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Drug Addiction and How to Counter It: Some Reflections and Experiences from Slovenia

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ABSTRACT

This paper discusses challenges of drug addiction treatments in general and presents treatment programs and their development in Slovenia. Since Slovenia shares similarities in socio-cultural background with the Western Balkans countries, we think the Slovene experiences could be useful for them. This is even more, since all the countries from the region formally expressed their foreign policy ambition to join the EU, an area where Slovenia can offer much of experiences and expertize. Generally speaking, drug addiction and its countering activities are part of the negotiation Chapters 24 (Justice, freedom and security) as well as 28 (Consumer and health protection). Slovenia pays its main attention on ensuring development of comprehensive measures and activities, while addressing these problems. Prevention activities are carried out through a variety of health centers and non-governmental organizations, having destigmatization as an important element of the whole rehabilitation process.

KEYWORDS: drug addiction, Slovenia, psychoactive substances, treatment, opioid maintenance treatment, prison

POVZETEK

V prispevku predstavljamo izzive zdravljenja odvisnosti od psihoaktivnih snovi na splošno ter razvoj programov za zdravljenje odvisnosti in pregled stanja v Sloveniji. Ker ima Slovenija podobnosti v socio-kulturnem ozadju z državami Zahodnega Balkana, menimo, da bi bile slovenske izkušnje lahko uporabne tudi v teh državah. Še posebej glede na dejstvo, da so vse te države formalno izrazile svojo zunanjopolitično ambicijo po članstvu v EU, kjer lahko Slovenija z njimi deli vrsto izkušenj. Na splošno lahko rečemo, da je to področje zajeto v pogajalskih poglavjih 24 (pravosodje, svoboda in varnost) in 28 (zaščita potrošnikov in zdravstvena zaščita). Slovenija posveča osrednjo pozornost zagotavljanju razvoja celovitih ukrepov in aktivnosti pri soočanju s problemi odvisnosti. Aktivnosti za preprečevanje odvisnosti od psihoaktivnih snovi v večini izvajajo različni zdravstveni centri in nevladne organizacije, med pomembnejšimi pristopi v procesu zdravljenja pa je destigmatizacija oseb, ki imajo težave zaradi odvisnosti od drog.

KLJUČNE BESEDE: odvisnost od drog, Slovenija, psihoaktivne snovi, zdravljenje, vzdrževalna opioidna terapija, zapor

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Introduction

Drug and alcohol addictions are global issues and the European Union (EU) struggles in addressing as well. Addictions in the EU vary across the countries (Addiction Center, 2014). Drug addiction presents also a challenege for the region of the Western Balkans and its countries on their way towards becoming EU member states. The challenges that the region has experienced can generate structural conditions conducive to a high risk enviroment in the context of illicit drug use (European Monitoring Centre for Drugs and Drug Addiction, 2019a). Past studies have indicated that, in general within the region, there is a combination of state programmes and services provided by non-governmental organizations (NGOs), frequently with the support of international donors and regional networks (European Monitoring Centre for Drugs and Drug Addiction, 2019a).

The aim of this paper is to present and discuss drug addiction treatment programmes and their developments in Slovenia, a country with a similar socio-cultural background to the Western Balkans region, but within the EU legal order. Hence, the Slovenian experiences can serve well the region when implementing the acqius communaitaire and exercising negotiations, as well as at reforming processes. Additionally, the purpose of this paper is also to provide interested countries in the region of the Western Balkans with the Slovenian experience and lessons learned. Here we point out that medical issues in a broader sense are part of two negotiation chapters, namely Chapter 24 (Justice, freedom and security) (European Comission, 2021) and Chapter 28 (Consumer and health protection) (European Comission, 2021). The first is focusing primarily on institutional preventive measures (like national strategies to fight drug addiction), while the latter deals primarily with a drug addiction and drug prevention, as health issues. However, the EU legislation and acquis in general leave this area mostly to national legislations and implementations. This henceforth also means that concrete experience from member states, in this case Slovenia, could be of even higher importance for the candidate and aspirant countries.

This contribution is based on the review of the literature dwelling on the substance use and treatment in Slovenia, analysis and description of the treatments. The article is based on the results from the following research methods: description, analysis, synthesis, comparison, comment, and observation with one's own participation, since the author

comes from the respective field.

Definition and Diagnostic Criteria of Addiction

According to the World Health Organization (WHO), addiction is a state of physiological and/or psychological addiction to any psychoactive substance (PAS) (World Health Organization, 1992). The International Classification of Diseases (ICD-10) defines the addiction syndrome as a group of behavioral, cognitive and physiological phenomena that develop after repeated use of PAS and are characterized by a strong desire to consume PAS, difficulty in controlling PAS intake, persistence in using PAS despite the harmful consequences, greater commitment to the use of PAS than other activities and obligations, increased tolerance, and possibly physical disturbances due to PAS withdrawal (World Health Organization, 1992). The new ICD-11 will come into effect on 1 January 2022 (World Health Organization, 2018).

