings.
	- CCP section 199 opening of criminal proceedings (if the offender is known. In practice this decision is taken by the police	Yes - submission of indictment
	CCP section 206 bringing of charges	Yes
	- CCP section 214 transfer of case (the prosecutor transfers the case to another authority if the results of the investigation or accelerated investigation show that the alleged offence was not a criminal offence but an act that could be classified as a misdemeanour or another administrative offence or could be dealt with through disciplinary proceedings.)	Yes - other prosecution office - according to the classification of the case

[143] According to section 10 (1) of the Code of Criminal Procedure the authorities responsible for criminal proceedings are police officers and prosecutors.

	- CCP section 215 suspension of criminal proceedings (if charges have been brought) the prosecutor may discontinue criminal proceedings if the act to which criminal proceedings relate did not take place or was not a crime and there are no grounds to transfer the case – e.g. if the police find unknown drugs on an arrestee that are not listed pursuant to Act No. 139/1998 on NPS.	Yes
	- CCP section 216 conditional suspension of criminal proceedings (in proceedings on transgressions – less serious offences) - CCP section 218 conditional suspension of criminal proceedings in the event of the cooperation of an accused person	Yes (separately in the event of cooperation of an accused person)
	- CCP 220 conciliation (in proceedings on transgressions – less serious offences, the prosecutor may decide to approve conciliation and suspend criminal proceedings with the agreement of the accused and the injured party)	Yes - decision on the approval of conciliation and the suspension of criminal proceedings
	- CCP section 228 adjournment of criminal proceedings (the prosecutor shall adjourn criminal proceedings if he or she has submitted a motion for proceedings on a question that he or she is not authorised to decide on in these proceedings)	Yes
	- CCP section 232 proceedings on an agreement on a guilty plea (If there has not been an agreement on protective treatment, protective upbringing, protective supervision or the impounding of property, the prosecutor shall proceed in accordance with section 236 (1)).	Yes - submission of proposal
	- CCP section 234 indictment (after the submission of an indictment the prosecutor may instruct the police officer to provide evidence necessary for proceedings before a court.)	Yes - specific proposed type of punishment (suspended imprisonment, imprisonment, fine etc. See Table 11.2.1 - Courts)
		-adoption of an indictment from another prosecution office - extradition - incorrect entry
Courts[144]	NCC section 46 imprisonment	Yes - non-suspended – youth
	NCC section 47 life imprisonment	Yes - with the possibility of conditional release (CR) - without the possibility of CR
	NCC section 48 external differentiation of imprisonment (minimum, medium and maximum security)	Yes - non-suspended with minimum security - non-suspended with medium security - non-suspended with maximum security
	NCC section 50 – suspended sentence of imprisonment (the court shall set a trial period of one to five years)	Yes -without the imposition of reasonable restrictions (RR) - with the imposition of RR
		Yes
	NCC section 51 – suspended sentence of imprisonment with probation supervision not exceeding 3 years (supervision by probation officers) (NCC section 52 – if the person on whom the sentence has been imposed leads a correct life during the trial period and abides by the conditions of probation and complies with all instructions and	

[144] A has the same powers as authorities responsible for criminal proceedings to undertake the procedures specified in CCP sections 214, 215, 216, 218 and 220.

	restriction the court shall declare that the person has proved himself or herself, otherwise the person shall be imprisoned. Imprisonment may be imposed during the trial period)	
	NCC section 53 – Home curfew (For at most one year during the term of the sentence, the person on whom it is imposed may leave his or her place of abode only with the prior consent of a probation and mediation officer).	Yes (in months)
	NCC section 54 – Community service, (up to 40–300 hours, if the court decides to impose it for a minor offence for which the law allows imprisonment for a maximum of five years	Yes (in hours)
	NCC section 56 – Fine (a court may impose a fine of SKK 5 000 to SKK 10 000 000 on the perpetrator of a crime who obtained or sought to obtain material benefit).	Yes (specific amount)
	section 60 Forfeiture of goods	Yes
	section 83 Impounding of property (if a sentence of forfeiture of property was not imposed pursuant to section 60 (1), the court shall impound property).	Yes (recorded in protective measures)
	section 73 Protective treatment (subsection 2c [the court may order protective treatment if the offender committed an offence] under the influence of an addictive substance or in relation to its use alongside punishment or in combination with a waiver of punishment	Yes, see table no. 11.3 (MJ)

