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RECOMMENDATIONS FOR THE PLANNING AND ASSESSMENT OF PREVENTION INITIATIVES

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6.1 IMPROVING THE PLANNING AND ASSESSMENT PROCESSES OF DRUG ADDICTION PREVENTION POLICIES: THE “WHAT” AND THE “HOW”

The effectiveness of policies to prevent drug addiction can be attributed to two closely connected factors: the first regarding the planning processes, the “how” of planning, and the second to the contents themselves, i.e. “what” it is decided to implement, the measures and actions supported by particular programmes. These factors interact and contribute to determining the impacts and effects of prevention policies.

How

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decision-making processes underpinning the allocation of resources and adequate means of implementation (see analysis of organisational concepts)

What

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relevant and effective initiatives and methodologies

In the following paragraphs we will analytically observe the two factors and for each of them indicate some brief recommendations aimed at the main stakeholders: the local health authority (ASL) planners and the local planning managers for initiatives.

6.2 THE “HOW”: ORDINARY PLANNING, MANAGEMENT OF THE DRUG FIGHTING FUND UNDER LAW 45/99 AND THE CONSTRUCTION OF PUBLIC COMPETITIONS

An initial series of considerations concerns the decision-making processes which form the basis of prevention activities and these determine the methods for allocating resources and also, broadly speaking, the approaches adopted and the contents of the programmes.

Let's start by distinguishing decision-making processes in relation to the financial resources which they bring into play. In regard to drug addiction prevention, decision-makers refer to two types of financial resources: ordinary and extraordinary financing connected to specific laws and, to a lesser extent, occasional financing from particular bodies (e.g.: schools, foundations). Among the ordinary resources we would basically mention the activities and services realised by the staff of the local health authority (ASL), drug addiction departments or services, prevention departments and, secondarily, the maternity and children sector (n.b. family and youth advice centres). We would also mention, among the activities undertaken with ordinary resources, projects on the “promotion of wellbeing” and on non-specific and universal prevention promoted by many local authorities: many Italian town councils, and sometimes also provincial administrations, promote, using their own resources, as part of their youth and childhood policies, prevention projects based, for example, on the development of free time and social activities, local education projects or community development initiatives. Regional decisions connected to the division and priorities for using the FNPS (National Social Policies Fund) and local plans developed on the basis of Law 328/00 can be considered as ordinary and not extraordinary planning tools which also partially involve the prevention of drug addiction.

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Among the extraordinary resources used so far (n.b. in various regions there is a tendency to amalgamate all the specific laws under the FNPS and ordinary planning through Area plans) for the prevention of drug addiction, on the other hand, we would cite some sector-specific laws: the national drug fighting fund under Law 45/99 (managed, depending on the region, by the local health authority or by the town council), Law 285/98 on childhood and adolescence, and some regional laws in favour of young people and minors.

The way in which planning is undertaken and the way in which public competitions are managed also indirectly, and with unexpected outcomes, influences the very contents of planning.

6.2.1 A SOCIAL NETWORK FOR PREVENTION: DEALINGS BETWEEN DEPARTMENTS AND SERVICES WHICH UNDERTAKE PREVENTION INITIATIVES AND HEALTH PROMOTION

The institutional arrangements and rules for access to financing tend to create a network of key players who systematically come into contact and, at the same time, exclude some subjects from particular processes. In addition, the initiatives' systems and organisational and institutional arrangements shape the form and contents of cultural reflection and the related scientific output. The sector of drug addiction prevention responds to such arrangements, as do other sectors in the healthcare and socio-healthcare field.

The underlying strategies used in prevention in the healthcare field are not infinite and policy makers tend, for example, to reuse in their addiction prevention programmes mechanisms which have proved effective in prevention programmes aimed at users of alcohol and illegal substances. The prevention of drug addiction has proven to be a specific sector in terms of the aims and objectives of programmes, but also a field shared between education agencies, institutions and policy sectors (see interaction with areas of damage reduction and treatment, with policies of repressing and controlling drug trafficking, with social policies and town planning policies, with incentives and regulatory measures aimed at regulating demand for or access to legal and illegal substances, etc.) in terms of the need for exchange and interconnection and methodological comparison on health promotion and education strategies.

The results of the survey given in the third chapter have highlighted that one of the factors connected to the success of projects is the presence of explicit strategies for the prevention and reduction of harm at the local health authority level: the probability of adopting methods and approaches based on evidence of effectiveness is higher when the local health authorities take on a managerial role and identify clear strategies.

One strategy involves the detailed determination of a problem (the process of problem-setting), of some macro-objectives and of a coordinated set of tactics to achieve these objectives.

“Strategies guide social actions, although not determining specific means and solutions. The same end (...), at least in the short term, can be achieved by using different and contrasting strategies and it is for this reason that in implementing a project it is necessary to identify carefully the strategies, the underlying philosophy, rather than focus solely on factors such as the objectives”. (Leone, p.64, 1999)

We talk of “cascade” strategies when a local health authority decides to implement initiatives aimed at enhancing the skills of other educational agencies and limits its own prevention activities aimed directly at minors. Again we talk of a strategy when a drug addiction department decides not to dedicate its own resources for counselling activities within the school Consultancy and Information Centres (CICs) and concentrates its activities on “specific” prevention initiatives and on programmes based on life skills.

From the logical and theoretical viewpoint and, not least, for the purposes of effective planning, it would be an excellent idea to plan updates for operators and joint planning, at least to avoid initiatives overlapping in the same place at the same time (see the excessive number of initiatives in some schools) and to optimise the costs connected to institutional communication.

The prevention departments of the local health authority and the drug addiction services or departments, and, to a lesser extent, the family advice centres of the maternity and children sector, undertake projects which are fully part of the policies for drug addiction prevention. They undertake initiatives of promotion and education, the objectives for which also include issues connected to misuse and to problem consumption of various substances. Community and school medical services, also through the establishment of services for health education under managerial staff, undertake awareness-raising initiatives aimed at teachers, doctors and trainers on the issues of

doping, programmes for the prevention of addiction, dietary education, and the responsible use of medicines by the general public and by prescribing doctors.

