



European Monitoring Centre
for Drugs and Drug Addiction



NÁRODNÉ MONITOROVACIE CENTRUM PRE DROGY
GENERÁLNY SEKRETARIÁT VÝBORU MINISTROV
PRE DROGOVÉ ZÁVISLOSTI A KONTROLU DROG
ÚRAD VLÁDY SLOVENSKEJ REPUBLIKY

**2006 NATIONAL REPORT (2005 data) TO THE
EMCDDA**

By the Reitox National Focal Point

“SLOVAK REPUBLIC”

**New Development, Trends and in-depth information on
selected issues**

REITOX

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2006 National Report has been consulted and approved by the members of Advisory body on the issues of monitoring drug situation in Slovakia in October 2006.

Introduction

A year has passed and the National Monitoring Centre for Drugs at the General Secretariat of the Committee of Ministers for Drug Addiction and Drug Control of the Slovak Republic Government Office is submitting already the third National Report on drugs and drug addictions in Slovakia. Compared to the previous two, this report includes several changes.

It is of a much smaller scope than the previous one and yet it contains, in the required structure and according to the requirements of the European Monitoring Centre for Drugs and Drug Addiction, all basic information on the drug issue in Slovakia. It is clearer and more readable. More technical issues and more extensive analyses will be gradually issued by the National Monitoring Centre for Drugs in the Slovak Republic as separate studies and publications and they will comprise its important complementation and extensions. For 2006 already, we have several such studies ready and we believe that we will be able to process and publish them as early as possible, which depend not only on our effort but also on the cooperation with external authors and expert fellow workers.

Another change, even if not that visible, is the move from mostly individually authored contributions by national experts and other specialists in drug field to a higher participation of specialised institutions and to a higher extent of the participation of expert workgroups. The three years of the National Monitoring Centre for Drugs' existence in Slovakia and the growing base of cooperating experts gradually lead to the National Monitoring Centre for Drugs being able to involve greater group of their parent institutions in its work. We have at our disposal incomparably more statistical data, overviews, analyses, surveys, and various summaries and studies compared to previous years. We would hereby like to thank the National Health Information Centre, the Public Health Authority, the Slovak Medical University, the Healthcare Surveillance Authority, the State Institute for Drug Control, the Statistical Office of the Slovak Republic and specially its Public Opinion Research Institute, the Institute of Information and Prognoses in Education, the Ministry of Labour, Social Affairs and Family, the Ministry of Justice, the Ministry of Interior, and the healthcare insurance companies, for their cooperation. We are especially pleased by the amenability of non-governmental organisations in preparation of the National Report on Drugs and Drug Situation in the Slovak Republic.

The least visible, but perhaps for the preparation of the report the most important change is the growing proportion of expert cooperation and the role of expert teams, whose work involves an ever greater number of external fellow workers from all over Slovakia. This was significantly aided by the launch of specialised workgroups' activity for individual key indicators of the European Monitoring Centre for Drugs and Drug Addiction and the ever more active professional leadership by national experts for individual indicators monitored. We believe that this positive trend will only continue which will not only expand the circle of co-authors of the report but will also attract authors of future separate and report-complementing studies, analyses and publications.

The present National Report on Drugs in the Slovak Republic is based primarily on data for 2005; this year was the tenth year since the establishment of the Committee of Ministers for Drug Addiction and Drug Control in the Slovak Republic. In the everyday busy work we have not even realised that ten years have passed since the days when a group of enthusiastic and committed professionals achieved the establishment of an anti-drug, super-sectoral coordination body on the highest political level in the Slovak Republic. Thanks to the cooperation of experts, politicians, state administration and also thanks to the support of deputies of the National Council of the Slovak Republic, the Slovak Republic has already its third National Programme for the Fight against Drugs, which is fully compatible with the European Drug Strategy and its Action Plans. This National Report may be small „thank you” to these experts for their efforts and work they have done and continue doing in the field of the fight against drugs in Slovakia.

The changes in the preparation and presentation of the present National Report include its new graphic layout reflecting the common graphic design, which, from now on, will visually link all

publications of the National Monitoring Centre for Drugs and of the General Secretariat of the Committee of Ministers for Drug Addiction and Drug Control in the Slovak Republic.

In conclusion, I thank the entire author team of the National Report on Drugs and Drug Addictions in the Slovak Republic, the national experts for individual key indicators, and also all those who provided us with necessary data and information. I would specially like to thank the new team of the National Monitoring Centre for Drugs staff, who, under the leadership by the coordinator, Ms. Lucia Kiššová, made a great job in compiling this publication.

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Summary and new trends

In 2005, the present drug strategy, the National Programme for the Fight against Drugs 2004 – 2008, was further developed into Action Plans of ministries and regional authorities. At the same time, a Methodological Instruction of the Slovak Republic Government Office was issued which determines the activities of regional authorities in the field of drugs and unifies the procedure for establishment of regional coordination commissions for drug issues.

In addition to the above, the implementation of the twinning part of the Transition Facility 2004 was launched under the title “Support for the Implementation of the National Programme for the Fight against Drugs in the Slovak Republic for the Period of 2004 – 2008”, whose main task is to strengthen, through communication, the coordination and cooperation of the involved entities operating in the drug field. Except for the Penal Code and the Code on Criminal Procedure, which became effective on 1st January 2006, and Act on Social and Legal Protection of Children and on Social Custody (effective as of 1st September 2005), which are in greater detail mentioned in the 2005 National Report, there were no substantial changes in the legislative, institutional, and executive framework.

The situation in the number of drug users in treatment is relatively stable. It has dropped by 237 patients, whereby the number of clients in treatment got approximately to the level of 2002, and 2003 respectively. In 2005, 2,078 drug users were treated in total, including patients treated in medical facilities of other sectors (e.g. justice). Conversely, by approximately 550 more clients were in contact with social field work organisations in 2005 than in the year before, which is 3,979 clients in total, mostly comprising injecting users and/or users of heroin and pervitin.

According to surveys by the Statistical Office of the Slovak Republic, the lifelong prevalence of heroin use in Slovakia's population has been low in a long term (0.6% and 1.2%, respectively). A similarly low percentage (1.1%) resulted from a survey conducted in 2005 by the Institute of Information and Prognoses in Education (hereinafter “IIPE”) among 15 – 26 years old young people. In 2005 the decreasing trend of opiate users in treatment continued, albeit more moderately, the treatment demand dropped since 2000 by more than 55%. In 2005 there were 857 treatment demands reported. In this year, 14 opiate related deaths were recorded, similarly as in 2004 (13 deaths).

According to both surveys, the experience with pervitin use is relatively low; however, a comparison with previous surveys shows a slight increase. The lifetime prevalence of pervitin use in Slovakia's population increased from 0.6% (in 2002) to 1.5% (in 2004) and, in youth, from 3.4% (2004) to 4.5% (2005). Conversely, for the first time ever, a moderate decrease in the pervitin users in treatment occurred (minus 74 persons, 489 patients treated in 2005); however, their proportion in the total number of the treated has not changed compared to the last year (24 %).

The trend of growing preference for marijuana continued also in 2005. Since 2000, when the lifetime prevalence of marijuana use in Slovakia's population (15 – 64 years) represented 11.7%, it increased to 15.6% in 2004. At the same time, the trend of the increasing treatment demands for marijuana continued with 400 patients treated in 2005, representing 25% share in total amount of treated patients comparing 17% in 2004.

For the time being, cocaine is used only rarely in Slovakia and as the primary drug it was not recorded for any of the low-threshold agencies clients. In 2005, 11 cocaine users were reported from treatment. Cocaine is mostly of recreational – weekend use and is linked to various disco parties, etc. In the five years' period, four cocaine related deaths were reported (in 2000 and 2003).

Certain part of the population of drug users remains hidden, who are not in contact with any therapeutic centre, social services or police/courts. What is worrying is the number of problem drug users whose manner/degree of drug use carries the risks of health, social, or criminal consequences. A study was conducted by the National Monitoring Centre for Drugs has

estimated the number of problem drug users defined as injecting drug users or long-term regular opiate and/or pervitin users at approx. 18,500 (4.8/1000 inhabitants) with the range of 13,500 – 32,000 persons. Of this number, approximately 10 thousands are estimated to be opiate users, 8 thousands are pervitin users and 18 thousands injecting drug users.

The results of the above-mentioned study and the data obtained from social field work organisations indicated insufficient coverage of Slovakia with needle and syringe programmes (harm reduction programmes). In 2005, these services were provided by 6 organisations in 8 cities (for 3,979 clients). Yet fewer than 20% of the estimated injecting drug users (11% - 26%) are in contact with low-threshold agencies. Some areas are not covered at all, e.g., the southern part of Slovakia or the entire region of Žilina.

In 2005, the number of drug-related deaths reported remained on the same level as in the previous year. The total reported number of drug related deaths was 123 with 46 having been due to direct overdose and 77 in the condition of influence of a psychoactive substance. The most frequent cause of death is the abuse of medical drugs, primarily benzodiazepines. In the group of amphetamines and cannabinoids, a decrease in the number of deaths was observed in 2005.

In 2005, no new case of HIV/AIDS infection among injecting drug users was recorded. So far, one drug user is infected with this virus in Slovakia. The incidence of acute hepatitis B in injecting users has been relatively low in recent years. The information from the Regional Health Authority in Banská Bystrica indicates a reduction of the proportion of injection users in the incidence of acute hepatitis C reported (in 2005, their percentage was 28%) as well as in chronic hepatitis C (24.5% in 2005).

The availability of treatment is relatively good. Compared to previous years, waiting periods remain unchanged and their length depends, to a considerable extent, from the health insurance company. In 2005, treatment was provided by 6 specialised treatment centres for drug dependency, 54 workplaces of specialised AT departments of psychiatric hospitals and facilities, and by offices of psychiatrists or psychiatrists specialised in drug addiction treatment. Social reintegration and residential care for clients having received medical treatment were provided by 20 social reintegration centres with the total capacity of approximately 300 beds.

A substitution treatment register is still nonexistent in Slovakia. Until 2005, methadone maintenance programme was available in only one city, namely Bratislava, where it had existed since 1997. (In 2004, 490 patients were included.) In 2005, another methadone maintenance treatment programme was launched in Banská Bystrica. Subutex is used for substitution treatment particularly outside of Bratislava.

Drug use can be understood as a consequence or the cause of social exclusion, which may be, on the one hand, the reason for starting to use drugs, or may lead to a use involving greater problems, while on the other hand, (problem) drug use may cause deterioration of individual's living conditions. One of the social consequences of drug use is crime. In 2005, the number of criminal offences (1,638) committed in relation to production, distribution and consumption of drugs continued to grow, as did the number of prosecuted persons (1,308).

In the given year, the number of persons convicted of drug criminal offences dropped, however, the moderately growing trend of the number of people convicted due to illegal possession of drugs for personal use continued (205 convicts). At the same time, the long-term trend of the falling number of convicts, who committed a criminal offence under the influence of drugs, continued.

The number of drug seizures by law enforcement agencies in 2005 increased, the greatest percentage in the increase being attributable to marijuana seizures (nearly 63%). The growing trend in the number of seizures as well as in the quantity of pervitin seized continued. The quantity of drugs seized further increased for heroin and ecstasy. In 2005, the greatest amount of the mushroom of the Psilocybe family was seized in a 5 years' period – 2.76 kg, which may

corroborate the growing trend in young people's experimenting with the so called "magic mushrooms" in Europe.

In recent years, the average purity increased in marijuana (THC – 7.8%) as well as in pervitin (58.3%) and heroin (12.5%). In ecstasy tablets, a decrease in purity was observed in 2005. In 2005, first cases occurred where the tablets contained m-CPP¹, which is not currently included in the national list of narcotic and psychotropic substances.

The prices of drugs in Slovakia, according to the National Anti-Drug Unit, are relatively stable except for the drop in heroin price with its growing concentration. Next the price of cocaine can be expected to fall. Its price moderately decreased already as the drug cartels are trying to gain new markets.

Bratislava October 2006

Lucia Kiššová
Slovak National Focal Point

¹ 1-(m-chlorophenyl)piperazine, a stimulant

Part A: New development and trends

In part A the National Report describes the national situation in 2005 as well as new developments and trends regarding the year 2006. The later part especially applies to section 1. Furthermore it reports the results of major national research and studies.

1 National policy and its context

The establishment and implementation of the drug policy² of the society is the responsibility of the Government of the Slovak Republic. It approves the national strategy, defines its objectives and principles, including creating an appropriate legislative environment. The strategy is formulated in the National Programme for the Fight against Drugs (hereinafter “NPF”). Already the third NPF for the period of 2004 – 2008 is currently being implemented and was further developed into Action Plans of ministries and regional state authorities in 2005.

The Slovak Government’s consulting body for the issues of drug policy is the Committee of Ministers for Drug Addiction and Drug Control (hereinafter “CM DADC”), whose members include ministers of selected sectors, and the General Prosecutor. The executive body of the CM DADC – the CM DADC General Secretariat (hereinafter “General Secretariat”)– coordinates, methodologically guides, and controls the implementation of the drug policy on central and regional levels and also ensures the representation of the Slovak Republic in international institutions of the EU and the UN in the field of drug issues. Resolution of the Government No. 534/2002 established, at the CM DADC General Secretariat, the National Monitoring Centre for Drugs (NMCD), which is the national representation of the EU specialised agency – the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

The coordination of the state drug policy on local and regional levels is the task of the regional authorities (hereinafter “RA”). At each of them³ a position of a coordinator was created since 1 January 2004, who ensures the tasks related to coordination of common tasks in the field of prevention, treatment, and social reintegration of drug addictions⁴. Besides the implementation of the national policy in the given region, the RA’s participate in creating regional drug strategies. A Methodological Instruction of the Slovak Republic Government Office No. 4/2006-GSVMDZKD of 13 December 2005 was issued with the objective of unifying the RA’s procedures in the field of drug issues. It determines the activities of regional authorities in the field of drugs and unifies the procedure for establishment of regional coordination commissions for drug issues.

1.1 Legislative framework

Legislative development

The legal framework for drug issue in Slovakia as well as its important changes in 2005 are presented in detail in the report “The State of Drug Addiction and Drug Control in Slovakia 2005” (thereinafter “2005 National Report”). As at the date of writing this report, there was no new law or amendment to an existing drug law approved, therefore we will recapitulate at this point the basic information of 2005.

- Act No. 300/2005, the Penal Code, as amended by Act No. 650/2005 (hereinafter the “Penal Code”) modifies also the preceding regulation of drug-related criminal acts in Act No. 140/1961, the Criminal Law, as amended. The Act became effective the 1st January 2006.
- Act No. 301/2005, call on Criminal Proceedings, as amended by Act No. 650/2005 (hereinafter the “Code of Criminal Procedure”) provides for the procedure of law enforcement agencies and courts, which was originally provided for by Act No. 141/1961 on

² The drug policy concerns illegal drugs – legal psychoactive substances (alcohol and tobacco) are subject to individual strategies – see more in the 2005 Report, Chapter 12.

³ In each of 8 Slovakia’s regions, besides local self-governments, also state administration operates in the form of Regional Authorities.

⁴ Methodical Instruction of the Slovak Republic Government Office No. 4/2006-GSVMDZKD of 13 December 2005.

Criminal Court Proceedings (the Criminal Code). The Act became effective the 1st January 2006.

- Act No. 305/2005 on Social and Legal Protection of Children and on Social Custody, which constitutes a separate regulation of social and legal protection of children and the first legal regulation of social custody. The Act became effective on the 1st September 2005.
- Act No. 36/2005 on Family as amended – enables the authority of the court to decide on imposition of an educational measure, or, as the case may exceptionally be, on temporary removal of a minor child⁵ from the care of the parents (or other persons who were entrusted such child or who take care of him or her), this being even contrary to their will, and to order the child's residence in diagnostic or specialised facilities. In serious cases of drug addiction, the court may order the child's residence in a social reintegration facility for drug addicts.
- Act No. 331/2005 on State Administration Authorities in the Affairs of Drug Precursors as amended (hereinafter the "Act on State Administration Authorities in the Affairs of Drug Precursors"). The Act provides for the competence of state administration authorities in the affairs of drug precursors, measures to control monitoring of movement and handling of drug precursors, and imposition of administrative sanctions and penalties for violation of operators' obligations. The Act became effective on the 18th August 2005. At the same time, this Act abolished Act No. 219/2003 on the Handling of Chemical Substances, which Might be Abused for the Illicit Manufacture of Narcotic Drugs and Psychotropic Substances and on Amendment to Act No. 455/1991 on Small Businesses (Small Business Act) as amended, and Decree of the Ministry of Economy of the Slovak Republic No. 349/2003 as amended by Decree of the Ministry of Economy of the Slovak Republic No. 101/2004 implementing certain provisions of Act No. 219/2003.

From the viewpoint of these legal regulations, the most important changes concerned Act on Social and Legal Protection of Children and on Social Custody, which is described in greater detail in Chapter 9, and the Penal Code, particularly the provision for criminality of drug possession for personal use (Sections 171 and 135) and drug trafficking (Section 172)⁶.

The elements of the offence pursuant to Section 171 of the Penal Code enable that a criminal liability arises against a perpetrator who possesses drug for his or her own use without authorisation. Possession is distinguished according to the amount of drug possessed.

- a sentence of imprisonment of up to 3 years may be imposed on a perpetrator who possesses a drug for his or her own use in an amount corresponding to a maximum of three times the usual single dose for personal use,
- a sentence of imprisonment of up to 5 years may be imposed on a perpetrator who possesses a drug for his or her own use in an amount corresponding to a maximum of ten times the usual single dose for personal use.

Section 172 of the Penal Code defines the penalty for the perpetrator who possesses, for his or her own use, an amount of drug bigger than that mentioned in Section 171, as well as the sanction for a perpetrator involved in drug trafficking or otherwise handling drugs in an unauthorised manner. At the same time, the Penal Code reduces the lower limit of criminal liability from 15 to 14 years of age (more in Chapter 11).

Law enforcement and implementation

In 2005, no changes occurred in this field compared to the state described in the 2005 National Report. For law enforcement with respect to the number of persons convicted of drug-related criminal offences, etc., see Chapter 8.

Implementation of the EU Drugs Strategy (2005 – 2012)

⁵ a child of under 15 years of age

⁶ Sections 171 and 172 of the Penal Code provide for the criminal offence of illegal production of narcotic and psychotropic substances, poisons or precursors, their possession and trade therein.

Priorities of the European Drug Strategy (2005 – 2012) were reflected and implemented in the National Programme for the Fight against Drugs (NPF) for the Period of 2004 – 2008⁷. In the course of 2005, “Action Plans Implementing the objectives of NPF 2005 – 2008 in line with the EU Drug Strategy and of the European Action Plan on Drugs in the Conditions of the Ministries” were adopted⁸ (hereafter “Action Plans”). At the same time, the Parliament asked the Government of the Slovak Republic to ensure the implementation of the Action Plans also within ministries and regional authorities and to allocate funds necessary for their implementation.

Following the above, in 2006, the Government passed a document entitled “Analysis of the Present Situation in NPF Funding and the Principles of Anti-Drug Policy Funding for the Subsequent Period in Accordance with the EU Strategy and the NPF”, in which the recommendations of the EU Strategy concerning national drug policy funding were fully accepted. The General Secretariat was entrusted to submit a draft strategy for state drug policy funding in a medium- and long-term perspective by 31st June 2007.

1.2 Institutional framework, strategies, and policies

Slovak Republic’s drug strategy

The principles of the state drug policy are defined in the current NPF for the period of 2004 – 2008. Its main objective was to create efficient tools to prevent further deterioration of situation in drug abuse and drug addictions in Slovakia with an emphasis on children and youth. The main pillars of the Slovak Republic’s drug policy are: prevention, treatment, social reintegration, and law enforcement (2005 Report, Chapter 1, and 2004 Report, Appendix 15.1).

Coordination and the institutional framework

Coordination of drug policy of the Slovak Republic Government is the task of the Ministerial Committee for Drug Addiction and Drug Control⁹ (CM DADC). The Committee has fifteen members; it is chaired by the Deputy Prime Minister of the Slovak Republic for Knowledge Society, European Affairs, Human Rights and Minorities, Committee’s deputy chairpersons are ministers of health and education, and members are individual ministers and the General Prosecutor – all ex officio. The Committee sessions are generally held twice a year. It assesses the drug situation and, on its basis, updates the main lines of drug strategy and submits them to the Government of the Slovak Republic (2005 National Report).

In 2005, at the CM DADC sessions the following topics were discussed: the assessment of security situation in the Slovak Republic from the drugs viewpoint, a report of the Minister of Health on the transformation of drug addiction treatment centres into non-profit organisations and their separation from the direct control of the Ministry, the National Action Programme for Problems with Alcohol for the period of 2006 - 2010, a report of the Minister of Culture on the implementation of the state drug policy in culture, a report of the Minister of Defence on the implementation of the NPF in the defence sector, the compositions and activities of expert commissions at the General Secretariat was approved by the Committee. The Committee also discussed the procedure regarding coordination activities of regional coordinators and regional anti-drug commissions, and other issues. The Committee paid special attention to the issues of preparation of the state drug policy funding strategy and the participation of the Slovak Republic in EU projects concerning the fight against drugs.

The executive body of the Committee responsible for the implementation of the Committee’s conclusions and for the coordination of anti-drug activities on the level of ministries and central state administration authorities is the CM DADC General Secretariat. There are 4 following expert commissions operating at the General Secretariat: commission for prevention of drug

⁷ The Programme was approved by Resolution of the Government of the Slovak Republic No. 289 of 15 April 2004 and by Resolution of the National Council of the Slovak Republic No. 1072 of 25 June 2004.

⁸ The document was approved by Resolution of the Government of the Slovak Republic No. 498 of 29 June 2005. The National Council of the Slovak Republic acknowledged it by its Resolution No. 1859 of 27 September 2005.

⁹ Established by Resolution of the Government No. 583 of 8 August 1995. The Resolution approved the Statute of the Committee including details of its activity and organisation.

addiction, for drug addiction treatment and social reintegration, for legislative issues and law enforcement in the drug field and the commission for communication strategies in the fight against drugs. The activity of these expert commissions was approved on 13 December 2005¹⁰. An Inter-ministerial Anti-Drug Action Group has been operating at the General Secretariat since 2004. In 2005 it has dealt particularly with issues of legality and the social impact of selling food products containing marijuana in retail networks and with the problems of the spread of synthetic drugs.

At the spring session of the CM DADC in March 2006, the Committee took notice of the activity of 6 working groups of the NMCD. The individual working groups cover 4¹¹ key indicators, the law-enforcement data, and the Early Warning System - that enables the exchange of information among the involved entities on new drugs and the methods of use. Forming working groups comprising of experts from relevant fields should provide a better coordination in the field of monitoring and data collection.

On the ministerial level, the implementation of measures in the drug field is the responsibility of ministers of the competent ministries. The tasks of individual ministries and the institutional framework concerning drugs are described in detail in the 2005 National Report.

In the course of 2005, no substantial changes occurred in the institutional framework.

In accordance with Act on State Administration Authorities in the Affairs of Drug Precursors, which became effective in August 2005 (Chapter 1.1.1), the following entities execute state administration in the field of drug precursors:

- State Institute for Drug Control¹² – the law expanded its competences and its field of action is provided for by Section 3 of the Act,
- Ministry of Economy of the Slovak Republic (Section 4 of the Act),
- Ministry of Interior of the Slovak Republic (Section 5 of the Act),
- Customs Directorate of the Slovak Republic, customs authorities, and the Customs Criminal Office (Section 5 of the Act).

The Customs Criminal Office (hereafter “CCO”) was established by Act No. 652/2004 on State Administration Bodies in Customs with effect on 1st January 2005. The CCO operates, inter alia, in the field of the fight against illicit import, export, and transit of narcotic substances, psychotropic substances, and their precursors.

In the field of institutional provisions for the implementation of prevention, Centres of counselling and psychological services underwent transformation in 2005 and the number of educational and psychological prevention centre was reduced (see Chapter 3).

Coordination on local and regional level

Within their competences on regional level, regional authorities (state administration) participate in the implementation of the state drug policy defined by the NPDF. The coordination of anti-drug activities on regional and local levels requires close cooperation of all involved components, particularly the participation of self-government bodies, i.e., self-governing counties, towns, and municipalities of the Slovak Republic.

The condition for such cooperation had been created by the following: in 2004 by establishing the position of a (drug) coordinator directly at regional state authorities, then by the Guideline of the Ministry of Interior of 3 January 2005, Art. 2, which ensured that the coordination of activities on local and regional level in the field of drugs became one of the basic tasks of regional authorities and, finally, by the Methodical Instruction¹³ of the Slovak Republic Government Office

¹⁰ CM DADC session

¹¹ Drug-related deaths and death rate, drug-related infectious diseases, treatment demand, population surveys.

¹² The Institute ensures the performance of state testing within the meaning of Act No. 30/1968 on State Testing as amended. In the capacity of a state testing institution, it issues certificates for medical devices, inorganic and organic chemicals for general use, and makes decisions on recognition of foreign testing institutions' certificates.

¹³ Effective as of 1st January 2006.

No. 4/2006-GSVMDZKD of 13 December 2005 for regional authorities determining type of activities of regional authorities in the field of drugs and unifying the procedure for establishment of regional drug-coordination commissions (prevention of drug addiction, drug treatment, social reintegration, and law enforcement). Above mentioned created better conditions for further development of activities and coordination at regional and local level concerning drug issues.

The strengthening and optimisation of cooperation on regional and local level is addressed also within the twinning part of the Transition Facility project 2004, "The Support of the Implementation of the NPDF in the Slovak Republic 2004 – 2008, within the component 4 (see below for more information).

Several dozens of non-governmental organisations (hereinafter "NGO") operate in the field of the fight against drugs on the national, regional, and local level. They are focused on drug prevention, social field work, education and training, social reintegration of drug addicts and their legal protection, treatment support, counselling, public opinion formation, organising campaigns, work with children and youth and leisure time activities (2005 National Report).

Implementation of policies and strategies

Implementation of the NPDF for 2004 – 2008

The implementation of the Transition Facility project 2004 comprising European Communities resources in the total volume of €1.5 million and subsidies from the Slovak Republic in the amount of €0.7 million was launched in 2005. The project is called "The Support of the Implementation of the National Programme for the Fight against Drugs in the Slovak Republic for the Period of 2004 – 2008". The project is conducted by the CM DADC General Secretariat in cooperation with the ministries operating within the CM DADC. The project has three parts: The Twinning (€0.9 million), the Small Grant Scheme (€1.05 million), and the Technical Assistance (€0.25 million).

1) The twinning part, whose main task is to strengthen, through communication and exchange of information, the coordination and cooperation of the involved entities, is conducted in 18 months in the period of 2005 – 2007 with foreign partners: the Federal Republic of Germany (senior partner) and the Czech Republic (junior partner). This part of the project is structured into 5 components:

- Introductory phase,
- Strengthening capacities in the system of drug demand reduction on the national level,
- Strengthening and further development of the national drug demand reduction system's capacities,
- Strengthening capacities in the system of drug demand reduction and strengthening the cooperation on regional and local level,
- Evaluation and a final conference.

Within the twinning part of the project, 48 events were planned for the period of 2005 – 2006 in the form of workshops, seminars, training courses, of which most have already taken place. In total, these events will be participated by over 30 foreign experts from the Federal republic of Germany and the Czech Republic and 500 participants from Slovakia. In 2006, a total of 50 drug experts from Slovakia have the possibility to visit various institutions and facilities operating in the drug field in the Germany and in the Czech Republic.

The final international conference on the Twinning project will be held on 12 to 13 December 2006.

Another part of the Transition Facility project 2004 is the Technical Assistance, which will be launched in 2006 with the aim of improving the quality and reliability of available information in drug field and strengthening the communication and information sharing among institutions involved in data collection, analysis, and evaluation. The funds allocated to this part will be used for institutional building of the Ministry of Defence, the Ministry of Interior, and the CM DADC

General Secretariat, which will use the funds to expand the activity of the drug information web portal.

The third part, the Small Grant Scheme, will be used to fund projects presented by state and private entities, NGO's, non-profit organisations of nationwide and regional scope, which operate in the field of prevention, treatment, or social reintegration in Slovakia. Support will be provided for programmes and initiatives that will substantially influence the implementation of the NPF in all its priorities. A grant is defined in the range of €25 – €50 thousand with the project duration of 10 – 14 months. In the first round, the commission approved projects of 12 applicants (out of total number of 32) with the total amount of €600 thousand. The second grant round will be held in October 2006, allocating the amount of €400 thousand.

Strengthening national monitoring of drugs and drug abuse

In the framework of the Financial Memorandum 2005, a project was approved entitled "Strengthening National Monitoring of Drugs and Drug Abuse" in the total amount of €400,000 using EU funds and €100,000 from national co-financing. The project was drafted by the Healthcare Surveillance Authority of the Slovak Republic (hereinafter "HSA SR") with a significant contribution from the CM DADC General Secretariat staff. The implementation will proceed in 2007 – 2008 at the HAS SR. Monitoring and supervision is ensured by a Steering Committee with the participation of the Ministry of Health, HAS SR, Central Financial and Contractual Unit and NMCD. The CM DADC General Secretariat participates in the project as an observer.

The objective of the project is to ensure monitoring and provision of valid data on drug-related deaths (one of the five key indicators of the EMCDDA) as well as to strengthen and complete the toxicological laboratory in Bratislava (Petržalka) so that it can be accredited as a National Reference Laboratory responsible for necroptic toxicology.

Improving the quality and expanding the social reintegration and rehabilitation services for persons addicted to psychoactive substances.

This project has been approved in the framework of the Financial Memorandum 2006 in the total volume of €950,000 from EU funds and €200,000 from national co-financing funds for the period of 2007 – 2008. The implementation of the project, which was prepared by the CM DADC General Secretariat in cooperation with the Ministry of Labour, Social Affairs and Family of the Slovak Republic (hereinafter "MLSAF SR") and with the Association of Social Reintegration Centres, will proceed at the General Secretariat and at the MLSAF SR, which will be providing professional guidance of the project together with the Association of Social Reintegration Centres.

The objective of the project is to achieve a level of social reintegration and rehabilitation care for addicted persons comparable to that in other EU countries. The project will be implemented through 3 components – twinning, technical assistance, and a grant scheme.

1.3 Budget and public expenditure

The budget or funding arrangements of drug policy are not direct part of the NPF 2004 – 2008. Each ministry prepares annually its own budget proposal, in which it includes also the costs for drug policy activities (e.g., MLSAF SR/Office of Labour, Social Affairs, and Family, see Chapter 9.2). To support the activity of legal entities and individuals operating in the field of the fight against drugs, an Anti-Drug Fund was established in 1996 (hereafter "ADF"), which annually receives the amount of SKK 50 million (approx €1.3 million¹⁴) from the state budget.

The 2004 – 2008 NPF and its action plans are financed from the state budget in their parts concerning ministries and regional authorities, which constitutes about 70% of drug policy costs. Approximately 15% of costs are spent on drug treatment and are supplied from health insurance companies' funds. The remaining 15% are financed from other sources: budgets of towns and

¹⁴ Average exchange rate of EUR in 2005 = SKK 38.59, www.nbs.sk

municipalities, budgets of self-governing counties, donations of natural persons and legal entities, own financial income for services provided (e.g., in the field of social reintegration), projects and programmes from EU funds. The total costs of the fight against drugs are approximately SKK 700 million (€19.5 million¹⁴, i.e., €3.614 per capita)¹⁵.

The most recent detailed information on funding of state drug policy in the framework of individual ministries was published in the 2005 National Report.

In 2005, 570 projects were submitted to the ADF¹⁶, of which 356 (62%) were approved. The greatest number of projects was approved for the Bratislava region (91) also due to the fact that many of these projects are of nationwide scope, through which information and education activities are implemented as well as publishing activities. Higher numbers of projects were approved also for the regions of Košice (64) and Nitra (56).

The total value of the projects was SKK 135,917,167 (approx. €3.5 million) and the subsidy from the ADF reached the value of SKK 48,503,116 (approx. €1.2 million) (Tab. 1.1). Compared to 2004, the ADF approved more projects but with lower average subsidy per project.

Table 1.1: Approved projects by regions

Regions	Number of projects approved	Value of projects in SKK	Requested subsidy in SKK	Approved subsidy in SKK
Bratislava	91	70,213,834	27,770,982	19,698,701
Trnava	32	7,648,556	6,964,078	2,714,535
Trenčín	18	2,008,726	1,511,216	1,166,646
Nitra	56	13,428,914	6,076,200	4,961,758
Žilina	24	5,027,242	2,785,502	2,121,208
Banská Bystrica	41	17,668,729	11,515,329	7,964,245
Prešov	30	9,307,110	3,829,733	2,437,653
Košice	64	10,614,056	8,683,857	7,438,370
Total	356	135,917,167	69,136,897	48,503,116

Source: ADF, 2006

In the framework of ADF priorities, emphasis was laid upon: the support and cooperation on the municipal level, creation of cooperating networks, upon the support of research, education and innovative projects in the area of low-threshold services, social rehabilitation implemented by NGO's. The basic task is to ensure availability and sustainability of proven programmes in the field of prevention, treatment, and social reintegration.

Compared to previous years, a significant increase of approvals was seen in projects from the field of media (focused on creation of professional and edification materials, additional instructional texts, audiovisual works, sensitisation of the public in printed and electronic media, etc.).

¹⁵ Qualified estimation by the CM DADC General Secretariat. The EMCDDA questionnaire – SQ 32, Political and institutional framework

¹⁶ ADF was established by Act No. 381/1996 as a non-state special-purpose fund, to distribute finances for drug prevention, treatment and social reintegration assistance to drug addicts.

Table 1.2: Approved ADF subsidies by areas

Area	Amount	%
Prevention 1 – School projects	11,562,687	24
Prevention 2	9,937,218	20
Media	8,935,162	19
Social reintegration	7,960,752	16
Treatment	6,432,384	13
Harm reduction	3,674,913	8
Total	48,503,116	-

Source: ADF, 2006

Funding at regional-level

Activities in the field of fight against drugs in regions are economically supported by the allocated budget funds, which, however, are often sufficient only to cover the standard operation. Further the activities can be supported through projects funded by individual ministries, ADF (see Table 1.1 for regional break down), European Union, or by the contributions from various subsidies and non-state entities, however meanwhile without significant contribution from self-government bodies.

To learn more about the operational scope of regional self-governments in drug field and also about drug-activities funding, the CM DADC General Secretariat/NMCD sent a questionnaire concerning these topics to self-governing regions. According to information obtained, the self-governing regions support particularly the social services (social counselling, social prevention, and social reintegration) from their budgets and in 2005 they allocated SKK 56,696,000 (approx. €1.5 million) in total to this purpose.

Table 1.3: Overview of self-governing regions' funds spent on social services in 2005

Self-governing region	Area	Amount in Skk	
		2004	2005
Bratislava	social counselling, prevention	1,500,000	2,300,000
Trnava	social reintegration	n.a.	8,017,000
Nitra	social reintegration	n.a.	11,030,000
	social counselling, prevention	n.a.	625,000
	Total	n.a.	11,655,000
Trenčín	reintegration	n.a.	3,010,000
Žilina	social counselling, prevention	2,946,000	3,100,000
	social reintegration	n.a.	900,000
	Total	2,946,000	4,000,000
Banská Bystrica	social reintegration	3,318,000	3,600,000
	shelters	13,276,000	12,749,000
	homes for singles	2,541,000	1,792,000
	Total	19,135,000	18,141,000
Prešov	social reintegration	n.a.	4500,000
Košice	social reintegration	3,104,752	4,448,000
	social counselling, prevention	651,917	625,000
	Total	3,756,669	9,573,000
Total		27,337,669	56,696,000

Note. Data reported in this table have only informational character due to different data collection at individual self-governing regions and the level of understanding drug issues

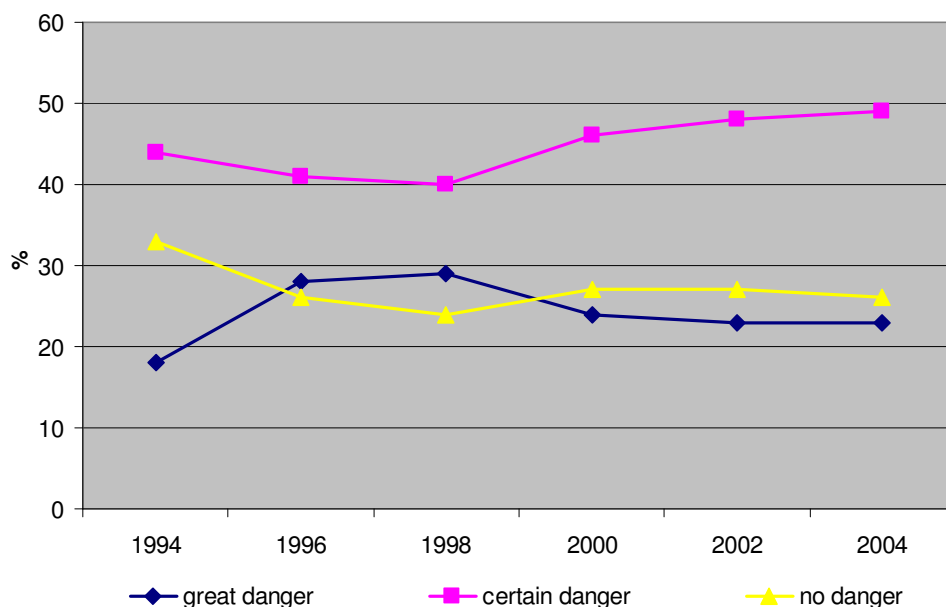
Source: NMCD, 2006

1.4 Social and cultural context

Public opinions concerning drugs

According to surveys conducted by the Public Opinion Research Institute at the Statistical Office of the Slovak Republic, (hereinafter “PORI at SO SR”)¹⁷, the subjective perception of drug addiction threat to the respondents, their children and family in the course of ten years (1994 – 2004) has not changed significantly. The perception of “a certain danger, but without significant concerns” is slightly increasing.

Figure 1.1: Subjective perception of the threat of drug addiction, age group 18+



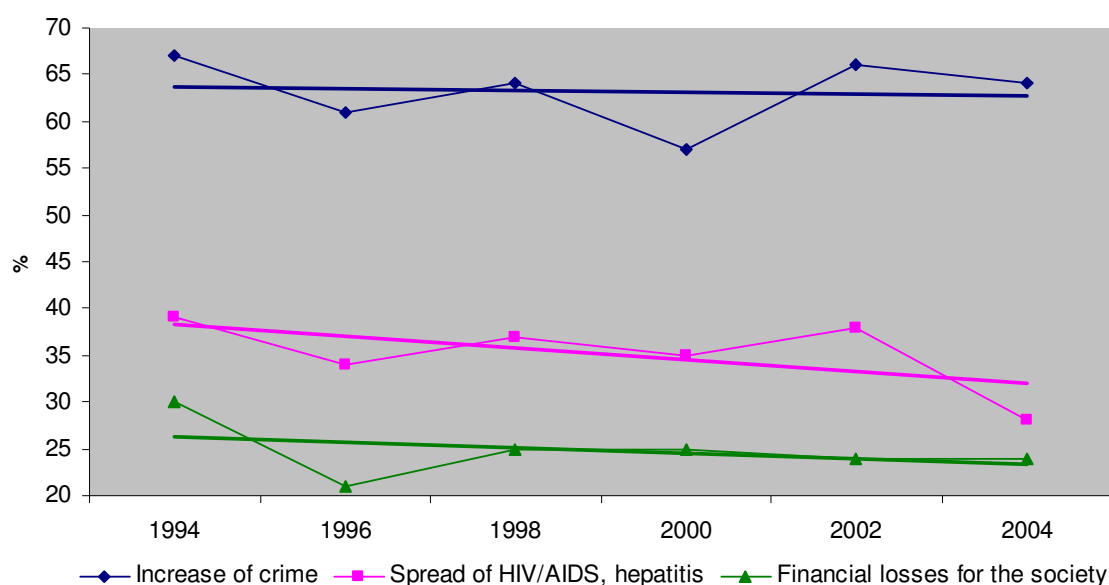
Data source: PORI at SO SR, 2004

The question concerning danger of drug use and drug addiction to the society offered several optional answers. In the ten years' period, the first rank has been kept by the “increase of crime” as the greatest danger. The next danger is seen by the respondents of all three groups in the “spread of infectious diseases” – HIV/AIDS and B-type hepatitis. A decreasing trend in the perception of this danger was more observed in the last survey cycle, probably as a result of providing objective information on the low occurrence of HIV/AIDS and B-type hepatitis in the Slovak Republic.

The third rank was taken by the “risk of financial losses” for the society, likewise with a slightly falling trend.

¹⁷ For more details, see Chapter 2.

Figure 1.2: Development of public opinions on the main dangers of drug use for the society



Source: PORI at SO SR, 2004

Attitudes to drugs and drug users

For information on public attitudes to drugs and drug users for the last 10 years, see Chapter 2.

Media coverage of the issue

According to independent external media monitoring¹⁸, 1 283 media outputs in total were conducted in 2005 (keywords – drug addictions, drugs). Monitored radio and television stations had broadcast 384 relevant outputs. In 2005, again, the media coverage of drug addiction and drug control issues was provided mostly by public service media – Slovak Radio (81 outputs) and Slovak Television (60 outputs). News reporting is the most frequent format of communication; commentaries are more seldom and contact-type broadcasts were absent. Quantitatively greater space than in radio and television to this issue is devoted in press (Pravda, Sme, Hospodárske noviny), including specialised periodicals (e.g. Zdravotnícke noviny - Healthcare Journal).

Media outputs covered 5 press conferences of the CM DADC. These included: two regular conferences regarding the spring and autumn sessions of the CM DADC; conferences regarding the issue of funding the treatment in drug dependencies treatment centres by Health Insurance companies; launching of the Internet portal www.infodrogy.sk, and finally regarding the study presentation in September 2005 “Social and Economic Costs Related with Drug Use in the Slovak Republic”.

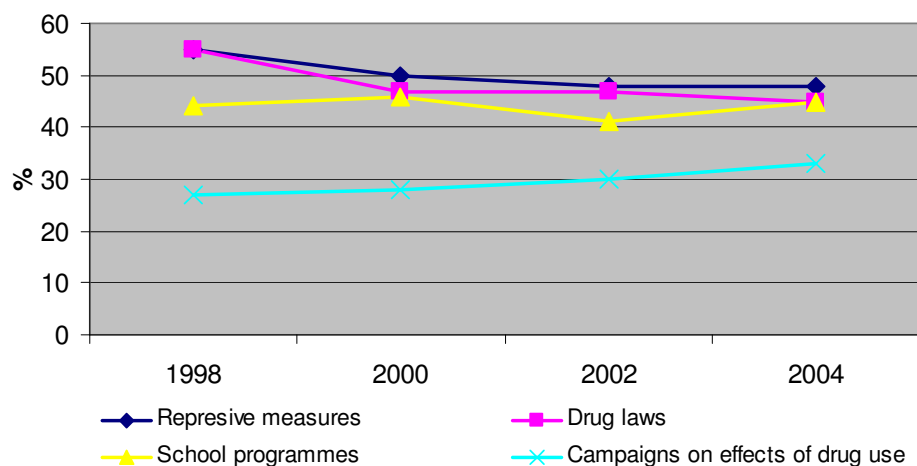
Findings of the study, conducted by the CM DADC General Secretariat, concerning the amount of money spent by heroin-addicts and other regular/occasional drug users for drugs, shocked the public. The estimated amount SKK 3.6 – 4.7 billion a year (approx. €93 million – €121 million), according to public responses in on-line discussions, was perceived negatively. On the contrary, information mapping the extent of funds spent on anti-drug activities in 2004 (prevention, treatment, social reintegration, and repression) provoked minimum responses. Concerning the structure of the amount of SKK 565,343,154 (€14.5 million¹⁹) in total including two basic categories – demand reduction and supply reduction – expenditures were higher in law enforcement (repression), while lower expenditures were allocated into prevention, treatment, and social reintegration.

¹⁸ STORIN - Media Monitoring Agency

¹⁹ NBS exchange rate as at 31 December 2004: EUR = SKK 38.80

Minimum reactions of the public may correspond to the trends found in the PORI at SO SR surveys in 1998 – 2004. According to this survey there is a long-term trend to prefer repressive measures (law enforcement) to prevention. However certain shifts in this respect can be observed (more respondents, and particularly in the critical age – from the point of being at higher risk of drug use, abuse, and addiction - favour measures such as school drug programmes and campaigns aimed at harmful effects on health).

Figure 1.3: Opinions of the youth of the Slovak Republic aged 15 – 29 concerning certain measures to be taken against the drug addiction



Source: PORI at SO SR, 2004

While in 2004, public discussions concerned legalisation or decriminalisation of marijuana, in 2005, the media and public reflected gradual integration of marijuana use into the “common patterns” of young people’s behaviour.

Comparing 2004 when seldom “incorrect”²⁰ information was recorded, in 2005, there were at least four media outputs that presented marijuana use in various forms as an activity with low harmfulness on health, moreover justified by the right of personal freedom and the right of choice. The image of marijuana as a low-risk drug is supported by its natural origin and therapeutic effects on the accompanying symptoms of certain serious chronic diseases.

In reality, with the image of marijuana presented in media, corresponds the availability of imported food products containing THC which are sold freely (soft energy drinks, Swiss Hamp, C-ICE, beer, etc.) as well as indicating certain food products as “marijuana containing”, although they actually contain no THC²¹. Besides food products, other mercantile are freely on sale associating marijuana use – posters, joints-smoking figures, cup mats, T-shirts, cigarette lighters, and aromatic sticks with the typical cannabis plant leave.

This environment favouring especially marijuana use is in variance with the opinions on legalisation of “soft drugs” recorded in surveys conducted by the institute of Information and Prognoses of Education in 2005 and by the PORI at SO SR until 2004 (see Chapter 2).

Communication with the public

Besides the above-mentioned press conferences and subsequent media outputs, the communication of the CM DADC General Secretariat/NMCD with the public in 2005 was conducted via newly established Internet portal www.infodrogy.sk²². The development of the

²⁰ correct information = marijuana therapeutic effects mitigating certain accompanying symptoms of chronic diseases

²¹ The latter case involves a marketing move but also deceptive advertising.

²² In operation from 3 May 2005.

Drug Information Portal of the NMCD was supported from the ADF²³ grant; the initial analyses and graphical design were provided from the NMCD funds.

The information portal is fully operational and fulfils all objectives set out in the project. During one year of its operation the portal was seen by over 60,000 visitors who viewed approximately half a million of pages and downloaded nearly 6,000 documents in electronic form. Its special benefit is the operation of 4 anonymous counselling services: Answers to Parents and Teachers; On Drugs and Addictions; Questions for Doctor and a Legal Counselling service. All which are managed by well known experts. The introduction of the counselling services in the respective month nearly doubled the portal's visiting rate compared to the previous month (from 1,655 to 3,020). In the period of 20th October – 31st December 2005, the counselling services answered 53 questions.

Upon the initiative of the CM DADC General Secretariat and with financial support from the ADF, a project of the Slovak Syndicate of Journalists was implemented under the title "Life without the Drug". Its objective was to stimulate media to deal with this issue, particularly concerning prevention, treatment, and social reintegration. Fifteen competitors enrolled in the competition, some of them with multiple contributions. 2006 is the second year of the competition.

²³ On the occasion of the International Day against Drug Abuse and Illicit Drug Trafficking (26 June), the ADF evaluated projects for 2005 in several areas. www.infodrogy.sk ranked third in the category of media projects.

2 Drug use in the population

Key representative population surveys focused on the spread of drugs in the Slovak Republic and opinions of the citizens concerning the problems connected with drug addiction in Slovakia have been conducted since 1994 in two-year intervals by the Statistical Office of the Slovak Republic within its unit of Public Opinion Research Institute. To ensure representativeness of the selected group, quota selection is used with randomisation in the last step. PORI implemented surveys in three selection groups: 1 – Adult population of the Slovak Republic (18+), 2 – Youth of the Slovak Republic in the age of 15 – 29 years, and 3 – Youth of Bratislava, 15 – 29 years.