Table 11.2: Procedure in response to drug production, dealing and trafficking

Criminal justice system	Procedure in response to drug production, dealing and trafficking (NCC section 172)	Statistics recorded
Police	The same procedure as for possession of drugs for personal use (previous table)	
Prosecution office	The same procedure as for possession of drugs for personal use (previous table)	
Courts	The same procedure as for possession of drugs for personal use (previous table) NCC section 58 – Forfeiture of property (subsection 2 – The court shall impose the stated punishment if it sentences the offender for the offence of the unauthorised production of NPS, poisons or precursors, possession of such or dealing in such section 172 – the offence of laundering the proceeds of crime) .	Yes

Table 11.3: Procedure in response to drug in driving (Endangerment under the influence of an addictive substance)

Criminal justice system	Procedure in response to driving a motor vehicle under the influence of drugs (NCC section 289)	Statistics recorded
Police	The procedure for the opening and adjournment of criminal proceedings is the same as in the case of sections 171 and 172	
Prosecution office	The procedure for the opening and adjournment of criminal proceedings is the same as in the case of sections 171 and 172	
Courts	NCC section 61 – Banning of activity A court may impose a ban from an activity for one to ten years. (The person on whom the sentence is imposed is banned for the term of the sentence from holding a certain employment or function, from performing a type of work or from performing an activity that requires specific permission and/or special regulations)	Yes - driving ban - employment ban - ban from occupation - ban from function - other ban

11.3 Data collection system

Table 11.4: Data collection systems of criminal justice institutions in the Slovak Republic (Data source: MJ, 2008; GPO, 2008; MI, 2008)

	MI (PPF)	GPO	MJ
Existence of an exhaustive data collection system	Yes Includes statistical data from: - PPF (NADU OCO PPF, FEI PF) - CCO	Yes Includes statistical data from: - regional public prosecution offices (8) - military prosecution offices (4)	Yes MJ statistics bring together data from: - district courts (54) - regional courts (8) - the special court (1) Other institutions in the area of competence of the MJ: Military courts (4), the Supreme Court (1) and the GD PCGF keep their own statistics, though these are published together in the MJ statistical yearbook
Completeness of the data collection system	Yes Monitoring and statistical recording of drug types began from 1 June 2006	Yes Monitoring and statistical recording of drug types began from 1 January 2008	Yes Monitoring and statistical recording of drug types began from 1 January 2007
Reporting period	The period covered by statistics is the year (1 January to 31 December)	The period covered by statistics is the year (1 January to 31 December)	The period covered by statistics is the year (1 January to 31 December)
Interval of reports	Continuously Monthly Quarterly – processing	Continuously at bi-weekly intervals	Continuously Monthly
Statistical unit	Offender - initiation of prosecution Offence (according to the specific section of the NCC or OCC)	Offender - termination of prosecution - accused Offence (according to the specific section of the NCC or OCC)	Offender - convicted Offence (according to the specific section of the NCC or OCC)
Records of multiple offences (committed by a single offender)	The police bring charges against an offender for one or more offences in a single proceeding. The maximum number is set at 99 offences for administrative reasons	7 offences are recorded, without ranking for gravity[145] (Though usually the offence listed first is the gravest)	Up to 9 offences are recorded, in order of gravity (The offence listed first is the gravest)

[145] When presenting statistical summaries GPO states the gravest subsection/section under which the offender is prosecuted - the one with the highest tariff. This means that if an offender committed three offences under

Records of multiple sanctions (imposed on one offender)	NA	NA	4 imposed punishments In order of the gravity of the offence (set by the judge)

Note: The statistical systems of the MI, the GPO and MJ are not currently linked to each other and therefore it is not possible to compare and associate data from the different systems. In 2006 as part of the Twinning Project (GS – further information on the implementation of the project is given in the 2006 report – the situation in drug addiction and drug control in Slovakia, p. 17) it was proposed that unified recording of offenders and offences by drug type should be introduced at all levels of the criminal justice system. The MI, GPO and MJ committed themselves to this agreement and implemented the proposed changes in their statistical systems (for details of introduction, see table no. 11.3 "Completeness of the data collection system")

11.4 Data collected

MI (PPF)

The MI (PPF) statistical system provides data on offences and on offenders in cases where an offender has been charged.

