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Evaluation of substitution maintenance treatment in Slovenia – assessing quality and efficiency

Trimbos Institute - Netherlands Institute of Mental Health and Addiction
Faculty of Social Work, University of Ljubljana
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The **Trimbos Institute – the Netherlands Institute of Mental Health and Addiction** is an independent national centre of expertise providing, on scientific grounds, services in the field of mental health care, substance use and the care of addicts. The Institute’s main activities include research, the promotion of expertise, health education and the dissemination of information. It also has ample international experience in supporting governmental organisations and NGOs in EU and CEE countries in the field of policies and practices. The Trimbos Institute is primarily responsible for this evaluation research.

The **Faculty of Social Work of the University of Ljubljana** has ample research experience in the drugs field.

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Executive summary

The project

In the years after the formal start of substitution maintenance treatment (SMT) in Slovenia in 1994, this treatment option has been implemented nation-wide. In the summer of 2006 the Slovene Minister of Health presented a call for proposals for an evaluation, using funds from the European Commission. The aim of this evaluation is to assist in improving the quality of SMT in Slovenia. The evaluation should explore the quality of SMT, its cost-effectiveness and its impact on patients. The Trimbos Institute (the Netherlands Institute of Mental Health and Addiction) was selected to do this evaluation in cooperation with the Faculty of Social Work of the University of Ljubljana. For several reasons, the cost-effectiveness analysis and the impact analysis were not considered feasible. This resulted in an adapted outline of this evaluation. In agreement with the Slovene Ministry of Health, the first analysis was changed in a qualitative exploration of aspects of management, organization and costs of SMT. The impact analysis was abandoned and replaced by detailed recommendations on how to monitor and evaluate the impact of SMT on patients in the future.

The report

After a chapter describing the methods used, this report starts with presenting context information on SMT in Slovenia, including a description of the background and the current organization of SMT. Its rationale, aims, and the available evidence of effectiveness of SMT are briefly reviewed. We also included a qualitative force field analysis that gives an impression of the forces and interests influencing policy choices on SMT.

The report continues with an assessment of the quality of SMT, based on several core items from the literature. Here we also included an analysis on patient satisfaction. Next, the results are presented of an indicative inventory of the efficiency of SMT. This was done by assessing the funds and expenditures, aspects of SMT management and some organizational issues. For a broader view on SMT, a selection of data from reference countries is briefly presented to enable a rough comparison between the Slovene situation, and that in four other EU countries.

Background and organisation of SMT in Slovenia

This chapter describes the background of SMT in Slovenia starting with some basic epidemiological information on problem heroin use and a short history of drug treatment. After an unofficial start of SMT in the late 1980s the national SMT programme took off in 1994. At the same time the first non-
medication assisted forms of drug treatment started. Today there is a reasonable variety of drug treatment services available. What follows is a description of how SMT is organised in Slovenia today, starting with the political responsibility of the Ministry of Health. Then the focus is on different aspects of the actual management of SMT (guidelines, supervision/monitoring, financing, staff and patient numbers, cooperation with other services). The final part is an overview of treatment issues (prescribed substitution substances, modalities of prescription, dosage, access to treatment and other services provided).

**Aims of SMT and scientific evidence for effectiveness**

Substitution treatment has several goals. It may aim at stopping or reducing the use of heroin, at reducing harm for problem heroin users and at reducing harm and nuisance for their surroundings.

Initially, substitution treatment was introduced in several countries as an abstinence-oriented treatment option. However, during the past decades, it became clear that substitution medications can also be effectively used as a maintenance treatment for reducing harm and nuisance. It increases treatment retention and it reduces opiate use and several risk behaviours related to infectious diseases. Therefore the target has shifted to stabilising the life of patients and at the same time reducing harm for them and for their environment. Methadone is the substitution drug that is most frequently used, but the scientific evidence shows that other substitution drugs that are in use in Slovenia and other countries, i.e. buprenorphine and slow-release morphine may also be effective alternatives for specific patient groups. On average the effectiveness of SMT is increased when supportive psychosocial care is added to it.

**Force field analysis**

SMT is still a controversial, highly politicised issue in Slovenia. There are two main themes in the dispute. Expressed in broad terms they are an ideological disagreement between an abstinence-oriented and a harm reduction-oriented view on drug treatment and a financial consideration: Is it worth spending so much money on SMT? The force field analysis gives a sketch of some important forces and interests of influence on SMT.

Three main perspectives are discerned. Viewed from a political-ideological perspective, it becomes clear that conservative political parties are generally not in favour of SMT (e.g. because it does not present a short-term way out of addiction) while the attitude of liberal or progressive parties seem to be (on average) more positively (e.g. because SMT reduces several risks for the drug user and its environment). The current Slovene government is considered not supporting SMT.
The professional perspective is dominated on the one hand by a medical and on the other hand by a psycho-social view on problem drug use. From the medical perspective, problem drug use is mainly viewed as a (psychiatric) disorder for which medication assisted treatment is important. From the psycho-social viewpoint, the focus is primarily on the psychological health, well-being and psycho-social functioning of the patient, i.e. on the individual and on his/her social environment. As the medical viewpoint is dominant in SMT in Slovenia the psycho-social components of SMT are not optimally used.

The (political) power perspective – overlapping the previous two – concerns the perceived power of individuals or organizations for being of substantial influence on SMT in Slovenia. Here again two main groups can be discerned, namely an abstinence-oriented and a harm reduction-oriented one. In general, it is clear that SMT is not an important issue in the public (political) debate but that at the same time public opinion and media are clearly more in favour of abstinence-oriented drug treatment.

Quality of SMT
Quality covers many characteristics that partly overlap those of efficiency. These mainly cover staff availability/capacity, expertise, and training, work motivation, job satisfaction and attitude towards patients, time spent on patient contacts, SMT (intake and maintenance), managing patient complaints, registration, SMT accessibility, monitoring and evaluation of SMT, process management and cooperation with other organisations.

Staff availability/capacity
Medical doctors and nurses are present in all 18 centres. The majority of the nurses are engaged in SMT full-time. Medical doctors vary from full-time to part-time mostly in smaller centres. More than half of the centres also have a part-time psychologist. Social workers are employed in two centres. This also goes for laboratory personnel. Laboratory tests are mainly done in the Primary Health Care Centres (PHCCs). Insufficient staff capacity is reported at all levels. Explanations of this may be found in growing patient numbers, frequently changing personnel, and many part-time appointments. Finally, SMT work is not attractive because of its low status.

SMTC staff are satisfied with the direct management (e.g. accessibility, taking good care of work atmosphere, giving support). In general there are good working relationships inside SMTCs.

Team meetings (often weekly and in many cases informal) are used to discuss the difficulties met. Staff training is mainly provided through the Coordination Committee.
Work motivation, job satisfaction and attitude towards patients

SMTC staff is on average fairly satisfied with the work and think it very useful, although it may frequently be rather stressful. The majority receives feedback on their work however satisfaction with the feedback differs. Staff opinion also differs on their ability to keep up with developments in this work field.

Patient contacts with medical doctors are most frequent during intake and starting phase of SMT. During the maintenance phase it generally declines. Other problems (e.g. due to poly-drug use or psychological problems) are met in only some of the centres.

Regular medical examinations of patients in the first phases of SMT are present in most cases. Drug dependence is determined during intake in different ways but without a pre-validated instrument. Urine tests (usually unannounced, in some centres on specific days) are used in all SMTCs to check if the medication has been taken, and to control for illegal drug use. However, the test frequency differs substantially between centres. The majority of centres have specific interventions addressing special patient groups, e.g. pregnant women, former inmates and dual diagnosis patients.

In all 18 SMTCs a treatment plan is determined by the medical doctor, in 15 centres with involvement of the nurse. In all centres a treatment plan is signed by the doctor and the patient, but intermediate treatment changes often take place without formal evaluation procedures. Though several inclusion criteria are in use (e.g. having a health insurance, aged above 18 years, minimal heroin dependence of two years), these are mostly negotiable depending on the patients attitude and situation.

For maintenance treatment, SMTCs offer methadone, buprenorphine and slow-release morphine. The frequency of evaluation of dosage adequacy depends in many cases on the individual patient situation.

It is possible for patients to complain about SMT, and half of the centres have a guideline for this. Complaints are in most cases about sanctions due to positive urine tests.

Patient data collection systems are used in all centres, but there are differences between them. The patient systems in use do not allow for monitoring the patient’s development during treatment.

SMTCs are open every working day but opening times vary and some are also open for some hours during the weekend. Travelling time may on average vary between five minutes and an hour and a half per centre. The data indicate that the geographical coverage of the SMTCs is large. Waiting lists do
not exist apart from delays due to part-time work of the medical doctor. To improve access in some places the substitution medication is dispensed by general practitioners or pharmacies in the towns/villages where patients live.

**Monitoring, evaluation and guidelines**
Staff activities are usually monitored on an informal peer-to-peer basis and not via formal procedures (“everybody knows each other”). All SMTCs report using guidelines for their work, 17 use the Euro-Methwork guidelines, some of these use even more than one, among which also local ones. Twelve SMTCs think that the guidelines used are sufficient for doing the work in a proper way.

The primary responsibility for *financial management* is with the PHCCs. More than half of the SMTCs think that the PHCC *management support* is insufficient, e.g. in getting the amount of staff needed. Most centres say they have a privacy policy and indeed take several measures to guarantee patient privacy.

**Cooperation with other organisations**
SMTCs are cooperating with many other professionals and organizations, e.g. with general hospitals when patients need hospital care and with psychiatric wards for dual diagnosis patients. The relationship with the PHCC is generally good. Pharmacies are involved in preparing the individual dosages of substitution drugs, especially for take-home dosages. Cooperation with some Centres for Social Work is focused on the psycho-social problems of patients, e.g. housing, employment, child care. For different reasons cooperation with NGOs is more limited.

**Patient satisfaction**
Patient satisfaction covers topics like the medication prescribed, their well-being, the information on SMT given to them, accessibility, flexibility of SMT, additional services (besides the dispensing of substitution drugs) and the attitude of SMT personnel towards patients (privacy and contacts).

A large majority was satisfied with their medication. A minority preferred another substance or dosage prescribed. They were on average very positive about the impact of SMT on their life. Almost all patients said to be informed about their treatment by the doctor or the nurse, though they are in general better informed about the medication prescribed to them than about other medications. Patients’ judgment on the access of SMT (distance, travel time, opening hours, take-home medication, etc.) was generally rather positive. Additional services most frequently mentioned as considered necessary by patients are counselling, testing for infectious diseases, and psychiatric help.
Most patients are satisfied with their relationship with the SMT staff and with possibilities to complain in case of dissatisfaction. One quarter to one third of the patients interviewed felt worried about their privacy.

**Data on management, organization and costs** were more difficult to collect than data on aforementioned subjects. We found substantial differences between data from different sources.

Funding for SMTC organisational costs is based on the number of patients in the preceding year. Different registration systems are in use resulting in different calculations and outcomes. The Health Insurance Institute Slovenia allocated around 2.2 million Euro for organisational costs of SMTCs in 2006. The SMT medication costs were 2.7 million Euro, so the total costs in 2006 were nearly 5 million Euro.

The average normative number of staff full-time equivalent (FTE) for 100 patients is 1.91. However, there are substantial differences between staff numbers reported and the normative number. Medical doctors usually work part-time in SMTCs. In around one third of the SMTCs there seem to be no nurse employed with the required bachelor degree. Instead secondary school educated nurses do the work and most of these are engaged full-time with SMT. Two SMTCs have a social worker appointed to the staff. Finally, the time spent on patients is highly variable, depending on the patient characteristics and treatment phase.

**Discussion**
Subjects that are considered important for the discussion chapter are concentrating on quality and efficiency of SMT. These discussion subjects are targeting staff, patients, treatment and internal and external organisation matters.

**Recommendations**
In the recommendations chapter we focus on practical advice for the SMTCs e.g. regarding better team functioning, patient and management data collection and on recommendations for policy makers to create conditions and take responsibility for among others monitoring and evaluation, and efficient and effective cooperation in the demand reduction field.
1. Introduction

Substitution maintenance treatment (SMT) started in Slovenia in 1994 as an officially accepted drug treatment option. Since then SMT has developed in a widely implemented programme now covering the whole country (see chapter 3.1). At the same time, it has remained a highly debated form of drug treatment. Economic and ideological arguments played a prominent role in this debate (see chapter 3.3). This is one of the reasons why the need for an evaluation has been repeatedly emphasised from different sides. Finally, in summer 2006 the Slovene Ministry of Health presented a call for proposals for an evaluation using European Commission funds with the aim of improving the quality and giving insights into the cost-effectiveness of substitution programmes for opiate dependent persons in Slovenia. This call for proposals stated that the evaluation should assess the following elements of SMT:

- the quality of services delivered, shedding light on the following matters:
  - appropriateness of the internal processes;
  - having in place and implementing protocols;
  - team qualification and expertise;
  - patient satisfaction.
- the cost-effectiveness of the programme, assessing the input (human resources, finances) – output (patient numbers, interventions/services) relation;
- the impact of the programme on patients, assessing the development of a selection of patients in a specified time interval starting at the time they enter the programme. The focus should be on all relevant life areas, i.e. physical health, psychological health, psycho-social functioning, education, work, juridical issues (criminal behaviour), etc.

The Trimbos Institute in cooperation with the Faculty of Social Work of the University of Ljubljana carried out this evaluation.

The evaluation plan

We did not decide on an extensive scientific evaluation study of the effectiveness of SMT as such or on cost-effectiveness in the strict scientific sense. This type of evaluation would be impossible within the timeframe of the project (eight months, from March to October 2007). Furthermore, the effectiveness of SMT has been established – especially for methadone – through numerous studies. We have summarised this evidence in chapter 3.2. SMT is an effective treatment for problem heroin users acknowledged and

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1 The project was carried out in the format of a so-called twinning light project, i.e. an intergovernmental project involving cooperation between the Slovene Ministry of Health and the Netherlands Ministry of Health, Welfare and Sport, with European Commission funding from the 2006 Transition Facility National Programme for Slovenia. The Trimbos Institute operated in this project as a mandated body of the Netherlands Ministry of Health, Welfare and Sport.

Insufficient data and indicators were available for the analyses required for a thorough cost-effectiveness study. This is true for the patient data as well as for indicators and reference standards to assess input and output, e.g. to allow an assessment of the societal gains of SMT compared to other forms of treatment or to no treatment. Instead, in agreement with the Slovene Ministry of Health we focused in this evaluation primarily on the quality and the efficiency (management, organisation and costs) of the SMT programmes in Slovenia.

For an actual evaluation of the impact of SMT on patients we faced the same problem of insufficient data and indicators. The patient registration system in use in SMTCs is not suitable for monitoring or evaluating this impact. However, there are a number of well-developed instruments that do assess the impact of SMT on patients. Sophisticated instruments have been developed particularly in trials on the medical prescription of heroin in Switzerland, the Netherlands and Germany. Most of these instruments are based on the European Addiction Severity Index (EuropASI), a tool to determine the health and social status of patients covering alcohol use, illegal drug use, work, criminality, physical health, social health and mental health (Fureman et al. 1990, Blanken et al. 1996). However, to adapt such an instrument and use it to assess the impact of SMT on patients would be impossible in an eight month project. To determine if SMT has an impact on the health and social status of a patient a minimum time interval of six months between intake and re-assessment would be required. Therefore we decided to develop a recommendation for an assessment tool based on EuropASI to allow thorough monitoring of patients’ development in SMT over time and to provide data for evaluating the impact of SMT on patients.

These considerations resulted in a slightly adapted outline for the evaluation including the following elements, which will be briefly explained below:

- Rationale, aims and evidence for the effectiveness of SMT;
- Force field analysis;
- Assessment of the SMT quality (including patient satisfaction);
- Assessment of the efficiency of the SMTCs;
- A rough comparison with pre-selected reference countries.

**Rationale, aims and evidence for the effectiveness of SMT**

Despite the relatively long tradition of SMT in Slovenia, it is still a highly debated drug treatment option. In this debate there are many misconceptions about what SMT is and can achieve. Therefore we decided to include a

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2 Based on the First Treatment Demand Indicator of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)
chapter in which we briefly present the justification for SMT, its aims and the research evidence for the effectiveness of SMT. This chapter is based on desk research (scientific literature and other documents).

**Force field analysis**
The fact that SMT is quite a controversial issue in Slovenia also led us to the decision to include a force field analysis to reflect the highly politicised debate about SMT and the force field in which SMTCs operate in Slovenia. This analysis gives an impression of the different forces and interests influencing the policy and practice of SMT in Slovenia.

**Assessment of SMT quality**
There is extensive literature on quality and quality indicators for SMT. For assessing the quality of SMT in Slovenia we selected some core items of treatment quality from this literature, such as:

- Professional training, motivation and number of staff;
- Management of SMTCs (especially focusing on team management);
- Quality control through regular monitoring and evaluation and through the use of treatment guidelines or protocols;
- Access to SMT (opening hours, patients’ travelling time to the SMTC, waiting lists, etc.);
- Cooperation with organisations and agencies offering services for the same target group;
- Patient satisfaction.

Under patient satisfaction we decided to focus on:

- Treatment issues (medication, dosage, perceived effects);
- Information about SMT (e.g. effects and side effects of different substitution medication, treatment “rules”);
- Treatment access issues (opening hours, distance to the SMTC, flexibility in dispensing methods);
- Additional services offered (e.g. social work, infectious disease counselling);
- Treatment conditions (e.g. privacy, attitude of personnel, premises).

**Assessment of the efficiency of the SMTCs**
The aim of this part of the evaluation was to assess the efficiency of the SMTCs, i.e. the financing system and the way in which the work in SMTCs is organised and managed. These matters not only tell something about the efficiency of SMT but also have a substantial influence on the quality of the services delivered. We focused on financial issues (budget received, budget spent on staff and medication, financial control) and management and organisational issues (patient numbers, staff numbers, staff structure, staff availability, etc).
Reference countries
When preparing the assessment of the quality and efficiency of SMT it became clear that one would at least need some reference standards for a better understanding of the findings and to allow comparative statements about the quality or efficiency. Therefore we decided to include a sketchy description of SMT in four selected EU Member States, against which one can compare the findings on Slovene SMT.

Defining the focus of the evaluation
The focus of this evaluation is exclusively on SMT. This means we did not include the use of methadone in the detoxification phase of abstinence-oriented treatment. We also did not include SMT in prisons. These programmes are managed and financed by the Ministry of Justice and have a regime that differs from the SMT centres in the community. Finally, it should be kept in mind that this evaluation is not an audit, neither with regards to the treatment process and the operational procedures of the SMTCs nor as a formal check of the finances.

The contents of this report
This report starts with a short overview of the methodological considerations and a description of the methods used in this evaluation (chapter 2). Chapter 3 consists of a description of the context of SMT in Slovenia. This entails: a description of the development and actual situation of SMT in Slovenia (chapter 3.1); a summary of the rationale, aims and evidence for the effectiveness of SMT (chapter 3.2); and a brief analysis of the force field around SMT in Slovenia (chapter 3.3). In chapter 4 we present the findings on SMT quality deriving from interviews with SMTC staff (chapter 4.1) and from patient satisfaction interviews (chapter 4.2). Chapter 5 contains the findings from the interviews with SMTC staff on the efficiency of the SMTCs. In chapter 6 we present the findings from the interviews and desk research on SMT in the four reference countries. The discussion of all these findings can be found in chapter 7. We present our recommendations in chapter 8.
2. Methodology

The aim of this evaluation project was to assess the quality and efficiency of SMT in Slovenia. In this study a well-known model for the evaluation of health care programmes, the CIPP model, was used. It incorporates four components: Context (what needs to be done?), Input (how should it be done?), Process (how far is it being done?) and Product (how far did it succeed?) (Stufflebeam 2000). Applying this model to the evaluation of Slovene SMT resulted in the research questions listed in Table 1. To answer these questions, we used a combination of qualitative (document analysis, semi-structured interviews) and quantitative (structured interviews, structured questionnaire with cost items) research methods, which are summarised in the last column of the table. Details on each of these methods are provided in the remainder of the chapter.

Table 1: the CIPP model applied to the evaluation of Slovene SMT

<table>
<thead>
<tr>
<th>CIPP component</th>
<th>Research question</th>
<th>Research method/tool</th>
</tr>
</thead>
</table>
| Context (What needs to be done?) | How is SMT for problem heroin users in need of medical treatment organised in Slovenia?  
What are the most important traits of the views on this issue of influential stakeholders in SMT? | Analysis of information on background and organisation of SMT in Slovenia  
Force field analysis |
| Input (How should it be done?) | What are the rationale, the aims and the available evidence for the effectiveness of SMT? | Desk research on SMT treatment options and a literature review on the evidence of the effectiveness of SMT |
| Process (How far is it being done?) | Are the internal processes appropriate?  
Are protocols in place and implemented? Is the team qualified and experienced? | Staff questionnaire on quality issues of SMT and questionnaire on patient satisfaction  
Comparison with reference countries |
| Product (How far did it succeed?) | How efficient is the management and organisation of SMT?  
How do the consumers (patients) rate this treatment?  
How does Slovene SMT function, compared to other countries? | Questionnaire on the efficiency of SMT  
Questionnaire on patient satisfaction  
Comparison with reference countries |

In all 18 SMTCs data were collected on indicators for treatment quality and for the efficiency of their functioning. Additionally, 6 SMTCs were selected for in-depth data collection. In addition to the heads and one staff member of these SMTCs (the staff member proved to be in all cases a nurse, as nurses are the most common staff in SMTCs), the directors of the Primary Health Care Centres (PHCCs) – in which SMTCs are incorporated - and at least 10 patients in each of these 6 centres were interviewed. We did not strive for a strictly representative sample, but focused on covering a wide range of SMTCs, considering several criteria. Ljubljana is naturally the biggest of the SMTCs in Slovenia and is in many ways different from other SMTCs, thus its inclusion is “obligatory”. The other centres were selected on the basis of a qualitative judgment of differences between treatment services available, in size (number of patients in SMT and staff capacity), and in characteristics of the local drug scene. As far as possible, we also took into account the
geographical spread of the SMTCs. As a result of these qualitative judgments we selected the SMTCs located in Kočevje, Koper, Logatec, Nova Gorica and Velenje for in-depth study.

**Table 2: Description of the centres selected for the in-depth data collection**

<table>
<thead>
<tr>
<th>Centre</th>
<th>Size</th>
<th>No of patients 2005</th>
<th>SMT staff in FTE</th>
<th>Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kočevje</td>
<td>small</td>
<td>65</td>
<td>0.49</td>
<td>S</td>
</tr>
<tr>
<td>Koper</td>
<td>big</td>
<td>204</td>
<td>1.36</td>
<td>Coast</td>
</tr>
<tr>
<td>Ljubljana</td>
<td>big</td>
<td>538</td>
<td>3.50</td>
<td>Ljubljana</td>
</tr>
<tr>
<td>Logatec</td>
<td>big</td>
<td>107</td>
<td>0.72</td>
<td>Central</td>
</tr>
<tr>
<td>Nova Gorica</td>
<td>big</td>
<td>190</td>
<td>1.74</td>
<td>NW</td>
</tr>
<tr>
<td>Velenje</td>
<td>small</td>
<td>90</td>
<td>0.66</td>
<td>NE</td>
</tr>
</tbody>
</table>

Source for number of SMT patients 2005: Sector Agreement for Primary Health Care Centres and Private Medical Care³ (ZZZS 2007a)

As already stated in the introduction (chapter 1), this study is an evaluation of the existing practice of SMT. It is **not** an assessment of the effectiveness of SMT (which ideally would require a randomised controlled trial to compare the effects to no treatment or other forms of treatment).

**Research methods and tools**

**Information on background and organisation of SMT**

In order to get information on the background and organisation of current SMT practice in Slovenia, we conducted open interviews with 16 stakeholders, some involved in current drug policy, some involved in the early stages of SMT in Slovenia.⁴ The interviews were conducted by experts of the Trimbos Institute, with the exception of interviewees who did not speak English; in this case the interview was conducted by a Slovene member of the evaluation team.

The topic list for the interviews included the following issues:
- Financing system: who is financing the SMTCs? How is the budget divided among the centres? Are guidelines in place on how the funding should be

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³ A Sector Agreement for Primary Health Care Centres and Private Medical Care is made every year defining the budget for and the way of financing the Primary Health Care Centres and Private Practices with Concession. The agreement is signed by the Ministry of Health of Republic Slovenia, the Federation of the Health Care Institutions of Slovenia, the Medical Chamber of Slovenia and the Health Insurance Institute of Slovenia.

⁴ We interviewed four current and two former staff of the Ministry of Health, two staff of the Public Health Institute, one staff member of the Health Insurance Institute Slovenia, two researchers of the University of Ljubljana, 5 experts from drug (treatment) services.
spent? If so, what guidelines? How is the money spent on SMT monitored/controlled?

- Political system: who is politically responsible for the SMTCs? How are the centres monitored/controlled? Are there specified rules or regulations for SMT? Are there guidelines for the tasks of the SMTCs (definition of obligatory tasks, treatment protocols, quality standards, etc.)? If so, how are the centres controlled as to whether they adhere to these guidelines? What are the reporting obligations of the centres?
- Treatment system: is SMT embedded in a broader treatment package of additional interventions, e.g. counselling or psycho-social support?

This background information was supplemented with data from various documents, such as the Slovene National Reports of 2004 and 2005 to the EMCDDA, the Supervision Report of 2003 (Dernovšek and Rogač Cvetko 2004) and the Resolution on the National Program in the Area of Drugs 2004-2009 (Resolucija o nacionalnem ... 2004).

**Overview of medication assisted maintenance treatment options and evidence for effectiveness**

We collected data on the evidence for the effectiveness of SMT via a literature review using Medline, PsychInfo. Articles on the effectiveness of SMT in peer-reviewed journals and in the Cochrane Library of the most recent systematic reviews and meta-analyses, plus some publications of recent primary studies were evaluated. We used well-established methods for determining and grading the available evidence for effectiveness. This means that in this report the judgment “effective” for a specific substitution substance represents *significant but average* results. When looking at the available literature on long-term substitution treatment, many significant advantageous effects are present although not in average, i.e. for every client nor for every treatment goal. It is also important to realise that many aspects of SMT have not been studied in an accepted scientific way, so there is currently no proof for its effectiveness regarding these aspects, simply because it has not yet been studied. Therefore, “no proof of effectiveness” is *not* equal to proven ineffectiveness. In these cases we simply do not know enough as yet about effectiveness.