The American Psychiatric Association (APA) classification The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) divides the Substance related disorders into Substance use disorders and Substance induced disorders. A substance use disorder is defined as a problematic pattern of taking substances causing clinically significant problems.

They manifest as at least two of the following, which would have occurred in the last 12 months: a substance is abused/consumed in larger quantities or for a longer time than planned; a constant desire or unsuccessful attempts to stop an individual from taking or trying to control the use of the substance; much of the time spent on activities related to substance acquisition, use or recovery after its effects emerge; a strong desire or sense of compulsion to take the substance; persisting with the substance use despite the overtly harmful consequences, such as harm to the liver caused by excessive drinking, depressive mood states consequent to periods of heavy substance use, or drug-related impairment of cognitive functioning; efforts should be made to determine that the user was actually, or could be expected to be, aware of the nature and the extent of the harm; important social, professional and recreational activities are abandoned or reduced due to the use of the PAS; using the substance in situations that are physically threatening; continuing to take the substance despite being aware that it is causing psychological and physical problems; tolerance, defined as: the need for a substantially increased substance intake in order for an individual

to achieve intoxication or a desired effect; or a markedly reduced effect of the substance when consuming the usual amount; a physiological withdrawal state when the substance use has ceased or has been reduced, as evidenced by the characteristic withdrawal syndrome, or the use of the same (or closely related) substance with the intention of relieving or avoiding withdrawal symptoms (American Psychiatric Association, 2013).

The DSM-5 distinguishes between an early and a stable remission and whether the remission was achieved in a safe environment.[2] According to the number of symptoms, disorders due to the use of substance are divided into mild, moderate and severe. Also, in the new American classification, the word "addiction" is not applied as a diagnostic term. The more neutral term "substance use disorder" is used to describe the wide range of the disorder, (from mild to severe, frequent relapses and compulsive taking of substances) (American Psychiatric Association, 2013).

The group of the substance induced disorders includes different mental states, such as poisoning, withdrawal, and other substance-related mental disorders (psychotic, bipolar, depressive, anxiety, obsessive-compulsive, sleep disorders, sexual dysfunction, delirium, and neurocognitive disorders). Substances are classified into 11 groups: alcohol, caffeine, cannabis, hallucinogens (with special categories for phencyclidine and other hallucinogens), inhalants, opioids, sedatives, hypnotics and anxiolytics, stimulants (amphetamines, cocaine, and other stimulants); tobacco, and other (unknown) substances.

All substances, when taken excessively, activate the reward system in the brain, causing repetitive behaviors and the formation of memories of experiencing pleasure and discomfort while taking substances.[3] Activation of the reward system can be so strong that other (previously important) activities are neglected (American Psychiatric Association, 2013).

2 Remission is either the reduction or disappearance of the signs and symptoms of a disease. The term may also be used to refer to the period during which this diminution occurs.

3 The reward system (the mesocorticolimbic circuit) is a group of neural structures responsible for incentive salience (i.e., "wanting"; desire or craving for a reward and motivation), associative learning (primarily positive reinforcement and classical conditioning), and positively-valenced emotions, particularly ones involving pleasure as a core component (e.g., joy, euphoria and ecstasy).

Substance use in Slovenia

History of Substance use and Treatment Development in Slovenia

The problem of the excessive drinking of alcohol in Slovenia is being monitored in a more detailed way for about two hundred years. Alcoholic beverages are also a regular accompaniment to the socialising, with a special place and praise accorded to them. Wet culture in Slovenia is characterised by an attitude of tolerance towards drinking alcohol, the presence of alcohol in the culture and customs, where drinking alcohol is encouraged, with the pattern of alcohol drinking handed down from generation to generation, along with easy access to alcohol and an inadequate number of demonstrably effective prevention programmes (Hočevar, 2020).

The history of the drug use in Slovenia is slightly different. The European Monitoring Center for Drugs and Drug Addiction (EMCDDA) began monitoring the drug situation in Slovenia after its accession to the EU. In the 1990s, a new wave of heroin use was detected in Slovenia, followed by the use of ecstasy and cocaine (Dekleva et al., 1997).