Nonetheless, it is very unusual for different local health authority departments to compare experiences and only occasionally are integration and coordination envisaged at an organisational level.

Each department and service tends to minimise interactions, for understandable reasons connected to the tendency to specialise in their work, to the need to minimise external restrictions and conditioning and competitive problems related to the access to resources which by definition are increasingly limited.

6.2.2 A REFLECTION ON “SPECIFIC PREVENTION”, HEALTH PROMOTION AND LIFE STYLES

Also at a cultural level there are subdivisions seen in the departmental model on the basis of the organisation of the local health authority: in studies and systematic reviews on the evidence of the effectiveness of prevention, we find a series of segments which reproduce behaviour which is institutionally disposed to action, but which does not necessarily correspond to the needs of regional and local health authority planners nor to knowledge and theoretical needs. As we have been able to observe, one of the limits of various meta-assessments regarding the prevention of drug addiction, is caused by the fact that the selection criterion for studies is largely determined by the characteristics of the substance or behaviour being considered rather than by the underlying strategies and theoretical models. On the other hand, I would once again point out that the theoretical models for prevention initiatives are fairly limited and absolutely agreed on whether we are talking about consumption of alcohol, tobacco, cocaine, poppers, or drugs. Kurt Lewin’s studies regarding the consumption behaviour of families (Ossicini, 1974) and the channels which influenced the purchase by women of some food items such as fresh milk, orange juice, or giblets of chickens during the Second World War in the United States and the attempt to modify such consumption, are, in my view, fully part of health education programmes. Such studies have given us the theoretical bases (n.b. the theory of social balance as almost stationary), to understand how the consumption patterns of the population can be influenced, in order to understand group dynamics, the mechanisms of social pressure and the reasons why particular information sources are more credible and influential than others.

What changes markedly in relation to the various forms of drug addiction is the regulatory system which determines the level of lawfulness of a particular form of behaviour and substances and delimits the characteristics of the intervention system. It should be noted that in some European countries, such as Portugal, but only partially in our own, the services for the treatment and prevention of alcoholism are separate from those for other forms of addiction and that there are different national agencies. In this way there is a tendency to reproduce a false separation between systems which, although dealing with health promotion and the prevention of various forms of addiction, operate on the “legal” or “illegal” side of the fence.

This is probably one of the reasons why, in relation to the abuse of medicines and doping, we see a significant lag both in cultural terms and in terms of the system responsible for the initiatives.

The managers of the drug addiction departments of 11 local health authorities in North Italy involved in a joint meeting(1) expressed their ideas regarding the future role of prevention also in relation to the abuse of legal substances (see drugs life style) such as medicines, psycho-pharmaceuticals and doping substances.

(1) Seminar organised by CEVAS as part of the Religo project on 6-9-05.

Among the managers of drug addiction departments of local health authorities, the idea of prevention understood as health protection and the promotion of wellbeing prevails and is capable of theoretically contemplating within a coherent operating framework and a shared methodology the abuse of both legal and illegal substances. The area in which prevention is included moves from the model of dissuasion and alarmism to that of responsible consumption.

As observed by Gunter Amendt, *“Prevention under the umbrella of acceptance has had to distance itself from the classical arrangement, which implied the ideal of a just and suitable objective (the same people who decide to adopt preventative measures also define the objective of their measures). For this reason giving up the imposition of a style of life is one of the essential conditions for a form of prevention which wishes to distinguish itself from propaganda.”* (Amendt, p.144, 2004).

Except for a minority of young people termed “thrill seekers”, who regard drugs and dangerous sports as the playing out of a risky and suicidal game, most people do not intend to put their own health at risk and they develop self-protective behaviour.

There is awareness among operators that prevention in the drug addiction field should start very early, in early childhood, when we cannot talk of substances which have been voluntarily taken and which create an addiction. Awareness of one’s own health presupposes a knowledge of one’s body which is acquired very early and initially has a significant impact on diet. As seen in the aforementioned text it is unlikely that *“a person who wolfs down what the fast food industry offers, will have many qualms about swallowing a coloured pill”*. (Amendt, p.145, 2004). These different observations reinforce the idea that the prevention of drug addiction cannot allow itself to be separate from a policy of education and health promotion: the ‘specific nature’ of prevention for drugs cannot consist in the fact that the substances which produce addiction are named, but rather derives from the following two factors:

- action is taken to modify the addiction mechanisms and to work on the ability to handle social pressures (n.b. in particular from the media) which induce consumption without adequate awareness;
- it is targeted at those most at risk (see selective and indicated prevention).

Various theories, both sociological and neurobiological, tend to confirm the limited importance of distinguishing between legal and illegal substances in explaining the mechanisms of addiction and the initiation of consumption. However, policies are generally constructed around this distinction and from this there arises a series of segmentations which concern the competences of centrally and locally responsible institutions to handle the various phenomena of addiction and the organisation of these services.

Another contribution in this sense comes from the work of CEDRO, a well-known Dutch institute. Peter Cohen (Cohen, 1998) maintains that the implicit assumptions which underlie most drug addiction policies presuppose that anyone consuming drugs in even small quantities will be led over time to increase their consumption or move on to more dangerous substances. The implicit syllogism ends with the belief that the only road to follow is the oppression of the consumption of illegal substances; this assumption, according to the author, is not applied to legal substances which can produce addiction.

In the author’s opinion, on the other hand, on the basis of the empirical research results, most drug takers manage to control drug use and dosage, maintaining intact their social and personal functions. Therefore, it is recommended to orient programmes on the promotion of means of self-control and self-regulation in the use of drugs instead of on repression and to maintain a critical and watchful approach towards the theoretical assumptions which prove to be anything but universal.