Since 2004, this research has been done with a change in the first group to include Slovakia's population in the age of 15+. These groups are combined to form a group in the age of 15 – 64 years, which is needed for the ST 01 standard table of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Face-to-face interviews are done by trained enquirers, mostly in respondents' households. The survey covers alcohol and tobacco.

Table 2.1: Overview of the basic parameters of the PORI's surveys for the SR population group

Year	1994	1996	1998	2000	2002	2004
Survey type	Initial	Repeated	Repeated	Repeated	Repeated	Repeated
Context	alcohol, tobacco	alcohol, tobacco	alcohol, tobacco	alcohol, tobacco	alcohol, tobacco	alcohol, tobacco
Enquiry method	standardised interview	standardised interview	standardised interview	standardised interview	standardised interview	standardised interview
Selection group size n =	1338	1423	1359	1396	1405	1376
Return rate	95.60%	94%	91.10%	93.40%	94.20%	96%
Age	18+	15+	15+	15-64	15-64	15-64

Source: Luha J. ST 01 for Reitox (1996 - 2004)

In the individual survey cycles, the items of the questionnaire used in the standardized interview have been gradually modified and harmonised towards the European Model Questionnaire (EMQ) with the objective of achieving a higher compatibility with the required data structure for the EMCDDA. In the time being the seventh cycle of this representative survey is carried out and data will be introduced into Report 2007. However some basic trends concerning Slovak population's drug behaviour as reflected in the surveys between 1994 and 2004 are presented in this Chapter.

New information for 2005 is available only from representative school survey HBSC²⁴ (see part 2.2.1.3) and repeated research of IIPE²⁵ for year 2005 (see part 2.2.2)

2.1 Drug use in the population

Data from the most recent survey cycle performed in 2004 is contained in the 2005 National Report²⁶ and, in a greater detail, in the 2004 issued publication of the Statistical Office entitled "Drug use spread in Slovakia and opinions of citizens on problems connected with drug addiction", (hereinafter "Prevalence of drug use in the SR"), which includes data of all cycles of this population survey.

²⁴ Health Behaviour of School Children

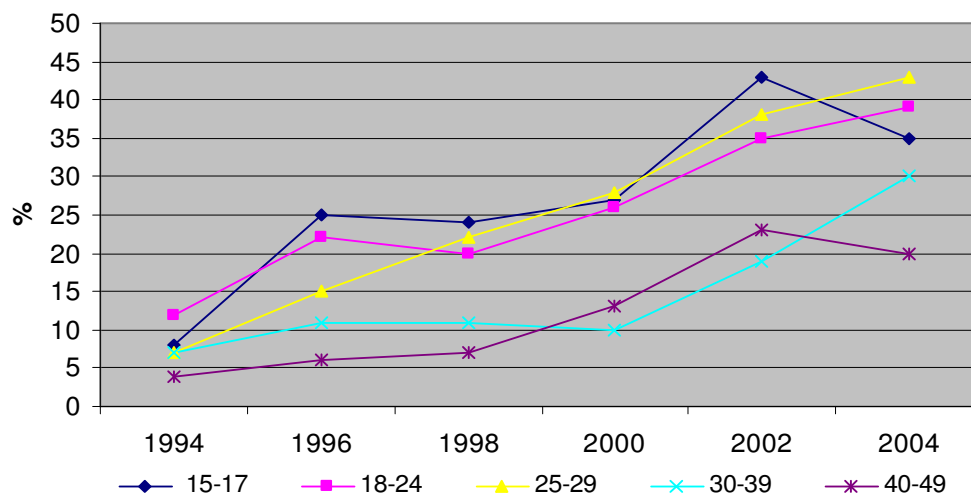
²⁵ Institute of Information and Prognoses of Education

²⁶ Chapters: 1, 2, 11

The experience with drugs in population of SR

The experience with drugs in population survey of PORI at SO SR includes a broad category of users from those who used a drug only once in a lifetime (incl. medicinal product users to regular users). The greatest proportion of persons with experience thus defined is concentrated in age groups in the range of 15 – 39 years.

Figure 2.1: Drug experience by individual age groups



Source: Prevalence of drug use in the SR. SO SR, 2004, Public opinion, p.19

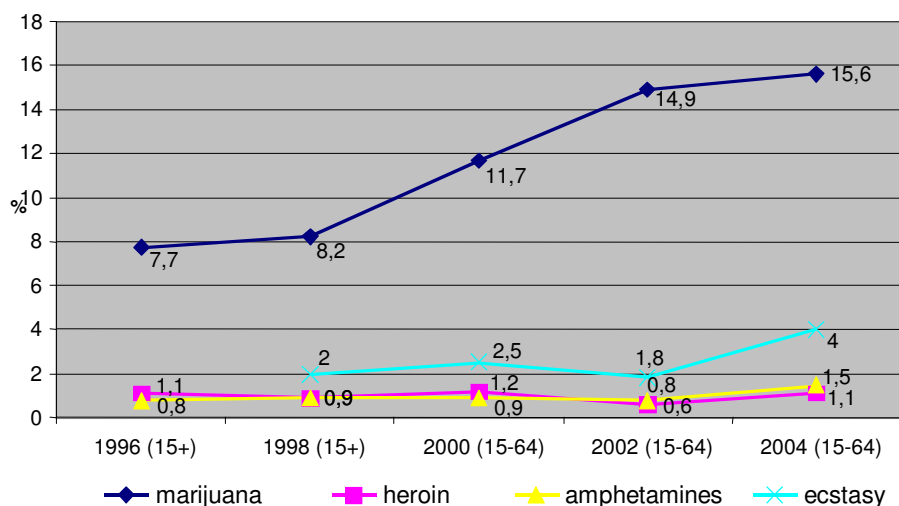
Around 1994, the question of the PORI's questionnaire worded "Do you know a person in your neighbourhood who is or was addicted to drugs such as marijuana, hashish, cocaine, heroin, LSD, ecstasy?" was answered by 13% of respondents from the group of 15 – 29 years old (Youth of the SR) that they did know such a person among their friends and only 1% that they had such a person in their family.

Ten years later²⁷ as many as 27%, answered that they knew such a person among their friends and 3% had such a person in their family.

According to the results of five research cycles, the Slovak population has the most extensive and growing experience with marijuana, hashish, which is related to their availability documented by the growing number of seizures by police and customs authorities (Chapter 10), but also by the growth of the number of persons treated for marijuana addiction (Chapter 4).

Figure 2.2: Lifetime prevalence of use of cannabis, heroin, amphetamines and ecstasy in Slovak population

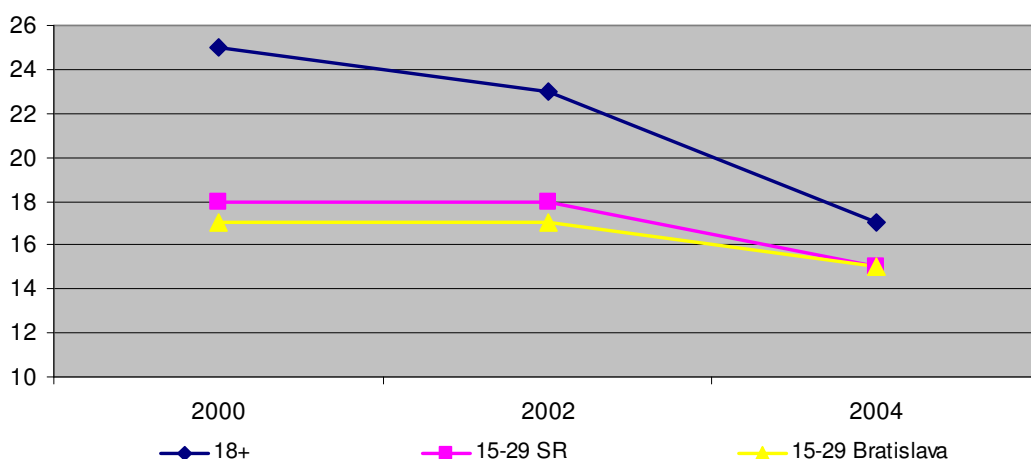
²⁷ Tab. 2.1.1 knowing a drug addicted person, In: National Report, 2005 p. 58



Source: Luha J., ST 01 for REITOX, 1996 to 2004

According to information from respondents, the average age of first-time drug use changed in the period of 2000 – 2004 decreasing in all three surveyed groups.

Figure 2.3: Age at the first contact with an illegal drug



Source: Prevalence of drug use in the SR, 2004, p. 27

The socio-demographic structure of the respondents with drug use experience has not changed significantly and the experience with drug was declared in a greater extent by respondents from large agglomerations with populations of 50 to 100 thousand (38%) and the residents of the regions of Bratislava (31%), Trenčín (34%) and Žilina (35%).

Since 1998, the educational structure of persons with drug experience has been changing. The differences among individual educational groups (from basic education up to university level) are diminishing, particularly thanks to the significant growth of drug use (one-time, occasional or regular) among persons with university education in a nationwide scope.

2.2 Drug use in the school population and among the youth

2.2.1 School surveys

The history of school surveys in the context of other indicators in Slovakia dates back to 1992.

2.2.1.1 The original Slovak survey Tobacco – Alcohol – Drugs (hereinafter “TAD”) was conducted as a representative one at elementary and secondary schools in 1993/1994, 1998,

and 2002. The relevant data for the past period²⁸ are contained in the 2004 National Report²⁹ and, in particular, in the publication “Surveys on drugs, alcohol, and tobacco in the Slovak youth”³⁰. The tables and graphs are available also from www.infodrogy.sk.

The fourth wave of the TAD survey was conducted by the author, Alojz Nociar, in cooperation with the Research Institute for Child Psychology and Pathopsychology (hereinafter “RICPaP”), the Institute of Information and Prognoses of Education (hereinafter “IIFE”), and the Public Health Authority (hereinafter “PHA”) in April 2006. The results will be published in the 2007 Report.

2.2.1.2 The European School Survey Project on Alcohol and Drugs (ESPAD) has been implemented in the Slovak Republic since 1995 with the last cycle taking place in 2003; the results of all three cycles are contained in the cited publication of the Slovak survey coordinator. The next cycle of the survey among secondary school students of the age of 15 – 16 years to 18 – 19 years will be conducted in cooperation with RICPaP and the PHA in spring 2007.

Based on the present results of the TAD and ESPAD school surveys, the following can be concluded in particular according to Nociar (2004)³¹:

- Growth of problems with alcohol, tobacco, and other drugs among children and adolescents,
- The age of the first contact with alcohol and tobacco oscillates about 10 years and efforts to move it to an older age are failing.
- The perceived availability of illegal drugs, particularly of marijuana, is increasing while the perceived risk of its use is decreasing.
- Legal and illegal drugs are rooting in the society.

2.2.1.3 Health Behaviour of School Children

The coordinator of a survey based on the Health Behaviour of School Children WHO surveys in Slovakia and conducted under the name “Secondary School Youth Lifestyle Monitoring” has been, since 2005, the Regional Public Health Authority³² at Spišská Nová Ves, where valid data from a questionnaire survey of 10,283 respondents (5,301 boys and 4,982 girls) in the age of 15 – 19 years were processed.

The anonymous questionnaire was administered at schools (school year 2004/2005) through professional workers of all regional public health authorities in the Slovak Republic (36 authorities). Ten areas surveyed included also monitoring of addictions, namely to medicinal products, coffee, cigarettes/tobacco, alcohol, drugs, and slot machines.

According to information from this survey, 33% of the youth smoked in the age of 15 – 19 years, of whom nearly 25% daily; boys start smoking on average in the age of 11.5 years, girls at about 13 years.

Nearly one quarter of boys is regular consumers of beer, for girls it is 5%. The average age of the first experience with beer is 12.4 for both genders; boys start as early as at about 10 years of age, girls in the age of fourteen. The condition of drunkenness has not been experienced by only 22% of young people and only 30% of secondary school students have no experience with beer, 2% with wine, and 25% with distillates.

When monitoring the frequency of the use of medicinal products without the knowledge of parents and doctors it was found that 15% use them several times in a month against pain, 0.6% against insomnia, 1.2% for stimulation, and 1% of all respondents also for sedation.

²⁸ Certain data concerning the age group of 11 – 14 years old pupils (TAD 1) are presented in Chapter 11.

²⁹ Drug addiction status and drug control in the Slovak Republic 2004

³⁰ Author: PhDr. Alojz Nociar, CSc.

³¹ Nociar A.: Surveys on alcohol, tobacco, and drugs in the Slovak youth, p. 65

³² Gajdošová, E., Rešovský J., Mišenda P., Mederiová, T: Secondary School Youth Lifestyle Monitoring”

According to survey information, experience with the use of drugs excluding alcohol and cigarettes was declared by 30% of respondents. Most often, children start to experiment in 15 years of age. Present users most frequently use a drug 1 – 3 times a month, with nearly 6% of them declaring drug use 3 – 5 times a week.

The most frequent pattern of use is smoking, which is preferred by as many as 80% of all consumers, followed by oral use (2.3%), snuffing (1.8%), inhalation (1.5%), and intravenous administration (0.4%). In repeated use, respondents reported also combined use, the most frequently occurring combination being smoking with snuffing or oral use or inhalation.

Help related to drugs was sought by 8.3% of users, 2.5% were forced to do so by parents or teachers, 25% wanted but did not know where to seek the appropriate service or failed to find the courage. 55% of all users believe that they do not need such assistance.

In respondents' family environments, drugs are used in a very low extent, namely by 0.2% of fathers a likewise by mothers. As far as siblings are concerned, the enquired stated that they took drugs in more than 2.5%. However, most of them reported use among friends – as many as 20% of their peers.

2.2.1.4 Local survey at school environment

There was an entry test/survey carried out within the preventive intervention “We know that...” in school year 2004/2005. The aim was to find out on the knowledge, opinions and attitudes of elementary school pupils and students of secondary schools who participated at the preventive programme. The survey was carried out among 815 pupils and students (12-18 years) in Nitra region. According to the results as many as 17, 7% of young people have personal experience with drugs, frequent consumption of drugs was reported by 2, 7% of respondents. Illicit drugs are used mostly by boys; respondents in the age 16-17 years; students of secondary vocational schools and secondary vocational apprentice schools. In case marijuana is offered to respondents 13, 1% would try it from a curiosity and 5, 3% would try it with enthusiasm.

In 2005, local enquiries were also conducted at schools in small groups among secondary school students aged 15 – 17 years (see Duchoň, M³³, Korbeľová, B.), which confirmed marijuana as the drug most frequently experimented with.³⁴

2.2.2 Youth surveys

Data for 2005 is available, which has been obtained from key longitudinal sociological research among the youth since 1995 by the Institute of Information and Prognoses of Education (IPE) on a representative sample of 15 – 26 years old youth of Slovakia³⁵. Every year, the basic problems of smoking³⁶, the use of alcohol and illegal drugs are monitored in a different context.

In 2005, the questionnaire survey (the questionnaire being administered by enquirers mostly in households) covered 947 respondents, of whom 196 (20.8%) declared to have experience with illegal drugs.

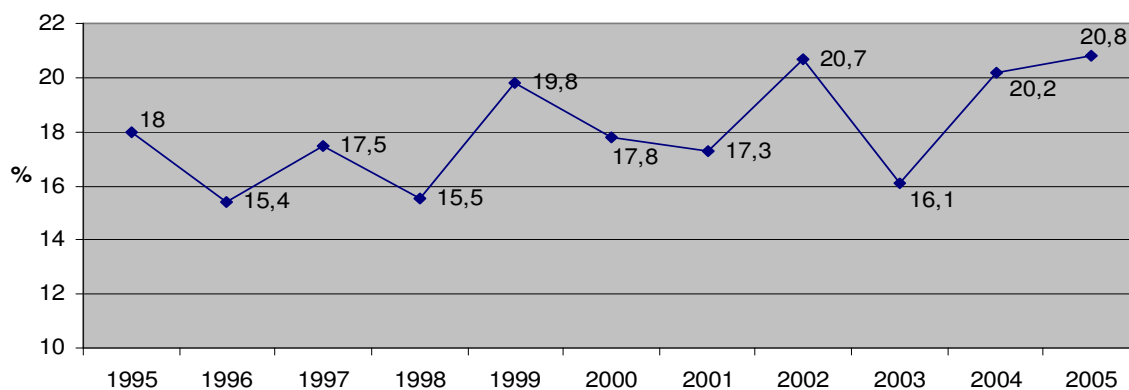
Figure 2.4: Respondents in IPE surveys, who declared experience with illegal drugs in the period of 1995 – 2005

³³ Survey of the youth's leisure time spending, criminal activity, use of legal and illegal drugs, and the relation of their use by parents and their children. Duchoň Miroslav, Metropolitan Police of Nitra, 2005
<http://www.infodrogy.sk/index.cfm?module=ActiveWeb&Page=WebPage&DocumentID=1860>

³⁴ See also Chapter 3, Prevention

³⁵ The sample represents 536,233 residents of Slovakia of this age. Source: Statistical Office of the Slovak Republic – Mean Population Status as at 1st July 2005

³⁶ In 2001 and 2003, smoking and the use of alcohol were monitored also in elementary school pupils.



Source: IIPE, 2005

Some further results and development trends in subgroup declaring experience with illegal drugs.

- The most frequently used drugs include marijuana (49.7%), hashish (7.5%), ecstasy (6.7%), volatile substances (6.1%), tablets combined with alcohol (5.6%), tablets (4.8%), pervitin (4.5%), and cocaine and magic mushrooms (3.8% each). Other illegal drugs such as LSD (2.9%), heroin (1.1%) and crack (0.3%) are experimenting by the respondents only in isolated cases, with 3.5% of the enquired being unable to determine the type of drug they used.
- Respondents who already tried drugs are more often smokers and/or have higher alcohol consumption. Parents of these people smoke in a greater number of cases – both parents and at least one of them – and they use alcoholic drinks in a significantly greater extent than fathers and mothers of young people without drug experience.
- On the basis of the statistical significance found it can be stated that the respondents, who have experience with drugs, more often come from incomplete and completed families and state in greater numbers that there are deteriorated relationships in their families.
- The most frequently reported age of first experiments with a drug was 16 years, the lowest age being 12 years.
- When experimenting with a drug for the first time, more than one half of the respondents obtained the drug from a friend and 30.7% of the enquired were offered the drug by a classmate; 90.1% of young people were provided with the drug by a peer. For the entire period monitored, there have been a very high number of respondents who were provided drugs by friends and classmates. Males most frequently obtain drugs from a classmate, colleague, sibling, or dealer, while females are more frequently offered the drug by friends or by strangers. 46.3% of young people got a drug for free and more than one third bought it; 3.7% of the enquired grew the drug themselves.
- Since 1996, the number of respondents, whose friends have already tried illegal drugs, has been moderately increasing. In 2005, 58.9% of respondents had friends, who had already tried some illegal drug (in 1996 it was 49%). The results signalise comparably great availability of drugs for young people through their friends, who already tried drugs. In the group of respondents, who have experience with drugs, as many as 94.8% of the enquired have friends who also tried drugs.
- As places, where young people can most easily buy or get a drug, the respondents indicated discos and concerts, entertainment and gambling establishments, school hostels, schools, and public areas.
- Since 1996, there have been an increased number of young people experimenting with each of the drug use methods. In the group of drugs that are smoked, an increasing trend has

been seen, with the increase being more moderate for drugs that are used intravenously, by inhalation and swallowing.

- The respondents largely underestimate not only the danger of drug addiction but also that of the transmission of infectious diseases such as AIDS or hepatitis. The respondents consider the most frequent reasons for experimenting with drugs to be the wish to conform to a peer group, curiosity, boredom, and escape from the family environment. The number of respondents reporting pleasant and very pleasant feelings increases with the growing frequency of drug use.

2.3 Drug use in special population groups

NMCD has no data available of 2005³⁷ concerning drug use among conscripts or soldiers in mandatory military service³⁸ in the Army of the Slovak Republic.

Non-governmental organisations operating in the field of harm reduction including for persons working in the sex business do not monitor whether or not these persons are drug users at the same time. Surveys are not available.

Persons serving sentences of imprisonments declare drug use in civil life when starting their sentence on voluntary basis. In 2005, such drug use was reported by 651 persons, which was 11.6% of the total number of the accused and convicted as at 31st December 2005.

Recreational environment

In 2005³⁹, a drug use (legal and illegal) survey was conducted in participants of open air events “Pohoda” in Trenčín, “Hodokvas”, and a dancing event “Be Free”. Of 268 respondents, 85% (227) were in the age of 15 – 29 years, including 33 (12%) persons of 18 years of age. The data indicated that the lifetime prevalence of the use of legal drugs (alcohol and tobacco) increases regularly with the age. The subgroup of < 18 years had the highest presence of heroin in all age groups.

Comparison with data from population surveys by PORI at SO SR (2004) in the same age group of 15 – 29 year-olds showed significant differences among visitors of music events and “common” population of youth. There was a marked difference between the prevalence of marijuana use in the last month, while in the representative population survey, marijuana use in the last month was declared by 4% of youth in the age of 15 – 29 years; in the group of 15 – 29 years old visitors of music events (n = 227) it was as many as 36%.

Risk groups

Residents of special foster care facilities – re-education homes (hereinafter “RDM” or “RDD”⁴⁰) – represent a risk group in several aspects. At least 70% of inmates were, before admission, clients of pedagogical psychological counselling centres (hereinafter “PPCC”) and more than a third were clients of centres of educational and psychological prevention (hereinafter “EPPC”)⁴¹. According to data from another research⁴², 39.3% of residents were in the care of a child psychiatrist.

³⁷ Last survey led by: Bianchi, G., Popper, M., Lukšík, I., Supeková, M (2000): Interaction of sexual and drug risks to health of the soldiers of mandatory military service – Human Communication Studies Vol. VI. Slovak Academy of Sciences, 2000

³⁸ The mandatory military service was abolished in 2005. As of 1 January 2006, the Slovak Republic has a professional army.

³⁹ For details see the 2005 National Report, pp. 198 – 207.

⁴⁰ RDM – re-education home for youth up to 19 years); RDD – re-education home for children up to 15 years) - special educational facility within the Education sector

⁴¹ Hudečková, V.: Our reformatories in the new millennium. In: Prevencia 1/2006, V. pp. 89 – 90, Bratislava ISSN 133-3689

⁴² Fehérová, L., Mikulčíková, K., Sotník, D.: Fundamental aspects of diagnostics of youth with behavioural disorders. In: Prevencia 1/2006, Bratislava ISSN 133-3689, pp.19 – 25

According to Pétiová (2005)⁴³, causality could be seen between the unfavourable family environment and subsequent failures of young people resulting in their placement in a re-education facility.

Table 2.2: Basic information on survey groups and the percentage of respondents who declared smoking and drinking of alcohol in %

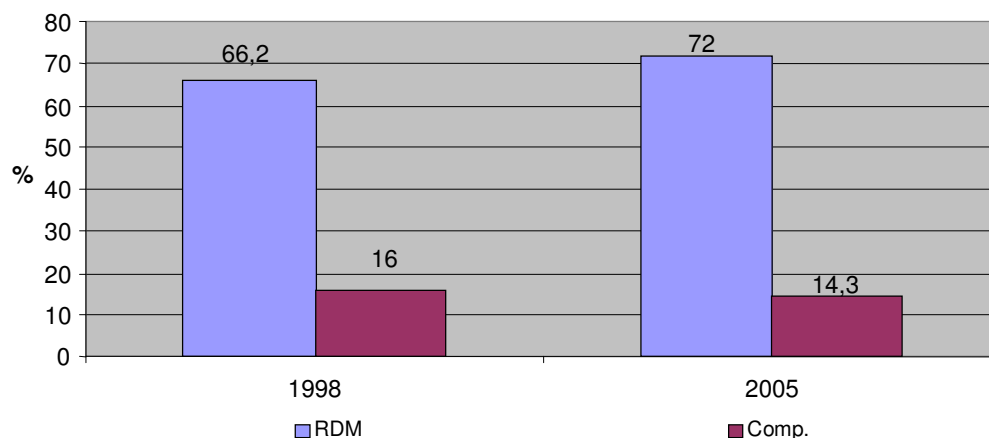
Number of respondents in the age	1998		2005	
Re-education homes, 15 – 19 years, n =	486		304	
Comparative group, 15 – 17, n =	486		223	
Cigarette smoking	Re-education homes		Comparative group	
	1998	2005	1998	2005
Smokes occasionally	8.7	10.2	17.3	10.8
Smokes daily	82.7	72.7	18.4	12.6
Does not smoke	8.6	17.1	64.3	76.6
Consumption of alcoholic drinks	Re-education homes		Comparative group	
	1998	2005	1998	2005
Drinks frequently	26.2	31.6	8.1	5.4
Drinks occasionally	60.1	60.2	55.1	53.8
Does not drink	13.7	8.2	36.8	40.8

Source: Pétiová, M., IIPE, 2005

In 2005, only 8.2% did not drink and only 17.1% did not smoke among RDM inmates, compared to 76.6% of non-smokers and 40.8% of non-drinking young people of the comparative sample.

Figure 2.5 illustrates the difference between experiences with an illegal drug, which was 72% in RDM residents in 2005 as opposed to respondents of the comparative sample (14.3%).

Figure 2.5: Comparison of experience with illegal drugs in the “re-education home” group and in the comparative sample in 1998 and 2005



Source: Pétiová M., IIPE, 2005

The lowest age of the first contact/experimenting with a drug in the comparative group was recorded in 12 years; among the residents of re-education facilities, the first contact occurred as early as in 9 years. The greatest percentage was in RDM both in 1998 and 2005 corresponded to the age of 14 years.

In the comparative group, in 1998, drugs were most experimented with in the age of 16 years; seven years later, experimenting starts a year earlier, in 15 years of age.

As for the experience with individual illegal drugs, marijuana leads in both groups; however, the comparative group has a high lead with nearly double values. In 1998, marijuana was followed by inhalants, tablets, heroin, LSD, and pervitin in RDM residents.

⁴³ Pétiová, M.: Opinions and attitudes of young people living in diagnostic centres and in re-education homes for youth in the Slovak Republic concerning drug use. IIPE 2005

In 2005, young people from re-education facilities mentioned marijuana followed by hashish, inhalants, tablets with alcohol, pervitin (the use of pervitin was indicated in 9.2% compared to 4.7% in 1998), and medicinal products (Table 2.3).

Table 2.3: Use of illegal substances by RDM's youths and in a comparative group

Use of illegal drugs	Re-education homes		Comparative group	
	1998	2005	1998	2005
Volatile substances	22.4	10.2	10.7	5.8
Marijuana	35.4	25.1	68.0	59.6
Pervitin	4.7	9.2	1.0	1.9
Ecstasy	1.0	7.6	1.0	5.8
Heroin	9.2	2.8	2.9	0
Cocaine	3.9	2.6	1.0	5.8
LSD	5.1	4.2	1.0	0
Tablets	15.5	8.6	10.7	5.8
Tablets with alcohol	n/a	9.5	n/a	3.8
Hashish	2.8	10.7	3.9	3.8
Crack	n/a	2.4	n/a	0
Magic mushrooms	n/a	6.0	n/a	1.9
Unable to determine drug type	0.3	1.1	0	5.8

Source: Pétiová, M., IIPE, 2005

Roma minority children

In the Slovak Republic, there is the second⁴⁴ most numerous minority – official statistics in 2001 reported 99,448⁴⁵ persons and qualified estimates range from 320 to 450 thousand of citizens. According to a report by the Slovak Republic Government Office⁴⁶, this community faces the most complex package of problems in Slovakia and struggles with its own cultural identity as well as with significant social problems. Especially children from this socially disadvantaged environment have problems in integration into majority's institutions – the schools.

A survey among children in the context of health education (as universal prevention⁴⁷ as well as with respect to problems with addictive substances) was conducted in school years 2003/2004, and 2004/2005 at elementary schools of the districts of Eastern Slovakia - Prešov, Vranov nad Topľou, Trebišov, and Stará Ľubovňa. The survey covered 1,012 Roma pupils of the third grade⁴⁸ of the elementary schools – not differentiating by age and gender. The selection of the group was done using the procedure of random selection. The respondents were administered a questionnaire with the difficulty and comprehensibility being evaluated by a pre-survey. The findings were expanded using semi-standardised interviews with teachers.

The NMCD does not have quantified data available and the author⁴⁹ points out limitations to generalisation of the findings. The quantitative conclusions of this survey among 3rd grade pupils from socially disadvantaged environment in certain Roma settlements indicated:

- Tolerated drinking of alcohol, smoking and use of volatile substances (toluene), particularly in boys of the group surveyed, not realising the harmfulness of alcohol and tobacco – common part of life.
- Use of the above addictive substances as early as in the younger school age, in some cases even in the pre-school age (5 to 10 years).
- Effect of the family – operates as a negative identification model also with respect to addictive substances.

⁴⁴ After the Hungarian minority

⁴⁵ <http://www.statistics.sk/webdata/slov/scitanie/nami.htm> - downloaded on 26 September 2006

⁴⁶ http://www.government.gov.sk/aktuality_start.php3?id_ele=6169&print_me=1, downloaded on 16 February 2006

⁴⁷ See Chapter 3 Prevention

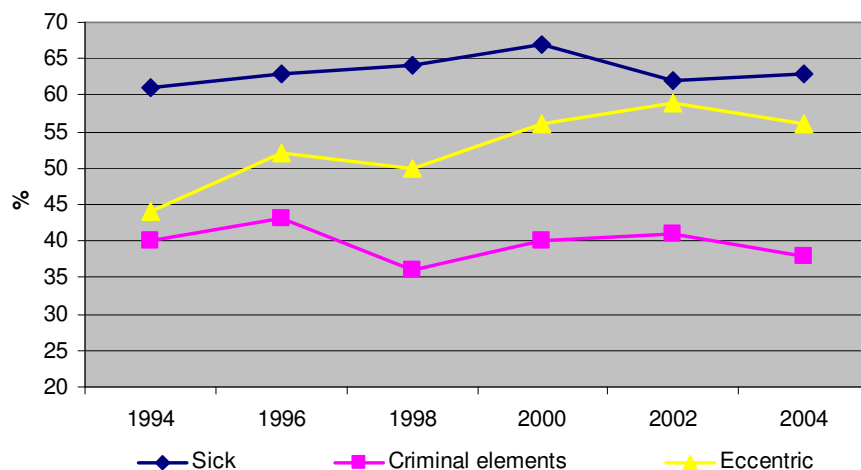
⁴⁸ In the third grade of elementary schools, this typically involves 9 years old children.

⁴⁹ Prof. PaedDr. Jozef Liba, PhD, Pedagogical Faculty, University of Prešov; Experience and frequency of Roma pupils' contacts with addictive substances, Information for NMCD, March 2006, not yet published

2.4 Attitudes to drug use and users

In the ten years' period, according to surveys by the PORI at SOSR, the proportion of the two basic attitudes of the public has not changed, namely of the majority one – that drug users are ill people (63% on average) and the minority one – that they are criminal elements (39.6% on average). A moderate increase has been seen in the opinion that they are “eccentric people dissatisfied with everyday life” (44% in 1994 and 56% in 2004).

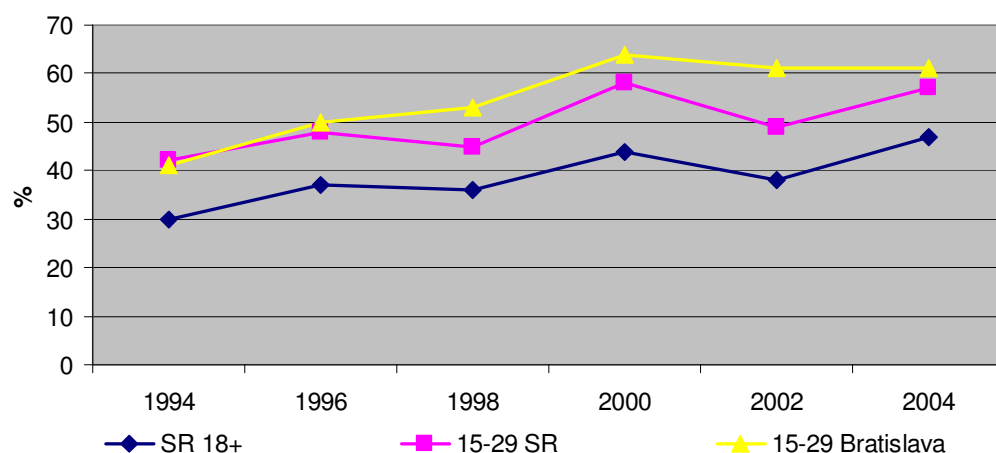
Figure 2.6: Development in most frequently occurring opinions concerning drug addicts



Source of data: Prevalence of drug use in the SR. 2004, p. 49

The number of people who declared in the survey consent with provision of injection needles and syringes to the drug addicted free of charge (or at a minimum charge), increased. On the contrary, the number of respondents, who are against the provision of needles and syringes, has been decreasing since 1994. (Figure 2.7)

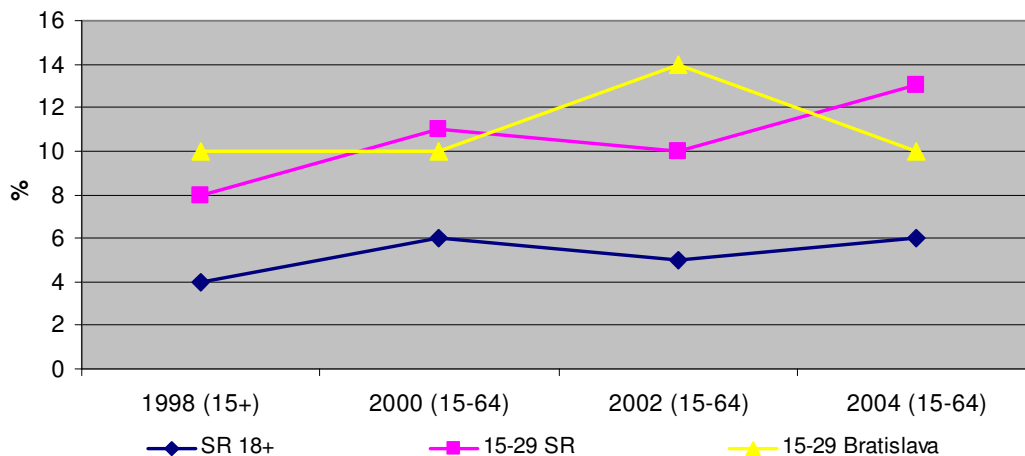
Figure 2.7: Development of the positive attitude towards harm reduction in %



Source of data: Prevalence of drug use in the SR. 2004, p. 59

The options that the PORI survey respondents were offered to choose from with respect to measures that should be taken against the spread of drug addiction include also legalisation of “soft” drugs. The proportion of those who consider legalisation of soft drugs is not high – in 2004 there were 6% of respondents in the group of the Slovak Republic 18+, 13% in the group of the Slovakia’s youth 15-29 and 10% in the group of Bratislava’s youth, but since 1998, there has been a moderate increase of pro-legalisation attitude (Figure 2.8).

Figure 2.8: Development of the number of respondents with approving attitude to legalisation of soft drugs



Source of data : Prevalence of drug use in the SR, 2004, p. 57

In 2004⁵⁰, marijuana legalisation without any limitations⁵¹ was approved by 8% of the respondents in the group of the youth of Bratislava and 7% of the young people in the group of Slovakia's youth, and 3% of the group of the Slovak Republic (18+).

Also according to IIPE's surveys (see part 2.2.2), most of the respondents (51.4%) are against legalisation of soft drugs, but their proportion since 1999 (58,2%) moderately fell in favour of those who could not take a position with respect to this serious issue (41.5%).

⁵⁰ Prevalence of drug use in the Slovak Republic, Statistical Office of the Slovak Republic, Public Opinion 2004, p.61

⁵¹ Other options offered were: marijuana legalisation with some restrictions, legalisation of all drugs with some restrictions, all drugs should be prohibited, all drugs should be legalized.

3 Prevention

The National Programme for the Fight against Drugs (NPF) 2004 – 2008 in the Slovak Republic defines prevention as “activities aimed at reducing the drug demand”⁵² and in reduction of drug demand attaches a dominant position thereto.

The objectives of prevention include, inter alia, reduction of drug use prevalence among youth under 18 years of age,⁵³ or increasing the age first contact with a drug in children and youth. To satisfy these objectives, the following is necessary according to the NPF:

- Focus the education process on the support of life quality, healthy lifestyle, and protection of people’s own health,
- focus leisure-time education on creative use of leisure time as a significant preventive alternative to drugs,
- to target preventive programmes at legal and illegal drugs and involve youth in creation and implementation of preventive programmes.

According to Vojtová (2006)⁵⁴, the objectives of preventive activities, in addition to the above, may include:

- Drug use and drug addiction prevention itself.
- Reducing drug user problems in his or her social environment.
- Activities focused on the prevention of criminal behaviour.

The National Strategy defines also key ministries for the implementation of prevention: Ministry of Education, Ministry of Health, Ministry of Labour, Social Affairs and Family. The ministries of interior and culture also play an important role in prevention. Ever more competences and actions in implementation of preventive activities are transferred to regional structures of public administration (territorial state administration and self-government) and citizens’ associations. The Anti-Drug Fund plays an essential role in the funding of anti-drug activities.

There is presently no central register of all specific/non-specific⁵⁵ preventive programmes/activities performed by various entities. The most precise records are kept by the Institute of Information and Prognoses of Education (IPE), which collects and analyses data of preventive programmes implemented for the target group of school population and ensures processing and records of projects requesting support from the ADF.

Problems of NMCD in obtaining data on preventive programmes/activities are contributed to, inter alia, by the terminology and distinguishing the prevention levels to primary, secondary, and tertiary⁵⁶, as well as newly used terms – universal, selective, and indicated prevention⁵⁷. In practice, such strict categorisation is a problem as there are overlaps among the degrees of “progress” of the disease and among the target groups. Considering preventive work with youth, some experts think the division into primary and secondary prevention does not make much sense⁵⁸. The threat in an early stage of development cannot always be recognised and, in the field of school and work with youth, it is not possible to separate young users not (yet) at risk

⁵² 2004 Report, p. 146

⁵³ A specific priority – laid down in the Action Plan of the Ministry of Education – is to improve the preventive measures and to increase the efficiency of preventive school programmes with the objective of significantly increasing the age of first-time users of legal and illegal drugs and reducing their total number.

⁵⁴ Vojtová, Z. Comprehensive approach to prevention in the Slovak Republic, 10 May 2006, <http://www.infodrogy.sk/index.cfm?module=Library&page=Document&DocumentID=238>

⁵⁵ The non-specific prevention comprises part of the primary prevention and has a protective potential as it reduces the risk of development of any undesirable forms of behaviour.

⁵⁶ Medically viewed prevention according to the course of the disease

⁵⁷ According to target groups or individuals

⁵⁸ Frühintervention bei erstauffälligen Drogenkonsumenten - FreD (Early intervention in experimenting drug users), manual, 2004 p.18

from those (already) at risk⁵⁹. A common feature for both prevention levels should be the building of competences as factors of protection from drug use harmful to health.

The categorisation of preventive programmes is influenced by the optics of professional, sectoral, or interest-based viewing of the basic direction of prevention – while in the sector of education, the notion of prevention covers nearly the entire area of social pathology, the sector of interior (home affairs) understands prevention as prevention of crime (social, situational, and victimisation crime).

Projects of preventive programmes/activities requesting subsidies from the Anti-Drug Fund are categorised into groups of Prevention I. (school projects) and Prevention II. (edification, NGO's, self-government). A special group of media projects includes projects with a primary preventive objective, which communicate with various target groups through media.

For the purposes of the present report, with respect to the EMCDDA's definitions of prevention, activities falling within the following categories are presented here:

- **“Universal prevention”** – meaning prevention addressed to the entire population, whether universally (campaigns, media), locally (community programmes), or addressed to a certain part of population (school population). The activities approach the target group with a message aimed at prevention in general or to postpone the use of alcohol, tobacco, and drug for a later age.
- **“Selective prevention”** concerns preventive activities designed for population groups subject to a higher risk of drug addiction. Risk and high-risk groups may be defined at various levels of several factors known to be associated with drug use. In a greater detail, this report mentions high-risk groups – residents of re-education homes in the age of 15 – 19 years (Chapter 2), children from socially disadvantaged environment of Roma settlements in Eastern Slovakia (Chapter 2), and children with the ADHD syndrome (Chapter 11).
- **“Indicated prevention”** covers activities designed for individuals, who are not satisfying medical diagnostic criteria of DSM-IV or ICD-10, but do exhibit signs of use of addictive substances, and targets them through special interventions. The term of indicated prevention is used, e.g., in connection with activities conducted with respect to youth that already violated the law.

Leisure-time activities as prevention

The emphasis placed by the NPF on leisure-time activities as a positive alternative is justified in Slovakia – the economic transformation since 1989 has brought a range of changes into the working systems of school and after-school education of children and youth. The changes led to reducing the non commercial availability of sports, culture, and active leisure time spending.

Yet the leisure time has an important function in child's life – a socialisation, compensation (balancing work and school load), as well as preventive function. According to information for the Second Implementation Report on the (UN) Convention on the Rights of the Child in the Slovak Republic for the period of 2001 – 2005⁶⁰, active extracurricular activity in young people is present only occasionally. Only 15.7% of youth are involved in it frequently and 35.1% occasionally as the nationwide average. Nearly half of children and youth does not involve in extra-curricular activities at all.

3.1 Universal prevention

Besides the sector of education, in which most of the preventive activities/programmes targeting school population are conducted (more in section 3.1.1), the support of health and education towards health⁶¹ is the universal message applied in the healthcare sector. The concept is

⁵⁹ Hallmann, H.-J., 2002: Primary prevention or secondary prevention? Current assessment of too non-current terms. In: Kammerer, B., Kretschmar, K., Rumrich, R., 2002 (Ed.): Future of addiction prevention, Nuremberg: emwe publishing house. In FreD, www.infodrogy.sk

⁶⁰ March 2006

⁶¹ For example, in Germany, primary prevention is about health support (Salutogenese) and life skills support.

formally⁶² anchored in the document “National Health Promotion Programme” and generally covers prevention against all psychoactive substances (e.g., development and support of programmes for health damage reduction in injection drug users). Health support and protection is supported by the legislative framework and measures stemming there from (such as the ban on smoking in public buildings – including schools and school facilities, etc., ban on cigarette advertising, ban on sales of alcohol and cigarettes to persons of under 18 years of age, etc. including economic measures⁶³ – increasing consumer taxes of ethanol, alcohol and cigarettes).

3.1.1 Counselling, edification and preventive activities are conducted through Public Health Authorities.

For instance a preventive activity entitled “Marijuana known and unknown”⁶⁴ was prepared by the staff of the PHA SR in Bratislava at some secondary grammar schools of Bratislava in 2005. According to information from January 2006, nearly 200 students in the age of 16 – 17 years were presented information on the drug, on the consequences of marijuana use and abuse, connected with a personal account by an abstaining young man addicted to marijuana. The students are administered a short questionnaire containing basic orientation questions concerning the knowledge on the drug, the perceived risk, and actual consequences. The objective is to increase the perception of the risk of this drug abuse.

Counselling services for adult clients are provided by 36 regional public health authorities and by the central Public Health Authority of the Slovak Republic. Counselling cover the problem of different nature: smoking cessation, advices for families of alcoholics, prevention of addictions, (including eating disorders and gambling).

In 2005, the activities of universal prevention were contributed to through educational and edification presentations for various population groups – especially for secondary school population and youth – by experts from specialised medical facilities for the treatment of drug addictions and by other experts from the field of addictions.

The spectrum of media presentations by medical experts in the field of drug addictions was broad also in 2005. According to the STORIN media monitoring agency, in the course of 2005, there were 40 presentations connected with prevention registered in the nationwide and local media monitored. In 2005, the PHA SR participated in the EU’s anti-smoking campaign, HELP, which, according to the survey, was noticed by as many as 91% of Slovakia’s population (age 15+)⁶⁵.

According to the main expert of the Ministry of Health of the Slovak Republic for the drug addictions, Ľubomír Okruhlica⁶⁶, the primary (health) prevention faces the task of reducing marijuana consumption, but particularly the task of reducing the early initiation of alcohol drinking in juveniles and even children.

3.1.2 School programmes and programmes targeting children and youth

In the field of education and upbringing of children and youth, prevention is understood comprehensively and the central idea of addiction prevention is the support/protection of health and/or development and building/strengthening life skills.

The largest target group of universal and partially also selective and indicated prevention is the school population. In 2005, there were 804,923 children in the age of 6 – 16 years, which is the age of the ten years’ compulsory school attendance. The secondary school population (17 – 19) comprised 253,553 young people.

⁶² The said programme is not fully operational and is implemented sporadically depending on funding.

⁶³ Ochaba, R.: Ban on advertising and increasing prices reduce the number of smokers. Alcoholism and drug addictions (Protialkoholický obzor) 38, 2003, pp. 117 – 120

⁶⁴ Korbelová, B (2006): Marijuana known and unknown, February 2006, Report for the NMCD

⁶⁵ Stop smoking, www.stopfajceni.sk

⁶⁶ Prevencia drogových závislostí [Prevention of drug addictions] – information and educational bulletin of the Ministry of Culture 2/2006, Bratislava, ISSN: 1336-9679, p. 12

Institutional provisions for prevention for the school population

The drug issue is an integral part of the education process at schools supported through additional instructional texts⁶⁷. The positions of drug prevention coordinators were created at schools. In the network of school facilities, there are Pedagogical and Psychological Counselling Centres (PPCC) in each district; in 48 cases, besides a PPCC, there is also an Educational and Psychological Prevention Centre (EPPC), and 2 EPPC's operated as autonomous facilities⁶⁸.

PPCC's and EPPC's participate in implementation of preventive programmes/activities in the field of drug prevention, focused on prevention of socially pathological phenomena, problem behaviour of elementary school pupils and secondary school students, conduct training courses for peer activists, teacher training, and provide methodological assistance to school psychologists and educational counsellors. School facilities are to provide prevention in behavioural problems and special assistance and services for risk children/clients.

The EPPC, a special education facility, working close with the family and natural social environment, provides specific social, psychological, therapeutic and educational care to children threatened by socially pathological phenomena, usually in an out-client form. It participates in field social work and contributes to educational supervision over children at risk including those with interrupted or terminated institutional care⁶⁹.

Table 3.1: Activities and participants in prevention of drug addiction in the 2004/2005 school year

Activities and participants		PPCC		EPPC	
		activities	participants	activities	participants
Group client activity		1,983	51,476	2,211	54,733
includ- ing	training groups	905	19,509	818	18,243
	lectures, discussions	1,078	31,967	1,393	36,490
Services to pedagogues		443	1,845	444	1,477
includ- ing	methodological consulting	397	1,034	396	674
	courses, seminars	46	811	48	803
Preventivist training		72	1,172	234	3,705
Other professional activities		392	15,947	373	13,540
Preventive programmes		916	89,768	1,535	96,768
Total		3,806	160,208	4,797	170,223,

Source: IIPE, 2006

EPPC's, in the 2004/2005 school year, conducted 1,535 preventive programmes, of which over one third was designed for elementary school pupils, then for kindergartens and peer groups. The evaluation covered 36.81% of programmes.

⁶⁷ (For lower classes of the elementary school: Do not destroy your wise body (Raynerová); higher classes of the elementary school: How do I know myself (Kašparová, Houška, Uhereková);

Secondary schools: How to be myself (Zelina, Uhereková).

⁶⁸ With respect to the austerity measures in the sector of education, in 2005, the number of autonomous EPPC's decreased to 2 and the number of professional staff was reduced. Merging the facilities of counselling services provided by the PPCC's with the educational prevention facilities, in experts' opinion, does not necessarily have to benefit the application of the early prevention principle in high-risk groups of pupils and students.