**Force field analysis**

In addition, we decided to include an explorative analysis of the force field in which SMT operates in Slovenia (see chapter 3.3). The reason for this was that SMT is a controversial, highly politicised issue in Slovenia. A force field analysis may give important information on the different forces and interests influencing the policy and practice of SMT in Slovenia.

We conducted 16 semi-structured interviews to reveal opinions about the drug situation and drug policy in Slovenia, about drug treatment in general and about SMT specifically. We interviewed selected stakeholders
representing different societal layers that are assumed to have an interest in and/or influence on (implementing) drug policy. These stakeholders involved political parties (representing different positions in the political spectrum), governmental bodies (directorates of the ministries involved and the police), non-governmental organisations (pro and con SMT), and the media (also representing different positions in the political spectrum). We succeeded in having interviews with five representatives from the media, four from governmental bodies, four from non-governmental organisations and three from political parties. These 16 interviews do not constitute a representative sample or a complete picture, but an impression of key aspects is nevertheless considered useful as additional information in this evaluation project. A representative sample of influential individuals and representatives of the most important institutions was not considered realistic within the context and scope of this study.

The interviewers were staff members of the Trimbos Institute, accompanied by staff members of the Faculty of Social Work of the University of Ljubljana. Interviews that had to be conducted in the Slovene language were performed by the Slovene team. The information from both context interviews and force field analysis was further used for an intermediate fine-tuning of the research questions and data collection.

**Assessing SMT quality**

Many examples of quality indicators for methadone maintenance programmes are present in the literature (Ärztekammer Westfalen-Lippe 2001, Ward et al. 1998, Health Care Inspectorate 2004, Health Council 2002). For assessing the quality of SMT in Slovenia we selected some core items of treatment quality from this literature and designed a questionnaire that focused on the following aspects:

- **Staff**: available staff and expertise, time spent on patient contact, the degree of professional education or training of staff and staff meetings.
- **Personal motivation, job satisfaction, and attitude towards patients**: relations with the patients, communication in the team, satisfaction with the direct management, and work pressures.
- **Treatment**: intake procedure, procedures of maintenance treatment, individually adjusted dosages, additional psychiatric, psycho-social or nursing interventions, treatment retention rates, measures to prevent leakage of substitution substances, presence and use of a registration system, patient complaints, patient registration system.
- **Accessibility of the centres**: working time, travelling time to the centre, involvement of general practitioners/pharmacies in medication dispensation, and waiting lists.
- **Monitoring and evaluation of the staff activities**.
- **Guidelines, protocols, and monitoring**: guidelines used, problems encountered with the guidelines, sufficiency of the content of these guidelines.
• Process management: existing arrangements concerning division of labour, regulation of patient privacy, financial management, management support.
• Cooperation with other organisations: specifically with general hospitals, PHCCs, psychiatric wards, pharmacies, high threshold NGOs, low threshold NGOs, centres for social work, prisons, self-help groups, and families.

The above items were assessed with a structured face-to-face interview in each SMTC, which took on average one hour. These interviews took place from 16 May until 30 July, 2007. In all 18 SMTCs the interviews were conducted with the head of the centre (in all cases a medical doctor) and with one staff member of the centre (in all cases a nurse). The interviews with the centre heads were generally carried out by representatives of the Trimbos Institute, but again only when the interviewees spoke English. Staff members were mainly interviewed by the representatives of the Faculty of Social Work of the University of Ljubljana, to avoid language problems.

In total, 37 interviews were conducted, 18 with medical doctors and 19 with nurses. In two (of the envisaged six) cases we succeeded in speaking to the directors of PHCCs. These talks were not formal interviews. The directors stated that not they but the heads of the SMTCs were the right people to address our questions to.

Assessing patient satisfaction
As patient satisfaction is an important indicator to assess treatment quality, interviews with patients in SMT were also part of the evaluation. We designed a structured patient satisfaction questionnaire covering the following items:
• Socio-demographic data of interviewees;
• Treatment issues (medication, dosage, dispensation modalities, counselling, perceived effects of SMT);
• Information about SMT (e.g. effects and side effects of different substitution medication, treatment “rules”);
• Treatment access issues (opening hours, distance to the SMTC, flexibility in dispensing methods);
• Additional services offered (e.g. social work, infectious disease counselling);
• Treatment conditions (e.g. privacy, organisation of SMT, attitude of personnel, premises);
• Recommendations by respondents on how SMT could be improved (open-ended question).

Patient satisfaction interviews were carried out in six selected centres (see Table 2 above and Table 3 below) and comprised 75 interviews altogether. The interviews took on average half an hour each and were carried out between May and June 2007. Patients were approached to participate while
they were visiting the centre to collect their medication. Most of the interviews were conducted in the morning (between 7:00 and 12:00 am). In some locations this meant that the first group of patients had already taken their medication, e.g. before they went to work (in some locations the opening hours were from 6:00 am). This may have induced a bias in the selection of the patients interviewed (leaving out some of the more stable patients). Nevertheless these interviews deliver a first insight into the satisfaction of problem heroin users in Slovenia with their substitution treatment regarding service quality, adaptation to individual needs, perception of support, clinic conditions, etc.

Table 3: Number of patient interviews per centre

<table>
<thead>
<tr>
<th>Location</th>
<th>No of interviews</th>
<th>No of SMT patients 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Logatec</td>
<td>11</td>
<td>107</td>
</tr>
<tr>
<td>2. Velenje</td>
<td>10</td>
<td>90</td>
</tr>
<tr>
<td>3. Nova Gorica</td>
<td>12</td>
<td>190</td>
</tr>
<tr>
<td>4. Ljubljana</td>
<td>16</td>
<td>538</td>
</tr>
<tr>
<td>5. Koper</td>
<td>14</td>
<td>204</td>
</tr>
<tr>
<td>6. Kočevje</td>
<td>12</td>
<td>65</td>
</tr>
<tr>
<td>Total:</td>
<td>75</td>
<td>1,194</td>
</tr>
</tbody>
</table>

Source for number of SMT patients 2005: ZZZS 2007a

Interviewers
The patient satisfaction interviews were carried out by eight (seven female, one male) interviewers. The interviewers were selected among students and graduate (ex-) students of the University of Ljubljana (Faculty of Social Work) during March 2007. They were trained by the research staff of the Faculty of Social Work in Ljubljana and an expert of the Trimbos Institute team during a one-day training course on 16 April, 2007.

Arrangements for the patient interviews
The interviewees were approached in the clinic after having received their daily dose. Creating a supportive environment for interviewing patients about SMT was assumed to be important. Thus in preparing for the interview, a peaceful and ‘safe’ place was arranged (a café or NGO around the corner) where patients could feel free to talk. The interviewers were further instructed to clearly inform the respondents about the aims (“to help improve the system of substitution treatment in Slovenia”), about the importance of also interviewing patients, and about the independence of this study (not driven by specific interests in the treatment, independent of staff/management of the centres, responses will remain anonymous and not be communicated to anybody not belonging to the research team).

Assessing efficiency of the SMTCs
To evaluate the efficiency of the SMT programmes, we designed a semi-structured questionnaire focusing on the following issues:
• Financial issues (budget received; budget spent for staff and medication, financial control)
• Management and organisation issues such as patient numbers (in SMT and other forms of treatment), staff (numbers, structure, availability, education, etc), average prescribed dosage per patient specified per substance, etc.

The data collection started in May 2007 with a letter sent to all SMTCs in which they were informed about the contents and scope of the evaluation and the visit of the interviewers to the SMTC for the quality and efficiency interview. This was meant to enable the SMTCs to prepare the answers in advance, so these could be handed over during the interviews that were held later. As SMTCs did not succeed in having all the requested data available at the time of the visit, they were asked to complete the questionnaire within 1-2 weeks after the interview.

**Comparison with reference countries**

For an assessment of the quality and the efficiency of SMT in one country, some reference standards are needed. Therefore, for a broader understanding of the findings and for explorative comparative statements about the quality or efficiency in Slovenia we included a basic description of SMT in four selected EU Member States.

We decided to select two new EU Member States, i.e. post-communist countries (Czech Republic and Lithuania) and two old EU Member States (Germany and The Netherlands). These countries were selected because they – like Slovenia – have a (relatively) long tradition and broad geographical coverage of SMT.

For data collecting we decided to interview key informants and to use existing documents. To facilitate comparison we developed a standardized questionnaire covering selected key questions from the quality and efficiency questionnaires developed earlier. The same questionnaire was used for guidance in analysing the documents. In each of the four countries we selected three key experts, i.e. one expert from the National Focal Point, one expert with extensive expertise and experience in harm reduction services, and one expert who has done research in the field of SMT in his/her country. These experts were interviewed by phone after they had received the questionnaire in advance.

**Statistical analyses**

The research design used in this project is a qualitative (explorative) evaluation. It is the first study trying to give an overview of the situation of
SMT in Slovenia. Furthermore, the analysis is focused on a limited number of centres (all 18 SMTCs in Slovenia) and many variables or characteristics. We thus restricted the statistical analyses to descriptive statistics, e.g. frequencies, means (and in case of a skewed distribution) medians, with minimum and maximum values. The data were stored in Excel and processed with SPSS software.

**Quality aspects of the data**

Because in some cases figures may be of low quality (e.g. missing data, invalid or inconsistent answers) and answers may be biased, questions from both questionnaires partly overlapped in order to enable comparison and unfolding inconsistencies (e.g. between the answers of medical doctors and nurses). In case of inconsistencies, further questioning (probing) started (by telephone or during the last interviews with several people working in the field). In addition, documents were checked in order to settle these differences.

**National Medical Ethics Committee**

The research proposal was presented to the Slovene National Medical Ethics Committee for approval. The Committee decided that our research is in line with its ethical requirements and confirmed by letter that it is in accordance with its mandates.
3. Context information

3.1 Background and organisation of SMT in Slovenia

Introduction

In this chapter we briefly summarise basic information on heroin use in Slovenia and the background environment and arrangements of SMT in Slovenia.

**Heroin use in Slovenia**

In Slovenia, it is estimated that there are about 7,500 problem drug users (poly drug use including opiates). The main drugs used by this group include heroin, alcohol, cannabis, benzodiazepines, and (more recently) cocaine. One gram of heroin costs around € 20-25. Heroin use is not restricted to cities and larger towns. Heroin users tend to stay in their community, i.e. also in smaller towns and villages. The most recent treatment demand data show that (in the outpatient treatment centres) the majority of patients are male (78% male against 22% female). The average age is 27.14 years; the youngest patient is 13 (female), the oldest 61 (male). Three quarters of the patients are younger than 30 years, 8.5% under 19 years. 90.5% of all patients look for treatment due to problem heroin use. Injecting is still quite a common route of administration as about half the patients (for all forms of problem drug use) inject.

**Substitution Maintenance Treatment**

The start of SMT in Slovenia can be traced back to the initiative of a doctor in Vojnik in 1988 who started to prescribe methadone to a number of problem heroin users. This initiative was stopped but was the start of a debate about SMT, fitting in with the growing attention and support for harm reduction measures. This resulted in 1994 in the start of a national SMT programme for problem heroin users under the final responsibility of the Ministry of Health.

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5 The most recent (published) data available are estimates for 2000 and 2001: the former 5.4/1,000 (total population), meaning 7,399 problem drug users and the latter 5.3/1,000 (total population), meaning 7,535 problem drug users. Problem drug users are defined as those with intravenous drug use (IDU) or long duration/regular use of opiates, cocaine or amphetamines, during a one-year period, in the age group 15-64. 2004 National Report (p. 29) and Grgič-Vitek 2004.

6 2005 National Report , p. 34

7 National guidelines for the treatment of problem heroin users, including methadone maintenance treatment, were adopted by the Health Council at the Ministry of Health in 1994 and methadone maintenance programme policies were confirmed (Kastelic and Kostnapfel-Rihtar 2000).
Since then the number of centres providing this treatment has increased. At the end of 2006, Slovenia had 18 SMT centres (officially called ‘Centres for the prevention and treatment of addiction to illegal drugs’) spread over 18 cities and towns. The SMT Centres (SMTCs) differ significantly from each other, e.g. in patient numbers (from 530 patients in Ljubljana to 50 patients in Ilirska Bistrica), staffing, size of the location, available services, cooperation with other services, prescribed medication and dosage level. In addition to these centres, a few general practitioners and pharmacists are involved in dispensing substitution medication (see chapter 5). This service has been developed in rural regions where travelling from smaller communities to the SMTC takes too much time. However, general practitioners or pharmacies are not prepared to get involved in SMT in all the cases where this option would be appropriate.

**Non-medication assisted treatment and care options**

In the early nineties the first non-medication assisted treatment facilities for problem heroin users were established. Today, a variety of psychiatric, psychological and social treatment options are available. Their primary aim is abstinence.

There is one detoxification centre, based in Ljubljana. Furthermore, spread over different regions in Slovenia, there are eight high threshold abstinence-oriented programmes, two therapeutic communities established by NGOs and 6 therapeutic communities based on Don Pierino’s approach and established by the Slovene Caritas. All therapeutic communities (TCs) receive funding from the Ministry of Labour, Family and Social Affairs and FIHO (Foundation for Financing of Organizations for the Handicapped and Humanitarian Organizations in the Republic of Slovenia, which is a lottery company) and some other sources. Some NGOs have programmes connected with TCs abroad and prepare their patients for entering those communities. There are also different NGOs specialized in harm reduction interventions. These NGOs are generally based in bigger cities with a substantial population of (problem) heroin users or a more prominent drug problem. The services offered include needle and syringe exchange, drop-in centres and outreach work. Also some self-help groups (Narcotics Anonymous) exist, e.g. in Centres for Social Work and in NGOs.

Besides the Ministry of Health the Ministry of Labour, Family and Social Affairs is an important funder for drug services in Slovenia, both low- and high-threshold programmes. In 2006 38 programmes (including seven drug prevention programmes) received € 1,278,208. This amount is representing 80% of the budget the programmes receive. They are obliged to find the remaining 20% from other sources.

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8 An aid organisation linked to the Roman Catholic church.
Table 4: Funding of drug programmes by Ministry of Labour, Family and Social Affairs

<table>
<thead>
<tr>
<th>Funding in €</th>
<th>High-threshold programmes</th>
<th>Low-threshold programmes</th>
<th>Programmes for relatives</th>
<th>Programmes for ex-users</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>872,679.79</td>
<td>384,930.93</td>
<td>18,093.62</td>
<td>2,503.75</td>
</tr>
</tbody>
</table>

Source: Nagode & Smolej 2007

From this € 1,278,208 high-threshold programmes received € 872,679.79, low-threshold programmes € 384,930.93, programmes for relatives € 2,503.75 and programmes for ex-users € 18,093.62 (Nagode & Smolej 2007).

In general the work of NGOs in the drugs field is not very well-documented. In order to get a grasp of the capacity and numbers of regular clients of NGOs working in the field of drug treatment, we decided to present data from two leading NGOs in Ljubljana, Project Človek and Društvo STIGMA, for which sufficient data and information are available.

Project Človek is a high threshold NGO that has 17 full-time staff, eight part-time staff, and about 20-25 volunteers; its number of core clients in 2006 was 459 (among whom 91 were abstinent persons and 118 problem drug users), and 341 others (mainly parents and relatives of clients). The budget Človek received was € 544,562. Društvo STIGMA, the leading low threshold NGO, has nine full-time staff, three part-time staff and 22 volunteers; in 2006 STIGMA reported 538 regular clients plus 437 irregular contacts via outreach.
work, work in prisons, and informative counselling. Društvo STIGMA received in 2006 a budget of € 125,731.9

Moreover, in 2006 the Ministry of Health provided funding of € 51,293 for safe injecting material (e.g. syringes, alcohol pads) and condom distribution.

It is not clear whether these treatment and care options meet all the needs of problem drug users. A number of them seek help abroad, especially in drug-free treatment facilities in Italy and Spain. Pressure from influential persons (parents, church, etc) may affect the decision to be treated in foreign TCs.

Organisational aspects of SMTCs

Responsibility
The final responsibility for the SMTCs in Slovenia is in the hands of the Ministry of Health. All other drug services and forms of drug treatment fall under the responsibility of the directorate of public health. For the coordination and professional support of the SMTCs a Coordination Committee has been installed, based on a requirement in the order ‘Prevention of the Use of Illicit Drugs and Dealing with Consumers of Illicit Drugs Act’ (Zakon o preprečevanju ... 1999).

Guidelines/protocols
In 1995 the Medical Council approved guidelines for methadone treatment describing the tasks and protocols (definition of obligatory tasks, treatment protocols, quality standards, etc.) were developed. The current revised version of these guidelines is an adaptation of the European Guidelines for Methadone of Euro-Methwork (Verster and Buning 2000). In 2005 the Coordination Committee developed guidelines for buprenorphine and slow-release morphine. All these guidelines put into effect by the Coordination Committee are currently being revised.

Supervision/monitoring/training
The Coordination Committee is also the responsible body for substitution treatment in Slovenia. It therefore has the task of controlling the adherence of the centres to the Guidelines and of providing professional support through supervision and training. For this purpose monthly meetings are organised for the heads of the SMTCs. The agenda of these monthly meetings covers a variety of issues including presentations and discussions on new developments, training, and discussions of exceptional treatment cases. Besides training at the monthly meetings there are some other training possibilities. For new staff, once or twice a year a basic course in drug treatment is organised. All the staff are obliged to be involved in training at

9 Source: Annual Reports of NGOs to the Ministry of Labour, Family and Social Affairs
least once per year. This training is conducted on a variety of issues by the NGO Sound of Reflection.

Furthermore, the Coordination Committee reflects on new developments in SMT. Finally, it is in control of assessing and authorizing exceptional individual treatment decisions. The Committee, however, is not responsible for the formal control and does not audit the work of the centres.

The formal control or audit is the responsibility of the Ministry of Health. The Medical Chamber of Slovenia is responsible for auditing the medical treatment provided for financial auditing Health Insurance Institute of Slovenia. According to the current law, auditing over the work of SMTCs is also in the hands of Supervisory Committee (Pravilnik o izvajanju ... 2000).

The latest supervision was carried out in 2003 (Dernovšek and Rogač Cvetko 2004). A Supervisory Commission consisting of 11 experts\textsuperscript{10} was installed to do the supervision. This commission was coordinated by the Ministry of Health. The supervision was accomplished through visits to the SMTCs and a questionnaire covering a variety of questions focusing on two areas, i.e. the financing and staffing structure and factors regarding the quality of the network of the SMTCs. These questionnaires were sent out to all the SMTCs. In 2000 a report about the SMTCs’ activities for the period 1995-2000 was written (Kastelic & Kostnapfel-Rihtar 2000). For 2002 a Work Programme for the Centres for Prevention and Treatment of Illicit Drug Use was published (Kostnapfel-Rihtar & Kastelic 2001).

\textbf{Financing}

SMT in Slovenia is financed by funds from the Health Insurance Institute of Slovenia (HIIS) and consists of two parts. The funding for the operational costs of the centres is separated from the financing of the medication. In 2006 € 2,226,772 was spent on substitution treatment programmes, i.e. \textsuperscript{10} Composition of the Supervisory Commission:

President of the Commission: Mojca Z. Dernovšek, MD, PhD, Assist. Prof., Health Protection Institute of RS

Members of the Supervisory Commission:

Jasna Čuk Rupnik, MD, Vice Representative of the Centres for the Prevention and Treatment of Addiction to Illegal Drugs

Andrej Kastelic, MD, Representative of the Co-ordination of the Centres for the Prevention and Treatment of Addiction to Illegal Drugs

Dean Klančič, MDA, Representative of the Expanded Expert Collegium for Family Medicine

Marga Kocmur, MD, PhD, Assist. Prof., Representative of the Expanded Expert Collegium for Psychiatry

Miha Kovač, MD, PhD, Representative of the Expanded Expert Collegium for Family Medicine

Milan Krek, MDA, Office of the Government of RS for Drugs

Lidiija Kristančič, BA in Org. Sc., Ministry of Health of RS

Mercedes Lovrečič, MD, Health Protection Institute of RS

Vesna Kerstin Petrič, MD, Ministry of Health of RS

Dušica Pleterski Rigler, MD, Head Physician, Representative of the Medical Chamber of Slovenia

Cvetka Rogač Cvetko, BA in Econ., Ministry of Health of RS
salaries and other organizational costs for SMT and € 2,735,012 on medication (ZZZS 2007b).

Based on the total number of patients in all the SMTCs during one year, the following year’s budget for the SMTCs is established in a three-party discussion (the Ministry of Health, the HIIS, and the service providers, i.e. the Coordination Committee of the SMTCs). In this three-party discussion is also decided whether the SMTCs or new forms of SMT will receive funding. The HIIS has no real, independent influence on the decisions taken. It is, in fact, an executive body responsible for implementing the decisions taken by the Ministry of Health.

The individual SMTCs get their share of this total budget according to their case-load in the preceding year. This case-load includes all patients, i.e. not only the patients receiving SMT but also patients who receive other forms of treatment (see below under treatment). For the calculation of the numbers of patients per centre patients receiving SMT are counted as 100%, patients in other forms of treatment as 50%.

The budget SMTCs receive is a lump sum funding. However, it is up to the head of the centre or, because the SMTCs are part of the PHCCs, up to the director of the PHCC to decide how to spend the funding for the SMTC.

The costs of the substitution medication (methadone, buprenorphine, slow-release morphine) are covered by the HIIS, based on the prescriptions per patient.11

SMTCs are obliged to send a financial report twice a year to the HIIS. However, as the centres are part of the PHCCs, these financial reports are included as a paragraph in the reports of the PHCCs.

**Staff**

The number of staff in a SMTC is based on the (previous year’s) caseload of the centre. In the Sector Agreement for Primary Health Care Centres and Private Medical Care for the year 2004 (ZZZS 2004) the following staff norm was defined per 100 patients: 0.52 FTE general practitioner; 0.58 FTE bachelor degree nurse; 0.15 FTE psychiatrist; 0.15 FTE psychologist; 0.23 FTE laboratory analyst; and 0.28 FTE administrative worker, adding up to 1.91 FTE staff per 100 patients. The medical doctor of a SMTC is usually also the head of the centre. The general shortage of medical doctors in Slovenia is

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11 On average the price of (liquid) methadone per 100 ml is € 22.5 (+ 8.5 % tax) (Krka and Alkaloid), Bbuprenorphine (Subutex) costs € 22.71 (+ 8.5 tax) for 28x2 mg tablets and € 81.81 (+ 8.5% tax) for 28x8 mg tablets. Substitol, the brand name of slow-release morphine prescribed in Slovenia, costs €49.23 (+ 8.5 % tax) for 30x120 mg tablets and € 80.43 (+8.5 tax) for 30x200 mg tablets. Personal communication with representative of Kemofarmacija d.d., Ljubljana (www.kemfarm.si/si)
also a problem for the centres. It is difficult to find doctors for the work in SMTCs, also because working in drug treatment has a low status. This is also true for other professions involved in the work of SMTCs.

Social work is not included in the funding for the SMTCs. Nevertheless, in some centres social workers are included in the staff. In some cities or towns the Centres for Social Work offer their services to the SMTCs patients. There are around 60 Centres for Social Work in Slovenia, of which 20 work with drug users.

**Patients**

In the supervision report of 2003, 2,385 patients were registered within the centres (Dernovšek and Rogač Cvetko 2004). The last official count of the HIIS from the end of 2005 shows that 3,633 patients were registered in the SMTCs. 2,411 of the total received SMT, 1,222 patients attended the centres for other sorts of treatment and care, such as counselling (ZZZS 2007b). On 31 October 2006 the total number of patients in SMTCs was 4,419, of which 2,689 were in SMT.\(^{12}\)

Based on the above-mentioned estimate of 7,500 problem drug users in Slovenia, this would mean that slightly fewer than half (3,633) of the problem drug users are registered at the centres, and about one third of all problem drug users (2,411 of the estimated 7,500) receive SMT. This means that within the EU Slovenia has a relatively high national coverage of SMT (Van der Gouwe et al. 2006).

**Cooperation of methadone centres with other organizations**

SMTCs generally cooperate with other centres or with NGOs or Centres for Social Work. There is cooperation with the PHCCs with regards to diagnosis and the treatment of infectious diseases, and cooperation with the Centres for Social Work, etc. However, the form and intensity of this cooperation varies from centre to centre. Different factors play a role here, such as the local availability of relevant services.

**Treatment**

**Prescribed substitution substances**

In Slovene SMTCs three substitution substances are prescribed, methadone, buprenorphine and slow-release morphine. Methadone is generally prescribed in liquid form, but in exceptional cases some centres prescribe tablets. These cases have to be presented to the Coordination Committee. Methadone tablets from Croatia are available on the black market – in South Slovenia. In 2006, 81% of the patients in SMT received methadone. Since 2005

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\(^{12}\) Personal communication with Dr. Kastelic
Buprenorphine has also been prescribed (in tablet form), taken by 13% of the patients in SMT in 2006. This number is growing. Newly registered, young patients in particular receive buprenorphine. Finally, since 2005, slow-release morphine tablets have also been prescribed, taken by about 6% of the patients in SMT. 

In addition to treatment with opiate agonists (see chapter 1), some patients receive – after detoxification – antagonist treatment with Naltrexone. Although in principle the above-mentioned four medications are available in all 18 centres, some centres are more experienced with specific forms of medication than others (e.g. Naltrexone is mainly used in two SMTCs). This year (2007) a mixture of buprenorphine and naloxone will also become available for prescription in SMTCs.

Besides receiving substitution medication, quite a number of patients are reported to receive benzodiazepines, not only through the SMTCs but also through general practitioners and other doctors.

**Access to treatment**

Access to SMT is relatively easy, although the intake procedure in some centres may take up to two weeks. The reason for this is that intakes should be carried out by a medical doctor and they are not available every day in most of the SMTCs because they work part-time. The criteria for accessing SMT are largely based upon the Euro-Methwork Guidelines. The questionnaire of the Treatment Demand Indicator developed by the EMCDDA is used at the intake of new patients to collect information on the patient’s situation. There are differences between the SMTCs with regard to the diagnostic instruments used. There is no general agreement on the way to assess the health and social situation of the patients.

