# Results of the WHO/UNODC Substance Use Disorder Treatment Facility Survey

Republic of Serbia

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**This Report represents an overview of the situation of substance use disorder treatment in the Republic of Serbia and does not fully reflect the current situation, considering the limited sample of the facilities that responded to the questionnaire provided.**

**Opinions and attitudes presented in the report are those of the authors and do not necessarily reflect the attitudes of UNODC and WHO.**

## ACRONYMS

ART – Antiretroviral treatment

DRID – Drug-related infectious diseases

EMCDDA – European Monitoring Centre for Drugs and Drug Addiction

ESPAD – European School Project on Alcohol and Other Drugs

FTE – Full Time Equivalent

GFATM – The Global Fund to Fight AIDS, Tuberculosis and Malaria

GPS – General Population Survey

HBV – Hepatitis B virus

HCV – Hepatitis C virus

HRDU – High-risk drug use

IDU – Injecting Drug Users

IPHS – Institute for Public Health of Serbia

MDMA – Methylenedioxy-N-methylamphetamine (ecstasy)

MESTD – Ministry of Education, Science and Technological Development

MoH – Ministry of Health

MoLEVSA – Ministry of Labour, Employment, Veteran and Social Affairs

NPS – New Psychoactive Substances

NGO – Non-governmental organisation

OST – Opioid Substitution Therapy

PHI – Public Health Institute

SHADD – Special Hospital for Alcohol and Drug Dependence

TDI – Treatment Demand Indicator

UNODC – United Nations Office on Drugs and Crime

VCCT – Voluntary Confidential Counselling and Testing

WHO – World Health Organisation

**CONTENTS**

# 1. INTRODUCTION

The aim of the survey was to collect information on substance use disorder treatment systems, including their characteristics, usage by clients, staff, service quality management, interventions and types of services provided and distribution. It supplements other EMCDDA, UNODC and WHO standards which include data collection instruments on the drug user treatment systems. Information collected within this survey, together with other information is crucial for comprehensive planning, intervention needs assessment and support to investment-related decisions.

The survey was conducted using a Substance Use Disorder Treatment Facility Survey questionnaire, developed by UNODC and WHO, in coordination with Serbian Ministry of Health and expert and technical support of the Republic Expert Committee for Dependence Diseases and UNODC Serbia.

# 2. SITUATION IN THE AREA OF DRUG USER TREATMENT

## 2.1. Prevalence and trends

The first representative General Population Survey (GPS) in Serbia was conducted in 2014, on a sample of 5,385 persons, 18-64 years of age.[1] Survey results indicate that drug use in Serbia is still low in comparison with the majority of European Union (EU) member states. Approximately 8% of the adult population in Serbia has used some illegal psychoactive substance at least once during their lifetime, whereas drug use is more prevalent among younger adult population, 18-34 years of age (12.8%). The use of other substances, such as amphetamines, cocaine and 3,4 methylenedioxy-N-methylamphetamine (MDMA/ecstasy) is rarer among the general population in Serbia. The survey also covered the use of new psychoactive substances (NPS) in the general adult population, and it was found that approximately 0.1% of younger adult population (18-34 years of age) reported having used some NPS during the previous year.

Data on drug use among students 15-16 years of age come from the European School Project on Alcohol and Other Drugs – ESPAD. The survey was conducted in Serbia in 2008 and 2011. Available data show that in 2011, the use of cannabis at least once during the lifetime and the use of other drugs were less prevalent among students in Serbia in comparison with the average in other countries in the same survey. Approximately 8% of students in Serbia, 15-16 years of age, had used an illegal substance during their lifetime, without any changes in the period 2008-2011, and 7% had tried cannabis during their lifetime. Generally speaking, the use of illegal substances is more frequent among boys than girls, with the exception of the use of sedatives without prescription, which is more frequent among girls. In addition, the use of sedatives without prescription was in line with the average in all the countries that participated in this survey.

[1] National Survey on Life Styles of Citizens in Serbia 2014 – Substance Use and Gambling, IPHS Dr Milan Jovanović Batut, Belgrade 2014

### 2.2 High-risk drug use

Studies that provide an assessment of high-risk drug use (HRDU) may help to identify the scope of more serious drug-related problems, while data on the number of persons that start treatment in specialised drug use disorder treatment centres for the first time, considered together with other indicators, may help to understand the nature and trends of HRDU.

The latest available assessment of HRDU prevalence is based on indirect assessment (multiplier method, 'capture-recapture') using available data sources: the 2013 integrated bio-behavioural research among injecting drug users (IDU)[2]; the 2014 National Survey on Life Styles of Citizens in Serbia – Substance Abuse and Gambling[3]; data taken from the needle and syringe exchange programme; opioid substitution treatment and detox programmes in health facilities. The IDU population is defined as persons 18-64 years of age that have injected drugs for non-medicinal purposes in the past year. Based on consensus among different stakeholders, the most reliable estimation was done using the multiplier method based on the nomination card from the GPS 2014 and data from the needle and syringe exchange programmes. Based on this assessment, in 2013 in Serbia, there were 20,500 IDUs (95% confidence interval 16,300-27,700). It is believed that the majority of IDUs used opioids.

## 3. THE EFFECTS OF DRUG USE

### 3.1 Drug-related infectious diseases

Data on drug-related infectious diseases (DRID) in Serbia come from national registers for people infected with HIV and people suffering from AIDS and other infectious diseases reported to the Public Health Institute of Serbia (PHIS), through a routine comprehensive surveillance system in accordance with the national legislation, as well as from bio-behavioural surveillance studies (Bio-BSS) implemented by PHIS (in 2008, 2010, 2012 and 2013).[4]

According to PHIS, 178 newly diagnosed HIV cases were registered in 2015, which is an increase of 37% in relation to 2014. Out of all the cases with the known transmission route (90%), 2.5% were IDU, which is the smallest share ever recorded. In 2002, 17% of newly diagnosed HIV infections were IDUs (18 out of the total of 81 cases), and a downward trend since 1991 was recorded (70% IDU out of 81 newly diagnosed HIV cases), with signs of stabilisation over the previous years.

The number of newly registered cases of hepatitis B virus infection (HBV) continues to drop (154 cases in 2015, in comparison with 429 cases in 2001), which is attributed to routine vaccination introduced in 2006. Reliable information on the method of transmission in 63 cases (41%) of acute HBV reported in 2015, and among those cases injecting drug use was the method of transmission in only three cases (5%).

[2] Research among Populations Most at Risk to HIV and among People Living with HIV, Key Findings, 2013, IPHS Dr Milan Jovanović Batut, Belgrade

[3] National Survey on Life Styles of Citizens in Serbia 2014 - Substance Use and Gambling, IPHS Dr Milan Jovanović Batut, Belgrade

[4] Narrative Progress Report on HIV/AIDS Response of Republic of Serbia in 2015, IPH of Serbia 'Dr Milan Jovanovic Batut', Belgrade

The incidence of newly diagnosed cases of acute and chronic infection of hepatitis C virus (HCV) showed a downward trend in the period 2007-2015. The information on the method of transmission was available for 74 cases of acute and 326 cases of chronic infection reported in 2015. Out of those cases, injecting drug use, which was with high probability related to HCV, was reported in 34 cases of acute and 78 cases of chronic HCV infection.

In 2013, a bio-behavioural study was implemented in Belgrade, Novi Sad and Niš, with support of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) project.[5] A sample was used with respondents, and rapid HIV and HCV tests were administered on blood samples. The results showed that in Belgrade, HIV infection prevalence decreased in the period 2008-2013 (4.7% to 1.5%). Although in the previous studies HIV infection prevalence was higher among women, the latest study showed that there were no significant differences between men and women (1.5% and 1.3% respectively). Data suggested that HIV infection prevalence was higher among persons over 34 years of age. No HIV cases were identified among persons 18-24 years of age, or among those that had been injecting drugs for under 2 years.

HCV antibody prevalence in the IDU sample in Belgrade also decreased in the period 2008-2013, from 74.8% to 61.4%. HCV prevalence remained higher among women in comparison with men and among IDUs over 34 years of age, as well as those that had injected for over 10 years. Under 50% of persons injecting drugs for under two years were HCV-positive.

The 2013 study also indicated a decrease in HIV and HCV infection prevalence in Niš and Novi Sad in the period 2008-2013. In Niš, HIV infection prevalence was 1.0%, while in Novi Sad there were no positive HIV test results recorded; in 2008, prevalence was 1.6% and 0.8% respectively. In 2008, HCV prevalence was 54.7% in Niš and 50.2% in Novi Sad (58.4% in Niš and 51.6% in Novi Sad).

Data collected through the Treatment Demand Indicator (TDI) registry in 2014, indicate that HIV infection prevalence among those starting treatment and having experience with injecting during their lifetime was 1.8%, while approximately 41.5% reported they were infected with HCV.

### 3.2 Drug-related emergencies

Data on drug-related emergencies come from the Clinic for Emergency and Clinical Toxicology of the National Poison Control Centre within the Military Medical Academy.[6] In 2014, a total of 312 clients were treated for overdose. Eight out of 10 clients that were treated were in the age group 19-40 years, and the same proportion of clients were male.

More than one-half of clients were treated for heroin overdose (54.5%) and the majority was older than 30 years. Approximately four out of 10 clients had mild poisoning. A total of 50 clients (16%) were admitted because of the use of cannabis, and these clients were younger than opioid users, considering that one-half were 20-24 years of age. The majority of cases of cannabis intoxication were mild poisonings. With stimulants overdose, clients were most

[5] Internet: https://www.theglobalfund.org/en/portfolio/country/?loc=SRB&k=230dc866-39f9-4332-9c9d-6b9145dc667a
[6] Yearbook of the National Poison Control Centre 2014, National Poison Control Centre in the Military Medical Academy

commonly treated for amphetamine (18 cases), followed by cocaine (13 cases) and MDMA (11 cases) overdose.

### 3.3 Deaths caused by drugs

Deaths caused by drugs are those that can be directly linked to drug use (e.g. poisoning or overdose).

According to the National Statistical Office, 31 deaths were recorded in 2015 caused by drug use, which indicated a decreasing trend in the number of deaths caused by drug use in Serbia since 2009 (2009 – 119 deaths; 2010 – 75; 2011 – 39; 2012 – 50; 2013 – 65; 2014 – 52).[7] In 2015, 18 deaths were related to opioids. Almost one-half of deaths were in the age group 25-34 years. On average, the year of death was 33.2 for men and 32.5 for women. The majority of the deceased were male.

These cases referred to unnatural deaths for which the investigative judge demanded autopsy. Autopsy and toxicology examination results were included in the death certificates sent to the National Statistical Office. Toxicology analyses of post mortem samples were done in the Military Medical Academy and in Forensic Medicine Institutes in Belgrade, Novi Sad, Niš and Kragujevac.

## 4. PREVENTION

Preventative activities in Serbia are implemented by the Ministry of Health, Institute for Public Health of Serbia with a network of 24 public health institutes, Ministry of Interior (MoI), Ministry of Youth and Sports, Ministry of Education, Science and Technological Development (MESTD), drug treatment facilities, local self-government and non-governmental organisations (NGOs).

### 4.1 Preventative interventions

Preventative interventions include various approaches. Universal strategies target the entire population; selective prevention is directed at vulnerable groups that may be under increased risk of drug use; and indicated prevention focuses on at-risk individuals.

In Serbia, the majority of implemented preventative activities fall under the domain of universal prevention and are implemented in schools, in the family and in the community. Drug use prevention is included in primary school curriculum and is implemented within biology and chemistry classes. In schools, preventative activities are often implemented with the support of health facilities at the primary health care level, as well as in partnership with the MoI. With the aim to raise awareness, drug use prevention workshops and activities are also implemented within national programmes for health promotion. These programmes are implemented by the IPHS with its network of 24 regional public health institutes (PHIs). Staff in health centres and the educational sector, as well as community representatives, as a team, implement activities to promote health in the community, pre-schools and schools. Activities mainly focus on providing information on drugs and raising awareness on different topics related to drug use.

[7] Health Statistical Yearbook of the Republic of Serbia 2015, IPHS Dr Milan Jovanović Batut, Belgrade

Reports on activities implemented by PHIs are sent to the IPHS but are rarely evaluated. In order to improve preventative activities in schools, teachers are trained to implement drug prevention programmes, within their mandatory training programme for the prevention of violence, abuse and neglect.

United Nations Office for Drugs and Crime (UNODC), has provided support to initiate various preventative activities in Serbia. In the period 2010-2011 in Belgrade (New Belgrade and Zvezdara municipalities) a training programme was implemented for the development of family skills for drug use, HIV/AIDS, crime and delinquency prevention among youth – Strengthening Families Programme 10-14. In addition, with the support of the MESTD, and supported by UNODC and Lions Club International Foundation, the Lions Quest Skills for Adolescence programme was implemented in 17 primary schools in Belgrade during the 2014/2015 school year, covering over 750 students. This life skills-based programme, targets youth, with the aim to develop their skills and empower them to take accountability and provide them education on ways of effective communication and healthy decision-making, as well as resisting peer pressure to take alcohol and drugs. The evaluation of this intervention includes the following outcomes: substance use, risk perception, intent to use drugs and normative beliefs. Available data for Serbia indicate that the project has strengthened skills to resist peer pressure and reduced intention to use alcohol, tobacco and cannabis.

In addition, many preventative activities are implemented at the local level in Serbia, but selective and indicated preventive activities are still rare.

# 5. HARM REDUCTION

Comprehensive harm reduction activities for IDUs include opioid substitution therapy (OST), needle and syringe exchange programmes and voluntary and confidential counselling and testing (VCCT) on infectious diseases related to drug use. On 29 July 2002, Médecins du Monde launched the first needle and syringe exchange programme in Belgrade. In the period between mid-2007 and mid-2014, Serbia received support from the GFATM programme, reinforcing these activities.[8] With GFATM support, NGOs in four towns in Serbia (Belgrade, Novi Sad, Niš and Kragujevac) implemented needle and syringe exchange programmes in drop-in centres and mobile units. The estimated number of beneficiaries of these programme throughout the duration of the programme, annually, was around 2,000. In addition to sterile needles and syringes, these services also provided medical and social assistance.

After the end of the GFATM project, NGO Prevent continued to implement needle and syringe exchange programmes in Novi Sad. During 2015, a total of 465 clients used these services, received advice on safe injecting, proper use of condoms and sexually transmitted diseases; VCCT for HIV; as well as information on methadone maintenance programme and opportunities for other forms of treatment, rehabilitation and resocialisation. Within the programme, around 12,910 syringes and injecting kits were distributed to clients. NGO Veza provided harm reduction services during the first half of 2015, reaching 156 clients. This organisation did not continue operations in 2016.

[8] Internet: https://www.theglobalfund.org/en/portfolio/country/?loc=SRB&k=230dc866-39f9-4332-9c9d-6b9145dc667a, op. cit.

VCCT for HIV and HCV is available in 24 regional PHIs, Special Hospital for Alcohol and Drug Dependence (SHADD), Institute for Student Health Care in Belgrade and NGO Jazas. According to available data in 2015, 279 drug users (214 IDUs) were counselled and tested on HIV, which is a decrease in comparison with the previous years, when tests were provided by GFATM in SHADD. In 2016, IPHS distributed rapid HIV tests to the SHADD, in order to improve VCCT for drug users in SHADD. In 2015, a total of 150 drug users (among whom 12 IDUs) were counselled and tested on HCV and 107 (81 IDU) on HBV.

Harm reduction interventions at party locations (clubs and festivals) are implemented by NGO ReGeneration.

# 6. TREATMENT

## 6.1 Treatment system

The drug use disorder treatment is under the mandate of the Serbian Ministry of Health (MoH). MoH has established a coordination and advisory body on drugs: The Republic Expert Committee for Dependence Diseases.

Drug use treatment is regulated by the Law on Psychoactive Controlled Substances, Law on Health Care, Law on the Protection of Persons with Mental Health Difficulties, Law on Patients' Rights and Law on Medicines and Medical Devices. The objectives of the Strategy for Fight against Drug Abuse 2014-2021, emphasise treatment variety and quality by introducing new therapeutic approaches; promoting treatment contributing to the reduction of infectious diseases related to drug use and deaths caused by drug use; providing broader access to treatment in prisons; and promoting social protection, rehabilitation and reintegration programmes for drug users in order to minimise their social exclusion and discrimination.[9]

Treatment in Serbia includes medical detoxification, psychosocial treatment, short-term interventions (motivational interview, individual psychosocial counselling, individual and group psychotherapy), long-term rehabilitation group and family therapy, and medically assisted treatment (with agonists and antagonists). In general, treatment is funded by the national Health Insurance Fund.