Various managers in the drug addiction sector envisage an intensification of the issue of addiction from legal substances; there is a sense of a delay in particular with regard to the problems of medicinal addiction and doping. They see great contradictions in attitudes in the adult world and the growth of a cultural attitude oriented, also in relation to the sporting performance of minors, systematically to performance mediated by “medicines” (see the incitement to consume vitamins and other substances used to “integrate” normal individual performance).

At the same time there is emerging concern over the huge resources and energies which it would be necessary to invest; there often emerges the need to coordinate with other local health authority services and to involve family doctors to avoid also “the risk of producing locally incoherent and disorientating effects for targets.” There are people who are now starting some initiatives to dialogue with other departments, some who for some years have been trying out cooperation and integration among the various organisations and people, on the other hand, who consider it objectively unrealistic to have dialogue on integration and cooperation between departments and services in the absence of an overall strategy to impact on the resource allocation criteria (n.b. greater ethics) and to define the priorities for the local health authority.

6.2.3 THE FUNCTION OF “DIRECTION” WITHIN THE PLANNING OF SEVERAL SECTOR LAWS AND RISKS OF PROLIFERATION OF “COORDINATION GROUPS”

As we observed in chapters 3 and 4 the degree of overlap between local social policies and social plans and drug addiction prevention financed under Law 45/99 varies significantly from region to region: where the fund has been managed by the local authority health division, the local health authorities have had a dominant role in governing planning, where, vice versa, the Law 45/99 fund together with other funds for laws in the sector, has fallen under the competence of the regional social policies division, the governance role of local administrations has prevailed and consequently the tool of Area plans under Law 328/00 has also prevailed. Some questions which emerged in the seminars held in various local health authorities concern the need to interpret the “direction” function within the planning of several sector laws(2) and to avoid risks of the proliferation of “coordination groups” and the dispersion of energy and resources(3).

Both local managers and contacts from the non-profit sector and directors of local health authority departments have highlighted the need to enhance moments of dialogue between coordinating groups created in different times on the basis of the sector’s laws and Planning Offices set up under Law 328/00.

What solutions have been adopted locally or at a higher district level and what solutions are suggested by those concerned?

In recent years (1998-2004) at a provincial, local health authority or district level a range of coordinating groups has been established on the basis of sector laws (e.g.: Law 45/99, Law 285/97, Regional Law 23/99) and bodies with a role in planning (e.g.: groups dedicated to prevention under drug addiction departments, groups for local coordination under Law 45/99, groups on youth unrest, technical groups on particular themes, etc.). Today a strong demand for dialogue and integration comes from the local territory, both local managers and technical operators have highlighted the need to enhance moments of dialogue among coordination groups created in different eras and Planning Offices created following Law 328/00: “there are too many groups round tables, only carpenters are getting anything out of it!”, “We don’t have the time and resources to take part in all the groups!”

2 In the Region of Lombardy the direction was entrusted up to 2005 to the local health authorities also in regard to Law 328/00

3 We would recall that the healthcare plan for 2002-2004 of the Region of Lombardy raised similar questions. The fact was mentioned that in 2000 alone fully 1,800 projects were approved and financed thanks to specific laws in the healthcare sector and this enabled the achievement of some important results such as the dissemination of initiatives capable of responding to the social needs expressed by the local territory and a culture of planning, and facilitating the “...overcoming of sectoral divisions, through better redefinition of the planning role of institutions and promoting cooperation between institutions and the services sector for the use of resources and skills.”

The same healthcare plan, however, highlights the risks connected to weak local micro-planning from the viewpoint of overall planning strategies. *The planning, which has been realised so far on the basis of specific sector laws, however has some weaknesses represented by the lack of an overall strategy and by the difficulty of governance due to the high number of projects, some of which overlap with the normal activity of the services. The high number of projects, often of a limited size, determines in addition a loss of efficiency owing to the lack of economies of scale and purpose.*”

Some local health authorities in Lombardy, in their recent POFAs (the annual plans for company organisation and operations) have envisaged the establishment of a specific service, under the ASSI Department (e.g.: Brescia local health authority) for the planning and checking of plans and projects financed by Law 328/00 and by different specific laws. The Observatory of the Drug Addiction Department would go to various local health authorities to act from this viewpoint as a technical body to support planning functions for the specific sector of drug addiction.

The training of operators and managers represents one of the soft tools to manage integration processes: various training programmes are underway for the managers of planning offices and coordination meetings have been started in some local health authorities (e.g.: Lecco health authority), chaired by the office management and social services manager, with initiatives on health and prevention education undertaken in schools (see single presentation by the whole local health authority of the health education offer in schools) by various departments and services.

6.2.4 THE ESTABLISHMENT OF PUBLIC COMPETITIONS FOR ACCESS TO EXTRAORDINARY RESOURCES

6.2.4.1 Characteristics of the network of management bodies and links with the contents of the initiatives

We now describe how some restrictions relating to those who have access to resources can have an unexpected influence on the type of measures supported.

We know, for example, that in relation to public competition Law 45/99 the targets of financing are not all partners in the projects and also in the non-profit sector itself there are limitations (e.g.: the accredited bodies, type B social cooperatives, but not all the type A social cooperatives). The fact that lawmakers have indicated some subjects as targets of financing ensures that in planning and negotiating groups and, finally, in the prevention projects themselves, other bodies which could have an important role do not appear at all as partners. In Great Britain for-profit companies and major companies (e.g.: Levis) have been important partners in various cases in drug addiction prevention programmes. In Italy the relationship between for-profit companies, the labour market and the system of services in the field of drug addiction is a little weak and limited largely to nightclubs, discos and leisure facilities.