⁶⁹ Slovíková, M.: What do results and data present in the school year 2004/2005? Čistý deň 3, 2006, p. 29.

Table 3.2: Number of EPPC preventive programmes

Preventive programmes	Total	preventive programme type aimed on						
		kindergartens	Elementary schools	Peer programmes	risk groups	secondary schools	leisure-time activities	lectures, discussions
	1,535	290	584	234	188	97	125	17
%	100	18.89	38.05	15.24	12.25	6.32	8.14	1.04
including by target group								
- pre-school children	287	287	-	-	-	-	-	-
- elementary school pupils	978	-	564	169	184	1	56	4
- students of vocational, apprentice, and grammar schools	164	-	7	62	1	90	-	4
- special elementary school pupils	1	-	1	-	-	-	-	-
- parents	72	-	1	-	1	-	69	1
- teachers (coordinators, educational counsellors)	23	2	5	2	-	6	-	8
of which								
- short-term	564	47	390	19	38	38	25	7
- medium-term	141	3	63	53	7	12	-	3
- long-term	830	240	131	162	143	47	100	7
Number of programmes under assessment	565	247	122	32	40	26	95	3

Source: IIPE, 2006

3.1.2.1 Programme “Healthy School”

In cooperation with the Ministry of Education, the Ministry of Health conducts preventive activities with a focus on children and youth. The longest running programme⁷⁰ of this type is the Healthy School of the World Health Organisation. This health educational programme has two levels – building a generally positive attitude to health and the willingness to learn about health issues.⁷¹ A priority of the project is to ensure personality development and mental health of children applying the concept of mental health.

In Slovakia, there is a “National Network of Schools Promoting Health” established with over 2000 entities – starting from kindergartens⁷². An analysis by the Research Institute of Child Psychology and Pathopsychology (hereinafter “RICPaP”) in 2005 has shown that pupils of schools, in which the programme was conducted, had a significantly higher interest in health topics compared to pupils without the project⁷³.

Health at Schools

In 2005 for the first time, the Ministry of Education launched and conducted a development project entitled Health at Schools⁷⁴. The following topics were selected: education towards health, healthy lifestyle, prevention of civilisation diseases, protection and support of physical and mental health, improvement of children’s and youth’s health, addictive substance use prevention, training of pedagogical and non-pedagogical staff of the sector of education, and teacher health support⁷⁵. In 2005, 130 submitted projects were considered and the section of

⁷⁰ Since 1992 it has been part of the National Health Promotion Programme.

⁷¹ Hroncová, J. et al., Social pathology, Banská Bystrica, 2004, p. 70.

⁷² Földes, T., Slovíková, M.: Assessment of schools’ involvement in the National Network of Schools Supporting Health, December 2004, Bratislava, IIPE

⁷³ Vojtová, Z., Kopasová, D.: Schools Promoting Health – coordination and evaluation. In: RICPaP 2005 Annual Report, www.minedu.sk.

⁷⁴ This grant system is also monitored by the IIPE

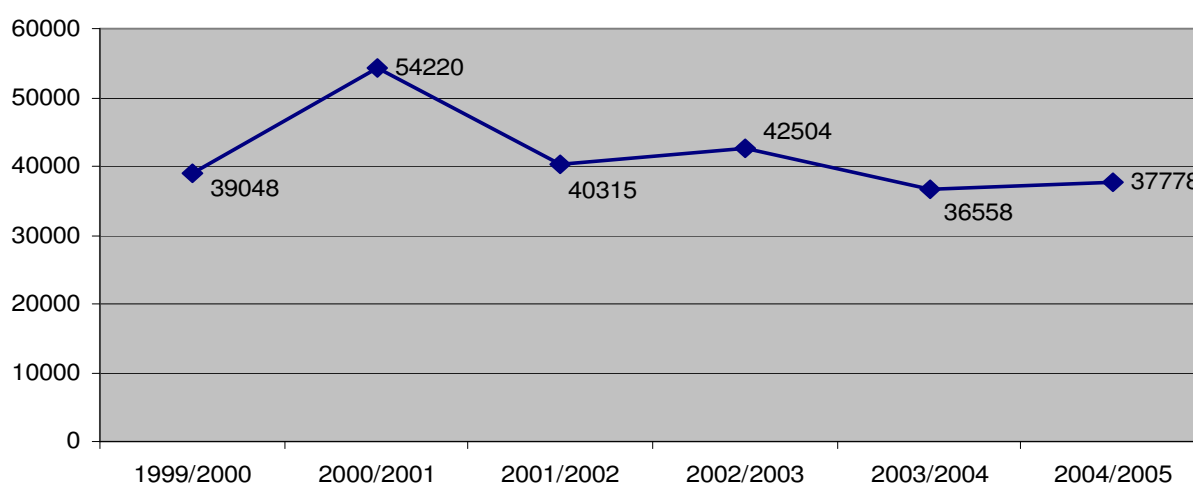
⁷⁵ Material for a session of the Committee of Ministers for Drug Addiction and Drug Control, March 2006, www.infodrogy.sk

regional schools of Ministry of Education has supported 34 projects realised by elementary, secondary and special schools⁷⁶.

3.1.2.2 A Way to Emotional Maturity

The competence-strengthening (“life skills”) school programme “A Way to Emotional Maturity” (hereinafter the “Way”) authored by Štefan Matula, after six years⁷⁷, has become a stable part of the education process in higher classes of elementary schools and in lower classes of eight-years grammar schools. This group programme is designed for the age group of 12 – 15 years old pupils and is conducted mostly in the framework of ethical education alternating with religious education. The programme is conducted by professionally trained teachers. Through training and model situations, emotional maturity in children is developed including with respect to such consumer offers as alcohol, smoking, and drug use. In the 2004/2005 school year, the programme was conducted in 75 districts. The programme covered 37,778 (14.3%) of elementary school children and secondary school students.⁷⁸

Figure 3.1: Numbers of 12 – 15 years old pupils who underwent the programme



Source: IIPE, 2005

3.1.2.3 Used in the Slovak Republic since 1995 as a school anti-drug programme for secondary school students, the computer preventive programme by Barbara Thomas was updated in 2005. The 6 modules (alcohol, tobacco, marijuana, other psychotropic substances, street drugs, and cocaine) were extended by a module to test drug knowledge obtained, which provides an opportunity to test the efficiency of the programme. Several hundreds of CD carriers were produced in 2005 to introduce the programme to schools.

3.1.2.4 Behave Normally

In the framework of crime prevention, a preventive programme “Behave Normally” has been conducted at elementary schools for the seventh year under the sponsorship of the Police Corps Presidium of the Ministry of Interior⁷⁹. The project is designed for 5th grade pupils (age of 10 – 11 years). A policeperson in a uniform presents 10 topics to children, including that of alcohol and drug addiction. In the 2004/2005 school year, 257 elementary schools and 260 policepersons were involved in the project; currently (the 2005/2006 school year), the project is being implemented in all eight regions of Slovakia and the number of trainers increased (269 state policepersons and 39 metropolitan policepersons).

3.1.1.5 We Know that...!

⁷⁶ www.minedu.sk, 20 July 2006.

⁷⁷ Throughout the six years’ period, the preventive programme “A Way to Emotional Maturity” was applied in 14,885 classes and it was undergone by 251,111 pupils in total.

⁷⁸ Slovíková, M. A way to emotional maturity 2004/2005, Information for NMCD 2006

⁷⁹ Material for a session of the CM DADC, March 2006

In the 2004/2005 and 2005/2006 school years, a programme “We Know that...!” is being conducted for the 7th grades (12 – 13 years). Originally, this was a preventive project of the Dutch Police Institute modified⁸⁰ for the purposes of the Slovak Republic. Twelve lessons deal with problems in children’s and youth’s behaviour, racism, xenophobia, multicultural education, anti-drug education, addictions to drugs and other addictive substances, and anti-criminal behaviour. The objective of the project is to increase pupils’ responsibility for their behaviour and to improve the efficiency of socially pathological phenomena prevention on the local level. This is one of the few projects, whose efficiency is assessed (entry⁸¹ and exit tests⁸² of programme participants). In the 2005/2006 school year, the regional project covered 35 schools and 902 pupils of the Nitra region.

After-school programmes and leisure-time activities

The objective of education in leisure time is the development of children’s and youth’s personalities as well as the prevention of possible negative influences of the environment in cooperation with the family, based on individual mental and physical special features. The educational facilities include pre-school facilities, children’s school clubs, leisure time centres, and school centres of extra-curricular activity, youth homes, and open-air schools.

In the field of leisure-time education, there are 219 leisure-time facilities in the Slovak Republic, 145 being leisure-time centres (hereinafter “LTC”) and 74 being school centres of extra-curricular activity (hereinafter “SCECA”)⁸³.

In 2005, 7,354 hobby groups with 102,268 members were involved in LTC’s and SCECA’s regular activity, which represents an increase of 19,285 members (+23.2%) compared to the previous school year; the growth can be attributed also to the “educational vouchers”. Of the total number of members, 80.7% of children were under 15 years of age, which represents approximately 12.5% of the population of this age (<15). The LTC’s operate all year round and comprise, besides the regular one, also occasional extracurricular activity and vacation activities.

Facilities in the sector of culture – regional and local edification centres and libraries – also constitute a space where leisure time can be spent usefully and creatively, but also a space for relevant form of social prevention. In the framework of primary prevention of drug addictions, events and activities are organised, whose objective is not only to provide knowledge of this area but also to influence the desirable change with respect to their attitudes to drugs and addictions in favour of pro-social behaviour⁸⁴. The key project of the sector of culture is the original nationwide project aimed at drug demand reduction in youth. The project is based on the idea of expressing feelings of children and youth through a creative art competition “Why I am happy to be in the world⁸⁵” and on the subsequent travelling exhibitions of the project. The authors aged 14 – 18 years – individuals or teams of art schools, children’s homes, diagnostic centres, and special schools, can express their attitude to drugs and other harmful addictions using painting, collage or graphics. In 2005, the eleventh year⁸⁶ has been held under the patronage of the National Council of the Slovak Republic, which was exceptional from the viewpoint of the project. Thirty selected works by Slovak and foreign authors were presented at the UN grounds in Geneva. The winning works are annually used as motives for the production of T-shirts, baseball caps, posters, calendars, postcards, puzzles, and other artefacts, which

⁸⁰ Zelina, M., Lenárt, M.: We know that... Complementary, educational and training text for pupils, methodological guide for the lecturers. Bratislava 2004.

⁸¹ see part 2.2.1.4

⁸² Entry and exit tests of the programme participants are processed by the IIPE. See Chapter 2

⁸³ Slovíková, M. et al.: The analysis of the activity of LTC’s and SCECA’s as at 1 November 2005, IIPE

⁸⁴ Romanovská, V.: Prevention of drug addictions in extracurricular activities in the Hron Region Edification Centre, Sociálna prevencia, 2/2006, ISSN 1336-9679, p. 29.

⁸⁵ www.nocka.sk

⁸⁶ In its 11 years, the final rounds were participated by over 10,400 boys and girls. The project also drew the attention of foreign countries and young people from Finland, Italy, Norway, and Uzbekistan took part in the competition.

serve the project organisers as prizes for the best competitors and subsequently at the travelling exhibition.

The leisure-time activities on the community level cover also low-threshold centres. In 2005, there were 15 of them, designed for children and youth not involved in organised leisure time activities. Examples include the Kopčany Community Centre in Petržalka of Bratislava operated by the Odysseus CA or Mix club – low-threshold agency for children and youth run by Children’s Fund of SR.

3.2 Selective/indicated prevention

In relation to the target risk and high-risk groups of children, besides school facilities (see section 3.1.1, tab.3.2 and section 3.2.2), the institutions and institutes linked to the Ministry of Labour, Social Affairs and Family are gaining importance. However, in the course of 2005, autonomous centres for counselling and psychological service for individuals, couples, and families (hereinafter “CCPS”) transformed and, starting from 1st September 2005, professional assistance to children, adults and their families in the field of drug and other addictions through a system of counselling psychological services is provided at separate departments of social and legal protection units of the offices of labour, social affairs, and family operating in all 79 districts of the Slovak Republic. Previously, CCPS’s operated in the field of universal prevention (e.g., peer programmes for secondary school youth), but mainly operated in prevention and social reintegration in high-risk groups⁸⁷.

In 2005, CCPS and its territorial workplaces and subsequently the offices of labour, social affairs and family implemented particularly the following preventive education and counselling programmes:

- the project “High-Risk Environment and Social Groups from the Aspect of Drug and other Addictions in the Preventive Activities of CCPS’s in 2005”,
- implementation of the preventive programme “Say it Straight”⁸⁸ in individual regions (in Bratislava, Dunajská Streda, Veľký Meder, Trnava, and Košice),
- continuation of the long-term training of working with the family with the problem of addiction – family therapy according to the V. Satir model – strengthening psychosocial immunity of marriage and family, a peer-programme for secondary school youth (Rimavská Sobota, Veľký Krtíš, Senica, Dunajská Streda, Nové Zámky).

Certain harm-reduction activities are the domain of citizens’ associations, which provide field social services (Chapter 7) entering into the natural environment of persons who are in need of help but do not seek it. In 2005, the Odysseus CA, within its low-threshold Community Centre at Petržalka residential quarter of Bratislava, provided services to 120 children and young people in the age of 6 – 20 years⁸⁹ living in socially and culturally not stimulating environment.

Another K-club is operated in this largest Slovak residential quarter by the Prima CA since June 2005, which provided its services to 75 clients.

3.2.1 High-risk environments - selective prevention

Recreational environment

The Odysseus CA has been operating in the field of reducing risks related to drug use in the environment of summer music festivals since 2001⁹⁰. The objective of the project Sex and Drugs is the prevention of risks and reducing the damage related to drug use and sexual behaviour in young people. The Odysseus CA operates in the biggest⁹¹ music event in Slovakia, “Pohoda” in

⁸⁷ Selective prevention: threatened and high-risk groups – children in children’s homes, mentally handicapped children, counselling and therapeutic work with the problem of addiction and the so-called co-addiction in the family; indicated prevention: (out-client social reintegration); in children’s homes, specialised autonomous groups for drug-addicted children after completion of the treatment.

⁸⁸ The programme “Say it straight” is accredited by the Ministry of Education of the Slovak Republic.

⁸⁹ When pragmatism has a controversial action. Information brochure of the Odysseus CA, Bratislava, 2006, 11 p.

⁹⁰ <http://www.odysseus.sk>

⁹¹ In 2005, it was visited by 50,000 participants.

Trenčín⁹², and in 2005 also at the event “Hodokvas” in Pezinok. It provides counselling on drugs and drug use, contacts to assisting institutions and information sources, and distributes info-educational materials. In 2005, info booths of the Odysseus CA were visited by 1,705 young participants, 622 persons were provided with consulting on drugs, safer sex, HIV/AIDS, and the service of testing on syphilis antibodies was used by 64 participants⁹³. For injection users it provides a programme of exchange and safe disposal of injection utensils.

A professional medical contribution to prevention in recreational environments is provided by the Institute of Drug Addictions of the Centre for Treatment of Drug Dependencies of Bratislava.

In 2006,⁹⁴ NMCD initiated a survey of drug use in a different type of setting – in “cosier” clubs and discos. The objective of the survey conducted by social field workers of the Prima CA is, inter alia, to ascertain the need of preventive actions in the context of a safer nightlife in these environments. 72% of 300 survey participants stated that they have already witnessed negative consequences of drug use; nevertheless, nearly 12% were willing to try any new drug.

Army environment

The army environment is considered to constitute a high-risk environment with respect to the specific and cultural conditions represented by this service. In 2005, the sector of defence continued preventive activities through trained multipliers/preventivists, which performed edification aimed at the fight against drugs, but also against alcohol and high-risk sexual behaviour. With respect to addictive substances – the illegal ones – as early as in 2002, special measures were taken that were and are of preventive but also repressive nature⁹⁵. Under Order No. 1/2002 of the Chief of the Slovak Republic’s Armed Forces General Staff on the implementation of the NPF in the defence sector, drug addiction was a “counter-indication” to mandatory military service but also to any other appointment within the defence sector. Should drug addiction be revealed, a treatment is followed by release from duty⁹⁶. As of 1st January 2006, there is a professional army in the Slovak Republic and the issue of legal drugs, particularly of alcohol, and illegal drugs was transferred to the level of regulation of psychoactive substance use in working time and on the workplace.

Persons working in the sex business

The Podchod (Subway) club (operated by Odysseus CA) is an isolated project in the territory of the Slovak Republic; it is the only one⁹⁷ to deal with the issue of prevention in sex business in this form. It is focused on women and men providing sexual services. It is opened twice a week in the evening with simple refreshment available and, in particular, with a space for information exchange (e.g. on deviant clients). In 2005, it provided services to 133 persons.

Other interventions

Reports⁹⁸ from six CTDD’s inform on social prevention also in 2005: e.g., the screening of “street children” and their preparation for a profession, publishing the “Nezávislosť” (Independence) magazine, counselling and therapy for parents, family members of drug addicted patients, lectures for specific groups of Roma youth, a series of lectures for miners on the topic “Alcohol Addiction” and “Pathological Gambling”.

Prevention of relapses includes the improvement of cooperation with the family and launching the daytime facility’s operation.

CTDD in Bratislava, through its website www.drogy.sk, offers individual counselling in the field of social prevention.

⁹² Info on the festival is available at <http://www.pohodafestival.sk> including relevant information of the Odysseus CA.

⁹³ When pragmatism has a controversial action. Information brochure of the Odysseus CA, Bratislava, 2006, 11 p.

⁹⁴ The survey results will be published in the 2007 Report.

⁹⁵ “Preventive Security Actions Aimed at the Use of Alcohol and other Addictive Substances”

⁹⁶ Source: Ministry of Defence of the Slovak Republic, PhDr. Mária Gašparová, Personnel Management Staff, February 2006, oral information.

⁹⁷ When pragmatism has a controversial action. Information brochure of the Odysseus CA, Bratislava, 2006, p. 10.

⁹⁸ A Material for a session of the CM DADC, March 2006

3.2.2 High-risk groups

Information on individual preventive programmes/activities for high-risk groups, particularly for children and youth, is available in professional periodicals “Prevencia” (Prevention)⁹⁹ and “Psychológia a patopsychológia dieťaťa” (Child Psychology and Pathopsychology).

Brief annotations of the projects can be found in the list¹⁰⁰ of projects financed from the ADF. The funds allocated in 2005 to high-risk and threatened groups represented 56% of over SKK 48 million Skk (approx. €1,244 thousand¹⁰¹).

According to information from the IIPE, the number of children with personality and emotional problems is increasing, including children suffering from neuroses, psychosomatic disorders, threatened by social pathology (9.3%)¹⁰² and developmental learning disorders, but also of children from socially disadvantaged environments threatened by poverty (30%)¹⁰³. At schools, serious relational problems and conflicts are rising, not only in the communication of pupils among themselves but also with respect to parents and teachers. Children and youth are also often subject to inadequate load and crisis situations. In the past already, counselling services (in sector of education) reported to have been sought by approximately 10% of this population, while presently this figure ranges over 20%¹⁰⁴.

Truancy

Truancy and problem behaviour belong to the group of socially-pathological phenomena, which, in many cases, precede experimenting with drugs or delinquency. With respect to the present unfavourable development in the occurrence of truancy and in the proportion of pupils with a reduced behaviour rank in school report (Table 3.3) or the reasons for clients coming to EPPC's and PPCC's, could these groups be also considered as high-risk groups.

Table 3.3: Truancy and problem behaviour at elementary and secondary schools in the 2004/2005 school year

The 2004/2005 school year		Truancy	Problem behaviour	
		Number of unexcused absence hours per pupil	Pupils with a reduced rank in behaviour	% of total
Elementary schools	Lower classes	2.7	2,530	1.1
	Higher classes	4.7	13,573	4.2
	Total	3.8	16,103	2.9
Secondary schools	Grammar schools	0.48	1,115	1.1
	Vocational schools	1.39	2,684	3.5
	Conservatoire	2.11	109	6.2
	Apprentice schools	10.69	10,268	14.6
	Grouped secondary schools	5.59	5,739	9.2

Source: Slovíková, M., IIPE, 2006

Clients and/or inmates of special facilities in the education sector

In the 2004/2005 school year, 19% of the total number of 12,141 of EPPC clients and less than 1% of the total number of 72,574 of PPCC clients became the clients of these facilities due to socially pathological phenomena.

⁹⁹ A bulletin focused on the prevention of socially pathological phenomena in the sector of education.

¹⁰⁰ <http://www.protidrogovyfond.sk>

¹⁰¹ Average exchange rate of EUR in 2005 = SKK 38.59, www.nbs.sk

¹⁰² Screening of children with problem behaviour – RICPaP, 2005.

¹⁰³ National report on youth policy in the Slovak Republic. Report for the Council of Europe – Ministry of Education of the Slovak Republic, august 2005. www.minedu.sk

¹⁰⁴ From IIPE reports on the activity of the pedagogical and psychological counselling centre (PPCC).

As at 31 October 2005, 30 special care facilities operated in the territory of the Slovak Republic in addition to PPCC's and EPPC's. These included 6 treatment and educational sanatoria, 3 diagnostic centres for children and 2 for youth, 8 re-education children's homes, 9 re-education homes for youth, and 2 re-education homes for mothers with children. These facilities provided special educational care to 1,322 individuals in total, including 27.8% of girls. In these facilities, children under 15 years of age comprised 40.32% (533).

Table 3.4: Number of clients in special care facilities as at 31 October 2005

	Number of facilities	Pre-school age	In the age of compulsory school attendance (6 – 16)			After compulsory school attendance		Total Count
		Total	Total	of which females	up to 15 years	Total	of which females	
Re-education children's home RDD	8	-	302	69	209	-	-	302
RH for youth - RDM	9	-	-	-	-	481	180	481
Treatment and educational sanatorium	6	7	232	25	220	20	-	259
DC for children	3	44	127	38	104	-	-	171
DC for youth	2	-	-	-	-	58	30	58
RH for mothers with children	2	25	-	-	-	26	26	51
Total	30	76	661	132	533	585	236	1 322

DC – Diagnostic Centre, RH – Re-education Home

Source: Slovíková, M., IIPE, 2006

The IIPE survey "Opinions and attitudes of young people living in diagnostic centres and in re-education homes for youth in the Slovak Republic concerning drug use"¹⁰⁵ (in Chapter 2 XXXX) and many other sources confirm that these are high-risk groups considering drug use, abuse, and addiction as well as a potential social failure in the future.

Institutional care in the sector of the MLSAF SR

In 2005, according to the Headquarter of Labour, Social Affairs, and Family¹⁰⁶, there were 5,467 inmates in institutional care including 4,054 children of up to 15 years of age. In 273 cases, the reason for placing the child in a children's home was the parents' addiction to addictive substances. Addiction to addictive substances of the residents themselves was the reason for institutional care in 36 cases, which includes also 15 new cases in the course of 2005.

Children and youth with ADHD/ADD¹⁰⁷

Endogenously determined attention deficiency hyperactivity disorder, moreover in combination with behavioural disorders, constitutes the psychiatric diagnosis F 90. A risk factor in this group is the pharmacological treatment through amphetamines, which may lead to a subsequent addiction to psychoactive substances. Within the sector of education, basic theoretic starting points for the issue in question were worked out as well as a systematic overview of domestic and foreign approaches to children with ADHD and the pedagogical public was informed¹⁰⁸ on inclusion of this nosological unit in the ICD 10. Methodological Information Material¹⁰⁹ of the National Institute of Education are also designed for pedagogues, including instructions and

¹⁰⁵ Pétióvá, M. et al.: Opinions and attitudes of young people living in diagnostic centres and in re-education homes for youth in the Slovak Republic concerning drug use (comparative study), IIPE, Bratislava 2005.

¹⁰⁶ Pipíšková, I., Office of Labour, Social Affairs, and Family, 2006

¹⁰⁷ See also Chapter 11

¹⁰⁸ Matula, Š. Kopányiová, A., Vojtová, Z., Smíková, E., Tesař, M., Lazníbatová, J.: Psychological and educational aspects of educating pupils with activity and attention disorders. In: RICPaP 2005 Annual Report. www.minedu.sk

¹⁰⁹ Effective as of 2 September 2004.

recommendations concerning education and care for children with behavioural disorders, including the endogenously determined ones.

3.3 Other interventions

Since May 2005, the Internet portal at www.infodrogy.sk operated by the General Secretariat of the CM DADC performs the task of a universal information and communication medium in the field of drug addictions and drug control. In the field of information, it specialises in 3 target groups – teenagers, parents, and pedagogical staff. As of October 2005, services of four counselling centres with special topics have been operated in the portal. The new services were promoted, inter alia, also through free cards distributed in restaurants, clubs, bars, etc. as part of the activities within the Week of the Fight against Drugs in November 2005. The efficiency of this form of communication was immediately reflected in an increase of the site's visiting rate.

The Child Safety Line (CL)¹¹⁰ specialises in the issues of children and youth (more in Chapter 11) and, since 1996, it has been providing its services (including social and legal counselling; parent line being also available as well as an attractive form of an Internet chat) – continuously, anonymously, and with professional guarantees. In 2005, on the CL's initiative, the crisis centre named Rainbow was established providing immediate assistance to children and to mothers with children.

Community type prevention

When considering preventive activities in the region of Nitra, the preventivist of the Metropolitan Police (hereafter MsP), Miroslav Duchoň started from his school survey conducted in 2005 among local secondary school students¹¹¹. Then proposals based on results of the survey for targeted prevention included involvement of local youth in building leisure-time facilities, introducing the prevention of crime and other socially pathological phenomena into elementary and secondary school curricula, and more intensive involvement of parents in preventive programmes.

The MsP¹¹² of Stará Turá in the region of Trenčín initiated the formation of voluntary patrols as of April 2005. Nightwalkers walk the town every weekend (except for certain winter weekends) in the night time. Approximately 50 volunteers take turns in two-three member patrols in the vicinity of entertainment settings and discos visited by young people. The "Night Ravens" patrols are a success and the neighbourhood appreciates these activities. MsP at Stará Turá has already organised 2 seminars for interested parties from other cities (MsP at Žilina, Vrbové, Dolný Kubín, and other cities), who wished to become involved in this form of youth crime prevention.

3.4 Assessment and efficiency of preventive interventions

An assessment of a preventive intervention¹¹³, project, or programme means a systematic collection, analysis, and interpretation of information as to the intervention's action and effects. Within this meaning, effectiveness of preventive interventions in the Slovak Republic is evaluated only rarely.

IPE collects and analyses statistical data from the field of preventive programmes/activities in the education sector and also keeps records of and processes all projects presented to the ADF. Gradually, the analyses expand to cover qualitative interpretation of preventive programme

¹¹⁰ <http://www.unicef.sk/ldi/>

¹¹¹ Using a questionnaire method, he obtained data from 105 secondary school students in Nitra (in the age of 15 – 17 years), which concerned the level and specification of leisure time spending, antisocial activity, use of legal and illegal drugs, and the causative relation of their use by parents and their children.

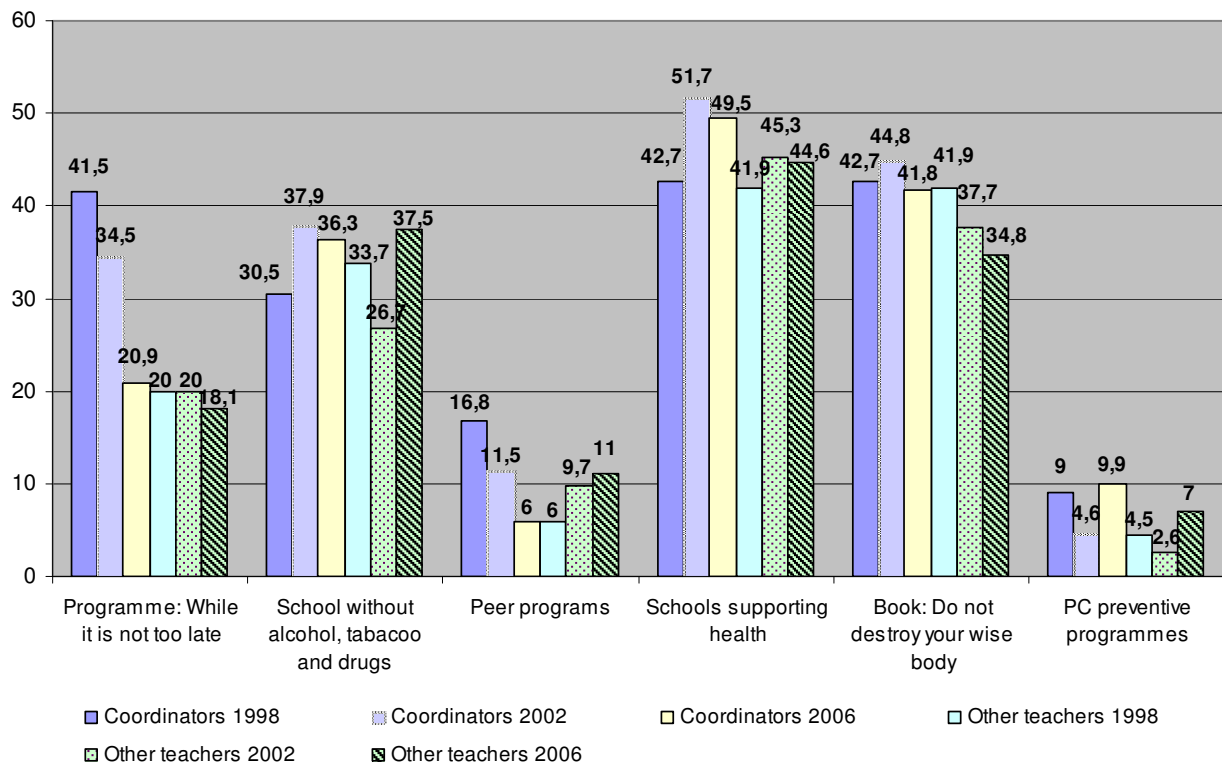
¹¹² Lubomír Málek, Chief of the MsP of Stará Turá, a report for the NMCD, September 2006

¹¹³ Kroeger, Ch., Winter, H., Shaw, R.: Guide to drug prevention evaluation, Slovak translation by Alojz Nociar, 1000 copies, 2004, 2nd issue.

efficiencies, e.g., in 2004, 333 programmes or programme objectives were evaluated in various ways¹¹⁴.

A different view with respect to evaluation is offered by Nociar¹¹⁵ on the basis of information from TAD3 (Chapter 2). To provide an overview on the use of programmes for drug addiction prevention, Nociar prepared a graphic appendix containing comparisons of the results of prevention coordinators with their colleagues – pedagogues at elementary and secondary schools in 1998 to 2006.

Figure 3.2 Comparison of drug prevention coordinators with teachers of elementary and secondary schools (Using preventive programmes or methodological tools)



Source: Nociar A., 2006

Nociar (2006) notes: *“Although in 1998 to 2006, only short probing surveys were involved, these confirmed that the drug prevention coordinator training received was reflected not only in their more extensive knowledge of the issue, in a somewhat higher sensitivity to the alcohol or drug problem in a pupil or student, but also in the necessary motivation and attitudes considering the commitment to conducting prevention.*

On the other hand it is obvious that in other teachers, after four years in the given field, a certain decrease in motivation to conduct prevention occurred, probably caused by their excessive workload, perhaps also by the feeling of threat and probably also by insufficient prevention of the frequent, so-called burnout syndrome¹¹⁶, which often occurs in professions requiring long-term personal commitment (teachers, therapists, rescuers, policepersons, etc.).”

One of the possible basic problems in school coordinator’s activity is the fact that his/her position is not sufficiently defined in the school system and is not even mentioned in the relevant decrees of the Ministry of Education, and the remuneration for this demanding activity is limited by the funds available to the school management.

¹¹⁴ Interview, questionnaire, psychological tests, enquiry, written report.

¹¹⁵ Nociar, A: Results on TAD 3, 2006 not yet published In: Comments to Chapter 3 of NR 2006, 25 September 2006

¹¹⁶ Wilder, J. F.: Recognizing burnout in health professionals. Psychosomatics, 1981, 22, 653 – 656.

Starting from 2005, projects conducted using the ADF financial resources have to be evaluated using a special questionnaire of ADF project evaluation¹¹⁷, whose need stemmed also from the effort to harmonise data on preventive programmes (so called good practice examples) with the requirements of the European information system called EDDRA¹¹⁸.

In 2005, the ADF approved 356 projects including 176 projects for 117 school authors (Prevention 1). The target groups/beneficiaries were dominated by the group of children and youth at risk (30.06%) followed by professional staff (education) in the prevention, treatment, and social reintegration (26.12%) and the group of children of under 15 years of age (children at schools) with the share of 23.88%.

Table 3.5: The approved ADF subsidy to school programmes in 2005

Area	Amount in SKK	Amount in €
Education	4,604,628	119,322
Prevention	3,893,594	100,896
Preventive programmes and activities	1,001,077	25,941
Edification activity	840,400	21,777
Leisure-time activities	790,970	20,497
Publishing activity	454,280	11,772
Equipment for clubs and hobby groups	343,346	8,897

Source: IIPE, 2006

Besides the school projects (Prevention I.), the ADF subsidies in 2005 were channelled into edification activity (Prevention II. e.g., the project “Why I am happy to be in the world”), treatment, social reintegration, and media (e.g., an animated film on smoking). For ADF subsidies approved, see Chapter 1.

¹¹⁷ ADF project evaluation questionnaire - <http://www.protidrogovyfond.sk/formulare/dotaznik.pdf>

¹¹⁸ Exchange on Drug Demand Reduction Action

4 Problem drug use

Data available from official reporting systems on drug addicts such as those from health care facilities, do not describe real situation in number of drug users. Certain population of drug users that is not in contact with health, social services or with police/justice system remains hidden. The number of problem drug users whose pattern or degree of use bears the risk of health, social or criminal consequences is always in concern.

The definition of problem drug use in Slovakia is based on the EMCDDA definition according to which, problem drug users are defined as injecting, long duration/regular users of opiates (heroin, Subutex and other opiates) and/or pervitin and/or cocaine, in the age group of 15 – 64 years. However, cocaine occurs only rarely in Slovakia.

The number of problem drug users in Slovakia can be estimated at approximately 18,500 with the range of 13,500 to 32,000 persons at 95% confidence interval. Of this number, approximately 18 thousands are injecting drug users, 10 thousands are opiate users and 8 thousands are pervitin users.

Problem users according to the EMCDDA definition comprised almost 69% of all patients in treatment. In 2005, 2,078 patients were treated (237 patients fewer than in the last year). Since 2000, more than 55% reduction occurred in the number of treated due to problems with opiates. The population of heroin users, whose age is continuously increasing, is the “oldest” group of the treated. They are 8 years older compared to marijuana users, whose average age has been unchanged for almost 4 years (20.5 years). The number of first treatment demands in 2005, in which opiates are indicated as the primary drug, was 265. However, the greatest number of first treatment demands was related to problems with pervitin (288) and marijuana (277).

Problem drug users (hereinafter “PDU”) constitute about 43% of the clientele of social reintegration centres and over 90% of the clientele of low-threshold agencies. In 2005, low-threshold agencies reported a growth in the number of their clients of approximately 550 persons in total - the greatest increase occurred in Košice and Bratislava (Prima CA). There are also regional and local differences in the kind of drug used. While in Púchov, there are exclusively pervitin users reported, Banská Bystrica is dominated by heroin and for Košice, the almost exclusively used opiate) is pentazocine (Fortral), which is not reported from other low-threshold programmes at all.

4.1 Prevalence and incidence estimates

In the framework of the Twinning project “the Support of the Implementation of NPF 2004 – 2008”, a study on PDUs estimate was carried out by Slovak NMCD supervised by junior partner - Czech NMC. Study used multiplication method and worked with information on the number of clients in contact with low-threshold agencies. The method is based on the principle that certain part of the problem drug users is in contact with low-threshold agencies and that the proportion of such persons in-contact in their total number (in-treatment rate, hereinafter “ITR”) can be determined or estimated.

To find the ITR, a survey was conducted among the clients of 6¹¹⁹ low-threshold programmes in eight Slovak cities: Bratislava, Trnava, Nitra, Sered', Banská Bystrica, Žiar nad Hronom, Prešov and Košice. The nomination technique was used; the respondents were asked 2 questions: (1) “How many friends do you have, who regularly use opiates and/or pervitin and/or cocaine?” (2) “How many of them go to change their needles regularly?” ITR then equals to the fraction $\frac{\sum (2)}{\sum (1)}$. In total, 294 questionnaires were collected; however, only those respondents were included in the ITR calculation that indicated the number of drug-taking friends less than 30 and, at the same time, properly answered both questions necessary for the ITR calculation. The number of valid questionnaires was thus reduced to 223. ITR was calculated separately for all cities.

¹¹⁹ NGOs - Citizens' Associations: Prima, Storm, Heureka, Centrum dobrovoľníctva, Risen, Pomocná ruka

Table 4.1: Input data for ITR calculation

CITY	Number of respondents with valid responses	Number of friends total	Number of friends coming to exchange	ITR	95% confidence interval	
					Lower ITR limit	Upper ITR limit
Bratislava	88	780	580	0.74	0.65	0.83
Nitra, Sered, Trnava	37	583	405	0.69	0.55	0.84
Banská Bystrica	11	163	46	0.28	0.02	0.55
Žiar nad Hronom	14	240	190	0.79	0.58	1.00
Prešov	56	176	88	0.50	0.37	0.63
Košice	17	241	105	0.44	0.20	0.67
Total	223	2,183	1,414	0.65	0.59	0.71

Source: "Survey on PDU population - Questionnaire for determination of multipliers, NMCD, 2006

The calculation was further based on information on the number of problem drug users who are the clients of the low-threshold agencies (determined on the basis of EMCDDA definition). The information was available thanks to "low-threshold client and programme reports" containing basic information on the client structure and programmes provided. These reports were filled in by all organisations of social field work operating in 2005 (6 in total). (See Chapter 7 for more information.)

Table 4.2: Number of PDU clients of low-threshold facilities in 2005 – "low-threshold programme report"

CITY	Number of low-threshold agency clients	Number of clients classified as PDU	Number of injecting users	Number of opiate/opioid users	Number of perritin users	Number of cocaine users
Bratislava - Prima	1,001	1,001	938	298	703	0
Bratislava - Odysseus	1,852	1,656	1,656	946	274	0
Bratislava total	2,853	2,657	2,594	1,244	977	0
Púchov	111	110	110	0	110	0
Nitra, Sered'	180	172	172	145	27	0
Banská Bystrica (Heuréka)	64	64	64	50	14	0
Žiar nad Hronom	76	76	76	74	2	0
Prešov	225*	91	90	19	72	0
Košice	470	470	470	254	216	0
Total	3,979	3,640	3,576	1,786	1,418	0

*Note: 112 clients are alcohol consumers.

Source: "Low-threshold client and programme report", NMCD 2006

The estimation of problem drug user population was subsequently calculated as: number of PDU's in contact with low-threshold agencies/ITR (e.g., for Bratislava 2657/0.74).

Table 4.3: Estimate of PDU's in selected cities of Slovakia

CITY	PDU estimate	Lower limit of PDU estimate	Upper limit of PDU estimate	Estimate per 1,000 inhabitants
Bratislava	3,573	3,183	4,073	11.21
Nitra, Sered', Trnava	248	204	315	1.92
Banská Bystrica	227	117	3,943	3.66
Žiar nad Hronom	96	76	131	6.61
Prešov	182	144	247	2.71
Košice	1,079	700	2,350	6.24
Total in surveyed cities except for Bratislava	1,601	1,121	3,038	4.17

Source: NMCD 2006

The estimate per 1,000 inhabitants in cities except for Bratislava was further used to estimate the total number of PDU's in Slovakia except for Bratislava. The total estimate of PDU's in Slovakia then equals to the sum of the estimate for Bratislava and that for the rest of Slovakia. Central estimate of PDU's in Slovakia is approximately 18,500 with the range of 13,500 to 32,000 persons at 95% confidence interval (Tab. 4.4).

Table 4.4: Estimate of PDU's in Slovakia

	PDU estimate	Lower limit of PDU estimate	Upper limit of PDU estimate	Relative estimate per 1,000 residents
Bratislava	3,573	3,183	4,073	11.21
Slovakia total except for Bratislava	14,820	10,382	28,109	4.18
Slovakia total	18,393	13,565	32,182	4.76

Source: NMCD 2006

In 6 agencies (in 8 cities), for which a "low-threshold programme report" was filled in, 3,640 PDU's were registered in 2005 in total, of whom 3,576 (98.2%) were injecting users. Opiate users comprised 55.7% and pervitin users represented 44.3% of the problem users in contact with the low-threshold agencies, for whom the basic drug was known. Maintaining the same ratios in the total estimated population of problem drug users in Slovakia, an estimate can be made of approximately 18,000 intravenous users, 10,000 opiate users and 8,000 pervitin users.

4.2 Profile of clients in treatment

Information on patients in treatment are available particularly in the information system of health sector and health statistics administered by the National Health Information Centre (hereinafter "NHIC")¹²⁰. NHIC collects and proceeds data through the "Drug User Treatment Report" in the framework of a Program of Statistical Determination. The system provides reliable strictly defined cases (data) on the number of treated users, kind of misused substances and trends in drug addiction in Slovakia. The system is in line with the EMCDDA methodological guidelines for TDI. The obligations to report¹²¹ have all health care facilities and individuals authorised for providing drug related treatment. In 2005 it represented 335 units.

In 2005, 82 outpatient and 54 inpatient health care facilities (Ministry of Health) and 18¹²² prison health care units of the Ministry of Justice reported to the above mentioned information system. The greatest drop in the number of patients treated in 2005 occurred in outpatient facilities (29.8%) and in the facilities under the competence of the Ministry of Justice (26.7%). On the contrary, the total number of reported patients grew in outpatient facilities by 29.8% (219 cases).

The situation regarding the number of treated and primary drug used in Slovakia has stabilised. In 2005, 2,078 patients were treated (minus 237 patients less than in last year), of which 963 were first-time treatments. The drugs reported most frequently in 2005 remained heroin, pervitin and marijuana (see Tab. 4.5). Inhalants were recorded for 161 patients, hypnotics and sedatives for 84 patients, hallucinogens for 6 and other drugs for 13 patients. The proportion of males and females in the total number of the treated as well as the first-treated remains the same, approximately 4:1 (79.7% men and 20.3% women in the total number of treated). In total, 1,723 drug users were treated in facilities under the competence of the Ministry of Health.

¹²⁰ NHIC – In 2006, ÚZIŠ (Ústav zdravotníckych informácií a štatistiky – Institute of Health Information and Statistics) merged with "Slovenská lekárska knižnica" (Slovak Medical Library) and was renamed to "Národné centrum zdravotníckych informácií" (National Health Information Centre).

¹²¹ The obligation stems from Act No. 540/2001 on State Statistics based on Decree of the Statistical Office of the Slovak Republic No. 613/2002, which issued the programme of statistical surveys for the period of 2003 – 2005

¹²² General practitioners' offices in institutions, autonomous psychiatric offices, psychiatric department of the hospital for the accused and convicted.

Table 4.5: The number of the treated according to the primary drug type; comparison of 2004 and 2005

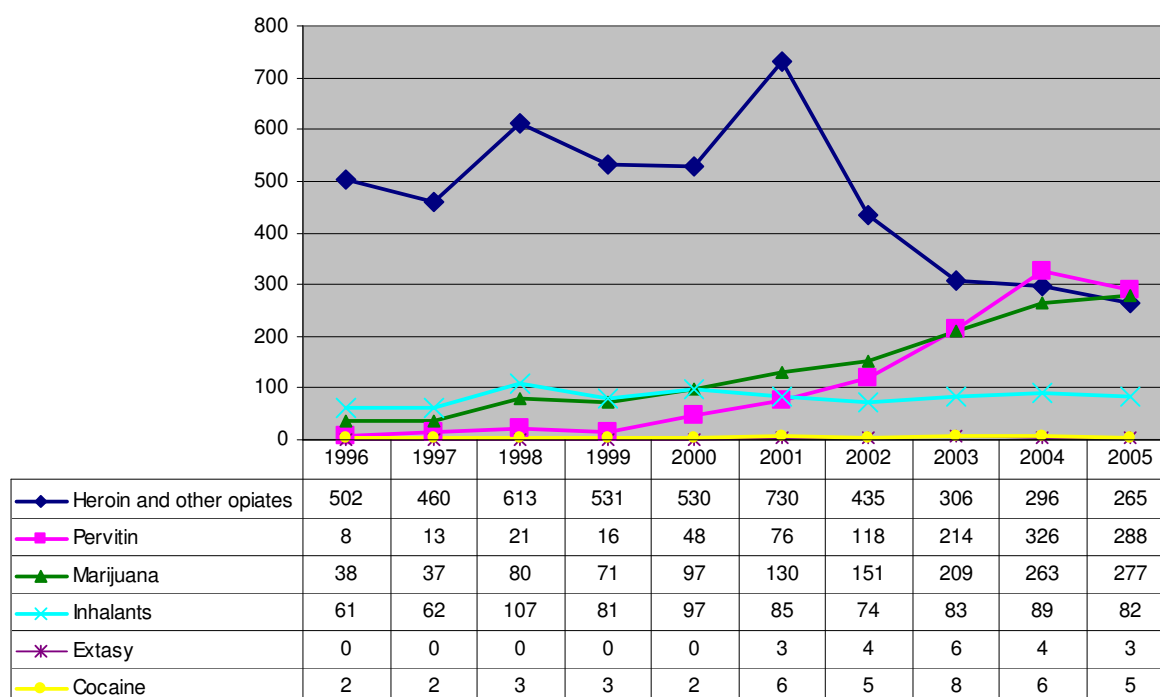
	Year	Heroin	Other opiates	Pervitin	Ecstasy	Cocaine	Amphetamines	Marijuana	Number of treated
All treatment demands	2005	857 (41%)	45	489 (24%)	6	11	5	400 (25%)	2078
	2004	936 (40%)	51	563 (24%)	5	14	8	398 (17%)	2315
First treatment demands	2005	253 (26%)	12	288 (30%)	3	5	2	277 (29%)	963
	2004	281 (27%)	15	326 (31%)	4	6	4	263 (25%)	1045

Source: NHIC, 2006

Throughout ten years of monitoring, the proportion between main groups of primary drugs used has changed. Although the group around heroin continues to lead in the number of reports, the ratio between heroin and marijuana changed compared to 1995 from approximately 40:1 to 2:1 in 2005. The number of treatment demand culminated in 2000 (2,619 patients, of whom 2,029 for opiates). Since that year, an over 55% reduction occurred in the number of patients treated for opiate problems. In 2005, only 902 treatment requests were reported with the primary drug being opiates. In 95% of cases, heroin was involved, which was used daily in almost 70% of cases.