Drug dependence treatment is provided in state health facilities and some privately-owned health facilities. At the primary health care level, treatment is possible in health centres, which includes mainly counselling. Clients are referred to the secondary and tertiary level of health care for further treatment. At the secondary level, the treatment is led by general hospital psychiatrists, while specialised drug dependence treatment (tertiary level) is available in Belgrade, Novi Sad, Kragujevac and Niš. These are reference centres for health care provision and supervision and the development of methodology for the prevention of drug abuse, treatment and rehabilitation. Stationary treatment is provided also by the Serbian Orthodox Church in six therapeutic communities (one of these is for women), which have over the past years had around 200 clients a year. In 2014, NGO Duga provided care and accommodation for 72 drug users.

[9] The Strategy for the Prevention of Drug Abuse for the period 2014-2021

Methadone maintenance treatment (MMT) programme was introduced in Serbia for the first time in 1970s, while buprenorphine was registered for treatment of opioid dependence in 2010, and currently OST is available in all types of health facilities (26 units in 2015). OST can be initiated in both out-patient and in-patient facilities, and the decision to start the programme is made by the treatment team.

In 2016, MoH conducted a mapping of treatment facilities in Serbia, with UNODC support.

In 2014, data on treated drug users were delivered to the MoH by 16 out-patient facilities (out of a total of 26) and three in-patient facilities. A total of 494 clients were treated in Serbia, out of whom the majority were treated as out-patients. However, it is necessary to emphasise that the majority of clients starting treatment for the first time were treated in hospital-type facilities.

Data on treatment were collected based on EMCDDA treatment demand indicators (Protocol 3.0).[10] However, data collection system is implemented mainly in the centres for opioid substitution therapy, so that the majority of the data related to individuals using primarily opioids. In 2014, around one-third of clients started treatment for the first time (135 out of 464). Less than two out of 10 clients treated were women. The majority of men that were in the treatment system were 30-34 years of age, while women were somewhat younger, and the majority of them between 24 and 29 years of age.

On average, new clients in the treatment system started using basic substances at the age of 20-21 years and started treatment after ten years of using drugs. Injecting had remained the usual way of taking drugs for nearly 45% of clients who started treatment for the first time and those that were already in the treatment system.

## 6.2 Treatment in prisons

In Serbia, treatment units in prisons provide treatment for prisoners in cooperation with regional health facilities, while specialised treatment is available only in Special Prison Hospital in Belgrade. Patients from other prison hospitals are referred to regional health facilities for drug use treatment, where the type of therapy is determined, and treatment provided.

In the period 2013-2015, VCCT for all newly admitted patients, as well as individual and group counselling on risk behaviour, HIV and HCV infection prevention and overdose, was provided in prison treatment units. In 2014, the Special Prison Hospital implemented VCCT on HIV and HCV and individual and group counselling on risk behaviour, prevention of HIV and HCV infection and overdose, for 343 newly admitted prisoners, and in 2015 these services covered 320 prisoners.

Methadone substitution therapy can be provided to opioid users in prisons, and the Special Prison Hospital has the mandate to initiate this form of treatment for prisoners. In 2014, 343, and in 2015, 320 prisoners were treated in the Special Prison Hospital.

[10] TDI, EMCDDA

In 2014, 413 individuals were on substitution therapy in all prisons in Serbia, while in 2015, 487 prisoners were on this type of treatment.

The prison in Niš and Special Prison Hospital have drug free units. The condition for a prisoner to be admitted into these units is absolute abstinence from all psychoactive substances.

# 7. NATIONAL ANTI-DRUGS STRATEGY AND COORDINATION

In 2014, the Serbian Government adopted the Strategy for the Prevention of Drug Abuse 2014-2021 and relevant Action Plan 2014-2017.[11] The Strategy deals with individual and social harm caused by drug use, as well as drug-related crimes and their effects. The objectives of the Strategy are structured in two main chapters – drug demand and supply reduction, and it defines five anti-drug policy actions: reduced drug demand; reduced drug supply; coordination; international cooperation; and research, monitoring and evaluation.

Interventions in the area of reduced drug demand are focused on the following issues:
1. Ensure that the state is in charge of the issues related to drugs at the local and national levels equally with other social, health, safety and economic issues in the country, and adopt the necessary systemic measures based on this;
2. Raise community awareness of the issue of drug abuse and the need to prevent it and promote healthy lifestyles;
3. Coordinate various activities at the local level and harmonise coordination activities at the local level with those at the national level;
4. Provide various and high-quality capacities and programmes focusing on drug treatment and introduce diverse approaches in treating dependence diseases;
5. Support the development of interventions that would help sustain or reduce the number of HIV and hepatitis infections, sexually transmitted diseases (STDs), tuberculosis and lethal outcomes of overdose;
6. Ensure conditions enabling the extension of institutional treatment programmes in educational and penal facilities;
7. Encourage the development of social protection programmes for drug users, public rehabilitation and resocialisation facilities, therapeutic communities and communes and civil society organisations (CSOs), including harm reduction programmes, which will prevent social exclusion of drug users and discrimination – this also refers to programmes and activities within social protection in prisons and correctional facilities;
8. Raise awareness and improve the skills of all stakeholders working on the prevention of drug abuse, treatment and rehabilitation of drug users and harm reduction measures and programmes;
9. Encourage the development and implementation of preventative activities in this area and various programmes focusing on the drug demand reduction, especially activities related to the appearance and distribution of new psychoactive substances and the use of several psychoactive substances simultaneously.

Interventions in the area of supply reduction are focused on the following objectives:

[11] The Strategy for the Prevention of Drug Abuse for the period 2014-2021

1. Strengthen activities directed against organised crime, illegal drug trafficking, money laundering and other forms of drug-related crime;
2. Improve cooperation between the police, customs and judicial system within the country, regional and international cooperation;
3. Improve information gathering and analytical work on detecting criminal activities;
4. Raise the level of knowledge among judicial authorities;
5. Implement all existing and creating new measures to detect drug transport routes along the so-called Balkan Route;
6. Establish an early warning system on new psychoactive substances;
7. Strengthen the control of precursors and cooperation in this area between the customs, police, manufacturers and distributors of precursors to monitor precursor trade and abuse;
8. Intensify and maintain cooperation with other countries in the region, in Europe and globally.

In addition to the mentioned aims, the Strategy is also focused on achieving the following specific objectives:

1. Ensure gradual functionality of the National Focal Point as part of the system for collection, integration and provision of data and information in the area of drugs as well as EMCDDA reporting;

2. Provide political and financial support to implement activities defined in the Action Plan 2014-2017, as well as activities that are yet to be defined as priorities in future action plans at the local and national levels;

3. Encourage cooperation between different stakeholders, develop partnerships with the civil society in all spheres related to drugs, including strengthening the role of CSOs;

4. Encourage training for all professionals working in the field and encourage all activities directed at creating the environment for the development of different training programmes at the national level;

5. Ensure evaluation and stable funding of verified programmes, including mid-term evaluation of the Strategy.

For the development of the Strategy on the Prevention of Drug Abuse 2014-2021 and the relevant Action Plan 2014-2017, the results of the mid-term analysis of the previous National Strategy were used, implemented in cooperation between MoH and UNODC.[12]

[12] Ibid.

# 8. METHODOLOGY

## 8.1 Introduction

UNODC and WHO developed a questionnaire for assessing the treatment of substance abuse within the UNODC-WHO Programme on Drug Dependence Treatment and Care, in order to assist relevant national agencies to map available resources for substance use disorder treatment, which would enable further planning and monitoring. UNODC-WHO survey questionnaire consists of five sections (Part A: Contact details; Part B: Contact details of the treatment facility; Part C: About the treatment facility; Part D: Volume of treatment; Part E: Patients and resources). Its aim is to collect administrative details, basic information on the facilities, information on the scope of treatment services provided, consolidated data on the number of patients, available human resources and the facilities' structural resources.

UNODC-WHO survey questionnaire is available in hard copy and online. Serbian authorities have opted for the online version of the survey, using an interactive online platform (website) developed in cooperation between the MoH and UNODC, and is one of the first countries in European region that has piloted the UNODC-WHO in this version, and the experiences from this process additionally supported the finalisation of the survey and the methodology.

The implementation of the survey in Serbia was coordinated by the MoH Monitoring Centre for Drugs and Drug Dependence, in cooperation with the Republic Expert Committee for Dependence Diseases, and the entire process was technically supported by UNODC.

The preparatory process of data collection was initiated in 2015 when the survey questionnaire for UNODC-WHO survey was submitted to relevant national partners for review, suggestions and comments. The questionnaire was adapted at the national level based on feedback received through this process.

A pilot online survey, using LimeSurvey on WHO server was done in June 2016. It was participated by 62 facilities, and it was soon identified that some of the questions, mainly in relation to the scope of treatment, were insufficiently clear or non-applicable to some facilities. After the first implementation cycle, additional changes were made to improve the instrument for mapping drug treatment facilities in Serbia.

Another pilot study was initiated in September 2016. In addition to the standard questionnaire, a one-day census of patients was offered, which included facilities that may not have had other data on the number of patients. The process of total data collection lasted for two months, and the information was provided by 18 treatment facilities throughout the country. After receiving feedback from the second round of data collection, the data showed that only five facilities answered all of the questions. The data were collected, processed and published in adequate format to be presented to the professional audience.

In March 2017, the results were presented to the Republic Expert Committee for Dependence Diseases, which reviewed the importance and use value of received data, but a weakness appeared in the small number of facilities that had provided the data. It was concluded at the Committee meeting that the study needed to be repeated, with additions and corrections, and focus placed on increasing the scope of facilities.

Following this, a working group was formed to implement the survey, composed of teachers at university psychiatric clinics, representatives of MoH and UNODC in Belgrade. The survey was re-evaluated, and suggestions and draft of the final version submitted to UNODC.

In October 2017, a meeting was organised for representatives of the drug use disorder treatment facilities. The meeting was divided into two parts. In the first part, UNODC and MoH representatives explained the importance of the survey and its background. In the other part of the meeting, all the participants were introduced to the survey in detail, in a workshop. The survey was presented in hard copy, the participants were explained all the questions in detail, and then the online version was also presented with precise instructions for filling out the survey questionnaire. The meeting was also used to present the draft version of the website, including all the important chapters and sections it would contain.

In the period between 15 October and 1 December 2017, focal points in the drug use disorder treatment facilities submitted information to UNODC Office in Belgrade. Call for the facilities to submit data was sent out by the MoH, after which the focal points that did not submit the report were contacted on the phone. During the survey period, facilities were reminded twice via email that the deadline for filling in the questionnaire was approaching. After these interventions, data were collected from 39 out of the 53 reported facilities. Data were processed by UNODC in Belgrade, forwarding them on for further analysis to the working group members.

| **Type of treatment unit** | **Number of invited units** | **The number and proportion of units that filled in the survey (%)** | **The number and proportion non-accredited units (%)** |
|---|---|---|---|
| Outpatient/clinic/policlinic | 22 | 22 | 100% |
| Hospital | 27 | 13 | 48% |
| Non-hospital residential treatment | 0 | 0 | 0 |
| Therapeutic community | 5 | 4 | 80% |
| Low threshold unit | 0 | 0 | 0 |
| **Total** | 53 | 39 | 73.58% |

The UNODC-WHO substance use disorder treatment assessment questionnaire was sent to 53 email addresses of drug use treatment facilities, including 27 hospitals, 21 clinics and polyclinics and four therapeutic communities. District prisons, of which there were five, considering that

they follow the clinical model, were included under the category clinics and polyclinics. Out of the total number of survey calls, 39 facilities, or 73.58%, responded.

### 8.2 Data collection process

Data on drug use treatment facilities were collected through the new website in accordance with the agreement with the government. UNODC provided technical assistance for the drug use treatment facilities survey. The MoH Monitoring Centre for Drugs and Drug Dependence sent out the appropriate invitations. If needed, the facilities were given contact details in the MoH and UNODC for further communication and clarifications.

The final report will be submitted to the MoH.

### 8.3 Data collection instrument

The first version of the mapping tool was finalised in June 2015. It was then translated into the local language and submitted to MoH and the Government Commission for the Control of Psychoactive Controlled Substances for review and comments. The comments related to the terminology used in the instrument and provided more information on the necessary specific cultural adaptation of some terms using those that were considered to be clearer for treatment facilities. As agreed with MoH, the instrument was strategically developed as online draft version, using the LimeSurvey platform, based on WHO server in Geneva. Administrative password for data entry and additional modification of the instrument was submitted to the MoH for further use and overall control of the mapping process.

The call to participate in the mapping survey was sent to all facilities in June 2016, from MoH email address, calling on the facilities to use the LimeSurvey web platform to enter data. In this first wave of data collection, the questions were submitted by the participating facilities over the telephone, and the facilities were additionally provided with technical support to enable data entry. Many facilities had administrative problems regarding the reporting on the data requested on the total number of treated patients, because their local data collection systems could not provide these precise numbers. One of the reasons was also that the organisations providing broader health services felt it was unethical to use the data on the total number and structure of patients to particularly identify patients with substance use disorder. In a large number of cases, manual count of patients was requested, for which reason an additional data collection instrument was introduced – daily census that was delivered in hard copy.

As additional protection, before the second cycle of the mapping survey, three facilities (two clinics in Belgrade and one specialised hospital) were called to discuss the new format of the questionnaire, in order to additionally confirm the reporting format. No additional comments were received and after the final approval by the MoH, the second wave was initiated in September 2016, and lasted for two months.

The second pilot study initiated in September 2016, used the LimeSurvey web platform at the WHO server, as previously agreed with the Government. As an addition to the standard questionnaire, daily patient census was offered to the facilities that might not have data on the number of patients. The process of total data collection took two months, and information was received from 18 treatment facilities from across the country. After received feedback from the second round of data collection, data showed that only five facilities responded to all of the questions.

Data were collected, processed and published in adequate format in order to be presented to the public. The report was produced on 42 pages, results presented in tables and charts, and the interpretation of the results provided very clearly and precisely. In March 2017, the results were presented to the Republic Expert Committee for Dependence Diseases, which reviewed the importance and use value of received data, but a weakness appeared in the small number of facilities that had provided the data. It was concluded at the Committee meeting that the study needed to be repeated, with additions and corrections, and focus placed on increasing the scope of facilities.

Between 15 October and 01 December 2017, using the survey website portal, and in accordance with the proposals of the working group, drug user treatment facilities were contacted to deliver data. Calls to submit data were sent by the MoH, and further contact with the persons that did not submit the report was established over the telephone. After these interventions, data were collected from 39 among the reported 53 facilities.

In the period between 15 October and 1 December 2017, using the created website for survey, and in accordance with the working group suggestions, substance use disorder treatment facilities were contacted to request data submission. The calls to the facilities to submit data was sent by the MoH, after which the focal points that did not submit the report were contacted on the phone. After these interventions, data were collected from 39 out of the 53 reported facilities.

| **Means of completion of facility mapping** | |
|---|---|
| **Online** | 20 |
| **Offline (Word Document):** | |
| **Electronically filled** | 15 |
| **Scanned** | 2 |
| **Sent by mail** | 2 |
| **Total** | 39* |

Among 39 facilities, 20 provided the data online, 15 filled in the questionnaire electronically, two facilities sent scanned questionnaires, and two replied via email. The results show that not all facilities in Serbia were entirely prepared for online surveys, the reasons for this being the lack of technical equipment, and, perhaps, insufficient technical literacy.

The data were processed by UNODC in Belgrade and submitted for further analysis to working group members.