Lawmakers did not intend to prevent partnerships in the co-planning stage between drug treatment services, local health authority contacts under Law 285/98 on infancy and adolescence, occupational medicine, employers and sector-specific associations, Inail – consider the problem of workplace safety and the connections with the abuse of alcohol or other substances by staff or risks connected to the consumption of cocaine among the professions, such as business managers, surgeons, public transport drivers, financial consultants – yet from analysing hundreds of prevention projects we learn that the limitations placed by lawmakers on access to the resources of a specific law and the type of targets of financing, have been translated into impediments and obstacles which, in various ways, condition partnerships and the contents of initiatives.

6.2.4.2 Equity in access to services and prevention initiatives

Other considerations concern the question of equity: public competitions which determine which projects will have the right to access particular public funds should pay more attention to the issue of equity in access to resources by citizens and targets of a programme by reducing obstacles to access which create disadvantages for the weakest citizens. Local public competitions tend to reproduce and ‘translate’ into good and bad some financing mechanisms typical of the programmes financed by the EU through structural funds.

I have often observed, both in citizen plans under Law 285/98, and in plans and competitions under Law 45/99, some distortions and unexpected outcomes connected to the criteria for allocating resources.

The fact that at the competition stage there are no clearly and transparently envisaged restrictions regarding the specific local context (borough, healthcare district, etc.) where particular actions must be undertaken ensures that the economic resources are more driven by the choices of each implementing body. We are talking about planning “driven by demand from managers”.

If we analyse over 3-5 years the ability to attract economic resources made available under different specific laws and from EU funds, such as the Youth Programme (Leone, 2003), we notice that particular districts, provinces or even more specifically particular councils, are systematically excluded: young people from those areas are therefore heavily disadvantaged in terms of opportunity of access.

This phenomenon occurs systematically and depends on the following two factors.

Local administrations and bodies in the service sector tend to develop know how in relation to the means of planning and the capacity to access public funds, which leads them year after year to increase their competitive advantage. In addition, we would note that the non-profit sector, and in particular social cooperation, is by its very nature strongly rooted locally and that it therefore tends to use its links with local administrations and other institutions (e.g.: schools with engaged and aware teachers and managers who make space available for afternoon activities) and to consequently favour projects where it holds or has access to particular locations, relational networks and space (e.g.: premises for meeting points).

A further undesired effect connected to not envisaging restrictions during planning concerns the 'cut' of the project: it is necessary to set limits not only in relation to the budget destined to each project but also to the budget destined to each priority or action area so as to avoid undesired and unplanned concentrations (Leone, 2003 a).

Although the award mechanism underlying public competitions is also aimed at promoting emulation by administrations which are less capable of attracting funds, there are some conditions linked to the awareness and competence of directors, operators and managers, to previous experience, but also to the size of the local authorities and the ability to network between local authorities and administrations of differing political hues, to geographical conformation, and to the efficiency of transport systems which systematically disadvantage citizens of particular areas.

Sometimes initiatives have been financed which have absorbed an excessive amount of resources in relation to those available for the very reason that the maximum limits were not set in advance in the public competition, or in any case the amounts which it was intended to put towards particular priorities. It is a simple error which can heavily distort the coherence of a project programme. In a concrete case, the first project in terms of ranking, and therefore 100% financed, envisaged prevention initiatives in schools and had absorbed 50% of resources available in that year for the whole local healthcare authority.

We should therefore, in public competitions and during planning, carefully consider the mechanisms which involuntarily reproduce imbalances and inequitable conditions in terms of access to services by supporting, for example, projects to bind implementers to acting in the most disadvantaged areas.

A second problem indirectly connected to the previous one is again the issue of accessibility, but refers this time to the personal and social characteristics of the target.

Planners rarely precisely specify the characteristics of the target they intend the initiatives to be aimed at and often just give general indications connected to the age group and the distinction between non-users or problem users of substances. The issue of analysing needs and determining risk factors is considered an area for the competence and discretion of the individual planners or in any case of those who choose how to direct the individual initiatives. In this way some targets are hard to reach, but are indicated by the sector literature as most at risk, and possible targets of selective and indicated prevention programmes (see ch. 2) are in fact systematically disadvantaged: there are few prevention initiatives, for example, aimed at young offenders, the children of drug-addicted parents and minors who have abandoned schooling and training at an early age.

Universal prevention initiatives, which as we have observed from the results of our research, are those which are most common in the drug addiction prevention sector, cannot, by their very nature, be aimed, for example, at people who have left the school system early (due to early withdrawal from education but more likely due to a low level of schooling). It can be seen that the problem is cross-cutting and that in some provinces in North and North East Italy (e.g.: Mantua), as also in Sicily (e.g.: Enna), for completely different reasons, the lowest percentage levels of education have been recorded (Ministry of Education, 2000 p. 218 and p. 222).

6.2.4.3 Attention to the requirement of the broad partnership

Generally public competitions include among the binding requirements for access to the resources the presence of a structured partnership; it is presumed that the reliability of a proposal and the quality of a project are directly proportional to the breadth and characteristics of the proposing bodies; in addition, a judgement is made of the previous experience in the sector and the financial capacity. It is particularly important that the partnership is mixed, with bodies from the non-profit sector (n.b. present in almost all the prevention initiatives assessed by us in the Religo study) and public bodies.

Of less importance in the assessment stage is the judgment relating to the congruence between the project set-up and the specific resources and know how provided by each player. The quality of the partnership does not depend on how many partners are formally engaged in the presentation stage of the application but, vice versa, on the degree of relevance of the partners involved with regard to the needs of the project and to the skills needed to realise it. The concepts underlying partnerships created specifically to access sector financing tend to guarantee balance, reciprocity of alliances and the stability of the system; professional technical needs are not, therefore, necessarily those which dominate.

The same insistence with which public competitions (n.b. products largely modelled on that proposed in EU financing) favour and reward “networks” and wide partnerships tends to create ‘local monopolies’ among the various organisations in the non-profit sector with obstacles to access and sub-divisions of local areas and areas of competence.

Although the recommendations which have emerged from effectiveness studies on drug addiction prevention support the idea that it is necessary to promote programmes which operate in the local community with a global approach, our research has shown (see Ch. 3) that the results of projects are not connected negatively or positively to the mere presence of more partners.