Regarding the first treatment demands in 2004, pervitin exceeded, for the first time, the number of treatment demands for opiates. In 2005, opiates ranked third after pervitin (288 first treatments) and marijuana (277 first treatments) (Figure 4.1)

Figure 4.1: Development of first treatment demand by drug type

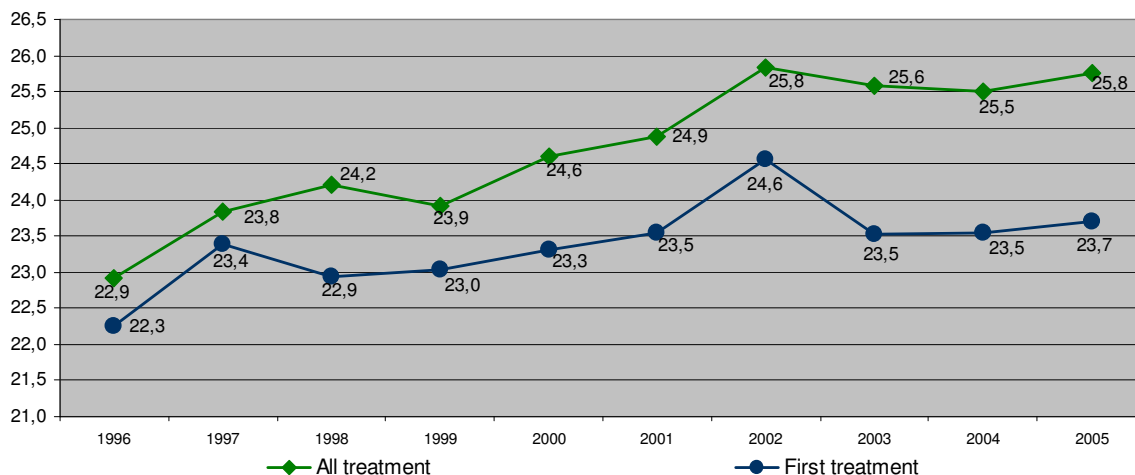


Source: NHIC, 2006

Age of clients in treatment

The greatest age group of all patients, regardless the drug type, compared to the last year continues to be the group of 20 – 24 years. The average age of treated drug users increased approximately by 3 years in 10 years. Since 2003, the average age of all the treated ranges from 25.5 - 26 years; for the first treatments 23.5 - 24 years.

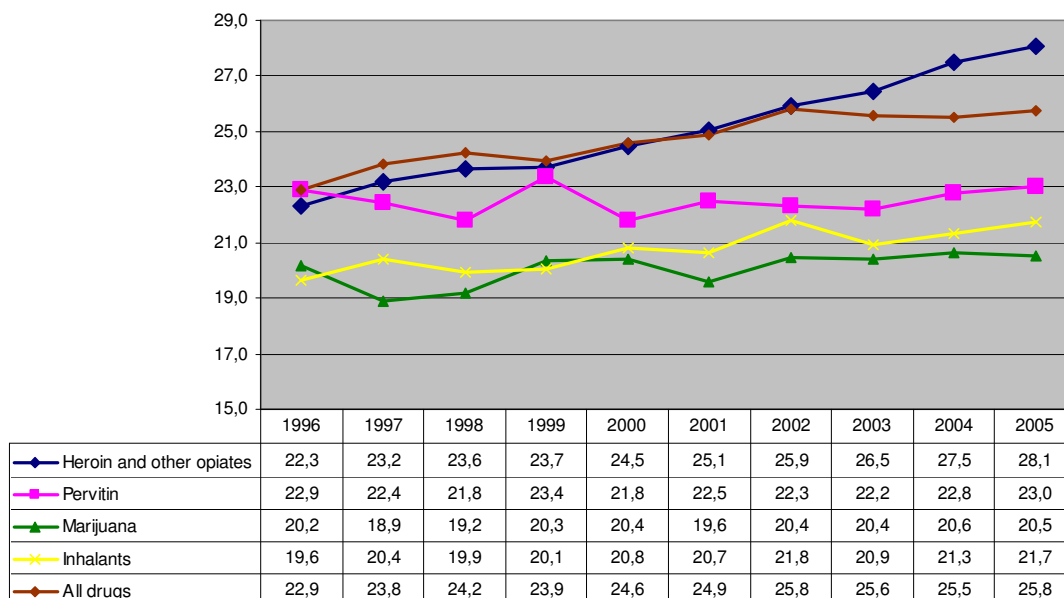
Figure 4.2: Average age of the drug users in treatment



Source: NHIC, 2006

The population of heroin users, whose age is continuously increasing, is the “oldest” group of all drug users in treatment. They are 8 years older compared to marijuana users, whose average age has been unchanged for almost 4 years (20.5 years) (Figure 4.3). Those treated for the first time due to problems with heroin are one year younger; for marijuana, the difference is only half a year. While for pervitin users, the average age has ranged, in the 10 years’ period, between 22 and 23 years, for first treatments it increased from 20 to 22.7 years. Concerning the less frequently used drugs such as cocaine or ecstasy, due to the low number of the treated, a development cannot be assessed. In 2005, the average age of the treated due to problems with cocaine (11 patients) was 29.9 years and for ecstasy (6 patients) 26 years.

Figure 4.3: Average age of all patients in treatment by drug type



Source: NHIC, 2006

Patterns of use

The most frequent patterns of drug use in 2005 are shown in table 4.6. Injection was the common pattern used in more than three quarters of all heroin cases and two fifths of amphetamine cases.

Proportion of injecting users in the total number of treated due to opiate problems have oscillated around 80% since 1998. The proportion of injecting users in the number of stimulant

users (amphetamines, cocaine and other stimulants) significantly dropped between 2000 and 2003 from 64% to 36%; their proportion has stabilised below the level of 40% (Figure 4.4).

The pattern of marijuana use, smoking, continues to prevail, however in 5% of cases injection has been reported. All other drugs are used orally or by smoking.

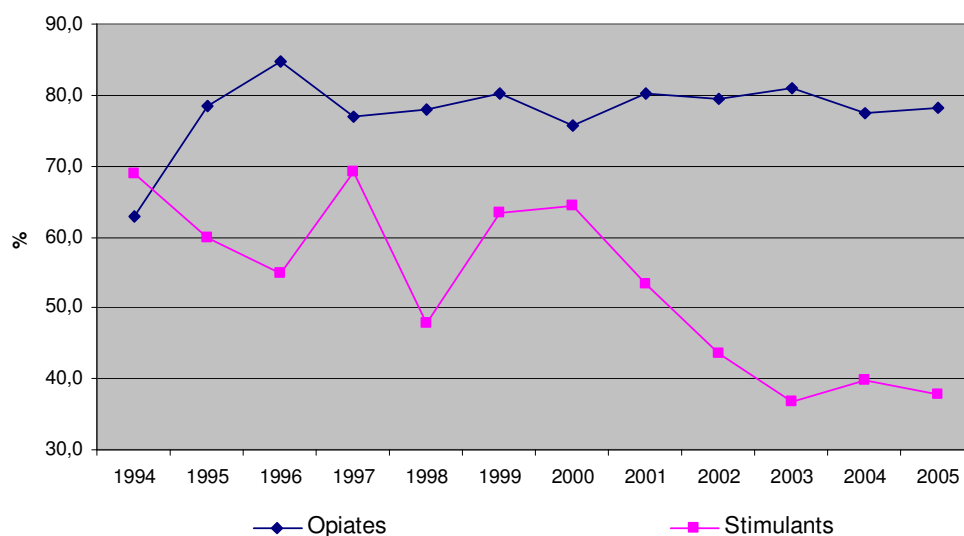
Table 4.6: The most frequent patterns of drug use in 2005

Substance	Method of use					Number of the treated
	Injection	Smoking	Orally	Sniff	Other	
Heroin	80.9 %	13.5 %	0.7 %	3.6 %	0.2 %	857
Other opiates	28.9 %	35.6 %	31.1 %	0.0 %	4.4 %	45
Amphetamine	38.7 %	23.5 %	4.7 %	26.5 %	4.3 %	494
Cocaine*	3	0	0	6	2	11
Other stimulants*	0	1	5	1	0	7
Cannabis	5.0 %	90.5 %	1.0 %	1.8 %	0.5 %	400

*Note: due to the low number of cases, we present only absolute figures.

Data source: TDI 34, 2006

Figure 4.4: Percentage of injecting users of the total number of patients treated due to opiates and stimulant (amphetamines, cocaine and other stimulants) problems



Data source: Drug dependency – treatment of drug users in Slovakia, health statistics, 1995 – 2005. Institute of Health Information and Statistics

Note: The great percentage of injecting use of stimulants and the fluctuations in the development in the period of 1994 – 2000 might have been caused by the low number of the patients treated (29 persons in 1994 to 98 persons in 2000). Since 2000, the patients count hundreds of cases (152 in 2001, 512 in 2005).

Profile of clients by centre type

In 2005, 954 patients were treated in outpatient treatment centres, 769 in hospital facilities. On the basis of a comparison of data from outpatient and inpatient treatment centres by drug type, a shift occurred last year in number of opiate users towards outpatient treatment centres (the proportion of opiate users in outpatient treatment was 50%). On the other hand, there were greater proportion of patients addicted to hypnotics and inhalants treated in hospital facilities. There were a relative high proportion of marijuana users (22%) in inpatient treatment centres. The proportion of other drugs within/among both treatment centre types remains the same. (Tab.4.7)

Table 4.7: Proportions of males and females in treatment by treatment facility type and by drug

		Outpatient treatment			Inpatient treatment			Healthcare facilities of the Ministry of Justice ¹²³		
		Males %	Females %	Total %	Males %	Females %	Total %	Males %	Females %	Total %
Opiates	2005	47.7	57.4	50.0	30.5	30.3	30.4	48.1	91.5	53.8%
	2004	29.2	37.3	31.0	44.5	50.8	46.0	48.7	83.6	52.7%
Stimulants	2005	21.8	24.7	22.4	26.3	23.7	25.7	28.6	2.1	25.1%
	2004	27.9	16.0	25.2	26.1	31.8	27.5	20.5	9.1	19.2%
Hypnotics	2005	0.4	3.6	1.2	4.9	26.3	9.1	0.6	2.1	0.8%
	2004	5.8	30.8	11.6	0.6	3.9	1.4	1.4	1.8	1.4%
Cannabis	2005	22.8	11.2	20.1	24.8	11.8	22.2	11.7	2.1	10.4%
	2004	17.3	7.7	15.1	21.5	11.2	19.1	18.2	0.0	16.1%
Inhalants	2005	6.2	2.7	5.3	11.7	3.3	10.0	10.4	2.1	9.3%
	2004	17.7	4.1	14.6	5.7	1.9	4.8	7.7	1.8	7.0%
Other	2005	0.1	0.4	0.2	0.8	3.9	1.4	0.0	0.0	0.0%
	2004	0.5	3.0	1.1	0.1	0.0	0.1	1.9	1.8	1.9%
Total	2005	731	223	954	617	152	769	308	47	355
	2004	566	169	735	838	258	1096	429	55	484

Source: NHIC, 2006

4.3 Main characteristics and patterns of use from non-treatment sources

Main characteristics and patterns of use in social reintegration centres

Since no social reintegration facility contributes to the NHIC's information system on treatment demand, NMCD performed a questionnaire survey in May 2006 among 20 social reintegration facilities. However, only 11 questionnaires were returned including information from sheltered housing.

The assessment of the survey results was limited to an extent by some insufficiently filled-in questionnaires. In spite of that, the data can provide us with a certain insight into the structure of social reintegration centres' clients.

Problem users constitute about 43% of the clientele of social reintegration centres. The ratio of opiate/opioid users to pervitin users is approximately 59% to 41%. The third major group of clients is marijuana users (15%). The average age of clients in all social reintegration centres participating in the survey is 32 years, the lowest mean age in individual cases being 23.5 and the highest 43 years (See Chapter 9 for more information on social reintegration).

Table 4.8. Structure of drug users in social reintegration centres

	Number of clients	Percentage
Number of clients total	280	-
New clients in 2005	163	-
Males	224	80
Of which injecting users	92	32.8
Of which heroin as the primary drug	68	24
Of which pervitin as the primary drug	50	17.8
Of which cannabinoids as the primary drug	43	15.4
Of which ecstasy as the primary drug	1	0.3
Of which volatiles as the primary drug	8	2.8
Of which legal Subutex as the primary drug	4	1.4
Consuming alcohol	15	-
Slot machines	2	-

Source: "The reintegration client and programme report" NMCD, 2006

¹²³ General practitioners' offices in institutions, autonomous psychiatric offices, psychiatric department of the hospital for the accused and convicted.

Main characteristics and patterns of use in low-threshold agencies

Information on the structure of clients of low-threshold agencies existing in 2005 are available thanks to the willingness of all NGO's to fill in a special questionnaire of National Focal Point (NMCD) concerning the client structure and types of services provided by such NGO's (see also Chapter 7). In tables presented in this chapter, duplicities cannot be avoided in the number of persons in several facilities, particularly in Bratislava.

As opposed to the reduced number of patients in treatment in 2005, social and field work programmes reported a growth in the number of their clients of approximately 550 persons in total. The most significant increase in the number of clients, drug users, by almost 200 persons, was reported by Prima CA in Bratislava and by Pomocná ruka CA in Košice.

Table 4.9: Number clients of low-threshold agencies

NGOs	2004	2005	Difference
Prima – Bratislava	811	1,001	190
Odyseus – Bratislava	1,828	1,852	24
Odyseus – Púchov	80	111	31
Heureka – Banská Bystrica	80*	140	60*
Storm – Nitra	150*	180	30
Risen – Prešov**	192	225	33
Pomocná ruka – Košice	265*	470	205*
Total	3,401*	3,979	573*

* Estimate

** Of the number shown, there were 80 illegal drug users in 2004 and 90 in 2005

The greatest group (95%) of drug-using clients of low-threshold agencies is the injecting users. Almost 38% of clients, for whom the primary drug was known, used heroin, 37.5% used pervitin, 7% used pentazocine (Fortral), which is used mainly in Košice, and approximately 3% used Subutex, obtained on prescription or illegally. See Chapter 4.1 for the proportion of problem drug users. Cocaine as the primary drug was not recorded for any of the low-threshold agencies clients. The average age of the clients is about 29 years and the males constitute 71% of the clientele.

Table 4.10: The structure of client of law-threshold agencies

Basic characteristics of clients in field programme	Number of clients	Percentage
Number of clients	3979	-
Drug users	3661*	100%
Of which injecting users	3576	94.78%
Of which heroin as the primary drug	1430	37.90%
Of which pervitin as the primary drug	1418	37.58%
Of which pentazocine as the primary drug	247	6.55%
Of which cannabinoids as the primary drug	6	0.16%
Of which ecstasy as the primary drug	10	0.27%
Of which volatiles as the primary drug	5	0.13%
Of which illegal Subutex as the primary drug	42	1.11%
Of which Subutex on prescription as the primary drug	67	1.78%
Of which alcohol as the primary drug	112	2.97%
Average age of the users	29	-

* The number shown does not include the clients of the Risen CA of Prešov using alcohol (112 clients)

Source: "Low-threshold client and programme report", NMCD 2006

There are regional and local differences in the population of problem drug users, particularly in the proportion of opiates and pervitin users. In Púchov, exclusively pervitin users are reported. Heroin significantly prevails in Banská Bystrica and also in cities like Nitra, Sered'. In Žiar nad Hronom in 86% of cases Subutex is abused. In Košice and Bratislava, the ratio of pervitin and

opiate users is nearly balanced. However, exclusively in Košice, the opiate (opioid) used for nearly 5 years has been pentazocine (Fortral), which is not reported from other low-threshold agencies at all. There are also differences between the two low-threshold agencies of Bratislava with pervitin users prevailing among the clients of the Prima CA, while heroin users dominate the clients of the Odysseus CA – which can be the effect of different environments in Bratislava, in which the agencies operate.

Table 4.11. Structure of low-threshold facility clients in individual agency

	Bratislava		Nitra, Sereď	Púchov
	Prima	Odysseus		
Number of clients	1001	1852	180	111
Drug users	1001	1656	173	110
Of which injecting users	938	1656	172	110
Of which heroin as the primary drug	298 (30%)	946 (57%)	102 (59%)	
Of which pervitin as the primary drug	703 (70%)	27 (17%)	27 (16%)	110
Of which Subutex as the primary drug			43 (25%)*	
Of which cannabinoids as the primary drug			1	
Percentage of males	57%	72%	85%	75%
Average age of the client1)	30	31	26.5	27

*Note: of whom 2 use Subutex legally

Continuing: Structure of low-threshold facility clients - continuing

	Žiar nad Hronom	Banská Bystrica	Prešov	Košice
Number of clients	76	64	225	470
Drug users	76	64	111	470
Of which injecting users	76	64	90	470
Of which heroin as the primary drug	9	50 (78%)	18 (16%)	7
Of which pervitin as the primary drug	2	14 (22%)	72 (65%)	216 (46%)
Of which Subutex as the primary drug	65 (86%)**		1	
Of which pentazocine (Fortral) as the primary drug				24 (53%)
Of which ecstasy as the primary drug			10	
Of which cannabinoids as the primary drug			5	
Of which volatiles as the primary drug			5	
Percentage of males	87%	86%	87%	79%
Average age of the client1)		24.5	25	29

** Note: They use Subutex legally – on prescription

Source: "Low-threshold client and programme report", NMCD 2006

Misuse of Fortral in Košice

According to information provided by Pomocná ruka CA in Košice, the misuse of Fortral has started in the early 90's. At the beginning it has been used as experimental substance, later it had been prescribed in one outpatient treatment centre for substitution treatment. The use of Fortral has reached a great extend and in last years heroin is used only in 1% of cases. Fortral users prefer to take this drug by injecting of dissolved tablets. Due to short effect it has to be injected several times a day. The use of non-sterilized water, needles and syringes and common use of Fortral, melted Fortral is dragged from one bottle into a common needle and then into individual syringes, caused high prevalence of hepatitis C among drug users (45% according to estimates). Fortral is usually obtained by prescription, receipt falsification or from a black market. A price for one tablet is SKK 30-50, (€ 0,7 – €1,3) in case of low availability it rises up to SKK 70,- (€1,8). However the situation in Košice is changing thanks to the existence of harm-reduction programme.

5 Treatment

Treatment is characterised as deliberately influencing a person's health condition with the objective of restoring his or her health, achieving abstinence/reduction of drug use, preventing deterioration of health condition or mitigating the consequences of the disease (reducing the frequency and severity of a relapse), with an effort to involve patients in a fully-fledged life in a natural environment.

Regarding the system of drug treatment the phases of therapeutic care for drug users are divided into: preclinical treatment (counselling, minimisation of health damage, motivation to treatment), detoxification treatment, and withdrawal treatment – drug-free treatment, maintenance/substitution treatment, and follow-up care programmes – social reintegration, rehabilitation¹²⁴. An outpatient and residential healthcare both is conducted in specialised drug addiction treatment centres, in specialised AT departments of psychiatric hospitals and facilities, and in offices of psychiatrists or psychiatrists specialised in drug addiction treatment from AT.

In the course of 2005, individual Centres for the Treatment of Drug Dependencies (CTDD) (Bratislava, Banská Bystrica, Nové Zámky, Žilina, Košice, Predná Hora – semi-budgetary organisations) were submitting projects with the intention of transforming into non-profit organisations. In the course of the year, OLÚP Predná Hora was thus transformed into a non-profit organisation and by the end of 2005; transformation projects of the remaining centres were submitted except for Banská Bystrica a Nové Zámky¹²⁵. In 2005, two CTDD did not exist anymore, namely in Nitra and Humenné. In 2005, a methadone maintenance treatment programme was successfully launched at the CTDD of Banská Bystrica, while the CTDD of Žilina was preparing its introduction. In the first half of 2005, a non-state specialised facility called Slovdóm was operating in Trstená, later discontinuing its activity.

According to TDI data from the “Drug User Treatment Report” which are collected and processed¹²⁶ by the NHIC there were 2,078 patients treated in medical facilities in 2005. According an other source so called “Hospitalised Patient Statistical Record” informed about 1,492 drug users who were admitted to psychiatric centres in 2005 (diagnosis F11-F19) and 5,575 examinations of drug users were conducted at psychiatric offices (diagnosis F11-F19), of which 3,279 due to the addiction syndrome.

5.1 The treatment system in the Slovak Republic

The basis of the therapeutic approaches in Slovakia is the medicinal model, which, in accordance with ICD-10, defines the line between drug users without a diagnosis indicating health damage and those, in whom the drug use resulted in damage to their health. The concept of the specialisation of “drug addictions” as a specialised additional domain of psychiatry was approved in 1994 and published in the Journal of the Ministry of Health of the Slovak Republic in 1995, Volumes 8 – 9.¹²⁷

Drug treatment is concentrated particularly within the competence of the Ministry of Health. Treatment and healthcare is methodologically guided by the main expert of the Ministry of Health for the field of drug addictions (2004 National Report, p. 83). Treatment is also administered in healthcare facilities of other ministries, particularly those of the Ministry of Justice, conducting both voluntary treatment and court-ordered treatment at the facilities of the Corps of Prison and Court Guards (since 1996). The Ministry of Defence and the Ministry of Interior also conduct treatment in their respective medical facilities. The Ministry of Labour, Social Affairs and Family supports the activity of social reintegration facilities for the addicted

¹²⁴ 2004 National Report

¹²⁵ 2005 Report on Implementation of the Slovak Republic Government's Anti-Drug Policy – health sector, A material for the session of the CM DADC, March 2006

¹²⁶ on the basis of a methodology developed in accordance with the EMCDDA methodology of TDI (Treatment Demand Indicator),

¹²⁷ Organisation of healthcare in patients with drug addiction in the Slovak Republic, MUDr. Nadežda Stowasserová, national training “Consultancy in drug addiction issues, 2005

and thus, following up the treatment in medical facilities, the continuity of long-term treatment process of addictions is ensured.

For the time being, a general practitioner may become involved in drug treatment only on the first contact level, or in the framework of a follow-up treatment¹²⁸. A permit to perform specialised treatment of drug addiction may be obtained by a doctor with attestation in the field of psychiatry and with the additional specialisation in drug addictions. General psychiatric services contribute to the treatment of drug-addicted patients primarily by detoxification and by outpatient, so called drug-free, treatment (2005 National Report). Psychiatric departments specialise also in management of acute conditions of drug-related mental decompensation or alteration and in resolution of problems resulting from psychiatric comorbidity. Outpatient and institutional therapy is conducted at specialised medical facilities – CTDD, at offices of AT psychiatrists, and at specialised AT departments of psychiatric hospitals. Specialised drug addiction treatment offices also administer substitution therapy in patients addicted to opioids. Patient care can be then passed on to social reintegration programmes performed at social reintegration facilities (residential form) or in an outpatient form through various abstinence clubs.

Table 5.1: Classification of treatment centres defined by the methodological guideline as units reporting to the TDI (number of centres reporting in 2005)

Treatment facility classification – unit/workplace	Number	
	of workplaces	of patients treated
1. Outpatient treatment facilities		954
Offices at CTDD's	15	687
Daytime facility at CTDD's	-	-
Psychiatrist offices	63	243
Office at an inpatient psychiatric department	4	24
Daytime facility at an inpatient psychiatric department	-	-
Daytime facility (autonomous)	-	-
2. Inpatient treatment facilities		769
CTDD inpatient department, alcoholism and drug addiction treatment departments*	20	284
Psychiatric inpatient department	33	481
Therapeutic communities	-	-
Other	1	4
3. Low-threshold street agency (drop-in)**		
Low-threshold street agency (drop-in)	-	-
4. General practitioners		
General practitioner	-	-
Paediatrician	-	-
Other	-	-
5. Treatment facilities in prisons – imprisonment and custody		355
General practitioner for adults	15	336
Autonomous psychiatrist office	1	5
Daytime facility (autonomous)	-	-
Psychiatric inpatient department	2	14
Office at an inpatient psychiatric department	-	-
Voluntary treatment unit	-	-
Other	-	-
Total	154	2 078

¹²⁸ 2004 National Report, p. 85

* Separate departments at psychiatric hospitals and hospitals with policlinics

** Low-threshold agencies do not report drug user treatments to the NHIC, however they are mentioned in the methodological guideline of the Ministry of Health for filling in the drug user treatment report as unites that could report.

Source: NHIC, 2006

According to TDI data on patients, most patients per 100 thousand residents come from the regions of Bratislava (137 patients), Trnava (40 patients), Nitra (38 patients), Banská Bystrica (36 patients), and Trenčín (30 patients). According to the treatment facility location, most patients are treated in the region of Bratislava (158 patients per 100 thousand inhabitants) and then in the regions of Nitra and Banská Bystrica (47/ 100 thousand).

Map 5.1: Treated patients by domicile per 100 thousand inhabitants



Map 5.2: Treated patients by treatment facility location per 100 thousand inhabitants



CTDD's as specialised medical facilities provide healthcare to drug users with a broader range of therapeutic and preventive programmes (Tab. 5.2). Earlier in 2005, the CTDD of Nové Zámky admitted also adolescent under 18 years of age. Due to problems in the community regime, in which this age group requires a special approach, this activity was suspended as of March 2005¹²⁹. A methadone maintenance treatment programme was successfully launched at the CTDD of Banská Bystrica, while the CTDD of Žilina was only preparing its introduction.

¹²⁹ 2005 Report on Implementation of the Slovak Republic Government's Anti-Drug Policy – Healthcare sector, a material for the session of the CM DADC, March 2006. www.infodrogy.sk

Table 5.2: Treatment programmes provided by CTDD in 2005

	Outpatient treatment	Inpatient treatment	Other
CTDD of Banská Bystrica	<ul style="list-style-type: none"> - withdrawal treatment of alcoholism and drug addictions - screening of drug-transmitted diseases - methadone treatment - groups of drug-addicted abstainers 	<ul style="list-style-type: none"> - abstinence syndrome treatment ICU's - medium-term withdrawal treatment in a therapeutic community 	<ul style="list-style-type: none"> - cooperation with socio-therapeutic clubs and social reintegration facilities - needle replacement - vaccination against HBV
CTDD of Bratislava	<ul style="list-style-type: none"> - detoxification treatment - alcohol addiction treatment - opiate addiction treatment - stimulants addiction treatment (pervitín) - treatment for people with marijuana use problems - gambling addiction treatment - tobacco addiction treatment - methadone maintenance treatment 	<ul style="list-style-type: none"> - detoxification treatment - medium-term treatment 	<ul style="list-style-type: none"> - vaccination against HBV - provision of needles and syringes - provision of condoms - follow-up care and treatment programmes in cooperation with a social reintegration facility - court-ordered alcohol and drug treatments - counselling groups and therapeutic programmes for parents/family members
CTDD of Žilina	n.a.	<ul style="list-style-type: none"> - medium-term treatment 	<ul style="list-style-type: none"> - methadone treatment preparation - cooperation with social reintegration centres - prevention of socially pathological phenomena
CTDD of Košice	<ul style="list-style-type: none"> - addiction diagnostics and follow-up treatment - abstinence condition treatment - counselling - diagnostics of blood-transmitted infections 	<ul style="list-style-type: none"> - detoxification treatment - group activities – psychotherapy, therapeutic communities 	<ul style="list-style-type: none"> - short-term reinforcement courses for the abstaining - court-ordered alcohol and drug treatments - follow-up care programmes
OLÚP Predná Hora	<ul style="list-style-type: none"> - first aid for the addicted, district of Revúca - psych. examination (including juveniles) upon suspected addiction - examination and treatment of the addicted with dual diagnoses - preventive counselling including specific groups - telephone intervention - outpatient protective treatment - screening of transmitted diseases 	<ul style="list-style-type: none"> - detoxification treatment - medium-term treatment - protective treatments - treatment of toxic psychoses in the addicted - treatment of the addicted with a psychiatric disorder - rehabilitation and reconditioning treatment - cooperation with long-term abstainers - family therapy 	<ul style="list-style-type: none"> - socio-therapeutic clubs and structured abstinence clubs – N club (abstaining drug addicts), A club (abstaining alcoholics), G club (abstaining gamblers)

CTDD of Nové Zámky	- early diagnostics of all addiction types, - preparation of patients for treatment - follow-up treatment after release - toxicological examinations as needed	- medium-term regime treatment, - group psychotherapy, - serologic diagnostics and screening - reinforcement weekly follow-up treatments for abstainers	- community regime treatment in a daytime facility - cooperation with social reintegration facilities and motivating patients to social reintegration - linking to and communication with abstainer clubs and self-help groups
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Source: 2005 Report on Implementation of the Slovak Republic Government's Anti-Drug Policy – Health sector, a material for the session of the CM DADC, March 2006

5.2 Drug-free treatment

Drug-free treatment involves the application of psychosocial and educational techniques to achieve long-term abstinence from drugs¹³⁰. A combination of individual and group psychotherapeutic procedures as well as supporting, motivational and family psychotherapy, logotherapy, relapse prevention technique, arttherapy, etc. are used. In the treatment system in Slovakia, inpatient treatment within drug-free treatment is typically combined with an outpatient treatment and vice versa. This is the prevailing form of withdrawal treatment in Slovakia (2004 National Report, p.87).

5.2.1 Inpatient treatment

The institutional form of treatment is conducted in inpatient departments of CTDD's, inpatient departments of psychiatric hospitals, and in specialised psychiatric institutes (2004 National Report, pp. 83-86). Having received inpatient or outpatient treatment, the patient may undergo therapeutic activities within the follow-up treatment, so-called abstainer clubs. Some patients are recommended continuing a long-term treatment in a social reintegration centre with the purpose of their rehabilitation and social reintegration. For information on social reintegration centres, see Chapter 9.

Map 5.3: Location of inpatient centres



Source: NHIC, 2006

According to TDI data, in 2005, inpatient centres (54 sites) treated 769 patients, by 327 (29.8%) patients fewer than in 2004 (1,096 patients). The treatment involved 30.4% of opiate users, then 25.7% stimulant users, 22.2% marijuana users, 10% of volatile substances and hypnotics in 9.1% cases. The average age of clients was 26 years with the most numerous age group comprising patients in the age of 20 – 29 years (nearly 57%) (See also Chapter 4).

¹³⁰ www.emcdda.europa.eu

The capacity of inpatient facilities and the proportion of drug users in treatment in individual centre types are shown in Table 5.3.

Table 5.3: Summary of the treatment care for drug users in the Slovak Republic in 2005

	places/beds	Number of hospitalisations	Proportion of drug addicts hospitalised (In %)
Psychiatric departments	3,780	32,991	2.99%
of which			
at psychiatric hospitals	1,088	6,616	3.61%
at psychiatric facilities	650	2,044	2.92%
in prisons	60	400	10.59%
Alcoholism and other drug addiction treatment departments	449	2,828	23.41%
of which			
at CTDD's	145	1,013	39.22%
at psychiatric hospitals	57	426	13.89%
at psychiatric facilities	160	775	13.74%

Source: NHIC, 2006

*hospitalisation = continuous stay of a patient at the given department. One patient may have several hospitalisations in the given year.

5.2.2 Outpatient treatment

Outpatient treatment as a systematic outpatient therapeutic care is provided by healthcare professionals and rarely by other employees in healthcare if a drug-free treatment is involved. It is provided by physicians and psychologists, nurses with appropriate professional education and training for the field of drug addictions, by special pedagogues and psychotherapists.

In 2005, as opposed to the inpatient treatment, the number of reported treatment demand in outpatient centres increased by 29.8% (219 cases) and there were 954 treatment demands in total. Compared to the year before, opiate addiction treatment was conducted as outpatient treatment in a greater extent – in 50% of cases, 22.4% of cases involved addiction to stimulants, and 20.1% to marijuana. Addictions to volatile substances or hypnotics were subject to outpatient treatment in a very low extent. The average age of clients was 24 years. 54% of clients were 15 – 24 years old followed by 25 – 29-year-olds with a minimum difference.

5.3 Medically assisted treatment

5.3.1 Detoxification treatment

In the Slovakia, detoxification treatment is conducted in outpatient and inpatient treatment centres. It is undergone by most of patients addicted particularly to opiates. Another large group of patients included in detoxification treatment are the users of hypnotics and sedatives and those addicted to volatile substances.

In treatment of opiate addiction, the recommended medicinal products are buprenorfin and also opiate receptor agonists, which include codeine, ethyl morphine, methadone, and slow-release morphine. Sometimes the medically assisted detoxification in opiate addiction is performed even without agonists, using benzodiazepines or neuroleptics.

Detailed information on antagonist treatment of opiate addiction is not available. Since October 2005 the pharmaceutical product Nemexin (naltrexone) has been officially registered with State institute for Drug Control¹³¹ and recommended for complex drug therapy.

¹³¹ www.sukl.sk State institute for Drug Control

5.3.2 Substitution treatment by methadone

This kind of treatment is available in the Slovakia in only two cities. Until 2005, a methadone programme had existed (since 1997) only at the CTDD of Slovak capital Bratislava. The average number of patients ranged about 300 – 350 clients (2004 National Report). According to the most recent available data, the number of patients on methadone treatment was 457 in 2003 and 490 in 2004 (EMCDDA). Another methadone maintenance treatment programme was launched in the course of 2005 in Banská Bystrica. Considering the shortness of the programme's existence, only about 5 patients received a treatment in the given year.

For the time being, there is no central register of substitution treatment, which would serve as the source of information on the number of patients receiving substitution treatment. Data from treatment demand provide information on the number of patients treated, who received such treatment in the past or are receiving such treatment at present.

Organisational guidance to methadone treatment administration is provided by the Methodological Instruction to Provide Methadone Maintenance Treatment (MMT) for Patients Addicted to Opiates with a Chronic Course of the Disease of 2004 (published in Volumes 21 – 27 of the Journal of the Ministry of Health of the Slovak Republic on 31 March 2004).

This methodological instruction justifies the introduction of methadone maintenance treatment, its forms available in Slovakia, preparation, administration, storage, criteria for patient's entry (non-entry) in the methadone programme, examinations before entry into programme, provides a detailed description of switching to methadone, as well as where – in which specialised facility – methadone maintenance treatment is conducted (CTDD), who is responsible for such treatment (head physician specialised in psychiatry and with appropriate additional specialised training (additional attestation of drug addictions or 2nd level attestation of psychiatry and a training at the Institute for Drug Dependencies in the form of a practical clinical fellowship at the CTDD of Bratislava).

In 2005 the methadone treatment was partly funding from the Anti-Drug Fund.

5.3.3 Buprenorfin substitution treatment

Subutex is used for substitution treatment particularly outside of Bratislava, since methadone maintenance treatment is not available elsewhere. Subutex has been available in Slovakia since 2000; however, according to data reported in 2004 National Report its prescription is not widespread. According to information from the State Institute for Drug Control, so far the greatest amount of Subutex was sold 6,189 of packages (7 tbl. á 2 mg in one package) in 2005. The limited prescription is caused by its high price and restrictions on its prescription by the Health Insurance companies (2004 National Report).

Subutex may be prescribed by psychiatrists with an additional attestation in the field of drug addictions or psychiatrists working at a CTDD. General practitioners are not authorised to prescribe Subutex.

Besides data reported in 2004 National Report, no other systematic data is available and no surveys have been conducted that would map the information on the number of clients on buprenorfin treatment, its prescription of abuse. Orientation information was provided by a survey among clients of social field work organisations in eight cities (Chapter 4). Based on these information 109 clients of low-threshold agencies used Subutex as their primary drug. 65 clients obtained Subutex on prescription at a doctor and the rest by its purchasing in the black market. Obtaining Subutex from a black marked is mainly true for cities like Nitra and Sered', which may confirm the persistent situation in misuse of Buprenorphine in Southern part of Slovakia. (2004 National Report, p.129). In Žiar nad Hronom and Banská Bystrica, obtaining Subutex on prescription at a doctor dominates.

6 Health implications and consequences of drug use

The numbers of deaths reported forensic medicine and pathologic units of the Health Surveillance Authority (hereinafter “HSA”) in relation to the use of psychoactive substances have not significantly changed compared to 2004. In 2005, the total number of deaths under the influence of a psychoactive substance reported was 123 (124 in 2004), with 46 having been due to direct overdose and 77 in the condition of being under the influence of a psychoactive substance. The most frequent cause of death, according to the results obtained in 2004 and 2005, is the abuse of the medical drugs group, primarily of benzodiazepines, which prevail particularly in higher age groups. A significant reduction in the number of deaths (50% and more) was seen in 2005 in the group of amphetamines/methamphetamines, cannabinoids, and solvents.

The occurrence of the HIV/AIDS infection among injecting users in Slovakia is one of the lowest in the world in a long term. At present, there is one person with HIV transmitted by injection drug use. According to information from the Regional Public Health Authority of Banská Bystrica, the incidence of acute hepatitis B in injection users has been relatively low in recent years. In 2005, of the total number of 124 cases, 9 were reported in injecting users. Acute hepatitis C was recorded in 2005 in 7 IDU cases of the total number of 28 and in chronic hepatitis C, there were 27 cases reported for injection users of the total of 110.

The results of a pilot analysis of the number of patients hospitalised showed that 12 – 14% of patients had also another psychiatric diagnosis in addition to that of addiction.

6.1 Deaths related to psychoactive substance use and the death rate of psychoactive substance users

With respect to the use of statistical data on drug-related deaths from the so-called general mortality registers in other EU member states, newly established NMCD working group for drug-related deaths and mortality of drug users extracted data on drug-related deaths (hereinafter “DRD”) for the last 11 years from the register maintained by the Statistical Office of the Slovak Republic. The selection was based on the definition of the protocol for the implementation of the DRD key indicator according to EMCDDA; however, this definition could not be complied with in full extent. The limitations were caused by insufficient and incomplete records of the cause of death according to the clinical finding including a three-character diagnosis code according to the ICD-10 rather than a four-character in the post-mortem examination sheet, this being applicable throughout the monitored period.

Cases were included in the selection, if the cause of death was indicated as a mental and behavioural disorder caused by the use of psychoactive substances (F11-12, F14-16 and F19 including F18). The selection further included diagnoses indicated as accidental poisoning and exposure (X41, X42, X49), intentional self-poisoning and exposure (X61, X62, X64, X69), or poisoning and exposure with undetermined intent (Y11, Y12, Y14, Y19). Diagnoses under X41, X61, Y11 were selected in combination with T42¹³², T43¹³³, diagnoses X42, X62, Y12 in combination with T40¹³⁴, and diagnoses X49, X64, X69, Y14, Y19 in combination with T50¹³⁵. For comparison, data on deaths with unknown or unspecified causes (R96, R98, and R99) were also obtained from the register.

¹³² Poisoning by antiepileptic, sedative-hypnotic and antiparkinsonism drugs

¹³³ Poisoning by psychotropic drugs, not elsewhere classified

¹³⁴ Poisoning by narcotics and psychodysleptics [hallucinogens]

¹³⁵ Poisoning by diuretics and other and unspecified drugs, medicaments and biological substances

The results obtained indicate that the numbers of drug-related deaths are seemingly low (Table 6.1). That the data obtained does not reflect the reality is evidenced by the comparison of the number of deaths in 2004 and 2005 with information from the SO SR and with information obtained from necroptic units of the HSA.

Table 6.1: Drug-related deaths in absolute figures

Diagnosis/Year	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
F codes	1	0	1	2	9	6	7	1	6	0	2	0
X,Y,T codes	27	39	42	52	45	31	37	45	26	39	33	35
R codes	182	190	207	263	308	386	451	324	383	448	438	523
Total	210	229	250	317	362	423	495	370	415	487	473	558

Source: SO SR, 2006

Much more accurate and reliable data are provided by a special register, which is based on information from forensic medicine and pathologic units of the HSA, through which, similarly as for 2004, data for 2005 were collected retrospectively in close cooperation with the NMCD.

Direct drug-related death (overdose, poisoning)

In 2005, the forensic medicine and pathologic units of the HSA reported 46 cases of direct drug-related death. Medical drugs prevailed – they were found in 29 cases representing 63% of all deaths in this group. They occurred in higher age groups, primarily over 34 years. The greatest proportion comprised benzodiazepines – 20 cases (69%). The representation of males and females was surprisingly balanced, i.e., 50% of all cases reported. There were 17 deaths of people in younger age groups less than 34 years, directly related to psychoactive substances from other groups monitored. A detailed overview of the cases found, structured by psychoactive substance groups, age groups, and gender, is given in Table 6.2.

Table 6.2: Deaths caused by psychoactive substance overdose in the Slovak Republic in 2005 by psychoactive substance groups, age groups, and gender (M/F)

Psychoactive substance/age group	< 15	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65 <	Total
Only opioids (without methadone)	-	-	2/-	-	-	-	-/1	-	-	-	-	-	3 (2/1)
Only methadone	-	-	-	-	-	-	-	-	-	-	-	-	-
Polysubstances including opioids	-	-	2/3	1/-	2/1	-	-	-	-/2	-	-	-	11 (5/6)
Polysubstances excluding opioids	-	-	1/-	1/-	1/-	-	-	-	-	-	-	-	3 (3/-)
Psychoactive medical drugs	-	-	1/1	1/-	2/3	-/2	2/1	1/4	2/1	3/-	1/1	-/3	29 (13/16)
Unspecified substances	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	-	-	6/4	3/-	5/4	-/2	2/2	1/4	2/3	3/-	1/1	-/3	46 (23/23)

Source: HSA, 2006 (processed by: Šidlo J.)

Deaths under the influence of psychoactive substances

This group includes all deaths under the influence of psychoactive substances, where the cause of death is other than poisoning or overdose of the given substance. In 2005, a total of 77 deaths were reported in this group. Medical drugs were found in 51 cases, which represent 66.2%. The greatest proportion was found in the group of benzodiazepines – 36 cases representing 70.6% of deaths under the influence of medical drugs. Males comprised nearly two thirds of the cases registered. Deaths were approximately proportionally represented in all age groups with a more prominent increase in the number of cases in the group of 25 – 29-year-olds and in the group of over 65 years and with a drop in the number of cases in the age group of 40 – 44-year-olds and 60 – 64-year-olds.

Table 6.3: Deaths under the influence of a psychoactive substance in 2005 by substance groups, death causes, and gender (males/females)

Psychoactive s. / cause of death	Natural/ internal	Accident	Suicide	Homicide	Undetermined	Total	Percentage
							v %
Opioids	1/4	2/-	3/-	-/1	-	11 (6/5)	14,3
AMT/MAMT	1/-	1/2	2/-	1/-	-	7 (5/2)	9,1
Cannabinoids	-	3/1	2/-	-	-	6 (5/1)	7,8
Solvents	-	1/-	-	-	-	1 (1/-)	1,3
Cocaine	-	1/-	-	-	-	1 (1/-)	1,3
Benzodiazepines	5/2	8/3	6/4	1/2	5/-	36 (25/11)	46,7
Other medical drugs	1/5	3/4	2/-	-	-	15 (6/9)	19,5
Total	19 (8/11)	29 19/10	19 (15/4)	5 (2/3)	5 (5/-)	77 (49/28)	

Source: HSA, 2006 (processed by Šidlo, J.) Note: AMT – amphetamine, MAMT – methamphetamine.

According to information from the SO SR, 53,475 people died in the Slovak Republic in 2005. Of this number, the HSA indicates 9,677 deceased subject to autopsy. Based on this data we can conclude that the autopsy rate in the Slovak Republic was 18% in 2005. The above implies that during the first year of HSA's existence, the autopsy rate in the Slovak Republic increased by 5.5%, which is a positive piece of information from the viewpoint of monitoring of drug-related deaths, since this increases the probability of capturing a higher number of deaths belonging to this group.

Comparison of data obtained for 2004 and 2005

The numbers of drug-related deaths reported for 2004 and 2005 in Slovakia are very similar. All the deceased were subject to autopsy and in all cases, a chemical toxicological examination was done. The total number of deaths was 124 in 2004 and 123 in 2005. There were 46 cases directly related to the use of the substances monitored in each of the years. The relation between the substances used and the age groups has not changed. Medical drugs prevailed in higher age groups, while other substances monitored prevailed in lower age groups. Between these groups of substances and, at the same time, between the age groups in the group of deaths due to overdose, there is a virtual border at the age of 34 – 35 years. The numbers in individual groups of psychoactive substances vary only moderately. A significant drop in 2005 was seen in the group of polysubstances without opioids.

In the group of deaths in the condition of being under the influence of a psychoactive substance, there were 78 cases in 2004 and 77 cases in 2005. From the viewpoint of psychoactive substances found, the number of cases was the same for opioids; a significant drop (50% and more) was seen in the group of amphetamines/methamphetamines, cannabinoids, and solvents; a moderate increase was recorded in benzodiazepines; and a significant increase in the group of other medical drugs. The distribution of cases by individual death categories varied only slightly. The number of cases with an unspecified cause of death dropped more significantly.

On the basis of the analysis results it can be concluded that in the monitored period of 2004 – 2005, medical drugs clearly prevail among the psychoactive substances used or abused in the Slovak Republic, particularly those from the group of benzodiazepines.

6.2 Drug-related infectious disease

HIV/AIDS prevalence

In the course of 11 years (1995 – 2005), 194 HIV-positive cases were confirmed in Slovakia, of which 34% are foreigners. The occurrence of the HIV infection among injection drug users in Slovakia is one of the lowest in a long term. Currently, there is 1 person, in whom HIV transmission by intravenous use was confirmed. Another person already died from AIDS. In both cases, they had been infected abroad.

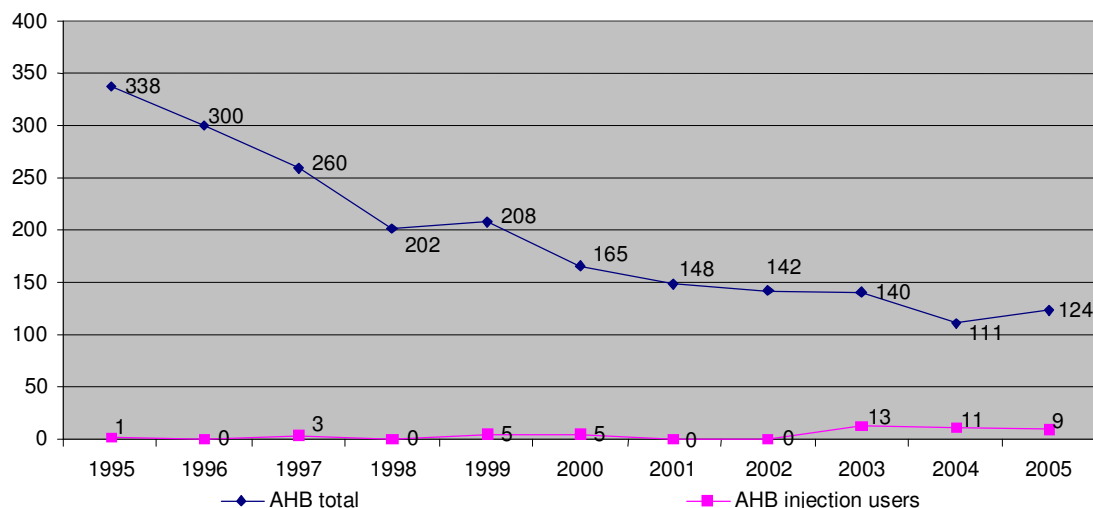
According to information of the National Reference Centre for HIV/AIDS, 8,094 examinations of HIV antibodies were conducted in the group of drug users by the end of 2005. No new case of HIV infection was discovered among drug users in the framework of the National Reference Centre for HIV/AIDS. In the framework of needle and syringe replacement programmes, HIV antibody testing is provided anonymously only in Prešov.

Hepatitis prevalence

According to data provided by the RPHA SR in Banská Bystrica, which collects the information from other RPHA and regional laboratories diagnosing infectious diseases, there were 9 cases of injection drug users reported in 2005 among new cases of virus hepatitis A (HAV) of the total number of 528 cases. The total prevalence of acute hepatitis A virus in Slovakia has a decreasing trend in a long term.

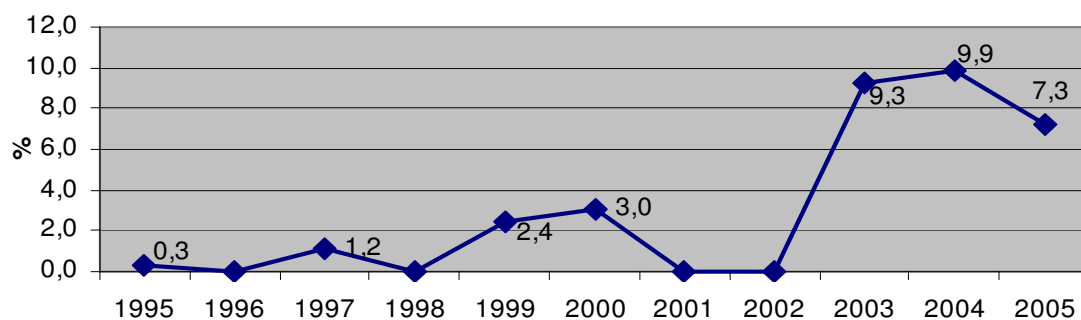
The incidence of acute hepatitis B reported has had a decreasing trend since 1995 – its total prevalence dropped by approximately 63% (Fig. 6.1). The incidence of acute hepatitis B in injection drug users has been relatively low except for 2003 when an increased number of cases were reported in injection users. Their percentage in the Slovak Republic in 2003 reached 9.3%. In 2005, their percentage in the total prevalence of acute hepatitis B dropped to 7.3% (Fig. 6.2).