### 8.4 Legal and ethical issues

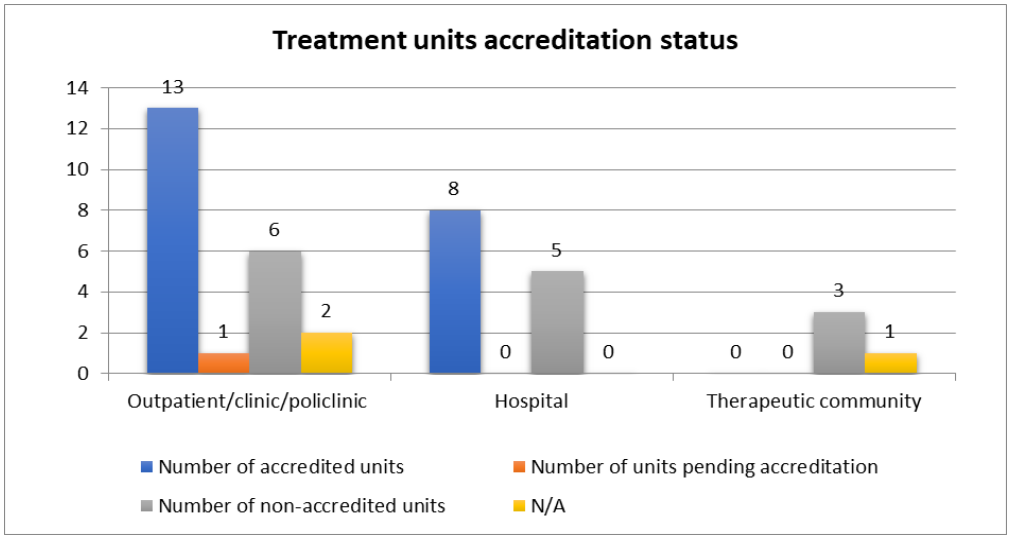
The survey was implemented and coordinated with the MoH. It was agreed that contact data on facilities providing information would not be published, and that the information on the scope of services provided to clients in relation to primary substances (Section D), would be available only to the administrators (MoH).

## 9. RESULTS

The survey questionnaire in Serbia consists of five areas as follows: Part A: Contact details; Part B: Contact details of the treatment facility; Part C: About the treatment facility; Part D: Volume of treatment; Part E: Patients and resources. Its aim is to collect administrative details, basic information on the facilities and the scope of provided treatment services, and consolidated data on the number of patients, available resources and the institution's structural resources.

### 9.1 Accreditation

Chart 1. Data on treatment units' accreditation status




Out of the facilities that responded to the received questionnaire, 53% of drug treatment facilities in Serbia were accredited (21 institution), six facilities (15.38%) did not complete the accreditation process, nine facilities (23%) were not accredited, and three facilities did not provide this information. 59% of the outpatient treatment facilities and 61% of the hospital facilities were accredited. None of the therapeutic communities were accredited to work with drug users. Out of the 21 issued accreditations, 15 accreditations were issued by the MoH, 5 by

the MoH Accreditation Agency, and one by the MoH Health Inspectorate. Data are presented in the annex (Table 1).

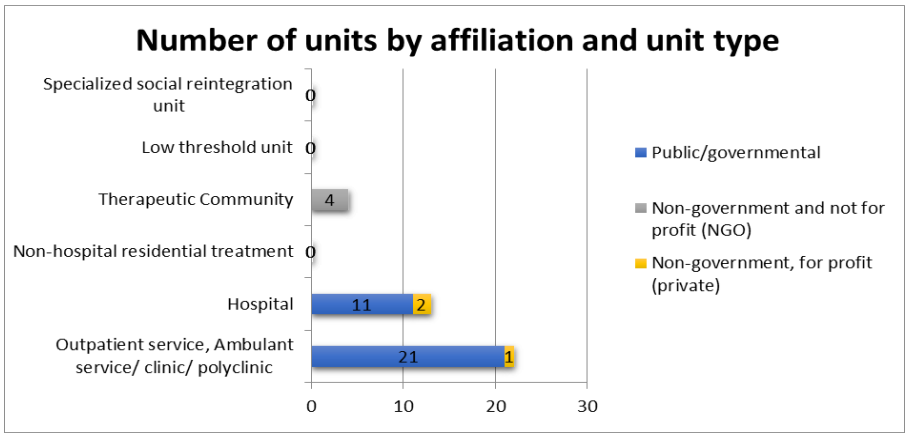
### 9.1.1 Discussion

Over one-half of the drug treatment facilities are accredited, but under one-half of the facilities, 47%, are not accredited for treating drug users. The majority of accredited facilities are hospitals, 61%. Accreditations are issued exclusively by the MoH, while other ministries did not issue any accreditations. None of the therapeutic communities are accredited for drug user treatment.

In the future, the conditions and rulebooks for accreditation of health facilities need to be standardised, and a body defined that would implement the accreditation of drug user treatment facilities and implement the accreditation process. It is necessary to define who is authorised to accredit facilities outside the health sector, therapeutic communities, low-threshold units and residential units that currently do not exist in Serbia. In addition to determining the ministry that would be responsible for accreditation, it is also necessary to define the conditions necessary for accreditation, and these are the available space, as well as human resources and methodology used. This would contribute to better and more balanced quality of drug use treatment across all the sectors dealing with these issues.

## 9.2 Data on treatment units

Chart 2. The number of accredited facilities

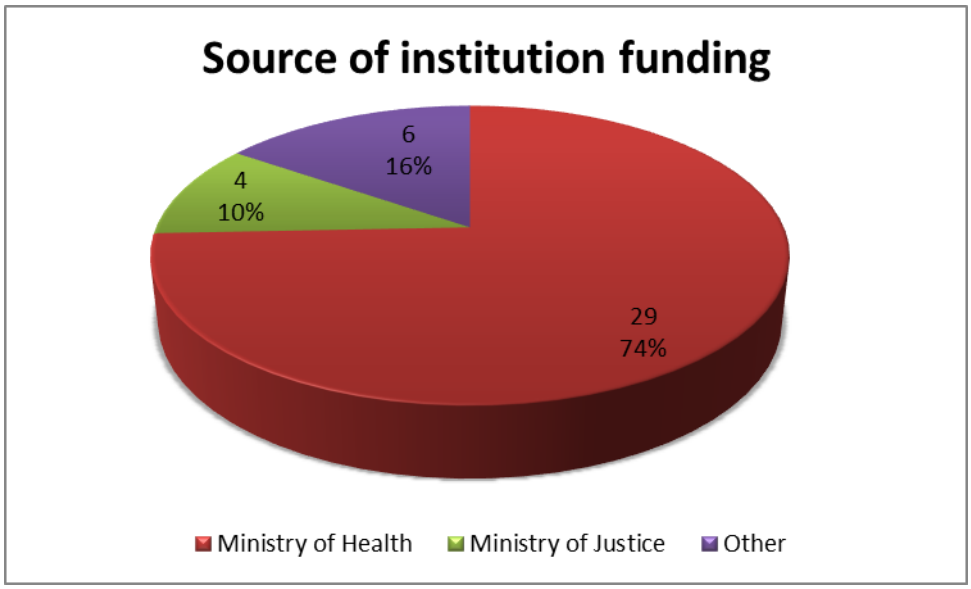



The highest percentage, 60.25% of drug user treatment facilities in Serbia, are in-patient and out-patient clinics, 30% are hospital units, and 9.75% therapeutic communities (Table 2).

### Sources of funding

Funding is received from the Government by 82% of the facilities, 9.75% are non-governmental private non-profit facilities, which are mainly therapeutic communities connected with religious communities, and 7.6% are profit facilities – mainly private clinics (Table 3).

Chart 3. Sources of funding




Among the Government facilities, the MoH represents the main source of funding with 74.3% or 29 facilities, Ministry of Justice is funding 10.2% or 4 facilities, while all other ministries are funding 15.5% of the facilities (Table 4). Ministry of Labour, Employment, Veteran and Social Affairs is not funding any of the facilities.

### 9.2.1. Discussion

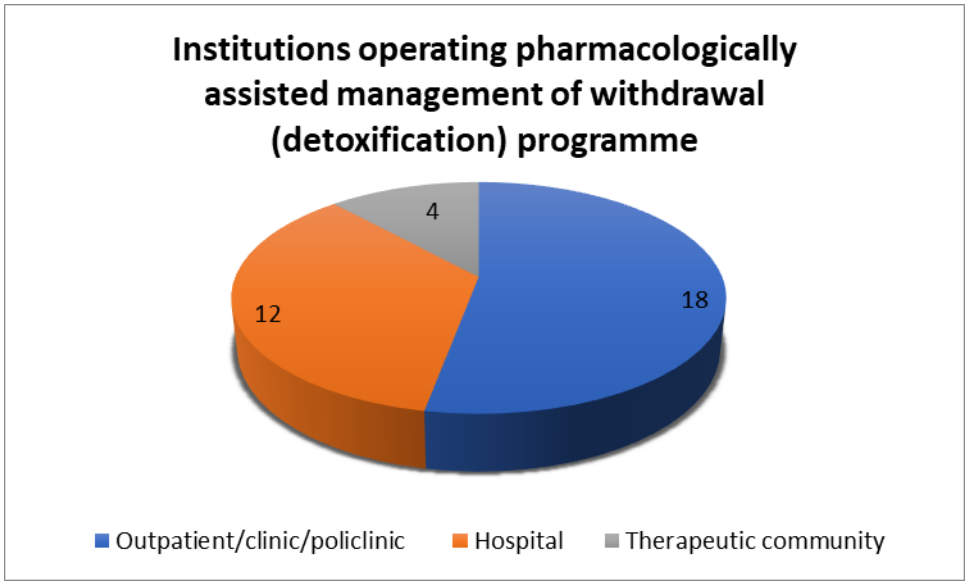
Drug user treatment facilities are funded from government resources, mostly the Ministry of Health funds. Other ministries participate far less in the funding. The Ministry of Labour, Employment, Veteran and Social Affairs (MoLEVSA) particularly stands out, as they do not fund any facilities. These data show a lack of intersectoral approach to funding, and particularly a lack of funding in the social services sector. This could explain the lower level of social reintegration and resocialisation in Serbia.

Private funding in privately-owned facilities constituted 7% of the total funding, while non-profit NGOs constituted 10% of the funding of costs for drug user treatment. Data indicate a greater need in terms of the services provided by public health facilities, by almost 20%.

In the future, it is necessary to consider funding by other ministries, MoLEVSA in particular, so that drug user treatment and protection programmes could be provided equally and fully across all the necessary social sectors.

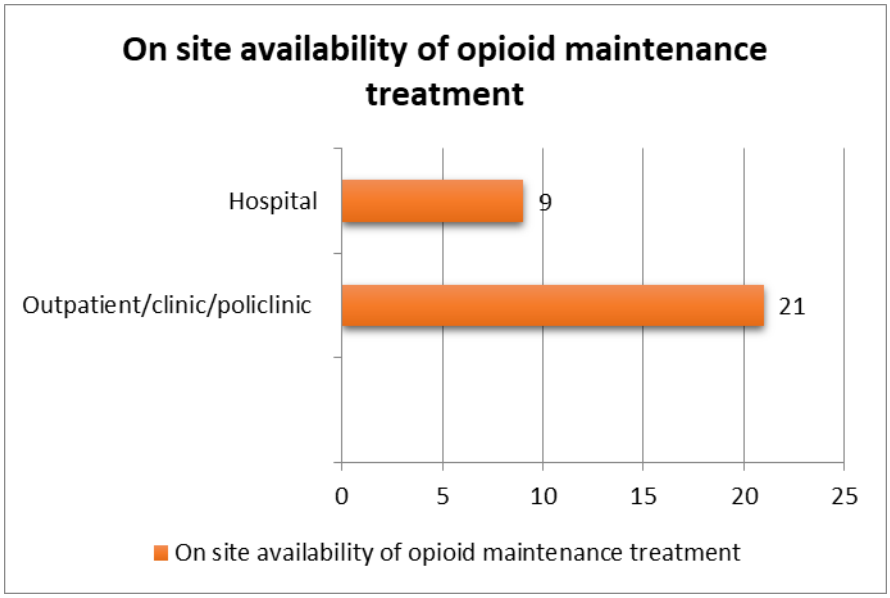
### 9.3 Service availability

Chart 4. Data on facilities operating detoxification programmes



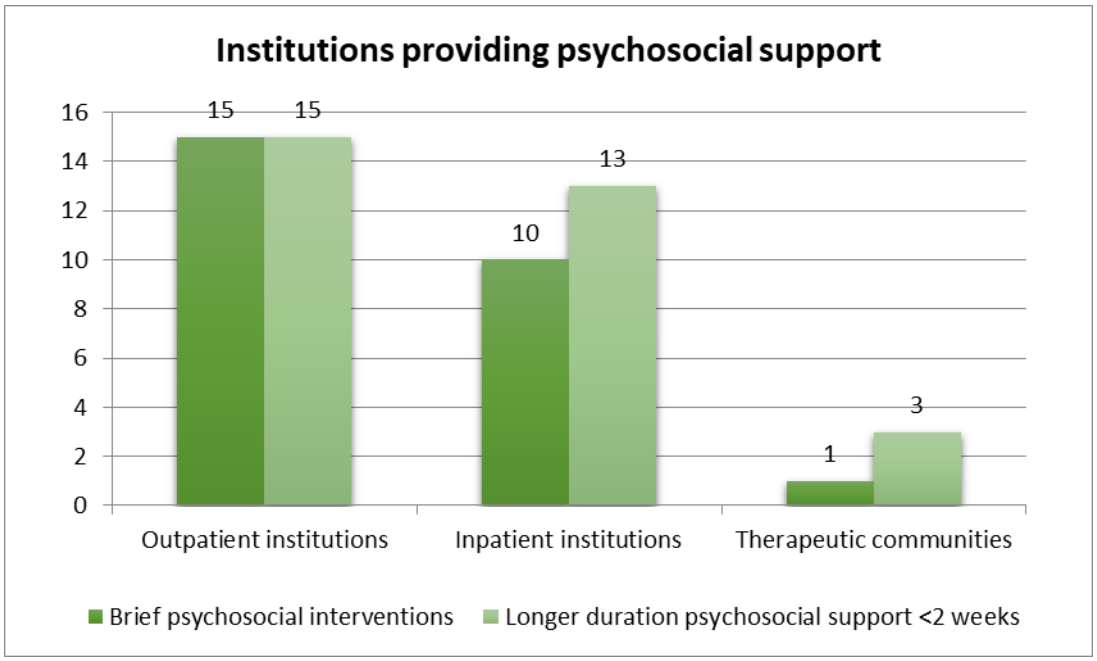

Among the 39 facilities that have filled in the questionnaire, detox programme is operated in 34 or 91.38% (Table 5). This tells us that there is a broad and organised network of detox facilities. Considering that detox constitutes the smaller part of treatment programmes, these data probably speak more of the treatment potential than the number of services provided.

Chart 5. Data on facilities providing substitution treatment



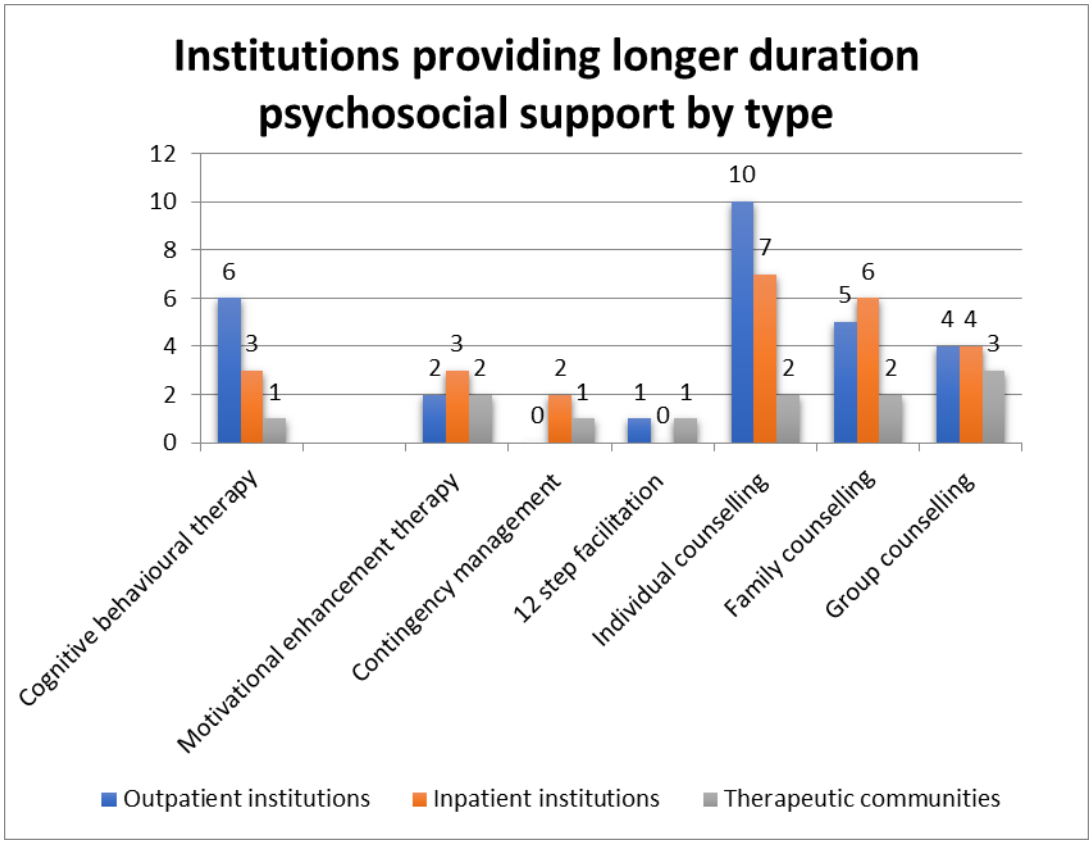

According to data submitted in the Serbian version of the survey, opioid agonist maintenance treatment for opioid dependents is available in 85% of health facilities in Serbia. In relation to outpatient treatment where substitution treatment is provided in 82% of the facilities, in hospital facilities substitution treatment is provided in 92% of the facilities (Table 6). 2,250 users are being treated in out-patient and in-patient clinics and polyclinics, and 139 in hospitals, which means that in Serbia, 2,389 drug users are on substitution treatment.