According to the Drug Report for Slovenia in 2003, the main drug problem in Ljubljana was the abuse of heroin. It represented more than 85% of all drug cases. Those who came for treatment in 1991 (specialised treatments for drug use in Slovenia started in 1991) had been on heroin for up to ten years. The route of the administration of heroin was an important factor, which influences the duration of the period from the first use of heroin and the onset of treatment.

The probability of starting a treatment earlier on was higher for non-injectors. There was also a possible explanation involving the availability of facilities and the enhanced awareness of drug-risk behaviour. Considerable changes in latency time were also due to the availability and price of heroin (European Monitoring Center for Drugs and Drug Addiction, 2004).

Until 2008, no survey on the prevalence of the use of psychoactive substances has been carried out among the adult population in Slovenia. The only data on the use of illicit psychoactive substances, acquired from representative samples of adult residents of Slovenia, is the data from the Slovene Public Opinion surveys. The question on lifetime use of illicit psychoactive substances was posed to the interviewees

in 1994 and 1999 (Toš et al., 1999, Toš et al., 1994). In 1994, 4.3 % of respondents answered that they had used one or more of the following psychoactive substances: cannabis/hashish, cocaine, heroin, LSD, mescaline or other drugs in their lives (Toš et al., 1994). In 1999 a question was posed on whether the interviewees have ever tried any of the following psychoactive substances: cannabis/hashish, heroin, cocaine, amphetamine, LSD or other hallucinogens, ecstasy, tranquilizers not prescribed by a doctor, a combination of alcohol and pills, injected drugs with an injection needle. 10.6 % of the respondents have used one or more of the listed drugs in their lives. 8.8 % indicated that they have used cannabis, 2.3 % of the respondents have used tranquilizers not prescribed by a doctor, 1.4 % used ecstasy, and 1.3 % used alcohol and pills. Other psychoactive substances were used by less than 1 % of the interviewed persons. The majority of those who responded that they had used heroin, ecstasy, cocaine and LSD, had also tried cannabis. Among cannabis users, statistically significant differences according to the sex and age were established: cannabis was more frequently used by younger respondents (18-29 years, 30-39 years) and males (Toš et al., 1999, European Monitoring Center for Drugs and Drug Addiction, 2010).

It is estimated that in 2012, there were 6917 high-risk opioid users in Slovenia, in the age group of 15 to 64 years.[4] The population of high-risk drug users in Slovenia is ageing, and this presents new challenges, such as increased social problems, including homelessness, and a higher frequency of acute and chronic illnesses (National Institute of Public Health, 2014). In 2013, compared to 2012, the use of heroin, solvents, opioid substitution drugs, synthetic drugs and cannabis decreased, while the use of cocaine increased (National Institute of Public Health, 2014). Injecting was still the predominant method of use among heroin and cocaine users. The latter was still the most common risky behavior among the participants in the harm reduction programmes, and risky sexuality was also very common (National Institute of Public Health, 2014). Compared to the previous years, in 2013 the sharing of the same needle and overdose increased (National Institute of Public Health, 2014). Otherwise, the population of drug users seeking help in harm reduction programs was aging. The share in the oldest age group was increasing.

4 According to the definition used by EMCDDA, problem drug use is defined as injecting drug use or long-duration/regular use of opioids, cocaine and/or amphetamines in the 15-64 age group over a oneyear period.

As many as 40% of respondents had other health problems in addition to addiction, most often citing hepatitis C and mental health problems (National Institute of Public Health, 2014) (Table 1).

Table 1: Problematic drug use among participants in harm reduction programmes in Slovenia in 2012 and 2013

	2012 (%)	2013 (%)
heroin	66	54
opioid substitution drugs	77	69.7
synthetic drugs	36	53.7
solvents	9	8
cocaine	62	64
predominant method of use of heroin in cocaine (injection)	85	76.5
sharing of the same needle	23	28
overdose	38	40
most often health problem	hepatitis C, mental health problems	hepatitis C

Source: National Institute of Public Health, 2014

Drug-induced deaths are deaths that can be directly attributed to the use of illicit drugs (i.e. poisonings and overdoses). The available data indicate an upward trend in the number of drug-induced deaths in Slovenia since 2015. In 2017, the general mortality register reported the highest number of deaths since 2007. Since the end of 2016, the Detection System for Poisoning by New Psychoactive Substances in Slovenia has been operational (European Monitoring Center for Drugs and Drug Addiction, 2019).

Drug Policy

Three paradigms are distinguished within international drug policy: the policy of war; the public health paradigm; and the classical liberal paradigm.

The public health model, whose main goal is to care for public health, tries to reduce the harmful consequences of drug use such as the spread of infectious diseases (hepatitis B, C, HIV/AIDS), and deaths (overdoses). Advocates of this model claim that the recurrent use of drugs is a chronic repeating illness. Hence, it follows that drug users

are chronic patients. By classifying drug use as an illness and drug users as patients, this model can reduce the harmful consequences of drug use and the criminalisation of drug users in the short term but, in the long term, it imposes on them the stigma of mentally ill patients.