The police collect and record data using the statistical form on a known offender and the statistical form on an offence. These forms provide information on the basic socio-demographic characteristics of offenders, data on previous criminal proceedings/convictions, the number of proven offences, the circumstances of the commission and investigation of the offence and the concurrency of criminal acts and the conclusion of the phase of criminal proceedings within the competence of the police.

GPO

The General Prosecutors Office (GPO) keeps records of the numbers of offenders charged, indicted and convicted of offences and the number of criminal acts.

The GPO collects and records data based on its own statistical record form which is composed of three parts: act, offender and arrest/custody. Offences that have been committed are therefore primary and the starting point of criminal proceedings in relation to an offender/act. The form can be used to determine the length of each phase of the criminal justice process: the dates of the start and end of preliminary proceedings, criminal proceedings, the bringing and cancellation of charges and so on, the conclusion of individual phases of the criminal justice process, taking into custody and the proposed punishment. The form also contains information on previous convictions and punishments.

MJ

The courts (MJ) provide the ministerial statistics with data on offenders convicted of individual offences (including relevant drug related offences under the old and new criminal codes).

The MJ system includes data from Statistics sheet T, which is completed systematically for each convicted offender. The form presents a description of the final phase of the criminal justice process – it determines the final kind and length of sentence and whether the sentence tariff was reduced. As in the case of the previous statistics, this form records the number of previous convictions of the offender and the type of sentence previously imposed. A simplified outline of this data is given in table 11.5

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section 172 (1)(d) the statistics will not show that the offender committed the offence three times but will show a point with a higher tariff because of the repeated offence.

Table 11.5: The character and type of data collected by the systems of Slovak criminal justice authorities

	MI (PPF)	GPO	MJ
Basic characteristics and variables included in each data collection system *(gender, age/date of birth, principal drug involved (and how it is defined as principal), type of outcome given, size of outcome given, recidivism)*	1) The following characteristics of known offenders are routinely monitored: age, gender, citizenship, nationality, family status, education, upbringing, employment, criminal profile of offender (previous offences..), ethnic and national group, number of offences (for intentional or unintentional crimes), proven offences of offender (max. 10). 2) The following aspects of offences are routinely monitored: classification of the act (transgression, wrongdoing, crime), the place in which the offence was committed or detected, use of a weapon, in the case of assault – the person or object assaulted, the classification of the offence under criminal law (for which criminal proceedings were begun, according to the old or new criminal code), concurrency (a further 3 offences that occurred concurrently with the main offence), the conclusion (for specific forms of conclusion, see 11.1)	Section on the offender: - citizenship - occupation - education - motive for offence - violence against people - property damaged as a result of offence - previous convictions - offences committed: under the influence of - alcohol - NPS b) addiction of the offender to addictive substances - alcohol - NPS - protective measures as a result of previous convictions if an offence was committed - persons injured by the offence - proposed type of punishment - proposed protective measures Section on the act: - preliminary proceedings - who decided/acted in preliminary proceedings - police proposal - involvement of a prosecutor in investigations - return for additional work by the prosecutor - identification of offences (max. 7) (the above shall include: stage section, subsection and point of the criminal code , number of attacks, form of criminal collaboration), - form of offence - result of offence - final decision (see table11.2.1)) - expert appraisal - order/consent of prosecutor - foreign legal contacts Section on detaining and securing witnesses: - detention, arrest and securing of witnesses - reason for custody - conclusion of custody in preliminary proceedings	- gender - youth - state / nationality - education - social group - provisions on aggregate punishment[146] - provision on combined punishment[147] – case dealt with – number of previous convictions – last sentence – repeat offender (recognised by court) – time in custody (in preliminary proceedings, court custody) – specific motive for offence (*including drug addiction*) – type of punishment (see table no. 11.1.1) *- length of punishment (in months, hours)* *- protective measures (11.3)* *- qualification of act under old or new criminal code* *- type of offence (transgression, crime, especially grave crime)* *- specific objective of offence (which may include drugs)* - influence of a) alcohol b) a drug or other toxic substance *- type of drug*, record of the following: marihuana (including cannabis derivatives and hashish), heroin, cocaine, pervitin, ecstasy, LSD other (synthetic) drugs, other AMT and abused medicines - number of entries, where all offences committed by the offender are recorded (max. 9)