Chart 6. Data on facilities providing psychosocial support



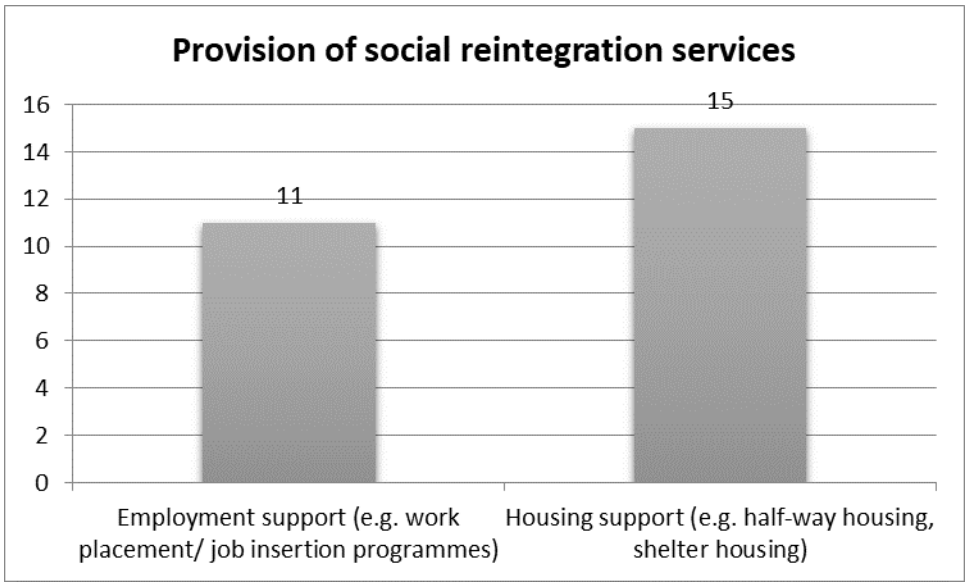

Among the 22 out-patient facilities, 15 provide brief psychosocial intervention services, and the same number or 68% provide psychosocial intervention services for over two weeks, and they exist in all facilities, while brief psychosocial interventions are available in 76% of the facilities. In therapeutic communities, psychosocial interventions longer than two weeks also prevail, and they are provided in 75% of the facilities, while psychosocial interventions are available only in 25% of therapeutic communities.

Chart 7. Data on the type of psychological support




In terms of psychosocial treatment options, 26 out of 39 facilities, or 66.6%, provide brief psychotherapeutic interventions, while extended psychotherapy for longer than two weeks is provided by 74.3%. Long-term psychosocial therapy includes approaches such as the cognitive behavioural therapy in 10 facilities (25.6%), motivational enhancement therapy in seven facilities (17.9%), family counselling available in 13 facilities (33.3%), individual counselling available in five facilities (12.8%), group counselling available in 11 facilities (28.2%), as well as the 12-step facilitation technique in two facilities, or 5% (Table 7). Individual counselling is the most common form of psychosocial assistance in outpatient and hospital treatment. It is recommended to improve other forms of treatment, particularly group counselling, because it is more efficient for the users and more cost effective.

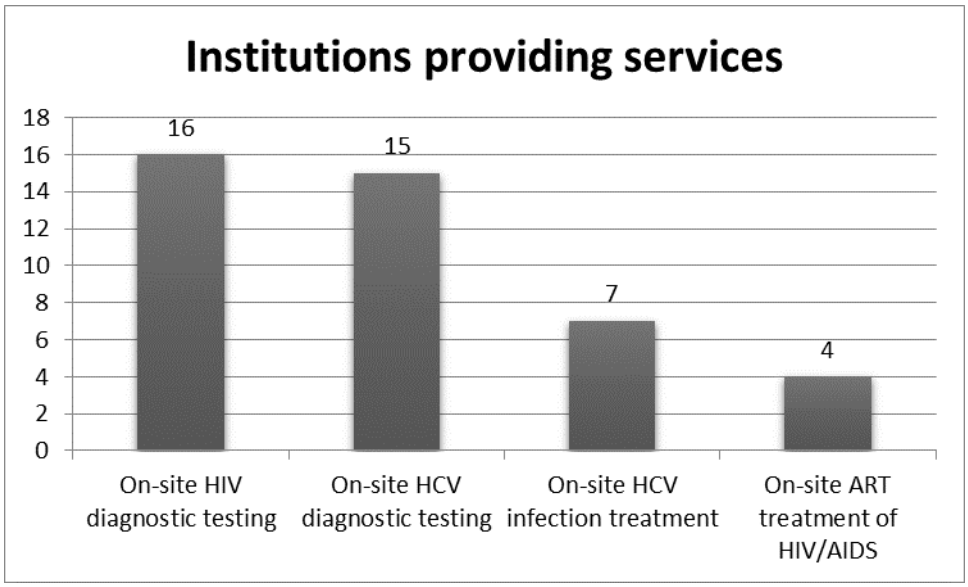
Chart 8. Data on facilities providing social reintegration services




Some specific social reintegration services are available in surveyed facilities, and particularly employment support provided by 15 facilities, or 38.5% (Table 8). Considering that unemployment is one of the main problems of drug users, the implementation of social protection activities in less than one-third of the facilities may be considered insufficient. It is important to mention here that funding of these programmes is not supported by the MoLEVSA.

Harm reduction programmes are implemented by only one therapeutic community, while the said programme is not financially supported by the government (Table 9).

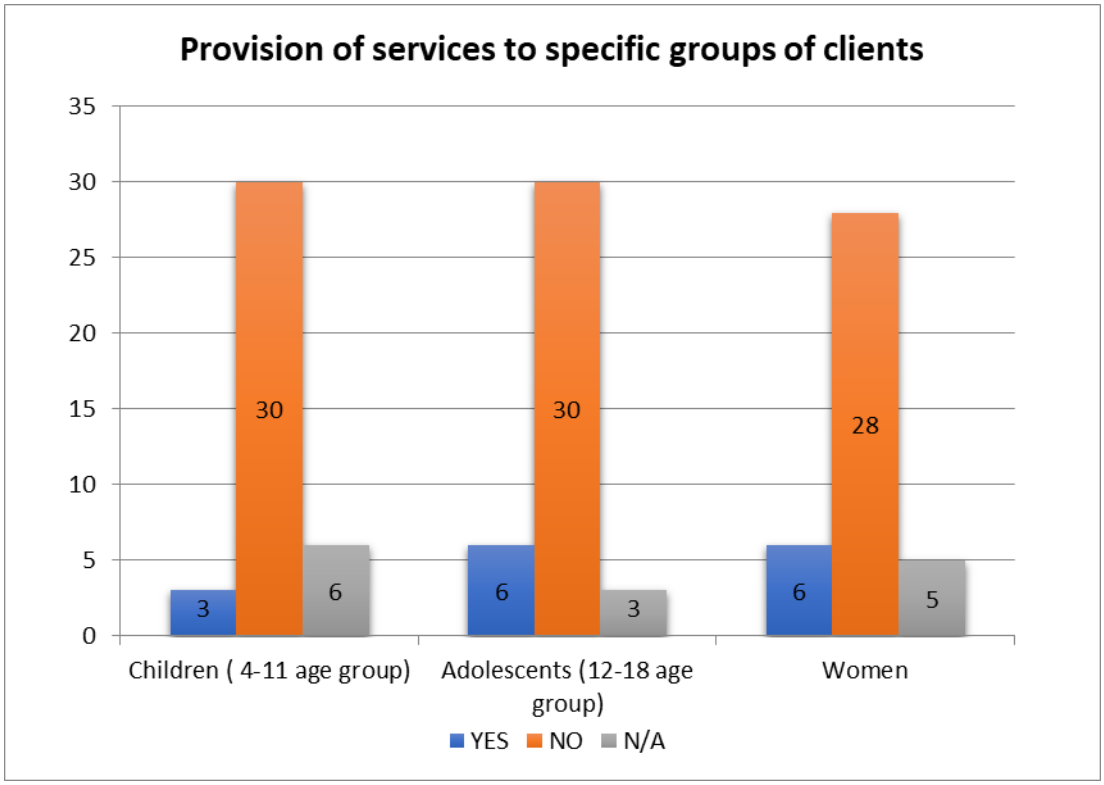
Chart 9. Data on facilities providing testing and treatment for infectious diseases




Limited number of facilities have reported the availability of specific services of infectious disease testing, such as HIV testing (available in 16 out of 39 facilities, or 41%), HCV testing (available in 15 out of 39 facilities, or 38.5%), hepatitis C treatment available in seven facilities

(17.9%), while ART (antiretroviral treatment) is available in four out of 18 services (10.2%). HBV testing and treatment is not available in any of the facilities (Tables 10 and 11).

Chart 10. Data on facilities providing treatment for at-risk groups




Treatment of children under 11 years of age who have issues with psychoactive substance abuse is provided in three facilities, or 7.6%, treatment of adolescents under 18 in six facilities, or 15.2%, while assistance to women is also provided in six facilities (Table 12).

### 9.3.1. Discussion

The questionnaire was responded to by facilities that fall under three categories: clinical services (out-patient and polyclinics), hospitals and therapeutic communities. Detox is provided in over 90% of the facilities, equally in clinics and hospitals, and OST in 85% of the facilities. Nearly all clinics and polyclinics provide substitution therapy. Currently, there are 2,389 drug users on substitution therapy in Serbia. OST is not provided in therapeutic communities. A recommendation could be to consider opening therapeutic communities that use the medicinal model, in which pharmacotherapy would also be available.

Psychosocial treatment is organised as short and long-term psychosocial therapy. Long-term psychosocial therapy is provided in all hospital facilities and 15 (38.5%) of out-patient treatment facilities. The lack of psychosocial treatment in out-patient clinics and polyclinics is the result of the workload of the doctors in these services.

Out of the psychotherapeutic interventions, the most common are individual and family counselling. Group psychotherapy is less common, which puts additional pressure on the staff. Other forms of psychotherapy also exist, but in lower percentage.

Psychosocial reintegration programmes include employment support and housing in 25-35% of the facilities. Education and vocational therapy are not provided in Serbia. Data indicate weaker social support in Serbia, which corresponds with the data on insufficient involvement of the MoLEVSA in issues regarding drug user treatment.

Only one facility reported that they provide a harm reduction programme. The lack of such programmes represents risk for appearance of drug use effects. HIV and hepatitis C testing is available in under one-half of the facilities, and hepatitis B in any of the facilities. Tests are mostly administered in public health facilities and infectious diseases wards. Hepatitis B treatment was not reported by facilities that participated in the survey.

Services targeting vulnerable groups (children under 11, adolescents under 18 and women) are provided in one in six facilities. Seeing as women users constitute 20% of the total number of users, this capacity could be considered satisfactory, but the issue of regional distribution remains.

### 9.4 Volume of treatment

Chart 11. Number of clients by type of institution

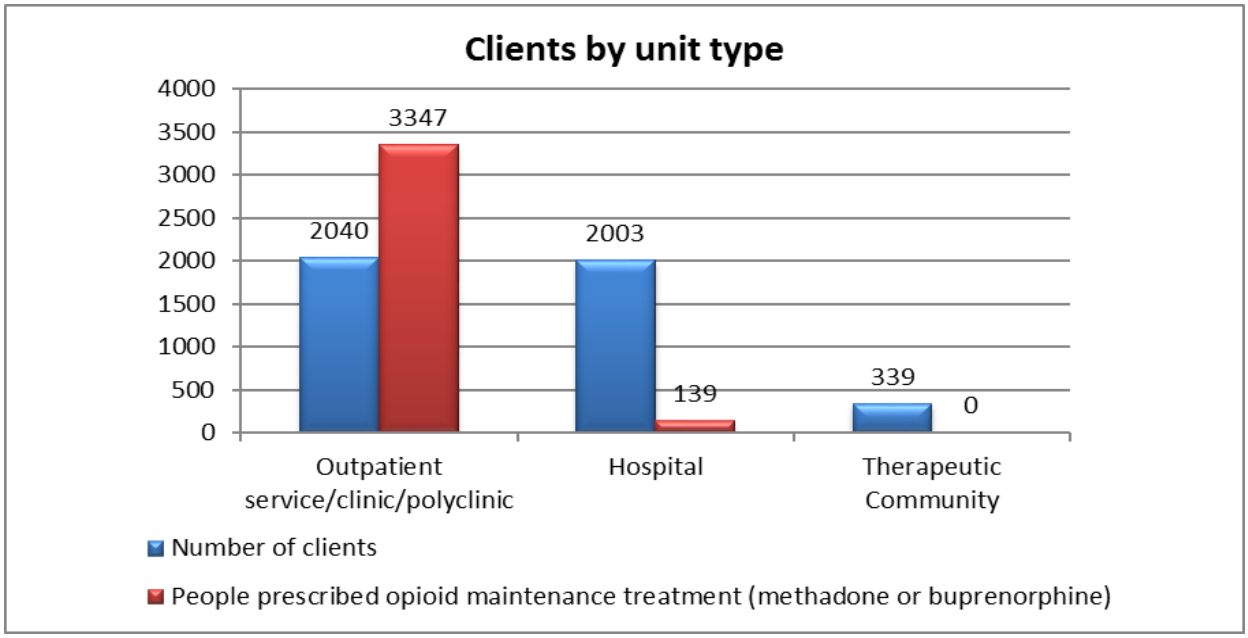
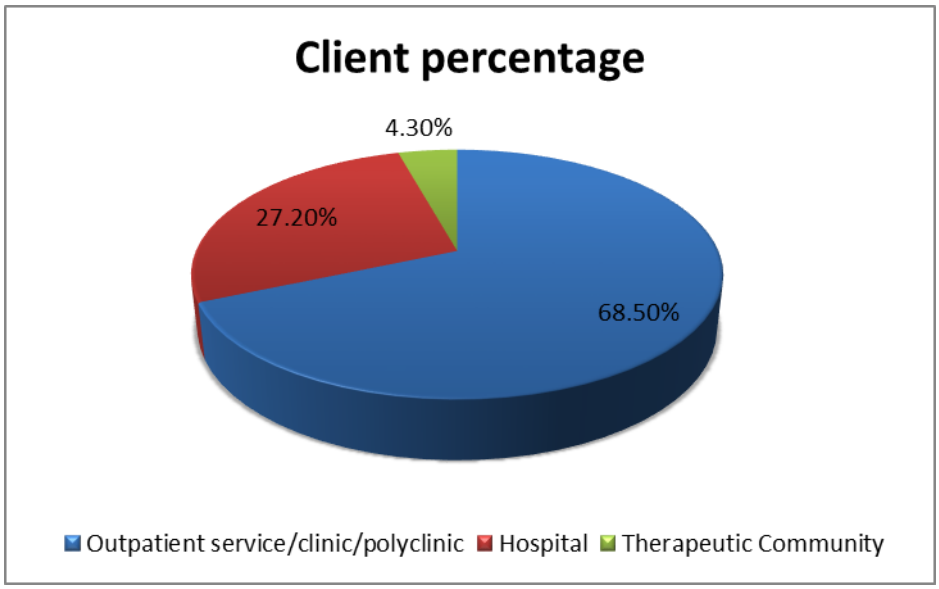