In general, the minimum age for starting methadone substitution treatment is 16 years and for buprenorphine substitution treatment 15 years. However, in specific cases the medical doctor or psychiatrist may decide differently. In some centres people below the age of 15 or 16 years receive SMT. These exceptions have to be reported to the Coordination Committee.

At the start of a new substitution treatment an agreement (treatment plan) is signed between the medical doctor and the patient. This agreement includes the conditions under which treatment is given and some general rules and regulations (e.g. code of conduct, mutual respect, etc).

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13 Personal communication with Dr. Kastelic
**Prescription of medication**

Medical doctors prescribe the substitution medication. They have the final responsibility for choosing the appropriate substitution substance, defining the dosage for each patient and deciding on the frequency of picking up the medication. Medical doctors are also responsible for the intakes of new patients. As medical doctors in the SMTCs usually work part-time, the nurse is also authorized to dispense the medication. This is actually the general practice.

Whether a patient has to pick up his medication on a daily basis or receives take-home dosages depends on a number of factors such as: the estimated general behavioural characteristics of the client; the use of other non-prescribed substances besides methadone (mostly heroin); and patients’ obligations such as work or study during the centre’s opening hours. The rules for giving take-home dosages differ between SMTCs. The number of staff available and the motivation of the staff play a role here, too. Take-home dosages are generally a bonus that patients can get by showing good and stable behaviour. In general, the policy on take-home dosages is flexible. For instance, in the case of holidays, patients can receive the medication for up to two weeks. Usually the maximum of take-home medication is one week.

In general, patients have to pick up their medication at a SMTC. In Zalec, a town in the surroundings of Velenje, stable patients can pick up their medication daily at the local NGO. The NGO receives the medication from the SMTC in Velenje. In some other towns and villages general practitioners and pharmacies are also involved in the distribution of the medication. This is generally the case in remote areas where the journey from the place of residence to the SMTC takes a long time. The intake takes place at the SMTC, and then the general practitioner or local pharmacy carries out the dispensing. Patients have regular contacts with the SMTC about the development of the maintenance treatment. In the case of pharmacies, the prescription is issued at the centre and the medication (including daily dosages) is picked up at the pharmacy.

**Target and dosages**

The methadone, buprenorphine and slow-release morphine dosage prescribed varies widely between the centres. Dosages higher than the pre-defined maximum values are possible but need (by law) to be presented (with proper argumentation) to and approved by the psychiatrist. Like other exceptional treatments, these have to be reported to the Coordination Committee and are generally the subject of a case discussion at the monthly meetings.
Other services rendered
SMTCs offer not only SMT, but also other forms of treatment, including psychosocial support to patients, social activities, or working with patients’ parents (in groups or individually).\textsuperscript{14}

There are substantial differences between the SMTCs with regards to the services and treatment offered. Some small centres in rural areas have little more than just SMT. But there are also centres where the majority of patients receive other treatment than SMT, e.g. in Nova Gorica, where in 2006 only 145 patients out of the total of 626 were reported to receive SMT. Other forms of treatment offered include counselling and psychotherapy, not only for problem heroin users but also for their parents. The SMTC in Nova Gorica employs a psychotherapist for this work.

SMTCs offer patients a number of services concerning drug-related infectious diseases. Patients have the possibility of being tested for these infectious diseases, sometimes at the centre itself, sometimes at the PHCC. This includes screening for Hepatitis B, C and HIV. Vaccination against Hepatitis B and treatment of infectious diseases is also offered through the centres. For instance, some centres provide alfa-interferon to treat patients infected with the Hepatitis C virus. This also applies to active drug users.

Abuse of medically prescribed (substitution) medication
There are strict regulations in place to avoid abuse of the substitution medication by patients who try to get ‘double’ medication (by ‘shopping’ at multiple SMTCs) or who sell the prescribed substances.

Although this is difficult to substantiate, ‘double’ substitution medication may be quite rare. However, patients of SMTCs receive medication not only from the centres but also from other doctors. This is true for benzodiazepines, for instance.

Diversion of methadone dispensed by the SMTCs to the black market is reported by staff, patients and other sources. It is also reported that

\textsuperscript{14} Other forms of treatment and services offered at the SMTCs:
- psycho-social counselling from nurses, psychologists and/or social workers;
- psycho-social support from nurses, psychologists and/or social workers;
- psychiatric treatment;
- information about infectious diseases from nurses and/or doctors;
- prevention of overdose through information from nurses;
- post-detox treatment with naltrexone;
- support groups for parents and patients guided by nurses and/or psychologist and/or social worker;
- individual work with specific groups (pregnant women, ex-inmates, young drug users, young mothers and mothers with under-aged children, patients with a dual diagnosis) by doctors and/or nurses and/or psychiatrist and/or psychologists and/or social workers.
methadone tablets purchased in Croatia are sold on the black market. SMTCs undertake different measures to prevent leakage, e.g. measures to make sure that patients swallow the medication; urine control in the case of take-home dosages; the return of empty bottles with the right label and a prohibition on selling methadone to other persons.
3.2 SMT: Rationale, aims and evidence for (cost-) effectiveness

Rationale and aims of SMT

Heroin is an opiate with high addictive properties. Use of heroin may easily develop into problematic use. When several criteria are met, problematic use can be classified as a psychiatric disorder (dependence or abuse, according to the official criteria of the American Association of Psychiatry, formulated in the Diagnostic Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association 2000). Usually heroin dependence is difficult to cure and most patients become chronic patients.

Substitution treatment for problem heroin users is a form of medical care using another substance with properties and actions similar to heroin. Sometimes even the same substance (heroin) is used as in the controlled medically controlled heroin prescription programmes in Switzerland, the Netherlands, Spain and Germany. This type of substitution substance is called an agonist. Using agonists as substitution substances facilitates a more controllable form of addiction. Using these substances alleviates withdrawal symptoms generally experienced by problem heroin users and reduces the health and social risks related to problem heroin use. When given in the right dosage it also reduces the craving for opiates.

There are different opiate agonists. Methadone is the most widely used one in the treatment of problem heroin users. Other opiate agonists used in the substitution treatment of heroin addicts are slow-release morphine and codeine. Nowadays buprenorphine is also more frequently used. This substance is a mixed agonist-antagonist medication and not a pure but a partial opiate agonist. An antagonist is a blocking agent which occupies the same receptors in the brain as heroin (or other opiates) but is not addictive. When someone takes an antagonist, the opiate receptors in the brain are occupied, meaning that taking (additional) heroin (or another opiate) does not have the usual and desired mood-altering effect.

Pure antagonists are also used in the treatment of problem heroin users. Naltrexone, for instance, is used in various countries as an alternative to substitution maintenance treatment (SMT), generally preceded by a detoxification programme to overcome withdrawal from heroin. Naltrexone is also used as relapse prevention for patients leaving drug-free treatment programmes and re-entering the community. Another opiate antagonist, Naloxone, is used as a remedy in case of a heroin overdose.

Substitution treatment can serve several purposes. Initially it was introduced as the start of abstinence-oriented treatment of mainly problem heroin users.
This was – and still is – undertaken by using a scheme of reducing step by step the daily dosage of an agonist, generally methadone. Nowadays it is still widely used in detoxification schemes, frequently as the starting point for long-term (in-patient) therapy or rehabilitation programmes.

Later (in Europe from the late seventies on) also substitution maintenance programmes were developed, starting with methadone as the most generally used agonist. In the early years the primary aim of prescribing methadone as maintenance treatment was to provide a total substitute for (and thus stop) heroin use. Methadone maintenance was seen as the first step to becoming drug-free in the long run, i.e. also stopping the use of methadone. This abstinence-oriented aim was then debated as experiences with substitution drugs – especially methadone – in many countries showed that abstinence first from heroin and then also from methadone appeared to be an over-optimistic goal for most problem heroin users. Thus long-term SMT programmes began to develop with broader aims than just addressing the addiction problem. This long-term SMT has proved to be more effective than shorter-term treatment or detoxification. This also reflects the frequently chronic nature of heroin addiction for most problem heroin users. Many patients appeared to require treatment for an indefinite period of time.

Experiences with SMT made clear that its value “lies in the opportunity it provides for dependent drug users to reduce their exposure to risk behaviours and to stabilise their lives in health and social terms. Substitution treatment is generally considered for dependent users who find it difficult to stop their drug use and achieve complete withdrawal. (…) Furthermore, the substitution of prescribed medication for an illicit drug helps in reducing criminal activity by supporting the process of lifestyle change.” (Verster & Buning 2003)

The aims of SMT are:

- To assist the patient to remain healthy until, with the appropriate care and support, they can achieve a life free of illicit drugs;
- To reduce the use of illicit or non-prescribed drugs by the individual;
- To deal with problems related to drug misuse;
- To reduce the dangers associated with drug misuse, particularly the risk of death by overdose and of HIV, hepatitis B & C, and other blood-borne infections from injecting and sharing injecting paraphernalia;
- To reduce the duration of episodes of drug misuse;
- To reduce the chances of future relapse to drug misuse;
- To reduce the need for criminal activity to finance drug misuse;
- To stabilise the patient where appropriate on a substitute medication to alleviate withdrawal symptoms;
- To improve participation in other medical care;
- To improve overall personal, social and family functioning.
“These goals are achieved almost from day one of treatment for many patients. Substitution treatment can be compared to other drugs that are effective in treating serious chronic conditions such as hypertension and diabetes. These conditions, like opiate dependence, are chronic, require daily treatment, and have a high risk of adverse effects if treatment is stopped.” (Verster & Buning 2003)

**Evidence for effectiveness**

For more than a decade it has become a standard procedure to assess the amount of available evidence for the effectiveness of medical and other interventions for specific target groups. Considerable consensus has been reached on methods for determining and grading the available scientific evidence for effectiveness based on meta-analyses, systematic reviews and primary studies. Methadone for SMT is the most frequently studied substance in addiction research (Krambeer et al., 2001). Buprenorphine has been studied in more recent years and is far less frequently evaluated but now this delay is being compensated for substantially. Nowadays a combination of buprenorphine and naloxone is also being studied and there seem to be less side-effects.

To avoid misunderstanding, it should be clear that the judgment “effective” for a specific substitution substance presents *significant but average* results. Of course, not all drug users will show the same results. When the available literature on long-term substitution treatment is consulted, many advantageous effects are seen to be present although not for every client nor for every treatment goal.

**Effects of substitution substances**

The scientific literature shows that, on average, both methadone and buprenorphine have many favourable effects (see below) when used as a long-term substitution treatment for problem opiate users. Buprenorphine maintenance treatment has fewer side effects and a longer half-life time, thus delaying possible withdrawal symptoms when refraining from opiate use. It is increasingly considered a qualified alternative substitution substance when – for whatever reason – SMT patients prefer buprenorphine or do not tolerate methadone very well (Davids & Gastpar, 2004). Less research has been done on slow-release morphine. This substance was evaluated in the Netherlands and elsewhere in former decades (e.g. Derks, 1990) but these studies were not persuasive in showing advantageous effects (Van Gageldonk et al., 1996). However, more recent studies tend to show that its effects on patients are comparable with those of methadone and buprenorphine. The most convincing study to date showed no differences in opiate use and treatment.
retention between methadone and slow-release morphine patients. But slow-release morphine patients had significantly fewer mental disorder symptoms and fewer physical complaints (Eder et al., 2005). Other studies were less convincing due to the low quality of the research design (cf. Mitchell et al., 2004; Vasilev et al., 2006). So there are some indications that slow-release morphine can be a good alternative to methadone for some patients.

The material in the following two paragraphs (‘effects’ and ‘effective treatment’) is based on scientific evidence from meta-analyses, systematic reviews and high-quality primary studies.

**Effects of SMT**

**Reduction of opiate use and risk of infectious diseases**

On average, SMT with methadone and buprenorphine reduces illicit opiate use. According to a German study the decline in illicit use of opioids is related to the duration of participation in treatment. After one year in SMT, urine analysis shows a decrease in heroin use of 80 to 90%. Staying in SMT for a longer period of time also strongly tends to result in a decline in, or termination of, the additional use of other psychotropic substances (Michels, Stöver, Gerlach, 2007).

SMT with methadone and buprenorphine also reduces risk behaviours related to HIV transmission (e.g. injecting drug use or needle sharing). Although we still lack the evidence, these favourable results can also be expected for risk behaviours related to the transmission of other infectious diseases like Hepatitis C. Substitution treatment with both substances thus also reduces both individual health risks and public health risks (Gowing et al., 2004; 2006).

Recent reviews of SMT show outcomes indirectly related to a reduction of HIV/AIDS (Gowing et al., 2004; 2006). Twenty-eight studies, the majority dealing with high-threshold methadone maintenance programmes, showed that methadone maintenance treatment is effective in reducing injecting drug use and needle sharing. Four studies of varying quality, which also reported rates of HIV seroconversion, showed lower rates associated with substitution treatment, indicating that reductions in risk behaviours possibly result in reductions of HIV infections. New studies are needed to determine if these results are also valid for low-threshold substitution treatment.

**Prevention of overdose death**

Methadone and buprenorphine substitution treatment may reduce the number of overdose deaths, but for this outcome the evidence is less strong (Caplehorn et al., 1996; Brugal et al., 2005, see Farrell et al.).
**Reduction of drug related criminality**
Methadone is probably less effective in reducing drug-related criminality (Mattick et al., 2003).

**Factors influencing effectiveness**

**Dosage**
Higher doses of methadone that are clinically adapted to the individual patient (more than 60 mg per day) are in general more effective than lower doses (Faggiano et al., 2003). For buprenorphine dosages between 12 and 24 mg/day are indicated.

**Increase of effectiveness by psycho-social care and support**
On average the effectiveness of methadone is increased by adding psycho-social support or counselling to substitution treatment (Amato et al., 2004; Farrell et al., 2005). It is defensible from daily experience, but not yet supported by evidence, that supportive nursing interventions (caring for wounds, abscesses, etc.) during substitution treatment is more beneficial than merely distributing the substitution drug (Hunt et al., 2005).

**Methadone vs. buprenorphine**
The choice of methadone (an agonist) or buprenorphine (partly agonist and antagonist) as a substitution substance in maintenance treatment is often dependent on several factors, e.g. buprenorphine is much more expensive than methadone, and buprenorphine may be a more appropriate substitution drug when the client is motivated to give up heroin use. High quality studies that compare the cost-effectiveness studies of both substances could not be found. The choice between the two should therefore be made based on proper information about both substitution substances (there are still many myths about these drugs), adequate training of professionals for administering these drugs and their availability and costs.

**Cost-effectiveness of SMT**
There are no scientifically valid methods yet to summarise cost-effectiveness studies, and costs and effects may differ per country or region. Consequently, there is still much uncertainty about the generalizability of the outcomes of these studies. Moreover, the methods differ from fairly simple comparisons and weightings of costs against the effects to fairly complex methods using outcomes like Quality Adjusted Life Years (QALYs) and methods like bootstrap analyses, a cost-effectiveness plain and cost-effectiveness acceptability curves.
Many authors use the term “economic evaluation” for presenting the less complex types of studies. Here we present some illustrative studies that all indicate that substitution treatment is most probably a cost-effective treatment for problem opiate users compared to no treatment.

Studies from the US and the UK already gave some insight into the feasible cost savings that may be apparent for SMT (Gossop et al., 1998; Nordlund et al., 2004). These savings may primarily be caused by reductions in criminality, in police arrests, in imprisonments, victim costs, hospital admissions and the use of other (mental) health care services. Many cost-evaluation studies have since been published with a large diversity of methods.

The results of the most recent review of cost-effectiveness are equal to older systematic reviews, namely, that both flexible-dose methadone and buprenorphine are more effective (increased retention in SMT and reduced opiate use) than no medication, although methadone may increase staying in treatment somewhat longer than buprenorphine, resulting in a slightly higher health gain and lower costs in the long run. The authors suggest balancing this conclusion with the higher mortality risk of methadone, with the individual preferences of problem heroin users themselves, and with the possible interactions of substitution drugs with other medication and poly-drug use (Connock et al., 2007).

These studies indicate that there may be several (cost-)effective possibilities for treating problem heroin users, depending on the desirable outcomes and the costs that are included. Furthermore, it should be noted that costs and cost savings may differ between countries e.g. because of local arrangements and possibilities.
3.3 The force field around SMT in Slovenia

Introduction

SMT is a controversial, highly politicised issue in Slovenia, as it also is in some other European countries. For a number of stakeholders the prescription of substitution medication to problem heroin users appears to be a questionable service, while others have no objections to or support this treatment. There are two main themes in the dispute. One is an ideological disagreement which can be roughly expressed as an abstinence-oriented and a harm reduction-oriented view on the treatment of problem heroin use. In the first view, the only legitimate aim of drug treatment is abstinence. Substitution treatment is thus not really considered as a treatment but rather as maintaining addiction by providing another drug. In the second view, SMT is a necessary option for problem drug users who for whatever reason cannot or do not stop using heroin. SMT reduces further risk behaviour and health damage associated with the use of illicit drugs and offers perspectives for both stabilising and improving the patients’ health and psycho-social functioning.

The second theme in the dispute is a financial one. Is it worth spending so much money on SMT? Of course both themes are intertwined. People who doubt the value of SMT or are against it will obviously also have serious doubts about (governmental) financing of SMT, especially because SMT requires substantial funding.

From the very beginning of the project we were regularly confronted with this controversy. Statements and remarks by stakeholders in informal discussions made it clear that the evaluation of SMT could be perceived as either useful element or a threatening one in this controversy. Some people involved in SMT feared that the evaluation was meant or could be used for finding arguments legitimizing budget cuts for the SMT programme in Slovenia. Especially when the government is not in favour of SMT. From opponents of SMT we received clear signals that the evaluation was indeed expected to deliver these arguments. This resulted in distrust of the evaluation from both parties. On the one hand, we were seen as a possible accomplice of the government and on the other, there was fear that an institute from the Netherlands would simply deliver ideological support to the SMT programme in Slovenia because of the long tradition of SMT in that country.

Therefore we decided to include in this evaluation a basic analysis of the force field in which SMT operates in Slovenia. This analysis gives an impression of the different forces and interests influencing the policy and practice of SMT in Slovenia.
Results

From the interviews, three main perspectives on SMT can be established: the political-ideological, the professional, and the (political) power perspectives. It should be noted that these three perspectives are interconnected.

The political-ideological perspective
The differentiation between – at one end of the political spectrum – conservative and – at the other end – liberal or progressive politics is no longer clear-cut. In spite of this it still applies to some issues, including the approach to the drugs problem. Conservative political parties are generally not in favour of or are more doubtful regarding a harm reduction approach (including SMT), while liberal or progressive parties – again in general – have a more positive attitude towards harm reduction interventions. Our interviews (and observations from informal talks with stakeholders) show that this is also the case in Slovenia. By a number of respondents it was noted that the present government in Slovenia is not supporting or even against SMT.

The professional perspective
The different professions involved in drug treatment have different views on SMT. This is particularly true when comparing medical professionals (medical doctors or psychiatrists) with ‘psycho-social’ professionals (e.g. sociologists, psychologists, social workers). From the medical perspective, problem drug use is mainly viewed as a (psychiatric) disorder for which medically assisted treatment is important. SMT is therefore seen as primarily belonging to the medical domain. From the psycho-social viewpoint, the focus is primarily on the patient’s psychological health or well-being and on psycho-social functioning, i.e. on the individual and on his/her social environment. This perspective also (or more explicitly) targets societal issues, e.g. the reduction of public nuisance or drug-related criminality. It also partly includes public health issues such as prevention of infectious diseases. The latter includes interventions aiming at behaviour change which are based on educational and psychological expertise.

Health is still primarily a medical concept in Slovenia, though health involves much more than medical aspects, e.g. psycho-social well-functioning and self-perceived well-being.

Due to the higher status and self-esteem of the medical profession (compared with the ‘psycho-social’ professions) and the medical nature of substitution treatment, the medical viewpoint is dominant in SMT in Slovenia. This means that the psycho-social components of medically assisted treatment such as SMT are not fully appreciated. The effect of these ‘two worlds’ is that the present-day often cited bio-psycho-social nature of problem drug use is therefore not fully acknowledged.
The (political) power perspective

The political power perspective overlaps the two above. It concerns the power attributed to persons or organisations to influence SMT in Slovenia, e.g. the ability to raise and maintain funds and to influence political decision-making. Different stakeholders stated that in Slovenia (political) power, i.e. factual influence on political decision-making, depends considerably on personal relationships rather than on a decision-making process following formal rules and regulations. This implies that decisions are – at least partly – taken ‘behind the curtain’.

The Ministry of Health has the formal political responsibility for SMT programmes and several other drug demand reduction issues. Several other ministries are responsible for other parts of drug policy, e.g. the Ministry of Labour, Family and Social Affairs for social work, the Ministry of Education for drug prevention in schools, and the Ministry of Internal Affairs for a substantial part of drug supply reduction issues.

A so-called Drug Commission, an inter-ministerial committee\(^1\), is supposed to bring together the separate ministerial parties in order to coordinate drug policy by reaching consensus on and formulating a coherent drug demand reduction policy. This would, of course, include SMT as one of the different drug treatment options. Many interviewed stakeholders, however, think that in reality these Ministries do not cooperate, or at least not sufficiently, in the field of drug policy. There is no real inter-ministerial consensus on drug demand reduction policy partly because the Drug Commission does not meet on a regular basis. Some stakeholders suggested that a formally installed and independent committee could improve this inter-ministerial cooperation.

With regards to drug treatment there seem to be two main groups, which are roughly divided along the line described above. One is abstinence-oriented and the other is a harm reduction-oriented group. A group of medical doctors, psychiatrists and some researchers who play a leading role in SMT have been named as important players in the harm reduction group (supporting SMT). Other stakeholders such as politicians from progressive or liberal parties, heads of SMTCs and representatives of other harm reduction services are seen as less influential at the moment. Finally, the manufacturers of substitution substances, the pharmaceutical industry, are also mentioned as having some influence in this field.

Important players in the abstinence-oriented group are conservative politicians, religious organisations and drug-free therapeutic communities.

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Overall remarks

The interviews also made clear that SMT is not an issue which really plays a role in (public) political debate. The political parties do not have a clearly formulated stance pro or con. However, different stakeholders referred to disapproving remarks about SMT made by conservative politicians as just maintaining addiction and being too expensive.

Also in the media SMT is not really an issue. Recently there has been hardly any media coverage, while on the other hand there appears to be quite some attention paid to the approach of drug-free communities. In early summer 2007 there have been two international conferences in Ljubljana, i.e. the 11th E.F.T.C. European Conference on Rehabilitation and Drug Policy, 6 - 9 June 2007 and The First World Conference on Medication Assisted Treatment of Opiate Addiction, 1 - 3 July 2007. The first was well covered in the media. The second conference got less media coverage. Assuming that the media in general cover issues that attract attention or that are in line with public opinion, this can be seen as support for the idea that public opinion – followed and supported by the media – is more in favour of abstinence-oriented treatment. This is well in line with statements of different stakeholders that SMT of course is important but that abstinence-oriented treatment is the only real way out.

It is noteworthy that scientific evidence on the effectiveness of both treatment options has almost no bearing on the coverage of drug treatment in the public domain.
4. Quality of SMT

4.1 Staff view on quality issues of the SMT programmes

The centres have been analysed together. Categories have been created to compare small and large centres (definition used: small centres reported fewer than 100 patients in SMT in 2005, according to the latest available official data in ZZZS 2007a\(^{16}\)). Also differences in the answers of the medical and the nursing staff are compared. The figures in brackets in the following text show the number of respondents answering a specific question. We mention the names of the centres when questions refer to management or organisational issues. When questions concern personal judgement of staff we present the number of the different answers given.

**Staff – availability and expertise**

**Table 5:** Professions available at SMTCs

<table>
<thead>
<tr>
<th>Professions</th>
<th>Available in # SMTCs (n=18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical doctor</td>
<td>18</td>
</tr>
<tr>
<td>Nurse</td>
<td>18</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>17</td>
</tr>
<tr>
<td>Psychologists</td>
<td>11</td>
</tr>
<tr>
<td>Social workers</td>
<td>2</td>
</tr>
<tr>
<td>Laboratory staff</td>
<td>2</td>
</tr>
</tbody>
</table>

In all SMTCs a medical doctor is available. In 12 centres the general medical tasks are done by general practitioners, in two centres these are done by a psychiatrist, in two centres by a specialist in school medicine, in one by a paediatrician and in one by a doctor of social medicine. Three large centres (Kranj, Ljubljana, Trbovlje) employ a general practitioner for more than one FTE. However, in three other large centres (Celje, Murska Sobota, Nova Gorica), the general practitioners are available less than fulltime. There is one large centre (Koper) where the medical tasks are carried out by a psychiatrist and a doctor of social medicine. Still, both the head of staff and the interviewed nurse consider the staff in this centre to be insufficient to cover the needs of the patients, but it is not clear whether this is due to the absence of a general practitioner or to other factors. In smaller SMTCs medical doctors are employed part-time. For instance the SMTC in Murska Sobota, one of the smaller centres, employs a general practitioner who has

\(^{16}\) Small centres are: Brežice, Ilirska Bistrica, Izola, Kočevje, Murska Sobota, Novo Mesto, Pivka, Sežana, Velenje. Big centres are: Celje, Koper, Kranj, Ljubljana, Logatec, Maribor, Nova Gorica, Piran, Trbovlje
only a few hours available for consultation (less than half a day per week). Only one SMTC (Murska Sobota) does not have a psychiatrist employed.

In all the centres specific expertise in pharmacology and infectious diseases is limited, regardless of the size of the centre. Expertise in infectious diseases is available at the Primary Health Care Centres.