In Slovenia, where the dominant approach of drugs policy is the public health paradigm, we are witnesses to the so-called negative medicalization. A qualitative research among drug users with a lot of experience with different types of treatments shows that the user of drugs becomes stigmatised after they enter a treatment programme and that this aspect of the treatment is not managed with a special attention, public campaigns. (The European Monitoring Center for Drugs and Drug Addiction, 2004). The most problematic issue was the long-term methadone maintenance treatment.

The analysis of the research and the findings on illicit drugs show that the existing paradigms of drugs policies are inefficient. The presumption that in the world of human rights individuals have the right to use drugs, leads to the debate on the limits of human rights and the rights of an individual. Most drug users and drug users' associations advocate the right to use drugs and appeal to the right to live. Within international drugs policy, which normatively prohibits the use of illicit drugs, these claims are not realisable. The drug issue reveals the conflict between an individual (drug user) and his wishes or needs on one hand, and the community (interests) on the other hand. Qualitative research and analysis of interviews with users confirm that drugs are always an element of political relations. Illicit drugs are a criterion for differentiating persons, given that individuals who use drugs are beyond the tolerance threshold. Such persons are usually pushed into the area of unacceptability. The users of illicit drugs are placed into the category of the sick, pathological, unacceptable, deviant, criminal, or alien. At the level of an everyday life, the universalisation of the stigmatised differences linked to the drug use is taking place. The contribution of this qualitative study is that it shows different approaches and reveals some otherwise hidden information about the policy of drug use in Slovenia (The European Monitoring Center for Drugs and Drug Addiction, 2004).

Today, we can say, that the main focus of Slovenia's drug policy is to ensure a comprehensive, balanced and an ongoing development of all measures, programmes and activities that address and help to tackle the problem of illicit drugs use in the country (National Institute of

Public Health, 2017). The overarching goal of the National Programme on Illicit Drugs 2014-2020 was to reduce and contain the harm that illicit drug use causes to individuals, their families, and society.

Of all the goals and missions, the following were pointed out: Firstly, seeking to promote illicit drug use prevention programmes in order to reduce the number of new drug users among the younger generations and to reduce the number of minor and criminal offences involving illicit drugs. Secondly, seeking to support the development of programmes to help stabilize or reduce the number of people infected with HIV, HBV and HCV, and deaths due to overdose.[5] Thirdly, seeking to develop and upgrade all coordinating structures working in the area of drugs at the local and national levels (National Institute of Public Health, 2017).

The action plan was drawn up by a working group made up of representatives from all ministries with authority over drug-related matters as well as representatives from the research community and NGOs. The Commission on Narcotic Drugs of the Government of the Republic of Slovenia monitored the action plan development process and approved the finalized action plan (National Institute of Public Health, 2017).

The country's highest-level coordinating body in the area of illicit drugs is the Commission on Narcotic Drugs of the Government, an interdepartmental authority. The Commission is made up of representatives from nine ministries (Ministry of the Interior; Labour, Family, Social Affairs and Equal Opportunities; Justice; Defence; Education, Science and Sport; Foreign Affairs; Agriculture, Forestry and Food; Finance; Health) and two representatives from two NGO Associations. Representatives from several other organizations may sit on the Commission. The governmental Commission on Narcotic Drugs and the Ministry of Health are responsible for coordinating activities in the area of illicit drugs use at the governmental level.

Within the Ministry of Health, the Health Promotion and Healthy Lifestyles Division is responsible for the day-to-day coordination of drug policy. At the local level, Local Action Groups continue to be the key coordinators of activities in local communities (National Institute of Public Health, 2017).

5 HIV-human immunodeficiencyvirus; HBV- hepatitis B virus; HCV-hepatitis C virus.

Treatment of Drug Addiction

Studies have shown that the treatment is effective (Gossop et al., 1999, Teesson et al., 2006). However, drug-related problems cannot fall into a single category and therefore, it is not possible to determine which drug treatment programme is the most effective. It is important that the treatment programme meets the needs of the individual and that we identify as soon as possible the factors that influence the achievement of treatment goals (Gossop, 1992). Despite different treatment approaches, many patients with drug addiction continue to use drugs during and after their treatment, and their life is usually punctuated by repeated treatment admissions and relapses which indicates that the problem being treated is of chronic and relapsing nature (Brewer et al., 1998).[6] In the field of the substance abuse treatment and mental health care in general, noncompletion of a treatment is a general problem. Approximately 50 percent of the patients in substance abuse treatment do not complete the first month of the treatment, which is associated with poor outcome (Stark, 1992). Attempts were made to improve outcomes of drug addiction treatment by addressing patient characteristics that predict continued drug use (Brewer et al., 1998, Delic, 2016).