The broad partnership may at the same time be a key to success but also a disadvantage, since it brings with it an increase in complexity in the management stage, in conflict and in coordination costs. Therefore, it is necessary to reduce in public competitions – and in particular at the assessment stage – the value attributed to the criterion of ‘partnership’ and avoid the partnership being created with the sole purpose of more easily accessing financing.

6.2.5 PROJECTS AS SINGLE ENTITIES OR PROGRAMMES? LIMITS AND SUGGESTIONS FOR AN ADEQUATE ASSESSMENT SYSTEM

The individual prevention project cannot be assessed and understood as if it were a single entity, but it is necessary to include it within the process which gave rise to the project in that particular area, considering a period of time sufficient to understand what has been done in the previous 2-3 years and what has been planned for subsequent years. This is one of the reasons why the assessment of individual projects may respond only partially to assessment requirements such as: “Is the project effective, i.e. does it reduce the likelihood that minors take particular substances or reduce the frequency of consumption? Is there a reduction in negative events for one’s own health or that of others connected to the consumption of particular substances? Does the number of weekend traffic accidents among young people fall?”

To judge the effectiveness of a prevention initiative we must develop assessment plans at district and local health authority level concerning the extent of the initiative, with a duration of at least 2-3 years and which can activate the necessary human and economic resources. If we have a small project, it is preferable to only judge the relevance of the initiative, the logical coherence of the implementation system, the result in terms of productivity and the ability to direct resources at a target which is congruous and coherent with the plan, and a pertinent and correct use of approaches to prevention and of recommendations relating to the evidence of effectiveness offered by the literature.

I always advise reviewing and using better monitoring systems, thus avoiding piles of paper and data which remain completely unused at all administrative levels and risk merely fulfilling information purposes. For individual prevention projects it is preferable to promote small self-assessment exercises and to channel attention to very limited and specific monitoring data at the system level by endlessly promoting publications and public discussions. As is well-known, every performance system within a short period tends to lose the stimulus effect which it might have had initially and develop mechanisms which are to the detriment of the very organisational objectives (n.b. to compile the application form in a way which is more advantageous for me I risk reducing the

effectiveness and efficiency of initiatives), for this reason the electronic diaries and indicators envisaged by monitoring systems should be reviewed at least once every two years.

The relevance of a particular initiative must be understood in the light of what has been done during recent years in a particular area and must be placed within a broader strategy. Let us look at an example to make the issue clearer. Let us imagine that following a public competition the committee asks us, at the assessment stage, whether or not a project should be approved and financed (managed in partnership by drug treatment services and the non-profit sector). The project is worth € 300,000 and in the last two years has organised with great skill and dedication a series of conferences, with the dissemination of brochures and radio broadcasts on the issue of drug addiction. Let us imagine that the project is adequately reported and that the forecast results and assessment methods are clearly set out. Finally, let us imagine that the public competition under Law 45/99 envisages financing 4-5 projects at the local health authority level in the prevention area for an overall value of € 900,000. Since there are no other criteria to comply with, and since it is a project which previously had been well managed, it is likely that it will be refinanced. In my opinion, this would not necessarily be the right choice as it is dictated by a form of planning which leads to focussing attention on some limited contingent aspects. The fact that a project has obtained good results in the past paradoxically must not be a free pass to access future financing. It is necessary to ask: does the fact that a third of resources are destined to a project based on activities which are solely for information purposes, considering the other actions in favour of the same targets in that area and in light of what has been done in the last 3-4 years, respond to the indications and recommendations regarding effective prevention provided by the sector literature? Are we responding with pertinent initiatives, i.e. which are adequate for the problems and needs?

As broadly highlighted in the second chapter, in the paragraph relating to the evidence of the effectiveness of information strategies aimed at the general public and groups, information activities in themselves have not proven to be effective in the prevention of drug addiction. These activities should be included in a balanced way in a broader educational strategy which globally impacts on the local community, the various institutions and the multiple educational agencies.

If, returning to the previous example, in that context informative activities for the general public had already been undertaken, it would have been better to reduce the size of the project and dedicate the limited resources to other initiatives based on strategies to promote education. These errors are naturally all the more likely the more the level of planning moves from the local level (healthcare districts) to the macro level (regions or in the past central ministries) or the more planning is conditioned and oriented to the planning proposals of the various implementing bodies.

When at the public competition stage there is no clear indication of the priorities, targets, project strategies and budgets which it is proportionally intended to allocate to individual target districts and project strategies, then operators and managing bodies are entrusted with planning choices which could lead to unexpected outcomes (n.b. much depends on the quality of the preliminary work of joint discussion and drafting among the various key players in the planning of the project). The sum of the individual projects, although well conducted, is no guarantee of an effective prevention policy; individual initiatives might be redundant, mistakenly directed only at some measures, mutually incoherent, absent in some areas or excessively focussed on particular targets to the detriment of others. Therefore, it is necessary to reason strategically and to strike a balance between planning based on the local area and local equilibrium and guidelines and measures at the local health authority level and higher, and also at regional and national level.

As we have seen from the research results only in half the cases are prevention initiatives placed within the clearer and more specific guidelines of the local health authority. Too often at the stage of selecting and assessing (prior to, during and after) projects, attention is focussed on the individual project, forgetting that it is the broader context and the collection of policies developed in the area which characterise the initiative and ultimately condition the effectiveness of particular actions. Also at the level of the EU and EMCDDA we can observe databanks (see EDDRA) which collect experiences connected to individual projects and pay less attention to mechanisms for drug addiction prevention planning at regional and provincial level. Following the recent changes in our Constitution in a federal sense, it will, however, be increasingly necessary to enhance

dialogue among the regions and the competences for the planning, direction and assessment of prevention policies in the healthcare and social assistance sectors.