Psychologists are reported to be available in 11 centres. Six SMTCS (Ilirska Bistrica, Logatec, Maribor, Murska Sobota) report that they do not have a psychologist, including two of the big centres, Trbovlje and Koper. The hours that psychologists are available for patient contact range from one to 40 hours per week, with the median being eight hours. In two small centres (Brežice, Izola) psychologists are available less than 10 hours, with 1 exception (Pivka), where 20 hours are available. In the majority of large centres, psychologists work more than half-time. There are two exceptions to this, Kranj and Piran, where psychologists are available for patient consultation for less than eight hours. These eight hours does not represent the actual number of working hours. Besides the number of hours the psychologist has available for patient consultation, he has other tasks, including client registration and treatment plan development, and occasional adjustments of these plans. Ten centres report having counselling expertise available (Brežice, Izola, Koper, Kranj, Maribor, Nova Gorica, Piran, Pivka, Trbovlje and Velenje). On the other hand, 17 of the centres (all except Ilirska Bistrica) report that they provide counselling, but this is done by the general practitioner or the nurse.

Nurses are available in all the SMTCs. Most of the large centres employ more than one nurse, and the majority of them work full-time. However, in several cases (Kranj, Murska Sobota, Nova Gorica, Velenje) these nurses were not fully available for the work in the SMTC. Furthermore, the level of education of those nurses employed was in some centres (Kranj, Murska Sobota, Velenje) not bachelor degree level17 as required in the 2004 Sector Agreement for Primary Health Care Centres and Private Medical Care (ZZZS 2004). In several of the larger centres with only one permanent nurse (Celje, Novo Mesto, Sežana) there is another nurse available from the health care centre to substitute in the case of holidays or illness.

Only in Maribor and Trbovlje are social workers employed in the SMTC, in Maribor full-time and in Trbovlje 1/3 full-time equivalent. Some other centres send patients to a local NGO and the Centre for Social Work for social assistance.

17 In Slovenia nursing education is divided into two levels: the lower level is the basic professional education level, and the higher level is the batchelor degree level.
Laboratory personnel are employed in two centres, while in others laboratory tests are performed as part of the work of the PHCC.

Table 6: Available staff sufficient to meet needs of patients

<table>
<thead>
<tr>
<th>Available Staff is sufficient to meet the needs of patients</th>
<th># SMTCs (n=18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sufficient</td>
<td>4</td>
</tr>
<tr>
<td>Insufficient</td>
<td>7</td>
</tr>
<tr>
<td>Disagreement between MD and nurse</td>
<td>7</td>
</tr>
</tbody>
</table>

The availability of staff is reported to be sufficient to cover the needs of the patients in four centres (Celje, Ljubljana, Nova Gorica, Pivka), insufficient in seven (Koper, Logatec, Murska Sobota, Novo Mesto, Sežana, Trbovlje, Velenje) while disagreement about the sufficiency of staff exists between the interviewed medical doctor and nurse in seven centres (Brežice, Ilirska Bistrica, Izola, Kočevje, Kranj, Maribor, Piran). Nurses are less satisfied regarding the sufficiency of staff, as two thirds mention that it is insufficient to cover the needs of the patients. Of those nurses who are dissatisfied, three quarters work in the smaller centres. In contrast, half of the medical doctors and psychologists rate the availability of staff in their centre as being sufficient. Here again, most of those who are dissatisfied with the available staff are working in small centres.

Staff tend to work more hours than they are appointed for to meet the needs of patients. As many staff are also employed part-time in the local PHCC, some of them are also available for SMT patients during their working time at the PHCC. Insufficient staff capacity is reported for all levels, including general practitioners, psychologists, social workers and nurses. This problem is considered more serious in the SMTCs where the number of patients is growing. Another problem in availability of staff is the frequent changes of personnel and the high number of part-time or temporary positions, resulting in inefficient use and loss of expertise. Work in SMTCs is not seen as attractive, it does not have a high status, making it difficult to find adequate staff. It should be noted that a higher staff number in many centres would lead to insufficient work space.

Time spent on patient contact

The time spent on contact with a patient is highly dependent on the stage of treatment. A first visit to the medical doctor may take one to three hours. During the following weeks, used to find the appropriate dose, weekly visits of 30 to 60 minutes are often required. The average time spent per patient after these first weeks is reported to be 23 minutes for medical doctors (range eight to 45 minutes) and 18 minutes for nurses (range two minutes, when the patient just comes to pick up the medication, to 30 minutes). About two
thirds of medical doctors and nurses report that this time is sufficient. To optimise treatment, most of them adjust the time spent according to the patient’s needs, e.g., in case of poly-drug use, infectious diseases or if the treatment demands it. Some centres have special opening hours for problematic patients. Others state they treat all patients equally.

Training of staff and staff meetings

Apart from the monthly meetings of the heads of the centres some centres (Murska Sobota, Novo Mesto, Trbovlje, Velenje) report to provide professional training for their staff once or twice a year. Only two centres (Kranj, Sežana) report a maximum of monthly professional training. Also in other centres professional training is offered but there is disagreement on the frequency between the reporting nurse and medical doctor. In six centres (Ilirska Bistrica, Koper, Logatec, Ljubljana, Trbovlje, Velenje) both medical doctors and nurses would prefer additional training to carry out their work more effectively. This wish is especially expressed in the centres providing training once a year or less. Topics for additional education that are mentioned include infectious diseases, poly-drug use, dual diagnosis (another psychiatric disorder as well as drug dependence), psychotherapeutic approaches (e.g., how to maintain abstinence, motivation enhancing techniques, group therapies, crisis management), pharmacological training (e.g., on the interactions of medication and drugs), burn-out among personnel and (team) supervision sessions on how other centres work with different problems. The more training is provided, the fewer staff report that they need additional training.

Team meetings are reported to be organised on a weekly basis in ten centres (Celje, Ilirska Bistrica, Izola, Koper, Kranj, Maribor, Nova Gorica, Novo Mesto, Piran, Trbovlje). In the other centres team meetings are organised only on request or not at all. With a few exceptions, team meetings are rated as sufficient, irrespective of their frequency, fulfilling the information needs and covering the relevant issues. One of the reasons for this may be the frequently reported informal meetings, taking place in the morning before opening, during the coffee break, or on request when a problem occurs. However, participation of a psychiatrist in team meetings is often lacking, and would be appreciated, e.g. to discuss the problems encountered with dual diagnosis patients.

Staff: personal motivation, job satisfaction, and attitude towards patients

Relations with the patients: Sixteen (out of 30) of the staff perceive they are treated by the patients with respect and 14 (out of 30) in a satisfactory
way. Nobody claimed to be treated disrespectfully. The SMTC staff are fairly content with the way they are treated by the patients. On average they rated their satisfaction 5.25 on a scale from one (very dissatisfied) to seven (very satisfied). The majority of the staff members are satisfied with the way the patients treat them. Twenty nine (out of 36) rated five (15) or six (14).

**Table 7:** Time for patients and usefulness of work

<table>
<thead>
<tr>
<th>Time for patients and usefulness of work</th>
<th>Not enough time for patients (n=34)</th>
<th>'My work is useful for the patients' (n=33)</th>
<th>'My colleagues think their work is useful for patients' (n=34)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>5</td>
<td>13</td>
<td>3</td>
</tr>
<tr>
<td>Agree</td>
<td>21</td>
<td>19</td>
<td>10</td>
</tr>
<tr>
<td>Don’t know</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Disagree</td>
<td>5</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

Most of the staff stated that they do not spend enough time on their patients. Twenty one (out of 34) agree and another five strongly agree that they should spend more time on their patients. They have almost no doubts that their work is useful for the patients. Nineteen (out of 32) agree, 13 (out of 32) strongly agree with this statement and only one states to be uncertain.

However, when asked if their colleagues think that their work is useful for the patients, 19 (out of 34) respondents reply negatively and thirteen (out of 34) reply positively.

**Communication within the team:** Twenty six (out of 35) of the staff interviewed claim to receive feedback on their work, whereas the remaining nine state that they do not. Of those who receive feedback 23 get it from colleagues, one receives it also from the management and two did not specify. The respondents’ opinion on the sufficiency of the feedback received is highly diverse. One (out of 31) strongly disagrees, ten disagree, ten cannot decide and ten agree that the feedback is sufficient.
**Satisfaction with the direct management:**

**Table 8a: Satisfaction with direct management**

<table>
<thead>
<tr>
<th>Satisfaction with direct management</th>
<th>Accessibility of managers (n=34)</th>
<th>Clearness of expectations (n=33)</th>
<th>Level of trust by direct managers (n=35)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very good</td>
<td>18</td>
<td>14</td>
<td>18</td>
</tr>
<tr>
<td>Good</td>
<td>13</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>Don’t know</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Bad</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Very bad</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

The SMTC staff almost unanimously agree on the accessibility of their managers. Eighteen (out of 34) respondents strongly agree and another 13 agree that their manager is accessible. Also the opinion on the clarity of expectations from the direct managers is very positive. Fourteen (out of 33) strongly agree and another 14 (out of 35) agree with the statement that expectations are clear. Respondents also think they are trusted by their direct managers. Eighteen (out of 35) strongly agree and another 14 agree with this statement. Heads of SMTCs systematically agree to a lesser degree with these statements.

**Table 8b: Satisfaction with direct management**

<table>
<thead>
<tr>
<th>Satisfaction with direct management</th>
<th>Manager is taking care for good atmosphere (n = 34)</th>
<th>Direct manager is supportive (n=32)</th>
<th>Division of labour is good (n=33)</th>
<th>Direct manager consults staff regarding important decisions (n=32)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>14</td>
<td>14</td>
<td>12</td>
<td>14</td>
</tr>
<tr>
<td>Agree</td>
<td>14</td>
<td>14</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Don’t know</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Disagree</td>
<td>2</td>
<td>1</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

The SMTC staff perceive the direct managers as taking care of maintaining a good atmosphere. Fourteen (out of 34) strongly agree and another 14 (out of 34) agree with this statement. The respondents also see the direct managers as supportive. Again 14 (out of 32) strongly agree and another 14 (out of 32) agree with this statement. These are the two areas where the nurses’ satisfaction differs from the doctors’. Nurses are clearly more satisfied with the direct management in taking care to maintain a good atmosphere (nurses average 4.5; others 3.7 on a 1 to 5 scale) and in giving support in case of problems at work (nurses average 4.5; others 3.8 on a 1 to 5 scale). The results indicate a difference between the good work relationships within the SMTC and a less good relationship between the SMTC and the PHCC of which the SMTC is a part.
The managers' care for a good division of labour between the staff is judged a little less positively. Nevertheless, 12 (out of 33) strongly agree and 12 (out of 33) agree, while only three cannot decide and six disagree with this statement. The respondents also claim that their direct manager often consults them before making an important decision. Fourteen (out of 32) strongly agree and 12 agree with this statement.

Table 8c: Satisfaction with direct management

<table>
<thead>
<tr>
<th>Satisfaction with direct management</th>
<th>Direct manager is unclear about his/her own tasks (n=33)</th>
<th>Direct manager is not open to new ideas (n=33)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Agree</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Don’t know</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Disagree</td>
<td>13</td>
<td>8</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>13</td>
<td>18</td>
</tr>
</tbody>
</table>

The staff interviewed disagree with the statement that their direct manager is unclear about their own tasks. Thirteen (out of 33) strongly disagree and 13 disagree. The same is true for the statement that the direct manager is not open to new ideas about the work. Eighteen (out of 33) strongly disagree and another eight disagree with this.

Work pressure

Table 9a: Work pressure

<table>
<thead>
<tr>
<th>Work pressure</th>
<th>Work is routine (n=35)</th>
<th>Work is not stressful (n=37)</th>
<th>Staff is not sufficient (n=35)</th>
<th>Work is very busy (n=35)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>1</td>
<td>0</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Agree</td>
<td>3</td>
<td>0</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Disagree</td>
<td>15</td>
<td>18</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>15</td>
<td>19</td>
<td>12</td>
<td>0</td>
</tr>
</tbody>
</table>

The respondents find their work not boring but rather stressful. Fifteen (out of 35) strongly disagree and 15 disagree with the statement that their work is routine. Fifteen (out of 35) strongly agree and 16 agree that their work often keeps them very busy. The opinion on having enough staff differs widely. Ten (out of 35) strongly agree and 11 agree with this statement, but 12 strongly disagree. The statement that their work is not stressful meets with complete disagreement. Nineteen (out of 37) strongly disagree and 18 disagree.
The opinion on their ability to keep up with developments in their field of work is less strong. The biggest group of the respondents agree (17 of 33), 9 cannot decide and seven disagree. The majority disagrees that there would be any ambiguity in their work. They also disagree with the statement that in their work they ‘never know if they are doing good or bad’. Eight (out of 36) respondents strongly disagree and 17 disagree.

**Treatment**

**Intake procedure**

A medical examination is standard procedure at the intake of every new patient. This is also true for the assessment of the severity of drug dependence, but only in a very limited number of centres is this done with an internationally validated instrument. Others estimate the severity by (hetero)anamnesis, assessing the presence of drugs in the urine and scoring withdrawal symptoms.

**Table 10: Intake procedure**

<table>
<thead>
<tr>
<th>Intake procedure</th>
<th># SMTCs (n=18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical examination processed at intake</td>
<td>18</td>
</tr>
<tr>
<td>Basic assessment of severity of drug dependency</td>
<td>18</td>
</tr>
<tr>
<td>Psychiatric examination processed at intake</td>
<td>14</td>
</tr>
<tr>
<td>Assessment of social situation</td>
<td>18</td>
</tr>
<tr>
<td>Treatment plan determined by GP/psychiatrist</td>
<td>18</td>
</tr>
<tr>
<td>Involvement of nurse in the treatment plan</td>
<td>15</td>
</tr>
<tr>
<td>Involvement of patient in the treatment plan</td>
<td>13</td>
</tr>
<tr>
<td>Exclusion criteria used for selecting patients to enter SMT</td>
<td>10</td>
</tr>
</tbody>
</table>

Psychiatric examination is not standard in four centres at intake (Ilirska Bistrica, Logatec, Ljubljana, Murska Sobota), but sometimes, on indication, later during treatment. In all the centres, the social situation of the patient is assessed, usually by the nurse and includes: housing; employment and often
the financial situation; availability of social support; and criminal behaviour. In all the centres, a treatment plan is determined by the general practitioner and/or psychiatrist. In almost all the centres (all except Ilirska Bistrica, Izola, Ljubljana) the nurse is also involved in making up the treatment plan. Social workers rarely contribute to the treatment plan.

In more than half of the centres (all except Brežice, Logatec, Murska Sobota, Nova Gorica, Novo Mesto) the patient’s viewpoint is taken into consideration. In all but two SMTCs (Trbovlje, Maribor) it is reported that the treatment plan is signed by the patient. Though in four centres (Celje, Kočevje, Ljubljana, Sežana) there is disagreement between the interviewed staff on this issue. There are three different versions of the treatment plan depending on the substitution medication a client is receiving (methadone, buprenorphine or slow-release morphine). In general the treatment plan includes: admission criteria; additional treatment possibilities besides SMT (psychosocial therapy); voluntary agreement for regular blood and urine testing by signing the agreement; take home regulations; exclusion criteria; benefits regulations and criteria; rules regarding passing on personal data; cooperation of relatives in the treatment; possibilities of choosing another therapist; and complaint procedure. The treatment plan is signed by the medical doctor and the patient. Changes are possible over time according to the individual’s needs, although such changes are usually not part of an official procedure or formal evaluation but are part of the therapeutic goals set between the therapist and the individual client.

Seven centres (Ilirska Bistrica, Maribor, Murska Sobota, Nova Gorica, Pivka, Trbovlje, Velenje) mention using exclusion criteria for selecting patients to enter SMT. In seven centres (Celje, Izola, Kranj, Ljubljana, Nova Gorica, Piran, Pivka) staff disagree on this issue. Exclusion criteria include: no basic health insurance; aged under 16 years (unless parents cooperate); minimum duration of dependence for two years; living outside the region (not an absolute exclusion criterion); and violence. Most of these criteria are negotiable depending on the client’s attitude and situation.

**Maintenance treatment**

All the centres provide in principle SMT with methadone, buprenorphine and slow-release morphine. Detoxification treatment is offered in all but two centres, Piran and Brežice. Benzodiazepines are prescribed in more than half the centres (Brežice, Ilirska Bistrica, Kočevje, Koper, Logatec, Nova Gorica, Novo Mesto, Piran, Sežana). There is no benzodiazepine prescription in five SMTCs (Celje, Maribor, Pivka, Trbovlje, Velenje). In four centres (Izola, Kranj, Ljubljana, Murska Sobota) there is disagreement on this issue. In total, data on prescribed substitution medication were provided for 2,405 patients, of whom 81% receive methadone, 13% buprenorphine and 6% slow-release morphine. Three centres, Kočevje, Izola and Brežice, did not report differentiated numbers for patients on the various substitution drugs. The
adequacy of the dosage is evaluated weekly in four centres, i.e. Izola, Kočevje, Ljubljana and Logatec, and monthly in two centres (Brežice and Pivka). More than half of all centres (Celje, Ilirska Bistrica, Izola, Kočevje, Ljubljana, Murska Sobota, Novo Mesto, Pivka, Sežana, Trbovlje) report that the frequency of the evaluation depends on the individual patient, on the stage in treatment (new patients are evaluated every other day) or on the use of a privilege (bonus/malus) system. The evaluation of other forms of treatment is highly diverse and ranges from weekly to once a year.

Frequency of contact with a medical doctor varies greatly among the centres and ranges from rare to “every day if the patient wishes to”. In many centres, the patient sees a doctor every week at the beginning of treatment, but this is reduced to once in several months when a stable situation has been reached. Counselling and psychosocial assistance are provided in all the SMTCs except for Ilirska Bistrica. Patients have by far the majority of contacts with a nurse. Specific nursing care for wounds and abscesses is given in 10 centres (Brežice, Ilirska Bistrica, Izola, Koper, Murska Sobota, Nova Gorica, Novo Mesto, Pivka, Trbovlje, Velenje).

Urine tests are used by all the centres to check whether the prescribed medicine has actually been taken. It is also used to check whether the patient is using other substances such as heroin or cocaine not prescribed by a doctor. Between the centres, the average frequency of urine tests ranges from once in three months to once a week (at least for some time) and may also depend on the individual patient. The average number of tests reported is once per month. Reasons for testing are: suspicion of heroin use; a change in substitution drug dosage; when privileges can be obtained. Urine tests are usually unannounced although some centres have standard days for performing urine tests. Urine tests are rare in the SMTC in Maribor, which uses saliva tests.

**Table 11:** Specific interventions in SMT

<table>
<thead>
<tr>
<th>Specific interventions</th>
<th># SMTCs (n=18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work with dual diagnosis patients</td>
<td>14</td>
</tr>
<tr>
<td>Work with pregnant women</td>
<td>13</td>
</tr>
<tr>
<td>Work with former inmates</td>
<td>10</td>
</tr>
<tr>
<td>Work with young drug users</td>
<td>10</td>
</tr>
<tr>
<td>Overdose prevention information</td>
<td>16</td>
</tr>
<tr>
<td>Information on infectious diseases</td>
<td>15</td>
</tr>
<tr>
<td>(Referral to) testing on HIV, HBV and HCV</td>
<td>18</td>
</tr>
<tr>
<td>Testing on STD</td>
<td>6</td>
</tr>
<tr>
<td>HBV vaccination</td>
<td>18</td>
</tr>
</tbody>
</table>

In the majority of the centres, there are interventions addressing special groups of patients, e.g. pregnant women (13 centres), former inmates (10 centres), young drug users (10 centres) and patients with a double diagnosis (14 centres).
Information regarding the prevention of drug overdose is distributed in all centres by written information materials or in talks. Information on drug-related infectious diseases is available in all centres except for Kočevje. Patients are offered testing (or are referred for testing) on HIV and hepatitis B and C in all the centres. In six centres (Kočevje, Kranj, Ljubljana, Piran, Pivka, Sežana,) they also report testing on sexually transmitted diseases. The frequency of testing is generally yearly, but depends among other things on risk behaviour. Hepatitis B vaccination is provided by all the centres. For treatment, patients are referred to the Department of Contagious Diseases and Fevers at the University Medical Centre in Ljubljana or to the departments of contagious diseases in the regional hospitals.

Although most patients are involved in SMT, there is still a substantial number of patients attending the centres who only make use of other services, such as HIV and hepatitis B and C testing, hepatitis B vaccination, psychosocial treatment and counselling, supporting therapy (especially after completed detoxification), and routine medical check-ups. According to the Sector Agreement for Primary Health Care Centres and Private Medical Care for the year 2005 there were 1,222 out of 3,633 SMTC patients who were not included in SMT (ZZZS 2007a).

Measures to prevent leakage of substitution substance

Many centres (Celje, Koper, Kranj, Ljubljana, Maribor, Nova Gorica, Sežana, Trbovlje, Izola, Logatec, Piran, Pivka, Velenje) report that they have taken measures to prevent substitution substances being sold, though in the latter five there is disagreement between staff on this issue. The measures include: daily (supervised) pick-up and intake of the medication; handing in of empty vials; monitoring of the premises with cameras; frequent urine testing; decreasing the dosage; weekend dosages to pick up at the pharmacy; enquiries to find out who is selling; critical approach in giving privileges; sanctioning the patient (by withdrawing privileges); and in extreme cases excluding a patient from the programme. It has been stressed by the interviewees that leakage is difficult to control, and it is hard to prevent someone from selling his/her medication.

Patient complaints

In all the centres, patients have the opportunity to complain about their treatment. Staff of most of the centres state that they use guidelines for complaints (all except for Brežice, Kočevje, Logatec, Murska Sobota, Novo Mesto) though in many centres there is disagreement on that. Usually the complaint is handled directly by the medical doctor, but in most centres it is also possible to make an anonymous complaint. If the problem cannot be
solved within the centre (by the medical doctor or the director), the issue is sent to the Coordination Committee. The way of filing complaints is comparable to the system used in other parts of health care. Complaints often concern an imposed restriction, e.g., when the urine test has been positive.

**Patient registration system**

All the centres have some form of patient registration, but the system does not always allow for following the patient throughout the treatment, to monitor his/her state of health and functioning. For statistical purposes and administration electronic files are often used, e.g. the treatment demand indicator (an epidemiological tool developed by the EMCDDA to collect data on (first) treatment demand on the country level but not designed for individual data collection). The services are also registered via electronic medical cards issued by the health insurance system, which are used to register the services, but not the outcomes of check-ups. The registration software is judged by staff as old. Registration data include: a daily keeping of records of the treatment and of the quantity of substitution; substances dispensed; the number of users; the number of absent users. Some centres lack a general registration system for personal data hampering the exchange of information between professions. Personal data is recorded in a notebook in several centres. In the majority of centres patient information is not exchanged regularly between staff members in other ways, e.g., through meetings, or between centres.

**Accessibility**

**Working time:** All SMTCs are open every working day. Their opening time varies widely, from one to 12 hours per day. This partly depends on the size of the centre. Most of the centres are opened before or at 07.00. For other services, e.g. for counselling, bigger centres are open between eight and 12 hours a day and smaller ones between two and six hours. Six (Celje, Ilirska Bistrica, Ljubljana, Pivka, Sežana, Trbovlje) of the SMTCs are also open on Saturdays (one to two hours, generally in the middle of the day). Two of these centres report being open on Sunday (Celje from 10:00 to 11:30 and Ilirska Bistrica from 19:00 to 19:30).

**Travelling time to the centre:** The average travelling time from home (or the place where patients normally are) to the centre depends on the geographical coverage of the centre. The interviewees from eight SMTCs estimate it takes less than 20 minutes (Izola only five minutes). In four SMTCs they estimate it at half an hour. Five SMTCs report travelling times in between these times and for one SMTC (Kočevje) we do not have information. In six of the SMTCs the interviewees estimate the maximum time
to be one hour and a half. In three SMTCs this is estimated at one hour and in another five SMTCs the maximum time is estimated from 30 to 45 minutes. In only four SMTCs is the maximum travelling time less than 30 minutes. These estimates are made for travelling by car or other motorised means of transport. These data indicate that the geographical coverage of the SMTCs can be quite large.

**Table 12:** Average travel time to the SMTCs by motorized means of transport (n=18)

<table>
<thead>
<tr>
<th>Average travel time to the SMTC by motorized means of transport</th>
<th># SMTC (n=18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;20 minutes</td>
<td>8</td>
</tr>
<tr>
<td>&gt;20 and &lt;30 minutes</td>
<td>4</td>
</tr>
<tr>
<td>&gt;30 and &lt;45 minutes</td>
<td>5</td>
</tr>
<tr>
<td>No information</td>
<td>1</td>
</tr>
</tbody>
</table>

**Table 13:** Maximum travel time to the SMTCs by motorized means of transport (n=18)

<table>
<thead>
<tr>
<th>Maximum travel time to the SMTC by motorized means of transport</th>
<th># SMTC (n=18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;30 minutes</td>
<td>4</td>
</tr>
<tr>
<td>&gt;30 and &lt;45 minutes</td>
<td>5</td>
</tr>
<tr>
<td>60 minutes</td>
<td>3</td>
</tr>
<tr>
<td>90 minutes</td>
<td>6</td>
</tr>
</tbody>
</table>

**Involvement of general practitioners/pharmacies in methadone dispensing:** Only a few private general practitioners\(^{18}\) and pharmacists are involved in the dispensing of maintenance medication. Pharmacies in particular are said to be reluctant to get involved in the dispensing of substitution medication. Nevertheless there are some exceptions. The SMTC in Ljubljana has an arrangement with pharmacies for eight patients living outside Ljubljana and the SMTC in Kranj occasionally cooperates with pharmacies for employed patients. The latter also has arrangements with the general practitioners in Tržič and Jesenice. Nova Gorica has some arrangements with general practitioners for Tolmin and Bovec. In Maribor two general practitioners cooperate with the SMTC in dispensing medication. The SMTC in Velenje has an arrangement with the NGO in Žalec, a town in the surroundings of Velenje, to dispense methadone for patients who have a job.

**Waiting list:** There are no waiting lists to enrol in SMT, but some of the interviewees reported that sometimes there is a waiting time of some days as they check some patient information which is necessary for entering SMT or to arrange an appointment with the doctor. In most of the centres waiting is due to the doctor’s limited working hours but in some of them waiting is part of the procedure.

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\(^{18}\) i.e. not employed by a SMTC
The most important reason for not taking a person in for treatment is of an administrative nature: the patients have to have valid basic health insurance and they have to have a personal general practitioner.