Opioid agonist treatment (OAT) is considered to be one of the most effective options for the management of heroin or other opioid drug addictions. It has expanded substantially in the European Union in the last two decades. It is a part of a recognised medical practice approved by the competent authorities. The best results occur when a patient receives a medication for as long as it provides a benefit. This approach is often called a "maintenance treatment." Once stabilized on OAT, many patients stop using illicit opioids completely. Others continue to use them for some time, but less frequently and in smaller amounts, which reduces their risk of morbidity and overdose death. OAT gives people the time and ability to make necessary life changes associated with a long-term remission and recovery (e.g., changing the people, places, and things connected with their drug use), and to do so more safely.

Maintenance treatment also minimizes cravings and withdrawal symptoms. Moreover, it lets people to better manage other aspects of their life, such as parenting, attending school, or working (Substance Abuse

6 A relapse happens when apersons stops maintaining his or her goal of reducing or avoiding use of alcohol or other drugs and returns to previous levels of use.

and Mental Health Services Administration (US), 2018). The treatment with methadone and other opioid maintenance medications is one of the key addiction treatment programmes in the context of the harm reduction. It is effective in reducing illicit opioids use, the risk of HIV and hepatitis infection, preventing other health problems, mortality, and criminal behavior. As it allows a large number of opioids drug users to contact the health service, it also provides an entrance door to help-seekers and a treatment for users in other programmes: from low-threshold to abstinence-oriented programmes.[7]

A medically supervised withdrawal is a process in which providers offer methadone or buprenorphine or SR morphine on a short-term basis to reduce physical withdrawal signs and symptoms. Formerly called detoxification, this process gradually decreases the dose until the medication is discontinued, typically over a period of days or weeks. Studies show that most patients with an OAT, who undergo medically supervised withdrawal, will start using opioids again and will not continue with the treatment in the recommended care (Substance Abuse and Mental Health Services Administration (US), 2018). Psychosocial treatment strategies can reduce the dropout from medically supervised withdrawal, opioid use during withdrawal, and opioid use following completion of withdrawal. A medically supervised withdrawal is necessary for patients starting naltrexone, which requires at least 7 days without short-acting opioids and 10 to 14 days without long-acting opioids.[8] Patients, who complete medically supervised withdrawal, are at risk of opioid overdose (Substance Abuse and Mental Health Services Administration (US), 2018).

The therapeutic community is a programme that lasts 6-12 months and usually takes place outside the hospital environment. Persons are admitted to a therapeutic community after a completed detoxification. The emphasis is on the "resocialization" of an individual. The programme of therapeutic communities is usually highly structured. In some hospitals, after completion of detoxification, patients continue with a rehabilitation programme according to the principles of the therapeutic community (NIDA, 2012). There are also short-term community programmes that provide short-term (3 to 6 weeks) intensive treatment based on a modified approach of 12 steps. This is usually fol-

7 Low-treshold programmes are programmes that make minimal demands on the patient, offering services without attempting to control their intake of drugs, and providing counselling only if requested.

8 Naltrexone blocks the effects of opioid medication, including pain relief or feelings of well being that can lead to opioid abuse.

lowed by long term self-help programmes (Narcotics Anonymous-NA, Alcoholics Anonymous-AA). The approach is developed in and applied particularly to the context of the alcoholism treatment (NIDA, 2012).

The prevalence of substance use disorders is higher among patients with other mental disorders than in the general population. The term co-occurring disorders (dual diagnosis) is used to describe the comorbid condition of a substance use disorder and another mental disorder. Regarding the prognosis of the treatment of patients with comorbid disorders, both disorders have a poorer outcome, when undertreated. The first step in structuring an effective treatment for dual-diagnosis patients is the definition of a correct psychiatric diagnosis; this is not always easy because there is an overlap area between outbursts of primary psychiatric disorders and drug- or alcohol-related psychopathology (European Monitoring Center for Drugs and Drug Addiction, 2004).

Treatment of Drug Addiction in Slovenia

Alcohol abstinence organizations were established in Slovenia in the late 19th and early 20th centuries. After the Second World War, political proposals for reducing alcohol consumption appeared, but without any special success. Treatment of the alcohol dependence has a long tradition within the national healthcare system (approximately 60 years). Development of treatments of drug addiction has taken a different way. In the mid-1980s, low-threshold programmes began to develop in response to the HIV and hepatitis epidemic. At the end of the 1980s and in the beginning of the 1990s, Slovenian drug policy began to take shape, as the use of illicit drugs, especially heroin, began to increase.