Often the assessment does not translate into communication and learning flows which interest and force into reciprocal transparency the various governance levels of the system (Committee of the Drug Addiction Department, Local Coordination Law 45/99, issue-based coordination groups, Project Offices, project body/manager, etc). Although sometimes the assessment is “taught” almost systematically, it is not put into practice or only represents a tool which has a marginal influence on decision-making processes. Therefore, we see the need to enhance support for centralised assessment by reserving to the local health authority or lead local authorities (see districts of Area plans) a share of resources to be dedicated to this end.

In my view, the issue of controlling economic resources is essential and influences the client, the mandate of the assessors and the relevant assessment requirements which can be replied to. There is not just one goal of assessment and it is necessary to better identify the specific details through a third-party assessment, commissioned by a local health authority or local council, and self-assessment managed by the implementing bodies, thus better orienting resources in relation to the aims which must be fulfilled.

6.2.5 IN CONCLUSION TO REINFORCE PLANNING

The prevention sector, and in particular the area of drug addiction, complains of its “residual” position compared to the other priorities of the local health authority and is characterised by some factors which, taken together, risk favouring intervention models which are easy to manage but of reduced or doubtful effectiveness. On the basis of the reflections developed in the chapter I think the need emerges to:

- enhance the intervention strategies at the local health authority level or as part of initiatives (see Area plans) and medium and long-term planning by eliminating the practice of public competitions with 1-year durations;
- enhance the interaction among sectors which are very active in health education and the promotion of minors and young people;
- regulate coalitions and networks by considering the dynamics of competition (focus on the increase in the turnover rate among operators);
- reduce the dependency of prevention activities on extraordinary resources;
- enhance focus on results for users, thus avoiding focussing on output or satisfaction indicators and on the idea of “performance” (e.g.: I finance and control the no. of services of each project or operator engaged in the project).

As we have amply shown in the research (see Chapter 3), there is a positive correlation between the reduced duration of projects, lack of strategies at the local health authority level and the prevalence of initiatives based on information strategies with low or doubtful evidence of effectiveness. These are projects which are easy to manage and which do not require complex coordination processes, but which translate into barely effective initiatives or which risk creating perverse effects (see increase in the interest of young people in relation to some little known substances). We must therefore enhance the planning processes which are, vice versa, connected to forms of initiatives which are considered more effective.

If we do not review on a cyclical basis our theoretical bases, and professional practices are not reviewed on the basis of the evidence of effectiveness (and not on the mere and meaningless satisfaction of targets), there is the risk that the know how accumulated in the sector in the last 15 years will be dispersed or cultural output may be weakened.

In addition, it may be hoped that there is a greater weight of scientific evidence at the planning stage and in defining the guidelines for public competitions and at the planning stage of initiatives. In the sector there is an emerging desire for methodological rigour: it is necessary to take on the task of discouraging and limiting ineffective initiatives and favouring the dissemination of guidelines and lessons taken from the assessments. As for the issue of assessment, in this case too the problem arises of the means deployed to influence the practices

of operators: will a training course be enough, or the dissemination of the main systematic reviews (4) or of guidelines such as those of NIDA, which have long been available in Italian? Will these actions be sufficient or is it necessary in parallel to enhance the economic or organisational restrictions and incentives? What role do the local health authority and the drug addiction department intend to play? It should be noted that in healthcare a significant debate has been ongoing for years (see ISS and ASSR) regarding the difficulties in adopting guidelines on the part of professionals and services.

In the following table we summarise the main points considered in this paragraph in the form of suggestions for planners.

Table 6.1 Summary of recommendations for the planning of prevention

- It is necessary to pay attention to **communication among the various sectors and departments** (see the work groups among the different institutions and bodies) which deal with prevention and health promotion, discomfort, policies for minors and young people and ensure continuity of initiatives throughout the young person's growth and the coherence of initiatives from different education agencies.
- Promote the knowledge and 'use' of **evidence** from scientific literature regarding the effectiveness of different prevention strategies.
- **Elaborate and disseminate ordinary planning tools for medium-term project strategies** at the local health authority and provincial level in the medium and long term, by clearly identifying priorities, expected multiplier effects and connections between different actions, objectives in terms of impacts for targets and not in terms of the offer of initiatives, destination of resources and needs to be responded to.
- **Focus on the choice of criteria to be included in public competitions:** a broad partnership among the public and non-profit sector is no guarantee of success, indicate clearly the amount of the budget which it is intended to allocate in order to determine priority actions, where initiatives must be undertaken and in whose favour.
- **Avoid redundant accounting and monitoring systems** and which are at the risk of distortion and guarantee their periodic review and the **periodic restitution** of all the data.
- Avoid the **excessive proliferation of working groups** in relation to different specific laws and better coordinate with local authorities in relation to the planning and implementation of the Area plans envisaged by framework law no. 328/00.
- **Promote prevention approaches which have proven to be effective** dissuading implementing bodies from the use of approaches with doubtful or non-existent evidence of effectiveness; in the case of testing pilot projects focus on checking the outcomes.
- Develop **continuity between prevention initiatives and damage reduction approaches** and reduction of risks connected to consumption (see indicated prevention aimed at users, even if not drug addicts).
- **Stimulate the adoption and dissemination**, also in the academic field and in training courses for operators, of guidelines and literature connected to the **evidence of effectiveness** in prevention and damage reduction.
- Consider the coherence of local projects and macro-level measures (regional, national): for example, the law connected to regulating the availability and consumption of drugs, alcohol and tobacco.
- Enhance support functions: optimise resources by promoting shared work on **needs analyses** without having to reproduce micro-mapping and partial micro-analysis for each project.
- Optimise resources for assessments by avoiding the vision of the project as a single unit and the cascade distribution of funds and assessment obligations for individual projects: **not everything is assessed but the important requirements are chosen!**
- **Improve monitoring systems**, by reviewing them periodically in compliance with the different demands and different users and preventing them becoming tacit agreements which waste implementers' time and resources in bureaucratic duties which have no real informative purpose and systematically distort information (see greater focus on target).