### Monitoring and evaluation of the staff activities

**Monitoring:** In 10 out of 14 SMTCs (Brežice, Celje, Izola, Koper, Kranj, Logatec, Murska Sobota, Nova Gorica, Piran, Pivka) the interviewees report that the staff activities are monitored regularly (monthly), in two centres out of 14 (Novo Mesto and Velenje) it is stated that staff activities are monitored once per year. In another two centres (Ljubljana and Maribor) staff disagrees on the frequency. One centre (Nova Gorica) reports a formal monitoring procedure. In all other centres there is only informal peer-to-peer monitoring of activities. This is also true of the two smallest centres (Ilirska Bistrica and Sežana). They report no need for formal monitoring because "everybody knows everything".

**Evaluation:** The same is true for evaluation of staff activities. Twelve SMTCs (Brežice, Ilirska Bistrica, Koper, Kranj, Maribor, Murska Sobota, Piran, Sežana, Celje, Ljubljana, Novo Mesto, Trbovlje) report that they evaluate the work of the staff. In the latter four there is disagreement between staff on this issue. Evaluation of staff activities is generally performed informally, mostly within team meetings and through day-to-day communication. Some of the interviewees report evaluation as a part of the monthly meetings of the Coordination Committee.

### Guidelines, protocols, monitoring

#### Guidelines

**Table 14:** Guideline issues

<table>
<thead>
<tr>
<th>Guidelines</th>
<th># SMTCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Euro-Methwork guidelines (n=18)</td>
<td>17</td>
</tr>
<tr>
<td>Slovene guidelines (n=18)</td>
<td>9</td>
</tr>
<tr>
<td>Locally developed guidelines (n=18)</td>
<td>4</td>
</tr>
<tr>
<td>Several guidelines mentioned above (n=18)</td>
<td>5</td>
</tr>
<tr>
<td>SMTCs reporting problems with current guidelines (n=18)</td>
<td>7</td>
</tr>
<tr>
<td>Guidelines used are sufficient (n=18)</td>
<td>12</td>
</tr>
</tbody>
</table>

All the centres report using guidelines for SMT, 17 report using the Euro-Methwork guidelines, nine report using Slovene guidelines (one uses only the 1994 guidelines, three only the 2000 guidelines and five both), four report also using locally developed guidelines. Three centres report using three guidelines (the Slovene 1994 and 2000 and the Euro-Methwork guidelines)
and two other centres report using the above-mentioned three complemented with local guidelines.

**Problems with the guidelines:** In seven centres at least one of the interviewees reports some problems with the guidelines. These problems seem not to be connected with the specific guidelines used. In one case (out of seven) (Nova Gorica) there is a problem with assessing addiction. In two cases (out of seven) there was a problem with the treatment plan and informing the patients. In general it could not be determined what was specifically meant by “using” guidelines. However one remark (Pivka) was that the guidelines were too detailed and another (Ilirska Bistrica) suggests adherence to them takes too much time.

**Sufficiency of the guidelines:** Staff of 14 centres (all except for Ilirska Bistrica, Kočevje, Kranj, Nova Gorica) claim that the guidelines they use are sufficient.

**Process management**

**Division of labour:** In two centres (Brežice and Logatec) there is no formally agreed division of responsibilities between different professional groups. In four centres (Celje, Ilirska Bistrica, Piran and Sežana) there is disagreement between the staff on this issue. However, it was stressed that every group knows its responsibilities. The latter is also true for centres where the interviewees claimed to have a formally agreed division of responsibilities. The same conclusion can be reached if we compare these answers with the answers about formal job descriptions. The interviewees are mostly not aware of any formal job description. In three centres (Kranj, Maribor, Nova Gorica) it was stated that they have formally assessed job descriptions. In four centres (Izola, Ljubljana, Piran, Pivka) staff disagreed on this issue. Thus in the majority of SMTCs there exists an implicit, factual division of responsibilities and implicit job descriptions. However, these seem to be clear enough for the staff.

**Privacy:** Thirteen centres (Celje, Izola, Kranj, Logatec, Maribor, Nova Gorica, Piran, Sežana, Trbovlje, Velenje, Ilirska Bistrica, Ljubljana, Pivka) report that they have a policy of guaranteeing the privacy of the patients, but in none of the centres is there anything written down on this issue. Most of the centres rely on the Slovene code of ethics for medical professionals. In their opinion, privacy is guaranteed by adherence to the treatment plan, the regulations of the primary health care centres and the Personal Data Protection Act (Zakon o varstvu ... 2004/2005/2007). The centres report that privacy is kept by allowing only one patient at a time in the consultation room; by keeping the notes locked away; and by not disclosing patient information.
**Financial management:** In four centres (Brežice, Koper, Logatec, Pivka) the interviewees report working with formally assessed financial procedures, but no special description was given except that they have to report to the regional office of the Health Insurance Institute Slovenia and to sign the ordering forms for materials and medication. The financial part is obviously not the responsibility of the staff of the centres but of the management of the PHCC. In three centres (Celje, Ilirska Bistrica, Nova Gorica) staff disagree on this issue.

**Management support**

**Table 15:** Management support for SMTC from PHCC

<table>
<thead>
<tr>
<th>Management support from PHCC</th>
<th># SMTCs (n=18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management support is sufficient</td>
<td>6</td>
</tr>
<tr>
<td>Management support is not sufficient</td>
<td>8</td>
</tr>
<tr>
<td>Mixed judgement</td>
<td>4</td>
</tr>
</tbody>
</table>

The opinion on the sufficiency of management support is divided. In 6 centres the unanimous judgement is sufficient, in 8 insufficient. In four centres the staff disagrees. The answers refer to the support SMTCs receive from PHCCs, as one can see from the answers regarding direct management (see above in this chapter). The main reasons for the negative evaluation of managerial support are: the rigidity of the administration; a lack of support from the management for getting the number of staff the centre needs; and feelings of being underestimated or pushed aside by the management. Some of the centres, however, report a supportive attitude from the management and the municipality (Brežice, where the director of the PHCC is the former head of the SMTC and Nova Gorica, where the municipality supports the centre financially) and some feel that they get support when they need it (Logatec, Celje).

**Cooperation**

**General hospitals**

According to the interviewees the SMTCs cooperate well with the hospitals, mostly when their patients are in need of hospital care. The main issue in this cooperation is continuing SMT while patients are in hospital. The answers of the interviewees reveal that in the past there have been problems with the latter. Now the staff of the SMTCs are actively involved in support and sometimes they provide the substitution medication. Some centres report especially good cooperation with the maternity wards and departments of infectious diseases.
Primary health care centres
It is reported that the centres mainly cooperate with their patients’ personal doctors and with some relevant departments of the PHCCs. Some of the interviewees think that cooperation with the PHCCs is not important or needed. Cooperation with the PHCCs varies. With some of the PHCC departments and with most of the personal doctors the cooperation is generally good. Yet some of the personal doctors and some of the specialist departments are said to be not interested in cooperation with the SMTCs. In some cases PHCC doctors prescribe additional medication (benzodiazepines) to patients of SMTCs without consultation.

Psychiatric wards
Apart from cooperation with the central detoxification clinic in Ljubljana, the centres cooperate with the psychiatric units in hospitals mostly in cases of double diagnosis. The interviewees stress the good relationship with the Detoxification Clinic in Ljubljana (a part of the University Psychiatric Clinic). They also have good experience with some of the other psychiatric wards. Nevertheless in the interviewees’ answers, there is a prevailing feeling that cooperation is lacking due to differences in views on SMT. The interviewees have the impression that many of the psychiatric wards and departments avoid cooperation since they have their doubts about maintenance treatment. The interviewees claim that in some cases the psychiatric staff try to replace maintenance medication with benzodiazepines.

Pharmacies
According to the interviewees cooperation with the pharmacies is good. The main element in this cooperation is the preparation of the methadone, especially for take-home dosages. Some interviewees see the reason for the pharmacies’ willingness to cooperate in their financial and professional interest. From the SMTCs’ side the preparation of the dosages by the pharmacies is more convenient, if more expensive. Some of the SMTCs collect the prescribed medication for their patients and dispense it at the SMTC. In two cities pharmacies dispense the methadone prescribed by the SMTC to some patients (see above).

High threshold NGOs
The interviewed SMTC staff report that high threshold NGOs are mostly reluctant to cooperate with the SMTCs, since they don’t approve of SMT, as it is, according to them, just replacing one drug by another drug. Mostly they get in touch with the SMTCs when they require their future patients to be tested on drug use and on infectious diseases. The SMTCs provide these tests for the NGO participants for free. Some interviewees, nevertheless, indicate the importance of the aims and methods of high threshold NGOs and there is a willingness to cooperate.
**Low threshold NGOs**
Many of the SMTCs report no cooperation with low threshold NGOs. This is mostly due to the fact that low threshold NGOs generally operate in urban areas. Some of the centres are aware of the low threshold NGOs in their surroundings, but keep their cooperation restricted to the level of the exchange of information and presentations. In rare cases, cooperation is much more positive and evaluated as very good, e.g. in Velenje, where methadone for patients in Žalec is dispensed through an NGO.

**Centres for Social Work**
The SMTCs report co-operating with the Centres of Social Work occasionally, mostly when the need arises to solve some of their patients’ problems regarding housing, financial support, employment, child care, etc. Good cooperation consists of efficiently solving the patients’ problems. In cooperation with the Centres for Social Work sometimes the same issues are raised as with the high threshold organisations. According to the interviewees in some Centres of Social Work, substitution medication is still seen as "just another drug".

**Prisons**
Since the beginning of the separate methadone dispensing in prisons, cooperation seems to be less close, but with less tension. The existing cooperation has to be explained by the fact that some SMTC patients are occasionally in prison. In some cases the cooperation is good due to the interchange of staff between the prison and SMTC. In one case the centre performs the SMT in the prison. In most cases they cooperate when needed, mostly by exchange of information. Some interviewees criticized the work of the prison medical staff (prescribing benzodiazepines, too low dosages of methadone, etc.).

**Self-help groups**
Mostly the SMTCs are not aware of any self-help groups in their environment. This is due partly to the fact that self-help groups are scarce in Slovenia and partly because the centres do not see that this cooperation would be of any importance. Only a few of the centres co-operate well with self-help groups (Koper, Logatec). It seems that cooperation is good where the self-help groups are well established and relatively strong.

**Family groups**
There are virtually no independent drug users' parents groups in Slovenia. An exception is Društvo Up, which concentrates primarily on reintegrating drug users who return from therapeutic communities. It thus acts as a high threshold NGO. Two of the interviewees (Trbovlje and Ilirska Bistrica) report good cooperation with the parents group (in Trbovlje the group is organised within the centre). Some of the centres try to organise a parents group but most of them work with parents individually.
**Other observations**

There are some examples of cooperation with other organisations, but it depends on the centre and its environment. The SMTC in Logatec reports good cooperation with some employers, who are prepared to employ patients from the centre. The centre in Murska Sobota reports co-operating with some schools. This cooperation depends on the attitude of the school management. Two of the centres (Kočevje, Novo Mesto) report cooperation with the Local Action Group, a local co-ordination body for dealing with the issues of drug addiction (mainly prevention) on a local level. The activities of these groups vary from city to city and so does their cooperation with the centres.
4.2 Patient satisfaction in SMT

Introduction

Patient satisfaction is an important indicator of quality of care. We therefore included patient satisfaction as a separate quality factor of SMT in Slovenia. We grouped the questions asked on patient satisfaction under five main topics: treatment issues (medication, dosage, and perceived effects); information about SMT (e.g. effects and side effects of different substitution medication, treatment “rules”); treatment access issues (opening hours, distance to the SMTC, flexibility in dispensing methods); additional services offered (e.g. social work, infectious disease counselling); and treatment conditions (e.g. privacy, attitude of personnel and premises). Seventy-five randomly selected patients from 6 SMTCs (Kočevje, Koper, Logatec, Ljubljana, Nova Gorica and Velenje) were interviewed. We do not have information on the characteristics of patients who did not want to participate. The total number of patients interviewed was 75 but not all 75 interviewees answered all the questions. Therefore we present the results in numbers and add the total number of respondents in brackets.

General characteristics of the interviewees

Some general characteristics of the respondents are presented in Table 1. This is meant to give the reader an impression of the interviewed subpopulation of SMTC patients. Our method did not aim at a representative sample (see chapter 2 on methodology).

Table 16: General characteristics of the respondents

<table>
<thead>
<tr>
<th>Gender(^{19}): male – female (n=75)</th>
<th>52 (69%) – 23 (31%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age (range) in years</td>
<td>29.7 (19 - 45)</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Men: mean age in years</td>
<td>30.6</td>
</tr>
<tr>
<td>Women: mean age in years</td>
<td>27.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employment status (n=75, 2 respondents filled in 2 options)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployed</td>
<td>35</td>
</tr>
<tr>
<td>Working occasionally</td>
<td>13</td>
</tr>
<tr>
<td>Working on a contract basis</td>
<td>12</td>
</tr>
<tr>
<td>Working on a regular basis</td>
<td>12</td>
</tr>
<tr>
<td>In education (school/study)</td>
<td>5</td>
</tr>
</tbody>
</table>

Mean years (range) of opiate use 10.3 (0.3 – 28)

\(^{19}\) The most recent data on the gender rate of patients in treatment are from 2004: total number involved in treatment: 2,902 of whom 78% are male and 22% female (2005 National Report, p. 34)
Mobility between SMTCs of the patients interviewed is quite limited. Only nine (out of 54) respondents started SMT in another location. Generally, patients tend to choose the centres closest to their place of living. Only five respondents mentioned they had chosen another SMTC, either because the prescribed dosage was more suitable to their needs (three respondents), or for other reasons (anonymity or better relations with staff).

**Reasons for starting treatment**

**Table 17: Reasons for starting treatment (n=74)**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical health problems</td>
<td>16</td>
</tr>
<tr>
<td>Looking for positive changes in life</td>
<td>24</td>
</tr>
<tr>
<td>To avoid being sentenced</td>
<td>4</td>
</tr>
<tr>
<td>Drugs were not or hardly available</td>
<td>7</td>
</tr>
<tr>
<td>Purchasing drugs was too expensive</td>
<td>21</td>
</tr>
<tr>
<td>Leading a more normal life</td>
<td>49</td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
</tr>
</tbody>
</table>

The reason for starting therapy may influence the attitude towards and satisfaction with the treatment offered. Almost all the patients formulated

<table>
<thead>
<tr>
<th>Use of other substances during SMT</th>
<th>Not using</th>
<th>Daily</th>
<th>Several times per week</th>
<th>Once per week</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol (n=70)</td>
<td>36</td>
<td>11</td>
<td>13</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Cannabis (n=68)</td>
<td>33</td>
<td>15</td>
<td>4</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Benzodiazepines (n=66)</td>
<td>35</td>
<td>17</td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Barbiturates (n=60)</td>
<td>52</td>
<td>5</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>*Other (heroin, cocaine, antidepressants) (n=63)</td>
<td>41</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Years in treatment (n=54)</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1 year</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-5 years</td>
<td>17</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5-10 years</td>
<td>21</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;10 years</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment medication mean dosage in mg (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methadone (n=59)</td>
</tr>
<tr>
<td>Buprenorphine (n=13)</td>
</tr>
<tr>
<td>Slow-release morphine (n=3)</td>
</tr>
</tbody>
</table>
positive reasons for choosing substitution treatment for their problematic opiate use. Two thirds of the respondents mentioned that they wanted to lead a more normal life. One third stated that they were looking for positive changes in life.

Thirty-two patients mentioned avoidance-driven (negative) reasons such as not being able to afford spending the money to purchase drugs, problems with availability of drugs and avoiding a sentence.

Other reasons for starting SMT were among others to overcome a crisis because of drug use and to abolish drug use (7 out of 74), and to keep a job (4 out of 74).

Table 18: Pressure to enter treatment (n=43)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Family doctor</td>
<td>2</td>
</tr>
<tr>
<td>Justice</td>
<td>2</td>
</tr>
<tr>
<td>Parents</td>
<td>19</td>
</tr>
<tr>
<td>Partner</td>
<td>9</td>
</tr>
<tr>
<td>Other drug users</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
</tr>
</tbody>
</table>

Finally, 43 respondents stated that there was some pressure on them from their surroundings to take up SMT.

Treatment issues: medication, dosage, and perceived effects

Prescribed medication and dosage

One indicator of the patients’ satisfaction with their treatment is the degree of influence they have on the choice of treatment and dosage of the prescribed medication. A large majority of respondents (61 out of 75) stated they were satisfied with the prescribed substance, while 14 (out of 75) respondents said they were not. An even larger majority of respondents (65 out of 75) also stated that they were able to influence the dosage. Only 6 respondents (out of 75) stated that they had no influence. Four (out of 75) respondents did not know.

Reasons for dissatisfaction were for 9 (out of 14) respondents their preference for another medication, for 2 (out of 14) another form of medication (e.g. tablets or liquids) and for one respondent not getting a different dosage. Five (out of 14) persons reported other reasons, i.e. not feeling well with the substance or undesirable side effects (3 out of 5).

Supervision of intake

More than two thirds of the respondents (51 out of 74) were satisfied with the way the intake of the medication was supervised. Respectful conduct by the staff was mentioned as a reason for satisfaction by 43 (out of 68) patients.
Eleven (out of 74) respondents were dissatisfied and 12 (out of 74) said that it depended on the circumstances. Patients receiving methadone (9 out of 61) as SMT seemed to be equally dissatisfied with the supervision of intake as patients receiving buprenorphine (2 out of 13). The reasons for dissatisfaction were the feeling that patients were: not seen as trustworthy (9 out of 39); a negative attitude from staff (7 out of 39); or degrading treatment (5 out of 39). Another reason for dissatisfaction mentioned was that patients had to wait too long (e.g. until the sublingual tablets of buprenorphine were dissolved). There is quite a diversity of other reasons, for example lack of privacy at urine tests, poor communication between the medical doctor and nurse and poor knowledge of staff about addiction.

**Injecting medication**

The question whether patients inject the dosage is a sensitive one; therefore we asked if others do so. Only nine respondents (out of 75) reported injecting the substitution substance, but when asked if others inject their substitution medication, 31 (out of 49) agreed. The high percentage of those who stated that others inject indicates that injecting substitution substances may not be exceptional. The reasons for injecting substitution substances are predominantly the different effects (e.g., quicker and more intense; 12 out of 24); because respondents for whatever reason like injecting (7 out of 24); or because they were interested in the effects of injecting (2 out of 24).

**Health and well-being**

Self-reports on how patients rate the impact of treatment on their health and well-being are further indicators of the positive effect of treatment and therefore of treatment quality. In our survey, respondents were asked to rate their health, psychological well-being, social situation (family, friends), their use of illegal drugs and drug-related criminality at three different periods. They were: before they started with SMT; currently (while being in treatment); and their expectations for the future (after one year). The scale ranged from five (“much better than when I started”) to one (“much worse than when I started”). On all the topics the patients thought that they would be much better off in the near future than before SMT.
Table 19: Self reports on well-being before the start of SMT, currently, and in the future

<table>
<thead>
<tr>
<th></th>
<th>Before</th>
<th>Now</th>
<th>In 1 year’s time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical health</td>
<td>Average</td>
<td>2.33</td>
<td>3.60</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>72</td>
<td>75</td>
</tr>
<tr>
<td>Perspective on work</td>
<td>Average</td>
<td>2.37</td>
<td>3.27</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>70</td>
<td>73</td>
</tr>
<tr>
<td>Diminishing illegal drug use</td>
<td>Average</td>
<td>2.86</td>
<td>4.43</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>64</td>
<td>65</td>
</tr>
<tr>
<td>Drug-related criminality</td>
<td>Average</td>
<td>2.62</td>
<td>3.62</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>71</td>
<td>74</td>
</tr>
<tr>
<td>Social situation (family, friends)</td>
<td>Average</td>
<td>2.00</td>
<td>3.55</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>69</td>
<td>73</td>
</tr>
<tr>
<td>Psychological well-being</td>
<td>Average</td>
<td>1.49</td>
<td>4.40</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>75</td>
<td>75</td>
</tr>
<tr>
<td>COMBINED</td>
<td>Average</td>
<td>2.39</td>
<td>3.76</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>58</td>
<td>61</td>
</tr>
</tbody>
</table>

Scale: 1 “much worse than when I started”; 2 “slightly worse than when I started”; 3 “no different”; 4 “slightly better than when I started”; 5 “much better than when I started”.

Table 19 shows an overall positive change on all the topics with regard to the current situation and the expectations for the future. The most important results from “before the start of SMT” to “now” might be the clear change in psychological well-being, the diminishing of illegal drug use, and the social situation. The highest degree of expectancy of improvement from “now” to “in one year’s time” is connected to finding work, improving the social situation and physical health, and the reduction of drug-related criminality. These positive expectations indicate that SMT gives them hope for improvements.

Information about SMT

In order to allow patients to make an informed decision about the most suitable type of medication for them, they need information about the characteristics and effects of the available substitution substances. The results show that in general, patients are better informed about the substitution medication they are using than about other medication. A second outcome is that patients on buprenorphine are better informed about alternatives to methadone.20

20 The majority of respondents (57 out of 73) feel well informed about the effects and risks of methadone. Forty-seven (out of 58) patients in methadone treatment feel sufficiently informed about methadone, while with patients using other substitution substances only 7 out of 12 rate
Half of the respondents (35 out of 70) said they received information about treatment from the medical doctor. Seventeen out of 70 respondents gave a non-specific answer (‘the staff’). NGOs seem to play a minor role in delivering information (3 out of 70). A substantial group (32 out of 70) stated that they got information from peers and through their own search for information e.g. on the internet. Twenty-four (out of 70) took information from leaflets. This fact shows that a substantial number of the patients take steps by themselves to get information.

A large majority of patients (63 out of 74) stated that they received a contract stating among other things the SMT rules and regulations when entering the programme. A high percentage was familiar with the content of this contract (59 out of 69). Ten (out of 74) respondents stated that they were not informed about a contract.

**Treatment access issues**

Another issue decisive for patient satisfaction is access to treatment, i.e. travel distance, travel time, opening hours, and required frequency of visits.

Travel time was reported to range from one minute to two hours (one patient). A large majority of the interviewees (62 out of 74) were able to travel to the SMTC in less than 20 minutes. The average time needed to reach the SMTC was 15.9 minutes.

Transportation to the centre is done by almost half of the respondents (36 out of 75) on foot and by more than one third (29 out of 75) by car. Nine (out of 75) go by bicycle and another nine (out of 75) use public transport. Hitch-hiking is done by six (out of 75). Some patients mentioned more than one mode of transport.

Opening hours determine the accessibility of treatment in a substantial way. For 51 respondents (out of 73) the opening hours were appropriate, and for the information on methadone as sufficient. The respondents feel less well informed about buprenorphine (34 out of 74) and slow-release morphine (31 out of 73). Only one of the patients in buprenorphine treatment feels poorly informed about this treatment, while about two thirds of the patients in other forms of substitution medication feel poorly informed about buprenorphine treatment (37 out of 58 methadone users and 2 out of 3 slow-release morphine users). With slow-release morphine the picture is somewhat similar. Only one third (20 out of 58) of the patients in methadone treatment feel well-informed about slow-release morphine treatment, while two thirds of the patients in treatment with other substitution medication (8 out of 12 on buprenorphine and 2 out of 3 on slow-release morphine) feel well informed about it. Only 6 (out of 23 of the interviewees that answered this question) feel well informed about antagonist treatment with naltrexone. The reasons for these differences may lie in the fact that methadone is the ‘oldest’ substitution substance, whereas the others are relatively new.
22 (out of 73) they were not. Reasons (some patients gave more than one reason) for this judgment were: that the opening hours did not fit with working times (12 out of 22); school (2 out of 22); parenting (1 of 22); and accidental reasons (e.g. holidays or qualification programmes (4 out of 22). Nine (out of 22) stated less specific reasons, e.g. that the centres are not open long enough or that opening hours are subject to change. Opening hours vary widely between centres. Improvements suggested by the respondents include earlier opening times in general (at 6:00 or at 5:00 a.m.) and earlier dispensing on Fridays; longer opening times or flexible opening possibilities during the day.

Distance from home to the treatment centre is especially important when patients have to pick up their medication daily. More than two thirds of the patients have to go to the centre daily in order to get their medication (51 out of 75). Eight (out of 75) receive their medication either twice or three times a week, while 16 (out of 75) reported that they get it once a week. Not surprisingly, a large majority of respondents would like to receive take-home medication for reasons of mobility and flexibility. Especially for travels and holidays, 62 (out of 75) respondents would like to get a take-home dosage, but many patients also mention other extraordinary situations (55 out of 75).

The degree of satisfaction with the rules for take-home medication is relatively high: 58 (out of 73) are satisfied, while only 12 (out of 73) state they are not satisfied because the current rules are discriminating (4 out of 12), limit social integration (3 out of 12) or interfere with other obligations (2 out of 12). Five (out of 12) mention other reasons, e.g. conditions being too difficult to get a take-home dosage (2 out of 5). Three (out of 73) gave no clear answers.

Take-home medication is only provided for patients who have spent some time in SMT, to allow the staff to make a judgement. This period in SMT varies. Nineteen (out of 64) respondents had to be in treatment for up to three months before they could get a take-home dosage. For 18 (out of 64) this period was three to six months, while 12 (out of 64) had to be in treatment for more than 12 months. For 15 others (out of 64) this question did not apply as they had been involved in treatment for too short a period of time to get take-home dosages.

The respondents were asked to rate the degree of flexibility of the substitution substance dispensing, e.g. in case they miss a day, or if they want to change the frequency of picking up their medication. The average was 4.6 (median 5.0) on a 7-point scale from 1 (very flexible) to 7 (not flexible). Twenty-seven (out of 73) judged the distribution to be flexible, 8 respondents (out of 73) were indifferent, and 38 (out of 73) rated the distribution as not flexible. However, the six centres included in this survey did not score equally. In three of the six centres patients proved to be more
dissatisfied with flexibility of distribution than in the other three, since 22 out of 38 patients interviewed in the first centres reported their dissatisfaction (score of 5 or more).