At that time, there were no special services for persons with drug addiction. Detoxification procedures performed in psychiatric hospitals were inadequate (Mejak, 2010). Between 1990 and 1991, multidisciplinary approach to the treatment of a drug addiction was introduced (Kvaternik Jenko, 2006). One of the first organizations which started to work in the field of illicit drugs problems was Stigma, which is a non-profit humanitarian organization working in the field of harm reduction with people who use drugs (Mejak, 2010).

Today, the treatment of a drug addiction in Slovenia is performed on

an outpatient and inpatient basis. The available treatment approaches include detoxification; psychosocial interventions; OAT and other medically assisted treatments; individual or group counselling with a sociotherapy or psychotherapy component, including assistance with rehabilitation and social reintegration; and links to home nursing, therapeutic communities and self- help groups (European Monitoring Center for Drugs and Drug Addiction, 2019).[9]

Most patients, who use drugs, are treated on an outpatient basis, and the most common treatment for opioid dependence is OAT, which is provided by a network of Centers for the Prevention and Treatment of Drug Addiction. Since 1995, 21 Centers for the Prevention and Treatment of Drug Addiction have been established in Slovenia (Kastelic and Kostnapfel, 2005). The network of centers covers all Slovenian regions and there are currently no waiting periods in these programs. These centers provide OAT for opioid dependence using opioid agonists or partial agonists such as methadone, buprenorphine, buprenorphine in combination with naloxone, and prolonged-release morphine. In 1994, the Health Council endorsed the doctrine of drug treatment and adopted Recommendations for Physicians for the Treatment of Drug Addiction, which also includes methadone treatment. Buprenorphine was registered in 2004, with extended-release morphine a year later. Buprenorphine in combination with naloxone has been on the market since 2007. Treatment with the opioid antagonist naltrexone is also present. In 2018, Slovenia's substitution treatment programmes had approximately 3.300 clients out of the estimated nearly 5.000 injecting drug users. In the same year, a mobile unit was established for the distribution of a substitution therapy. The Slovenian government estimates that the OAT coverage was at over 65% in 2019 (Eurasian Harm Reduction Association, 2019).

In Slovenia, responsibility for implementing a treatment lies predominantly at the national level, and the drug treatment is provided by various health and social care systems and civil society organisations.

The treatment is available at all levels of health services (from primary health care to tertiary health services with specialized treatment programmes) and in all enviroments (rural and urban areas). The Health Insurance Institute of Slovenia funds the drug treatment in the health sector and the treatment is free of charge for the patient. Treatment

9 Detoxification is a set of interventions aimed at managing acute intoxication and withdrawal.

programmes delivered through the social care system are mainly funded by the Ministry of Labour, Family, Social Affairs and Equal Opportunities, and the municipalities, or by other external resources, and may require a co-payment from clients.

The only specialized center for the treatment of drug addiction in Slovenia is the Centre for Treatment of Drug Addiction, which was established in 2003 at the University Psychiatric Clinic Ljubljana and provides inpatient and outpatient treatments. Priorities are focused on a long – term treatment, giving the patients with substance use disorders an opportunity to gradually restore bio – psycho – social functioning, which is defined as clinical progress, even if recovery is not fully achieved. The main treatment programme at the Centre has a high-threshold. A condition for the entry to hospital treatment is the abstinence from illicit drugs during opioid maintenance therapy or a more stable use of heroin or other substances.

It is desirable that persons involved in the maintenance opioid therapy learn to establish and maintain abstinence from heroin and other substances, while preparing for the hospital treatment. Some patients, despite an intensive outpatient treatment and also being included in a day hospital support preparation program, fail to achieve these goals, but may be admitted to the hospital treatment first for stabilization. Later, they can decide, together with the therapeutic team, also to continue the treatment in the hospital. Some patients are admitted urgently because of life-threatening conditions or to stop the relapse of the disease.

Hospital treatment takes place in two wards. Patients are initially treated on an outpatient basis. Later, the patient usually enters treatment in a closed ward for detoxification, where treatment takes place for six weeks. After this treatment, the patient continues the eight-week treatment in the ward for the intensive prolonged treatment (Center for the Treatment of Illicit Drug Addiction, 2006). After the completion of a 14-weeks treatment, patients can continue their treatment in a day hospital, which usually lasts six months, or in an outpatient, individual or a group treatment in the Center for Treatment of Drug Addiction or in the regional Center for the Prevention and Treatment of Drug Addiction. There are regular urine tests performed as an objective measure of abstinence (once up to several times a week) (CZOPD, 2006) (European Monitoring Centre for Drugs and Drug Addiction, 2019b).