4 On the CEVAS website (Bibliography) there is a specific section for the assessment of prevention in the drug addiction sector with short summaries and downloads of the main systematic reviews and guidelines http://www.cevas.it/bibliografia_e_link/valutazione_tossicodipendenza/index.htm

- Direct resources to guarantee equal access to services and increase **selective prevention** initiatives for at-risk contexts (see penal circuit services), families and subjects, at-risk targets and areas (disadvantaged areas, higher criminality, etc.).
- **Avoid sporadic actions**, initiatives of less than 18-24 months and planning by individual financial year.
- **Reduce** initiatives based on an **informative approach** and initiatives on individuals: they risk increasing consumption.
- **Reduce the age of the target** (preadolescents aged 10-13).

6.3 THE “WHAT”: EVIDENCE OF EFFECTIVENESS OF PREVENTION INITIATIVES AND THEORETICAL REFERENCE MODELS

6.3.1. USE AND LIMITS OF EVIDENCE: GENERAL INDICATIONS ON THE PREVENTION OF DRUG ADDICTION

In order to adequately use the indications which come from studies and research, it is necessary to understand how to treat the issue of generalisation and define the scope of application and the limits within which particular evidence and indications are valid. It has often been said elsewhere that assessment does not serve to define models of effective public policies which are therefore exportable; what we can export are the ‘lessons’ we learn. Returning to the reasoning proposed by realistic assessment, it is the outcome-context-mechanisms configurations (see ch. 2) which enable us to trace a collection of elements on the basis of which we could presumably find similar results in other contexts with similar characteristics.

Together with its many benefits, one of the widely recognised limits of meta-assessments in both qualitative and quantitative terms (therefore not only systematic reviews), derives from the fact that they tend to ignore and obscure the specific natures of the socio-economic and institutional contexts, and also of the targets and of the means of implementation within which particular outcomes of the programmes may be explained. For this reason it is difficult for policy makers, or also for planners, to use the ‘evidence’, ignoring for example the fact that the United States – the country from which most of the assessment studies come – differs profoundly from Europe in terms of value systems and the regulatory system in force for illegal substances.

Although it is not clearly set out in the studies analysed by us, the prohibition framework is a significant feature of many states in North America and some prevention measures developed locally on consumption, for example on alcohol, would be for a European citizen, and in particular someone from South Europe, considered inopportune and damaging of personal freedom. Vice versa, the laxity regarding the sale of doping substances, over the counter drugs and supplements which exists in the USA, is viewed with concern by our health experts. The evidence collected is the fruit of the political decisions from which the programmes derive, it tells us little or nothing about the possible greater effectiveness of innovative programmes or programmes based on other presuppositions.

Although fully sharing a cautious attitude in the use of indications which come from systematic reviews, and even more so for guidelines, we cannot adopt provincial attitudes based on a “do-it-yourself” philosophy. We must raise the question and force the comparison, thus avoiding a simplistic approach based on the presumption that our contexts, our young people, our policies etc., are so different as to make the results of assessments undertaken elsewhere unusable.

Very many indications regarding whether or not to promote information initiatives in schools, regarding the way to realise peer education initiatives, regarding the characteristics which a message should contain, have been known for many years and should be used by planners. It is necessary to return to the theories and the hypotheses which underlie the action, clarify our own strategies since we can set them out and verify what is obtained in terms of advantages, results and outcomes for targets.

If we analyse the original studies and the different meta-assessments from this viewpoint we can draw some very useful lessons since we can also help the emergence of many issues on which to base future considerations.

6.3.2 RECOMMENDATIONS FOR PLANNERS

From the analysis of the international sources consulted, some cross-cutting or general recurring indications have emerged, albeit in different forms, in different reviews and in different guidelines. We think it opportune to offer a key to understanding and summarise such evidence. To do this we will follow a hypothetical process of planning prevention initiatives, by initially reporting the main indications connected to the needs analysis stage and the identification of the target; indications will then follow in relation to the timeframes for implementation. On the other hand, we do not think it opportune to further summarise the indications which emerged in relation to the evidence of the effectiveness of different strategies and which were set out in the second chapter. The systematic reviews and meta-assessment are in themselves summaries of the outcomes of particular initiatives, a further summary of the summary would completely dilute the salient points and cause the disappearance of factors relating to the conditions in which particular initiatives may be effective.

From the analysis of the results of our research, an issue emerges which concerns, transversally, all local health authorities and all prevention models developed locally. It concerns the limited ability to verify the results and effectiveness of prevention initiatives; at an operational level this risks translating into:

- a) disagreements regarding the choice of models and difficulties in cooperating between groups of operators who differ in their educational provenance, orientation of the organisation they belong to, and professional skills;
- b) limited ability to account for results to the outside world, to citizens and to managers and limited visibility and a weak impact on local policies.

According to the same contacts and coordinators of projects, only in 24% of cases have prevention initiatives and damage reduction proven in their view to be effective in relation to a change in the consumption of drugs by the young targets; in the remaining cases the judgment is negative or there is no data available to express judgments (Religo Assessment research presented in ch. 3). Experience shows that the problem of the inward-looking nature of the services and the limited possibility of demonstrating the effects cannot be resolved simply by teaching operators to “assess” projects better.

It is necessary, on the other hand, also at the planning stage of the individual initiative, to make better use of the indications which come from the studies and assessments of many hundreds of prevention programmes, by adopting methods based on evidence, and thereafter to judge to what extent these indications are correctly used (n.b. the pragmatic approach to quality to which I refer in paragraph of Chapter 3 in relation to the methodology of the assessment research).

To do this it is essential to be familiar, if possible at first hand, with the literature which deals with the issue of evidence of effectiveness, adopting a thoughtful approach and not simply a literal translation of models imported from abroad.