Figure 6.1: Acute hepatitis B cases reported in the Slovak Republic and in the IDUs



Source: RPHA, Banská Bystrica, 2006

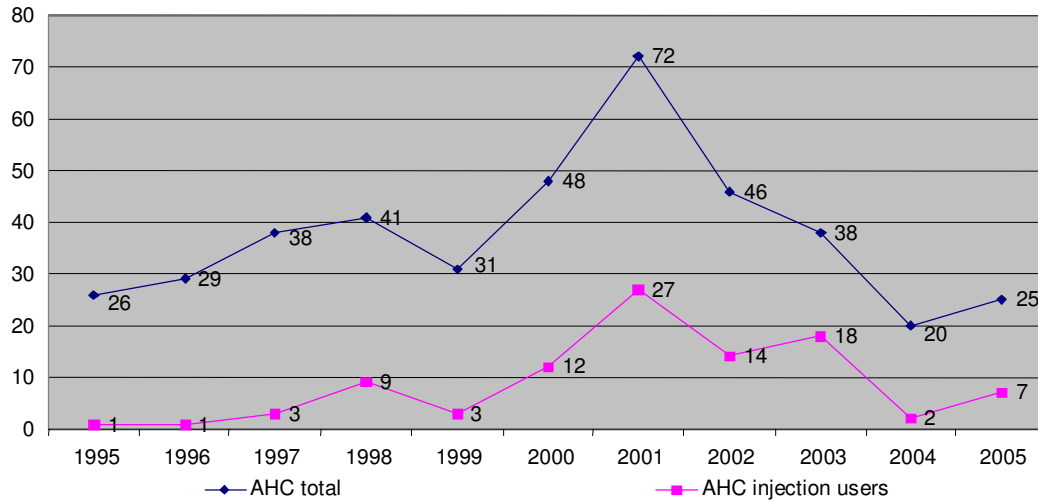
Figure 6.2: Proportion of acute hepatitis B in IDU's on total prevalence of this virus in Slovakia



Source: RPHA, Banská Bystrica, 2006

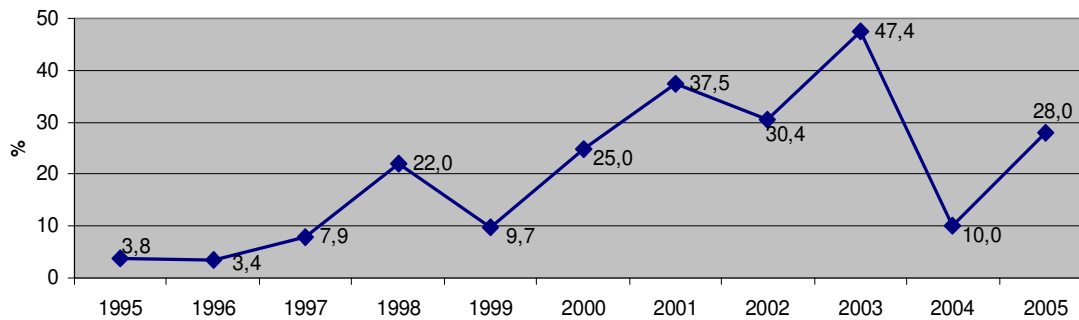
The incidence of acute hepatitis C reported has, conversely, been falling since 2001 (Fig. 6.3). The percentage of IDU's reported had had a growing trend until 2003 on the total prevalence of acute hepatitis C. In 2005, their proportion in their total number was 28% (Fig. 6.4).

Figure 6.3: Acute hepatitis C cases reported in Slovakia and in IDU's



Source: RPHA, Banská Bystrica, 2006

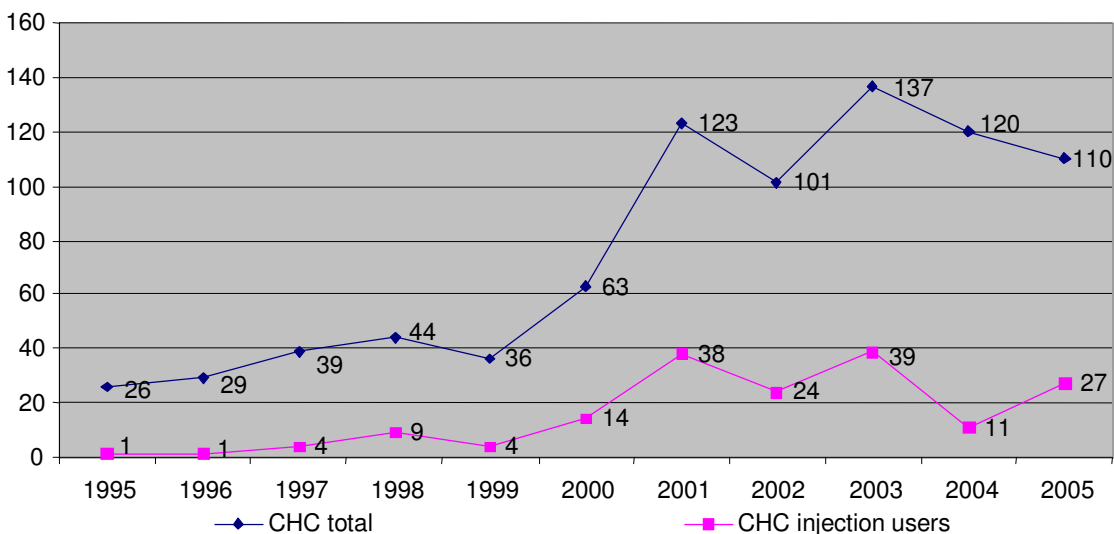
Figure 6.4: Proportion of acute hepatitis C in IDU's on total prevalence of this virus in Slovakia



Source: RPHA, Banská Bystrica, 2006

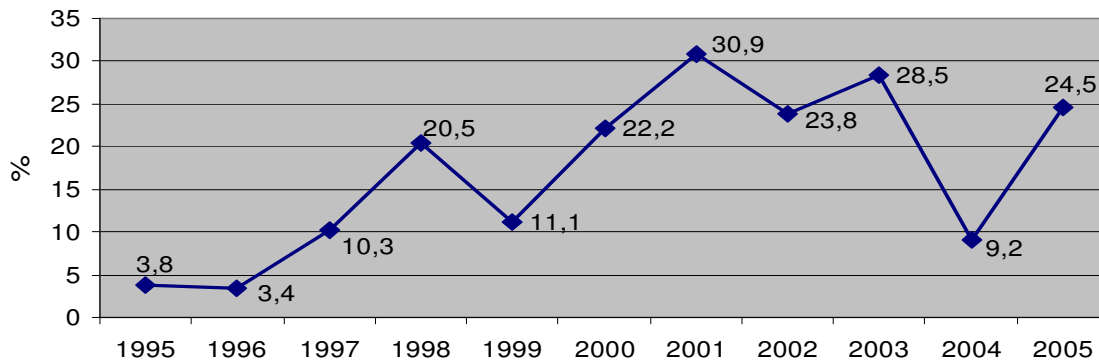
Before 2003, a continuous growth was seen in the number of chronic hepatitis C cases reported (Fig. 6.5). Similarly, the percentage of IDU's in the reported chronic hepatitis C cases had been increasing before 2001, when it reached 31%. In 2005, the percentage of IDU's in the total number of chronic hepatitis C reported in the Slovak Republic was 24.5% (Fig. 6.6).

Figure 6.5: Chronic hepatitis C cases reported in Slovakia and in the IDU's



Source: RPHA, Banská Bystrica, 2006

Figure 6.6: Proportion of chronic hepatitis C in IDU's on total prevalence of this virus in Slovakia

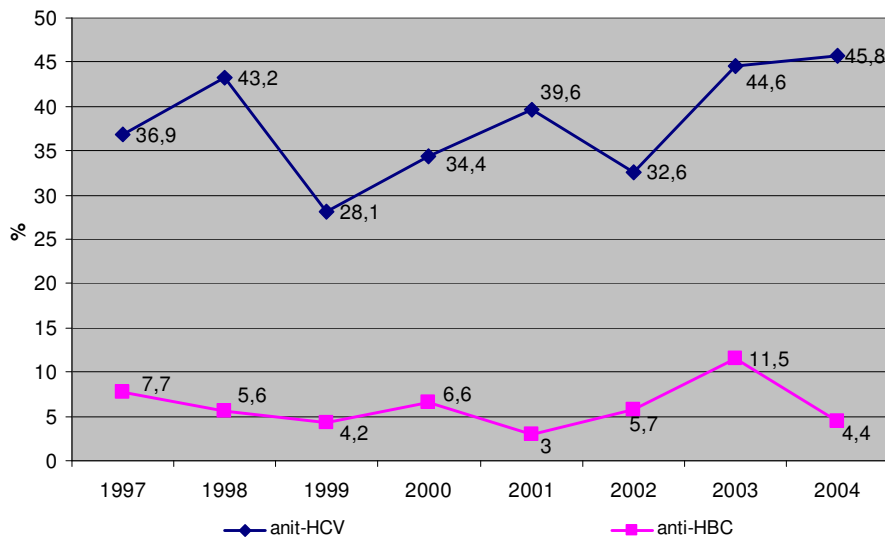


Source: RPHA, Banská Bystrica, 2006

Seroprevalence of virus diseases in IDU's in Bratislava

Since 1997, the CTDD – IDD Bratislava has been performing regular sentinel monitoring of infectious diseases among IDU's treated, who requested treatment in the given year for the first time. According to the most recent data available, of the total number of 72 patients tested, 45.8% were HCV antibody-positive and 4.4% were HBC-antibody positive (2005 National Report).

Figure 6.7: Prevalence of anti-HCV and anti-HBC among IDU's at the CTDD of Bratislava



Source: CTDD Bratislava, EMCDDA ST 09 standard tables, 2005 (2005 National Report)

Testing in prisons

In Penitentiary facilities, blood tests for HIV and virus hepatitis B and C were done as part of screening/early diagnostics of infectious diseases in risk-behaviour persons. The tested persons included particularly drug addicts with injection drug use, haemophiliacs, haemodialysed persons, professionally promiscuous persons, sexual partners of persons having any of the above-mentioned infectious diseases, recipients of organs and tissues before 1992, convicts starting their court-ordered anti-drug, sexuological, and anti-alcohol treatment as well as those suspected of an infectious disease.

In 2005, 919 blood tests for HIV antibodies were conducted in 18 Institutions. One case was recorded in the Prison Hospital of Trenčín. Of 862 anti-HCV examinations, 158 results were positive. Of 817 tested persons, 18 were HbsAg positive.

Table 6.4: Prevalence of anti-HCV and HBsAg in Custody and Prison Institutions in 2005

Test type	Number of tests	Number of positive tests	Positive results in %
HIV	919	1	0,1
anti HCV	862	158	18,3
HBsAg	817	18	2,2

Source: General Directorate of Corps of Prison and Court Guards, Healthcare Department

Testing on anti-HCV in 2005 was not conducted by any social field work organisation (Chapter 7).

6.3 Psychiatric comorbidity (dual diagnosis)

Psychiatric comorbidity of drug addicts has not been monitored in the Slovak Republic in a targeted manner. For the purposes of this chapter, a pilot analysis was conducted through the NHIC of patients who were hospitalised in psychiatric facilities of institutional care primarily due to drug addiction (F11 – F19) having another psychiatric diagnosis (F20 – F99) combined with this diagnosis. The results shown provide only an orientation view. A more comprehensive study is required for a more detailed analysis.

Processing of statistical sources (statistic card of a patient hospitalised in a psychiatric facility), which is sent for each patient of a psychiatric department or psychiatric hospital and facility, implies that approximately 12 – 14% have also other psychiatric diagnosis in addition to addiction. When comparing another statistical source (Annual Report of Ministry of Health 4-01 on the activity of psychiatric offices), the percentage of patients examined in psychiatric offices with the diagnosis of F11 – 19 is only 2.5% with half of them being examined for the addiction syndrome. This percentage remains relatively stable. For qualitative information on dual diagnosis, see the 2004 Report.

Table 6.5: Psychiatric comorbidity in drug addicted patients treated in psychiatric facilities of institutional care

	2001	2002	2003	2004
Hospitalised patients	38,861	39,250	38,410	39,039
Drug addicted patients	1,621	1,638	1,561	1,492
of which patients having also another psychiatric diagnosis ¹³⁶	201 (12%)	241 (15%)	217 (14%)	195 (13%)

Source: NHIC 2006, Statistical record of patient hospitalised in psychiatric facilities.

*hospitalisation = continuous stay of a patient at the given department. One patient may have several hospitalisations in the given year.

The healthcare statistics “Report on Causes and Circumstances of Intentional Self-Inflicted Damage” and “Drug User Treatment Report” showed that the number of suicides committed by drug users in 2000 – 2004 ranged at 3 – 12 in absolute figures representing 0.7% to 2.4% of suicides consummated by drug users reported/treated.

6.4 Other drug-related health consequences

In drug users, a range of other damages to health occurs, which require health care, such as: multiple dental caries; abscesses; tissue, skin, and muscle necroses at infections at injection sites, infectious and toxic hepatitides and hepatopathies, kidney damage, etc. (2004 National Report). More detailed studies and assessments have not been carried out in Slovakia yet.

Driving and other accidents

¹³⁶ Diagnoses in addition to a diagnosis of F11 to F19: F00 – F09: organic, including symptomatic, mental disorders, F10: mental and behavioural disorders due to use of alcohol, F20 – F29: Schizophrenia, schizotypal and delusional disorders, F30 – F39: Mood [affective] disorders, F40 – F49: Neurotic, stress-related and somatoform disorders, F50 – F59: Behavioural syndromes associated with physiological disturbances and physical factors, F60 – F69: Disorders of adult personality and behaviour, F70 – F79: Mental retardation, F80 – F89: Disorders of psychological development, F90 – F99: Behavioural and emotional disorders with onset usually occurring in childhood and adolescence.

An analysis of data from forensic medicine units HSA's in the period of 2000 – 2005 indicated 42 fatal traffic accidents caused by psychoactive substances other than alcohol (more in Chapter 13).

Pregnancy and children born to drug users

According to information from the NHIC, of the total number of mothers in 2005 (47,811), 495 indicated drug abuse in their subjective statement. The total number of children born in 2005 was 48,220, of whom 499 were born to mothers reporting drug abuse. Newborn withdrawal syndrome that can appear in 6-8 weeks after the childbirth¹³⁷ was diagnosed in 13 babies. In mothers that indicated drug abuse 6, 06% had to had caesarean operation, while in other mothers only in 5, 09%.

¹³⁷ "The insight of gynaecologist on addicted and HIV positive mothers", interview with Jaroslav Hinšt In: Čistý deň 4/2005, magazine, p. 10-11

7 Responses to health correlates and consequences

Measures aimed at reducing the health risks related to drug use are implemented in Slovakia particularly through non-governmental organisations active in field work, the CTDDs, or other healthcare facilities. Through a network of healthcare facilities (see Chapter 5), all drug users have healthcare available concerning illnesses related to drug use. As for drug users without health insurance, these will only be provided the necessary healthcare in the event of a threat to life.

The first syringe distribution programme was established in 1994 at the Centre for Treatment of Drug Dependencies of Bratislava. Later, NGO's started to be formed dealing with field work. In 2005 there were 6 such organizations in Slovakia (Odysseus, Prima, Storm at UKF, Heuréka, Risen, Pomocná ruka*) providing services in 8 towns (Bratislava, Nitra, Sered', Banská Bystrica, Žiar nad Hronom, Púchov, Prešov, Košice). In the given year, this service was not performed in the town of Zvolen due to lack of clients. On the contrary, in the beginning of 2005, low-threshold contacts centre for drug users in Bratislava were formed – “K-centrum” operated by the Prima CA.

There are not even 20% of estimated injecting drug users in contact with these organisations. At the same time the organisations provide services aimed at reducing drug related health and social risks, this being for drug users that are not yet motivated to treatment – such as needle and syringe exchange programmes, (hereinafter “NSP”), expert counselling, educating drug users, testing, etc. as well as for those who are only experimenting with drugs and the addiction has not yet developed. With their services, they help limit the spread of virus hepatitis and HIV among drug users, reduce the number of overdoses, inform on safer drug use and their effects, and motivate to less risky behaviour or to abstinence.

Map 7.1: Provision of the needle and syringe exchange programme



7.1 Prevention of drug-related deaths

There have been no significant changes in the preventive interventions of drug related deaths or unintentional overdoses compared to 2004. Besides substitution programmes, where the client is redirected from uncontrolled drug use to controllable use, prevention is implemented particularly through non-governmental organisations dealing with field work, through the CTDDs or other healthcare facilities, and this is namely by education and trainings of drug users about safer drug application and about measures how to prevent fatal overdoses or how to provide first aid to a fellow drug user. Education is provided in form of direct communication or information brochures and leaflets.

*Note: In 2005 Pomocná ruka in Košice provided fixed NSP in the CTDD. Taking into account that this regards only one civil association and only one fixed NSP of which data were available we have included data from Pomocná ruka among other outreach programmes.

There are no other activities available in Slovakia, which could be considered to constitute measures to reduce overdose, such as injection rooms for safe drug use, or direct distribution of antagonists to drug users.

7.2 Prevention and treatment of drug-related infectious diseases

The most frequent way to transmit infectious diseases, such as hepatitis, and HIV among drug users is the common use of syringes/needles and equipment for drug application which involves high risk of infection particularly of hepatitis C– and that even by using water, filter, etc. The most important interventions preventing the spread of infectious diseases include programmes providing sterile equipment¹³⁸ for injecting use and safe disposal of used syringes, programmes assisting drug users who are not in contact with healthcare facilities and, last but not least, drug user education on safer drug application and safer sex. Through implementation of such interventions, the frequency of needle and syringe sharing was reduced in the course of years (2005 Report, p.119). To perspective programmes consistent screening of diseases transmitted by blood as well as following management and treatment should belong.

Harm-reduction programmes

In 2005, harm-reduction programmes were implemented through 6 NGO's. The offering of the programmes was available exclusively in eight cities (Bratislava, Púchov, Nitra, Sereď, Banská Bystrica, Žiar nad Hronom, Prešov, and Košice). Slovak capital Bratislava got two field programmes existing in parallel and a contact centre, which was established at the beginning of 2005¹³⁹. Due to a low number of clients in 2005, Zvolen has not had an outreach programme, which had operated in the city since 2001.

Field (outreach) programmes are aimed on three groups of clients: active drug users, persons working in sex business, and the homeless. This is a direct work in the street and in places where the first contacts are made with these target groups, who are frequently dependent upon help and are not in contact with existing services. Field social workers work with a clientele that is not currently motivated to treatment or to a change of their way of life and they try to encourage them to change their behaviour. Often the programme is the only link to people of “normal population”, to which the client has no other access, whether due to fear, low motivation, or ignorance of the situation. However, this link works also vice versa.

Data on services and clients (Chapter 4) of outreach programmes existing in 2005 are available on the basis of the starting cooperation of the involved NGO's with the NMCD. Organisations were willing to fill in a special questionnaire concerning the client structure and kinds of services provided thereby. The results are shown in the tables below.

The total number of outreach programme clients in 2005 was 3,979, of whom 3,661 were illegal drug users in the average age of 29 years. Of available/known data on the number of males and females, 71% of clients were men and 29% were women. Of this the greatest proportion of contacts (6,760) was made by the Odysseus CA in Bratislava with the number of clients 1,852. The number of contacts in 2005 in all programmes was 29,657 (626 first-time contacts), which represents approximately 7 – 8 contacts per client.

¹³⁸ The sterile equipment, besides syringes, include other medical material such as: alcohol and dry tampons to disinfect the injection site, filters to separate impurities when aspirating the drug in the syringe, sterile water for injection to dissolve the drug and flush the syringe, ascorbic acid – vitamin C, which is used instead of acidulous water, adhesive plaster, bandages, condoms, sterile cap (SteriCup).

¹³⁹ In Bratislava, there is a low-threshold club called Klub Podchod – for persons working in the sex business (Odysseus Citizens' Association). However, this club is not primarily focused on drug users. Nevertheless, part of the persons working in sex business, who visit the Club, do use drugs.

Table 7.1: Services provided within outreach programmes (number of actions)

Service provided/location	Odysseus Bratislava	Prima Bratislava	Storm Nitra	Risen Prešov	Total
Number of contacts	7,602	4,559	1,652	987	
Food service	927 (fluids)	606		643 (soups)	2,176
Medical care	6	194	62	40	302
Individual counselling	1,511	173	238	25	1,947
Crisis intervention		68	1	2	71
References to K-centre	62	3,953			4,015
References to treatment	150	7	2	1	160
References to substitution treatment	150				150
References to healthcare facilities	81				81
Social assistance 3	27	68	2	15	112
Counselling phone calls			2	58	60
First aid		73		2	75
Legal counselling		38	13		51
References to other exchange programmes	65				65

Source: "Low-threshold client and programme report", NMCD 2006

The Risen CA offers its clients also work therapy, which was used in 2005 by 110 persons. Information on the number of intervention within the services provided or the number of persons using these services could not be collected for all organisations as not all of them keep such records or do not provide the above mentioned service at all.

In the framework of eight field NSPs in 2005, 254,730 syringes were collected in total and 336,358 syringes were distributed (Table 7.2), 55,653 condoms and 4,364 information-educational materials.

Table 7.2: Outreach NSP programmes

Field programme/location	Number of clients	Number of contacts	Number of syringes collected		Number of syringes distributed	
			2004	2005	2004	2005
Odysseus - Bratislava	1,852	6,760	148,886	131,281	173,576	155,729
Odysseus - Púchov	111	842	1,320	3,096	3,071	4,142
Prima - Bratislava – street work	926	3,953	53,518	31,724	71,319	49,297
Prima - Bratislava facility K-centrum	75	606	-	14,975	-	17,439
Storm at UKF, Nitra	83	1,033	6,545	19,107	9,091	23,173
Storm Sereď	97	619	15,054	23,774	18,097	26,420
Heureka - Banská Bystrica	64	212	2,301	3,531	4,822	6,944
Heureka - Žiar nad Hronom	76	338	8,789	27,242	1,936	34,298
Risen - Prešov	225**	987	n.a.	n.a.	n.a.	18,916
Pomocná ruka - Košice***	470	751	12,909	n.a.	16,023	25,697
TOTAL	3,979	16,101	249,322	254,730	297,935	362,055

* For the organisation as a whole

** Of which 112 alcohol users

*** fixed NSP

Source: "Low-threshold client and programme report", NMCD 2006

Sterile needles and syringes for drug users are provided also through stationary service at the Centre for Treatment of Drug Dependencies in Banská Bystrica and Bratislava. Another source of sterile needles and syringes with a broad geographic coverage are the pharmacies, which

provide or should provide them at a low price and without prescription (2005 National Report, p. 120).

Vaccination

An important preventive measure to prevent the spread of hepatitis B virus and other infectious diseases is vaccination. Vaccination against HBV is one of the most efficient healthcare interventions. The costs spent will pay back several times in a relatively short time. With the introduction of universal regular vaccination against HBV in children aged up to 12 years since 2002, the risk of infection in Slovakia is reduced (2005 Report, p. 120).

Considering the fact that in the Slovak Republic, vaccination of infants and vaccination of groups at risk (healthcare personnel, drug users, homosexuals) against HBV is already performed, vaccination of juveniles was also included in regular vaccination on the basis of Resolution of the Government No. 97/2003. The justification for this measure is based on their starting sexual activity and the growth of drug use¹⁴⁰.

Counselling and testing

Counselling as to how to prevent drug related health consequences is performed particularly through outreach social work programmes but also through specialised healthcare facilities.

The outreach programmes provide social counselling and assistance, which had primarily the following forms in 2005: outreach counselling service, visit by a medical specialist, assistance in arranging detoxification, outreach treatment and testing, and legal counselling.

Another form of counselling is the distribution of educational materials, of which 4,364 were distributed last year throughout Slovakia.

Certain outreach programmes offer their clients a possibility of testing on infectious diseases. However, this service is not generally available, only 2 organisations provided this service and that is moreover also depending on the amount of currently available funds.

Table 7.3: Testing of infectious diseases within field programmes

Type	Number of facilities performing the tests	Number of tests
HIV tests	1 - (Risen CA)	45
HCV tests	-	-
Pregnancy tests	-	-
Syphilis	2 - (Odysseus CA, Risen CA)	139

Source: "Low-threshold client and programme report", NMCD 2006

Testing of blood transmitted infectious diseases is actively provided to drug users entering the treatment at the Centre for Treatment of Drug Dependencies or other healthcare and social reintegration facilities. However, information on the number of tests made is not available.

Infectious diseases treatment

In 2005, the treatment of chronic hepatitis B and C remains available and free of charge except the persisting relative limitation for hepatitis C, where the Health Insurance companies require proof of at least 6 months' abstinence from drugs. The high cost of HCV treatment and possible relapses into drug use is the basic reason. The limitation applies to drug users in substitution programme and in their case, health insurance companies reject to finance HCV treatment. (2005 National Report, p. 121)

Treatment of infectious diseases is provided in specialised healthcare centres and in special outpatient centres. Medical specialists (hepatologists infectologists,) cooperate with addiction treatment specialists. A hepatitis treatment and its duration would differ according to genotypes

¹⁴⁰ Information on the Immunisation Programme Performance in the Slovak Republic, www.uvzsr.sk

and takes from 6 to 12 months in accordance with both the European and Slovak standard procedures. (2005 National Report).

Thanks to the rare occurrence of HIV and HBV infection among drug users, the availability of treatment is not a problem for those having health insurance. This therapy is also free.

7.3 Interventions connected with psychiatric comorbidity

Patients with psychiatric comorbidity are admitted for treatment in psychiatric departments of hospitals (2004 National Report).

7.4 Interventions related to other health correlates and consequences

Available healthcare for drug-using patients suffering from other health consequences is provided in healthcare centres within the treatment system in Slovakia. Likewise, free medical aid is provided in the case of overdose, whether through mobile emergency medical service or through medical personnel at hospital emergency departments.

For information on the prevention of driving accidents related to drug use see Chapter 13.

Interventions concerning pregnant women and children born to drug users

Counselling for addicted girls, women, and prostitutes is also regularly provided in Bratislava at the Faculty Hospital (Kramáre) and at the Centre for Treatment of Drug Dependencies Bratislava.

8 Social correlates and consequences

Drug use can be understood as a consequence or the cause of social exclusion – because social marginalisation may be, on one hand, the reason for starting to use drugs, or may lead to a more problematic use, while on the other hand, drug use may cause deterioration of living conditions (income, employment, housing, etc.).

Interventions to reduce the social exclusion of drug addicts represent an undifferentiated part of measures for the marginalised groups. The strategic document containing measures to reduce poverty and prevent social exclusion in the Slovak Republic is the National Action Plan of Social Inclusion for the period of 2004 – 2006.

One of the social consequences of drug use is crime. Drug-related crime has had a growing trend in Slovakia since 1999 without any slowdown. In 2005, the police registered 1,638 criminal offences related to production, distribution and consumption of drugs (an increase of 29.9%) and 1,308 prosecuted persons (an increase of 17.5%). In the course of the six years' period, the number of offenders convicted of illegal possession of drugs for personal use has been continuously growing (205 convicts in 2005). On the other hand according to data published by the Ministry of Justice, the number of convicts who committed a criminal offence under the influence of drugs dropped to one half since 2001.

8.1 Social exclusion and inclusion

Social exclusion and its consequences, such as unemployment, homelessness related to drugs are not specially monitored in Slovakia. There is also no information available of any special studies being done in this regard.

The strategic document containing interventions to reduce poverty and prevent social exclusion in Slovakia is the National Action Plan of Social Inclusion for the period of 2004 – 2006¹⁴¹ (hereinafter the “NAPSI”). The main population groups threatened with poverty and social exclusion are defined as: The unemployed and the long-term unemployed; families with children (with a higher risk for incomplete families and families with numerous children); Roma communities; people with disabilities; migrants; the homeless and other vulnerable population groups such as drug addicts, gamblers, mistreated and sexually abused children, victims of domestic violence, people serving a sentence in prison and after serving sentence, children after institutional or protective care.

The objective of the NAPSI is: to increase the employment and employability of all vulnerable population groups (including drug addicts); to reduce the risk of poverty for families with dependent children; to overcome the disadvantages related to low or insufficient education, and to support the integrity of Roma communities.

Unemployment

According to the World Bank report¹⁴² entitled “The Quest for Equitable Growth in the Slovak Republic”; high economic growth in Slovakia has not been reflected yet in an increase of employment. The greatest problems of the labour market include regional gaps/unbalance but also the striking differences in the availability of jobs for people with low and higher education. Information on the employment rate¹⁴³ of the Statistical Office of the Slovak Republic for 2005 indicate the percentage of 83.8% of employed of the economically active population of Slovakia (2,216.2 thousands). It means that the unemployment average rate in 2005 was about 16%.

Homelessness

The homeless are in high concentration particularly in Slovakia's capital¹⁴⁴. Information from NAPSI (2004) indicated 600 homeless people in Bratislava. The same number of the homeless

¹⁴¹ <http://ec.europa.eu>, <http://www.employment.gov.sk>

¹⁴² <http://www.profini.sk> downloaded on June 25, 2006

¹⁴³ www.statistics.sk

¹⁴⁴ Bratislava has the population of 425,155 (www.statistics.sk)

live in second biggest city Košice and fewer of them staying in other regional capitals; for example, 200 in Nitra.

According to information from NGO's working with the homeless, i.e., persons deprived of a home (which is not identical with the loss of housing), there are about 2 – 3 thousand of such persons staying in Bratislava only. Temporary shelters in winter 2006 during extremely harsh weather conditions in Bratislava were used by 1,123 persons, of whom 60% were domiciled in Bratislava and 38% were coming from other Slovak cities.

Care or assistance to homeless takes place on the local level in cooperation of municipalities with non-governmental and charity organisations. The homeless are provided meals, sanitary facilities, clothing and, in some cases, also temporary accommodation. The community regime sometimes requires work or a symbolic payment as the counter-value. The assistance to the homeless – especially the accommodation – is conditional upon the person not being under the influence of addictive substances. The building of shelters, hostels and low-threshold centres encounters “public concern” of local residents who are afraid of the growth of crime in their neighbourhoods. However, there are examples of homeless communities managing to integrate into the majority environment (the residents of the shelters in a Bratislava district of Lamač, or in Petržalka rebuilt a children's playground). In Bratislava, there is a problem caused by the lack of an Anti-alcohol Detention Room, where inadaptable persons under the influence of alcohol and other psychotropic substances could be placed in acute state.

Factors contributing to rise of homelessness include serving a sentence of imprisonment (particularly in a long term), long-term unemployment, and illness, leaving a foster home having reached the legal age, drug addiction, and alcohol addiction.

School drop out

During ten years' compulsory school attendance (starting at the age of 6) a pupil cannot be expelled from school. Expulsion in a higher year of a secondary school is possible on the basis of serious and repeated violations of school rules. School drop out is not registered in statistical system of educational sector and those, who leave an elementary school or a special elementary school in the age of 16 without achieved basic education, are not registered either. A possibility of central registration of such persons is available within the Headquarter of Labour, Social Affairs, and Family (hereinafter “HLSAF”), provided that they claim the request for social benefits or register as jobseekers.

Social characteristics of drug users in treatment

Certain indicators of deteriorating conditions, in which the drug users live, can be found in the social demographic data of the TDI information system (Chapter 4). Of 2,078 patients in treatment in 2005, 54% were unemployed and 9% did not have a permanent residence.

Table 8.1 Selected social characteristics of drug users in treatment (data in %)

	Number of the treated	Never went to school	Elementary school	Secondary school	Jobless	Homeless	Staying in institution
2005	2078	5.3	39.1	47.4	54	9	1.6
2004	2315	4.4	43	43.4	54.2	7.6	1.6
2003	2136	6	40.3	45.4	55.2	6.6	1.9

Source: NHIC 2006

Compared to 2003, the percentage of those coming from an unsteady environment rose by 2.35% and in 2005 comprised 8.95% of the total number of clients in treatment. The percentage of students treated in 2005 was 18.3% and compared to 2003 it slightly increased (by 2.4%). The percentage of students in first treatment demand is higher by 10% than among all treatment demands. Of the total number of treated; the second level of education was reached by 47.4% of patients.

In treatment facilities of the Ministry of Justice (persons serving a sentence of imprisonment), there is a higher percentage of unemployed as well as of users coming from an unstable

environment or living in various institutions than in treatment centres of the Ministry of Health (Tab. 8.2).

Table 8.2: Selected social characteristics of clients by centre type

Selected social characteristics of the treated	Outpatient treatment	Inpatient treatment	Facilities of the Ministry of Justice
Stabile accommodation	89%	89%	82%
Unstable accommodation and institutions	10%	8%	18%
Unemployed	54%	52%	59%
First level of education reached	42%	36%	39%
Second level of education reached	47%	49%	45%

Source: TDI 34, 2006

8.2 Drug-related crime

On the national level, registration and statistics of criminal offences are provided by the Department of Central Police Statistics of the Ministry of Interior. This statistics includes data on the number of all criminal offences and their perpetrators in the given year, including drug-related crime. The statistical system provides a general overview of the situation and development of crime. NMCD was provided data on drug-related crime and its perpetrators unstructured by sections of the law.

For the time being, none of the existing statistical systems in law enforcement institutions (the police, the General Prosecution Office and the Ministry of Justice) distinguishes criminal offences by individual drug types. However, within the Twinning project "Support of the Implementation NPF 2004 – 2008", this question was addressed to individual institutions and, as of 1 May 2006, the Police Corps Presidium introduced registration of the number of perpetrators by drug type. The Ministry of Justice and the General Prosecution Office plan to introduce such monitoring starting of 1 January 2007.

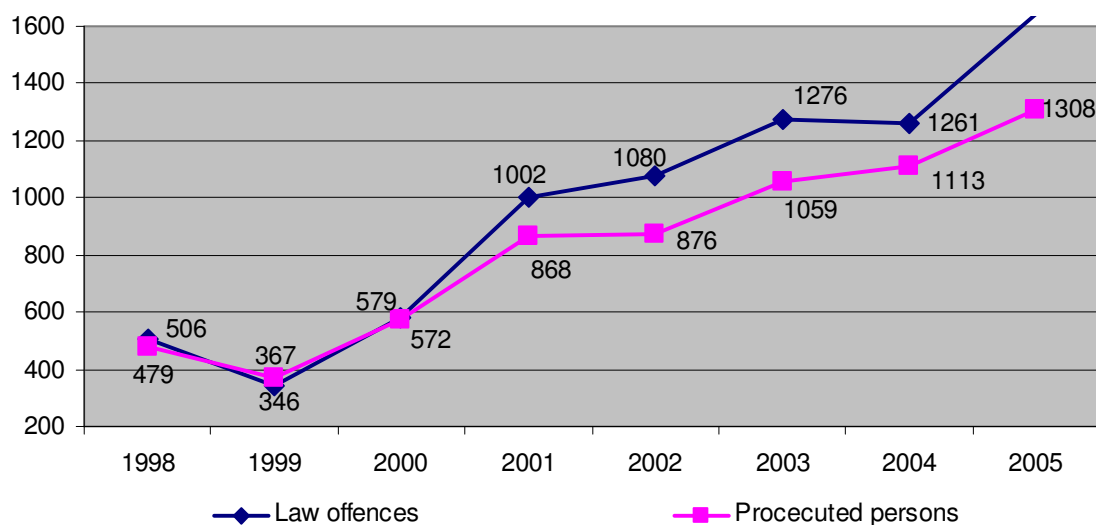
Number of criminal offences and prosecuted persons according to information from the Police Corps Presidium

Drug-related crime has had a growing trend since 1999 without any slowdown/continuously. In 2005, the police registered 1,638 criminal offences related to production, distribution and consumption of drugs, which is an increase of 377 cases (29.9%) compared to 2004. Likewise, an increase was seen in the number of the prosecuted persons against 2004 by 17.5% (from 1,113 to 1,308 persons), which represents 1.25 criminal offences per perpetrator in 2005 (see Figure 8.1).

The highest percentage (71.5%) of the total number of drug crime delinquents is in the age group of 18 – 30 years. The percentage of females among the perpetrators dropped from 10.3% to 8.6% in 2004. From the viewpoint of social status, the biggest group represented the unemployed – 848 (64.8%) and by education, the most numerous group included perpetrators with elementary education – 752, which is 57.5%, while in 2004, their percentage was 60.4 %¹⁴⁵.

¹⁴⁵ A material for Committee of Ministers for Drug Addiction and Drug Control, Report on the Security Situation in the Slovak Republic from the Aspect of Drug Crime in 2005, March 2006

Figure 8.1: Development of the number of drug-related criminal offences and the number of persons prosecuted for drug-related criminal offences



Data Source: The Police Corps Presidium, 2006

A similarly rising trend can be observed for the drug-related crime of juveniles. While in 1999, there were 49 persons prosecuted below 18 years of age, in 2005 there were 173 such persons. Compared to 2004, the number of juveniles prosecuted increased by 33 persons (See Tab. 8.4). Likewise, their proportion in the total number of prosecuted persons in 2005 increased compared to 2004 from 11.1% to 13.1%. In 2005, 20 children below 15 years of age exempt from criminal liability were also investigated (see Chapter 11).

Drug-related crime in regions according to the Police Corps Presidium

The greatest number of criminal offences was registered in the Bratislava region, whose share in the nationwide drug-related crime rate in 2005 was 62.5% (an increase of 2.1%). A drop of the percentage of criminal offences in the nationwide drug-related crime rate was only seen in the Žilina region (by 2.5%)¹⁴⁶.

The number of prosecuted increased in all regions except for Nitra (a drop by 5.9%) and Žilina (a drop by 9.1%). Similarly as with the number of criminal offences, the Bratislava region has a marked lead over other regions of Slovakia also in the number of the prosecuted persons. Of the total number of the prosecuted persons (1,308), 802 were prosecuted in the Bratislava region.

Table 8.3: Total number of persons prosecuted for drug-related criminal offences by regions

REGIO N	Bratislava	Trnava	Trenčín	Nitra	Žilina	Banská Bystrica	Prešov	Košice	Total
1998	267	45	21	26	20	43	22	35	479
1999	130	33	21	51	22	43	31	36	367
2000	232	43	44	57	25	89	40	42	572
2001	403	61	58	92	47	113	31	63	868
2002	345	93	115	85	69	90	29	50	876
2003	540	91	110	77	73	97	22	49	1059
2004	680	80	51	85	77	71	24	45	1113
2005	802	97	69	80	70	96	32	62	1308

Data Source: Police Corps Presidium, 2006

The following map shows the number of persons prosecuted for drug-related criminal offences per 100 thousand inhabitants. The Bratislava region has a clear lead (133 persons per 100 thousand inhabitants) followed by the regions of Trnava and Banská Bystrica (18/100 thousand

¹⁴⁶ A material for the Committee of Ministers for Drug Addiction and Drug Control, Report on the Security Situation in the Slovak Republic from the Aspect of Drug Crime in 2005, March 2006

and 15/100 thousand respectively). The lowest relative value shows the Prešov region (4 persons per 100 thousand inhabitants.).

Map 8.1: The number of persons prosecuted for drug-related criminal offences in 2005 per 100 thousand inhabitants



Surprisingly, the number of juvenile offenders below 18 years of age prosecuted for drug-related criminal offences remained unchanged in the regions of Bratislava and Trnava. The greatest increase of juvenile crime rate in 2005 was seen in the Banská Bystrica region (from 12 to 33 persons) and in the Prešov region (from 4 to 14 persons). Similarly as with the total number of the prosecuted persons (in total), the number of juveniles prosecuted in the regions of Nitra and Žilina decreased. For data see Tab. 5.4.

Table 8.4: Number of prosecuted juveniles below 18 years of age by region

REGION	Bratislava	Trnava	Trenčín	Nitra	Žilina	Banská Bystrica	Prešov	Košice	Total
1998	17	8	7	3	3	7	3	8	56
1999	5	3	5	9	7	4	10	6	49
2000	9	2	11	15	3	30	12	5	87
2001	35	6	9	13	9	35	4	14	125
2002	20	6	15	18	15	15	4	9	102
2003	48	7	25	10	12	26	3	4	135
2004	62	5	13	18	21	12	4	5	140
2005	62	5	17	12	20	33	14	10	173

Source: Police Corps Presidium, 2006

The number of the convicted according to the Ministry of Justice

The statistics of the Ministry of Justice records the number of cases (persons) sentenced for criminal offences in a structure of individual sections of the law. Registered cases are concluded in the given year by a legitimate court decision. Due to the fact that certain cases are tried by courts for long periods, even for several years, it is not possible to consider such data to constitute a realistic and current picture of the development of crime rate in the given year and the information is incomparable to the statistics issued by the Police Corps Presidium.

In a longer term, the data on the number of the convicted do have their information value considering development trends.

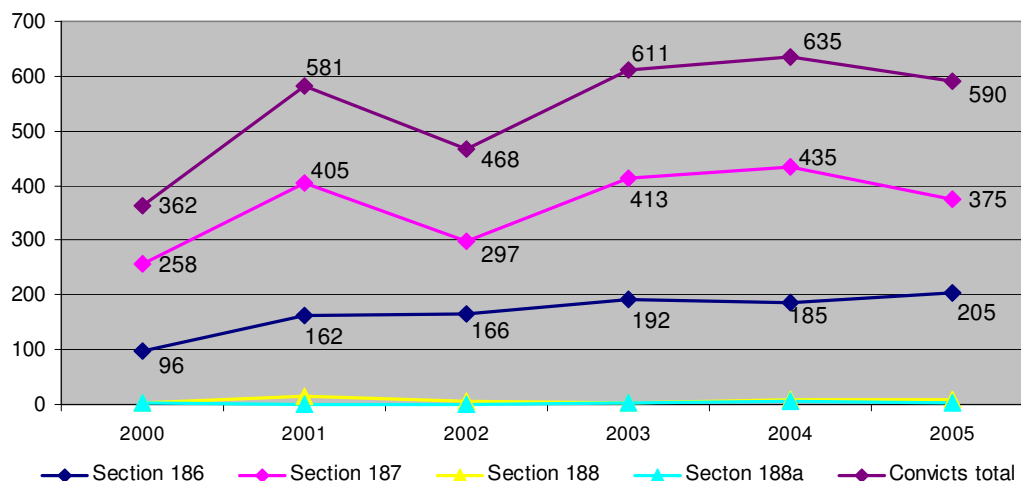
In 2005¹⁴⁷, 590 persons were convicted of the criminal offences under Section 186 – illegal possession of drugs for personal use, Section 187 – illegal production and possession of narcotic and psychotropic substances, Section 188 – illegal production and possession of items designed for production of narcotic and psychotropic substances, and Section 188a – propagation of drug addiction. This means a drop of 45 persons compared to 2004. In the number of convicts, there is a significant percentage of those sentenced on the basis of Section

¹⁴⁷ At the time of effect of the Penal Code No. 140/1961.

201 – threat under the influence of an addictive substance, whose number in 2005 was 485 persons (in 2004 there were 511 convicts). Considering the fact that this involves mostly criminal offences committed under the influence of alcohol, information for this section of the law is not employed in this Chapter.

In the course of the six years' period, the number of offenders convicted of illegal possession of drugs for personal use (Section 186) has been continuously growing. In 2005, there were 205 persons convicted of this criminal offence, which is 20 persons more than in 2004 (185 persons). There was a slight decrease in the number of persons convicted of criminal offences under Section 187, 188 and 188a (see Fig. 8.2).

Figure 8.2: Development of the number of persons convicted of criminal offences by individual sections of the law



Source: Ministry of Justice, 2006

The sentence most frequently imposed pursuant to Section 186 was the suspended imprisonment sentence (approximately in 71%). There was a falling trend in the unsuspended imprisonment sentence in the last 5 years; imprisonment sentence was imposed in 2005 only in 9% of cases (in 2001, this sentence constituted 14% of all sentences imposed under Section 186). In 2005, 11% of perpetrators of criminal offences under Section 186 were fined.

As for juveniles below 18 years of age, of whom 77 were convicted under this section of the law in the course of 6 years (2000 – 2005), in 40.3% of cases the sentence was waived and over 57% received a suspended sentence.

Young offenders

In 2005, 65 juveniles were convicted of drug-related criminal offences. In the course 6 years, nearly $\frac{3}{4}$ of juveniles were convicted of the criminal offence of illegal production and possession of narcotic and psychotropic substances (Tab. 8.5). Illegal possession of drugs for personal use was the basis for convicting 20 juveniles in the age of 15 – 18 years in 2005.

Table 8.5: The number of convicted juveniles below 18 years of age by individual sections of the Penal Code

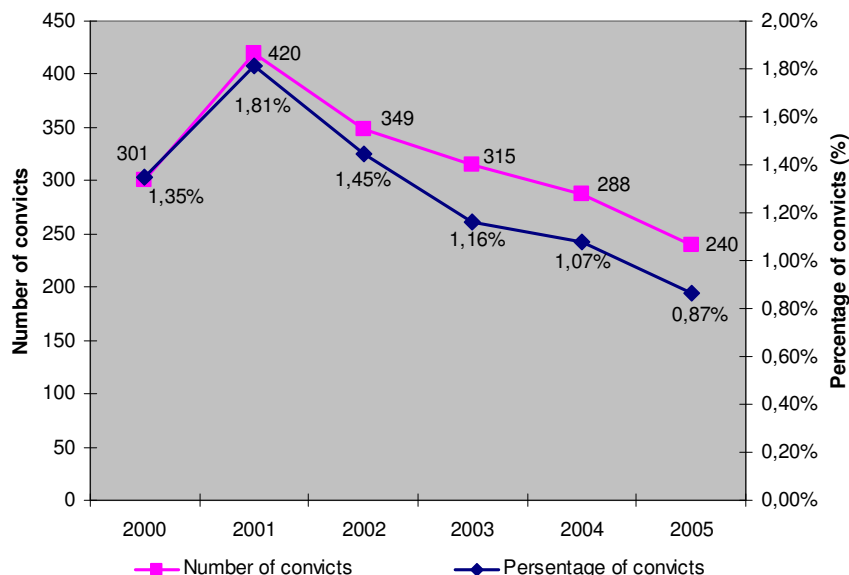
	Section 186	Section 187	Section 188	Section 188a	Total
2000	2	27	2	4	35
2001	18	53	1	0	72
2002	11	41	0	0	52
2003	20	45	1	2	68
2004	6	35	2	1	44
2005	20	43	1	1	65

Source: Ministry of Justice, 2006

Criminal offences committed under the influence of drugs

According to data published by the Ministry of Justice, the number of convicts who committed a criminal offence under the influence of drugs has been continuously falling since 2001. While in 2001, there were 420 convicts; in 2005, there were 240 of them, which is nearly half less (see Figure 8.3). On the other hand, the number of those convicted of a criminal offence under the influence of alcohol increased from 2,344 in 2001 to 2,850 in 2005. Their percentage in the total number of convicts ranges between 9.5 and 10.6%¹⁴⁸.

Figure 8.3: Influence of drugs on the crime rate



Source: Ministry of Justice, 2006

Other drug-related criminal offences (secondary drug-related crime)

Secondary drug-related crime means any criminal offences committed by drug users with the purpose of obtaining funds for personal drug use. For the period under examination, no information from the quoted sources was available.

8.3 Drugs in prison

The accused and the convicted, before entering penitentiary institutions (hereinafter the "penitentiary"), declare use of drugs in civil life on voluntary basis. In 2005, there were 651 persons thus registered in prisons, who reported the use of drugs in civil life (an increase by 28 persons compared to 2004). The greatest number was reported from prisons in Bratislava (238 persons) and in Leopoldov (78 persons). The most frequently reported drug was pervitin and heroin and the most frequently used pattern of application was injection. Of the total number of accused and convicted, there were 11.6% of drug users registered by 31 December 2005.