Chart 12. Percentage of clients by type of institution

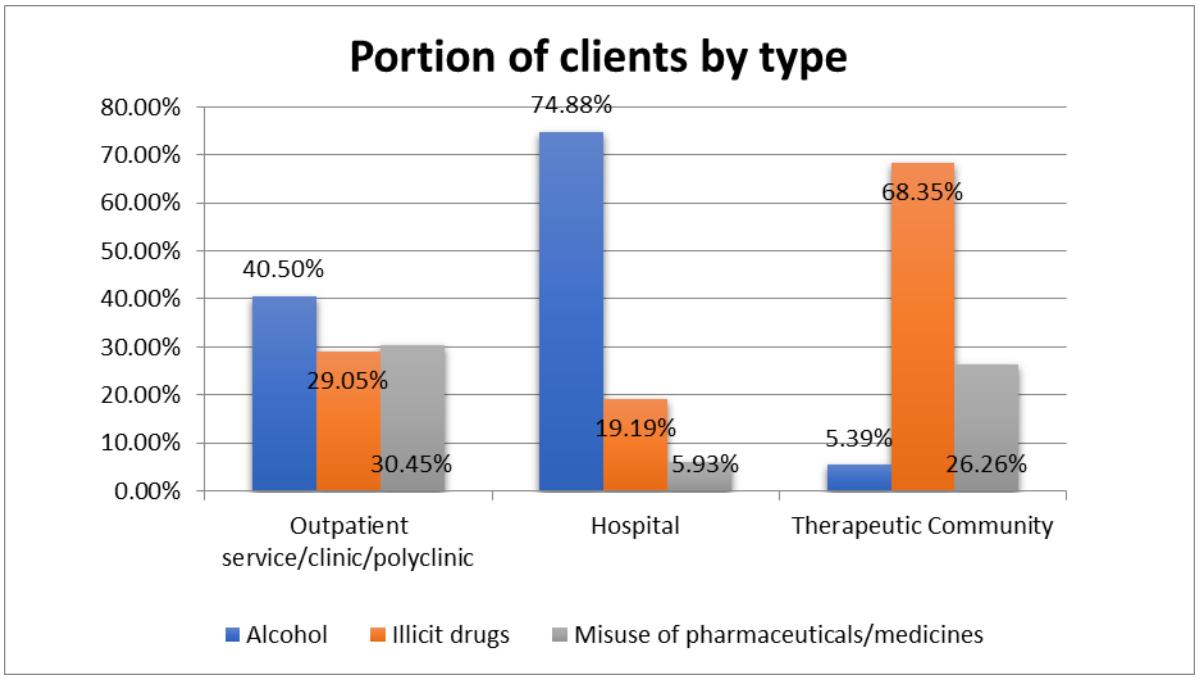



This survey was completed and submitted by 39 facilities, but not all facilities in the survey responded to all the questions. The number of facilities that provided responses to specific questions is provided in Table 13.

Among the 39 facilities, only 22 provided data on the total number of patients in 2016. Based on this information, in 2016, 7,868 illegal psychoactive substance users were admitted and treated. Out of the total number, 3,486 drug users were on substitution therapy and 4,382 users on other forms of drug use treatment. In clinics and polyclinics, services were provided to 5,387 clients (68,5%), in hospitals 2,142 clients (27,2%) and in therapeutic communities 399 users, or 4,3%.

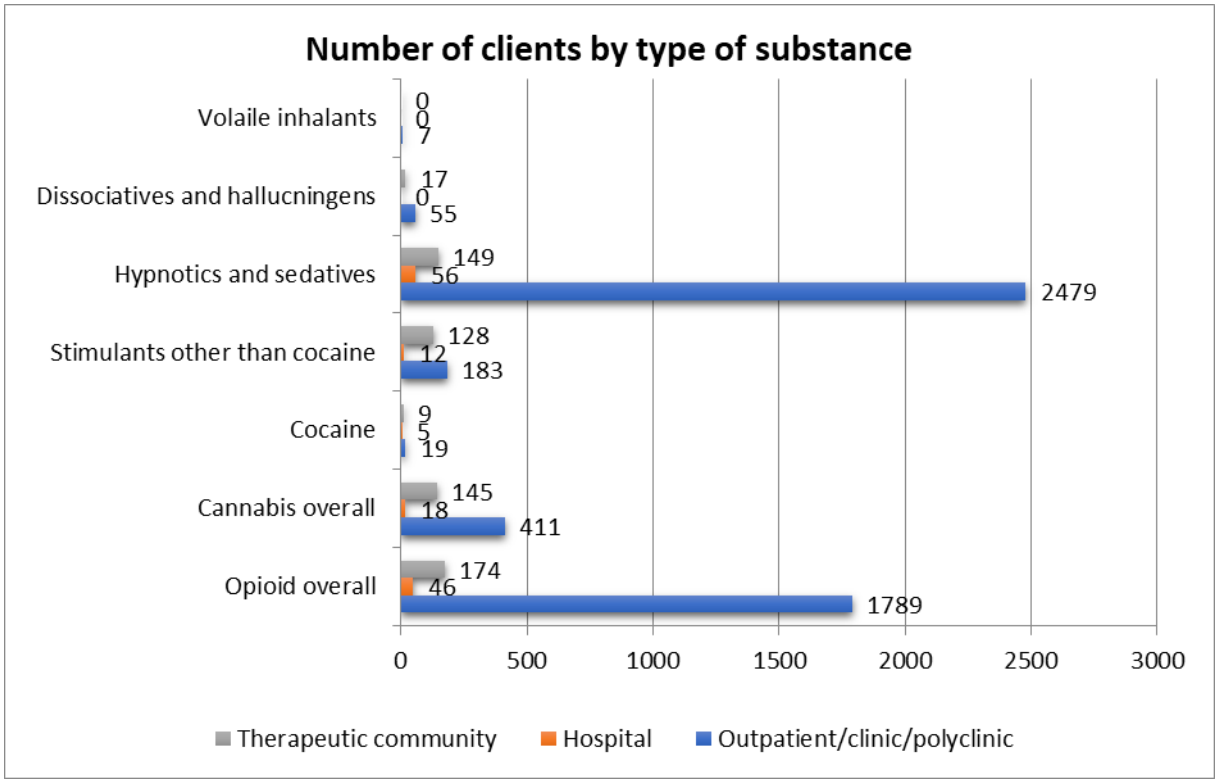
While 30 out of the total of 39 facilities that participated in the research indicated availability of opioid agonist treatment, only 26 provided data on the number of patients that were taking opioid agonists (Tables 5, 6 and 13).

Chart 13. The proportion of clients by primary substance type



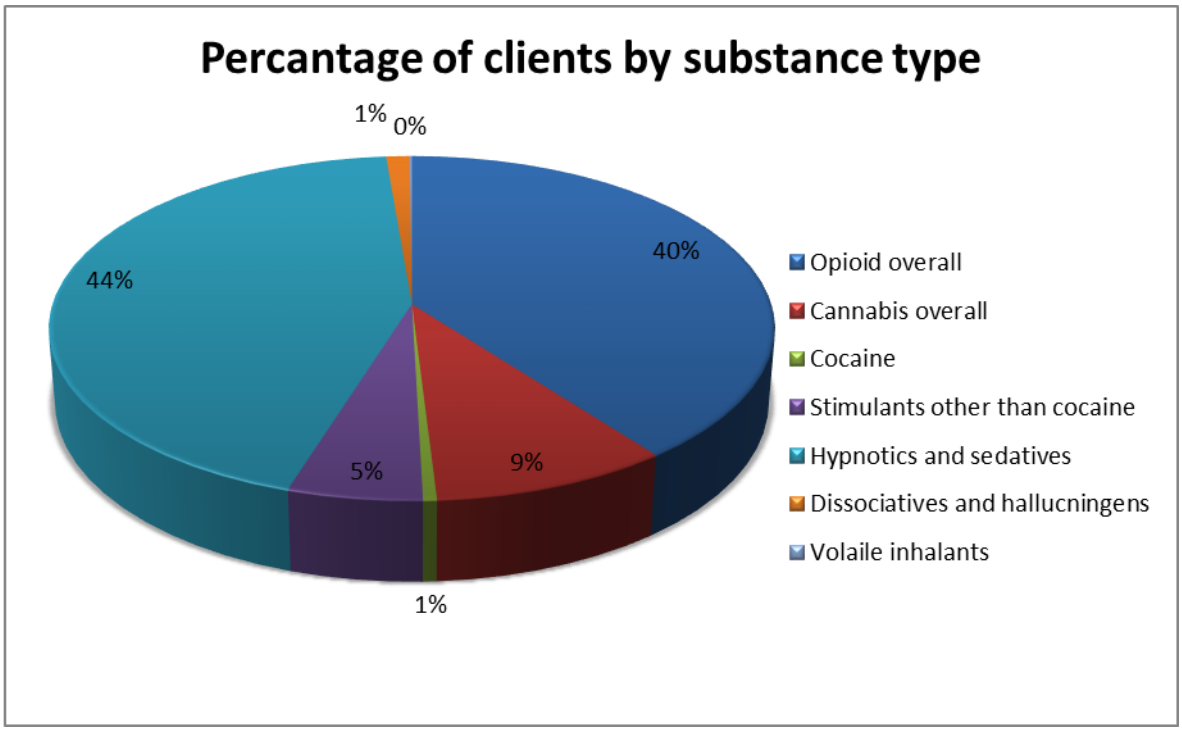

Depending on the type of facility, there are differences also between the primary substances treated. Thus, in clinics and polyclinics, 40,5% of services provided relate to the treatment of alcohol use related disorders, in hospitals treatment of issues related to alcohol constitutes 74.88% of services provided, and in therapeutic communities, services related to drug treatment prevail, with 68,35% of services (Table 14).

Chart 14. The number of clients by type of substance for which they sought assistance



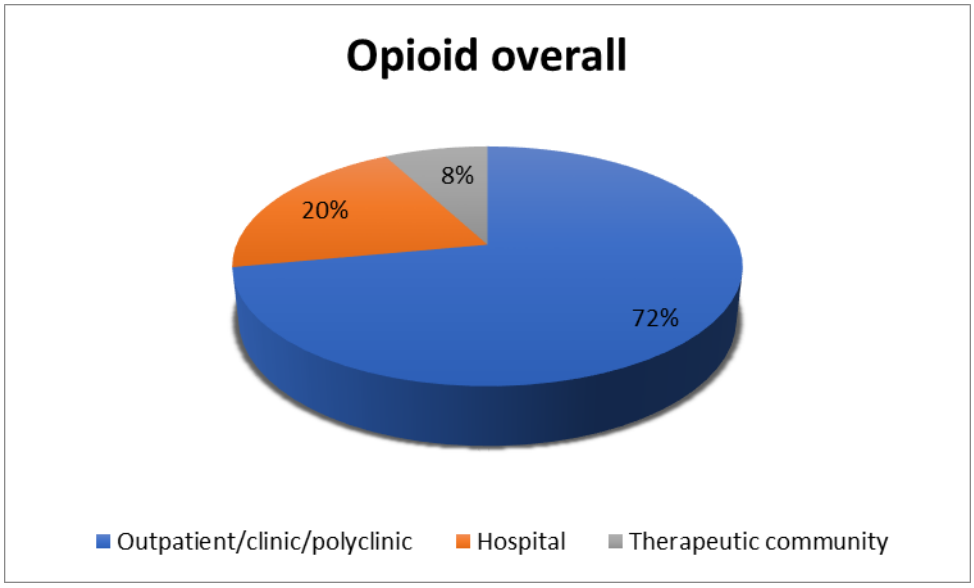
Although the number of clients that sought assistance for issues related to drug and alcohol use is approximately equal, the number of users treated in different types of facilities is different. In clinics, 3,656 users sought assistance related to alcohol use, and in hospitals 2,134 alcohol users. This difference is even greater when it comes to drugs, so assistance in clinics was provided to 5,242 clients, and in hospitals, 672 clients. The total number of alcohol users treated in 2016 was 5,837 clients (Table 16). According to the data submitted by the facilities, a total of 6,588 users were treated for drug use-related problems. This question in the survey was responded to by 16 out of 22 clinics and polyclinics, and 9 out of 13 hospitals (Table 16).

Chart 15. The proportion of clients by primary substance for which they sought assistance




The number of patients treated for using sedatives and hypnotics and opioids is the highest. The number of treatments for other substances is considerably lower than these two substances. 574 users were treated for the use of cannabis, the majority in hospitals (Table 16). Stimulants, except for cocaine, covered 323 users in 16 facilities out of the 39 that reported this data for 2016. The majority of treatments for stimulants are provided in clinics, polyclinics and therapeutic communities. No users were reported for primary treatment of nicotine use disorder. In the facilities that participated in the survey in 2016, 55 users were reported to have sought assistance for the abuse of hallucinogenic drugs and seven persons sought assistance for issues related to the abuse of inhalants. These users were provided with assistance in clinics and polyclinics. In the survey of facilities in Serbia, the data on treatment of persons who have issues with gambling were not collected, or more precisely, they were not available.

Chart 16. Opioid user treatment




Out of the total number of opioid users treated during 2016, 2,073 or 89% were treated in clinics and polyclinics, while only 20.1% or 581 users were treated in hospitals. Therapeutic communities provided treatment for 8% of opioid users (Table 18). These data might difer from the date presented in the chart number 11 (reference to table 13) where is reported 3,486 clients on treatment. The discrepancy has occurred because of variations in number of institutions that has reported to all questions.

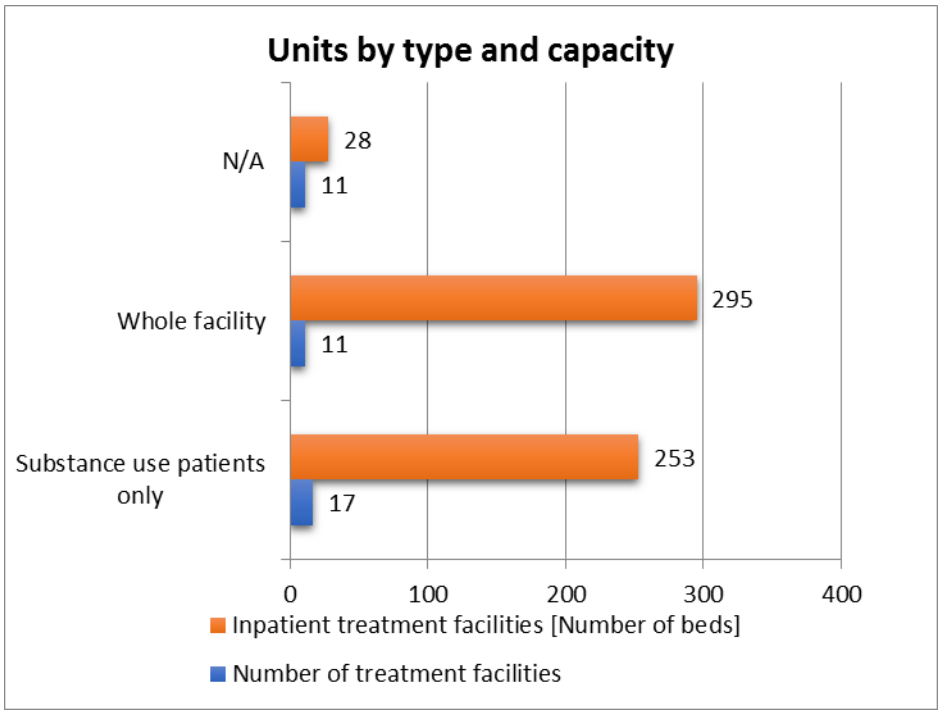
### 9.4.1. Discussion

The presented data show that the predominant substance abused in Serbia is alcohol. The number of services provided related to alcohol on one hand and all other drugs and sedative and hypnotic substances on the other is nearly the same. While issues related to alcohol are mostly treated in hospitals, the treatment of drugs and sedative and hypnotic substance use is predominant in clinics and polyclinics. Therapeutic communities mainly provide services related to opioids.

Data left out of this part are different from similar data from the previous part. The reason for this is the lack of responses to certain questions. Regardless of these discrepancies, data clearly indicate the scope of the problem.