Medical treatment is gender sensitive; there is a good collaboration between gynecologists and addictologists. Many tretament programmes are culturally sensitive. Informed consent is obtained from a patient before initiating a treatment. It guarantees the option to withdraw from the treatment at any time. Patient data are strictly confidential, and a registration of patients entering a treatment outside the health records is not allowed. Any research conducted in treatment services involving human subjects, is subject to review of human research ethical committees, and participation of service users in the research is strictly voluntary with informed written consent ensured in all cases (Patients' Rights Act – ZpacP No. 15/08, 2008, Mental Health Act – ZDZDR No. 77/08, 2008).

Other psychiatric hospitals and psychiatric outpatient units within the primary healthcare system can also provide a basic treatment. Non-governmental organizations, within the framework and funding of social welfare programmes, are involved mainly in the provision of treatment communities and non-hospital-based residential treatment programmes.

In Slovenia, the outpatient treatment of psychiatric comorbidity among substance users may be provided in drug use services and in mental health services, as well as in certain services that provide treatment for either mental or substance use disorders and for dual diagnoses. At inpatient level, psychiatric comorbidity is treated in drug use facilities or dual diagnosis facilities (Torrens et al., 2017). At the Center for Treatment of Drug Addiction there are the only specialized ward and day hospital for the treatment of patients with comorbidities.

In 1991, the Social Forum for Addictions and Intoxications comprising of a large number of experts in the field of addictology, contacted the Italian Centro Italiano di Solidarieta (Ce.I.S), which was then implementing its Progetto Uomo (Project Human) in more than 42 countries. The Forum's experts decided to transfer Ce.I.S's practice in the field of addiction treatment to Slovenia and adjust it to the situation in Slovenia. Thus, they launched the Slovenian Projekt Človek (Project Human) programme, which gradually evolved into a comprehensive programme, which now encompasses, in its basic form, a reception centre, a therapeutic community and a rehabilitation programme designed to help those, who have completed the therapeutic community programme for a return to their everyday life. In addition to these ba-

sic programmes, Projekt Človek also includes programmes for parents and a therapeutic community for addicted parents and their children and therapeutic community for patients with comorbidities. Addicted parents and their children join the therapeutic community and live there for at least two years, 24 hours a day (Socialni forum za zasvojenosti, 1995).

Another such programme also started in 1991, under the auspices of Caritas Slovenia, which was in contact with the Comunita Incontro programme from Italy. Even though this programme did not have any therapeutic communities in Slovenia, it started admitting persons with addiction problems to therapeutic communities in Italy and other countries through a preparatory centre in Italy. The first drug users to be sent from Slovenia to Italy were those who entered the Srečanje (Meeting) programme (Socialni forum za zasvojenosti, 1995). The therapeutic community Žarek (Ray) in Jesenice, which was established by the non-governmental organization Žarek, opened its doors in 2006. Its programme lasts for two years, and its users are encouraged to become gradually more responsible through following daily schedules and through work therapy, mutual acceptance, group and individual conversations, therapeutic monitoring, recreation in nature (European Monitoring Center for Drugs and Drug Addiction, 2012).

The legal basis for the operation of therapeutic communities in Slovenia was provided by the Act Regulating the Prevention of the Use of Illicit Drugs and the Treatment of Drug Users (Act Regulating the Prevention of the Use of Illicit Drugs and the Treatment of Drug Users, 1999). This Act specifies that social-security services aimed at preventing and eliminating social distress and problems associated with illicit drug use and performed in the framework of the public service include in particular: social prevention, social first aid, personal assistance, and support for families. These services or tasks are mostly carried out by centres for social work; there are 62 such centres in Slovenia. Services are carried out in accordance with the Social Security Act (Social Security Act, 2004) and with norms and standards laid down by the minister responsible for social affairs (European Monitoring Center for Drugs and Drug Addiction, 2012).

Table 2: Treatment programs in Slovenia

PROGRAMME	DURATION	THRESHOLD	AVAILABILITY IN SLOVENIA
Opioid agonist treatment (methadone, buprenorpfine, buprenorphine/naloxon, SR-morphine)	different	low and high	Network of Centers fort he Prevention and Treatment of Drug Addiction
Detoxification	up to 6 weeks	low and high	Center for Treatment of Drug Addiction, University Psychiatric Clinic Ljubljana (the only specialized programme); all psychiatric hospitals in Slovenia (mainly for alcohol, basic treatment for drug addiction)
Therapeutic community	months to years	low and high (drug free)	Different types (Projekt Človek, Pelikan Karitas, Žarek, Cenacolo, Reto…)
Narcotics anonymus	months to years	low	yes

Source: The author

In 2013, there were also 23 social rehabilitation programmes available in Slovenia for people with disabilities caused by the abuse of substances (high and low threshold), co-financed by the Ministry of Labor, Family, Social Affairs and Equal Opportunities (National Institute of Public Health, 2014).