[146] If a court convicts an offender for an offence committed before the offender was found guilty of another offence by a first instance court, an aggregate sentence shall be imposed (the sentence may not be more lenient than the sentence imposed by the broader judgement). The aggregate sentence may include, amongst other

Records of cases in which no further procedure is necessary / possible (e.g. on grounds of youth, successful treatment)	Grounds for the suspension of criminal proceedings *-rejection of the case* *- suspension of criminal proceedings* *– if there is no evidence that an offence was committed* *- transfer of the case*	NA	No *All cases end with a final court judgement*
Adjournment of criminal proceedings if the offender enters voluntary treatment	Not studied	Not studied	Not studied
Separate records of treatment for addiction to alcohol an illegal drugs	No	Yes In proposals for protective measures. -against alcoholism: inpatient/outpatient -against drug addiction: inpatient/outpatient	Yes In imposed protective measures -against alcoholism: inpatient / outpatient -against drug addiction: inpatient/outpatient
Separate records of driving bans on grounds of the use of alcohol and illegal drugs	No	No	Yes

11.5 Results available

This section of the chapter presents the available results in the form of absolute numbers of offenders to whom the above measures/punishments were applied, organised by offence category (a, b, c) in the last year.

The statistics on the total number of measures/punishments applied in each category of offences in 2007 includes measures/punishments imposed under the new Criminal Code (sections 171, 172 and 289 - NA) and the old Criminal Code (sections 186, 187 and 201 - NA). In 2007 the police submitted a recommendation of indictment in more than half of cases relating to possession of drugs for personal use (51.9% of cases) and proceeded in the same way in cases relating to drug production, dealing and trafficking (70.4%). See Table 11.6

Table 11.6: Measures/penalties imposed by the police for possession of drugs, producing and dealing in drugs and driving under the influence of drugs (Source: MI, 2008)

Possession of drugs for personal use						
conclusion	§171		§186		Σ	
	N	%	N	%	N	%
recommendation to suspend criminal proceedings	16	1.5	0		16	1.5
adjournment of criminal proceedings	265	24.8	0		265	24.8
agreement on guilt and punishment	42	3.9	0		42	3.9

punishments, forfeiture of property, a fine or the banning of activity if such a punishment was imposed in the broader judgement.

[147] If the court finds an offender guilty of two or more offences it shall impose an aggregate (combined) sentence which is based on the offence for which the more severe punishment is stipulated.

proposal of indictment	555	51.9	1	100	556	51.9
recommendation to conditionally suspend criminal proceedings	161	15	0		161	15
proposal to approve conciliation	1	0.1	0		1	0.1
other punishments	30	2.8	0		30	2.8
Total	1040	97.2	1	100	1071	97.2
Drug production, dealing and trafficking						
conclusion	**§172**		**§187**		**Σ**	
	N	**%**	**N**	**%**	**N**	**%**
recommendation to suspend criminal proceedings	6	1.9	0		6	1.9
adjournment of criminal proceedings	7	2.3	2	33.3	9	2.8
agreement on guilt and punishment	77	24.8	0		77	24.3
proposal of indictment	219	70.4	4	66.7	223	70.4
recommendation to conditionally suspend criminal proceedings	0	0	0		0	
proposal to approve conciliation	0	0	0		0	
other punishments	2	0.6	0		2	0.6
Total	311	100	6	100	317	100
Drug in driving - NA						

In 2007, the public prosecution office brought indictments in 44.1% of cases relating to the possession of drugs for personal use and just fewer than 33% of cases proposed the conditional suspension of criminal proceedings. With regard to the offence of drug production, dealing and trafficking, an indictment was brought in more than half the cases (52%), an agreement on guilt and punishment was concluded in over 35% of cases (For further information see table 11.7).