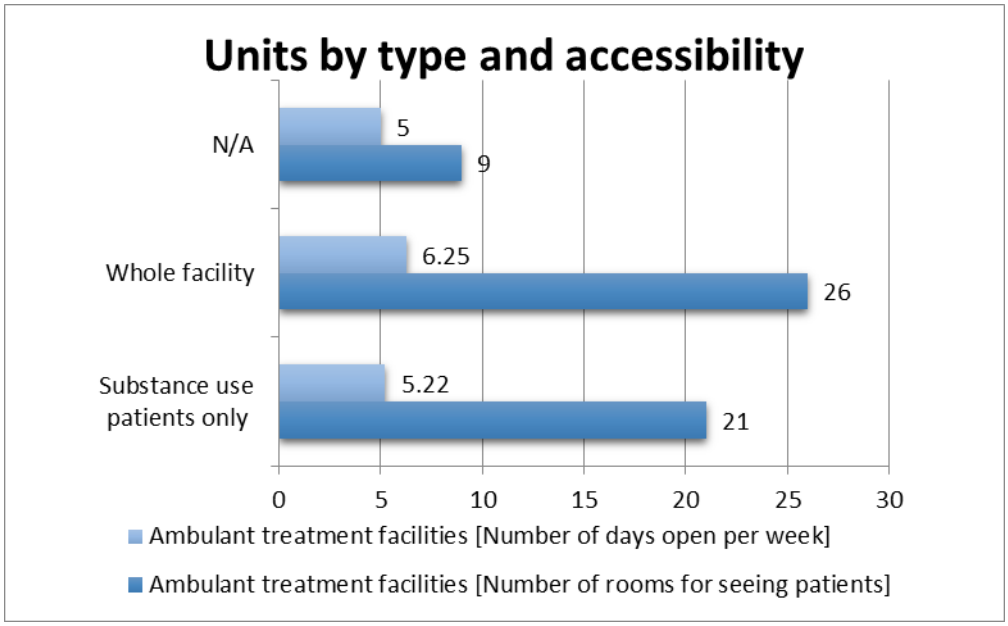
### 9.5 Patients and resources

Chart 17. Types and capacities of treatment units



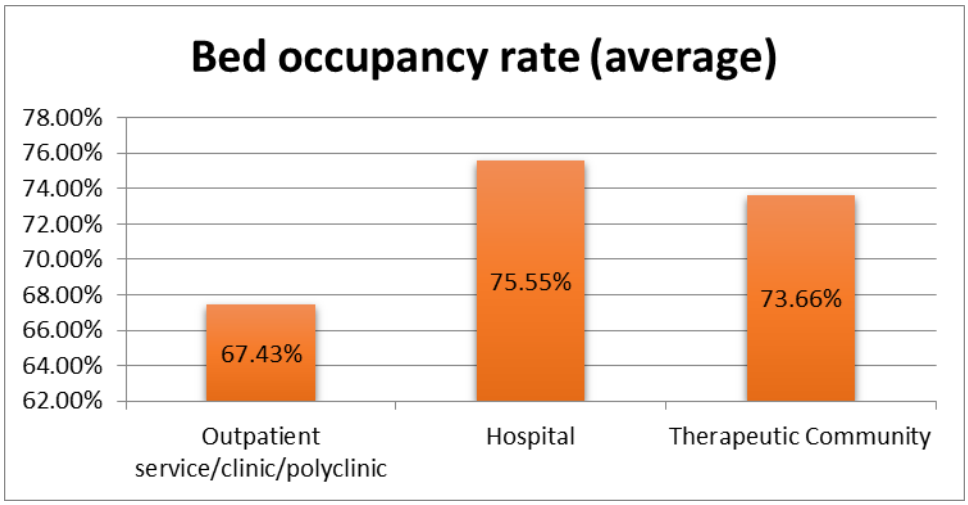

Among the 39 reported facilities, we have no data for 11 facilities or 28%, the same percentage of facilities providing treatment for all psychiatric disorders, and 17 facilities or 43.5% providing only drug and alcohol use disorder treatment. The number of beds is 295 in facilities providing several therapeutic programmes, and 253 beds are provided for the treatment of users in treatment facilities dealing only with drug and alcohol use. Other data are provided in Table 19.

Chart 18. The capacities in clinics and polyclinics



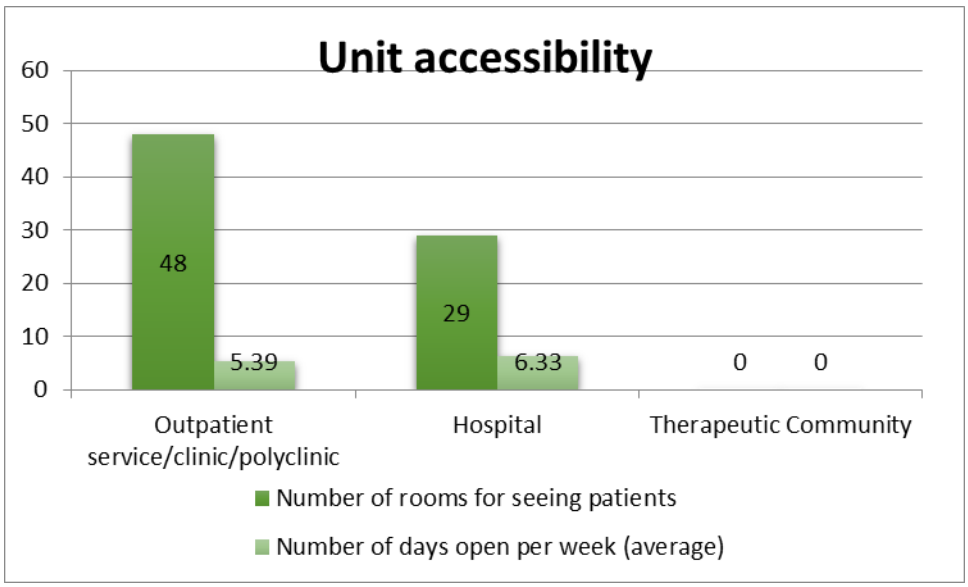
Among the clinics that provide treatment, data in response to this question were provided by 17 out of 22 facilities. Nine facilities reported they treated only drug users, four facilities that they treated other disorders also, while four facilities did not provide any data. According to the data provided, clinics operate 5.49 days a week on average, and they have 56 examination rooms available. On average, this would be between three and four rooms per facility (Table 19).

Chart 19. Capacities in hospitals



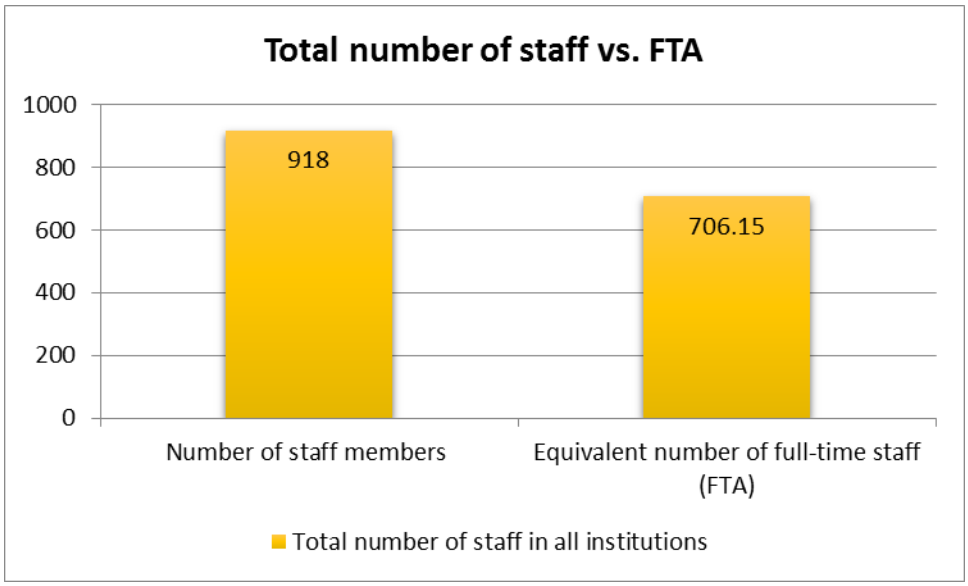

Bed occupancy rate in hospitals and therapeutic communities is approximately the same, 75.55% in hospitals, and 73.66% in communities. The occupancy rate in clinics is somewhat lower, at 67.43%. Data show that there are also vacant beds, at around 25% of the total number of beds (Table 20).

Chart 20. Capacities in clinics, polyclinics and hospitals



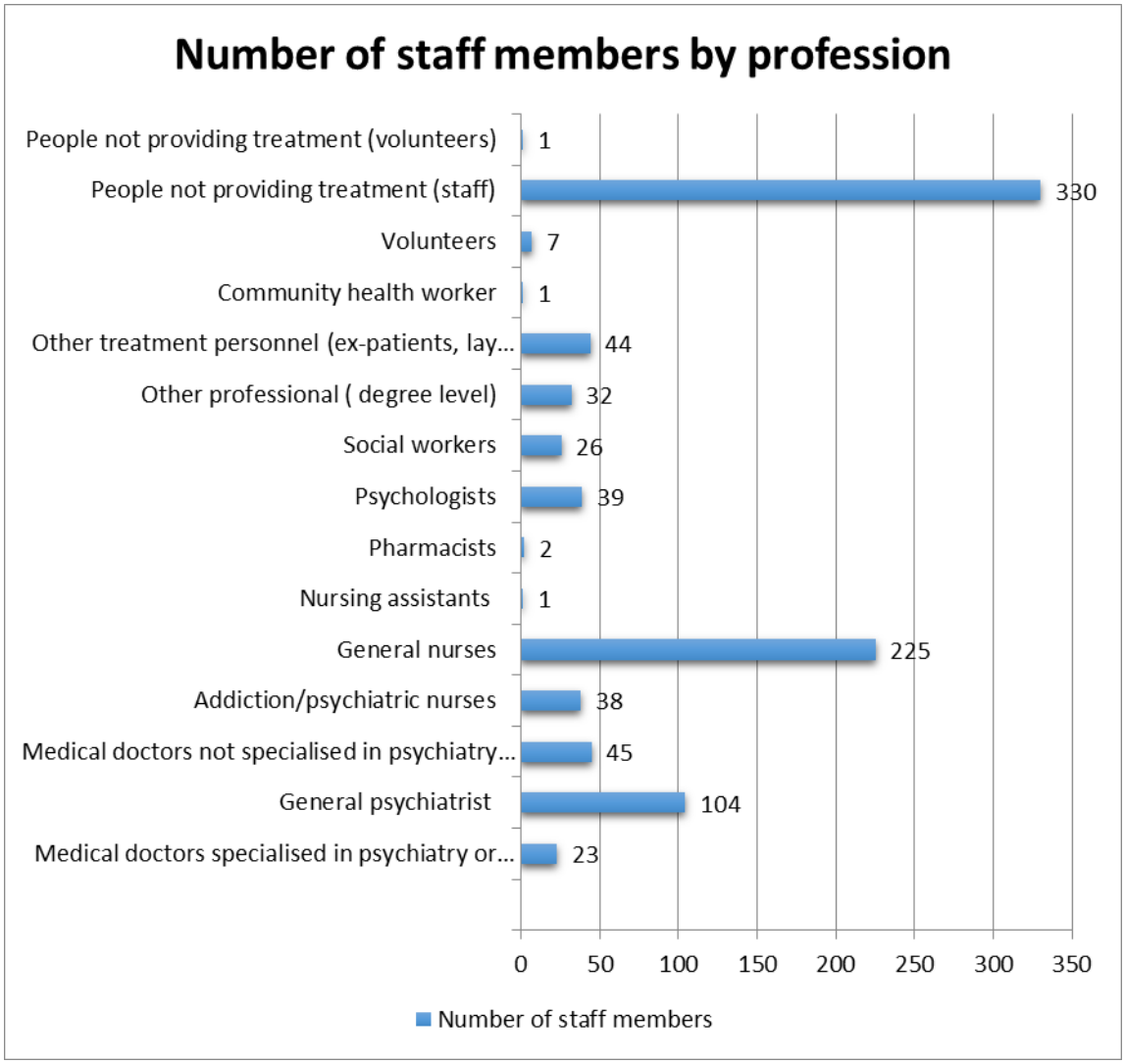

In clinics and polyclinics, the time open for clients is on average 5.39 days, while in hospitals it is 6.33 days. The number of examination rooms in clinics and polyclinics is 48, and in hospitals is 29 rooms (Table 21).

Chart 21. Total number of staff and full-time equivalent




In Serbia, 918 persons are engaged for the treatment of drug and alcohol use disorders, or 706 FTE, or full-time equivalent staff (Table 23).

Chart 22. Professional structure of the staff




In terms of staff structure, medical nurses/technicians are the most numerous (N=225 FTE), followed by doctors specialised in psychiatry (N=104) or dependence diseases (N=23) totalling 127 FTE (Table 22).

The number of staff providing non-medical services is N=330 FTE in over 15 facilities. There are 104 general psychiatrists or 69.5 FTE (over 26 facilities), 23 specialists for addiction medicine or 15.25 FTE (in 21 facilities), 39 psychologists or 20.8 FTE (over 25 facilities) and 225 psychiatric medical nurses or 146 FTE (in over 26 facilities). The number of social workers is 26 or 13.1 FTE in 21 facilities. Data on the number of volunteers are reported in 17 facilities and include a total of seven volunteers or seven FTE in total across all regions (Tables 24 and 25).

### 9.5.1. Discussion

There are units established in Serbia that deal exclusively with treatment, which include 17 facilities. Their capacities in relation to the number of beds in hospital-type facilities and the number of rooms for client examinations in clinics and polyclinics are somewhat smaller than in facilities doing also other forms of treatment of psychiatric disorders. Bed occupancy rate is around 75%, so in relation to the total number there is still opportunity to increase the number

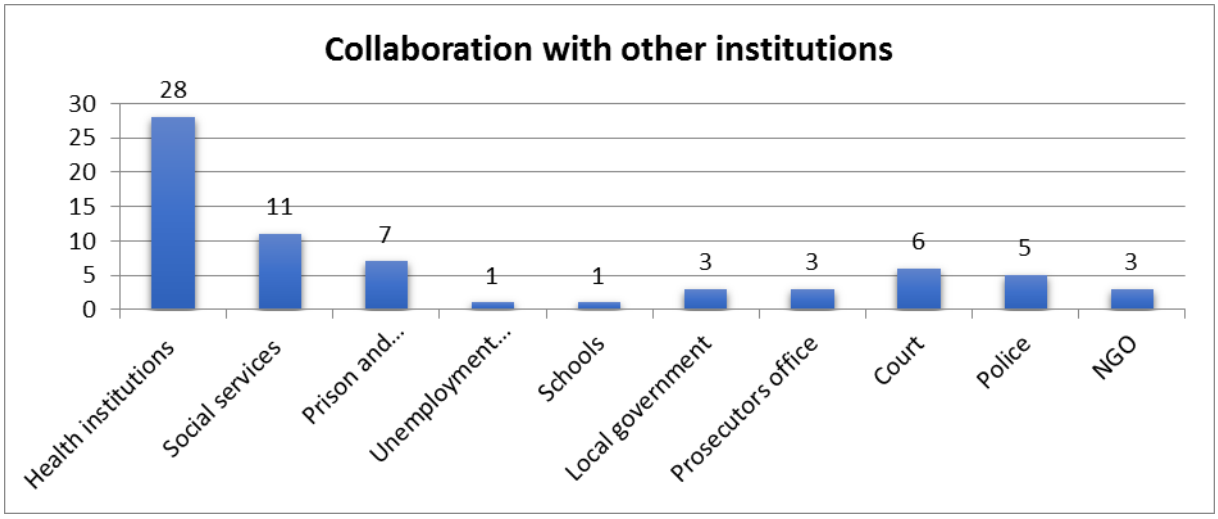
of services provided. In terms of the number of days in clinic-type conditions, which is 5.5, there is no significant opportunity to extend working hours.

The staff in drug use disorder treatment facilities are mainly experts, and a small number of facilities reports engagement of volunteers. General medicine nurses/technicians are the most numerous, followed by doctors specialised in psychiatry or addiction medicine. More psychiatrists are involved in providing substance use disorder treatment than doctors specialising in treating addiction, psychologists and social workers. The total number of full-time employees is higher in facilities for treating other disorders. There is a notably small number of reported data on field workers, community health workers and pharmacists, which could be interpreted in the context of reduced support with the expiration of GFATM support or limited connections between the drug and alcohol use disorder treatment facilities and the local community.