¹⁴⁸ Statistical yearbook 2005, Section of Judicial Informatics and Statistics of the Ministry of Justice of the Slovak Republic, p. 81

Table 8.6: Number of persons reporting drug use before entering an institution in the period of 2000 – 2005

Year	Number of persons reporting drug use before imprisonment	Increase	Average number of accused and convicted ¹⁴⁹
2000	563	-	-
2001	539	- 24	7 348
2002	696	+ 157	7 673
2003	596	- 100	8 813
2004	623	+ 27	9 329
2005	651	+ 28	9 327

Source: Healthcare Department of the General Directorate of Corps of Prison and Court Guards

According to information from the Corps of Prison and Court Guards (hereinafter the “Corps”), the number of convicts is growing who were ordered an anti-drug protective treatment and anti-alcohol protective treatment, so-called dry treatment, while in prison¹⁵⁰. In 2005, 379 persons received such treatment (in 2004, 264 persons) and 56 received anti-alcohol and anti-drug protective treatment voluntarily. However, according to information from the Ministry of Justice, in 2005, 324 convicts were imposed a protective anti-alcohol treatment and 109 convicts were imposed an anti-drug protective treatment (58 institutionally and 51 as outpatients)¹⁵¹. Such treatment did not necessarily have to take place in the given year from various reasons (insufficient capacities, unknown place of residence, etc.). In a long-term, the number of those who do not receive an anti-alcohol treatment from various reasons grows, but on the other hand the number of those who start protective anti-drug treatment grows as well¹⁵².

Due to abstinence symptoms, 20 persons were admitted to the Psychiatric Department of the Hospital for the Accused and Convicted, including one heroin user.

The risk of drug penetration into institutions is reduced using mobile testing laboratories, testing plates for drug screening in urine, and dogs trained to detect substances with specific odours. In 2005, 1,541 random examinations using urine drug screening plates were performed and in 166 cases, positive results were found. The substances most frequently found were benzodiazepines (91 cases) and cannabinoids (30 cases). They were followed by barbiturates (17), amphetamines (13), opiates (11), and other (4).

Mobile testing laboratories and testing plates were obtained in 2005 by the Corps from extra-budgetary sources, e.g., with the support of the Anti-Drug Fund, which provided the Corps with the amount of SKK 482,414 (approx. €12 000) for the given purpose on the basis of a project submitted.

8.4 Drug-related social costs

NMCD has no information available on the research of social costs with respect to illegal drugs. Measures under Act No. 305/2005 are financed from the state budget, from the self-governing regions or municipalities, from an accredited entity, and from legal entities or natural persons implementing measures of social legal protection and social custody. See Chapter 1 for information on funding of activities in the social field.

¹⁴⁹ Statistical yearbook 2005, Section of Judicial Informatics and Statistics of the Ministry of Justice of the Slovak Republic, p. 101

¹⁵⁰ In the Slovak Republic, substitution treatment is not provided in prisons.

¹⁵¹ Statistical yearbook 2005, Section of Judicial Informatics and Statistics of the Ministry of Justice of the Slovak Republic, p. 86

¹⁵² Statistical Yearbook 2005, Section of Judicial Informatics and Statistics of the Ministry of Justice of the Slovak Republic, p. 50

9 Responses to social correlates and consequences

In 2005, the attention in the field of drug demand reduction was focused on expansion of the possibilities of implementing new types of social prevention measures, particularly by creating legislative and institutional conditions for their implementation (particularly by passing Act No. 305/2005 on Social and Legal Protection of Children and on Social Custody). Even if they do not deal directly with the issue of housing, education and employment of drug addicts, the legislative measures adopted create prerequisites and come close to solving the most important existential questions of marginalised population groups, including the drug addicts.

Social reintegration in Slovakia is defined on two levels: social reintegration of drug addicts, which is performed through provision of residential-type services (social reintegration centres, sheltered housing facilities – so-called Half-Way Houses, crisis centres, etc.) and outpatient type (previously centres of counselling and psychological services – presently departments of counselling psychological services at the Office of Labour, Social Affairs, and Family). The final objective is the reintegration of drug addicts into a natural social environment. The second level is the social rehabilitation, which is focused on creating conditions for succeeding in the labour market (professional rehabilitation) and on supporting integration in the original social environment (social rehabilitation) (2005 National Report).

9.1 Institutional and legal interventions preventing social consequences of drug use

A specific feature of new Act No. 305/2005 on Social and Legal Protection of Children and on Social Custody (hereinafter “Act on SLPCSC”) is its connection to the family law, civil law and criminal law. It is the first separate provision for social and legal protection of children after more than forty years and the first legal provision for social custody in general. The objective of the legal provision is:

- the preventive nature of intervention;
- a focus not only on a specific client (a child, an adult), but also on his/her family, a broader social environment (group, community) and also
- focus on phenomena and processes in the society.

Interventions of primary prevention are now more targeted; environments in which the legal provisions are enforced¹⁵³ were adjusted, and interventions of financial nature have been introduced.

The term social custody is deemed by the law to mean a set of measures to eliminate, mitigate and prevent the deepening or repetition of disorders of mental, physical and social development of a child or of an adult and the provision of assistance depending on the severity of the disorder and situation, in which the child or adult is.

The performance of social custody for children was previously provided by employees, whose activity was usually cumulated with the agenda of social and legal protection. Legislatively, however, the institute of social custody was introduced for the first time by Act on SLPCSC which also defines its framework with respect to its content. Presently social custody for children is provided by 136 employees, who, in 2005, implemented measures for 21,120 children in 18,870 families.

Educational measures

These follow up the educational measures under Act on the Family. Educational measures may include, inter alia, an obligation to receive treatment in a specialised outpatient care facility, as well as an obligation to take part in an educational programme or in a social programme (for treatment of drug addiction of a child, an opinion of a medical doctor – specialist is required). A

¹⁵³ Natural environment, foster family environment, and open environment (public areas, public premises or streets/roads, which are the natural social environment for individuals and groups, in which environment they usually spend their time, and mobile or fixed premises – background of individuals and groups). Open and orderly environment for implementation of measures means, for example, children’s home, a crisis centre, a social reintegration centre for drug addicts, etc.

court may order a child to stay in a facility of professional diagnostics; in specialised facilities for a period not exceeding 6 months; and in a social reintegration centre for drug addicts. Special attention in performance of measures of social custody for adults is paid to young adults in the age of 18 – 25 years.

Table 9.1: Reasons for social custody for children in 2005

Reasons for social custody for children		Children total	Number of families
Behavioural disorders		21120	18870
including	poor school attendance	8636	7279
	criminal activity or otherwise punishable activity (below 15 years)	10091	9441
	before starting institutional or protective care	309	263
	during institutional or protective care	588	536
	after institutional or protective care	149	126
	drug addiction, experimenting with drugs	326	310
	return from a social reintegration centre	7	7
	return from an institutional treatment	30	26
	return from a crisis centre	6	6
Other	978	876	
Suspected maltreatment or sexual abuse		457	366
Juveniles without escort		265	256
Other		305	290

Source: Headquarters of Labour, Social Affairs, and Family, 2006

Table 9.2: Reasons for social custody for adults in 2005

Reasons for social custody for adults	Total	of which females
Released from prison	3805	202
Released from custody	377	27
Conditionally released from prison – probation ¹⁵⁴	1254	46
Suspended sentences – probation	1340	161
Released from a medical facility for treatment of drug addictions	18	4
Released from a social reintegration centre	21	4
Drug addiction	76	20
Released from a facility for institutional or protective care after reaching legal age	69	13
Justified suspicion of domestic violence against children	39	10
Justified suspicion of domestic violence against the partner	91	11
Long-term unemployment	458	85
Other ¹⁵⁵	1011	197
Total	8559	780

Source: Headquarters of Labour, Social Affairs, and Family, 2006

The act also regulates the care provisions in children's homes, namely the care in a separate group or in a separate diagnostic group. Such group may be established for children with behavioural disorders, drug-addicted, maltreated, sexually abused, and children with various disabilities.

Table 9.3 shows data on the number of children in 2005, in whose cases court decision was enforced of removing the children from their family environment and placing them in a facility, at

¹⁵⁴ if the person participates in probation or mediation pursuant to special regulations

¹⁵⁵ E.g., if they ask for assistance in solving a difficult life situation.

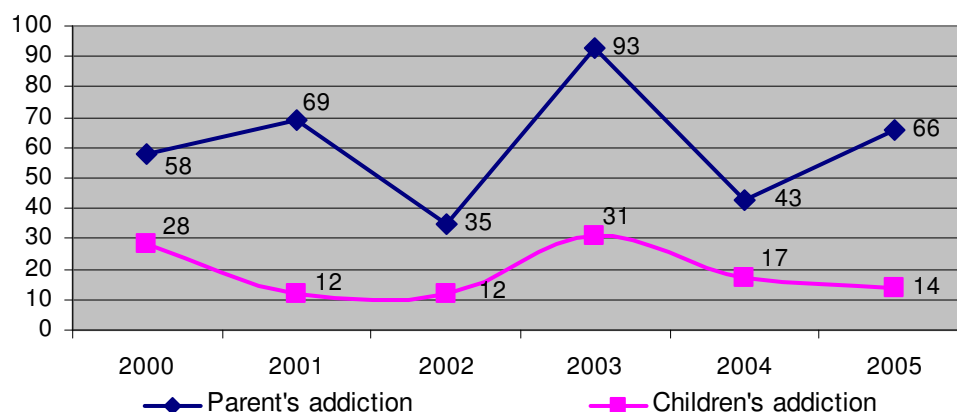
which such court decision is enforced. These include children's homes, crisis centres, but also social reintegration centres¹⁵⁶.

Table 9.3: The number of children, in whose cases a court decision was enforced of removing the children from their family environment

Reasons for placement		No. of children	of whom <15 years	neglect	parents' addiction	children's addiction	child's criminal activity	neglecting compulsory school attendance	other
Children placed, in 2005, in	institutional care	1027	820	625	65	2	6	28	301
	institutional care (behavioural disorders)	256	105	9	1	11	86	110	39
	protective care	23	10	0	0	2	20	0	1
Children not placed in	institutional care	68	48	40	2	2	3	6	15
	institutional and protective care (behavioural disorders)	54	19	0	0	2	28	21	3
Children registered, by 31 Dec 2005, in	institutional care	5467	4054	4221	273	10	37	136	790
	institutional care (behavioural disorders)	860	279	54	9	26	256	338	177
	protective care	69	10	0	0	0	61	7	1

Source: Annual report on interventions of social and legal protection of children and social custody for 2005, Ministry of Labour, Social Affairs and Family, 2006

Figure 9.1: Development of the number of children placed in institutional care due to parents' or their own addiction



Data source: Headquarters of Labour, Social Affairs, and Family, 2006

¹⁵⁶ A social reintegration centre, pursuant to Act on SLPSCS, is established for the purpose of activating children's and adults' own abilities to overcome mental, physical, and social consequences of drug addictions or other addictions and to become integrated in life in their natural environment. A social reintegration centre would perform, in particular, social work, special social counselling, social reintegration programmes, rehabilitation activities, work therapy, psychotherapy, health care, form conditions for succeeding in a job, for hobbies and cultural activities, provide psychological care, education, and preparation for a job. In a social reintegration centre, social reintegration of drug addicts and other addicts is performed in a residential form for the period of at least eight months.

Implementation of social custody and interventions of social-legal protection

From the organisational viewpoint, social custody is ensured at all 46 offices of labour, social affairs, and family and their 33 out posted workplaces (79 in total, 774 employees specialised in social custody for children; for adults; social and legal protection of children; plus departments of counselling and psychological services¹⁵⁷ – former centres of counselling and psychological services).

9.2 Social reintegration

Individual offices of labour, social affairs and family “order” a stay of a child in a social reintegration facility (a court decision on residential protective care). The office of labour, social affairs and family then pays for the child’s stay in the social reintegration centre. In total, 46 places were ordered in social reintegration centres in 2005 in the total amount of SKK 10,580,000 (approx. €274,000¹⁵⁸), 147 places in crisis centres SKK 31,605,000 (approx. € 819,000) and 139 places in foster care facilities SKK 11,120,000 (approx. €288,000)

Map 9.1: Locations of social reintegration centres



In 2004 the Association of Reintegration Centres has been established with the aim to integrate and defend the interest of reintegration centres in Slovakia. The Association, besides other activities, creates standards for operating of reintegration centres, as well as further develops the professional skills of their employees. Social reintegration centres are gradually also responding to the change of the legal provision concerning educational measures. A problem continues to be the introduction of supervision. Only 6 social reintegration centres report a supervision programme compliant with the criteria of supervision.

Activity of social reintegration centres

In 2006, the Ministry of Labour, Social Affairs and Family collected information on the number of clients in 18 social reintegration centres, which performed their activities in 2005 in full scope. Of the indicated number of 18 centres, 1 social reintegration centre has been established by a municipality and 1 by a self-governing region. However, the data is not statistically tested and verified by using other sources.

¹⁵⁷ The departments of counselling psychological services can also be useful in implementation of educational measures, particularly in working with children with behavioural disorders (such as truancy, criminal activity, bullying, and drug addiction). However, current human resources at the departments of counselling psychological services are insufficient and only enable to perform tasks in the field of foster family care. Compared to the originally transferred number of 176 employees of the former centres of counselling psychological services, there are presently 142 employees including 93 psychologists.

¹⁵⁸ Calculation into EUR currency in this Chapter were counted with the average exchange rate for 2005, 1 € =38,59,- Sk, Source : www.nbs.sk

Table 9.4: Clients in 18 social reintegration centres in 2005

	Beginning of 2005	End of 2005
Capacity (number of places)	252	271 (+7.5%)
Number of clients	255	260
- of which minors	n.a.	27
	Total	Males
Number of new clients	377	303
- of which minor clients	29 (7.7%)	19
Clients released during the year	370	312
- of which minors	13 (3.5%)	-
Clients released having completed an entire programme	154	-
Premature programme terminations	216	-
- of which at their own request	154	-
- within 2 weeks	65	-
- having passed 2/3 of the social reintegration programme	40	-
- of which due to violation of rules	52	-
- within 2 weeks	7	-

Source: Ministry of Labour, Social Affairs and Family, 2006

The greatest percentage of clients (36%) is in the age group of 18 – 26 years with approximately 3% being clients in the age of 16 – 18 years. (See Chapter 4 for information on the client structure by drug used.) The average capacity utilisation in the social reintegration centres during the year 2005 was 84.53%, the capacity utilisation of individual centres ranging from 35.8% to 100% - 1 centres having capacity utilisation higher than 90%.

Of the total number of 154 clients released having passed a complete social reintegration programme, 104 returned to their original environments, 22 were admitted to the so-called “half-way house”, and other solutions were found for 28 clients. Of the total number of clients who stayed in a social reintegration centre in the year under examination, 54.58% received benefits in material distress and contributions to the benefits, approximately 5% passed retraining courses or other type of job training, and approximately 5% took part, while in the centre, in some type of training to increase their qualification.

The monitoring of social reintegration centres' programme efficiency vary, particularly in using different methods of monitoring of abstinence after completion of the programme. According to available information (while not all centres provided data concerning follow up), in 77 cases that were monitored in a long term (i.e., for a period exceeding one year), as many as 74 clients were abstaining. However, data concerning monitoring of centres' efficiency and follow up cannot be considered unambiguously proven and, in the subsequent period. It is necessary, in cooperation with the social reintegration centres, to unify the approach to social reintegration programmes' efficiency monitoring and reporting.

The total amount of current costs for all social reintegration centres in 2005 was SKK 48,978,053 (€1,296,000) (with an average per centre being SKK 2,721,002.9 (€70,000)). The average amount of current costs per client and year, according to information from social reintegration centres, is SKK 180,730 (€4,600) (this amount ranges from SKK 150,000 – SKK 577,500 (€3,900 - €15,000) depending on the region, amount of contribution from the self-governing region, the number of paying clients, and last but not least, the scope and kinds of professional activities performed). The average monthly payment by a client is about SKK 3,300 (€85). Self-governing regions contributed to the social reintegration centres during the year 2005 an average amount of SKK 150,000 (€3,900) (information not including facilities established by local self-government) per client and year. The amount varies again depending on the region and ranges from SKK 120,000 - SKK 250,000 (€3,000 – €6,500) with most of the contributions corresponding to the average mentioned.

Based on a questionnaire survey performed by NMCD among 20 social reintegration centres including sheltered housing (of which only 11 questionnaires were returned), Table 9.5 shows the preview of f services provided by these facilities and the number of clients who used this service.

Table 9.5: Services provided by 11 reintegration centres involved in questionnaire survey

Service provided	No. of centres providing the service or recording data	Number of clients
Group therapy	11	271
Occupational therapy	11	260
Social work	9	198
Individual therapy, counselling	10	522*
Family therapy, counselling	8	184
Parent group	6	173
Crisis intervention	5	86
Intervention over the telephone	7	526
Assistance service	7	126
Number of HIV tests made	3	54
Number of HCV tests made	4	90
Number of pregnancy tests made	0	0
Number of drug presence tests made	9	867

Note: The number of clients includes also clients in treatment due to problems with alcohol – 15 – and gambling – 2

*including non-users (family members) who used the service

Source: "The reintegration client and programme report" NMCD, 2006

One facility provided 15 of its clients with assistance in job seeking. The services of social reintegration facilities and half-way houses were also used by 195 of clients' family members or close persons.

Housing

Long-term housing for drug addicts is provided particularly in sheltered housing facilities (most recent available data indicate 6 facilities), where housing and supervision is provided, and, to an extent, also in social reintegration centres. Provision of care in a sheltered housing facility is conditional upon passing the entire social reintegration process; in justified cases also upon successful completion of treatment lasting not less than 3 months, and upon contacts with the respective social reintegration centre.

A drug addict may further be provided with accommodation or shelter also in other social service facilities – such as shelters, crisis centres, which is conditional upon abstinence. (2005 National Report)

Education and employment

In Slovakia there are interventions aimed at education, preparation for the labour market, and interventions of active employment policy focused on disadvantaged jobseekers, which may include also drug users, however, not as a separate group.

9.3 Prevention of drug-related crime

Assistance to drug users in prisons

The Corps of Prison and Court Guards (Corps) performs systematic education in drug issues for members of the Corps and for the convicts serving their sentences in prison. The education activities comprised lectures and publications including educational texts, bulletins, and leaflets on drug issues. In 2005, the Corps' Educational Institute trained approximately 400 members of the Corps. General insight and education of Corps members in the field of addiction benefited from Corps' participation in the twinning project "Support of the Implementation of NPF 2004 –

2008”, activity “Support for Implementation of Preventive (Risk Mitigation) and Treatment Measures in Prisons”.

The convicts also received lectures on drug issues. The topic of drugs is included in a cycle of lectures, which each convict hears after starting to serve his/her sentence of imprisonment. Special attention is paid to convicts undergoing court-ordered anti-alcohol or anti-drug protective treatment and to those undergoing voluntary anti-drug treatment or placed in drug-free zones (6 with the capacity of 362 places).

Table 9.6: Anti-drug lectures given to convicts

TOPICS	Anti-drug lectures and discussions for convicts	
	Number of events	Number of participating convicts
Drugs, alcohol	179	4560
AIDS	37	834
TOTAL	216	5394

Source: Department of Custody and Prisons of the General Directorate of Corps of Prison and Court Guards

In prisons, there is a continuing practice of not providing drug addicted patients with substitution therapy or harm-reduction programmes such as NSP, distribution of paraphernalia, etc.

Penitentiary and post-penitentiary care

The Slovak Republic is one of the countries with high re-offending rate, the reasons including also the fact that penitentiary and post-penitentiary care was virtually nonexistent. As late as in 2005, this area was legislatively provided for in several regulations, which are interlinked (Act on Probation and Mediation Officers; Decree, which enacts the Prison Rules; and Act on Social and Legal Protection of Children and on Social Custody). For example, conditions have been created for establishment of so-called “exit teams”, whose main task is to prepare the convict for the conditions after release from prison and for his/her integration in the society.

Social reintegration benefit after release from prison

Pursuant to Act on SLPCSC, to facilitate social reintegration of juveniles and adults after release from prison or from custody, a so-called social reintegration benefit may be provided. This is a financial measure that a social custodian in combination with other measures of social custody may use and create thus prerequisites for efficient social reintegration. The benefit is not paid automatically after release from prison or from custody and the provision of this benefit must not be set against social benefits and contributions. Between 1st September 2005 and 31st January 2006, 366 social reintegration benefits were provided in the total amount of SKK 413,690 (€10.7000) to assist in integration in normal life.

Other interventions for prevention of drug-related crime

Crime prevention in Slovakia is ensured using a three-level system of control. Individual control levels are derived from the territorial administration structure of the Slovak Republic. These include the nationwide (Slovak Republic), regional (regions), and local levels (municipalities, cities or their districts). More than the others, the local level is characteristic with the targeted preventive activities i.e., the activities being done for certain specific group in a specific time and space (such as the patrols of the local police and parents – Nightwalkers – which ensure safety of children when returning home from discos). Information on measures focused specifically on the prevention of drug-related crime was not available for 2005.

10 Drug market

In 2005, the Slovak drug scene was not significantly different from the situation in the last year. The top ranking drugs are marijuana products and pervitin. The number of drug seizures by law enforcement agencies in 2005 increased by 354 cases, the greatest percentage in the increase being attributable to marijuana seizures (an increase by 222 cases). The quantity of drugs seized increased for heroin (3.7 kg), pervitin (1.99 kg), and ecstasy (1,698 tablets). In the case of marijuana, cocaine and LSD, the quantity of seized drugs dropped. In 2005, the greatest amount of the mushroom of the *Psilocybe* family was seized in a 5 years' period – 2.76 kg.

For marijuana and pervitin, the Slovak Republic is a producing country; however, the drug mostly stays in the territory of Slovakia. It is also a transit country for heroin and cocaine, where most of the shipments have a destination in another country.

In recent years, the concentration of THC, marijuana's active ingredient, has increased in this drug. In 2002, the concentration was 3%, while in 2005 it was 7.8%. Likewise the purity increased in pervitin (58.3%) and heroin (12.5%). In ecstasy tablets, a decrease in purity was observed in 2005. At the same time, first cases occurred where the tablets contained m-CPP, which is not currently included in the list of narcotic and psychotropic substances.

10.1 Availability and supply

The most frequently abused drug type is marijuana and marijuana products. According to information from the National Anti-Drug Unit, marijuana is generally perceived as the most readily available drug. Even the pupils of higher grades of elementary schools have accurate information on places where individual products are sold, on their available quality and price. The growing of marijuana in hydroponics continues to prevail, which enables several crops in a year and a higher percentage of the active ingredient – THC, e.g., 25% and more. (The highest concentration of THC in marijuana found in an analysis through the Institute of Forensic Science of the Police Corps in 2005 was 32 %.) Those involved in the laboratory growing of marijuana are primarily Slovak citizens and nearly the entire volume of drugs produced is also intended for Slovak consumers. Laboratories are built for permanent use usually outside of more densely populated areas and are carefully hidden.

Hashish trafficking is the domain particularly of organised groups of the Arabic community. Selling is concentrated primarily in Bratislava and in the spa of Piešťany, which is often visited by Arabic clientele.

In recent years, also on the basis of police data, a significant rise of pervitin (methamphetamine) can be observed in Slovakia. The number of seizures and the amount of pervitin as well as of its precursors – ephedrine and pseudo-ephedrine – is rising (see Chapter 10.2). Pervitin is mostly prepared in kitchen-type laboratories, which, if necessary, can be quickly dismantled and relocated. Due to its lower price and stronger stimulating effect, it is used as an alternative to cocaine. Most frequently, pervitin is produced in such laboratories from pseudo-ephedrine, which originates from medicinal products available in our market, e.g., Disophrol repetabs, Clarinase repetabs, Modafen, Paralen plus, etc. Ephedrine used in this production is smuggled through the Balkan route from Turkey, or it comes from local sources. The number of ephedrine and pseudo-ephedrine seizures increased from 3 in 2000 to 17 in 2005, when 2.3 kg of powder materials and 849 tablets were seized.

Heroin continues to be smuggled to our territory from Afghanistan through Turkey further through the Balkan route. The drug is transported primarily by perpetrators coming from the Balkan. Heroin trafficking in Slovakia is the domain of Albanian organised criminal groups. In the hierarchy of these groups, Slovak citizens are on the lowest positions – those of helpers, drivers, etc. Those selling heroin in apartments are mostly groups of Wallachian Roma. Seizures from neighbouring countries indicate smuggling of highly concentrated heroin in larger quantities.

Import and trafficking in cocaine is also part of the Albanian organised groups' sphere of interest. Cocaine imported to our territory comes from the countries of South America. Drug is most frequently smuggled by individual couriers or couples on their bodies or in the luggage. Since this is a relatively expensive drug, the price ranges from 2,000 to 3,000 SKK/g, its users are in the higher-income group. On the basis of information from the Police Corps Presidium, the demand in this drug is higher in the area of Bratislava than in other regions of Slovakia with respect to economic conditions. Since 2000, there has been no seizure of cocaine in the form of crack in our territory.

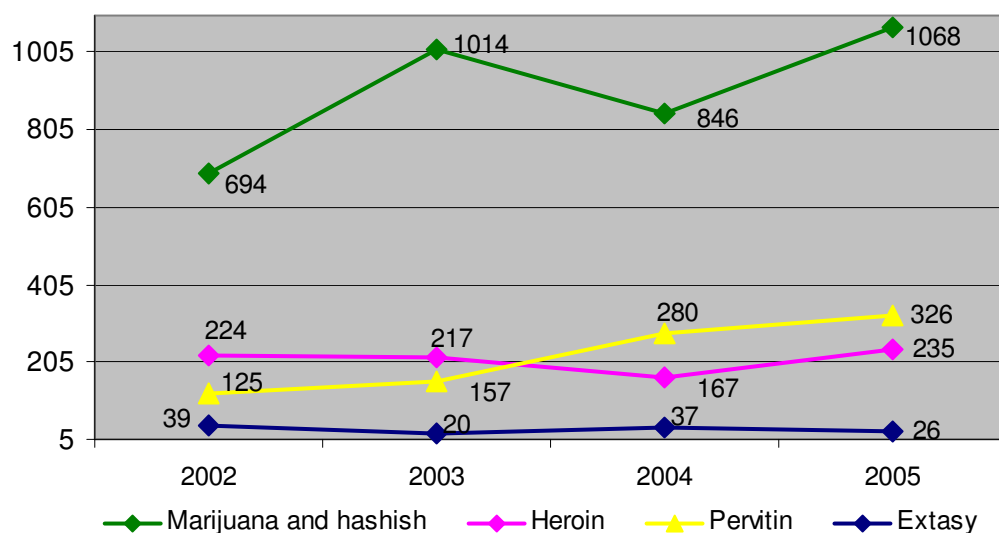
Ecstasy is also available in the Slovak drug market; however, the consumer demand in this drug has not reached the level of other EU countries. Slovakia is not an ecstasy-producing country and the drug is imported from other countries of Europe. In 2005 for the first time, ecstasy tablets were seized in Slovakia, which contained m-CPP as the active ingredient. This substance is presently not included in the list of narcotic and psychotropic substances. Throughout the year, there were 4 seizures of tablets containing m-CPP¹⁵⁹ (38 tablets) and 1 seizure of 99 tablets containing a mixture of m-CPP and MDMA (a substance commonly occurring in ecstasy tablets).

In 2005, 2.76 kg of Psilocybe family mushrooms were also seized, which is the largest amount in the last two years.

10.2 Seizures

According to information from the Police Corps Presidium, the number of drug seizures in 2005 generally increased to 1,682 compared to 2004 with 1,328 seizures. The number of seizures dropped only for LSD (from 6 to 2 cases) and ecstasy (from 37 to 26 cases). Compared to 2004, also the quantity of LSD seized dropped from 207 tablets to 11 tablets in 2005 and the number of ecstasy tablets seized fell by 689. The number of cocaine seizures increased from 12 cases in 2004 to 18, however, the quantity of seized cocaine was lower nevertheless (1.98 kg in 2004 and 360.01 g in 2005).

Figure 10.1: Number of seizures of selected drug types



Source: Institute of Forensic Science of the Police Corps, 2006

Since 2002, a growing trend in the number of cases and amount of pervitin seized can be observed (see Fig. 10.1 and Tab. 10.1).

¹⁵⁹ 1-(m-chlorophenyl)piperazine, stimulant

Table 10.1: Number and quantity of seized drugs

Drug	Unit of measurement	2002		2003		2004		2005	
		Number	Quantity	Number	Quantity	Number	Quantity	Number	Quantity
Marijuana	kg	664	725.4	991	619.23	817	1545.47	1039	1172.74
Hashish	kg	30	1.81	23	0.11	29	0.96	29	0.27
Heroin	kg	224	15.4	217	7.1	167	2.34	235	3.71
Cocaine	kg	32	0.07	15	0.9	12	1.98	18	0.36
Pervitin	kg	125	0.29	157	0.09	280	1.46	326	1.99
Ecstasy	tablets	39	435	20	1893	37	2387	26	1698
LSD	tablets	4	8	7	217	6	207	2	11

Source: Institute of Forensic Science of the Police Corps

According to information presented by the Institute of Forensic Science of the Police Corps and by the Customs Crime Office, of the above cases, customs authorities accomplished 3 seizures of ecstasy in 1,276 tablets, 14 seizures of marijuana (1.56 kg), plus they seized a small amount of pervitin (8 g) and 3 g of heroin.

10.3 Drug prices and purity

Drug prices

According to information from the National Anti-Drug Unit, drug prices have been relatively stable in recent years. Differences in prices occur within individual regions and on various levels of the distribution chain.

Drug prices are influenced by drug quality or country of origin. In the case of marijuana, which is grown freely in fields, the price depends on the season; for marijuana grown in hydroponics, the price ranges depending on the content of the active ingredient – THC.

In the case of hashish, the price is influenced also by the country of origin, i.e., whether a hashish of Slovak or foreign origin is concerned, particularly one from Morocco and neighbouring countries. In such case, the price per gram of hashish is higher. The price of cocaine is stable or very slightly lower (see Chapter 12 for more information).

Table 10.2: Prices of drugs in € (minimum and maximum price)

Drug type	Street price in €		Drug type	Street price in €	
	Min	Max		Min	Max
Marijuana – grown in hydroponics	5,-/g	10,-/g	Cocaine	10.3,-/injection	13,-/injection
	3.8,-/cigarette	6.5,-/cigarette		51.8,-/g	77.7,-/g
Marijuana – grown in the open	5.8,-/g	2.6,-/g	Heroin	7.7,-/dose	15.5,-/dose
	2,-/cigarette	3.8,-/cigarette	Pervitin	7.7,-/dose	13,-/dose
Hashish	2,-/g	7.7,-/g	Ecstasy	10,-/tbl.	15.5,-/tbl.
LSD	10,-/trip	13,-/trip			

Source: National Anti-Drug Unit, Office for the Fight against Organised Crime, Police Corps Presidium, 2006

According to information from the National Anti-Drug Unit, the number of seizures in the neighbouring countries indicates an increasing trend of heroin smuggling, and there is a decrease in price with increasing purity of heroine.

The Prima CA operating in the field of harm reduction questioned its clients to find the price of heroin and pervitin in the market of Bratislava. The questioning took place within six months and information was collected from approximately 400 active users. According to information thus collected, heroin price ranges from 500 - 1,200 SKK/g (€ 13 - € 31/g). The most frequently mentioned prices were those in the range of SKK 500 – 800 (€ 13 – € 21) and then SKK 1200 (€31). More than 100% difference between the highest and lowest heroin price indicates a very variable drug quality. According to information from the users, this substance often occurs in Bratislava's illegal market in a very impure form with a low percentage of opiates in the

substance. The concentration of heroin for the end user, according to findings of the Institute of Forensic Science of the Police Corps, ranged from 0.5% to 51.3% in 2005.

The price of pervitin, according to active users, ranges from 1,400 - 1,700 SKK/g (€ 36 - € 44/g) or 250 SKK/dose (€ 6, 5 /dose). In recent years, this price has been relatively stable.

Drug purity and composition

Information on the purity of drugs seized in the territory of Slovakia is provided by the Institute of Forensic Science of the Police Corps in Bratislava and its branches in Banská Bystrica and Košice.

In 2005, the Institute of Forensic Science performed quantitative drug analysis in 2,323 cases, which is 20.7% more than in 2004 (1,925 cases).

The table and figure below show information on the purity of individual drugs seized and intended for end users. In recent years, a rapid growth of the concentration of tetrahydrocannabinol (THC – active ingredient of marijuana) can be observed with 3% in 2002 and 7.8% in 2005, which is a 2.6-fold increase. The concentration is expected to continue increasing also in the years to come, although not as markedly.

For heroin, there is also a visible increase in purity from 9.9% in 2002 to 12.5% in 2005. Likewise, the concentration of the active ingredient in pervitin perceptibly increased from 46.4% in 2002 to 58.3% in 2005. As for cocaine, the purity has been stabilised in recent years.

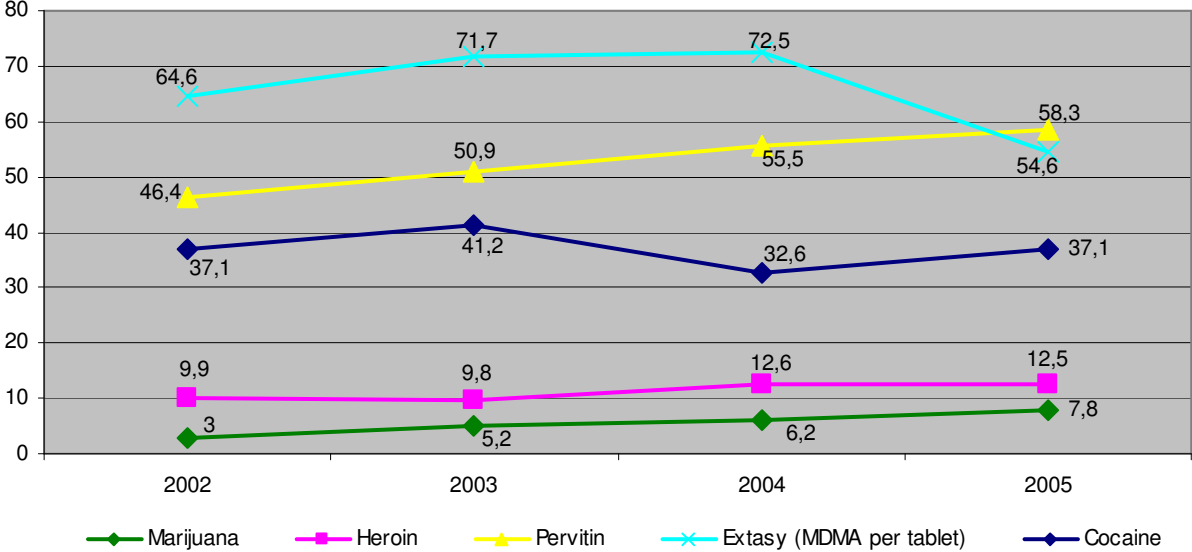
On the other hand, in ecstasy tablets, a decrease in the content of active ingredient was observed in 2005. At the same time, first cases occurred where the tablets contained m-CPP, which is not currently included in the national list of narcotic and psychotropic substances.

Table 10.3: Purity of selected drug types in the period of 2002 – 2005 in % (for ecstasy, in mg MDMA/tbl.)

		Marijuana	Heroin	Methamphetamine (pervitin)	Ecstasy (mg MDMA per tablet)	Cocaine
Number of samples analysed	2002	772	1454	130	40	21
	2003	1157	926	24	24	15
	2004	1096	1137	39	39	13
	2005	1219	898	386	1684	20
Minimum (lowest purity)	2002	0.1	1.2	2.4	25.7	9.7
	2003	0.1	1	1.8	12.7	7.7
	2004	0.01	1.9	5.1	31.8	6.5
	2005	0	0.5	3.7	14.4	8.6
Maximum (highest purity)	2002	33.2	33.7	78.8	98.8	65.8
	2003	35	30.7	80	140.1	82.5
	2004	32.7	38.7	80.9	114.7	50
	2005	32	51.3	88.8	127.9	78.8

Source: Institute of Forensic Science of the Police Corps, 2006

Figure 10.2: Development of mean concentration (median) of marijuana, heroin, pervitin, and cocaine in % and the amount of MDMA in mg in ecstasy tablets (see Tab. xx for the size of the sample tested in individual years)



Source: Institute of Forensic Science of the Police Corps, 2006

Part B: Selected issues

Three selected issues, which are selected by EMCDDA in cooperation with national monitoring centres according to actual needs, focus on development, new trends and findings of national studies in relevant topic for the period of 5 – 10 years.

11 Drug use and related problems among very young people (< 15 years)

In recent years, EU countries reported increasing drug use among young people younger than 15 years. The most frequently used drugs are marijuana and inhalants, but there are reports from certain countries on growing number of children (even 11 – 12 years old), who use heroin, cocaine or pharmacological products without prescription.

According to representative research, the Slovak children under 15 years of age have experience, besides alcohol and tobacco, particularly with marijuana. Information on treatment for the last three years (2003 – 2005) includes 59 children treated for medically indicated addiction; the proportion of those treated for problems with marijuana increased (from 29% to 43%), while the number of those treated for problems with inhalants decreased. The prevailing form of use is inhalation and smoking. In 2003, four children were treated due to problems with opiates (3 due to heroin). The age of the first experience with an illegal drug generally decreases. The difference between the “common population” and the high-risk groups is obvious – the more a population is under a risk, the lower the age of first use and the “richer” the range of psychoactive substances is.

According to information from a retrospective data collection from all 11 units of forensic medicine, there were no drug related deaths of children less than 15 years of age reported in the period of 2000 – 2005.

The legislative framework and further measures adequately restrict the availability of all psychoactive substances for this age group.

The central population of children in the age of up to 15 years in 2005 was 985,704 children with a moderate prevalence of boys (504,872). According to information from the Ministry of Education¹⁶⁰, there are 613,000 children in elementary schools (in the age of 6 – 15 years) (approx. 11% of the entire population)¹⁶¹.

11.1 Drug use in pupils and students

Population (school) surveys of up to 15 years of age

The efforts of mapping the drug behaviour (involving both legal and illegal drugs) in Slovakia with a focus on pupils¹⁶², students but also teachers date back to 1992, when the first comprehensive preventive programme was initiated under the name of School without Alcohol, Tobacco, and Drugs¹⁶³. It was necessary to objectively ascertain the situation among population and where the preventive intervention should be targeted¹⁶⁴. In 1994, first results obtained from the TAD1¹⁶⁵ survey in a sample of over 2,500 elementary school pupils were available. The survey was conducted by the National Health Support Centre and by the State Medical Institute as a repeated survey monitoring also the experience and attitudes of the teachers¹⁶⁶. The

¹⁶⁰ <http://www.minedu.sk>

¹⁶¹ Demographic data of the Statistical Office of the Slovak Republic. Mean Population Status as at 1 July 2005 is 5,387,285.

¹⁶² higher grades of elementary schools: 11 – 15 years

¹⁶³ Novotný I., Nociar A. (1994): School without alcohol, tobacco and drugs. – Preventive project and target population survey in Slovakia. Abstracts from meeting of International Institutes on the Prevention and Treatment of Alcoholism and Drug Dependence, Prague 1994, s.180.

¹⁶⁴ Nociar, A.(2004): Surveys on alcohol, tobacco, and drugs in the Slovak youth

¹⁶⁵ Tobacco – Alcohol – Drugs is a school survey focused on experience with legal and illegal substances, opinions and attitudes, family-, peer-, and school environment, and designed for the age group of pupils of the higher grades of elementary schools (11 – 15 years) – TAD 1, secondary school students (TAD 2) and teachers (TAD 3).

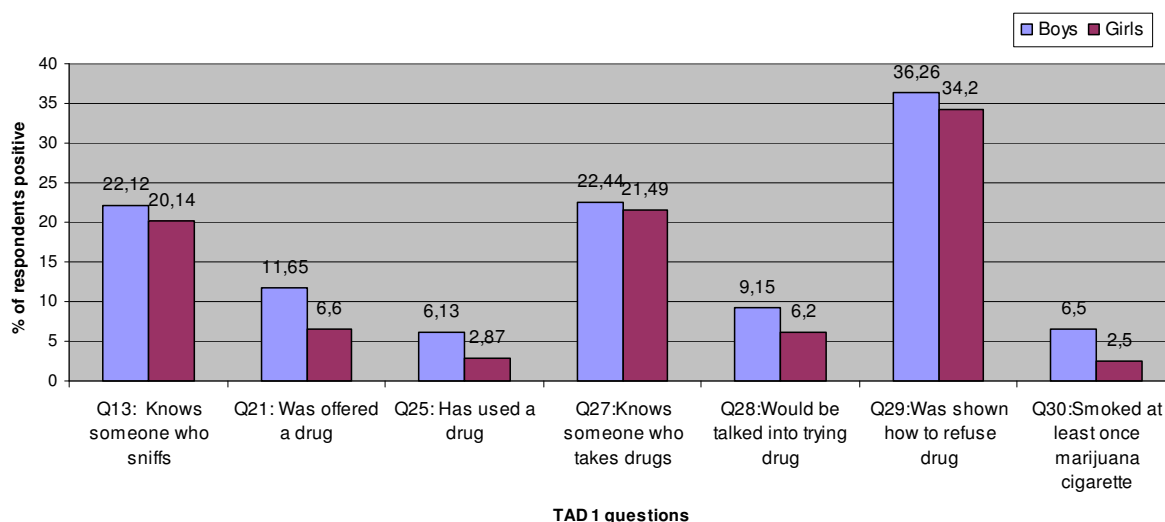
¹⁶⁶ E.g., 90.2% of the teachers were in favour of introducing anti-drug education in schools as early as in 1994.

results of TAD1, TAD2 and TAD3 are included in the publication “Prieskumy o drogách, alkohole a tabaku u slovenskej mládeže” (Surveys on drugs, alcohol, and tobacco in the Slovak youth”, 2000 Report on Bratislava¹⁶⁷ and partially also in the 2004 National Report.

In 2002, so far the most comprehensive, third wave of the TAD representative school survey was conducted, including TAD1 on a sample of 5,746 pupils of 5 to 8th grade of elementary schools (total number of pupils in 2002 in these grades was 281,837). A 30-item questionnaire covering tobacco, alcohol, and 7 questions on illegal drugs was administered in school classes, the anonymity of the respondents being ensured.

According to the TAD1 survey in 2002, over 20% of children knew someone, who sniffed, and knew about someone from their neighbourhood, who took drugs; over 6% of boys took a drug or smoked at least one marijuana cigarette; almost 2.9% of girls in the group of the average age of 12.5 years tried a drug – most frequently smoked at least one marijuana cigarette (2.5%). Only relatively positive information is that 35% of children in the age of 11 – 14 years in 2002 someone showed how to refuse a drug (Fig. 11.1).

Figure 11.1: Seven questions of TAD 1 relevant for illegal drugs



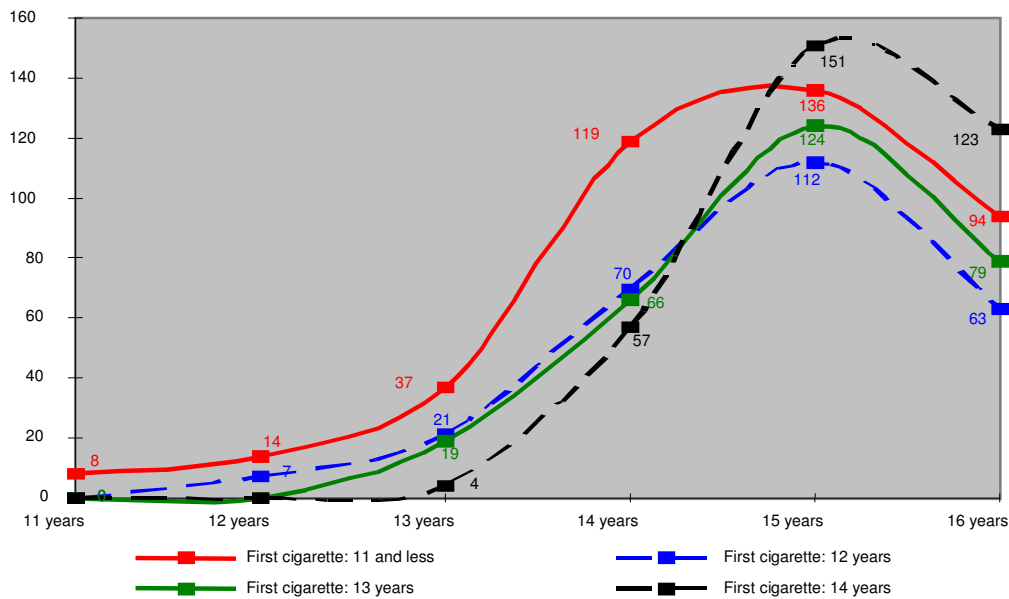
Note: Number of respondents n = 5746, average age 12.53, boys 2953 (aged 12.56), girls 2793 (aged 12.51).

Source: Nociar, A., 2004, p. 23

The relationship between smoking the first cigarette and the first marijuana cigarette is illustrated by Fig.11.2 below according to information from ESPAD (taken from <http://www.infodrogy.sk>) and Tab. 11.1 illustrates the growth of the willingness to try a marijuana cigarette according to information from TAD.

¹⁶⁷ Final report of the joint project of the Multicity study of the Council of Europe Pompidou Group and UNDCP

Figure 11.2: Early age of smoking the first tobacco cigarette in relation to the first experience with marijuana



Source: Nociar A., p.200

Table 11.1: Could you be talked into trying marijuana? Positive answers in percent

Survey year	11-year-olds	12-year-olds	13-year-olds	14-year-olds
1994	1.5	1.9	2.6	7.1
2002	2.6	4.2	10.7	13.6

Source: Nociar A., 2004¹⁶⁸

According to Nociar (2004), the results of TAD1 and TAD2 in 2002 showed that both occasional and regular smoking in pupils and students increased twofold compared to 1994.

Drinking of alcohol is becoming ever more problematic in part of youth, while drinking is globally continuing to form a common part of social atmosphere. “These facts given by the customs and culture and the change in the availability of alcohol, tobacco and other drugs are reflected in constantly growing numbers of smoking and drinking children and adolescents and, at the same time, in their growing willingness to experiment with illegal drugs, which increases the risk in part of young people of gradual addiction to ever broader range of illegal drugs.”¹⁶⁹

Smoking in pupils of elementary schools in the age of 10 – 15 years – results of a survey conducted by the IIPE.

A survey conducted by IIPE staff in 2001 and 2003¹⁷⁰ mapped the situation in smoking and alcohol consumption in pupils of elementary and secondary schools in the age of 10 - 18 years in the context of the family environment analysis as a significant factor influencing the child’s attitude to smoking and alcohol consumption. 1,013 questionnaires were processed in 2001 in total, of which 479 respondents were of the age of 10 – 15 years. In 2003, 516 respondents were of the age of 10 – 15 years and the total group comprised 1,016 respondents. A high return rate as well as the calculated confidence interval ensured the requirements of representativeness of the selected group of pupils of higher grades of elementary schools and students of secondary schools.