**Additional services**

Besides dispensing of the substitution medication, SMTCs also offer other services. Services mentioned by the respondents are listed in table 20. Some patients perceived these services as a necessary and thus obligatory part of SMT. This is specifically reported: for HIV/HCV-testing (50 out of 67); vaccinations (38 out of 67); counselling (25 out of 67); screening for infectious diseases (24 out of 67); psychiatric care (15 out of 67); psychosocial care (8 out of 67) or other services (9 out of 67) e.g. urine test (4 out of 9). Three-quarters of the respondents (53 out of 69) were satisfied with the frequency of urine tests.

The signed treatment plan states that signing this agreement means agreeing with being tested for HIV. However, SMTCs cannot force people to participate in tests. Patients are allowed to decide freely on HIV and hepatitis testing.

**Table 20:** Additional services mentioned by the respondents (n=74, >1 answer possible)

<table>
<thead>
<tr>
<th>Service (excluding SMT) mentioned</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselling</td>
<td>55</td>
</tr>
<tr>
<td>Psychiatric help</td>
<td>46</td>
</tr>
<tr>
<td>Psycho-social care</td>
<td>31</td>
</tr>
<tr>
<td>Drug-related infectious disease testing (HIV and HCV)</td>
<td>50</td>
</tr>
<tr>
<td>Screening of other infectious diseases</td>
<td>39</td>
</tr>
<tr>
<td>Vaccinations</td>
<td>40</td>
</tr>
<tr>
<td>Getting extra information about addiction through workshops, seminars, lectures, training</td>
<td>11</td>
</tr>
</tbody>
</table>

Half of the patients would prefer more additional care services than they currently receive and the other half thought the provision sufficient. Those who wanted more services think in the first place about more (individual) counselling, treatment and support on medical, psychological and social issues. The aim is (20 out of 37) to enable patients to improve their psychosocial situation. The method may be both individual meetings and group meetings or therapies (e.g. self-help groups: a parents group, conversations with ex-drug users). A minority requested additional offers concerning a day structure (4 out of 34) to avoid boredom and as a stimulus to more become active.
Treatment conditions

Privacy
Privacy is important for more than three-quarters (57 out of 74) of SMT patients. Patients are afraid of the negative consequences of being seen and labelled as a drug user or do not like talking about sensitive topics and issues with others.

With regard to the intake, 55 (out of 74) respondents stated that enough privacy was given in this situation and 19 stated that this was not the case. Forty (out of 69) respondents were satisfied with the privacy during urine tests while 29 (out of 69) were not. Rating the degree of privacy - experienced in SMT in general - on a 7-point scale from 1 (not at all) to 7 (completely), on average the patients rated it 4.62.

Contact with the staff
Twenty patients (out of 74) had contact with the medical doctor every week. For another 20 (out of 74) this appeared to be once per month. Thirty-four (out of 74) stated that they saw the doctor upon request.

Asked if the respondents would like to see the doctor more often, almost three quarters (54 out of 74) declined and only one quarter (20 out of 74) wished to speak the doctor more often. On the other hand, the patients mentioned that too few doctors were present and that there was need of more staff, professional assistance and a more professional attitude.

Attitude of the staff
On average, the patients judge the relationship with SMTC personnel as positive. Asked directly how they are treated within SMT, 45 (out of 74) answered ‘with respect’, 20 (out of 74) as ‘normal’ (e.g. not good, not bad). Only a minority of respondents (5 out of 74) felt treated without respect. This smaller group referred to unfriendliness, the use of double standards and the lack of a humane and respectful attitude.

Rating the way they are treated by the staff on a 7-point scale from 1 (dissatisfied) to 7 (very satisfied), the average was 4.92, i.e. on the positive side of the continuum. The majority of the respondents (47 out of 75) also stated that they have some influence on how they are treated by the staff of their SMTC. One third (25 out of 75) disagreed with this.

The respondents were further asked if – in case of dissatisfaction - they could address their feelings of dissatisfaction effectively to the staff (i.e. without negative consequences). The average rating was 4.58 on a 7-point scale from 1 (never) to 7 (always). This shows that, in general, patients are fairly satisfied with things as they are.
Thirty-four patients presented suggestions for changing the way they are treated by the personnel. The answers reflect rather non-specific issues, e.g. more “respect” or “anonymity” or a more “humane” or “better attitude of the staff”. Some answers are more specific, e.g. referring to the rude behaviour of certain staff members.

Nine (out of 75) patients stated that they indeed once complained about staff treatment. Half of the patients (37 out of 75) thought that complaining could be useful, 25 (out of 75) thought that this was not so, while 13 (out of 75) did not know. Twenty-seven (out of 74) were satisfied with the complaint procedure, 30 (out of 74) were not satisfied and 17 (out of 74) did not know. Somewhat more than a third of the respondents (27 out of 75) stated that they were familiar with the procedure for formal complaints, but 46 (out of 75) were not familiar with it.

Finally, respondents were asked about the possibility of talking with the staff about everyday topics (an assumed indicator for a good relationship). The patients rated on average 5.18 on a 7-point scale from 1 (never) to 7 (always), which is a positive average judgment.

**Premises**

Ten respondents (out of 49) were not satisfied with different aspects of the premises or buildings. Examples are: a lack of privacy when giving urine samples (2 out of 10); a lack of (or inappropriate) waiting rooms (5 out of 10); unhygienic conditions in the building (1 out of 10); and a lack of possibilities for other activities in the building, e.g. workshops, sport activities or group work (2 out of 10). Suggestions for improvement included a warm waiting room, more privacy, more centres in the surroundings, and a shelter to protect them from the wind in winter.
5. Management, organisation and costs of SMT

Introduction

Collecting data on financial aspects, staff structure and related topics proved to be more time-consuming than on other evaluation subjects. The financial data we requested were related to 2006. Many data were not easily available and had to be looked up by the staff at the SMTCs. So when interviewing the staff of the SMTCs, we focused on the quality issues and on those parts of the management and organisational issues, including budget and cost issues, that were easily accessible. In six selected cities (Koper, Kočevje, Ljubljana, Logatec, Nova Gorica and Velenje) we also carried out interviews on management issues (interviews with directors of the health care centre). The SMTC staff were asked to fill out the rest of the required data on costs issues and staff structure later and to return them by mail. To fill in these data, several centres consulted their financial auditor. We further received the 2006 reports to the Health Insurance Institute Slovenia (HIIS). However, quite a lot of items in the structured datasheet used by the HIIS were not covered and despite requests from the Ministry of Health these gaps were not filled in. The reports to the HIIS include data on epidemiological activities, medical treatment, dispensing of substitution medication and psychotherapy. Thus we gathered data from all 18 SMTCs on management and organisation. However, for different reasons we received incomplete questionnaires from Maribor, Izola, Piran, Koper and Trbovlje. The SMTC in Izola, for example, refused to give answers to specific questions. In some other cases the collected information did not allow answers to all the questions. Only one centre (Nova Gorica) answered all the questions in the interview as addressed, and nine centres filled out most questions but not all of them.

Management and organisational issues

We received useful and comparable data on specific topics from 13 SMTCs (Brežice, Celje, Ilirska Bistrica, Kočevje, Kranj, Logatec, Ljubljana, Murska Sobota, Nova Gorica, Novo Mesto, Pivka, Sežana, Velenje). Examples of these topics are the actual number of patients in SMT; the average time spent on patients (during intake and daily dispensing); the average and maximum dosages; and staff structure. Still, there were significant differences between data reported from different sources. This is particularly so for the average working hours of different professionals within the SMTC staff, and the budget allocated for SMT in the centres in 2006.

We furthermore received some data about current numbers of registered patients. Different systems of patient registration are in use, resulting in different calculations and numbers. The reliability of the little data received on
the actual budget spent on SMT in 2006 per centre also appeared to be limited. A possible reason is that the financial administration of the SMTCs is primarily the responsibility of the director of the PHCC, not of the heads of the SMTCs. The latter therefore have in general little or no knowledge of what money has actually been spent on the work they perform. Therefore, in some cases questionnaires were returned stating ‘no data available’. Only four SMTCs (Brežice, Kranj, Nova Gorica, Pivka) specified the funds spent per substitution substance in 2006.

**Funds provided**

SMTCs receive regular funding (i.e. funding for salaries and other costs for running the centre, excluding the costs of medication) according to the number of patients in treatment. Eleven SMTCs provided a total overview for all patients receiving SMT, not differentiating per medication.

Three SMTCs also report that psycho-social support is financed through their regular funding from the HIIS (Kočevje, Novo Mesto and Pivka).

The information presented by 15 SMTCs that provided data on patient numbers shows that in 2006 SMT was provided for 2,224 patients in total. Overall, this is in line with the data of the HIIS as reported.

### Table 21: Number of patients in SMTCs reported by HIIS

<table>
<thead>
<tr>
<th>SMTC</th>
<th>Average number in period from 1.1.2005 - 31.12.2005</th>
<th>Number of patients in treatment</th>
<th>Number of patients in SMT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brežice</td>
<td>90</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>Celje</td>
<td>387</td>
<td>149</td>
<td></td>
</tr>
<tr>
<td>Ilirska Bistrica</td>
<td>70</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Izola</td>
<td>100</td>
<td>52</td>
<td></td>
</tr>
<tr>
<td>Koper</td>
<td>236</td>
<td>204</td>
<td></td>
</tr>
<tr>
<td>Kočevje</td>
<td>101</td>
<td>65</td>
<td></td>
</tr>
<tr>
<td>Kranj</td>
<td>135</td>
<td>130</td>
<td></td>
</tr>
<tr>
<td>Ljubljana</td>
<td>583</td>
<td>538</td>
<td></td>
</tr>
<tr>
<td>Logatec</td>
<td>126</td>
<td>107</td>
<td></td>
</tr>
<tr>
<td>Maribor</td>
<td>340</td>
<td>210</td>
<td></td>
</tr>
<tr>
<td>Murska Sobota</td>
<td>199</td>
<td>77</td>
<td></td>
</tr>
<tr>
<td>Nova Gorica</td>
<td>446</td>
<td>190</td>
<td></td>
</tr>
<tr>
<td>Novo Mesto</td>
<td>97</td>
<td>71</td>
<td></td>
</tr>
<tr>
<td>Piran</td>
<td>191</td>
<td>120</td>
<td></td>
</tr>
<tr>
<td>Pivka</td>
<td>93</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>Sežana</td>
<td>106</td>
<td>85</td>
<td></td>
</tr>
<tr>
<td>Trbovlje</td>
<td>202</td>
<td>148</td>
<td></td>
</tr>
<tr>
<td>Velenje</td>
<td>131</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3633</strong></td>
<td><strong>2411</strong></td>
<td></td>
</tr>
</tbody>
</table>

Source: ZZZS 2007a
Actual number of reported patients in substitution treatment

Centres reported substitution treatment with methadone, buprenorphine and slow-release morphine, but the number of patients per substitution substance differs considerably.

Most of the centres reported little difference between the number of patients on methadone at the beginning and at the end of 2006. Noticeable differences occurred only in two SMTCs.\textsuperscript{21} At the beginning of 2006, the number of patients on buprenorphine varied from 2 (Novo Mesto) to 36 (Nova Gorica) and at the end of the year from five (Celje) to 47 in Ljubljana. In all but one SMTC, the number of patients on buprenorphine treatment increased slightly during 2006. The number of patients receiving slow-release morphine at the beginning of 2006 was lowest in Ilirska Bistrica (just one from a total of 47 patients in SMT) and highest in Ljubljana (37 patients from a total of 581 patients in SMT). By the end of the year, both Sežana (65 SMT patients) and Nova Gorica (total 190 SMT patients) had one patient on slow-release morphine. In Ljubljana the percentage (15\%) did not change much (34 out of 526).

In short, the number of patients receiving methadone in 2006 was the largest and seemed to be fairly stable when compared with those receiving buprenorphine or slow-release morphine. It should be noted that these numbers may be biased because several SMTCs reported non-comparable numbers counted at different time points in the year.\textsuperscript{22} For several reasons, it is difficult to form an accurate picture of the actual number of patients in treatment. There are several explanations for this:

- Patients in SMT tend to enter and leave treatment. Centres use different criteria to assign a re-entering patient as new-in-treatment or continuing in treatment. E.g., a patient not coming to his appointment during a week will be seen as in treatment, but should this patient still be classified as in treatment when he comes back after a month?
- We interviewed the head and a nurse of each SMTC separately. Usually they provided different numbers of registered patients in SMT. This may be due to the fact that the doctors are not in charge of the daily practice of dispensing SMT, and therefore may not have an up-to-date overview of actual numbers of patients. The nurse is generally in charge of the daily

\textsuperscript{21} For instance, at the beginning of 2006 there were 36 patients reported in Ilirska Bistrica and 519 in Ljubljana. By the end of the same year, the number of patients was reduced to 24 in Ilirska Bistrica and to 445 in Ljubljana.

\textsuperscript{22} Velenje refers to the number on the day of interview, whereas Nova Gorica and Celje report the state of affairs on different dates. For instance, the number of methadone patients in Velenje is 38, in Nova Gorica 144 (27 July 2007) and in Celje 145 (31 May 2007). On these same dates buprenorphine is provided in Velenje to 24 patients, in Nova Gorica to 40 patients and in Celje to 15 patients. Similarly, slow-release morphine is provided to 2 persons in Velenje, in Nova Gorica to 5 patients, and to nobody in Celje.
work with the patients and therefore may have more accurate knowledge of these numbers.

- There are differences between the numbers mentioned during the quality interviews and those reported in the efficiency questionnaire. This could be explained by the fact that in the latter 2006 data were provided whereas in the interviews data on the current treatment population were presented.
- Many SMTCs use different registration systems. Some systems present the number of patients who have been in substitution treatment from the start of the centre, while other centres only count patients that are currently receiving SMT.
- Some SMTCs use computerised registration systems, others produce only handwritten notes of the dispensing of substitution drugs, and some use both types.
- Still another obstacle for collecting reliable numbers of patients in substitution treatment is that the data provided by the HIIS sometimes give higher numbers than those reported by SMTC staff and sometimes lower. For some centres data from the HIIS are even not available at all.

In conclusion, the numbers of patients presented here are just indications of the numbers of patients currently in SMT.

The above-mentioned irregularities in data registrations and reports considerably impair a more specific analysis of patient numbers. Such analyses may be directed at the total number of patients that stay in treatment for less than one year or patients that are released from treatment but return the same year, or at the average time of a patient in treatment with or without interruptions. The collected data on these issues also vary considerably. Only some make sense, e.g. data that show that patient numbers in SMT including interruptions are much higher than those without.²³

**Budgets allocated**

The Ministry of Health proposed for 2006 to the HIIS allocating €2,280,225 on salaries and other organizational costs for SMT (see table 22). However, the expenditures planned and allocated for SMT by the HIIS were somewhat lower, namely €2,242,628 (ZZSZ 2006b). The reasons for this reduction (€37,597) remain unclear.

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²³ The average stay of patients in SMT (without interruptions) varies from 6 months in Celje to 5 years in Ljubljana. The average stay in treatment (including interruption) varies from 2.5 years in Celje to 12 years in Velenje. In general most patients are in treatment for many years and the number of patients in treatment for less than one year varies greatly (e.g. 6 of all 108 SMT patients in Logatec and 101 of the 530 SMT patients in Ljubljana).
Table 22: SMT Budget 2006

<table>
<thead>
<tr>
<th>Budget in 2006</th>
<th>Salaries and other organizational costs</th>
<th>other</th>
<th>Medication costs</th>
<th>Total costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proposed</td>
<td>€ 2,280,225</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allocated</td>
<td>€ 2,242,628</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(difference)</td>
<td>- € 37,597</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spent</td>
<td>€ 2,226,772</td>
<td></td>
<td>€ 2,735,012</td>
<td>€ 4,961,784</td>
</tr>
<tr>
<td>(difference)</td>
<td>- € 15,856</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sources: ZZZS 2006a and 2006b

Budgets spent
In 2006 the actual insurance expenditures on SMTCs (salaries and medication) were € 4,961,784. The sums of € 2,226,772 were spent on salaries and organizational costs and of € 2,735,012 on all SMT medications. These costs include the costs of methadone, buprenorphine, and slow-release morphine.

By law the HIIS reports per region the annual amount of money spent on SMT. In general this money is allocated for spending in PHCCs. Thus SMTCs are not an autonomous part of PHCCs.

From 3 SMTCs (Izola, Koper, and Piran) we did not receive any budget data and two other centres (Celje and Maribor) report not having data available about the funding actually spent in 2006. This might be explained by the fact that in many of the SMTCs the director of the PHCC is in charge of the funding. From the 13 remaining SMTCs, 11 spent the complete allocated budget for 2006 (some slightly more, others slightly less). The two other SMTCs spent some 5-10 % more than the total funding allowed.

Additional funding for other activities
A few SMTCs have succeeded in receiving additional funding from other sources than the HIIS. In Nova Gorica, the municipality funds the treatment of gambling addiction as well as prevention work in general. The municipality of Trbovlje funds (preventive) work among youth and post-detoxification support. In Novo Mesto, the municipality funds lectures and a bulletin for drug users. Other SMTCs report no additional funding for these activities.

Other factors influencing the costs of SMT
Dosage
The dosage prescribed in Slovene SMTCs varies widely, and this holds true for methadone, buprenorphine and for slow-release morphine. Some use relatively low doses. It is not clear whether this is part of an explicit treatment policy or a different approach to patients by the treatment professionals. Some SMTCs have only one or two patients on slow-release morphine.
Table 23: Reported doses (mg/day) of methadone and buprenorphine (2006)

<table>
<thead>
<tr>
<th>Doses*</th>
<th>Methadone</th>
<th>Buprenorphine</th>
<th>Slow-release morphine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average</td>
<td>60-100</td>
<td>2-18</td>
<td>120-1,200</td>
</tr>
<tr>
<td>Maximum</td>
<td>140-450</td>
<td>18-48</td>
<td>420-1,800</td>
</tr>
</tbody>
</table>

* The ranges denote the average / maximum doses varying between the centres

**Time spent per patient**

Fourteen of the 18 SMTCs reported data regarding the average time spent per patient per intake and per ‘dispensing session’. Data are lacking from Koper, Piran, Izola and Pivka. Results show that the time a medical doctor spends on a new intake varies from 30 to 110 minutes. The time needed for one dispensing varies from five to 35 minutes. These data are estimates, and in several cases ranges are also reported.

**Staff structure**

The number of staff is calculated based on the following normative FTEs per 100 patients per centre: 0.52 medical doctor, 0.58 bachelor degree nurse, 0.15 psychiatrist, 0.15 psychologist, 0.23 laboratory analyst, 0.28 administrative worker, meaning in total 1.91 fulltime equivalent staff for 100 patients per centre. There are differences between the numbers reported by SMTCs and the normative numbers calculated. One explanation for this is that some SMTCs receive less and others more FTE from the PHCC than the norm-based number. Some SMTCs also get additional funding from other sources.

**Monthly working hours**

The results presented below are from the 17 SMTCs from which we received information on the monthly working hours per separate professional background. In most SMTCs, the medical doctor works part-time and in some of these centres the average number of his/her working hours is quite limited. The average number of working hours for medical doctors does not seem to be always linked to the number of patients in treatment.

In all the SMTCs from which we received data a psychiatrist is working. Here again, the average working hours differ substantially between the centres: in half of the SMTCs (8 out of 17) the average working hours of a psychiatrist is around 24 hours per month. In two SMTCs, however, the psychiatrist is

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24 No data on monthly working hours were received from Piran.

25 E.g.: 10 hours per month in Kočevje and 24 hours per month in Ilirska Bistrica. Not surprisingly, Ljubljana with the highest case load also has the highest number of working hours reported for the medical doctor (655 hours per month, i.e. around 3.7 fte).

26 For instance, in 2006 the SMTCs in Pivka and Ilirska Bistrica have similar numbers of patients in SMT, but Pivka has 70 hours per month available for a medical doctor, whereas Ilirska Bistrica has only 24 hours per month available.
available on average for 30 and 35 hours per month. In Ljubljana a psychiatrist is available for 189 hours per month, i.e. more than one FTE. In the remaining 6 SMTCs these hours are roughly between 32 and 80 per month (i.e. 8-20 hours per week).

Six out of the 17 SMTCs have no **psychologist**. From the 11 SMTCs with a psychologist, four centres (Ljubljana, Koper, Celje, and Nova Gorica) report average monthly working hours of a psychologist varying from 52 to 189 hours. Two other centres report somewhat fewer hours (43 and 35 for Kranj and Murska Sobota respectively. In five centres a psychologist's work schedule is less than 24 hours per month (Izola, Brežice, Piran, Pivka and Velenje).

The efficiency questionnaire gave less complete data on the educational background of nurses than the quality-questionnaire (see also chapter 2 on methodology). The efficiency questionnaire data showed that six of the 17 SMTCs do not have a **nurse with a bachelor degree** on the pay roll. According to the answers given, these centres employ nurses with secondary school education. Some centres employ nurses with both educational levels.

From the 11 SMTCs that employ nurses with a bachelor degree, Ljubljana reports the highest total number of working hours for nurses: 730 per month. Velenje has the lowest number: 46.4 per month.

All SMTCs can use the services of a laboratory which is part of the PHCC. Most of the centres have laboratory costs included in the last audit report. These costs are mostly based on a fixed rate because the money is spent by the PHCC (cf. Dernovšek & Cvetko, 2004). In two centres this is not done.²⁷ At the other 16 SMTCs the reported average monthly working hours of the laboratory analyst varies substantially.²⁸ In Pivka laboratory analyses are done by the nurse.

Finally, some centres report having hours available for other professions: Velenje (administrative work, 22.4 hours/month); Nova Gorica (psychotherapy 19 hours/month); Maribor (administrator when needed). The available FTE for administrative work seems to be generally included in the PHCC staff capacity.

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²⁷ In Izola they do not report a laboratory analyst among the staff and in Kočevje they have no fixed working hours for this, but the working hours are adjusted to the actual needs of the centre.

²⁸ I.e. from 4 hours/month in Ilirska Bistrica to 290 hours/month in Ljubljana.
6. Reference countries

A selection of data on SMT was collected from four EU Member States which we used as reference countries to enable a rough comparison with the situation in Slovenia. We selected two new EU Member States (Czech Republic and Lithuania) and two old EU Member States (Germany and The Netherlands) which all – like Slovenia – have a (relatively) long tradition and broad geographical coverage of SMT.

In some respects Slovene SMT scores well compared to the other countries although, of course, some reservations have to be made. SMTCs in Slovenia make use of guidelines and registration systems, and its SMT has been partly evaluated before. Treatment plans are used and there are no waiting lists for patients. A normative number of staff per 100 patients has been determined, while this feature is absent in the three other countries.

Slovene SMT is comparable to that in the other countries concerning professional expertise, the substitution drugs and average dosages used, and the additional interventions available. Additional treatment is probably less well organised than in most of the other countries in some aspects, i.e. staff training and the frequency of cooperative contacts with other organizations.

Unfortunately, the registration system does not make it possible to follow patients through the system but this is also true for two of the four other countries.