In terms of results, a high number of highly educated resources is noticeable. The ratio of specialists versus medical nurses is one to two. Other profiles, such as psychologists, social workers and other drug use disorder treatment professionals are few. The number of non-medical staff or staff not providing medical assistance is extremely high at 330 FTE. In relation to 706 FTE, which is the total engagement of staff, this accounts for 47.6% of total staff engaged.

## 9.6 Collaboration

Chart 23. Collaboration with other facilities




### 9.6.1. Discussion

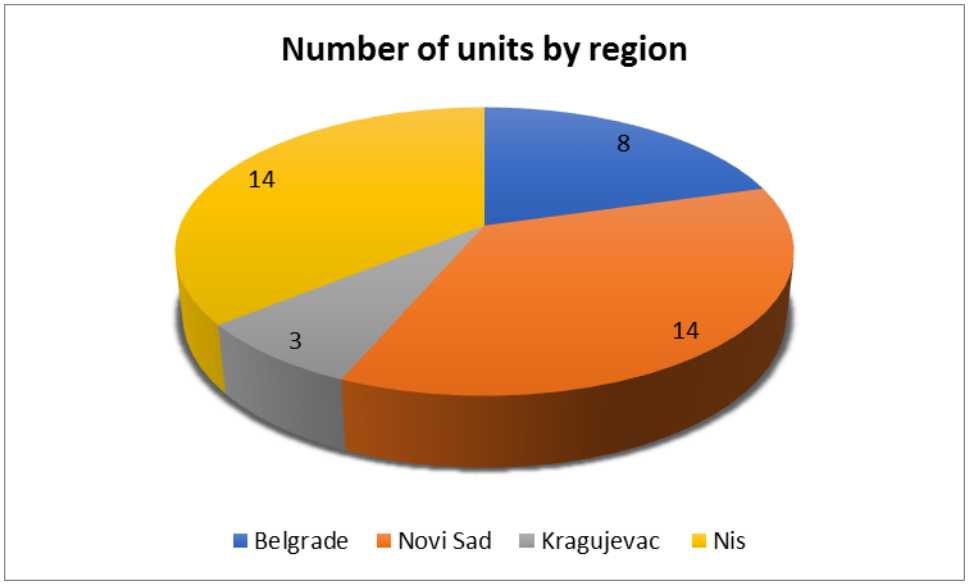
The collaboration between drug use disorder treatment facilities and other relevant facilities is considered stable and functional. Both at the regional and on the local levels, 28 facilities communicate regularly with other drug user treatment facilities (Tables 26 and 27).

Clinics reported links with other service providers, mainly hospitals, specialised hospitals for drug dependence treatment, prison drug treatment units and regional reference centres (clinical centres and special hospitals). There are no precise data on the way in which the collaboration is realised. Informal data from the field show that it mainly follows the model of occasional communication, while in a few cases, there are signed cooperation agreements.

### 9.7 Geographic and administrative characteristics

Data in this section come from a total of 39 facilities distributed in four regional centres: Belgrade, Novi Sad, Niš and Kragujevac (Table 28). The sample consisted of 22 clinics, 13 hospital facilities and four therapeutic communities. As shown, according to survey results, clinics are the most available units across the country, followed by treatment in hospital-type facilities. None of the facilities that responded to the survey self-identified as low-threshold facilities, specialised social reintegration units or units for non-hospital rehabilitation.

Chart 24. Regional distribution of facilities by numbers




The Belgrade region reported eight facilities, or 20.51%, Novi Sad and Niš reported 14 facilities each or 35.9%, and Kragujevac reported three facilities, or 7.69%. One therapeutic community from Novi Sad provided data as central organisation consisting of five units distributed throughout the country.

In terms of distribution of different treatment programmes, based on survey data, Novi Sad has greater variety in service provision, including both out-patient and in-patient units and four therapeutic communities, followed by the Niš Region with in-patient and out-patient units, as well as Belgrade and Kragujevac (Table 29).

Chart 25. Total number of clients in OST

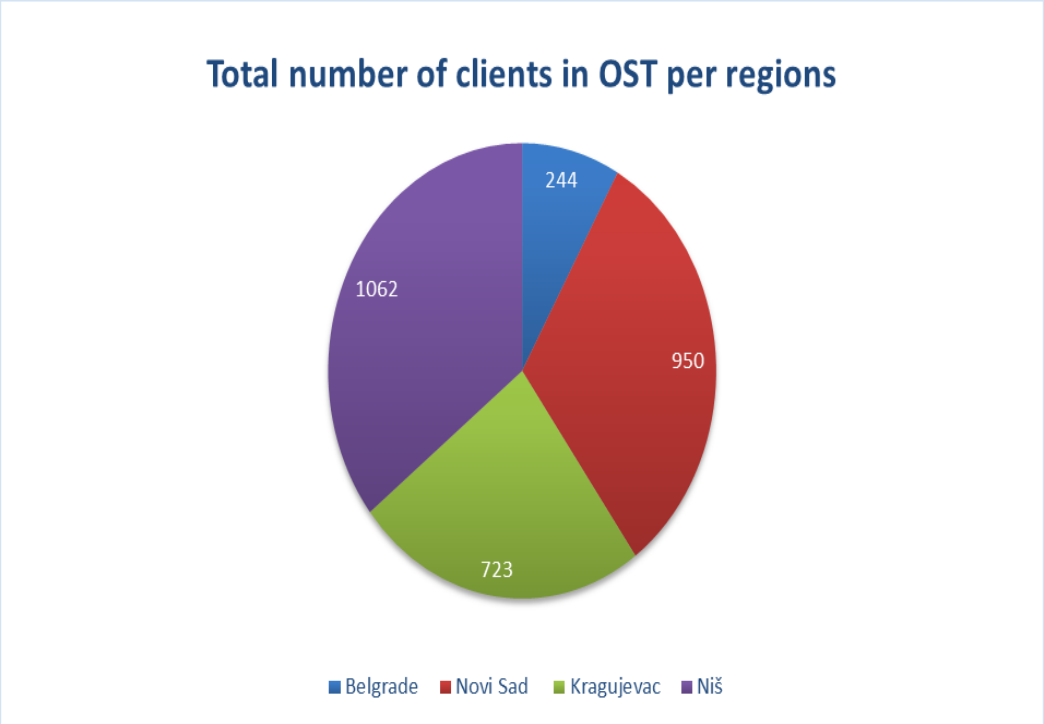
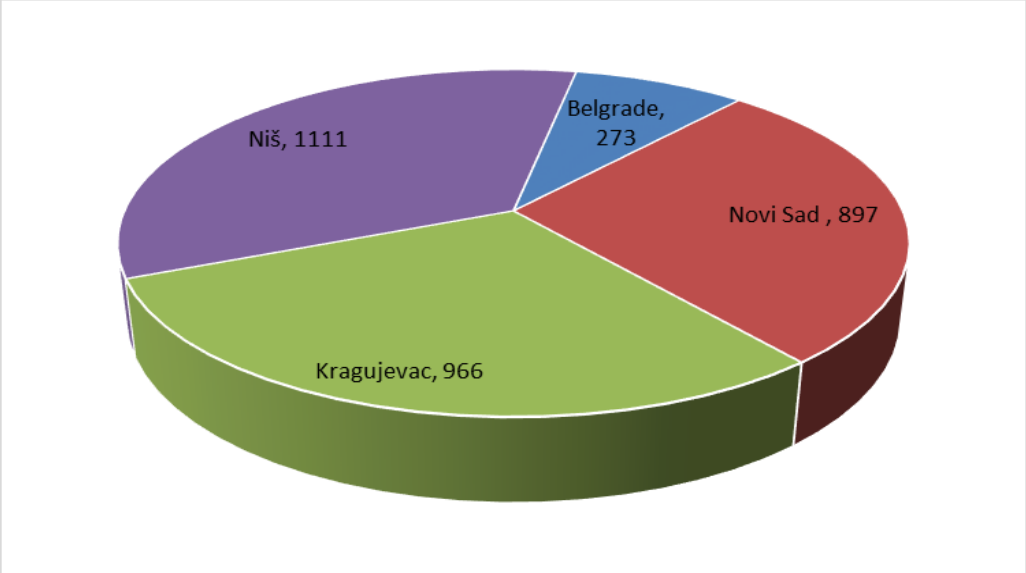



Chart 26. Total number of OST clients in 2016




In the Belgrade Region, 244 users are treated with OST, or 8.1%; 950 people in Novi Sad, or 31.1%; 723 people in Kragujevac, or 24.2%, and 1,026 people in the Niš Region, or 35.6%. In 2016, 273 clients were treated with OST in the Belgrade Region, or 8.4%; 897 people, or 27.6% in Novi Sad; 966 people or 30.6% in Kragujevac, and 1,111 people in Niš Region, or 34.2%.

### 9.7.1. Discussion

Based on data shown, we can conclude that there are certain differences between the regions. The Novi Sad region has the most modalities of treatment and assistance, while the Niš Region has the highest number of clients, both in general, as well as in 2016. Kragujevac Region submitted data for three facilities only, so probably the situation in the field is different than the one shown. Data from more facilities would probably show a similar structure, but also a higher number of service users.

# 10. ANNEXES

**10.1 Table 1. Number of units with state-recognised accreditation**

| Type of treatment unit | **Proportion of accredited units (%)** | **Portion of units pending accreditation (%)** | **Portion of non-accredited units (%)** | **Portion of N/A (%)** | **Accreditation Facility-Ministry of Health** | **Accreditation Facility-Agency for Accreditation of Health Facilities** | **Accreditation Facility-Inspection of the Ministry of Health** |
|---|---|---|---|---|---|---|---|
| Outpatient /clinic/policlinic | 13 out of 22 59.09% | 1 out of 22 4.54% | 6 out of 22 27.27% | 2 out of 22 9.1% | 8 | 4 | 1 |
| Hospital | 8 out of 13 61.54% | 5 out of 13 46% | 0 out of 13 0% | 0 out of 13 0% | 7 | 1 | 0 |
| Non-hospital residential treatment | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Therapeutic community | 0 out of 4 0% | 0 | 3 out of 4 75% | 1 out of 4 25% | 0 | 0 | 0 |
| -Low threshold unit | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total | 21 out of 39 53.85% | 6 out of 39 15.38% | 9 out of 39 23.09% | 3 out of 37 1.11% | 15 | 5 | 1 |

**10.2 Table 2. Type of drug use treatment facility**

| **Type of treatment facility** | **Number of units** | **%** |
|---|---|---|
| ***Clinic/polyclinic*** | 22 | 60.25% |
| ***Hospital*** | 13 | 30% |
| **Non-hospital residential treatment** | 0 | 0 |
| ***Therapeutic communities*** | 4 | 9.75% |
| **Low-threshold units** | **0** | **0** |
| **Specialised units for social reintegration** | 0 | 0 |
| **Total** | **39** | **100.00%** |

## 10.3 Table 3. Number of facilities by source of funding

| | Clinics, polyclinics | Hospital | Non-hospital residential treatment | Therapeutic communities | Low-threshold units | Specialised units for social reintegration | Total |
|---|---|---|---|---|---|---|---|
| **Government** | 21 | 11 | 0 | 0 | 0 | 0 | 32; 82% |
| **Profit NGOs (private)** | 0 | 0 | 0 | 4 | 0 | 0 | 4; 9.75% |
| **Other sources of funding** | 1 | 2 | 0 | 0 | 0 | 0 | 3; 7.6% |
| **Total** | **22** | **13** | **0** | **4** | **0** | **0** | **39** |

## 10.4 Table 4. Available sources and a number of units with different sources distribution

| Source of governmental funding if any | Ministry of Health | Ministry of Social Services | Ministry of drug Control | Ministry of Justice | Ministry of Interior | Ministry of Education | Other |
|---|---|---|---|---|---|---|---|
| | 29 | 0 | 0 | 4 | 0 | 0 | 6 |

## 10.5 Table 5. Number of units operating pharmacologically assisted management of withdrawal (detoxification) programme

| Type of treatment unit | Number of units | Proportion (%) |
|---|---|---|
| Outpatient/clinic/policlinic | 18 out of 22 | 81.82% |
| Hospital | 12 out of 13 | 92.31% |
| Non-hospital residential treatment | 0 | 0 |
| Therapeutic community | 4 out of 4 | 100% |
| Low threshold unit | 0 | 0 |
| Specialised social reintegration unit | 0 | 0 |
| **Total** | 34 | 91.38% |

## 10.6 Table 6. Number of units operating OST

| Type of treatment unit | On site availability of opioid maintenance treatment | Number of clients | |
|---|---|---|---|
| | | in OST in referen period | on waiting li for OST |

| | | | |
|---|---|---|---|
| **Outpatient/clinic/polyclinic** | 21 | 2250 n=19 | N/A |
| **Hospital** | 9 | 139 n=7 | N/A |
| **Therapeutic community** | 0 | 0 | N/A |
| **Total** | 30 | 2389 | N/A |

**10.7 Table 7. Provision of counselling/psychotherapy in units**

| **Service** | **Outpatient facilities** | **Inpatient facilities** | **Therapeutic communities** | **Available services (<2 weeks)** | **Outpatient facilities** | **Inpatient facilities** | **Therapeutic communities** |
|---|---|---|---|---|---|---|---|
| Brief psychosocial interventions | 15 | 10 | 1 | Cognitive behavioural therapy | 6 | 3 | 1 |
| Longer duration psychosocial support <2 weeks | 15 | 13 | 3 | | | | |
| | | | | Motivational enhancement therapy | 2 | 3 | 2 |
| | | | | Contingency management | 0 | 2 | 1 |
| | | | | 12 step facilitation | 1 | 0 | 1 |
| | | | | Individual counselling | 10 | 7 | 2 |
| | | | | Family counselling | 5 | 6 | 2 |
| | | | | Group counselling | 4 | 4 | 3 |

**10.8 Table 8. Provision of social reintegration services**

| Service | Outpatient facilities | Inpatient facilities | Therapeutic communities | Total |
|---|---|---|---|---|
| Employment support (e.g. work placement/ job insertion programmes) | 5 n=22 | 3 n=10 | 3 n=4 | 11 |
| Housing support (e.g. half-way housing, shelter housing) | 8 n=21 | 4 n=10 | 3 n=4 | 15 |
| Education and vocational training | n/a | n/a | n/a | n/a |

**10.9 Table 9. Provision of harm reduction services**

| Service | Outpatient facilities | Inpatient facilities | Therapeutic communities |
|---|---|---|---|
| Street outreach work | 0 n=21 | 0 n=10 | 1 n=4 |
| Distribution of syringes and other drug injecting equipment | 0 n=20 | 0 n=10 | 0 n=4 |
| Distribution of condoms and lubricant | n/a | n/a | n/a |
| Distribution of information material on safer injecting and drug overdose prevention | n/a | n/a | n/a |
| Distribution of information material targeted at recreational drug users and party-goers | n/a | n/a | n/a |

**10.10 Table 10. Providing testing and infectious diseases-related services**

| Service | Outpatient | Inpatient | Therapeutic Community | Total |
|---|---|---|---|---|
| On-site HIV diagnostic testing | 10 n=22 | 5 n=11 | 1 n=4 | 16 n=37 |
| On-site HCV diagnostic testing | 10 n=22 | 5 n=11 | 0 n=4 | 15 n=37 |
| On-site HBV diagnostic testing | n/a | n/a | n/a | n/a |
| On-site HBV vaccination | n/a | n/a | n/a | n/a |
| On-site HCV infection treatment | 5 n=22 | 2 n=10 | 0 n=4 | 7 n=36 |
| On-site ART treatment of HIV/AIDS | 2 n=22 | 2 n=10 | 0 n=4 | 4 n=36 |

**10.11 Table 11. Aggregate number of services for testing and treatment of infectious diseases**

| Services | Total |
|---|---|
| On-site HIV diagnostic testing | 16 |

| | |
|---|---|
| On-site HCV diagnostic testing | 15 |
| On-site HCV infection treatment | 7 |
| On-site HIV/AIDS treatment | 4 |

**10.12 Table 12. Services for specific, vulnerable groups**

| Type of client group | YES | NO | N/A |
|---|---|---|---|
| **Children (4-11 age group)** | 3 | 30 | 6 |
| **Adolescents (12-18 age group)** | 6 | 30 | 3 |
| **Women** | 6 | 28 | 5 |