Table 11.7: Penalties imposed by the prosecution office: for possession of drugs, producing and trafficking drugs and driving under the influence of drugs (Source: GPO statistical yearbook, 2008)

Possession of drugs for personal use						
Conclusion / punishment	**§171**		**§186**		**Σ**	
	N	**%**	**N**	**%**	**N**	**%**
Conditional suspension	376	34.5	17	16	393	32.9
Conciliation and suspension of criminal proceedings	1	0.1	0	0	1	0.1
agreement on guilt and punishment	124	11.4	9	8.5	133	11.1
indictment	473	43.5	53	50	526	44.1
Other conclusion	114	10.5	27	25.5	141	11.8
Total	1088	100	106	100	1194	100
Drug production, dealing and trafficking						
Conclusion / punishment	**§172**		**§187**		**Σ**	
	N	**%**	**N**	**%**	**N**	**%**
Conditional suspension	4	0.9	11	6.9	15	2.4
Conciliation and suspension of criminal proceedings	0	0	0	0	0	0
agreement on guilt and punishment	198	43.8	20	12.4	218	35.6
indictment	214	47.3	105	65.2	319	52
Other conclusion	36	8	25	15.5	61	10
Total	452	100	161	100	613	100
Drug in driving – NA						

In the majority of cases where an offender was convicted of the possession of drugs for personal use courts imposed a suspended prison sentence (63.9%). The next most frequent sentence was a fine, imposed in just fewer than 20% of cases. See table 11.8. In the case of convictions for drug production, dealing and trafficking the main sentences were: suspended imprisonment (63.3%) and imprisonment (33.9%).

Table 11.8: Punishments imposed by courts: for possession of drugs, producing and dealing in drugs and driving under the influence of drugs (Source: MJ, 2008)

Possession of drugs for personal use						
Sentence	§171		§186		Σ	
	N	%	N	%	N	%
Imprisonment	48	11.6	6	15	54	11.9
Suspended imprisonment	265	64	25	62.5	290	63.9
fine	82	19.8	7	17.5	89	19.6
other punishments	6	1.5	0	0	6	1.3
waiver of punishment	13	3.1	2	5	15	3.3
Total	414	100	40	100	454	100
Drug production, dealing and trafficking						
Sentence	§172		§187		Σ	
	N	%	N	%	N	%
Imprisonment	72	34.4	36	32.7	108	33.9
Suspended imprisonment	136	65.1	66	60	202	63.3
fine	0	0	8	7.3	8	2.5
other punishments	1	0.5	0	0	1	0.3
waiver of punishment	0	0	0	0	0	0
Total	209	100	110	100	319	100
Drug in driving - NA						

These statistical data are intended primarily for the needs of the criminal justice authorities themselves (the MI, the GPO and the MJ) but are also provided to central state administrative bodies involved in the monitoring of the drug situation and the creation of national anti-drug policy at the state level (the general secretariat of the committee of ministers on drug addiction and drug control, the NMCD), or ad hoc, to other interested parties in the area of drug policy (various research teams carrying out official studies and screening).

The MI prepares annual statistics in a transparent form, which are used mainly for the ministry's internal purposes and may be provided to other Slovak ministries or departments of the Government Office on submission of an official request. Parts of the information (usually specific reports) are published on the website www.minv.gov.sk .

The GPO publishes its annual results and summaries on the website www.genpro.gov.sk It also publishes annual hardcopy in the following publications: "Statistical yearbook of the GPO" and the "Report on the activities of the GPO", which include, amongst other things, a detailed analysis of drug crime from the perspective of the public prosecution office (as defined in the relevant sections of the old and new criminal codes).

The MJ publishes annual outputs from statistical monitoring on the website www.justice.gov.sk and in hardcopy in the publication "Statistical Yearbook of the MJ" The yearbooks of the MJ are provided to relevant organisations in the area of justice, prosecution, interior, education etc.

Part B

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Part C

15 Annexes

15.1 List of Tables

15.2 List of Figures

15. 3 List of abbreviations used in texts

ADF Anti-Drug Fund
ADHD Attention Deficiency Hyperactivity Disorder
ADS Alcohol Dependence Scale
AIDS Acquired Immune Deficiency Syndrome
AMT Amphetamines
BAT Barbiturates
BDZ Benzodiazepines
CA Civil associations
CAGE Cut-Annoyed-Guilty-Eye, screening test
CAST Cannabis Abuse Screening Test
CATI Standardised interview by telephone
CCO Customs of Criminal Office
CCP Code of Criminal Procedure
CCPS Centres for Counselling and Psychological Services
CEPP Centre for educational and psychological prevention
CTDD Centre for the Treatment of Drug Dependencies
CTDD-IDD Centre for the Treatment of Drug Dependencies - Institute of Drug Dependencies
CZ Czech Republic
DRID Drug Related Infection Diseases