Harm reduction refers to policies, programmes and practices that aim to minimise negative health, social and legal impacts, associated with drug use, drug policies and drug laws. It is grounded in justice and human rights. It focuses on positive change and on working with people without judgement, coercion, discrimination, or requiring that they

stop using drugs as a precondition of support. Harm reduction encompasses a range of health and social services and practices that apply to illicit and licit drugs (Harm Reduction International, 2020). Different organizations work in the field of harm reduction with people, who use drugs in Slovenia. There are twelve needle and syringe program (NSP) centres in Slovenia, half of which have a low threshold. Syringes and other injecting equipment are distributed in six NGO-run mobile NSPs across the country that also provide essential healthcare services and referrals. The National Institute of Public Health covers the cost of the sterile injecting supplies that it distributes to NPS centres, while the Ministry of Health, Ministry of Labour, Family, Social Affairs and Equal Opportunities, Foundation for Funding Disability and Humanitarian Organizations and local municipalities provide funding for their running (Eurasian Harm Reduction Association, 2019).

Treatment of Drug Addiction in Prison

In Slovenia, medical services in prison are provided by the healthcare services under the authority of the Ministry of Health, such as primary healthcare centres, operating in the areas, where prisons are located. In general, drug treatment in prisons follow the same guidance as that applied to drug treatment in the community, although in combination with the internal guidelines.

Drug treatment is primarily delivered by psychiatrists in healthcare clinics or medical practitioners in Centres for the Prevention and Treatment of Illicit Drug Addiction. Available treatment approaches include OAT, individual and group counselling, and psychosocial support programmes led by qualified professionals working in prisons. Prisoners with dependencies may enrol in low-, medium- and high-threshold programmes. In 2017, almost 60 % of prisoners with drug use problems received OAT. Those in OAT also follow an educational programme and may receive specific benefits, such as spending a weekend at home or being granted annual leave. All inmates have access to free, voluntary and anonymous testing and treatment for hepatitis and human immunodeficiency virus infections. Before the release from prison, prisoners are provided with information on overdose risk, and community treatment centres are contacted to ensure the continuity of care (European Monitoring Center for Drugs and Drug Addiction, 2019).

With the goal of implementing an alternative sanctioning, the Probation Act has been adopted in Slovenia and entered into force on 17 July 2017 (Probation Act, 2017). Probation manages criminal offenders with short-term sentences and supervises their behaviour with the purpose of eliminating the causes that influenced the offenders in committing the criminal offence. It is essential that the person remains in his/her living and working environment. At the same time, the person on probation is limited by the fact that certain obligations must be fulfilled (European Monitoring Center for Drugs and Drug Addiction, 2019).

Conclusion

The main focus of Slovenia's drug policy is to ensure a development of comprehensive measures and activities that address and help resolving the problem of illicit drugs in the country. Prevention activities are mainly carried out by the National Institute of Public Health, local health centers, social work centers and NGOs. The reduction of the drug-related harm has been one of the main objectives of several consecutive national strategies on drugs. It is particularly significant to point out that destigmatization is an important part of the overall drug policy. Availability of the treatment is essential because potential patients can remain out of the process, if treatment is not readily accessible.

All individuals who use substances have a free access to harm reduction programs, treatment, social rehabilitation and the integration into society. Addiction treatment programs in prisons are available on the basis of a good clinical practice; also there is an alternative way of sanctioning of those with short-term sentences in the form of probation.

In the last decade, the trend of drug consumption has changed and many new psychoactive substances (NPS) have appeared on the drug market and are in use. Regarding this, Slovenia supports the monitoring of new psychoactive substances and exchange information within the early warning system. Cooperation on this area could be highly important for the Western Balkan countries as well as Slovenia (and through it for the whole EU).

The author is of the opinion that these practices and system as such could provide useful lessons for the countries of the Western Balkans within the implementation of related activities as a part of the adoption of the Acquis Communitaire on their way to the EU membership. Among the most important experiences would be the longterm, systematic and regular monitoring, preventing and daily work with the addicted population. This could bring the most efficient influence on minimizing the level of addiction as well as help to build trust between the addicted persons and their caretakers. Without having trust among all the participants and actors in the process, little progress is achieved.

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