Thus on the whole, SMT in Slovenia functions fairly well compared to these other EU countries. Table 24 gives an overview of the findings on the reference countries.
Table 24: Overview findings on reference countries

<table>
<thead>
<tr>
<th></th>
<th>Czech Republic</th>
<th>Netherlands</th>
<th>Lithuania</th>
<th>Germany</th>
<th>Slovenia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Est. # SMTCs</strong></td>
<td>24 SMT outlets</td>
<td>100-140 SMT outlets and around 250-300 with pharmacies and GPs included</td>
<td>12 centres</td>
<td>2300-2600 GPs, unknown # centres</td>
<td>18</td>
</tr>
<tr>
<td><strong>Est. # total staff in SMTC</strong></td>
<td>Between 40 and 80 staff</td>
<td>Unknown</td>
<td>Around 50 staff</td>
<td>Unknown</td>
<td>Around 89 staff</td>
</tr>
<tr>
<td><strong>If GPs provide SMT do they receive extra training?</strong></td>
<td>Not obligatory</td>
<td>Not obligatory</td>
<td>No prescription by GPs</td>
<td>Special training is obligatory</td>
<td>Not obligatory</td>
</tr>
<tr>
<td><strong>Professional expertise available at the SMTC</strong></td>
<td>Medical: extensive to full Psychiatric: extensive to full Psychological: extensive to full Infectious diseases: extensive to full Pharmacological: extensive to full Counselling: extensive to full Social support: extensive to full</td>
<td>Medical: extensive Psychiatric: extensive Psychological: extensive to full almost non existing Infectious diseases: extensive Pharmacological: extensive Counselling: limited to extensive Social support: extensive</td>
<td>Medical and psychiatric: extensive Psychological: consultation expertise available extensive, no psychotherapy Infectious diseases: limited Pharmacological: limited Counselling: extensive Social support: limited</td>
<td>Medical: extensive Psychiatric: extensive Psychological: extensive Infectious diseases: limited Pharmacological: rare Counselling: limited to extensive Social support: extensive</td>
<td>Medical: extensive Psychiatric: extensive Psychological: extensive Infectious disease: limited Pharmacological: limited Counselling: limited Social support: rare</td>
</tr>
<tr>
<td><strong>Training/ prof. support for SMTC staff</strong></td>
<td>Available but rare</td>
<td>Limited</td>
<td>Regular and extensive</td>
<td>Limited but regular</td>
<td>Limited but regular</td>
</tr>
<tr>
<td><strong>Norm for # staff per # patients</strong></td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>1.91 staff per 100 patients</td>
</tr>
<tr>
<td><strong>Est. # problem drug users per # inhabitants (31.12.2005)</strong></td>
<td>32,000 (10,200,000)</td>
<td>33,500 (16,400,000)</td>
<td>5,400 (3,500,000)</td>
<td>78,000-195,000 (82,400,000)</td>
<td>7,500 (2,000,000)</td>
</tr>
<tr>
<td>Est. # patients in SMT 2006</td>
<td>Czech Republic</td>
<td>Netherlands</td>
<td>Lithuania</td>
<td>Germany</td>
<td>Slovenia</td>
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<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>Est. # patients: 592 – 973</td>
<td>Est. # patients: 13,410</td>
<td>Est. # of patients: 405</td>
<td>Est. # of patients: 64,500</td>
<td>Est. # of patients: 2,689</td>
<td></td>
</tr>
<tr>
<td>Est. # patients in SMT 2006</td>
<td>Methadone: 69%</td>
<td>Methadone: 96%</td>
<td>Methadone: 99%</td>
<td>Methadone: 81%</td>
<td>Methadone: 81%</td>
</tr>
<tr>
<td>Buprenorphine: av. 31%</td>
<td>Buprenorphine: 0,6%</td>
<td>Buprenorphine: 1%</td>
<td>Buprenorphine: 18%</td>
<td>Buprenorphine: 13%</td>
<td></td>
</tr>
<tr>
<td>/</td>
<td>Morphine: 0,4%</td>
<td>/</td>
<td>Codeine: 1%</td>
<td>Slow-release morphine: 6%</td>
<td></td>
</tr>
<tr>
<td>/</td>
<td>Heroin: 3%</td>
<td>/</td>
<td>/</td>
<td>/</td>
<td></td>
</tr>
<tr>
<td>Est. average and maximum dosages (mg/day) of SMT in 2006?</td>
<td>Methadone: average 70 -90 mg/d; maximum 350 - 480 mg/d. Buprenorphine: average: 6 mg/d and maximum unknown.</td>
<td>Methadone: average 40 - 55 mg/d; maximum 50 - 600 mg/d Buprenorphine: average 8 mg/d and maximum 32 mg/d.</td>
<td>Methadone: average 70-80 mg/d; maximum 120 – 200 mg/d/. Buprenorphine: average:12 mg/d and maximum is 24 mg/d.</td>
<td>Methadone: average 80 mg/d; maximum 200 - 800 mg/d. Buprenorphine: average 12 mg/d and maximum is 25 mg/d.</td>
<td></td>
</tr>
<tr>
<td>Est. total budget spent on SMT in 2006</td>
<td>€ 1,300,000</td>
<td>€ 40,000,000-50,000,000</td>
<td>€ 315,000</td>
<td>No information, different sources</td>
<td>€ 4,900,000</td>
</tr>
<tr>
<td>How is SMT dispensed?</td>
<td>Specialized centres and GPs</td>
<td>Mainly specialized centres and several GPs</td>
<td>Specialized centres</td>
<td>Mainly GPs but also specialized centres</td>
<td>By 18 centres, a few GPs and pharmacies</td>
</tr>
<tr>
<td>In case substitution treatment is done by SMTCs and GPs what is the ratio?</td>
<td>30-40% by centres; 60-70% by GPs</td>
<td>90% by centres; 10% by GPs</td>
<td>only provided by centres</td>
<td>10–15% by centres; 85–90% by GPs</td>
<td>Only few GP's prescribe treatment and supervised by SMTCs</td>
</tr>
<tr>
<td>Do GPs treat specific patient groups?</td>
<td>Unknown, probably not</td>
<td>Stable, socially integrated patients</td>
<td>Stable patients with good health status</td>
<td>GPs treat all patient groups</td>
<td>Patients in remote areas</td>
</tr>
<tr>
<td><strong>What is the task of these individual GPs?</strong></td>
<td><strong>Czech Republic</strong></td>
<td><strong>Netherlands</strong></td>
<td><strong>Lithuania</strong></td>
<td><strong>Germany</strong></td>
<td><strong>Slovenia</strong></td>
</tr>
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<td>--------------</td>
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<td>--------------</td>
</tr>
<tr>
<td>GPs are allowed to only prescribe buprenorphine</td>
<td>GPs prescribe substitution medication.</td>
<td>GPs not involved in SMT</td>
<td>GPs dispense substitution medication &amp; are responsible for the whole treatment</td>
<td>GPs dispense substitution medication prescribed by the centre</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Are the following interventions used in SMT?</strong></th>
<th><strong>Czech Republic</strong></th>
<th><strong>Netherlands</strong></th>
<th><strong>Lithuania</strong></th>
<th><strong>Germany</strong></th>
<th><strong>Slovenia</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing interventions: limited</td>
<td>Nursing interventions: limited</td>
<td>Nursing interventions: limited</td>
<td>Nursing interventions: limited</td>
<td>Nursing interventions: extensive</td>
<td></td>
</tr>
<tr>
<td>Counselling: extensive</td>
<td>Counselling: limited</td>
<td>Counselling: extensive</td>
<td>Counselling: extensive</td>
<td>Counselling: extensive</td>
<td></td>
</tr>
<tr>
<td>Psychological interventions: extensive</td>
<td>Psychological interventions: limited</td>
<td>Psychological interventions: limited</td>
<td>Psychological interventions: limited</td>
<td>Psychological interventions: limited</td>
<td></td>
</tr>
<tr>
<td>Family interventions: limited</td>
<td>Family interventions: limited</td>
<td>Family interventions: limited</td>
<td>Family interventions: limited</td>
<td>Family interventions: limited</td>
<td></td>
</tr>
<tr>
<td>Social support: extensive</td>
<td>Social support: extensive</td>
<td>Social support: extensive</td>
<td>Social support: extensive</td>
<td>Social support: extensive</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Are different approaches for specific target groups in place?</strong></th>
<th><strong>Czech Republic</strong></th>
<th><strong>Netherlands</strong></th>
<th><strong>Lithuania</strong></th>
<th><strong>Germany</strong></th>
<th><strong>Slovenia</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rare</td>
<td>In use</td>
<td>Rare</td>
<td>Rare</td>
<td>In use</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Is there a waiting list to get into SMT?</strong></th>
<th><strong>Czech Republic</strong></th>
<th><strong>Netherlands</strong></th>
<th><strong>Lithuania</strong></th>
<th><strong>Germany</strong></th>
<th><strong>Slovenia</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting lists (2 regions), up to 6 weeks to get into treatment. Reason: limited capacity centres</td>
<td>Waiting lists up to 2 weeks</td>
<td>Waiting lists up to 6 weeks to get into treatment. Reasons: limited capacity of centres and too few centres</td>
<td>Waiting lists to get into treatment in rural areas. Some GPs have bad facilities to provide ST</td>
<td>Sometimes it takes up to 2 weeks due to limited working hours of the doctor and to check personal data</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Are there exclusion criteria for SMT?</strong></th>
<th><strong>Czech Republic</strong></th>
<th><strong>Netherlands</strong></th>
<th><strong>Lithuania</strong></th>
<th><strong>Germany</strong></th>
<th><strong>Slovenia</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Unclear but possibly yes.</td>
<td>No exclusion criteria.</td>
<td>Not formally defined. Informal exclusion criteria may be violence against staff or patients, or not adjusting to the treatment protocol.</td>
<td>Exclusion criteria depend on the region and on the doctors. A lot depends on the doctor – patient relationship.</td>
<td>Formally defined: e.g. no basic health insurance, aged under 18, minimum opioid dependence &lt; 2 years. Living outside the region, and violence.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Czech Republic</td>
<td>Netherlands</td>
<td>Lithuania</td>
<td>Germany</td>
<td>Slovenia</td>
</tr>
<tr>
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<td>---------------------------------------------</td>
<td>--------------------------------------------</td>
<td>------------------------------------------</td>
<td>-----------------------------------------</td>
<td>-----------------------------------------</td>
</tr>
<tr>
<td>Are measures taken to prevent diversion/leakage?</td>
<td>Measures are taken, but unclear</td>
<td>Measures are taken, but rare</td>
<td>Measures are taken</td>
<td>Measures are taken</td>
<td>Measures are taken</td>
</tr>
<tr>
<td></td>
<td>Selective use of take home dosages</td>
<td>Take home dosages are not often given. Periodical urine testing; Supervised consumption.</td>
<td>Safe storage of medication. Supervised consumption. Take-home possible only for few patients. Urine testing.</td>
<td>Supervised consumption. Very few weekly dosages are given home. Urine examinations and blood tests</td>
<td>Supervised consumption. Mainly daily pick-up of the medication &amp; weekend dosages at pharmacy, monitoring of the premises with cameras, frequent urine testing</td>
</tr>
<tr>
<td>Do SMT providers cooperate with other services?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Are there SMT guidelines or protocols?</td>
<td>National guidelines, currently updated.</td>
<td>National guidelines RIOB, but are not in use yet</td>
<td>Guidelines since 1997</td>
<td>Regional or local guidelines exist.</td>
<td>National but also local guidelines are used</td>
</tr>
<tr>
<td></td>
<td>Czech republic</td>
<td>Netherlands</td>
<td>Lithuania</td>
<td>Germany</td>
<td>Slovenia</td>
</tr>
<tr>
<td>--------------------------</td>
<td>----------------</td>
<td>-------------</td>
<td>-----------</td>
<td>---------</td>
<td>----------</td>
</tr>
<tr>
<td><strong>Individual treatment plan per patient</strong></td>
<td>Generally</td>
<td>On a limited basis</td>
<td>Generally</td>
<td>On a limited basis</td>
<td>Generally</td>
</tr>
<tr>
<td><strong>Involvement patient in treatment plans?</strong></td>
<td>Patients are involved</td>
<td>Patient involvement is limited</td>
<td>Patient involvement is limited</td>
<td>Patient involvement is limited</td>
<td>In half of the centres patients are involved</td>
</tr>
<tr>
<td><strong>Are patient registration systems used?</strong></td>
<td>Registration system is used often, but not by GPs</td>
<td>Registration system in use, will be updated</td>
<td>Patient registration system is used often</td>
<td>No nationwide patient registration</td>
<td></td>
</tr>
<tr>
<td><strong>Does this registration system allow to follow patients through SMT programme?</strong></td>
<td>Generally it does not allow to follow the patient through the treatment, but system will be improved.</td>
<td>Generally it allows to follow the patient through the treatment.</td>
<td>Generally it does not allow to follow the patient through the treatment, system will be improved.</td>
<td>Patient registration exists but doesn’t allow to follow the patient through the treatment</td>
<td></td>
</tr>
<tr>
<td><strong>Was or is substitution treatment evaluated?</strong></td>
<td>No evaluation on different measures and approaches or on the quality of ST has been done</td>
<td>Some evaluations are have been done on an irregular basis</td>
<td>SMT is evaluated on an irregular basis. (2003 and 2006). Annual evaluation planned</td>
<td>SMT is evaluated annually. Scientific evaluations take place irregularly</td>
<td>SMT should be evaluated at least once a year. Last one was done in 2003</td>
</tr>
</tbody>
</table>

Estimated number of Problematic Drug Users: National Focal Points EMCDDA Annual Reports 2006 (data 2005)  
Number of inhabitants (www.europa-nu.nl)
7. Discussion

The discussion of the findings centres around the two main issues of this evaluation, i.e. the assessment of the quality and the efficiency of SMT in Slovenia. The findings on the reference countries were used as reference material for a better understanding of the findings on the Slovene SMT and to allow some basic comparative statements about the quality or efficiency. The discussion also included some reflection on the findings from the force field analysis.

We have discussed the findings and their implications not only in the Dutch-Slovene evaluation team but also with staff of SMTCs, some Slovene stakeholders and experts including five foreign experts. In this chapter we present the main issues arising from these discussions. We have grouped the issues under the following five headings:

- Staff issues
- Patient issues
- Treatment issues
- Internal organisation matters
- External organisation matters

We finish with a summary of the weak and strong points of the Slovene SMT.

Staff issues

**Staff capacity, availability and expertise**

Staff capacity, availability of staff and professional expertise are – at least in several smaller centres – issues that deserve attention. The majority of nurses and medical doctors are dissatisfied with the available staff capacity, especially in smaller SMTCs. Most of the staff stated that they could not spend enough time on SMT patients. The findings also show that two third of the nurses think that the staff capacity is not sufficient to cover the needs of the

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29 We organized a meeting on 4 October 2007 for the staff of SMTCs in which we presented and discussed the findings.

30 Ms Vesna Kerstin-Petrič, Head of the Sector Health Promotion and Healthy Lifestyle of the Ministry of Health; Ms Marjeta Ferlan-Istinič, directorate for social affairs, Ministry of Labour, Family and Social Affairs; Mr Andrej Kastelic, Head of the Centre for Treatment of Drug Addict University Psychiatric Hospital Ljubljana; Ms Nuša Konec-Juričič, Head of the Department of Social Medicine and Health Promotion, Regional Public Health Institute Celje; Ms Jasna Čuk-Rupnik, medical doctor, head of the SMTC in Logatec; Ms Metka Debevc Švegelj, nurse with bachelor degree, SMTC Ljubljana; Ms Barbara Loboda, nurse with bachelor degree, SMTC Piran.

31 Ms Anke Follmann, consultant and manager at the Landesärztekammer, Westfalen-Lippe, Mr Rob ter Haar, medical doctor involved in SMT in the Netherlands, Mr Victor Mravcik, head of the National Focal Point of Czech Republic, Mr Pat O'Hare, former director of the International Harm Reduction Association, Mr Emilis Subata, Director of Vilnius Centre of Addictive Disorders
patients (chapter 5). That nurses are more dissatisfied about this, may be explained by the fact that they have most of the daily patient contacts, thus they are most frequently confronted with this problematic situation.

Still, on the other hand it appears that the majority of patients is quite satisfied with the way things are done.

The official staff rate is 1.91 FTE per 100 patients (0.52 FTE general practitioner; 0.58 FTE bachelor degree nurse, 0.15 FTE psychiatrist; 0.15 FTE psychologist; 0.23 FTE laboratory analyst; 0.28 FTE administrative worker.) If we exclude 0.23 FTE for a laboratory analyst and 0.28 FTE for administrative staff, see chapter 3.1), the staff rate left over becomes 1.4 FTE for the actual treatment work. All four reference countries we selected do not have a normative staff rate. However, it is clear that the number of staff per 100 patients in the reference countries is higher. For example the Vilnius Centre of Addictive Disorders reports for 120 patients 2 FTE medical doctor, 3 FTE nurse and 2 FTE social work. In Czech Republic the number of staff is estimated to be 5 FTE per 100 patients. Moreover, in some centres in Slovenia staffing is less than the norm based on the number of patients. According to SMTC staff sometimes part of the staff capacity of the SMTC is used in the PHCC.

The current staff norm per 100 patients might be sufficient for basic SMT, including medical and psychological check-up and monitoring, substitution treatment, basic medical care and incidental counselling. As we know from the available scientific evidence SMT is more effective when psycho-social support is included. To be able to offer psycho-social support and more thorough (motivational) counselling the staff capacity of 0.15 psychologist for 100 patients is insufficient. In bigger cities and towns with bigger centres a solution to this problem can be found in cooperation with other services. Some centres succeeded in finding additional funding from other sources than HIIS. For smaller centres in smaller towns – lacking other services in their surroundings – a satisfactory solution is hard to find.

This problem for SMTCs is aggravated because staff turnover is high. Expertise is lost and it takes time to have new staff fully trained again. During the discussion of the evaluation findings with SMTC staff different participants stated that the PHCC management sometimes takes skilled staff from the SMTCs and appoints other staff at the centre (see also below under the heading ‘Relationship with PHCC’). In comparison with the reference countries it gets clear that SMTCs in Slovenia are facing rather a problem of capacity than available expertise. The latter can be judged as reasonable.

32 Personal communication with Emilis Subata

33 Personal communication with Victor Mravcik
An additional problem is the low status of staff working in drug treatment which may make it in general quite difficult to find staff for the SMTCs.

**Communication within the team** is – especially in small centres – often informal and on an ad-hoc basis. In smaller centres SMT teams generally consist of a (part-time) doctor and one or two (part-time) nurse(s), plus a consulting psychiatrist. Formal team meetings may not be necessary in those circumstances. The findings show that smaller SMTCs mostly use informal information exchange strategies. However, in part-time work and especially work on a consultancy basis, effective information exchange is not always easy to arrange. Moreover there are issues, like treatment policy, individual cases and the management of the centre, that require regular and – to a certain degree - formal discussions. The latter means that there should be an agenda and the discussions should result in (formal) decisions which are documented in minutes.

**Training and support of staff**

Training of SMTC staff in Slovenia is for an important part integrated in the monthly meetings of the heads of the SMTCs organised by the Coordination Committee. These meetings, generally attended by staff of all centres, also offer the possibility of professional support through case discussions and presentations on new developments in SMT etc. Besides this quite some centres provide professional training for their staff once or several times a year. For new staff, once or twice a year a basic course in drug treatment is organised.

Still, training of staff is judged as insufficient by several staff members and other stakeholders. In half of the centres both medical doctors and nurses would prefer additional training to carry out their work more effectively. During the discussion of the findings with SMTC staff it was stated that the limited available staff capacity result in insufficient time for training. Staff report that they sometimes take holidays to be able to follow training. The wish for more training is expressed especially in those centres with least frequent training opportunities, i.e. once a year or less.

There are many topics for additional training mentioned (see chapter 4.1). Some stakeholders also mention that staff training should be included in other forms of professional training, e.g. in the regular training of medical doctors. It is good to realise that despite these critical notes staff training in Slovenia is well provided for in comparison with the four reference countries. In the Czech Republic, Lithuania and The Netherlands training and professional support of SMT staff is rather rare. Only in Germany is training for staff provided on a regular basis. For medical doctors working in SMT in Germany, specialised training is obligatory (see chapter 6). The monthly SMTC meetings prove to be a unique feature of Slovenia compared with the reference countries not only with regards to training and professional support. They are
facilitating an exchange between the SMTCs and experts on professional issues.

Personal motivation and job satisfaction
Overall SMTC staff are motivated for their work (see chapter 4.1). The majority see the job as useful for the patients but also as quite stressful and difficult. The majority states that they receive feedback on their work from colleagues. However, one third perceives this feedback as insufficient. SMTC staff are very satisfied with their direct management (accessibility, taking care for good atmosphere, etc.). The SMTC staff are also fairly content with the way they are treated by the patients. The majority feels treated with respect, the rest states to be treated ‘normally’. The interesting thing is that patients state the same about the way they feel treated by staff. The vast majority of patients feels treated with respect or ‘normally’. This indicates that the relationship between treatment staff and patients is on average good. In conclusion it can be stated that staff are positive about their work but especially issues like work stress and feed-back require attention to keep motivation and prevent burn-out.

Patient issues

Treatment issues: medication, dosage, and perceived effects
Patient satisfaction about medication, dosage and intake is fairly high. Patients also rate the actual and expected impact of the treatment on their health and well-being clearly positive.

Information about SMT
Patients prove to be well informed about the substitution substances they get prescribed. They generally are less well informed about other substitution substances. This is especially true for patients in methadone treatment. One explanation for this might be that patients who are generally satisfied with the medication they receive are not looking for information about alternatives. This means that at least some patients do not have the necessary information for making an informed decision which substitution substance they would prefer.

Treatment access issues
Treatment access issues include travel distance, travel time, opening hours, required frequency of visits, but also flexibility in dispensing methods. In general again patients state to be satisfied with access to their SMTC.

Regarding travel time, the majority of patients can reach their SMTC within 20 minutes. The travel time is especially important for patients who have to pick up their medication on a daily basis. The longer the travel time the more dominant SMT is in their lives. More than two third of the interviewed patients
had to pick up their medication on a daily basis. Through a daily pick-up SMT becomes a dominating factor in their lives. This is especially true if it is combined with a relatively long travel time.

For a longer term perspective of a ‘normal’ life, actively participating in society and eventually getting drug-free, this daily life pattern is not helpful. To tackle the problem of long travel time in some places substitution medication is dispensed by general practitioners or pharmacies in the towns/villages where patients live. This remote dispensing is generally under the supervision of the regional SMTC. However, not many general practitioners or pharmacists seem to be prepared to get involved in this.

Take-home medication for several days or one week is another option to avoid the SMT is becoming dominant in the patients’ life. Take-home medication is generally offered to more stable patients and patients who have work, training or other obligations. Restricting take-home medication to a well-selected group of patients is one of the measures taken to prevent substitution substances being sold. Although the majority of patients would prefer more flexibility, i.e. take-home medication for certain occasions, most of the interviewed patients stated that they were satisfied with the rules for take-home medication.

Another factor influencing access to treatment are the opening hours of SMTCs. Appropriate opening hours are especially important for patients who have work or attend school or other education programmes. Overall the opening hours suited the majority of the patients interviewed. There was still a substantial number of patients (14 out of 73) for whom the opening hours of their SMTC did not fit with their work or education programme.

Overall, access to Slovene SMT is arranged well in comparison with the reference countries. Despite the relatively high level of satisfaction, SMT access is an important issue to discuss on centre level taking into account the specifics of the patients.

**Contact with staff**

The majority of patients is satisfied with regards to the frequency of their contacts with staff. One quarter would like to have more frequent contact with the doctor. With regards to the quality of the contacts with the SMTC staff a vast majority feels treated with respect or ‘normal’. Patients overall also have the feeling that they can address their dissatisfaction or complaints. These results (how clients judge their relationship with staff and the other way around) indicate in total a positive relationship between SMTC personnel and patients which can be seen as indicator for good quality of the SMTCs.
Privacy
Privacy is important for three-quarters (57 out of 74) of interviewed SMT patients. Though a majority of the interviewed patients stated that enough privacy is given, this is an issue worth improving. There have been especially complaints about lack of privacy around urine tests. In one SMTC people have to produce urine in a ‘corner’ behind a curtain.

Treatment issues

Additional services
Around half of the interviewed patients would prefer that the SMTCs provide more additional services than they currently receive, especially individual counselling, treatment and support on medical, psychological and social issues. As we know from the scientific evidence psycho-social support enhances the effectiveness of SMT. Incorporating psycho-social support through counselling in the treatment is important. Counselling can be done by social workers and/or by psychologists/psychotherapists. The latter is more oriented towards psycho-therapeutically while the former focuses more on the psycho-social living conditions of patients.

However, these services are generally quite time consuming. A substantially increased service programme might be difficult to realise within the existing budget. The existing staff norm does not include psycho-social support. Among many staff and stakeholders it is believed that the funding from the Health Insurance Institute Slovenia in principal does not cover the costs for social work as it is not medical treatment. However, this does not seem to be true. From the Health Insurance Institute Slovenia we understood that costs of social work could be covered if they were to receive a request to do so. Also in other medical treatment services (e.g. psychiatry, treatment of cancer patients) social work proves to play a part. The situation is unclear. We understood from the Coordination Committee that they had sent in several requests for getting the costs for a social worker at the centres covered, but these requests were not accepted.

Many SMTCs (especially the bigger ones) offer psychosocial support/counselling, generally through psychologists. In some cases they receive extra funding for this, e.g. from their PHCC or from the municipality. In some centres patients can receive psycho-social support/counselling from other services (NGOs, Centres for Social Work, etc.)35. All these options prove to be easier to implement in the bigger centres in bigger towns or cities.

34 Personal communication with Jurij Fürst, Head of Department of Medical Products of the Health Insurance Institute Slovenia
35 For a substantial part financed by the Ministry of Labour, Family and Social Affairs
smaller communities the problem will be more difficult to solve as the financial and staff capacity of the SMTC (and the PHCC) are quite limited and other services are hardly or not available.

Compared with the reference countries SMTCs in Slovenia offer the same range of additional services. However, especially in the smaller centres, these services are rather limited. Generally additional funding will be required to offer psycho-social support/counselling to patients in SMT. This is true for both scenarios, i.e. psycho-social support/counselling integrated in a SMTC or offered by another organisation.

Internal organisation matters

Treatment data collection
In most of the centres the First Treatment Demand Indicator (TDI), one of the five epidemiological key indicators of the EMCDDA is used at the intake of new patients to collect information on the patient’s situation. This information also serves as basis for formulating a treatment plan. The TDI is a basic questionnaire developed for epidemiological purposes. It is a general instrument not covering all relevant life areas. The TDI does not allow a tailor-made treatment plan per patient to be made which would follow the patient through the treatment and monitor their development. This means it is not suitable for monitoring or evaluating treatment impact. The same is true for the patient data collection in Czech Republic and Lithuania. In Germany and the Netherlands monitoring of the patients’ development during treatment is possible.

In many SMTCs treatment data is recorded in writing and not in a computer database. This means that the information is difficult to retrieve both for treatment purposes by the staff and for monitoring and evaluation purposes (see also ‘monitoring and evaluation’). A computerised system would be very useful here for more efficiency. As we understood from the discussion of the findings with the SMTC staff one SMTC had, in the past, developed a basic computer application for collecting treatment data on patients but this initiative did not receive financial support by the Ministry and the HIIS that was needed for national implementation of such a system.

Management data collection
Besides treatment data, monitoring and evaluation of the SMTCs requires management information, i.e. data on budget, spending (specified per budget item), patient numbers and staff capacity (FTE, working hours, salaries). One can opt for a quite basic system or a more sophisticated system, e.g. including caseload but also case severity. The management data collection is in quite some centres a weak point. Many data are still filled in by hand on paper forms. It proved to be difficult for us to collect these data. The
management data we received from some centres was incomplete and inconsistent with data we received from HIIS. From some centres we received information from the quality interviews that differed from the information provided in the efficiency questionnaire. As our task was evaluation of quality and efficiency of SMT and not auditing in the strict sense (financially or otherwise) our ability to retrieve these data and get insight into the aspects of costs of the SMT were restricted.

One explanation for the problems with collecting management data is that the data collection systems in some centres are inappropriate for retrieving the requested data with limited efforts. This also has to do with the fact that, for instance, financial and staff management is done on PHCC level. Some heads of SMTCs simply do not have the requested data. Collecting and comparing data on national level is therefore not really possible.

To assess the cost-effectiveness of SMT one would need data on funding and expenditure as well as sound data on the effects of SMT on the patients (e.g. in terms of treatment retention, number of prevented infectious diseases) which is both reliable and comparable across centres. To get this data would require uniform, detailed and computerised data collection systems and thorough (detailed) financial and administrative auditing.

Looking at the current state of treatment and management data collection the conclusion is that there is no reliable and uniform data system in use in Slovene SMTCs. What could be the product of “a simple push on a button” is for many centres still a time-consuming, painstaking activity with no guarantee of reliable results. The result of this is that there is no reliable and accurate data on SMT in Slovenia.

**Management**

An important factor already mentioned is that the actual management and accountancy is done on the level of the PHCCs. The budget made available for SMT is in fact decided by the PHCC director. This is not necessarily the same budget as made available by the HIIS based on the norm per actual number of patients. In some cases it is less and in some cases it is more. The budget does not go directly to the SMTCs as staff are employed (and in many cases also selected) and paid by the PHCC director. The heads of the SMTCs have no real management autonomy (see further under ‘Relationship with PHCC’ below).