**10.13 Table 13. Total number of clients in treatment facilities 2016**

| Type of treatment unit | Number of clients | People prescribed opioid maintenance treatment (methadone or buprenorphine) | Proportion (%) |
|---|---|---|---|
| **Outpatient service/clinic/polyclinic** | 2,040 n = 8 | 3,347 n = 19 | 44.66% |
| **Hospital** | 2,003 n = 11 | 139 n = 7 | 45.17% |
| **Non-hospital residential treatment** | 0 | 0 | 0% |
| **Therapeutic community** | 339 n = 3 | 0 | 10.17% |
| **Low-threshold unit** | 0 | 0 | 0.00% |
| **Specialized social reintegration unit** | 0 | 0 | 0% |
| **Total** | **4,382** | **3,386** | **100%** |

**10.14 Table 14. Proportion of clients by type of clients and unit type**

| Type of client | Outpatient service/clinic /polyclinic | Hospital | Non-hospital residential treatment | Therapeutic Community | Low-threshold unit |
|---|---|---|---|---|---|
| **Alcohol** | 41.09% n=16 | 76.05% n=9 | 0 | 6.52% n=2 | 0 |
| **Illicit drugs** | 27.86% n=18 | 21.95% n=7 | 0 | 72.81% n=3 | 0 |
| **Gambling** | 0 | 0 | 0 | 0 | 0 |

| | | | | | |
|---|---|---|---|---|---|
| **Misuse of pharmaceuticals/ medicines** | 31.05% n=13 | 2.00% n=5 | 0 | 20.67% n=3 | 0 |
| **Other disorders/health problems** | 0 | 0.00% | 0 | 0 | 0 |
| **Total** | 100% | 100% | 100% | 100% | 100% |

**10.15 Table 15. Aggregate proportion of clients by type of clients and unit type**

| *Type of client* | *Outpatient service/clinic/polyclinic* | *Hospital* | *Therapeutic Community* |
|---|---|---|---|
| **Alcohol** | 41.09% | 76.05% | 6.52% |
| **Illicit drugs** | 27.86% | 21.95% | 72.81% |
| **Abuse of pharmaceuticals/medicines** | 31.05% | 2.00% | 20.67% |

**10.16 Table 16. Number of clients in reference period by substance and unit type**

| Type of client | Outpatient/clinic/polyclinic | Hospital | Non-hospital residential clinic | Therapeutic community | Low-threshold unit | Total |
|---|---|---|---|---|---|---|
| **Alcohol** | 3656 n=16 | 2134 n=9 | 0 | 47 n=2 | 0 | 5837 |
| **Nicotine** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Illicit drugs** | 5242 n=17 | 672 n=7 | 0 | 674 n=4 | 0 | 6588 |
| | Opioids overall 2073 | Opioid overall 581 | 0 | Opioids overall=225 | 0 | 2879 |
| | Cannabis overall 426 | Cannabis overall 18 | 0 | Cannabis overall 145 | 0 | 589 |
| | Cocaine 19 | Cocaine 5 | 0 | Cocaine 9 | 0 | 33 |
| | Stimulants other than cocaine | Stimulants other than cocaine 12 | 0 | Stimulants other than cocaine 128 | 0 | 323 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | 183 | n=3,4 | | n=4,3,4 | | |
| | Hypnotics and Sedatives 2479 | Hypnotics and Sedatives 56 | 0 | Hypnotics and Sedatives 149 | 0 | 2684 |
| | Dissociatives and hallucinogens 55 | 0 | | Dissociatives and hallucinogens 18 | | 73 |
| | Volatile inhalants 7 | 0 | | 0 | | 7 |
| **Gambling** | n/a | n/a | n/a | n/a | n/a | n/a |
| **Total** | 8898 | 2806 | 0 | 721 | | 12425 |

**10.17 Table 17. Aggregate number of clients in reference period by substance and unit type**

| Type of client | Outpatient/clinic/polyclinic | Hospital | Therapeutic community | Total |
|---|---|---|---|---|
| **Opioid overall** | 2073 | 581 | 225 | 2879 |
| **Cannabis overall** | 426 | 18 | 145 | 589 |
| **Cocaine** | 19 | 5 | 9 | 33 |
| **Stimulants other than cocaine** | 183 | 12 | 128 | 323 |
| **Hypnotics and sedatives** | 2479 | 56 | 149 | 2684 |
| **Dissociatives and hallucinogens** | 55 | 0 | 18 | 73 |
| **Volatile inhalants** | 7 | 0 | 0 | 7 |

**10.18 Table 18. Total number of clients treated for opioid addiction**

| Type of client | Outpatient/clinic/polyclinic | Hospital | Therapeutic community |
|---|---|---|---|
| **Opioid overall** | 2073 | 581 | 225 |

**10.19 Table 19. Number of units by types, occupancy and accessibility per type of facility**

| Type of facility | Number of treatment facilities | Inpatient treatment facilities [Number of beds] | Inpatient treatment facilities [Bed occupancy rate (%)] | Out-patient treatment facilities [Number of rooms for seeing patients] | Out-patient treatment facilities [Number of days open per week] |
|---|---|---|---|---|---|
| **Substance use patients only** | 17 | 253 n=8 | 71.62% n=8 | 21 n=9 | 5.22 n=9 |
| **Whole facility** | 11 | 295 n=7 | 78.29% n=7 | 26 n=4 | 6.25 n=4 |
| **N/A** | 11 | 28 n=2 | 48.5 n=2 | 9 n=4 | 5 n=4 |
| **Total** | **39** | **576** | **66.14%** | **56** | **5.49** |

**10.20 Table 20. Number of units by types, occupancy and accessibility**

| Type | Number of beds | Bed occupancy rate (average) | Number of rooms for seeing patients | Number of days open per week (average) |
|---|---|---|---|---|
| **Outpatient service/clinic/polyclinic** | 103 n = 7 | 67.43% n = 7 | 48 n = 18 | 5.39 n = 18 |
| **Hospital** | 364 n = 9 | 75.55% n = 9 | 29 n = 6 | 6.33 n = 6 |
| **Non-hospital residential treatment** | 0 | 0 | 0 | 0 |
| **Therapeutic Community** | 178 n = 3 | 73.66% n = 3 | 0 | 0 |
| **Low-threshold unit** | 0 | 0 | 0 | 0 |
| **Specialized social reintegration unit** | 0 | 0 | 0 | 0 |

**10.21 Table 21. Aggregate number of units by types, occupancy and accessibility**

| Type | Number of beds | Bed occupancy rate (average) | Number of rooms for seeing patients | Number of days open per week (average) |
|---|---|---|---|---|
| **Outpatient service/clinic/polyclinic** | 103 | 67.43% | 48 | 5.39 |
| **Hospital** | 364 | 75.55% | 29 | 6.33 |
| **Therapeutic Community** | 178 | 73.66% | 0 | 0 |

**10.22 Table 22. Staffing of units**

| Staff categories | Number of staff members | Equivalent number of full-time staff (FTA) |
|---|---|---|
| Medical doctors specialised in psychiatry or addiction medicine | 23 n = 24 | 15.25 n = 21 |
| General psychiatrist | 104 n = 33 | 69.5 n = 26 |
| Medical doctors not specialised in psychiatry or addiction medicine | 45 n = 26 | 34.5 n = 22 |
| Addiction/psychiatric nurses | 38 n = 24 | 24.3 n = 19 |
| General nurses | 225 n = 33 | 149 n = 26 |
| Nursing assistants | 1 n = 15 | 1 n = 16 |
| Pharmacists | 2 n = 16 | 1,1 n = 17 |
| Psychologists | 39 n = 32 | 20.8 n = 25 |
| Social workers | 26 n = 28 | 13.1 n = 21 |
| Other professional (degree level) | 32 n = 15 | 33 n = 18 |
| Other treatment personnel (ex-patients, lay health workers…) | 44 n = 13 | 4.1 n = 17 |
| Community health worker | 1 n = 13 | 0 n = 16 |
| Volunteers | 7 n = 14 | 7 n = 17 |
| People not providing treatment (staff) | 330 n = 15 | 332.5 n = 18 |
| People not providing treatment (volunteers) | 1 n = 13 | 1 n = 16 |
| **Total** | **918** | **706.15** |

## 10.23 Table 23. Aggregated staffing of units

| | Number of staff members | Equivalent number of full-time staff (FTA) |
|---|---|---|
| Total number of staff in all facilities | 918 | 706.15 |

## 10.24 Table 24. Profile of staff engaged in units

| **Profile of engaged staff** | **Number of engaged staff** | **Equivalent number of full-time staff (FTE)** |
|---|---|---|
| **Medical doctors specialised in psychiatry or addiction medicine** | 23 | 15.25 n = 21 |
| **General psychiatrist** | 104 | 69.5 n = 26 |
| **Medical doctors not specialised in psychiatry or addiction medicine** | 45 | 34.5 n = 22 |
| **Addiction/psychiatric nurses** | 38 | 24.3 n = 19 |
| **General nurses** | 225 | 149 n = 26 |
| **Nursing assistants** | 1 | 1 n = 16 |
| **Pharmacists** | 2 | 1.1 n = 17 |
| **Psychologists** | 39 | 20.8 n = 25 |
| **Social workers** | 26 | 13.1 n = 21 |
| **Other professional (degree level)** | 32 | 33 n = 18 |
| **Other treatment personnel (ex-patients, lay health workers…)** | 44 | 4.1 n = 17 |
| **Community health worker** | 1 | 0 n = 16 |
| **Volunteers** | 7 | 7 n = 17 |
| **People not providing treatment (staff)** | 330 | 332.5 n = 18 |
| **People not providing treatment (volunteers)** | *1* | 1 n = 16 |
| **Total** | **918** | **706.15** |

## 10.25 Table 25. Staff by type of treatment and facility

| Type of facility | Substance use facility patient facility | | Whole facility | | N/A | |
|---|---|---|---|---|---|---|
| **Human resources** | **Number of staff members of each type** | **Number of full-time staff** | **Number of staff members of each type** | **Number of full-time staff** | **Number of staff members of each type** | **Number of full-time staff** |
| **- Medical doctors specializing in addiction medicine or addiction psychiatry** | 10 n = 12 | 6 n = 9 | 11 n = 8 | 4 n = 7 | 2 n = 4 | 2 n = 4 |
| **- General psychiatrists** | 43 N = 15 | 21 n = 10 | 31 n = 9 | 23 n = 8 | 30 n = 9 | 25 n = 7 |
| **- Medical doctors not specialized in psychiatry or addiction medicine** | 10 n = 11 | 8 n = 8 | 19 n = 7 | 16 n = 7 | 16 n = 8 | 10 n = 6 |
| **- Addiction/psychiatric nurses** | 10 n = 10 | 1 n = 7 | 12 n = 9 | 9 n = 8 | 16 n = 5 | 14 n = 4 |
| **- General nurses** | 77 N = 16 | 37 n = 12 | 48 n = 8 | 28 n = 7 | 100 n = 9 | 84 n = 7 |
| **Nursing assistants** | 1 n = 8 | 1 n = 7 | 0 n = 4 | 0 n = 6 | 0 n = 3 | 0 n = 3 |
| **Pharmacists** | 2 n = 9 | 1 n = 7 | 0 n = 4 | 0 n = 6 | 0 n = 3 | 0 n = 3 |
| **Psychologists** | 16 n = 14 | 8 n = 11 | 9 n = 8 | 5 n = 7 | 14 n = 10 | 7 n = 7 |
| **Social workers** | 11 n = 13 | 4 n = 9 | 7 n = 7 | 5 n = 7 | 8 n = 8 | 4 n = 5 |
| **Other professionals (specification n/a)** | 0 n = 7 | 0 n = 7 | 34 n = 6 | 33 n = 8 | 6 n = 5 | 0 n = 3 |
| **Other treatment personnel (ex-patients, lay health workers…)** | 0 n = 3 | 3 n = 8 | 0 n = 3 | 0 n = 6 | 0 n = 2 | 1 n = 3 |
| **- Outreach workers** | 1 n = 8 | 0 n = 8 | 3 n = 3 | 3 n = 6 | 2 n = 3 | 1 n = 3 |
| **- Community health workers** | 1 n = 8 | 0 n = 8 | 0 n = 3 | 0 n = 6 | 0 n = 2 | 0 n = 2 |
| **- Volunteers** | 0 n = 8 | 0 n = 8 | 7 n = 4 | 7 n = 7 | 1 n = 3 | 0 n = 2 |
| **- Others (specification n/a)** | 3 n = 8 | 3 n = 8 | 17 n = 5 | 0 n = 6 | 0 n = 2 | 1 n = 3 |
| **People not providing treatment** | | | | | | |
| **- Staff** | 6 n = 9 | 6 n = 9 | 327 n = 4 | 324 n = 6 | 2 n = 3 | 2 n = 3 |
| **- Volunteers** | 0 n = 8 | 0 n = 8 | 16 n = 3 | 1 n = 6 | 0 n = 2 | 0 n = 2 |
| **Total** | **191** | **99** | **541** | **458** | **197** | **151** |

## 10.26 Table 26. Interinstitutional collaboration

| Type of collaborating institution | Outpatient / clinic / policlinic n=16 | Hospital n=10 | Non-hospital residential treatment | Therapeutic community n=4 | -Low threshold unit | Specialised social reintegration unit | Total |
|---|---|---|---|---|---|---|---|

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Health facilities (e.g. hospitals, general practitioner, specialised drug and alcohol treatment services)** | 15 | 9 | n/a | 4 | n/a | n/a | **28** |
| **Social services (e.g. housing/education service providers)** | 7 | 3 | n/a | 1 | n/a | n/a | **11** |
| **Prison and probation services** | 7 | 0 | n/a | 0 | n/a | n/a | **7** |
| **Unemployment services (job centres)** | 1 | 0 | n/a | 0 | n/a | n/a | **1** |
| Other: | | | | | | | |
| **Schools** | 1 | 0 | n/a | 0 | n/a | n/a | **1** |
| **Local government** | 1 | 1 | n/a | 1 | n/a | n/a | **3** |
| **Prosecutors office** | 2 | 1 | n/a | 0 | n/a | n/a | **3** |
| **Court** | 3 | 3 | n/a | 0 | n/a | n/a | **6** |
| **Police** | 2 | 2 | n/a | 1 | n/a | n/a | **5** |
| **NGO** | 1 | 1 | n/a | 1 | n/a | n/a | **3** |

## 10.27 Table 27. Aggregated interinstitutional collaboration

| Type of collaborating institution | Total |
|---|---|
| **Health facilities** | **28** |
| **Social services** | **11** |
| **Prison and probation services** | **7** |
| **Unemployment services** | **1** |
| **Schools** | **1** |
| **Local government** | **3** |
| **Prosecutors office** | **3** |
| **Court** | **6** |
| **Police** | **5** |
| **NGO** | **3** |

## 10.28 Table 28. Distribution of units and clients by regions

| Type of treatment unit | Number of units operating OST | Total number of clients in OST | Total number of clients in OST in reference period | Number of outpatient facilities | Number of inpatient institution | Number of therapeutic communities | Total proportion by number of units operating OST (%) |
|---|---|---|---|---|---|---|---|

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Belgrade** | 8 | 244 n = 8 | 273 n = 6 | 6 | 2 | 0 | 8 out of 39 **20.51%** |
| **Novi Sad** | 14 | 950 n = 8 | 897 n = 6 | 4 | 6 | 4 | 14 out of 39 **35.90%** |
| **Kragujevac** | 3 | 723 n = 1 | 966 n = 2 | 2 | 1 | 0 | 3 out of 39 **7.69%** |
| **Nis** | 14 | 1,062 n = 13 | 1,111 n = 12 | 10 | 4 | 0 | 14 out of 39 **35.90%** |
| **Total** | **39** | **2,979** | **3,247** | **22** | 13 | 4 | **100%** |

## 10.29 Table 29. Aggregated distribution of units and clients by regions

| Type of treatment unit | Number of units operating OST | Total number of clients in OST | Total number of clients in OST in reference period | Number of outpatient facilities | Number of inpatient institution | Number of therapeutic communities |
|---|---|---|---|---|---|---|
| **Beograd** | 8 | 244 | 273 | 6 | 2 | 0 |
| **Novi Sad** | 14 | 950 | 897 | 4 | 6 | 4 |
| **Kragujevac** | 3 | 723 | 966 | 2 | 1 | 0 |
| **Niš** | 14 | 1,062 | 1,111 | 10 | 4 | 0 |
| **Total** | **39** | **2,979** | **3,247** | **22** | 13 | 4 |

# 11. RESOURCES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