Experience with smoking in the group of pupils of elementary school higher grades (10 – 15 years) was reported by 52.5% of the respondents (57% of boys and 47.6% of girls). Of the entire

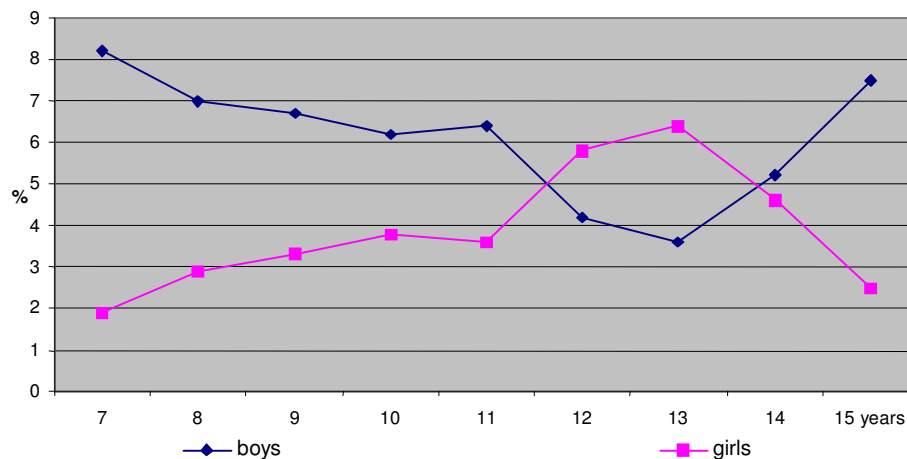
¹⁶⁸ <http://www.infodrogy.sk/indexAction.cfm?module=Library&action=GetFile&DocumentID=102>, copied 2nd. August 2006

¹⁶⁹ In: 2004 National Report, p. 36

¹⁷⁰ Bieliková, M: Smoking of elementary and secondary schools pupils and students

group of pupils approached, 24% indicated the age of first experiments with smoking to be 12 years and 21.1% the age of 13 years. While the greatest percentage of girls obtained the first experience with smoking in 13 years of age, boys are trying smoking much earlier. Every fourth boy requested tried smoking as early as in 10 years of age.

Figure 11.3: The age of the first experience with smoking in boys and girls



Source: IIPE. 2004

Against 2001, a growth was seen of the number of pupils who admit experience with smoking cigarettes; the percentage of those who smoke daily has increased, as has the number of occasional smokers. For regular smoking, pupils mostly indicated one cigarette a day. Of the group of respondents, who admitted smoking cigarettes, bad relations in the family are indicated by 14.3% of regular smokers and 12.3% of occasional smokers. At the same time, growth of smoking can be seen in elementary school pupils' friends – as many as 69% had a friend in their neighbourhood who smoked.

Table 11.2: Intensity of cigarette smoking in pupils of elementary school higher grades in %

Cigarette smoking	2001	2003
Every day	2.9	3.5
Only sometimes	12.0	13.0
Does not smoke	85.1	83.5

Source: IIPE, 2004

In a WHO-initiated comparative survey of the V4 countries in the framework of the Global Youth Tobacco Survey (GYTS)¹⁷¹, cigarette smoking was declared by 24.3 ± 2% of children of the age of 13 – 15 years. The highest percentage of positive answers of trying cigarettes in an age lower than 10 years was reached by the Slovak children, 29.3 ± 2%.

Of current local surveys – designated as part of primary prevention of socially pathological phenomena at schools – we could mention the survey¹⁷² at elementary schools in the district of Kežmarok in the school year of 2004/2005. Of 400 respondents, 261 were children of up to 10 years of age, the rest being of up to 13 years. The first contact with a cigarette was in the range of 5 – 10 years. In the answer to the question “Who is to be blamed for one’s smoking and drinking?” the lead was taken by friends followed by the answer “the person himself/herself”, media, and parents.

¹⁷¹ Baška, T., Sovinová, H., Németh, A. et al: Findings from the Global Youth Tobacco Survey (GYTS) in the Czech Republic, Hungary, Poland, and Slovakia. Soc. Prevent. Med., 51, 2006, p. 110 – 116.

The group of 16,918 respondents in the age of 13 – 15 years, the group from Slovakia including 4,594 pupils, conducted in 2002 – 2003

¹⁷² Pitoňáková, M.: Primárna prevencia drogových závislostí u žiakov ZŠ v Kežmarskom okrese – výsledky prieskumu (Primary prevention of drug addictions in elementary school pupils in the district of Kežmarok – survey results). Prevencia 2, 2006, volume V, p. 27 – 32

Alcohol consumption in pupils of up to 15 years of age

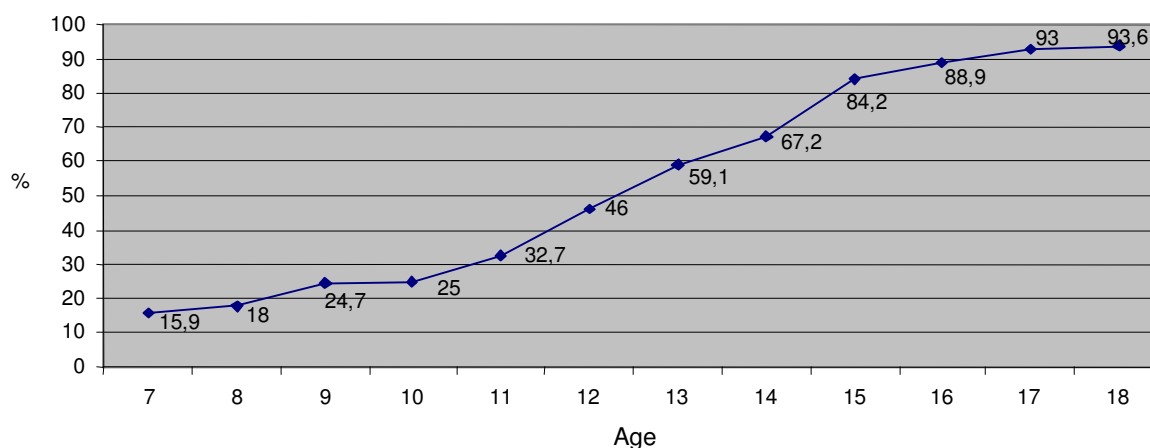
In the IIPE survey, the first contact with alcohol in the age of up to 15 years was admitted by as many as 70.3% of pupils. As for the type of alcohol used, the respondents most frequently reported wine (38.8%), beer (30.0%), distillates (19.3%) and liqueurs (11.8%). Against 2001, a growth in alcohol consumption in pupils of elementary school higher grades was seen, with the ranking of preferred types remaining unchanged in 2003. The results found confirmed the fact already indicated of general growth in legal drug consumption in the elementary school pupils examined.

When examining the experience with specific types of alcohol with respect to respondents' gender it was found that while beer and distillates dominate in boys, girls more often prefer wine and liqueurs.

Alcohol consumption in the respondents is closely interrelated with cigarette smoking experience. This nearly linear significance confirmed that the respondents, who admitted smoking a whole cigarette, also admitted alcohol consumption in as many as 87%. On the contrary, of the group of respondents refusing alcohol consumption, 85% stated to never have smoked a whole cigarette in their lives.

According to information of TAD1 of 2002 (Nociar, 2004, p. 27), children of 15 years of age taste beer for the first time in the age of 9.4; wine in 10.1 years and distillates in the age of 10.7 years. The growth of alcohol offers by adults in individual years of child's and adolescent's age according to information of TAD is illustrated by Figure 11.4

Figure 11.4: Offer by adults of any kind of alcohol once and more times in the lifetime



Note: Information for 11 to 18 years is from 2002; for 7 – 10 years, from past TAD surveys.

Source: National Action Plan for Alcohol Problems, Annex, figure 7¹⁷³

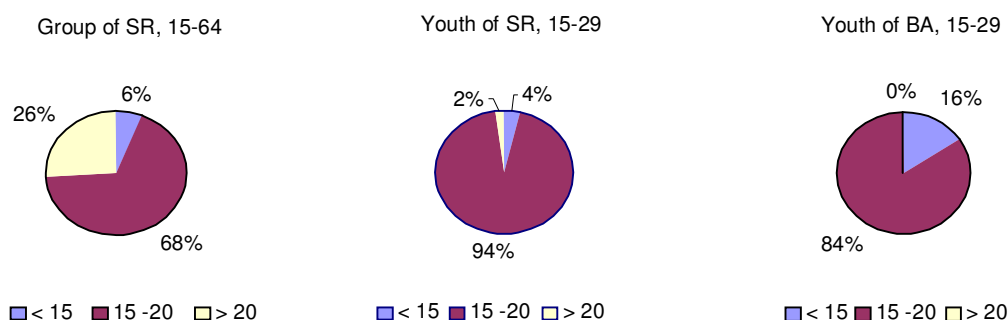
Age of the first experiments with illegal drugs

In three groups of a population survey by the PORI at SO SR¹⁷⁴ in 2004, the respondents of the group "Youth of Bratislava, 15 – 29 years", most frequently declared regular use of illegal drugs in an age lower than 15 years (in 16%).

¹⁷³ [http://www.rokovania.sk/appl/material.nsf/0/439DC382A1C86051C1256C16004949EE/\\$FILE/Zdroj.html](http://www.rokovania.sk/appl/material.nsf/0/439DC382A1C86051C1256C16004949EE/$FILE/Zdroj.html)

¹⁷⁴ Prevalence of drug use in population of Slovakia and opinions of citizens concerning drug-related problems, PORI at SOSR, 2004, p. 28.

Figure 11.5: Declared regular use of drugs by respondents in groups <15, 15 – 20, >20 years



Source: PORI at SO SR, 2004

According to Pétiová (2005)¹⁷⁵, 10.5% of young people of 14 years of age tried illegal drugs; boys start experimenting with drugs earlier than girls.

According to another survey¹⁷⁶ conducted in 1998 and 2005 by the same author, residents of re-education institutions (RDM) declared the lowest age of first contact with a drug of as little as 9 years and the age with the highest percentage was 14 years. A comparative group of youth aged 15 – 17 years was formed to the group of youth from re-education homes. The lowest age of the first experience with an illegal drug in this group was declared to be 12 years. The most numerous group in 1998 indicated the age of 16 years; seven years later, 15 years (41.9%). (See also Chapter 2 and 12)

Table 11.3: Age of the first contact with a drug in the re-education home residents and in the comparative group

Age when first experimenting with a drug	Re-education homes		Comparative group	
	1998	2005	1998	2005
9 years	0.8	1.0	0	0
10 years	0.4	6.4	0	0
11 years	3.4	7.3	0	0
12 years	14.1	12.2	1.2	3.2
13 years	17.5	22.7	2.5	6.5
14 years	29.9	26.8	16.0	16.1
15 years	25.6	17.7	29.6	41.9
16 years	6.4	4.1	30.9	22.6
17 years	1.7	1.8	19.7	9.7

Source: IIPE, Pétiová, 2005

In 2002, monitoring of alcohol, tobacco, and drug use in certain Roma settlements¹⁷⁷ mentions the youngest toluene snifter being 7 years old. (Hroncová J. et al., 2004, p.87).

11.2 Treatment and social reintegration

At present, there is no specialised medical facility for the treatment of drug addiction in children¹⁷⁸ in Slovakia. The only such centre in Pezinok¹⁷⁹ was dissolved.

Drug-addicted children may be treated at child psychiatric clinics or at psychiatric departments for adult patients (healthcare) or in diagnostic centres or therapy/education sanatoria (education sector).

¹⁷⁵ Pétiová, M. et al.: The Social-Pathological Issue of Problems of Youth in the Slovak Republic, final research report, IIPE, Bratislava 2005.

¹⁷⁶ Pétiová, M.: Comparison of data from a youth survey (a sample of 15 – 17-year-olds) and surveys of youth in the age of 15 – 19 years in re-education homes for youth in 1998 and 2005.

¹⁷⁷ Hroncová, J. et al., 2004. Social pathology. Banská Bystrica: PF, UMB, 2004, 191p. ISBN 80-8055-926-0

¹⁷⁸ Slovensko radio station; Rádiožurnál; 12:00; 3 min, 26 June 2006; author of the contribution: Zuzana Čižmáriková

¹⁷⁹ It had been established in 1995 in the Psychiatric Hospital of Philip Pinel in Pezinok as a result of unfavourable epidemiological situation and lack of possibilities of treatment of juveniles of up to 18 years of age, heroin addicts, coming mostly from Bratislava.

According to experts¹⁸⁰, a two-week' medical treatment without the possibility of a subsequent social reintegration is not a sufficient solution. Moreover, in the environment of adult psychiatric patients, children can assume much more risky forms of behaviour and the treatment is even counterproductive.¹⁸¹

At the beginning of 2005, those admitted to one of six specialised centres for drug dependency treatment within the competence of the Ministry of Health in Nové Zámky included also juveniles of less than 18 years of age. Due to problems in the community regime, in which this age group requires a special approach, this activity was suspended as of March 2005.¹⁸²

Healthcare centres treated 24 children of up to 15 years of age for drug addiction in 2003, in 2004 there were 53 children and in 2005 their number dropped to 35 (including 2 patients of this age treated in a facility of the Ministry of Justice). 25% children underwent repeated treatment. Boys prevail in the ratio of nearly 5:1. The drop in 2005 does not necessarily have to be linked to a primary cause but may be related to the availability of specialised drug treatment for children.

Table 11.4: Numbers of children at age <15 in outpatient/inpatient treatment in 2003 – 2005

	Outpatient treatment, Ministry of Health						Inpatient treatment, Ministry of Health					
	All treatments			First treatments			All treatments			First treatments		
Year	M	F	Total	M	F	Total	M	F	Total	M	F	Total
2003	7	3	10	5	2	7	9	5	14	9	5	14
2004	26	5	31	20	4	24	20	2	22	14	2	16
2005*	15	3	18	11	3	14	12	3	15	7	2	9
Total	48	11	59	36	9	45	41	10	51	30	9	39

Source: NHIC, 2006

*plus 2 children treated in the facilities of the Ministry of Justice

Table 11.5: Distribution by gender and age of children treated in 2005

Gender/age	10 years	11 years	12 years	13 years	14 years	Total
Boys	1	1	2	11	14	29
Girls	-	-	-	-	6	6
Total	1	1	2	11	20	35

Source: NHIC, 2006, EMCDDA special table

According to information from the NHIC, the greatest number of children of up to 15 years of age comes into treatment due to problems with inhalants and marijuana. The proportion of young clients with inhalant related problems in three years' period fell from 50% to 43%, while the number of those treated for marijuana related problems increased (from 29% to 43%). The prevailing form of use is inhalation and smoking. In 2003, four children were treated due to problems with opiates (3 due to heroin). In the subsequent years, no further such case was reported.

Most of child patients live with parents and most of the parents do not use drugs. Cases where a child lives alone occurred only three times. In 2004, with the so far highest number of children in treatment (53), there were 7 cases of children not having a stable accommodation – otherwise this number is 1 – 2 per year.

A possibility of specialised treatment for children is provided by the UNICORNIS crisis centre – a non-profit organisation in Bratislava. Martin Dzurilla – the director of the outpatient crisis centre for children addicted to psychoactive substances and family at risk, mentions¹⁸³ that in two years of Centre's operation, over 100 children and family members were included in a comprehensive

¹⁸⁰ Mgr. Ivana Szemzo – Institute for Drug Dependencies, Centre for the Treatment of Drug Dependencies, PhDr. Martin Dzurilla, UNICORNIS, MUDr. Igor Škodáček, Child Psychiatric Clinic of the Children's Faculty Hospital, Bratislava, expert supervisor of UNICORNIS

¹⁸¹ Slovak Radio, Studio Contact, 11:00, 60 min. A discussion on drug addiction, June, 20 2006.

¹⁸² 2005 Report on Implementation of the Slovak Republic Government's Anti-Drug Policy – health sector, A material for the session of the CM DADC, March 2006

¹⁸³ Dzurilla, M.: An Outpatient Crisis Centre Unicornis. Information for NMCD, 2006

intensive therapy. In the framework of counselling services and crisis intervention, UNICORNIS experts intervened in over 300 cases.

The age of children diagnosed with the addiction syndrome is decreasing compared preceding years. The Centre, being a multidisciplinary facility providing comprehensive individual care to children with psychoactive substance addiction and to their families, has lately been working primarily with clients of the age of 14 - 17 years with 70% of them comprising pupils of 14 - 15 years. Compared to child clients, there is a marked minority of young adults.

The drugs primarily abused by UNICORNIS clients are marijuana, alcohol, and pervitin. These are children in the age of 14 to 15 years, who passed the phase of experimenting and are already addicted to the drug. The period of experimenting with or first use of marijuana, as indicated by these children, is in the range of 12 – 13 years, for pervitin and alcohol – 14 years. Hallucinogenic drugs are also “in”, however, children use them irregularly, sometimes in specific seasons (vegetation periods of mushrooms or datura); use of LSD is mentioned rather exceptionally. In the framework of experimenting with their effects, child drug users abuse, at least once, almost every psychoactive substance offered by the market. The period of intensive approach ranges from 6 months to 1 year and includes, in addition to individual therapies of the child, also individual therapies of parents and a necessary family therapy. The intensive individual care includes medical, psychological, psychotherapeutic, and therapeutic pedagogical components.

Most of the parents visit the centre only when the child shows all generally known signs of drug addiction, which on its own indicates their insufficient information on the given problem. At the time of attending the centre, the relations in the family and its close social environment are usually severely disrupted and the child’s health condition is considerably unsatisfactory.

An important component of the therapeutic process is a social work with the family. During the treatment, the Centre is in contact with child’s school and teachers or, if applicable, with other organisations and authorities, which have an influence on the child or his/her family. In fact, the family is the basic component and object of Centre’s comprehensive care. In its approaches, the Centre enforces the model of curing the child along with improving the functioning of the family as a whole.

The existing social reintegration centres (the registered ones) admit clients in the age of 16 years and more, which was ensured also by the legal regulation of 2005, which reduced the original age limit of 18 years (the new Act on Social and Legal Protection of Children and on Social Custody).

The crisis centre “Pádkovo centrum” at Liptovský Mikuláš jointly with other entities (Anti-Drug Fund) launched an initiative to establish a specialised social reintegration centre for minors of up to 18 years of age. However, the initiative was halted by a “public concern” of the local population.

According to the Action Plan¹⁸⁴ of the Ministry of Labour, Social Affairs and Family, by the end of 2008, a specialised autonomous group for drug- and otherwise addicted children after treatment on the basis of recommendation of the healthcare provider should be established in each region (in institutional treatment facilities).

11.3 Risk groups

In the sector of education, no statistic on children prematurely leaving school is available.

According to a screening of problem children at elementary and secondary schools in Slovakia conducted by the Research Institute for Child Psychology and Pathopsychology (hereinafter

¹⁸⁴ Material for a session of the Ministerial Committee for Drug Addiction and Drug Control, March 2006, www.infodrogy.sk

“RICPaP”¹⁸⁵ – Methodical Research Cabinet in cooperation with IPE in 2005, it was found that 10% of children in Slovakia on average have behavioural problems.

According to IPE information¹⁸⁶, in 2005, there were 732 clients, of whom 151 girls of up to 15 years of age, in 17 protective care facilities (re-education homes, diagnostic facilities and therapy/education sanatoria) (Chapter 2).

The most frequent cause for placing a child or juvenile in institutional foster care is the neglect of compulsory care by the parents. As at 31st December 2005, according to the Headquarter of Labour, Social Affairs, and Family¹⁸⁷, there were 4,054 children of up to 15 years of age in institutional care. In 273 cases (app. 7%), the reason for placing the child in a children’s home was the parents’ addiction to addictive substances.

Socially disadvantaged children

Children from the Roma ethnic group from the communities in the settlements in Eastern Slovakia belong to the long-term high-risk and vulnerable groups of population.¹⁸⁸ They start smoking and drinking alcohol very early – in the pre-school age – and assumption of these harmful habits is stimulated by the model of parental behaviour, tolerance to drugs in the community, and very low health awareness. Conducted in 2005 at RICPP, the study examined the differences in the development of cognitive functions in Roma children of 5 – 10 years of age compared to the majority population. Although pointed out that a generalisation would require longitudinal observations of Roma children, the findings indicate that 9 – 11-years old Roma children perceive the family as a wider community and the settlement as the most important place of communication, however, at the same time, as a highly conflicting place. On the contrary, the school is perceived as a place with the highest requirements for performance of duties, but as a low-conflict environment¹⁸⁹. The proposed restoration¹⁹⁰ of the “all-day educational system”, influencing the health awareness of pupils and parents, especially the mothers, should then play an important role in socialisation and in changing the attitudes to their own health provided that measures are concurrently applied aimed at the entire community.

Besides interventions in the method of Roma pupil’s education (Ministry of Education), the “Health of Romas” (Open Society Fund) project is implemented in Roma settlements as well as other projects of community-focused social prevention. A current piece of information in this respect is that on low-threshold programmes/centres¹⁹¹ created as the best accessible, barrier-free social cultural leisure-time centres for socially threatened and disadvantaged children and youth from uninspiring environments.

Recreational environments

According to Ján Palider¹⁹², the director of the crisis centre (Pálkovo centrum) operating in a long term in Liptovský Mikuláš and Ružomberok, the nature of recreational and holiday environment in the region of the High Tatras is reflected in an increased risk to the local, particularly the young, people. On the basis of empirical data, the substances abused in the location include alcohol, marijuana (including in 12-years old children), pervitin, ecstasy, hallucinogens – datura, mushrooms, and solvents.

ADHD (Attention Deficiency Hyperactivity Disorder) syndrome

¹⁸⁵ Matula, Š., Čanigová, A., Kopányiová, A., Smiková, E., Vojtová Z.: Psychological prevention and psychological intervention as phases of integrated care for children and young people with behavioural disorders – RICPP 2005 Annual Report, www.minedu.sk

¹⁸⁶ www.uips.sk

¹⁸⁷ Pipíšková, I., Headquarter of Labour, Social Affairs, and Family 2006 – Information for the NMCD

¹⁸⁸ Chapter 2, Drug use in the population – high-risk groups

¹⁸⁹ Farkašová, E., Dočkal, V., Kopčanová, et al.: Psychological and pedagogical aspects of cognitive development and social integration of Roma pupils.

¹⁹⁰ Liba, Jozef : Information for NMCD, February 2006

¹⁹¹ Lohinová, N.: Low-threshold programmes for children and youth – review of a publication, *Prevencia* 2/2006, V. IPE, Bratislava 2006, pp. 59 – 60

¹⁹² Pallider, Ján: Information for NMCD, April 2006

Attention deficiency hyperactivity disorder is a frequent expression with respect to identification of causes to problem behaviour of children. Literature suggests various rates of occurrence – from 2% to 18% of population depending on the diagnostic criteria used. The development of the hyperactivity disorder and impulsivity is a social risk factor: 20 – 30% of these children have problems in adulthood with antisocial behaviour, alcohol, and drugs.¹⁹³ These links in older children are indicated by a survey aimed at statistical processing of history data for 15 – 18-years-old boys for the period of May 2003 – May 2005 at the Diagnostic Centre for Youth at Záhorská Bystrica.

The authors¹⁹⁴ state that in the examined sample of 168 boys of the average age of 16 years, signs of neurophysiologic immaturity of the CNS – ADD/ADHD – were present in as many as 70.8% of the boys. Among 11 reasons for placement of the entire sample into a diagnostic facility, there are 3 relevant reasons: alcohol in 23 cases, drugs in 19, and a combination of alcohol with a drug in 13 cases.

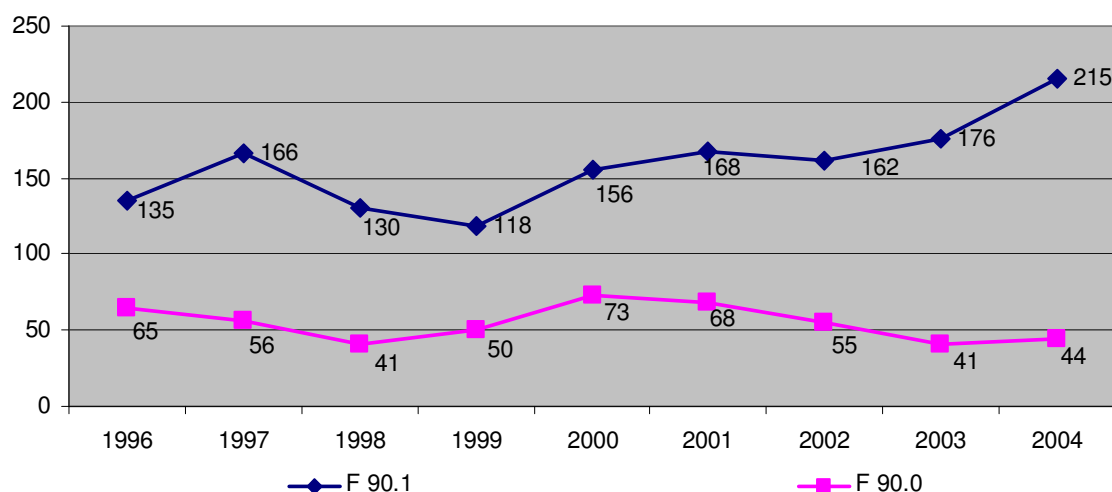
The medical statistics (NHIC) follow the data on ADHD as the F90.0 diagnosis in the framework of statistical sheets of patients hospitalised in a psychiatric centre. In the statistical report, besides the primary diagnosis, there is no other data that could associate the coincidence with drug use or abuse and/or a higher affinity to drug behaviour.

The ADD/ADHD syndrome diagnosis does not occur in statistical registers as frequently as it could be expected. In the course of 9 years, only 490 children of up to 14 years were thus diagnosed in Slovakia, with a marked prevalence of boys – 371 (75%), with the greatest number of them being diagnosed in 2000. An increase of the number of patients in the age of up to 14 years hospitalised in psychiatric facilities may be observed in the F90.1 diagnosis – hyperkinetic disorder and behavioural disorders. Compared to 1996, this is an increase of 59%. In this case as well, the growth is provided by male patients; the number of girls in the entire period of 1996 – 2004 represents 9 – 12%. According to NHIC data, in 2004, there were 47 patients hospitalised with the 90.0 diagnosis of up to 18 years of age (including 44 children of up to 14 years of whom 36 were boys). Since 1996, the number of patients under 18 years of age has a decreasing trend. Conversely, the number of patients of up to 18 years of age with the 90.1 diagnosis, including besides hyperactivity also behavioural disorders, has a growing trend and in 2004, there were 222 children of up to 18 years of age hospitalised with this disorder, of which 195 were boys.

¹⁹³ PhDr. Pavel Krivulka – www.dys.sk, downloaded on 30 July 2006.

¹⁹⁴ Fehérová L., Mikuličková K., Sotník, D.: Fundamental aspects of diagnostics of youth with behavioural disorders. *Prevenca* 1/2006, Volume V, IIPE Bratislava, pp. 19 – 26.

Figure 11.6: Comparison of children of up to 14 years of age hospitalised with the F 90.0/ 90.1 diagnoses – hyperactivity and attention disorders, and hyperactivity and behavioural disorders



Source: NHIC 2006. Statistical sheets of patients hospitalised in psychiatric facilities.
Note: Data of 2005 was not available.

NMCD does not have official data available on outpatient treatment of children with the F 90.0 and F 90.1 diagnoses of up to 14/15 years by child psychiatrists and general paediatricians, or data on pharmacologic treatment of children with ADD/ADHD.

According to IIPE statistics, over 200 clients of pedagogical psychological counselling centres (PPCC) and centres of educational and psychological prevention (EPPC) were recommended a psychiatric examination (in 182 cases, a neurological examination).

On the Slovak Internet, there is several information sources in operation, which have been initiated by experts or parents committed to early medical, psychological and psychotherapeutic intervention for children with ADHD and for their parents outside of official structures. E.g., <http://www.dys.sk> includes information on medicinal products that are part of medical therapy – amphetamines and methylphenidates (under the trade name of Ritalin) with a warning that they constitute substances that may lead to addiction.

11.4 Drug-related child crime

Detailed information on children of up to 15 years of age, who came into contact with a crime, is not fully available due to the fact that until 2006, criminal liability and prosecutability applied to juveniles only after reaching the 15th year of age. The Penal Code in force since 2006 reduced this age limit to 14 years (Section 22(1) of the Criminal Law) and considers juveniles to be persons of the age of 14 – 18 years.

Data in this part of the chapter is based on Police Corps Presidium's official statistics on drug crime and the number of investigated children of up to 15 years of age. Since 1998, in absolute figures, a growth of investigated children of up to 15 years of age has been recorded; however, their proportion in the total number of juveniles prosecuted (up to 18 years) is decreasing. This has been caused particularly by the marked growth of criminal activity of persons between 15 and 18 years of age (Tab. 11.6)

Table 11.6: Number of children of up to 15 years of age investigated by the Police Corps Presidium

Year	1998	1999	2000	2001	2002	2003	2004	2005
Juveniles of up to 18	56	49	87	125	102	135	140	173
of whom children of up to 15 years	9	14	10	18	19	13	21	20

Source: Police Corps Presidium, 2006

The Bratislava region leads in the general crime rate and likewise it has a top ranking in the crime of juveniles and investigated children of up to 15 years of age. In absolute figures, the

greatest numbers of children in 2005 were investigated in the Prešov region (5 children); however, when calculated per 10,000 residents of up to 15 years of age, the ranking changes with Bratislava are having the greatest number and fewest, i.e. none, being in the regions of Nitra and Trnava.

Table 11.7: Number of children investigated in relation to drug crime by regions

Region	Bratislava	Trnava	Trenčín	Nitra	Žilina	Banská Bystrica	Prešov	Košice
1998	3	1	5	0	0	0	0	0
1999	1	1	1	2	1	1	5	2
2000	0	0	1	0	0	7	2	0
2001	4	0	5	0	4	5	0	0
2002	2	3	2	5	3	3	1	0
2003	2	1	3	1	4	2	0	0
2004	8	0	3	0	6	3	1	0
2005	4	0	4	0	2	4	5	1

Source: Police Corps Presidium, 2006

11.5 Legal framework and measures

Basic legal framework of juvenile protection

The rights of the child included in individual articles of the Convention on the Rights of the Child¹⁹⁵ are, in the Slovak law, starting from the Constitution of the Slovak Republic, provided for particularly by the following laws:

- Act No. 36/2005 on Family and on Amendments and Additions to Certain Laws, which amends also Act No. 99/1963, the Code of Civil Judicial Procedure, as amended;
- Act No. 195/1998 on Social Assistance,
- Act No. 305/2005 on Social and Legal Protection of Children and on Social Custody,
- Act No. 452/2004 on Substitute Subsistence; Act No. 311/2001, the Labour Code, Act No. 300/2005, the Penal Code, No. 301/2005, Penal Order, as well as in other laws, e.g., the Public Healthcare Act as of 1 June 2006, and in other generally binding legal regulations.

In 2005, draft laws were prepared on the prevention of crime and a draft law on sports; however, they did not get into the approval process.

As of 1st January 2006, the new Penal Code introduced criminal responsibility of a natural person for an act committed upon reaching the 14 year of age. This limit was justified by the acceleration of development and the degree of biological, social, and mental maturity of a young person achieved earlier than in 15 years of age. The reduction of the lower age limit by one year should lead to the prevention of recidivism using all available, primarily educational, means¹⁹⁶. A person having reached the 14th year of his/her age and not having exceeded the 18th year of his/her age is considered by the new Penal Code to be a juvenile.

With respect to the juvenile person, the law includes certain special provisions (judging the severity of the act, imposition of penalties, probation upon sentencing, etc.), which cannot be used in a person older than 18 years, and introduces a mandatory psychological examination to determine the conditional legal responsibility. The law lays down that a juvenile, who has not achieved such level of mental and moral maturity at the time of committing the act to be able to recognise its illegality or to control his/her behaviour, shall not be responsible for such act.

¹⁹⁵ Convention on the Rights of the Child of 20 November 1989. The Slovak Republic has been a party to the Convention on the Rights of the Child as of 6 February 1991.

¹⁹⁶ "Although in many cases, elementary school pupils will be involved, the problem consists in the criminological finding that if such a young person repeats the criminal act before reaching adulthood, he/she will become, in further development, an adult recidivist. It affects the juveniles regardless of social origin; conversely, tendency towards crime is ever more frequently manifested in juveniles of wealthy background and the proportion of girls significantly grows. At the same time, certain part of youth is starting to be anomic with respect to the condition of the society," states the exposé to the law (Exposé to the law, <http://www.rokovania.sk>)

The criminal sanction for drug producers and drug traffickers has been made more severe as was the criminal sanction for the criminal offence of promoting drug addiction particularly with respect to protected persons including children. Any incitement to abuse of any addictive substance other than alcohol constitutes a criminal offence of promoting drug addiction.

As of 1st September 2005, Act on Social and Legal Protection of Children and on Social Custody is effective in Slovakia bringing changes in implementation of measures of social prevention and social and legal protection of children, which is described in greater detail in Chapter 9.

“Environmental” measures

The applicable legal framework in Slovakia provides regulation of availability of alcohol and tobacco in the public retail network for juveniles less than 18 years of age. Supervision over the enforcement of the ban on sale of tobacco, cigarettes, and alcohol (and serving alcohol) is ensured by the State Retail Inspectorate and by a sanction regime for retailers who violate the ban on sales to juveniles. Higher binding regulations of municipalities and towns in local conditions may specially provide for the closing time of restaurants, limit the places of sales, etc.

Since 1996, advertising of both substances is regulated in general and specially with respect to juveniles up to 18 years of age. A special legal regulation provides for advertising in television and radio (complete ban on advertising of tobacco products, cigarettes, banned also through a brand, e.g., “West Extra Dose”, and alcohol except for beer after 10 p.m.). Regulation of advertising is complemented by a self-regulatory authority of the advertising industry – the Advertising Standards Council¹⁹⁷, which specifies in its advertising code special requirements for advertising with respect to juveniles and advertising of alcohol.

As of 2002, Act on Broadcasting and Retransmission, under Section 19, introduced the obligation of television service broadcasters to indicate the age appropriateness of broadcasts for the age of 7, 12, 15 and 18 on the television using a single system of symbols¹⁹⁸, which informs the parents on the appropriateness of the broadcast viewed. With respect to alcohol, smoking, drugs, and other addictions, whose depiction is part of the broadcast (e.g., of a film, reality show, etc.), the classification into individual age appropriateness zones is based not only on the very presence of such behavioural model but also on the person presenting such behaviour (parents, attractive and popular show business personalities, generally recognised authorities).

Prevention interventions

Chapter 3, Prevention, mentions the institutional and organisational system operating for nearly million children – pupils of all school types within Slovakia’s school system. Legislation and other details are mentioned in both previous reports. It should be noted that drug issues, on the one hand, became an integral part of the education process at elementary and secondary schools, on the other hand, prevention and active protection of children and youth – in accordance with the Convention on the Rights of the Child, the Declaration of the Rights of the Child, and the relevant school legislation – concerns a whole complex of social pathological phenomena.

The system of early diagnostics and assistance is provided by a network of pedagogic psychological counselling centres (PPCC) and their departments or autonomous centres of educational and psychological prevention (EPPC), which had 84,715 clients in the school year 2004/2005 including 80% of children of under 16 years of age. Most of them remained in the care of the PPCC’s and EPPC’s- Approx. 500 clients entered into special care services in other school facilities (diagnostic centres, therapy/education sanatoria), and, working close with the MLSAF, education and upbringing is ensured in institutional care facilities – in foster homes and

¹⁹⁷ <http://www.rpr.sk/start.htm>

¹⁹⁸ Bobáková, E., Kutaš, R.: JSO concept and methodology. Report on the state of broadcasting in the Slovak Republic and on the activity of the Council for Broadcasting and Retransmission for 2001, printout of the National Council of the Slovak Republic No. 1347, Bratislava, March 2002, pp. 211 – 230, www.rada-rtv.sk

homes for youth and in protective care facilities (re-education homes for children and re-education homes for youth).

The most frequently used preventive programmes for this age group include, for example:

Table 11.8. Preventive programmes

Programme/Activity	Objective	Age group
Sweets as an addiction	Improve eating habits; consumption of sweets may contribute to the risk of later addictions	3 – 5 years Kindergarten
Do not destroy your wise body	Acquire positive attitudes to a healthy lifestyle	6 – 11 years Elementary school
Healthy school	A WHO project “Education to Health”	Elementary school
A way to emotional maturity ¹⁹⁹	Acquiring life skills	12 – 15 years Elementary school
Computer programmes of B. Thomas	Information on drugs	From 13 years
School without alcohol, tobacco, and drugs – Ivan Novotný	Support for a healthy lifestyle without ATOD	From 11 years
Do we know that...?	A programme of fight against evil, violence, addictions, prejudice, racism, and non-productive lifestyle	From 12 years

In the field of free-time education, there are 219 leisure time facilities in the Slovak Republic, 145 being leisure time centres and 74 being school centres of extra-curricular activity. As of July 2002, the competence to pursuit leisure time centres, school clubs, and school centres of extra-curricular activity passed from the state to municipalities. Leisure time centres operate in over 120 towns, school centres of extra-curricula activity in more than 15 towns, and school clubs are established in over 80% of elementary schools. These facilities constitute the base for creating conditions for useful leisure time spending primarily by children of under 15 years of age and, in part, also young people of under 26 years of age²⁰⁰.

Telephone Help Line

As of 1996, a special Child Help Line²⁰¹ provides its services, being the first national telephone line specialising in the problems of children and youth. It was established as the Slovak UNICEF Committee’s own project. It works around the clock including weekends and public holidays; it is toll-free, anonymous, and professionally guaranteed.

The Child Line provides professional assistance and care to children and youth in crisis or stressful situations primarily through a telephone communication counselling service. Extended services are provided also in an outclient (outpatient) form in crisis intervention and social law consulting. As of 2005, it created conditions for provision of direct assistance through the Rainbow crisis centre for children and for mothers with children.

In 2005²⁰², the toll-free telephone Child Line at 0800 500 500 provided 46,377 interventions. Counselling was provided in 8,663 cases, i.e., approximately 23 counselling calls per day; other calls were of informative nature. The line was used most frequently by children in the age of 11 – 14 years and their problems most often concerned partnership relations, relations in the family, and the need of communication. In 2005, questions related to alcohol use, smoking, or

¹⁹⁹ This is the most universal school programme implemented in the Slovak Republic.

²⁰⁰ National report on youth policy in the Slovak Republic (Report for the Council of Europe), August 2005, http://www.minedu.sk/DaM/DOCDaM/20051219_narodna_sprava_o_politike_mladeze_SR_pre_RE.pdf

²⁰¹ <http://www.unicef.sk/ldi/>

²⁰² In: 2006 Annual Report – <http://www.unicef.sk/down/55/vyrocnasprava2005.doc>

illegal drugs were handled primarily by professional consultants at the Child Line 350 times²⁰³ (250 for alcohol and tobacco and 100 telephone contacts concerned issues of illegal drugs).

Responses in juvenile prison

The only specialised penitentiary institution for juveniles in the age of 14 – 18 years in Sučany provides comprehensive pedagogic, psychological, labour, and reintegration activities, which are aimed at a trouble-free return of the delinquents to the society. Inter alia, they have the possibility to undergo a drug treatment on voluntary basis. However, experts²⁰⁴ from the Custody Institution for Juveniles of the Corps of Prison and Court Guards in Sučany concluded that after release from prison, contact with this group of young treated people is lost. The gap in the post-penitentiary care could presently be filled in by social services, namely by custodianship (Act on Social and Legal Protection of Children and on Social Custody as of 1st September 2005 – see more in Chapter 9). This problem is the focus of several activities in the framework of the Phare project “Support of the Implementation of NFBD” in the educational part of the twinning project, and specific projects with an application for a subsidy have been presented also within the Small Grant Scheme and ADF.

Measures for children with uncompleted elementary education

In Slovakia, no central statistic is available on children or juveniles, who, from various reasons, have not completed even the elementary - ten years - education. The assumption, that children without education (with incomplete elementary education) are or may be excluded and uninteresting for the current legal labour market, is confirmed by certain specific preventive activities of the non-governmental sector, inter alia, also by the Children of Slovakia Foundation.²⁰⁵ The grant programme “Hour for Children” of the Children of Slovakia Foundation covers six areas of support – inter alia, activities supporting integration in the natural environment, including street children.²⁰⁶

Lúč Foundation in Žilina provides daily stays in its social reintegration facility with a four-hour programme for handicapped “street children”²⁰⁷ with mental and drug problems. In addition to therapy, the programme provides the possibility for children with incomplete education to complete their qualification. For example, girls are qualified as needlewoman and, during 10 years of Foundation’s existence, 150 boys were trained in the specialisations of mason, carpenter, and plasterboard installer. Activities for “street children” are among the focus of certain local church associations (Salesians, Czech Brotherhood Church).

²⁰³ Eva Dzurindová, Managing director of the Child Help Line: Information for NMCD, August 4, 2006.

²⁰⁴ PhDr. Jaroslav Jánoš, PhD., Mgr. Lucia Kišková – “Drugs are not a child’s play”, a seminar for media, Senec, 19 – 20 June 2006

²⁰⁵ A child of Slovakia Foundation is the greatest non-governmental organisation with nationwide scope focused exclusively on children and young people.

²⁰⁶ **Street children:** Socially disadvantaged children who are coerced to satisfy their basic living needs outside of the family or outside of an institution they are entrusted to – in the event of their failure. These include, for example, children from settlements without basic infrastructure, accommodation premises for bad rent payers, children living in the street (having left institutional care and being unable to return to the family due to addiction, working in sex business, etc.). Source:

²⁰⁷ Chaban, I., director of the Centre for Treatment of Drug Dependencies in Žilina, written report for the NMCD, 9 June 2006

12 Cocaine and crack – situation and responses

In recent years, the attention of the public is rising as well as its concerns of growing use of cocaine and related problems. In 2001, EMCDDA aimed one of the selected issues of its Annual Report on the cocaine related problems (with data for 1999). Six years later, ever more reports on growing use of cocaine were reported in some countries. The consumption of this drug in Europe is rising. In West and Central Europe, it reached 25% of the estimated global consumption, North and South America ranging at 50%. In global extent, according to UNODC, there are about 13.4 million cocaine users in the age of 15 – 64 years, half of them living in Americas²⁰⁸.

So far the Slovak Republic is not a country with high cocaine consumption. According to surveys conducted, the experimenting with cocaine occurs only in scattered cases; lifetime prevalence of cocaine/crack use in the population aged of 15 – 64 years is below 1.2%. In 2005, there was no client reported from low-threshold agencies with cocaine being the primary drug; while there were 11 cocaine users reported in treatment. Cocaine is mostly of recreational – weekend use and is linked to various disco parties, etc.

On the other hand however, regardless of low prevalence, a moderate increase of cocaine/crack use is observable in school youth as well as in general population. According to the most recent ESPAD survey (2003), 1.4% of secondary school girls and 1.8% boys have already tried cocaine. A shift is occurring in opinions of secondary school youth on risk behaviour related in regular use of cocaine. In 1995, it was considered to be highly risky by 91% of respondents, while in 2003 the figure dropped to 75%. During 5 years period 3 cocaine related death were reported and one direct cocaine overdose in 2003. At the same time, according to information from the Police Corps Presidium, an increase of cocaine use can be expected as a result of reduction of its price, which has been moderately falling last year particularly in the area of Bratislava²⁰⁹ and the drug thus became more interesting.

Freebase cocaine – crack – practically does not occur in Slovakia.

12.1 Prevalence, patterns and trends of cocaine use

Cocaine use in general population

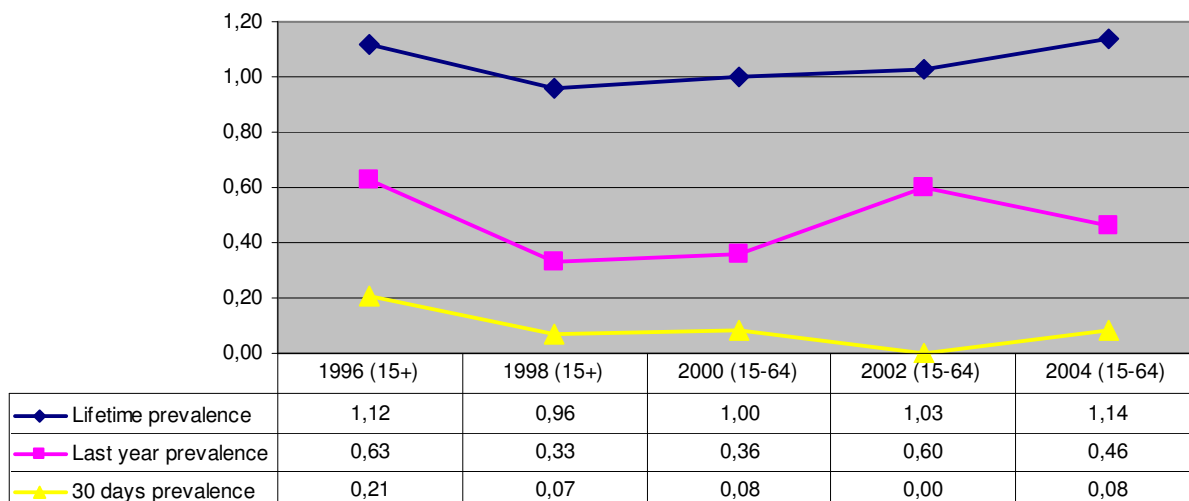
Cocaine use according to Public Opinion Research Institute at SO SR

Since 1996, the PORI at the Statistical Office has been regularly, every two years, performing a survey aimed at the issue of drug addictions (2005 National Report, p. 61). On the basis of this survey's results we can conclude that on average, as many as 98.2% of all three groups' respondents stated in the monitored period that they had not used cocaine/crack at all. Lifetime prevalence of cocaine use has had a moderately rising trend since 1998 and in 2004 it reached the level of 1996 (1.14%). On the other hand, use of cocaine/crack in the 30 days fell from 0.21% in 1996 to 0.08% in 2004 (Figure 12.1). In this Chapter data from ST 01 for lifetime, last year and 30 days prevalence have been used. The standard table is filled in for years 1996 and 1998 for the population of Slovakia at the age group 15+ and for remaining years 2000 – 2004 the age group represents 15 – 64 in line with EMCDDA categories.

²⁰⁸ www.aktuality.sk – UNODC, 27 June 2006

²⁰⁹ On the basis of information obtained by operating activity of the National Anti-Drug Unit, Office for the Fight against Organised Crime, Police Corps Presidium

Figure 12.1: Prevalence of cocaine use in the age group of 15+



Source: Luha J., ST 01 for Reitox 1996-2004

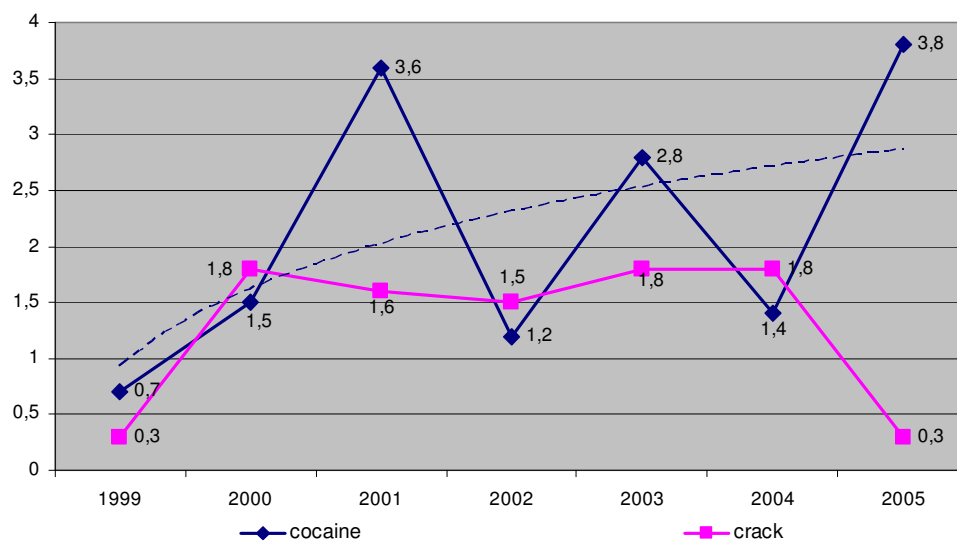
Cocaine use according to IIPE’s surveys in the age group of 15 – 26

Surveys covering also the issue of experimenting with illegal drugs in youth are dealt with by the Department of Analyses Youth and Sport of the IIPE (2005 National Report). Surveys on “youth attitudes to drug use” are conducted continually since 1995²¹⁰. Last survey in 2005 covered 947 respondents of whom 197 (20.8%) admitted experimenting with drugs.