Management in many SMTCs seems to be rather informal. This fits well in the picture of generally small teams of SMTCs with limited management tasks as part of the technical and human resource management is done at PHCC level. For instance, dividing the work to be done is – especially in the smaller SMTCs – decided in informal discussions.
In general the SMTC staff judge positively over their direct management. This also applies to the heads of the centres, meaning that they are in general satisfied with the management in the PHCC.

**Guidelines and protocols**

Seventeen SMTCs use the Methadone Guidelines of Euro-Methwork (Verster & Buning 2000). Some are using (besides the Euro-Methwork guidelines) the Slovene guidelines of 1994 and 2000. There are no essential differences between the Euro-Methwork and the Slovene guidelines. Overall the majority finds the guidelines they use sufficient. Critical remarks on the guidelines refer to not being specific enough on certain topics (e.g. dispensing of methadone for the weekends and exclusion criteria).

Our findings show that SMTCs differ substantially on a number of matters, e.g. minimum and maximum dosage of medication, rules for take-home medication, etc. This might be due to the use of general (unspecific) guidelines and a lack of direction or coordination. The situation in Czech Republic, Germany and the Netherlands seems to be quite comparable here: no national guidelines exist in these countries.

While discussing the findings with the staff of the SMTCs it became clear that the guidelines as such are satisfactory. Guidelines can be very general. Protocols are the more specific documents defining certain elements of treatment in concrete steps. However, there are some doubts about the usefulness of very elaborate protocols. Sometimes these instruments are too ‘heavy’ for daily practise. Moreover they can get outdated quickly. Checklists for certain elements of treatment might be more useful here.

These checklists can be developed by the Coordination Committee using the monthly meeting of the centres.

**External organisation matters**

**Political responsibility, auditing and control**

As described in Chapter 3.1 the Ministry of Health has final responsibility for the SMTCs in Slovenia. However, there are other governmental bodies which according to the ‘Prevention of the Use of Illicit Drugs and Dealing with Consumers of Illicit Drugs Act’ of 1999 have responsibilities here, i.e. the ‘Republic of Slovenia Government Office for Drugs’ (Office for Drugs) and the Commission of the Government of the Republic of Slovenia for Drugs” (Drug Commission).

The Office for Drugs was abolished in 2006 and its responsibilities have been assigned to the Ministry of Health. The Drug Commission, an inter-ministerial
committee, is supposed to bring together the separate ministerial parties in order to coordinate drug policy by reaching consensus on and formulating a coherent drug demand reduction policy. This would of course include SMT as one of the different drug treatment options. Many stakeholders interviewed think however, that in reality these Ministries do not or not sufficiently cooperate in the field of drug demand reduction. Our findings show that there is no real inter-ministerial consensus on drug demand reduction policy or on the specific issue of SMT. Some stakeholders suggested that a formally installed and independent committee could improve this inter-ministerial cooperation.

One of the tasks of the Ministry of Health is the supervision of, i.e. the formal control or audit of, the SMTCs. In 2003 the Ministry commissioned the most recent supervision report (Dernovšek and Rogač Cvetko 2004). Our findings show that the data collection of the SMTCs both on treatment and on management is insufficient for thorough monitoring and evaluation. There are for, example, no clear standards for counting patients (e.g. if a SMT patient does not show up for a period, for how long is this patient still counted as patient). There are different data collection tools in use by the SMTCs (e.g. on patient numbers and on finances) which complicates comparability. Many SMTCs still record these data on paper which makes the retrieval and compilation of the data time-consuming. Part of the data collection (finances and staff) is in fact under the management responsibility of the PHCC. Uniform and computerised data collection systems, one for collecting treatment and one for collecting management data would facilitate the supervision task of the Ministry (see chapter 8).

As mentioned in chapter 3.1 the financing system of SMT is split. The operational costs of the centres are financed by funds from the HIIS. The costs of the substitution medication are covered by the HIIS based on the prescriptions per patient. The budget for operational costs is a lump sum established as a total for all SMTCs. The individual SMTCs get their share of this total budget according to their caseload in the preceding year.

There are weak points in this financing system and in the way it is handled. The system does not take into account eventual changes in patient numbers in a SMTC which can lead to capacity problems in SMTCs. It is based on (last year’s) caseload and does not take into consideration case severity.

Another weak point concerns the fact that the director of a PHCC can decide to use part of the operational budget allocated for the SMTC for other purposes. This also can be done ‘indirectly’ by using staff employed for SMT work for other work in the PHCC. The annual SMT budget is not always based

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on the patient numbers of the preceding year. For instance, the budget for 2007 was calculated on the basis of the 2005 patient numbers. Also these things can lead to capacity problems in SMTCs.

With regards to financial monitoring and control SMTCs are obliged to send a financial report twice a year to the (regional office of the) HIIS. However, when collecting information we found out that this is not always done properly. Not all data proved to be available, different forms were used by the SMTCs to collect this information.

**Coordination Committee**

The Coordination Committee’s responsibility is to look after the coordination and professional support of the SMTCs. This includes matters like training, developing guidelines and protocols, decisions on treatment exceptions (e.g. exceptionally high dosages).

As stated above there are substantial differences between SMTCs, e.g. concerning maximum and minimum dosage of medication and rules for take-home medication, which can be seen as an indicator of lack of coordination. The monthly meetings of the heads of the SMTCs organised by the Coordination Committee can be used for reaching consensus on matters like treatment rules. The Coordination Committee also has the responsibility of checking whether the treatment rules are implemented.

**Relationship with PHCC**

Although the SMTCs are part of the PHCCs we decided to deal with the relationship between these two under the heading ‘external organisation’ because the SMTCs are operating and perceived in the field as separate units. From our findings it can be assumed that the majority of the heads of the SMTCs are not satisfied with the management support they receive from the PHCCs.  

A number of heads of SMTCs made some critical remarks concerning the degree of autonomy of the SMTCs. During the meeting with SMTC staff to discuss the evaluation findings several SMTC heads stated that the lack of management autonomy is a problem. This is illustrated by the problems of staff capacity described above. Management decisions, for example, about the budget and staffing of a SMTC are formally the responsibility of the PHCC

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37 As stated above: in general the SMTC staff judge positively over their direct management. Also the judgement of the heads of SMTCs is positive here, however systematically less positive. When asked directly about the sufficiency of the management support the majority of heads rate the support as insufficient. This divergence in judgement may be explained by the fact that the questions about the direct management were perceived as questions regarding the person whereas the question about the sufficiency of the management support might have been perceived as (also) regarding the organisational and financial factors. The personal relations between the SMTC and the management of the PHCC seem to be relatively good, but other obstacles make that managerial support is rated as insufficient.
management. The PHCC director is entitled to define the budget of the SMTC (this can differ from the SMT budget the PHCC receives from HIIS) and to decide on the staff appointed at the SMTC. The way this is handled seems to depend on the personal view of the PHCC director on SMT. In some cases this affects the quality of SMT because the SMTC receives less funding than the HIIS budget and has to work with staff which is not according to its needs (see under the headings ‘Staff capacity, availability and expertise’ and ‘Management’ above).

During the meeting with SMTC staff it was suggested that SMTCs should have more management autonomy but should remain part of the PHCC. Being integrated in a PHCC also means easy access to certain services (e.g. testing and treatment for infectious diseases).

**Cooperation**

The findings show that – as in the four reference countries – SMTCs cooperate with a number of health and social services and that this cooperation is mainly working well. Though in general, according to the SMTCs, there is not much time available to invest in more structural cooperation like a well-functioning network. Developing this sort of cooperation needs a large time investment. A well-established and functioning network requires a clear definition of patient profiles and areas of responsibilities for all services involved (which service is responsible for which patients), patient referral protocols, case management, etc.

Cooperation with other services is again especially problematic for the smaller SMTCs operating in smaller towns. Staff of these centres have very limited time and generally almost no services in town with which they can cooperate. This often results in extra work for SMTC staff as they try to improvise additional services by themselves.

From the interviews with the staff of the SMTCs we get the picture that in some cities and towns cooperation is going relatively well and in others it is not. Frequently it seems to depend on individual initiatives and personal contacts. From the interviews and the meetings with the SMTCs we also get the impression that SMTCs in general are prepared to cooperate but some other services are not really keen on this. Cooperation with high-threshold NGOs like (church-based) therapeutic communities requires some attention here. Ideological differences seem to be the main problem here.

Cooperation with general practitioners and pharmacies partly works well. For example pharmacies are involved in preparing the daily dosages for SMT. However, getting general practitioners or pharmacies involved in ‘remote’ dispensing proves to be more difficult.
One problem which needs to be looked at (and if needed, tackled) quickly is the fact that patients of SMTCs receive medication not only from SMTCs but also from other doctors. This seems to be also true for psycho-active substances like benzodiazepines. There are reports of doctors prescribing substantial amounts of psycho-active medicines to SMT patients without co-operating with the SMTC. To provide adequate treatment and prevent problems a good medicines registration system and close cooperation between SMTCs is required.

**Weak points – strong points**

**Weak Points**
- The treatment data collection in use does not allow formulating an individual treatment plan and monitoring SMT on individual, centre and national level;
- The management data collection in use does not serve reliable and accurate data for thorough auditing;
- There are general guidelines but no (basic) protocols (e.g. how to do an intake, how to define an appropriate dosage) which results in substantial differences in treatment policy and practice between the SMTCs;
- The regular funding is limited regarding staff capacity for regular SMT services and insufficient for offering additional services like counselling or social work (in the SMTC);
- SMTCs are rather medically oriented, psycho-social aspects of problem drug use do not get sufficient attention (at least partly to be explained by insufficient staff capacity);
- SMTCs lack autonomy with regards to staff and financial management;
- Working in SMTCs (like in other drug services) has a relatively low status which makes it difficult to find appropriate staff.

**Strong Points**
- The practise of the prescription of substitution maintenance treatment in Slovenia is of a relative high standard if compared to other countries. It scores well on issues like different approaches for specific target groups, etc.;
- SMT has a high coverage; it covers nearly the whole country and around one third of the estimated total of problem heroin users.\(^{38}\)
- Access to SMT is good (no waiting lists, appropriate opening hours, no exceptional criteria for entering). Also in this respect SMT is scoring well compared to the reference countries;

\(^{38}\) The latter is in line with The Netherlands and Germany but clearly higher than Czech Republic and Lithuania. A good coverage is important for reducing health risks among problem heroin users and for offering possibilities to further treatment.
- Monthly meetings of SMTC staff facilitates cooperation between SMTCs and expert exchange on among others SMT developments, treatment issues and individual cases;
- Diversity of substitution substances prescribed (taking into account individual needs);
- Following and picking up latest developments in SMT quickly (e.g. introduction of Suboxone in Slovene SMT);
- Overall consensus between staff and clients on being treated with respect or ‘normally’ by the other party is an important indicator for quality.
8. Recommendations

The discussion of the findings and the list of the main strong and weak points of SMT in Slovenia are the basis for the recommendations presented in this chapter. For this we will follow a similar structure as in the discussion chapter:

- Staff and treatment issues;
- Patient issues;
- Internal organisation matters;
- External organisation matters.

Staff issues

**Staff capacity and services offered**

It is important to find a structural solution for the limited staff capacity of SMTCs (especially) for psycho-social support and thorough counselling (in the sense of a basic psychotherapeutical programme) but also for other additional services. There are two options for this. They are additional staff capacity for the SMTC team and cooperation with other services. For psychosocial support and counselling, drawing up formal contracts with the services involved should be considered. For example, Centres for Social Work and NGOs. Where there are no external services available, e.g. in smaller towns, a solution needs to be found in the centre itself.

A point of discussion might be the funding for this work. This of course is a political decision, e.g. whether the costs for psycho-social support (generally the task of social workers) should be covered from funds of the Ministry of Health or the Ministry of Labour, Family and Social Affairs. The Ministry of Health – being finally responsible for SMT – might initiate this discussion.

Problems with staff capacity, availability and expertise can also be reduced by making the staff norm (1.91 staff per 100 patients)\(^\text{39}\) obligatory. This would mean that the PHCC management has to assure that the defined staff is assigned to work in the SMTC. The selection of staff should be the responsibility of the head of the SMTC to assure that appropriate staff is employed. The heads should also get enabled to coach their staff to reduce staff changing quickly.

**Communication within the team**

A checklist of issues to be discussed in the team is worth considering to make sure that the communication in SMTC teams is sufficient to assure quality of treatment and good team functioning. This checklist should cover all issues

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\(^{39}\) as defined in the Sector Agreement for Primary Health Care Centres and Private Medical Care 2004 (ZZZS 2004)
that require regular and – to a certain degree - formal discussions like treatment policy, individual cases and the management of the centre. This checklist can be used to make up the agenda for a team meeting and could help to formalise meetings of small teams which would assure that no relevant issues for discussion are overlooked. The checklist should also include a format for basic minutes of these meetings as a reminder to document important points of a discussion and eventual decisions in minutes. In small teams with just two or three staff consideration should be given to setting a time when all relevant issues briefly would be discussed. The Coordination Committee could draft the checklist and have it discussed at one of the monthly meetings of the heads of SMTCs.

**Training and support of staff**

Though it is understood that training needs have been on the agenda of these monthly meetings an assessment of current training needs should be considered on a regular basis. A programme for staff training should be drawn on the basis of the needs assessment. This could be done for half a year or a year. Besides training on these current issues a general training programme such as the existing basic course on addiction for new staff should be maintained. The introduction of regular supervision or intervision not only for training purposes but also for social support should be considered. This can help to keep staff motivated and avoid burn-out.

To allow staff to participate in these training and supervision activities time should be allocated in the employment hours for training and individual or group supervision.

**Patient issues**

**Information about SMT**

Patients are well informed about the substitution substances they get prescribed but less well informed about other substitution substances. An active approach to inform (counsel) patients about other treatment options, i.e. not only regarding substitution medication but also about counselling, therapy and abstinence oriented treatment should be considered here. This could be one part of regular motivational counselling of patients not only in formal sessions but also informally, using everyday situations as triggers for a one to one chat. This ‘spontaneous’ counselling could also be an issue for staff training and individual or group supervision.

**Treatment access issues**

Though overall patients prove to be quite satisfied with the different aspects of treatment access there are some aspects which should be discussed. Our data show that at this point substantial differences between SMTCs exist,
especially when it comes to opening hours and rules for take home medication.

One important issue is to avoid as much as possible that SMT is becoming an over-dominant factor in the patients’ life. So distance to the SMTC and travelling time to it should be relatively short. In rural areas ‘remote’ dispensing of the substitution medication by general practitioners or pharmacies in the towns/villages where patients live (under supervision of the regional SMTC) should be further promoted. As well as the Coordination Committee, the Ministry of Health or the regional Public Health Institute can also contribute in convincing and motivating general practitioners and pharmacies to become involved in SMT.

There should be clear guidelines for take-home medication specifying patient groups and conditions. This would require defining the social stability of patients. Important criteria could be: having work; following training or an educational programme; having a (stable) family; being on a stable medication dose; not using other (illegal) substances.

Though many SMTCs have adapted their opening hours to the needs of patients (especially taking into account patients who have work or follow training) in some centres this still seems not to be the case.

A crucial issue for SMT is that it should allow and motivate patients to live a ‘normal’ life, actively participating in society and eventually becoming drug-free. This should be supported by an appropriate organisation of the treatment (opening hours, etc.) and by motivational counselling (see above).

**Internal organisation**

**Treatment data collection**

As an alternative to the instrument currently used by the centres to collect patient data, well-developed instruments exist for comprehensive treatment data collection that are worth considering. One of these tools is the Addiction Severity Index (ASI) or its European adaptation, the EuropASI (Fureman et al. 1990, Blanken et al. 1996). It is a validated instrument facilitating a high level of international comparability of data between different countries. With this tool, the health and social status of patients can be determined covering alcohol use, illegal drug use, work, criminality, physical health, social health and mental health. It can be used for diagnosing and making up an individual treatment plan and for monitoring the patient’s development over time and thereby for assessing the impact of SMT on patients. On the individual patient level this would give valuable information for adapting a treatment plan, e.g. by shifting priorities in treatment based on the actual problems of a patient.
Using a computerised system would also allow the impact of the work of each individual SMTC on its patient population to be assessed. It can provide information on the impact of the SMTC on the different life areas. This information can be used to adapt the treatment services offered by this SMTC. This data collection also can provide: individualised or aggregated and anonymised quantitative data; patient numbers; and patient characteristics (gender, age group, work, education level, etc.).

This data, in anonymised form, can also serve as data source for the Ministry to monitor and evaluate the work of SMTCs. Finally, this data also could be aggregated on national level to get a picture of the national SMT programme as a whole.

There are of course other data collection systems available. The EuropASI is generally seen as a quite heavy instrument. To take the full EuropASI during an intake of a new patient might take up to two hours. So one could also select a ‘light’ version as it has been done for instance in some regions in the Netherlands. But whatever tool may be chosen to collect data on the work of the SMTCs, it is essential that all centres use the same tool which of course for efficiency reasons should be computerised and allow comparison between centres.

**Management data collection**

A standardised and computerised system used in all SMTCs is a prerequisite for management data collection. This should include: financial data (a specified bookkeeping of budget received and budget spent); staff data (FTE, job descriptions, working hours); and patient data. The latter is of course closely linked to the patient data collection described above. For management purposes primarily cost-related treatment data is important. These are, for example: numbers of patients in treatment (SMT and other forms of treatment); medication (type and dosage); and use of other services.

One should consider choosing for a basic system using already available tools and data collection to limit the development costs and to make its use not too time-consuming for the SMTC staff. For instance, medication (type, dosage and frequency and thereby costs) can be monitored through the pharmacy. As the substitution medications are legally controlled substances their dispensing has to be controlled anyway.

The data on patients in treatment should not only reflect caseload but also case severity. It might be worth reconsidering the current system (counting a patient in SMT for 100% and a patient in other forms of treatment for 50%) because psychosocial support, motivational counselling or psychotherapy can be more intensive and time-consuming than basic SMT. It might be more appropriate to differentiate between several types and levels of intensity of treatment. SMT is then just one treatment element beside others. There are
systems where different treatment types and different scores on case severity are calculated using a point system indicating the time (and by this the cost) needed for this treatment. One may also make a distinction between different phases or stages in treatment. For instance the intake and starting phase of SMT is in general more time consuming than the actual maintenance phase.

For a clear view on SMT management issues the SMTC management data collection has to be separated from the PHCC data collection. One can either choose for a separate organisation or simply a separate chapter in the PHCC system.

Medication data collection (on type, dosage, frequency and costs of medication) is facilitated by the fact that substitution medications are legally controlled substances. This means that their dispensing has to be controlled by some form of registration anyway. It is evident that also in this case it is of importance to have a standardised and computerised data collection system covering all SMT in Slovenia. Collecting medication data for management purposes can be combined with other purposes. For example a system could be implemented that records the prescription by the medical doctor (daily dosage prescribed per patient, for which period) and actual dispensing per patient per day (or several days) by the pharmacy and/or the SMTC. Because in nearly all cases both pharmacy and centre are involved in the dispensing, this registration would include both the recording of the substitution substance delivered by the pharmacy to the centre (whether this is done in individual daily dosages per patient or bigger amounts of a substance that are prepared for individual patients by the SMTC) and the recording of the (daily) dosage actually dispensed to the patient.

This data collection can also be used to determine the number of patients actually in SMT (in one centre) as it allows an overview on a daily basis of who received which substitution medication. It also can be used to prevent patients from ‘shopping for’ substitution medication in different centres. This data collection also can be utilized on the level of one SMTC – to monitor the treatment of individual patients – and on centre, regional or national level – to monitor (and control) some quantitative aspects of SMT. Finally, the data collected can also be used for research. The system which was developed in the Netherlands, the so-called Central Methadone Registration (it actually covers more than methadone alone) is a good example of how all these functions can be combined and still all privacy rules are obeyed.

**Management**
As already stated above, consideration should be given to shifting some management responsibility for the SMTCs from the PHCC directors to the SMTC heads. This is especially important for personnel but also for financial issues. The selection of SMTC staff should be in the hands of the heads of the SMTCs to ensure that personnel have the required expertise and skills (and fit
in the team). The head of a SMTC should also have a say in the spending of the funds made available by the HIIS to this SMTC.

There are different options to give more management responsibility to the heads of SMTCs, from partial to full autonomy. During the discussion of the findings with SMTC staff the issue was raised that full autonomy is not the appropriate option as SMTCs also profit from their position as part of a PHCC, among others from the easy access to services that are important for their patients as tests for HIV and Hepatitis C. Partial autonomy could be realised in an agreement clearly dividing and defining the responsibilities of SMTC and PHCC management. This also could include the obligation that the budget received for SMT is actually used for this purpose.

**Guidelines and protocols**

Guidelines seem to be primarily used by SMTCs as point of orientation. They are seen as useful but apparently do not play a really important role in the daily work. As we understood revised guidelines are currently being worked on. In order to make these new guidelines it would be good to discuss the substantial differences we have found between SMTCs, e.g. on minimum and maximum dosage of medication and on rules for take-home medication. These discussions could help to explain the reasons for certain choices and to weigh the arguments for and against certain decisions. For example, why does the doctor in one centre decide for a higher maximum dosage of for instance methadone than the doctor in another centre or what are the effects of this? These discussions preferably should take into account good practice and experiences from other countries and – where available – research evidence. Discussions like this can contribute to evidence-based instead of eminence-based decisions, i.e. to a more standardised approach and to increased quality of the treatment offered. They could finally serve as a valuable input for new guidelines.

Besides guidelines that define points of orientation for the daily work, protocols are used describing more specifically which steps should be taken in certain parts of the treatment process. However, there are some doubts about the usefulness of elaborated protocols. They are sometimes too time-consuming to use and can become quickly outdated. Therefore one suggestion would be to develop checklists instead of protocols for certain steps in treatment that enable staff members to ensure that no important actions are overlooked. One example would be a checklist for the intake in which all important elements to be covered are summed up.

Both guidelines and checklists are the responsibility of the Coordination Committee and should preferably be developed in discussion with the SMTCs. The monthly meetings of the heads of the centres may be an adequate platform to discuss guidelines and checklists. It is also the Coordination Committee’s formal responsibility to ensure the adherence of the centres to
the Guidelines and checklists and to provide professional support through individual or group supervision and training.

**External organisation matters**

In the recommendations made above, many issues already have been raised which also involve external organisation matters, e.g. responsibilities of the Coordination Committee, aspects of PHCC management and issues concerning the management of SMT which belong to the responsibility of the Ministry of Health. In the following we elaborate in somewhat more detail on political responsibility and cooperation with other services.

**Political responsibility, auditing and control**

As already mentioned, the first step to a well-functioning system of auditing and control is to initiate and fund the development of a standardised and computerised treatment and management data collection to allow thorough monitoring and evaluation. This should take into account what has been mentioned above. This is not only true for SMT but also for other forms of drug demand (and harm) reduction programmes like drug prevention and abstinence oriented treatment. In these fields as well data collection is rather weak and auditing and control seems to be very limited.\(^{40}\)

In addition to the Ministry of Health, the Ministry of Labour, Family and Social Affairs and the Ministry of Education and Sport have political responsibility for parts of the demand reduction field. Therefore, well-functioning cooperation between those ministries involved is needed for auditing and control as well as for policy making in general. The existing model of a national Drug Commission can be a platform for this but as this commission also covers supply reduction working with sub-commissions covering certain parts of the drug policy field could be considered.

When it comes to the financing system it is worth considering to introduce a system that is based on services delivered to individual patients (taking into account caseload and case severity) instead of the current lump sum funding based on patient numbers of previous years. The existing system does not take into account eventual changes in patient numbers in a SMTC and case severity which can lead to capacity problems in SMTCs. However, as the existing financing system for SMT seems to be in line with the system generally in use of financing health services, it is evident that this change will require a broader discussion.

\(^{40}\) For chapter 3.1 we were looking among others for information on funding and patient numbers of harm reduction and abstinence-oriented treatment (therapeutic communities). With a few exceptions it proved to be very difficult to impossible to obtain this data. Also data for impact of these services on patients are not available.
Cooperation

Good cooperation between treatment and care services working with problem heroin users is important both for efficiency (an efficient use of the available resources) and for quality (offering appropriate services meeting the actual needs of patients). One way to develop cooperation is to organise a series of discussions between SMTCs and other treatment and care services about cooperation and defining the areas of responsibility of the different services and to explain what the task or function of the different types of service is.

One option would be national meetings between SMTCs and – for each meeting – one other type of service, e.g. abstinence-oriented drug treatment or Centres of Social Work. To underline the general interest in better cooperation between different drug treatments and care services it should be the Ministries – as standing above the parties – which organises these meetings. A round-table format would fit best to facilitate consensus finding. The aim is to reach agreement that different services, from low to high threshold, are simply different options for different people or sometimes even different options for one individual at different life stages.

These meetings also can form the start of developing the required tools such as clear definitions of patient profiles and areas of responsibilities for the services involved (which service is responsible for which patients). Patient referral protocols and case management could also be considered. The actual development of these tools can be done later by the services but should be monitored and controlled by the Ministries.

The results of these bilateral meetings could then be brought together in a national plan for drug treatment and care services. A national meeting could be considered to present and discuss this plan. One problem will be finding solutions for smaller centres in smaller towns where there are not many services available.

As stated above good cooperation does not come for free. The costs involved in developing these instruments should be covered. A financial incentive also can help to initiate cooperation in towns and cities where it is limited at the moment.

Finally, there are two issues in the medical field that should be looked at. One is the issue of ‘remote’ dispensing through general practitioners and pharmacies. Also here a formal discussion between the different stakeholders, preferably including the professional bodies representing general practitioners and pharmacists, might be useful to clarify things such as in which cases it should be used and under which conditions.

Another issue that requires attention is the fact that patients of SMTCs seem to receive medication, including psycho-active substances like
benzodiazepines, not only from SMTCs but also from other doctors. Here the Ministry of Health should consider initiating with the involved parties (medical doctors and pharmacies) the development of an appropriate medicine registration system.
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