EMCDDA European Monitoring Centre for Drug and Drug Additions
EMQ European model questionnaire
EPIS Epidemiological information system
EPPC Educational and Psychological Prevention Centres
ESPAD European School Survey Project on Alcohol and Other Drugs
EU European Union
EUROPAD European Opiate Addiction Treatment Association
FEI PF Forensic Expertise Institute of the Police Force
FreD German model of timely intervention for first-time drug delinquent
GD PCGF General directorate of the prison and court guard force
GPO General Prosecutor Office
GS General Secretariat of the Board of Ministers for Drug Addiction and Drug Control
HAV hepatitis type A
HBsAg antigen hepatitis type B
HBSC Health Behaviour of School aged Children
HBV hepatitis type B
HCV hepatitis type C
HIV Human Immunodeficiency Virus
HCSA Health Care Surveillance Authority
IDU Injection drug user
IIPE Institute of Information and Prognoses of Education
ITR In-treatment rate
LMP Last month prevalence
LSAF Labour, Social Affairs and Family
LSD Lysergic acid diethylamide
LTP Lifetime Prevalence
LYP Last Year Prevalence
mCPP 1-(4-chlorophenyl)piperazine
MDMA metylendioxymetamphetamine
ME Ministry of Education
MF The Ministry of Finance
MGS Grant Scheme of EU project
MH Ministry of Health
MI Ministry of Interior
MLSAF Ministry of Labour, Social Affairs and Family
MJ Ministry of Justice
MO Morphines
MUSTAP Multisession Standardised Printed Programme
NA Not available
NADU OCO PPF National Anti-drug Unit of the Organised Crime Office in the Presidium of the Police Force
NAPAP National Action Plan for Alcohol Problems
NC SR National Council of the Slovak Republic (*Parliament*)
NCMTCHB National Centre for the Management and Treatment of Chronic Hepatitis
NGO Non-Governmental Organization
NHIC National Health Information Centre
NMCD National Monitoring Centre for Drugs
NCC New Criminal Code
NPFD National Program for the Fight against Drugs
NRC National reference centre
OCC Old Criminal Code
OP Opioids
OSF Open Society Foundation
GD PCGF General Directorate of the Prison and Court Guard Force

PDU Problem Drug Users
PHA SR Public Health Authority of the Slovak Republic
PORI at SO SR The Public Opinion Research Institute at the Statistical Office of the Slovak Republic
PPF Presidium of the Police Force
PF Police Force
REITOX The European Information Network on Drugs and Drug Addiction
RICPaP Research Institute of Child Psychology and Pathopsychology
RNA Ribonucleic acid
RPHA Regional Public Health Authority
RR Reasonable restrictions
SKK Slovak koruna
SRC Social reintegration centre /facility, resocialisation centre
SO SR Statistical Office of the Slovak Republic
SQ standard questionnaire
ST Standard table
2-CB 4-bromo-2,5-dimethoxyphenethylamine
SYPH syphilis
TDI Treatment demand indicator
THC Tetrahydrocannabinol
UN United Nations
UNODC United Nations Office on Drugs and Crime
WHO World Health Organization

Part D

List of Standard Tables and Standard Questionnaires submitted to EMCDDA/ Reitox via Fonte reporting system

ST 02:	Methodology and results of school surveys on drug use
ST 03:	Characteristics of persons starting treatment for drugs
ST 05:	Acute direct drug-related death
ST 06:	Evolution of acute/direct related deaths
ST 07:	National prevalence estimates on problem drug use
ST 08:	Local prevalence estimates on problem drug use
ST 09:	Prevalence of hepatitis B/C and HIV infection among injecting drug users
ST 10:	Syringe availability
ST 11:	Arrests/Reports for drug law offences
ST 13:	Number and quantity of seizures of illicit drugs
ST 14:	Purity at street level of illicit drugs
ST 15:	Composition of tablets sold as illicit drugs
ST 16:	Price in Euros at street level of illicit drugs
ST 18:	Overall mortality and causes of deaths among drug users
ST 30:	Methods and Results of youth surveys
ST 34:	TDI data
SQ 27:	Treatment programmes (part I), Quality Assurance treatment (part II)
SQ 23 &29:	Prevention and reduction of health-related harm associated with drug use