The above-mentioned survey’s results imply that drugs like LSD, heroin, cocaine, and crack are experimenting by respondents in the age of 15 – 26 years only in isolated cases. On the contrary, the drugs most frequently tried are marijuana (49.7%), hashish (7.5%), ecstasy (6.7%), volatiles (6.1%), and use of medicinal products simultaneously with alcohol (5.6%), pills (4.8%), and pervitin (4.5%).

In 2005, cocaine was tried by only 3.8% of young respondents, but by as many as 5.8% in the age group of 15 – 17 years. The results of the above-mentioned surveys in individual years have an unstable course, however, the trend points to an increasing prevalence of cocaine use.

Figure 12.2: Young people in the age of 15 – 26 years experimenting with cocaine and crack



Source: Pétiová, M, IIPE, 2005

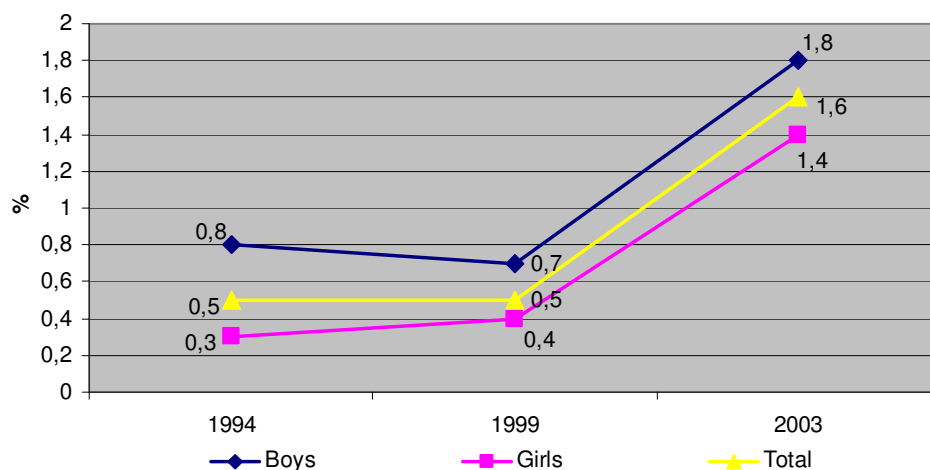
²¹⁰ A representative survey through face-to-face interviews

Cocaine use among school youth

Prevalence of cocaine use in secondary school students

The falling trend of cocaine use prevalence by 1998 – 1999 and its subsequent gradual increase in the general population copies the prevalence among secondary school youth according to ESPAD surveys. Lifelong prevalence in secondary school boys in 2003 reached 1.8% and 1.4% in girls. In the capital city Bratislava the prevalence reached 4.2% among boys and 5.6% among girls.

Figure 12.3: Lifetime prevalence of cocaine use among the students of 1st – 4th grade of secondary schools, ESPAD



Source: Nociar A, 2004, p. 94

Note: Number of questionnaires in 1995 – 8,179, in 1999 – 7,975, and in 2003 – 11,287.

Table 12.1: Frequency of cocaine use during the lifetime in secondary school youth according to the ESPAD survey

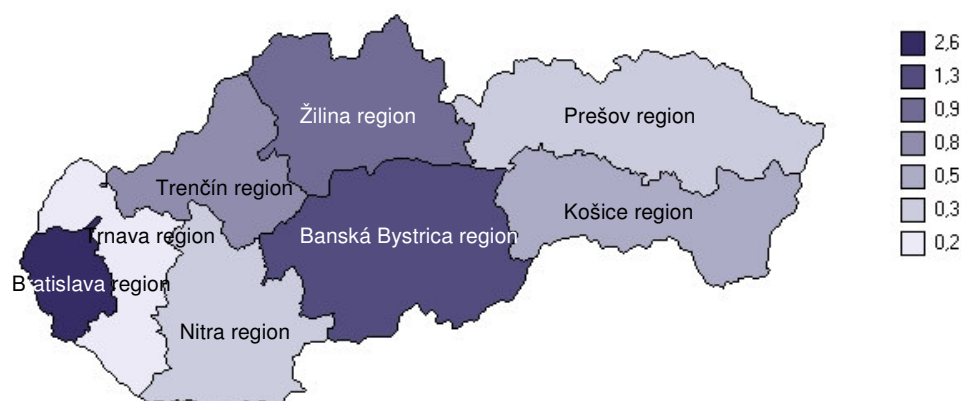
Frequency	Never	1 – 2 times	3 – 5 times	6 – 9 times	10 – 19 times	20 – 39 times	40+
1995	99.5	0.4	0.1	0	0	0	0
1999	99.5	0.4	0.1	0	0	0	0
2003	98.4	0.9	0.3	0.1	0.1	0.1	0.1

Source: Nociar A., 2004, p. 103

In June 2002, the third wave of the TAD 2 survey (Tobacco, Alcohol, Drugs) was performed in the students of secondary schools. The survey covered 5,598 students in first to third grade (2,481 males, 3,117 females) at 42 secondary schools. According to the results of this survey, the lifetime prevalence of cocaine use among young secondary school students of 15 – 18 years of age was 0.9%. The greatest number of secondary school students tried cocaine in the Bratislava region, where the prevalence reached 2.6%. Surprisingly, the lowest prevalence was found in the neighbouring Trnava region (0.2%).²¹¹ (Map 12.1)

²¹¹ The differences among the Bratislava, Trnava, Prešov, and Košice regions were confirmed also statistically on the significance level of $p < 0.01$.

Map 12.1. Lifetime prevalence of cocaine use among the students of secondary schools in %, TAD 2, 2002



Source: Nociar, A., 2004, p. 63

Cocaine use in elementary school pupils

Concurrently with the TAD2 survey in 2002, the TAD1 survey was done at 42 elementary schools in pupils of grades 5 – 8 (the age group of 11 – 14 years)²¹². According to this survey, out of drugs offered to pupils of elementary schools cocaine represented 3.42%. 5.2% pupils knew someone in their neighbourhood who used this drug.

According to the results of an ESPAD survey performed in 1995 and 2003²¹³, the perception of cocaine use being risk behaviour is decreasing. While in 1995, 4.9% of students considered trying cocaine once or twice in a lifetime to be of a moderate risk; in 2003 there was an increase in this perception up to 9.9%²¹⁴. The proportion of those who has considered such behaviour for highly risky dropped from 64.2% to 40.5%. The same shift can be seen also in opinions on risk behaviour such as of regular use of cocaine. In 1995, it was considered to be highly risky by 91% of respondents, while in 2003 the figure dropped to 75%. (Nociar A. 2004, pp.117-119).

The reduction in the perception of cocaine use as risk behaviour may be related to the manner of media coverage of celebrities, mostly from show bizz using drugs. Drug abuse, particularly of cocaine, by celebrities is often presented by media uncritically and the manner of presentation departs from negative picture of addiction and its consequences for the life of the celebrity to certain disregard to the seriousness of the state of drug addiction.

Cocaine/crack use and use patterns among specific groups

On the basis of a survey conducted by the IIPE, data is available on drug use among young people placed in special educational facilities providing substitute and protective care – re-education homes²¹⁵. (See also Chapter 2 and 11). The survey, which was done in 1998, covered 486 young people placed in re-education homes in the age of 15 – 19 years and 304 in 2005, boys having slight prevalence (52.6%) over girls (47.4%). As a comparative group of young people aged 15 – 17, data from the “youth attitudes to drug use” survey was used. The size of the comparative sample was 486 respondents in 1998 and 223 in 2005. Considering the small size of the samples, the data cannot be generalised.

²¹² The survey covered 5,746 pupils (2,953 boys, 2,793 girls)

²¹³ In 1995, 8,179 questionnaires were processed; in 2003 the figure was 11,287

²¹⁴ The figures indicate percentages of respondents who answered all questions

²¹⁵ The facilities provide education and care substituting natural family environment for children of up to 18 years of age, or until they complete job training. In these facilities, in the interests of correcting disorders in child's psychosocial development and in the interests of eliminating all causes, for which institutional care or protective care was imposed, educational measures and protective measures may be used. (Act No. 279/1993 on School Facilities)

While the prevalence of cocaine use in re-education homes between 1998 and 2005 fell from 3.9% to 2.6%, a rapid growth can be observed in the comparative group from 1% (1998) to 5.8% (2005).

Table 12.2: Comparison of drug use in re-education homes and by general population of young people

Illegal drugs used	Re-education homes		Comparative group	
	1998	2005	1998	2005
Volatiles	22.4	10.2	10.7	5.8
Marijuana	35.4	25.1	68	59.6
Pervitin	4.7	9.2	1.0	1.9
Ecstasy	1.0	7.6	1.0	5.8
Heroin	9.2	2.8	2.9	0
Cocaine	3.9	2.6	1.0	5.8
LSD	5.1	4.2	1.0	0

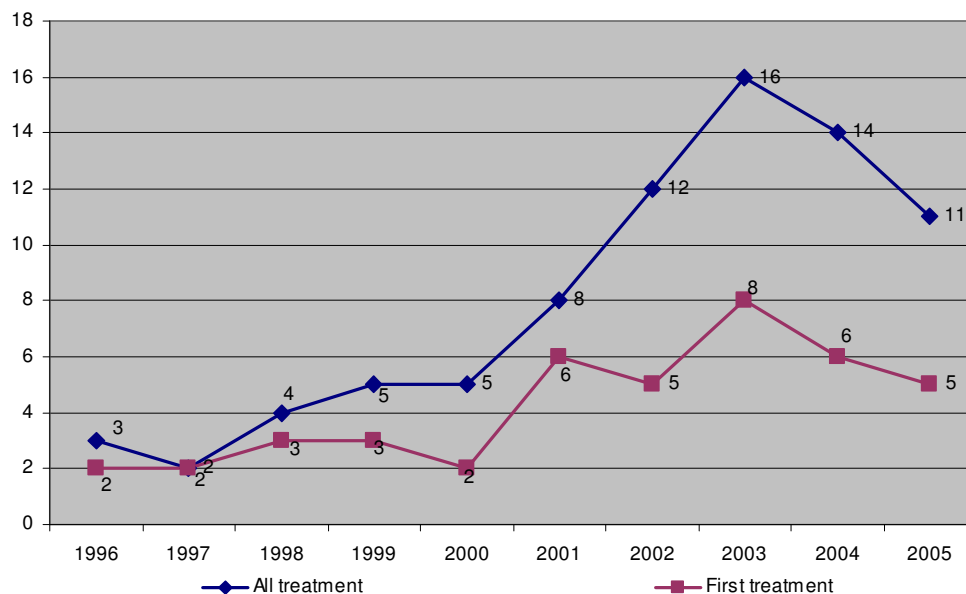
Source: Pétiová, M., IIPE 2004

The above-mentioned shifts in the prevalence of cocaine use in both groups can be explained with reference to the high price of the drug (Chapter 12.4). Young people in re-education homes start using drugs in a much younger age; however, they come from poorer families and cannot afford to buy cocaine/crack from financial reasons. This is indirectly confirmed by the results of three waves of ESPAD surveys²¹⁶ made among secondary school students. Comparisons according to drug type showed that in the case of more expensive or fashionable drugs, such as cocaine, LSD, anabolic steroids, and ecstasy, there is a slight but perceptible trend towards greater usage among those students who stated that they were very satisfied with their family's financial situation, as well as among those who stated that their family was much better off compared to other families in Slovakia. (2004 Report, p. 41)

12.2 Problems caused by cocaine/crack use

Since 1996, when 3 patients were treated, their number rose to 16 in 2003 and subsequently dropped to 11 in 2005 (Fig. 12.4). The patients treated were mostly in the age group of 25 – 29 years. The average age of the patients in individual years is shown in Fig.12.5

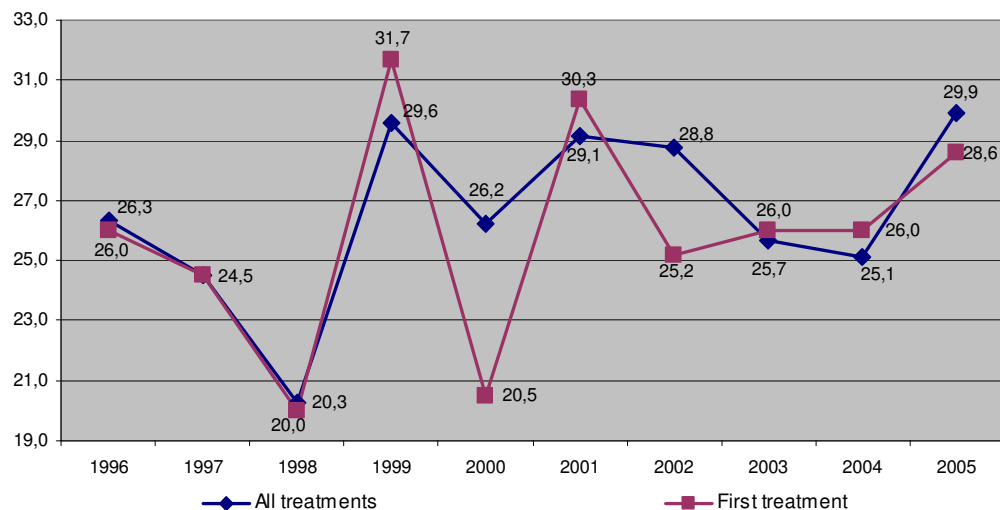
Figure 12.4: Number of patients treated for problems with cocaine



Source: NHIC, 2006

²¹⁶ European School Survey Project on Alcohol and Drugs

Figure 12.5: Average age of the cocaine users treated



Source: NHIC, 2006

Cocaine addiction and pregnancy

According to information from a neonatologist²¹⁷ cocaine occurs rarely in our country and its high price predestines it to be used in a community that can resolve pregnancy by, for example, abortion. In the last 8 – 9 years, she had not encountered a case of a pregnant woman that would mention the use of cocaine in her anamnesis.

Other problems related to cocaine use

In the period of 2000 – 2005 data from 11 forensic medicine and pathologic units retrospectively collected showed 4 cocaine related deaths (including of 1 woman) (see tab. 12.3)

Table 12.3: Deaths related to cocaine for the period of 2000 – 2005

	Year	Age	Gender
Cocaine being present	2000	31	Male
	2003	25	Male
	2003	29	Female
Cocaine as direct cause of death	2003	33	Male

Source: Healthcare Surveillance Authority, 2006 (prepared by: Šidlo J.)

12.3 Interventions related to cocaine use

Considering the fact that regular use of cocaine as well as the treatment demand for cocaine in Slovakia is very low, there is no specific (cocaine-related) treatment programmes established²¹⁸).

Certain form of intervention can be considered to be the harm-reduction programmes implemented by NGOs. However, these programmes are focused generally on the reduction of the risk of the use of any kind of drug, particularly through needle and syringe exchange programmes, professional counselling in the field, education of drug users, testing, etc. For more information on these programmes see Chapter 7.

Policy and strategies as an response to cocaine

Slovakia does not have specific strategies or laws that would deal specifically with cocaine/crack. Cocaine is classified in Act No. 139/1998 on Narcotic and Psychotropic Substances and Preparations in the 2nd group (narcotics), which Act also provides for the handling of these substances. Illegal handling of cocaine is any handling in a manner different

²¹⁷ Helena Drobná, MD, FNSP-neonatology department, Information for NMCD

²¹⁸ Ľubomír Okruhlica in EMCDDA Standard Table 27,2005

from that provided for by Section 4 (2) of this Act. At the same time it should be noted that the provision of Section 15 (1) of this Act prohibits the growing of coca in the territory of the Slovak Republic.

Illegal handling of cocaine as well as crack from the viewpoint of penalisation is provided for particularly in Sections 171 and 173 of the Criminal Law (criminal offence of illegal production of narcotic and psychotropic substances, poisons or precursors, their possession and trade therein) and Section 174 of the Penal Code (criminal offence of propagation of drug addiction). For the indicated provisions of the Penal Code see Chapter 1.

12.4 Crime related to cocaine and the cocaine market

Crime related to cocaine

Slovakia does not yet have a system established that would distinguish among persons prosecuted or convicted of drug-related criminal offences or the drug related criminal offences themselves by individual drug types. Due to this reason, the number of convicted or the number of criminal offences related to cocaine cannot be specified in a greater detail. (For the number of persons convicted of drug-related criminal offences see Chapter 8.)

Cocaine market

In Slovakia, cocaine is a less frequently abused and distributed drug compared to marijuana, pervitin or heroin, however, according to the National Anti-Drug Unit, Office for the Fight against Organised Crime, Police Corps Presidium, the interest in this drug is growing particularly in Bratislava and its neighbourhood but also in all greater cities and it gradually penetrates also to smaller cities.

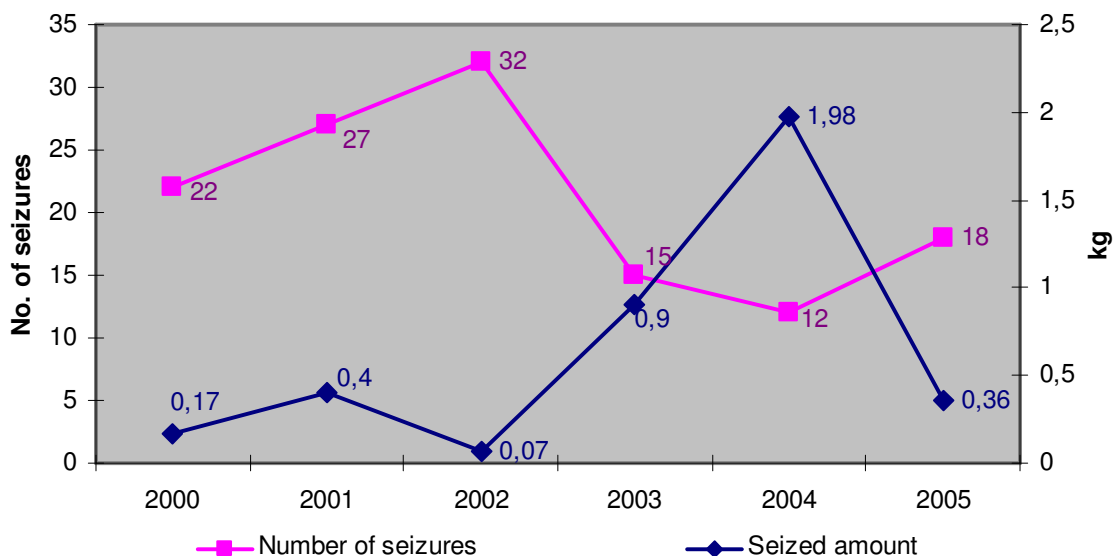
So far, the distribution of cocaine is not as open as, for example, in marijuana, heroin or pervitin; it is bound to various clubs, discos, and bars and runs mostly only on the basis of personal acquaintance of the seller and the buyer.

The main reason for lower popularity of cocaine compared to other European countries is its high price ranging from SKK 2,000 to 3,000 per gram of cocaine (€ 65 – 75), although this price has been moderately falling in the last year, particularly around capital Bratislava²¹⁹. Due to the price reduction, which is caused, in the National Anti-Drug Unit's opinion, by the fact that South-American drug cartels, in an effort to gain new markets, reduced the price of cocaine, the interest in cocaine increased and the drug became more interesting for a broader group of consumers. However, it is still a narrower group of users, an economically better-off population stratum with higher income, since the cocaine price is approximately one half of the minimum wages. Besides, there is a substantially cheaper stimulant type available in the Slovak drug market – pervitin.

The wholesale price of cocaine cannot be determined or can be determined only by estimation. There is no information on sales of a large volume of cocaine designed for the so-called wholesale and no greater amount of cocaine was seized in 2005 in Slovakia. Law enforcement services succeeded to accomplish 18 seizures of this drug in 2005 (12 seizures in 2004), however, the amount of cocaine seized was lower compared to the last year (1.98 kg in 2004 and 360.01g in 2005). The purity of cocaine seized most frequently ranged about 37% (see Tab. 12.4)

²¹⁹ On the basis of information obtained by operating activity of the National Anti-Drug Unit, Office for the Fight against Organised Crime, Police Corps Presidium

Figure 12.6: The number of cocaine seizures and the amount of cocaine seized in kg.



Source: Institute of Forensic Science of the Police Corps, 2006

Table 12.4: Purity of cocaine seized

Year	Number of samples analysed	Minimum	Maximum	Median (most frequent purity)
2002	21	9.7	65.8	37.1
2003	15	7.7	82.5	41.2
2004	13	6.5	50	32.6
2005	20	8.6	78.8	37.1

Source: Institute of Forensic Science of the Police Corps, 2006

The table shows the concentration of cocaine that is sold to the end user. It does not include concentrations of cocaine seized in a greater amount. In the event of seizure of a greater amount, cocaine is usually designed for further distribution and its concentration is higher than the median shown in the Table.

It is probably the high price of cocaine that causes virtually zero interest of the Slovak drug scene in freebase cocaine – crack. No crack was seized in the territory of the Slovak Republic since 2000 and, according to information from the NADU; there are no signals that this situation should change in the near future.

The source of cocaine for Slovak consumers is, besides the countries of West Europe, also the countries of South America. Its import and distribution involves groups of Slovak origin, but criminal groups of ethnic Albanians are gaining ever greater prominence, representing also a consumer group. The drug is usually smuggled fastened on courier's body or in his luggage. An attempt was also recorded of working cocaine into clothing with its subsequent extraction from courier's garments.

13 Drugs and driving

Marijuana and benzodiazepines²²⁰ are – besides alcohol – probably the two most important and, at the same time, differing substances. Both have high prevalence and there is a high probability that they affect driving. At the same time, there are differences between them as far as their legal status is concerned – one is an illicit drug and the other is a prescribed medicine. Extensive research has shown that already a small dose of marijuana affects a whole range of functions that significantly determine safe driving. A combination of a small amount of alcohol with a small dose of marijuana even causes very severe deterioration of driving capacities²²¹.

According to information from the Police Corps Presidium, over 600 participants of road traffic die annually in Slovakia and 42 deaths on average are caused by driving accidents under the influence of alcohol. The only set of information existing in Slovakia on drugs other than alcohol in driving comes from an analysis of data made at the Healthcare Surveillance Authority (HSA) in 2006. Of 42 drug-related deaths in traffic accidents for the period of 2000 – 2005, the most frequently detected substances were cannabinoids (23 cases) and benzodiazepines (7 cases). They were followed by medicinal products (other than benzodiazepines), opiates, and toluene – on their own but also in combinations. Combination with alcohol was found in 14 cases in total.

Information from other sources or studies is not available. In Slovakia, there are legal regulations and norms that provide for driving under the influence of alcohol and other addictive substances in general, but without distinguishing among specific drug types. The Department of Traffic Police of the Police Corps Presidium does not keep special statistic overviews on the number of persons driving under the influence of drugs²²². What is available is only statistical data concerning the use of alcohol, whose tolerance in blood is Zero. In 2007, the Police Corps Presidium plans to introduce testing drugs in the organism from saliva or sweat and, with respect to this procedure, an amendment of the relevant legal regulation is under preparation.

13.1 Legislative and legal framework

Since 1996, there are two main laws in effect, which provide for driving under the influence of alcohol or other addictive substances, namely Act No. 315/1996 on Road Traffic as amended and Act No. 219/1996 on the Protection against the Abuse of Alcoholic Beverages and on the Establishment and Operation of Anti-Alcoholic Detention Centres as amended.

From the viewpoint of criminal law, driving under the influence of alcohol or other addictive substances is provided for by Act No. 372/1990 on Offences as amended and by the Penal Code No. 300/2005.

By Resolution No. 335 of 26 June 2003, the National Council of the Slovak Republic asked the Government to adopt, by the end of 2003, in the framework of the National Programme for the Fight against Drugs (NPFĐ), effective measures to fight against drugs on roads. In Resolution No. 719 of 20 August 2003, this task was assigned to the Minister of Interior.

For the issues of road safety, Resolution No. 1162/2004 established the governmental structure Slovak Republic Government Council for Road Safety at the Ministry of Transport, Posts and Telecommunications with 7 professional working groups.

The Council is a permanent, consulting, coordinating and initiative body of the Slovak Republic Government to ensure comprehensive approach for increasing road safety.

In May 2005, the Government approved a basic document/strategy that contains the framework for activities and interventions to minimise the consequences of traffic accidents under the title “National Plan of Increasing Road Safety for the Second Half of 2005 with a Prospect to 2010 in

²²⁰ Group of substances used primarily as sedatives/hypnotics, muscle relaxants, antiepileptics and anxiolytics

²²¹ Ramström, J.: Adverse Health Consequences of Cannabis Use. National Institute of Public Health Sweden, 2004, 142 p. Slovak translation published by the Slovak Republic Government Office, Bratislava 2005

²²² Official statement by the Ministry of Interior of 27 March 2006 No. PPZ-317/ODP-2006

the Slovak Republic". In its planned interventions, the Plan focuses on reducing the number of traffic accidents caused under the influence of alcohol.

In spite of the above-mentioned legislative and institutional conditions, the problem of detecting and proving the influence of addictive substances other than alcohol in a driver and his/her subsequent penalisation has not been solved comprehensively until present. Since 2000, under the auspice of the Ministry of Health, intersectoral working meetings are held²²³ with the objective of resolving this issue with involved ministries.

In the course of 2006, the Ministry of Interior is preparing draft amendment to the Act No. 219/1996 with the objective of introducing tentative detection of drugs in drivers in 2007. By the end of 2006, the Police Corps Presidium should finalise comparative tests of testing devices for the presence of drugs in the organism from saliva or sweat and select the most advantageous product.

13.2 Prevalence and epidemiological methodology

Detection of alcohol and drugs in drivers

So far there are no statistical overviews available on drivers having used any drug or benzodiazepines. The present statistical system only records information on driving and road accidents caused under the influence of alcohol – it does not enable special records of cases by drug type even if there are legislative conditions under Act No. 315/1996 for provision of information from traffic accident records including the use of alcohol or drugs by drivers involved in the traffic accident (Section 86 of the quoted law).

The Police Corps Presidium may perform testing in routine checks in traffic. Presently, however, it is not possible to prove the presence of drugs in a driver as the Police Corps has no technical facility available at present to detect or prove the influence of drugs in a driver. Examination to find if a driver is under the influence of alcohol is presently performed using a device that determines the presence of alcohol in the organism, so called alcohol tester. Should a driver refuse to submit to such testing, medical examination may be performed upon request by the policeman by taking and examining blood or other biological material. Should the driver refuse such medical examination, the degree of drunkenness shall be determined by the physician on the basis of medical clinical symptoms. The Slovak Republic has a zero alcohol tolerance.

In the case that the driver shows symptoms of use of other drugs or medicaments, such person shall be escorted to a medical examination. As pursuant to Act No. 219/1996, examination to find the presence of other addictive substances in the organism must be determined exclusively by a medical examination. In the practice, however, there is no protocol or report of medical examination for the presence of addictive substances in a person's organism that could be used in further procedure²²⁴.

Upon traffic accidents, the presence of alcohol or drugs is tested always when the driver is suspected of being under the influence thereof. In the event of death and suspicion that the driver drove under the influence of alcohol/drugs, testing is part of examination and autopsy of the corpse by a medical expert.

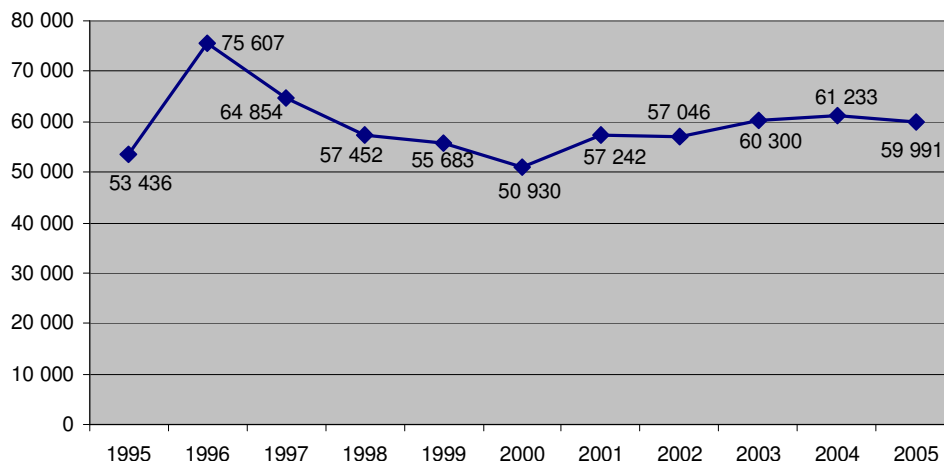
Statistical data

According to information based on the police statistics of the Traffic Police Department of the Police Corps Presidium, over 600 participants of road traffic die annually in Slovakia and 42 deaths per year on average are caused by traffic accidents under the influence of alcohol. The most frequent causes of road accidents in 2004 were the inappropriate driving behaviour (36%), violation of elemental duties (32%), and speeding (19%). The average number of traffic accidents caused by drivers under the influence of alcohol since 2000 has ranged about 4% with a moderate drop to 3.7% in 2005.

²²³ Resolution of the National Council of the Slovak Republic No. 335 of 26 June 2003

²²⁴ Official statement by the Ministry of Interior of 27 March 2006 No. PPZ-317/ODP-2006

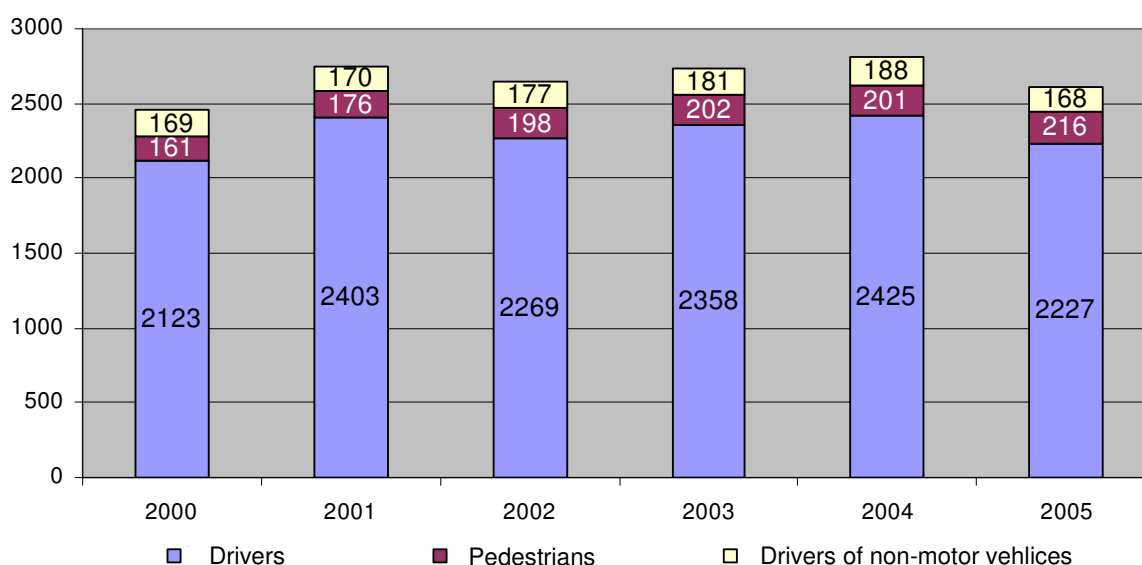
Figure 13.1: Development of the total number of road accidents



Data sources: Ministry of Interior - Traffic Police Department, 2006 and the National Plan of Increasing Traffic Safety for the Second Half of 2005 with an Outlook to 2005 in the Slovak Republic

The following figure shows the development of the number of traffic accidents caused by drivers of motor and non-motor vehicles under the influence of alcohol and by pedestrians under the influence of alcohol according to information from the Traffic Police Department, Ministry of Interior

Figure 13.2: Development of the number of traffic accidents under the influence of alcohol



Data source: Ministry of Interior, Traffic Police Department, 2006

Drug-related fatal road accidents

In 2006, the HealthCare Surveillance Authority performed a retrospective data collection from 11 forensic medicine and pathologic units concerning deaths related to psychoactive substances other than alcohol in road accidents for the period of 2000 – 2005 with a focus on marijuana and benzodiazepines.

Cases of drug related deaths in traffic accidents were reported from 4 units: in Bratislava at Antolská street (21 cases), in Košice (11 cases), Martin (7 cases), and Žilina (3 cases). Six units reported that they had not had such cases in the monitored period. One unit failed to send the report. In the period of six years, 42 cases of drug related deaths in traffic accidents were reported in total.

The mentioned cases involved 15 drivers of motor vehicles, 12 pedestrians, 12 motor vehicle passengers, 2 motorcycle drivers, and 1 cyclist. Data indicated the fact that if deaths of multiple passengers from a single motor vehicle were involved, mostly all of them were affected by a psychoactive substance.

Substances most frequently detected were marijuana, whether alone or in combination with other substances, which was the case in 23 events, 54.8% of the total number. This was followed by benzodiazepines, also alone or in combination with other substances in the total number of 7 cases (16.7%). Further cases involved medicaments (other than benzodiazepines), opiates, and toluene – alone and in combinations, 3 case each (7.1% each). One case was detected for each of amphetamine, cocaine, and methadone in combination with alcohol. Combination with alcohol was found in 14 cases in total (33%). The greatest number of deaths in road accidents was in the age group of 15 – 29 year olds (Tab. 13.1).

Table 13.1: Fatal consequences of traffic accidents by drug type in the period of 2000 – 2005

Year	Marijuana	Benzodiazepines	Pervitin	Other drugs	Total
2000	6	1	0	0	7
2001	2	2	0	2	6
2002	3	0	0	5	8
2003	3	1	0	2	6
2004	4	2	0	1	7
2005	5	1	0	2	8
Total	23	7	0	12	42

Source: Healthcare Surveillance Authority, 2006 (prepared by: Šidlo J.)

Detailed results of toxicological analyses by individual psychoactive substances and their combinations with respect to categorisation of traffic accident victims in 2005 are shown in Tab.13.2

Table 13.2: Classification of traffic accident victims by psychoactive substance found, 2005

TA victims Substance detected	Drivers	Pedestrians	Passengers	Motorcyclists	Cyclists	Total
Amphetamine	1	-	-	-	-	1
Benzodiazepines	-	3	-	-	-	3
+AMT/MAMT	-	1	-	-	-	1
+ETA	-	2	-	-	1	3
Cannabinoids	4	-	6	1	-	11
+AMT/MAMT	1	-	2	-	-	3
+ETA	2	2	3	-	-	7
+COC	1	-	-	-	-	1
+COC,ECS,ETA	1	-	-	-	-	1
Cocaine	1	-	-	-	-	1
Medicinal products	1	-	-	1	-	2
+ETA	1	-	-	-	-	1
Methadone + ETA	-	1	-	-	-	1
Opiates	1	-	-	-	-	1
+AMT/MAMT, BZD	-	1	-	-	-	1
+BZD	-	-	1	-	-	1
Toluene	1	1	-	-	-	2
+ETA	-	1	-	-	-	1
Total	15	12	12	2	1	42

Source: Health Care Surveillance Authority, 2006 (prepared by: Šidlo J.)

Note: TA – traffic accidents, AMT – amphetamine, BZD – benzodiazepines, ETA – ethyl alcohol, ECS ecstasy, COC – cocaine, MAMT – methamphetamine)

Table 13.3. Drug-related traffic accident, cases by age and gender (M/F)

Year/age	<15	15-19	20-24	25-29	30-34	35-39	40-44	50-54	55-59	>65	Total
2000	1/0	2/1	3/0	-	-	-	-	-	-	-	6/1
2001	-	1/0	1/0	-	1/0	1/0	1/0	1/0	-	-	6/0
2002	-	1/0	4/1	1/0	-	-	1/0	-	-	-	7/1
2003	-	-	1/0	1/1	1/0	1/0	-	-	1/0	-	5/1
2004	-	1/1	1/0	2/0	-	-	-	1/0	-	1/0	6/1
2005	-	1/1	2/0	2/0	-	-	-	1/0	-	1/0	7/1
Total	1/0	6/3	12/1	6/1	2/0	2/0	2/0	3/0	1/0	2/0	37/5

Source: Health Care Surveillance Authority, 2006 (prepared by: Šidlo J.)

13.3 Law enforcement

The authorisation of a policeman to stop vehicles is provided for by Act on Road Traffic as amended, pursuant to which the driver is obliged to comply with policeperson's instructions connected with the performance of his/her powers, to bear the performance of his/her powers, as well as to comply with instructions of other persons authorised thereto by this law. Moreover, pursuant to this law, a driver must not drive a vehicle immediately after consuming alcohol or drugs or during the time in which he/she might be under their influence.

Police Corps Traffic Police units perform annually several special checks and road-safety actions to inspect the compliance with traffic regulations concerning the prohibition of use of alcohol before or while driving. The best-known traffic safety action was the "Hawk" action.

Driving under the influence of alcohol/drugs is considered to constitute an offence against road safety and fluency pursuant to Act on Offences and the driver may be fined with a penalty of up to SKK 10,000 (app.€260) and prohibited to drive for up to 1 year.

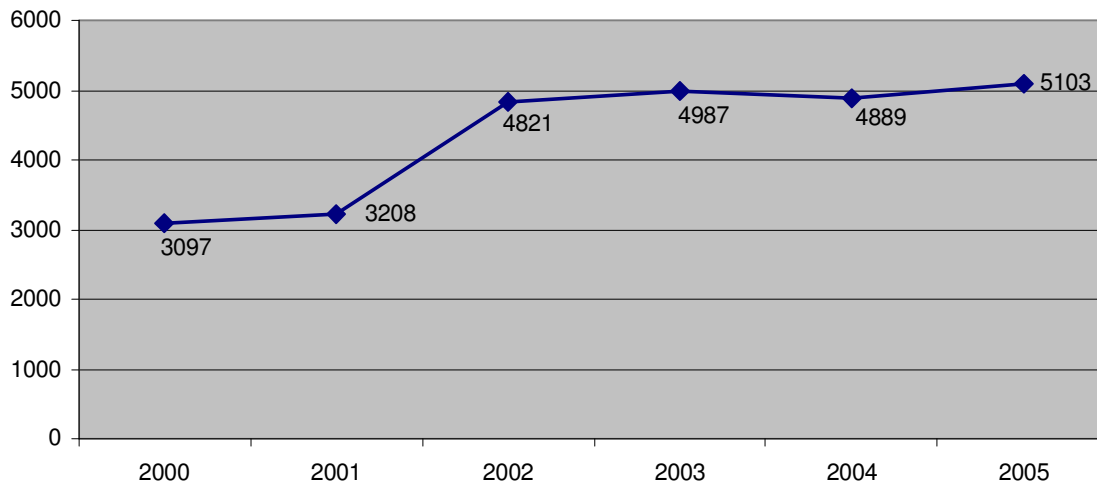
The new **Penal Code** provides for the amount of penalty for performing an occupation or other activity, at which peoples' health or life could be threatened or considerable damage to property could be caused. This constitutes the criminal act of endangering. Such activity is also the driving under the influence of drugs, including the start of the driving. In the event of repeating such act disregarding a previous conviction or penalty (for an offence) in the course of the last 24 months, and in the event of damage to health or a greater damage to property, such person may be sentenced to imprisonment of up to one year. This constitutes alternative conditions for prosecution for this criminal act. For acts, where the influence of an addictive substance is especially dangerous (in public transport), the sentence of imprisonment may be of 1 to 5 years²²⁵.

The following figure shows the number of cases²²⁶ of driving under the influence of alcohol as offences, for which the person was penalised with a penalty and driving prohibition.

²²⁵ In addition to driving means of mass transport (train, bus, airplane...), this includes also other cases (train dispatcher, engine driver...).

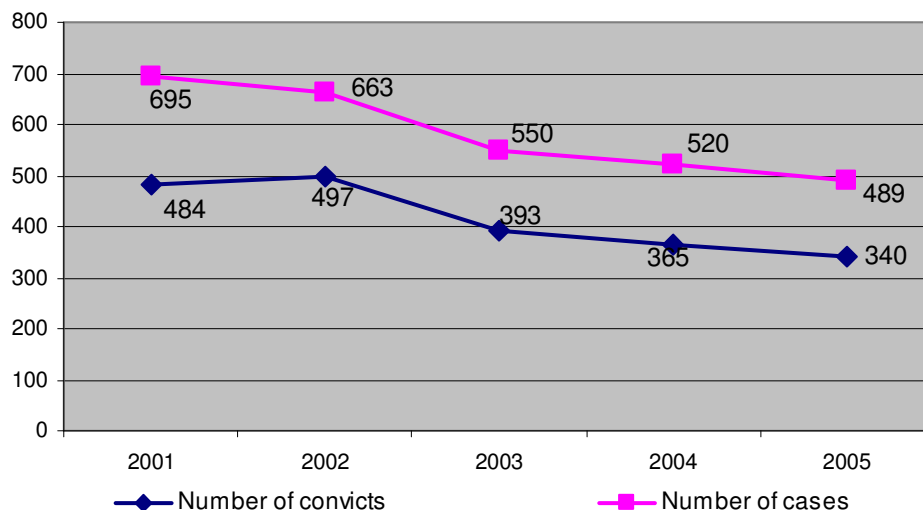
²²⁶ The cases were found by the Police Corps Presidium upon checks in traffic.

Figure 13.3: Cases of driving a motor vehicle under the influence of alcohol



Source: Ministry of Interior, Traffic Police Department, 2006

Figure 13.4: Development of the number of convicts and the number of acts of driving under the influence of alcohol



Source: Ministry of Justice, 2006

Training of police staff

In 2004, seminars “Drugs in Traffic” were held with the objective of familiarising policemen with the drug issue. The seminars included expert lectures focused on distinguishing and description of physiological symptoms, reactions and behaviours of people under the influence of addictive substances other than alcohol. The National Anti-Drug Unit, Office for the Fight against Organised Crime, Police Corps Presidium issued a methodological manual to the seminar “Drugs in Traffic”, which was distributed to all Traffic Police units.

This manual contains information on individual drug types, identification of their effects and risks, as well as information as to how to provide first aid in the event that the person checked collapses or certain symptoms of drug overdose are presented.

13.4 Prevention

Interventions planned to be performed on the national level are part of the National Plan of Increasing Road Safety for the Second Half of 2005 with a Prospect to 2010 (hereafter the “National Plan of Increasing Road Safety”), which was approved in May 2005.

Preventive activities are divided into several areas. In the framework of traffic education and edification, activities will be focused on: children and youth at schools and school facilities; on driving licence applicants through driving schools; on drivers of all age categories; and on all population groups with an emphasis on the need of complying with road regulations and supporting considerate behaviour in the traffic.

The competent ministries²²⁷ were tasked to apply, in school and driving-school programmes, the knowledge of the effects of alcohol and narcotic and psychotropic substances on the capacity to drive a motor vehicle and on road safety. Improve the drivers' information on the influence of certain medicaments on the capacity to drive and on their influence on the behaviour of other traffic participants²²⁸.

In the framework of supervision over the safety and fluency of road traffic, attention is to be paid to compliance with the law on use of alcoholic beverages and other addictive substances by drivers of motor and non-motor vehicles and by pedestrians. In the field of promotion in the media, a campaign is to be held focused on the risks of driving under the influence of alcohol, narcotic and psychotropic substances.

The annual spending on campaigns concerning traffic safety in general was envisaged in the amount of SKK 7 million (app. €181.000) in the first year and the subsequent years are subject to programme budgeting.

Police Corps Traffic Police units perform annually several special checks and traffic-safety actions to inspect the compliance with road regulations concerning the prohibition of use of alcohol before or while driving. The best known and most successful preventive programme is the nationwide traffic safety action "Hawk" declared by the Minister of Interior on the basis of the National Plan of Increasing Road Safety for the first time in 2004. The measure had a preventive action with the objective of eliminating traffic offences.

Driving schools

At driving schools, there are no specific preventive programmes established that would be focused only on drug use and driving. The risks of alcohol and drug consumption for the traffic are paid attention to at driving schools within the lessons on road safety and pursuant to Act No. 315/1996 on Traffic.

Labelling of medicinal products

In the Slovak Republic, all medicinal products, which may negatively affect the capability to drive a motor vehicle, are labelled on the packet with a visible warning pointing out this hazard.

Discussions in the media

In the media, no significant discussions concerning drugs and driving were recorded.

The information was presented in 2004 on commercial TV news programme concerning "mitigating" effects of marijuana on the state after alcohol consumption. (2005 National Report, Chapter 1.4, p. 51)

²²⁷ Ministry of Education, Ministry of Transport, Posts and Telecommunications, Ministry of Interior of the Slovak Republic

²²⁸ Part D – Health Education and Traffic Psychology, National Plan of Increasing Traffic Safety for the Second Half of 2005 with an Outlook to 2010 in the Slovak Republic

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15.4 List of abbreviations used in the text

ADF	Anti-Drug Fund
ATOD	Alcohol, Tobacco and Other Drugs
CA	Citizens' association
CCO	Customs Criminal Office
CCTIA	Central Control and Testing Institute of Agriculture
CG	correctional group
CLSAF	Centre for Labour, Social Affairs and Family
CM DADC	Committee of Ministers for Drug Addiction and Drug Control
CPCG	Corps of Prison and Court Guards
CCPS	Centre for Counselling and Psychological Service
CTDD – IDD	Centre for the Treatment of Drug Dependencies – Institute of Drug Dependencies
CTDD	Centre for the Treatment of Drug Dependencies
DC	Diagnosis Centres
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EPPC	Educational and Psychological Prevention Centres
ESPAD	European School project on Alcohol and Other Drugs
FEI PCP	Forensic Expertise Institute of the Police Corps Presidium
GS CM DADC	General Secretariat of the Committee of Ministers for Drug Addiction and Drug Control
GYTC	Global Youth Tobacco Survey
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
HSA	Healthcare Surveillance Authority
IIFE	Institute of Information and Prognoses in Education
INCB	International Narcotics Control Board
LTC	Leisure times activities
MLSAF SR	Ministry of Labour, Social Affairs and Family of the Slovak Republic
MP	methadone programme
MPC	Methodology and Pedagogical Centre
MsP	Metropolitan /community Police
NADU	National Anti-Drug Unit
NHIC	National Health Information Centre
NC SR	National Council of the Slovak Republic
NGO	Non-Governmental Organization
NIE	National Institute for Education of the Ministry of Education
NMCD	National Monitoring Centre for Drugs
NPFD	National Programme for the Fight against Drugs
NSP	Needle and syringe exchange programme
PCP MI SR	Police Corps Presidium of the Ministry of Interior of the Slovak Republic
PCP	Police Corps Presidium
PHA SR	Public Health Authority of the Slovak Republic
PORI SO SR	Public Opinion Research Institute at the Statistical Office of the Slovak Republic
PPCC	Pedagogical and Psychological Counselling Centres
RA	Regional Authority (state bodies of public administration)
RC	Resocialisation Centre
RH	Re-education Home
RHB	work rehabilitation
RICPaP	Research Institute of Child Psychology and Pathopsychology
SCECA	School centres of extra-curricular activity
SCI	Slovak Commercial Inspection
SGR	Self-governing Regions

SO SR	Statistical Office of the Slovak Republic
SRC	Social Reintegration Centres
SSTP	Section with special treatment programme
TAD	Tobacco-Alcohol-Drugs
TES	Treatment and Educational Sanatoria
UN	United Nations
UNOCD	United Nations Office for Crime and Drugs
WHO	World Health Organisation

Part D: Standard tables and structured questionnaires

- ST 03: Characteristics of persons starting treatment for drugs
- ST 05: Acute direct drug-related death
- ST 06: Evolution of acute direct drug-related death
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- SQ 31: Treatment as alternative imprisonment
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