Different studies highlight the fact that whoever deals with prevention should have a very good knowledge of the specific characteristics of the context in which it is intended to intervene, both from the viewpoint of taking substances (see prevalence data, the age of starting to experiment with substances, types of substances), and of characteristics of the targets of future projects (e.g. characteristics connected to gender, age, race, type and level of consumption, and their native culture) and to be able to adopt the appropriate methods to have an impact on the habits of the targets (Hawks, pp. 41- 42, 2002; NIDA 2003). The most effective prevention approaches are those built on the needs of each target (Hawks, p. 41, 2002). It is no coincidence, in fact, that recently the targets of initiatives have become actively involved in the planning and sometimes also in the implementation and assessment of prevention strategies designed for them. The World Health Organisation suggests, for example, either to undertake “background” research to better understand the context in which it is intended to intervene and the characteristics of the target population or to realise “pilot” projects in order to see in advance the level of effectiveness of initiatives (Hawks, p. 42, 2002).

In relation to strategies it is suggested to favour systemic approaches. The effectiveness of prevention initiatives increases when they are included within a broader programme which envisages initiatives over several areas: therefore not only for the individual but also for the family, school and community. Even the simple dissemination of correct information on drugs or on at-risk behaviour, typical of information campaigns, if not

included in a broader strategy which envisages the realisation of initiatives based also on other educational and community based approaches, is ineffective in reducing the consumption of substances (Brounstein et al., pp. 53, 67, 1998; Hawks, p. 48, 2002).

From the viewpoint of managing prevention initiatives, it is necessary to favour active learning methods: it is preferable to adopt methodologies other than lessons or conferences. The learning which is realised through the exchange of ideas and experiences of targets (in relation to substances and their consumption) is a strong point of initiatives, regardless of the type of approach which is used (Hawks, p. 47, p. 53, 2002; NIDA 2003, Brounstein et al., p. 54, 1998). Some studies are reported in the review of the WHO and show that if current prevention programmes used active learning methods, their effectiveness would increase by 8.5% (Hawks, p. 47, 2002). Finally, initiatives should be repeated and above all envisage over time booster sessions. It is not possible to realise only a couple of initiatives at schools, aimed at young people, lasting an hour and a half each and claim to codify this type of prevention as “educational” strategies based on the development of life skills; in fact they are sporadic information-based initiatives which, as we observed previously, have proven to be barely effective or completely ineffective in the field of drug addiction prevention.

Regarding the monitoring of projects it is strongly recommended to focus energy as far as possible on the following points:

- a) monitoring of qualitative characteristics of targets reached by the project;
- b) monitoring of quantitative characteristics of the target.

I have observed many times and in several plans a weakness in monitoring systems regarding this essential aspect: for reasons which are well known to those who operate in healthcare systems some distorting factors intervene between the planner-implementer-target connected to the fact that the targets which are reached are generally those in the most comfortable conditions or, in any case, not those in which the risk factors are found with the greatest intensity. This is one of the intuitions from which drop-in services arise. If we turn to classical prevention initiatives aimed at the parents of pupils, in most cases operators complain about the involvement of some parents who are slightly concerned but certainly not considerable “bearers of risk factors” and the total absence of others who have children with evident problems in the consumption of substances.

In relation to the quantitative element, it is necessary once again to mention the results of the assessment research presented in the third chapter which show that the projects only minimally reach the envisaged target: the situation is even more problematic for those target groups which are not so well covered by the initiatives (n.b. young people aged under 15 and young workers). This apparent incongruence is often seen and is caused by the fact that there are no reward systems to enhance initiatives aimed at hard to reach targets and indeed monitoring and control systems are favoured which frequently include in the “big picture” types of extremely complex initiatives and simpler types of initiative based on information strategies which impact on the general public.

The following suggestions are directed in particular to planners and those who manage projects. They arise in part from the recommendations from the systematic reviews and guidelines on the evidence of the effectiveness of the different approaches and in part from the findings of the assessment research set out in the third chapter. Although they are a follow-on from and coherent with the statements made in relation to planning, the following recommendations focus on the responsibilities for each project.

Table 6.2 Summary of recommendations to plan drug addiction prevention initiatives.

- **Greater orientation of initiatives** in relation to analysing the system of **needs** and the **characteristics of targets: age, sex, race, work experience and consumption.**
- **Greater attention on reaching the target envisaged in quantitative terms** (n.b. in our study only 1/3 of projects reached over 60% of the envisaged target).
- Improve the capacity to **use monitoring and assessments** by reporting the results to the different stakeholders (lenders, project team operators, citizens, partner network).

- **Use approaches which have proven effective** (see evidence based) strengthen laws and attitudes against the use of substances, strengthen life skills, intervene on risk factors and increase protective factors in families, strengthen social links; improve initiatives for **community development and for education promotion (life skills)**.
- Check the potential of **mentoring** and increase **peer education** also in terms of initiatives aimed at highly at-risk targets and damage reduction.
- **Reduce information-based initiatives** and in particular counselling initiatives aimed at individuals.
- Ensure that the initiatives are appropriate in relation to the characteristics of the target (it is hoped to reach): sex, age, social conditions.
- Activate a network with the **health education** sector.
- Consider the social and cultural context and the **consumption models** relating also to legal substances such as medicines and supplements.
- **Increase selective and “indicated” prevention initiatives** in relation to specific risk factors of particular targets and local contexts: e.g. initiatives aimed at young offenders, immigrant children in disadvantaged areas, minors with family members who take drugs, drug takers etc.
- **Intervene early** in the important development stages, in the moments of transition which foretell the subsequent abuse of substances and lower the age of the target (instead of the first years of high school, the last year of primary school and the first year of middle school).
- **Pay attention to involuntary losing sight of the target** which should always be carefully monitored: the initiatives tend to favour less at-risk groups and age groups from 15-20 to the detriment of others.
- Position the initiative by taking account of what has been done previously for that target and in that context and what it is intended to do in order to **strengthen initiatives over time**.